Moving Forward:
The Provincial Diabetes Strategy for
Newfoundland and Labrador

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Canadian Diabetes Association
Newfoundland and Labrador Region
Moving Forward: The Provincial Diabetes Strategy for Newfoundland and Labrador

Vision

All Newfoundlanders and Labradorians affected by diabetes will have access to the supports and resources needed for diabetes prevention and management.

Canadian Diabetes Association
Newfoundland and Labrador Region

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Acknowledgements

(To be included in the final draft)
Executive Summary

The human, social and economic impacts of diabetes on individuals, families and communities are well documented. Diabetes is a significant concern on international, national, provincial, community and household levels. Newfoundland and Labrador has the highest provincial rate of diabetes and the incidence and the number of people who are at risk for diabetes is increasing.

Diabetes impacts many Newfoundlander and Labradorians. It is estimated that more than 30,000 individuals in our province have diabetes and many more are at risk. However, a person living with diabetes does not live in isolation. Individuals with diabetes are part of families, workplaces, schools and communities. Diabetes can have a direct impact on those closest to a person with diabetes such as family members, friends and coworkers. On a broader scale, diabetes indirectly has impact on all individuals in Newfoundland and Labrador as this endocrine disorder has a significant effect on health care and provincial resources.

Moving Forward: The Provincial Diabetes Strategy in Newfoundland and Labrador provides direction to all stakeholders involved with diabetes prevention, management, education and care. This document is meant to serve as a guide for decision-making and advocacy efforts for diabetes in Newfoundland and Labrador. Partners in diabetes efforts include the health, social, academic, non-profit, government and commercial sectors and most importantly, people with diabetes, those at risk, and their families and caregivers. The actions in this strategy reflect what is needed to achieve the strategy vision.

Vision

All Newfoundlander and Labradorians affected by diabetes will have access to the supports and resources needed for diabetes prevention and management.

A number of these actions are already in the planning or implementation stages, particularly the activities which are part of the Provincial Diabetes Collaborative. These efforts are valuable and need to be sustained and enhanced. Additionally, there are actions needed in areas which are not currently being addressed.

The Provincial Diabetes Strategy consists of a number of priority areas recognized as the key areas of focus needed to achieve the strategy vision. The priority areas include:

- prevention and delaying the onset of type 2 diabetes
- screening for diabetes
- management of diabetes and prevention of complications
- treatment of diabetes complications.
These priority areas will be addressed through the following key directions:

- Provide provincial coordination and leadership.
- Ensure diabetes-related health services (public, private and community) meet the needs of those affected by diabetes (those at risk, individuals with diabetes and families and caregivers, and health care providers).
- Enhance diabetes awareness and screening efforts.
- Enhance the resources and capacity of those affected by diabetes (those at risk, individuals with diabetes and their families and caregivers, and health care providers).
- Enhance collaborative partnerships in chronic disease prevention and management and build upon relevant frameworks and strategies.

Key recommendations include:

1. Provincial leadership and coordination of chronic disease, including diabetes, should be formally established, enhanced and sustained by the Department of Health and Community Services.

2. People with diabetes should have timely access to new and appropriate treatment, medications, supplies and devices that can improve their immediate quality of life and diabetes outcomes.

3. Based on evaluation findings, the Provincial Diabetes Collaborative should be expanded province-wide and across the care continuum as part of chronic disease prevention and management initiatives.

4. The capacity of individuals living with diabetes should be enhanced so that they can reduce the incidence of complications and sustain quality of life.

5. The capacity of individuals who are at risk of diabetes should be enhanced so that they can prevent and delay the onset of type 2 diabetes.

6. The capacity of health care providers and organizations should be enhanced so that the needs of individuals with diabetes and those at risk are appropriately addressed.

7. Evidence-informed decision-making should be central to all processes.

Achieving the vision of the strategy is a monumental task. However, there are already partnerships, initiatives, processes and actions occurring which provide a strong foundation of support to move forward so that persons with and at risk for diabetes will have access to the supports and resources needed for diabetes prevention and management. These efforts will improve the health of the people of Newfoundland and Labrador and the overall health of the province.
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Guiding Principles and Assumptions

Moving Forward: The Provincial Diabetes Strategy in Newfoundland and Labrador is directed by guiding principles and assumptions. Guiding principles and assumptions provide the foundation for planning, implementation and evaluation.

“Guiding principles are fundamental assumptions intended to inform and shape decision-making. They reflect the values or principles underlying the approach to a circumstance or situation.”¹ The guiding principles for the provincial diabetes strategy are adapted from the Achieving Health and Wellness: Provincial Wellness Plan for Newfoundland and Labrador and Moving Forward Together: Mobilizing Primary Health Care in Newfoundland and Labrador. The guiding principles are:

- collective and collaborative
- integrated
- evidence-informed
- sustainable
- accountable.

“Planning assumptions are the internal and external factors and/or conditions necessary to achieve the planning objectives. They specify the conditions that must be in place for the plan to be executed and constitute the conditions necessary for the success of the plan.”² The planning assumptions for this strategy are:

- accessible
- person-centered
- population health-based
- an approach which is:
  - intersectoral
  - supported by information management
  - systematic
Introduction

The human, social and economic impacts of diabetes on individuals, families and communities are well documented. Diabetes is a significant concern on international, national, provincial, community and household levels. Newfoundland and Labrador has the highest provincial rate of diabetes and the incidence and the number of people who are at risk for diabetes continues to increase.

Diabetes is considered an epidemic. More than two million Canadians have diabetes and it is estimated that by 2010 this number will increase to three million. Diabetes is of special concern in certain populations including Aboriginal people, children, seniors and those of limited income. The cost of diabetes on the health care system is significant and escalating. It is estimated that diabetes costs the Canadian public approximately five billion dollars annually in health care costs. These costs are projected to increase to approximately eight billion dollars by the year 2016. Provincial costs are projected to increase from $79.4 million to $135.4 million per year in the period 2000-2016. These costs do not include the intangible costs of diabetes such as human suffering or the impact of diabetes on the quality of life of the person with diabetes and their loved ones.

The personal costs of diabetes are significant and include the increased likelihood of complications such as heart disease, stroke, kidney disease, blindness, amputation and erectile dysfunction. In fact, up to 80 per cent of people with diabetes will eventually die of cardiovascular disease, and more than 40 per cent will develop long-term medical complications requiring additional medical care. Four to ten per cent of people with diabetes will develop foot ulcers and 14 to 24 per cent of persons with diabetes and foot ulcers will require amputation. Additionally, between 50 to 70 percent of men with diabetes develop erectile dysfunction. Diabetes is also the leading cause of serious kidney disease and adult-onset blindness. Depression is also twice as common in people with diabetes as in the general population, and major depression is present in at least 15 per cent of people with diabetes.

Did you know?

The World Health Organization estimates diabetes deaths worldwide to be four million per year and that over 177 million people have diabetes. By 2025, this figure will top 300 million.

Pay now or pay later?

It costs approximately $50,000 per year for kidney dialysis for one person with diabetes. It costs about $74,000 for an amputation.
Diabetes is a contributing factor in the deaths of approximately 41,500 Canadians each year. Canadian adults with diabetes are twice as likely to die prematurely, compared to persons without diabetes. For example, a Canadian with diabetes is four times as likely to die at age 35 than a 35-year-old without diabetes. Life expectancy for people with type 1 diabetes may be shortened by as much as 15 years. Life expectancy for people with type 2 diabetes may be shortened by five to 10 years.

The financial burden on the person with diabetes can be enormous and overwhelming. The World Health Organization (WHO) estimates that people with diabetes also have medical expenses that are 2.4 times higher than would be incurred if they did not have diabetes. Estimates show a person with diabetes faces personal medical costs for drugs and medical supplies that are five times higher than the medical costs incurred by a person who does not have diabetes. Direct costs, medication and supplies, can range from $1,000 to $15,000 a year; indirect costs (higher insurance premiums, increased travel costs for diabetes care and education, increased costs for fresh food, child care costs, special footwear, etc.) can increase that cost up to $10,000 a year.

To reduce personal and public costs, diabetes prevention is critical. Type 1 diabetes cannot be prevented yet, but type 2 diabetes can be prevented or the onset of diabetes can be delayed. Healthy eating, physical activity and maintaining a healthy body weight have been the key strategies emphasized to help people reduce the risk of developing type 2 diabetes. Achieving and maintaining optimal glycemic control has been the focus of efforts to prevent diabetes complications in those with diabetes. However, addressing diabetes is more than just the provision of care to those individuals with diabetes and helping individuals reduce their risk for diabetes through lifestyle counselling. Addressing diabetes is also about addressing social inequities and facilitating change on individual, community, regional, and national levels. These changes need to be systematic and include a reorientation of services that addresses which services are provided, by whom, to whom, how and where. Efforts in addressing diabetes are numerous and widespread across Canada, but successes in addressing this epidemic have been limited.

In Newfoundland and Labrador, a coordinated approach to addressing diabetes as part of the Provincial Chronic Disease Prevention and Management (CDPM) Collaborative has been initiated through the primary health care teams in each of the Regional Health Authorities. With direction for both prevention and promotion at the community and service delivery level, this initiative shows great promise and provides a foundation on which to build future efforts and to realize future successes.

Diabetes is a chronic disease that has no cure. Once diagnosed, it can only be managed in order to prevent or delay serious complications. Although great strides can be made in the prevention of type 2 diabetes and the management of diabetes, optimal success will only be realized once diabetes is cured. There
have been significant advances in diabetes management since insulin was discovered in 1921, however the reality of diabetes is challenging for many.

Diabetes directly impacts many Newfoundlanders and Labradorians. It is estimated that more than 30,000 individuals in our province have diabetes and many more are at risk. Key risk factors for diabetes are obesity and physical inactivity. Seventy-one per cent of Newfoundlanders and Labradorians are overweight or obese\(^6\) and fifty-three per cent of Newfoundlanders and Labradorians are not physically active enough for health benefits\(^7\). The implications of not addressing these risk factors in the Newfoundland and Labrador population are enormous.

A person living with diabetes does not live in isolation. Individuals with diabetes are part of families, workplaces, schools and communities. Diabetes can have a direct impact on those closest to a person with diabetes such as family members, friends and coworkers. On a broader scale, diabetes indirectly has impact on all individuals in Newfoundland and Labrador as this endocrine disorder has a significant effect on health care and provincial resources.

Moving Forward: The Provincial Diabetes Strategy in Newfoundland and Labrador provides direction to all stakeholders involved with diabetes prevention, management, education and care. This document is meant to serve as a guide for decision-making and a support for advocacy efforts for diabetes in Newfoundland and Labrador. Partners in diabetes efforts include the health, social, academic, non-profit, government and commercial sectors and most importantly, people with diabetes, those at risk, and their families and caregivers. Collectively, current efforts can be built upon and further successes achieved so that one day all Newfoundlanders and Labradorians affected by diabetes will have access to the supports and resources needed for diabetes prevention and management.
The need to develop a provincial diabetes strategy was identified by the Canadian Diabetes Association (CDA) and the Government of Newfoundland and Labrador. To assist in funding the strategy process, the Department of Health and Community Services committed funding to complement the financial contribution of the Canadian Diabetes Association in the development of a provincial diabetes strategy.

The Canadian Diabetes Association (CDA) is an independently governed charitable organization focused on the needs of people affected by diabetes, committed to excellence, respecting the individual and believing that people are our greatest asset. Our mission is to promote the health of Canadians through diabetes research, education, service and advocacy.

Provincial Diabetes Strategy Advisory Committee
A Provincial Diabetes Strategy Advisory Committee was formed to provide guidance to CDA on the development of a provincial diabetes strategy. Stakeholder representation on this committee includes:

- Aboriginal groups
- Association of Registered Nurses of Newfoundland and Labrador
- Canadian Diabetes Association (Newfoundland and Labrador and Atlantic Regions)
- Consumers
- Diabetes Educator and Clinical and Scientific Sections of CDA
- Dietitians of Canada
- Department of Health and Community Services
- Newfoundland and Labrador Medical Association
- Newfoundland Pharmaceutical Association

To ensure inclusive and appropriate representation from provincial Aboriginal communities and organizations, an Aboriginal Ad Hoc Advisory Committee was formed with a representative from this group sitting on the Provincial Diabetes Strategy Advisory Committee.

General Process
A number of initiatives have been undertaken as part of the diabetes strategy development process including a provincial review of services and a provincial needs assessment targeting consumers, health providers and Regional Health Authorities. In addition, a background paper on diabetes in Newfoundland and Labrador is slated to be released in the Fall of 2006 by the Canadian Diabetes Association, Newfoundland and Labrador Region, and the Newfoundland and Labrador Centre for Health Information.
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Provincial Diabetes Collaborative
In the summer of 2004, the Canadian Diabetes Association, Newfoundland and Labrador Region, was offered the opportunity to partner with the Department of Health and Community Services, Office of Primary Health Care (OPHC), on the Provincial Diabetes Collaborative. Recognizing the value of this initiative to those affected by diabetes, the Provincial Diabetes Strategy Advisory Committee unanimously supported this partnership. The work plan and timelines of the development for the provincial diabetes strategy were changed to reflect the timelines and needs of the Provincial Diabetes Collaborative, a component of the Provincial Chronic Disease Prevention and Management (CDPM) Collaborative.

The Provincial CDPM Collaborative was initiated in the province in 2004. The goal of the collaborative is to plan, implement and evaluate a new and sustainable provincial approach to prevent and manage chronic diseases. This approach is based on relevant clinical practice guidelines, population health, expanded chronic care and quality improvement models, and uses chronic disease prevention and management collaborative teams to deliver health services as part of primary health care. Diabetes was identified as the first chronic disease to be addressed by the CDPM. The Provincial CDPM Working Group was formed, with representation from the Provincial Diabetes Strategy Advisory Committee and other key stakeholders, to act as steering committee for the planning, implementation and evaluation of provincial chronic disease collaboratives, including the Provincial Diabetes Collaborative. As part of the planning process for the Provincial Diabetes Collaborative significant efforts were made to ensure that the components, activities, and tools used were in alignment with standards and clinical guidelines including the Canadian Diabetes Association 2003 Clinical Practice Guidelines for Prevention and Management of Diabetes in Canada. Direction and support for health promotion and wellness was provided, as well as interprofessional development regarding diabetes at both the provincial and primary health care team levels. Additional information about the Provincial Chronic Disease Collaborative is located in Appendix A.

Other Provincial Initiatives
In addition to the Provincial Diabetes Collaborative, there are a number of initiatives which support the Provincial Diabetes Strategy including the provincial Wellness Plan, the provincial Poverty Reduction Strategy, the provincial Healthy Aging Strategy, the Provincial Food and Nutrition Framework and the Regaining Our Health, the provincial physical activity strategy. Additionally, provincial implementation of the federally-funded Aboriginal Diabetes Initiative is occurring in a number of Aboriginal communities in Newfoundland and Labrador.

The Canadian Diabetes Association provides support to health care providers through the Clinical and Scientific and Diabetes Educator Sections of CDA. These sections are actively involved in continuing professional education, clinical practice guideline and standard development and the provision of current professional and consumer resources. CDA provides public education through
programs, such as the Signature Program and Diabetes Expo/Symposium and enhanced programs such as a provincial diabetes camping program offered annually to children with type 1 diabetes. Information about diabetes is available to the public through CDA’s website (www.diabetes.ca) and regional resource centres. CDA also has advocacy committees in place on national and regional levels. Other non-profit organizations are also involved in activities which contribute to provincial diabetes prevention and management efforts in areas such as healthy eating, physical activity, smoking cessation, stress management, the promotion of healthy weight, food security and social inequities.

A number of these actions are already in the planning or implementation stages, including a number of activities which are part of the Provincial Diabetes Collaborative. These initiatives are valuable and need to be sustained and enhanced. Additionally, there are actions needed in areas which are not currently being addressed. Enhanced provincial coordination of diabetes efforts and collaborative partnerships will provide an opportunity to address these areas.
Key Priorities Areas and Population Groups

Key Priorities
The key priorities for the strategy reflect the continuum of diabetes and are in alignment with the Canadian Diabetes Association’s key areas of focus. These priority areas are as follows:

**Prevention and delaying the onset of diabetes**
Type 1 diabetes cannot be prevented yet. Type 2 diabetes can be delayed or prevented though the reduction of modifiable risk factors including obesity, physical inactivity, stress, unhealthy eating and poverty. Actions need to occur all on levels, federally, provincially, regionally and in communities where people live, work, learn and play.

**Screening for diabetes**
According to the 2003 Canadian Diabetes Association Clinical Practice Guidelines for the Prevention and Management of Diabetes in Canada, all individuals should be evaluated annually for type 2 diabetes risk and all adults, 40 years of age and older, should be screened for diabetes every three years. Earlier and more frequent screening should occur in people with additional risk factors. Screening for modifiable risk factors is important to assist individuals in making informed decisions to reduce their risk of diabetes. Early detection of diabetes is critical so that individuals can reduce their risk of having life-altering and costly complications.

**Management of diabetes and prevention of complications**
Effective diabetes management is critical to the prevention of diabetes complications and to quality of life. People with diabetes, their families and caregivers typically need considerable support to manage this disease which can impact on every area of life.

**Treatment of diabetes complications**
Individuals with diabetes complications including those which effect the heart, eyes, kidneys and nervous and circulatory systems need specialized care in order to delay the progression of complications and assist individuals, families and caregivers with quality of life issues.
Priority Population Groups
The priority population groups include:

Children
The prevalence of type 2 diabetes in children is increasing and children are being diagnosed at younger ages. Obesity and inactivity are the primary reasons for these occurrences. Thirty-six percent of Newfoundland and Labrador children between the ages of two and seventeen are overweight or obese. In addition to being at risk for diabetes as children, obese children are at a greater risk for obesity and diabetes in adulthood.

In regards to type 1 diabetes, children in the Avalon Peninsula have the highest rate of diabetes incidence in North America and one of the highest rates worldwide. Proposed causes include genetic and environmental factors.

Seniors
The incidence of chronic disease increases with age. In fact, more than 92 per cent of Newfoundlanders and Labradorians aged sixty-five and older report at least one chronic disease condition. Twenty-one per cent of seniors in the province reported being diagnosed with diabetes in 2002/2003 compared to 12 per cent of the Canadian senior population. Prevalence is expected to increase with an aging population and it is expected that aged 65 and older will make up 13.5 per cent of the provincial population by the year 2006 and 26 per cent by the year 2026.

Women who are pregnant or planning to become pregnant
Pregnancy is a time of promise and expectation, but it can also raise the possibility for some women that they will develop gestational diabetes mellitus (GDM). Approximately 3.5% of non-Aboriginal women, and up to 18 per cent of Aboriginal women will develop GDM.

Prompt diagnosis of GDM is important, as it carries several risks to both mother and infant. For example, children born to mothers with GDM may be macrosomic. This poses a risk of trauma to both mother and baby during the delivery. Macrosomic babies have a higher risk of hypoglycemia after birth as well as severe breathing problems. They are also at higher risk for potential long-term obesity and glucose intolerance.

Women with diabetes who wish to become pregnant should have pre-pregnancy counselling as well as close follow up by a specialized health team during pregnancy to promote optimal outcomes.
People experiencing social inequities
Social inequity is a risk factor for chronic disease as well as having an impact on the management of chronic diseases, such as diabetes. Inequity is an incidence of unfairness or injustice. Social inequities, in relation to health, occur when individuals have different outcomes in health as a result of being treated differently from other individuals as a result of economic and social decisions made by society and not by the individual. As an example, a person can choose not to smoke, but cannot change the minimum wage or the fact that they were born to poor parents.

A result of social inequities is social exclusion. Social exclusion occurs when an individual is unable to participate fully in society and life. This exclusion typically occurs as a result of socioeconomic or psychosocial situations and is impacted by factors such as poverty, employment and education. Social exclusion includes material deprivation, lack of participation in common social activities and exclusion from decision-making and civic participation. This in turn leads to material deprivation, excessive psychosocial stress and unhealthy behaviours which are often as a means of coping. Limited financial resources, stress and unhealthy behaviours all place an individual at increased risk for chronic disease.

Poverty is the primary reason for social inequity, impacts health and is a risk factor for chronic disease development. The association with type 2 diabetes and poverty has been documented and poverty is one of the strongest predictors of heart disease and a major cause of cardiovascular disease in Canada. In addition, not having the means to achieve and sustain good health as a result of low income causes feelings of uncertainty, insecurity and a lack of control over one’s lives which impact health significantly.

Social inequity is highlighted in this strategy as it is deemed of great importance in the prevention and management of diabetes and has been an area of focus for the Provincial Diabetes Strategy development efforts and the Provincial Diabetes Collaborative implementation.
Partnerships

Partnerships are integral to the success of any initiative. Due to the complexity of diabetes which affects all age groups and is impacted by many diverse variables, there are many partners. These partners include:

- People with diabetes, those at risk, and their families and caregivers
- Governments: federal, provincial/territorial and municipal
- Regional Health Authorities, including primary health care teams/collaboratives
- Aboriginal groups and communities
- Health care providers and their professional associations
- Other chronic disease organizations and NGOs
- Academic and educational facilities
- Community groups
- Communities
- Industry

The responsibility for these actions lies with the strategy partners. Each of these partners has a role to play in the successful realization of the strategy vision. These roles vary as does the responsibility for the strategy actions. In many cases, the accountability for these actions belongs to the Provincial Government or to CDA, however collectively all partners play a role.

The partnership of the Canadian Diabetes Association, Newfoundland and Labrador Region, and the Department of Health and Community Services, Office of Primary Health Care, on the development of the provincial diabetes strategy and the Provincial Diabetes Collaborative provides a strong foundation for future efforts and partnerships in chronic disease prevention and management. Other partners have been involved in the development of both initiatives and have contributed greatly to the successes realized to date.
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Key Directions with Actions

Key Direction One:
Provide provincial coordination and leadership

Diabetes is a complex disease and to effectively deal with this epidemic, provincial coordination and leadership is critical. The prevention and management of diabetes involves many stakeholders from different sectors. Ongoing communication between these stakeholders and sectors is critical to ensure that duplicate efforts are not occurring and that beneficial partnerships can be forged and maintained.

Health services need to be oriented so that basic diabetes services are available on a community level and referrals to health care providers; including diabetes health educators, physicians and specialists; occur in a manner which allows the best utilization of expertise and fiscal and human resources.

Research continually necessitates the need to update diabetes services. To provide efficient and effective services, health care providers and health teams need access to up-to-date information, support and training. Keeping current on new research and trends is a time consuming process and one which challenges health care providers, whose time is often already overtaxed in providing care. Knowledge transfer opportunities which provide valid information about diabetes are essential.

To properly evaluate how diabetes services are progressing in the province, information is needed about the population served, the services provided, client outcomes, as well as the needs of the providers. Comprehensive data which is useful and meaningful needs to be available and should serve as the foundation for evidence-informed decision-making on all levels.

People with diabetes, and their families and caregivers, need information to properly self-manage diabetes and its complications. Information needs to be relevant, accurate and consistent in all areas of the province. In addition, the internet contains a significant amount of information about diabetes, but it can be a challenge to discern the facts from the fallacies.

People affected by diabetes need to be heard. An avenue is needed to voice suggestions and concerns regarding diabetes care and gaps in service and to advocate for improvement.

Provincial coordination and leadership is a means to improve the provision of effective and efficient services which meets the needs and enhances the lives of persons with and at risk for diabetes. Additionally, provincial coordination is a means to reduce the duplication of services, to enhance the effectiveness of services provided as well as reduce the overall financial burden of diabetes to the province. These efforts should
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occur as part of provincial chronic disease initiatives, however the significance of the diabetes epidemic and the complexity of the disease requires dedicated provincial diabetes coordination and leadership.

Current Status
Provincial coordination and leadership for diabetes in the province has been visible, but limited. CDA provides leadership to health care providers through the Clinical and Scientific and Diabetes Educator Sections. These sections are actively involved in continuing professional education, clinical practice guideline and standard development and the provision of current professional and consumer resources. CDA provides leadership in public education and awareness through programs (e.g. Signature Program, Diabetes Expo/Symposium, provincial diabetes camping program).

At the Department of Health and Community Services, provincial coordination of lifestyle modifiable risk factors for chronic disease; such as healthy eating, physical activity and stress; is addressed primarily through the Health Promotion and Wellness Division. The Provincial Wellness Plan addresses healthy eating, physical activity, tobacco control, injury prevention, mental health promotion, environmental health, child and youth development and health protection. Provincial coordination for the reduction of modifiable risk factors will occur through the implementation of initiatives such as the Healthy Students, Healthy Schools and the Provincial Food and Nutrition Framework and Action Plan. In addition, various Department of Health and Community Services representatives participate in national diabetes committees. However, there is not a provincial position dedicated to diabetes, as there is in other provinces. Since January 2005, there has been provincial leadership for chronic disease prevention and management under the direction of the Office of Primary Health Care (OPHC). Leadership has been provided to the primary health care areas by the OPHC personnel through a variety of activities and services, including education and support in the areas of team development and scope of practice.

A Provincial Diabetes Collaborative was rolled out in 2005 in eight primary health care areas in the province as part of the Provincial CDPM Collaborative. This initiative is a partnership between the OPHC and CDA. The goal of the collaborative is to plan, implement and evaluate a new and sustainable provincial approach to prevent and manage diabetes. The collaborative is based on relevant clinical practice guidelines and uses chronic disease prevention and management collaborative teams to deliver health services as part of primary health care. As a result of the collaborative, there has been measurable change at the primary health care area level which has involved how services link and how resources, including health care providers, are used in diabetes care delivery. In addition to the focus on diabetes management, diabetes prevention efforts have occurred as well through linkages with health promotion and wellness teams.

In support of health care providers involved in the collaborative, a Provincial Diabetes Collaborative Toolkit was developed which includes an array of professional and
consumer tools. As part of the development of the toolkit, a review of diabetes services was conducted to determine what tools were being used for diabetes management in the province. The results of this review indicate that there was little consistency in the tools being used in the province. An evaluation of the toolkit is scheduled for September 2006.

As part of the collaborative, a provincial electronic clinical data base has been initiated in cooperation with the regions and is being supported by the Eastern Health Authority Information Management. This data base will provide information at the individual client, provider, PHC team, regional and provincial levels to support both clinical and service planning/decision-making. Other diabetes-related data is collected through various surveys and surveillance activities, and housed in the Newfoundland and Labrador Centre for Health Information. Research on diabetes is ongoing in the province; however there is no provincial coordination of these efforts. There has been efforts to identify research areas and funding sources in chronic disease research related to primary health care, but an ongoing process of identifying areas of diabetes related-research is lacking.

The Provincial Diabetes Strategy Advisory Committee has provided leadership and worked collaboratively with the Office of Primary Health Care and the Provincial CDPM Group on the development of the Provincial Diabetes Strategy and the Provincial Diabetes Collaborative.

The intent of the Provincial Diabetes Collaborative is to expand this initiative to all areas in the province; how this initiative will move forward within the Department of Health and Community services has not yet been detailed. Currently, an extensive evaluation process is occurring. The results of the evaluation will provide additional insights on how to implement this collaborative across the entire province.

**Recommended Actions**

1.1. Formalize and sustain provincial coordination and leadership through a Department of Health and Community Services’ position dedicated to diabetes prevention and management.

1.2. A central information center which allows all people living and working with diabetes access to current recommendations, guidelines, best practices and research should be developed, implemented and evaluated with leadership by the Department of Health and Community Services and CDA.

1.3. Through leadership of the Department of Health and Community Services and based on evaluation findings from the Diabetes Collaborative, recommendations for interprofessional diabetes care delivery in the province should be further developed and implemented.
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1.4. The Department of Health and Community Services should evaluate, revise, broadly implement and ensure sustainability of the Provincial Diabetes Collaborative Toolkit and ensure that this resource continues to be based on national clinical practice guidelines and standards.

1.5. All relevant stakeholders involved in diabetes health care delivery should examine the services provided and seek ways to provide more efficient, effective services and to enhance linkages between services.

1.6. The Provincial Government, in partnership with the Newfoundland and Labrador Centre for Health information and as part of the collaborative process, should identify, integrate and expand provincial data collection systems related to persons with diabetes, those at risk, and associated services and meaningful data should be available to providers and policy makers.

1.7. All stakeholders and partners should seek ways to promote diabetes qualitative and quantitative research in all aspects of diabetes prevention and management. To coordinate these efforts the Provincial Government should establish a data base of current diabetes-related research and distribute on an ongoing basis to health care providers.

1.8. The Canadian Diabetes Association should continue to provide a mechanism whereby health care providers and those with diabetes, those at risk, and their families and caregivers can voice suggestions and concerns regarding diabetes care and gaps in service and advocate for improvement.

1.9. The Provincial Diabetes Strategy Advisory Committee should provide leadership and guidance in the development, implementation and evaluation of the Provincial Diabetes Strategy through the support of the Provincial Government and in collaboration with the Provincial Chronic Disease Prevention and Management Working Group.
Key Direction Two:

Ensure diabetes-related health services (public, private and community) meet the needs of those affected by diabetes (those at risk, individuals with diabetes and families and caregivers, and health care providers).

Matching the needs of individuals and families with health services is an ongoing challenge for all health care providers, health-focused organizations and Regional Health Authorities. The traditional provision of diabetes care and efforts to prevent diabetes through lifestyle modification have shown limited success. Additionally, the complexity of diabetes requires the services of many health care providers, each whom has different skills sets and knowledge. Matching the health care provider with the needs of the person with diabetes or at risk is an essential component of effective utilization of services. As part of this process, health care providers’ scope of practices and professional development needs must be reviewed.

It is becoming increasingly recognized that a new model of care is needed for chronic disease and diabetes prevention and management. Central to this new model of care is a reorientation of health services which allows effective and efficient care to be provided by the appropriate health care provider and utilizes the expertise of a team.

Current Status
The Provincial Diabetes Collaborative is a reorientation of health services and is currently occurring in eight primary health care areas in the province with six more areas under development. The intent is that the experiences and results of this innovative process as well as the formal evaluation of the work to date will be used to further refine and implement a provincial diabetes care delivery model.

Consultation with health care providers and Regional Health Authorities is an integral part of the collaborative process and has occurred through the development, implementation and evaluation of the collaborative. At a provincial level, consultation has occurred through the interprofessional working group which includes key representatives from various health care professional associations and professions.

Health care professional education is a key component of the collaborative model. All primary health care teams have participated in the CDA Practical Diabetes Management Program. All primary health care teams and other stakeholders, have also participated in three two-day collaborative learning sessions. In addition, all primary health care teams have participated in a provincially relevant evidence-informed education program highlighting the potential impact of adherence to the clinical practice guidelines.

Dialogue with health care providers as well as the use of the Diabetes Collaborative Flow Sheet has highlighted the need for improved referral processes to meet the standards of care dictated by clinical practice guidelines. A means to examine the
health care provider referral process is recognized as an important piece to ensure the provision of efficient and effective services.

**Recommended Actions**

2.1. With the support of the Provincial Government and the Regional Health Authorities, and through the work of the Provincial Diabetes Collaborative, further develop, refine, implement and evaluate a provincial diabetes care delivery model which utilizes health care providers’ expertise and training to deliver effective and efficient care which:

- meets clinical practice guidelines.
- is in alignment with the Standards for Diabetes Education in Canada.
- meets the needs of those affected by diabetes.
- reaches those in remote and rural areas.
- ensures that individuals have reasonable access (e.g. close to home, in the community, in the home if needed).
- reorients diabetes services so that health provider expertise is aligned with consumer need
- addresses barriers to access (e.g. transportation, finances, literacy etc.).

2.1.1. Consultation with Regional Health Authorities, relevant health care providers and their respective professional associations concerning diabetes-related health services through committee work and dialogue should be continued as part of the collaborative process.

2.1.2. The review and consideration of various health professionals’ scopes of practice should continue as part of the collaborative.

2.1.3. The Department of Health and Community Services, in partnership with Regional Health Authorities and CDA, should review the additional training requirements needed to deliver the various components of diabetes care. Consideration should be given to programs which assist health care providers in achieving and maintaining expertise, such as the Canadian Diabetes Educator Board Certification process and distance education opportunities should be continued as part of the collaborative.

2.1.4. The review and revision of existing referral processes for diabetes health services should occur at both the provincial and regional levels as part of the Provincial Diabetes Collaborative and in collaboration with Regional Health Authorities.
Key Direction Three:

Enhance diabetes awareness and screening efforts

An important part of effectively managing diabetes and preventing type 2 diabetes is awareness. People need to be able to make informed decisions about their own health, and their family’s health. They need to know what are the risk factors for type 2 diabetes, how to prevent type 2 diabetes or delay the onset and should have the opportunity to be screened for modifiable risk factors.

In addition, individuals, groups, organizations and decision-makers in all levels of government need information about the realities of diabetes to make informed decisions. Supportive environments for people affected by diabetes are enhanced if family members, neighbors, co-workers and community members have a better understanding of diabetes and the associated challenges.

Awareness of diabetes screening is also important. Approximately one-third of the people with diabetes are unaware that they have diabetes. Unfortunately, some individuals find out that they have diabetes when they are diagnosed with the complications of diabetes, such as a heart attack or kidney disease. However, if diabetes is diagnosed early, costly and often life-altering complications can be prevented or delayed.

Current Status
Currently, there is no provincial diabetes screening program in place. There has been an increased emphasis on screening in the primary health care team areas as part of the Provincial Diabetes Collaborative. Conne River, through the Conne River Community Diabetes Program, conducts a community-wide screening for age ten years old and greater on an ongoing basis. The Canadian Diabetes Association holds media campaigns targeting diabetes screening. Regional Health Authorities initiatives often involve the promotion of diabetes screening, especially during diabetes month.

Regional Health Authorities offer programs, such as lifestyle clinics, which assist individuals in the screening and addressing of modifiable risk factors for chronic disease. The awareness of addressing modifiable risk factors has also been raised through the activities of the Provincial Diabetes Collaborative and the Regional Wellness Coalitions. The Provincial Wellness Plan includes numerous efforts which promote the awareness of chronic disease prevention, specifically in the area of healthy eating and physical activity. The PHC team areas and their Community Advisory Committees have been involved in health promotion and wellness activities (e.g. healthy eating school initiatives).

Awareness of the importance of addressing diabetes has been increased through the work of a number of provincial initiatives. Learning sessions held as part of the Provincial Diabetes Collaborative raised the profile of the community and personal
issues affecting persons living with diabetes and highlighted strategies to address some of these challenges. A number of the Canadian Diabetes Association activities including diabetes awareness campaigns, Expos/Symposia and advocacy initiatives raise public awareness of diabetes.

**Recommended Actions**

3.1. The Department of Health and Community Services, in collaboration with CDA and the Regional Health Authorities, should develop, implement, resource and evaluate a provincial diabetes screening program for all appropriate age groups which:
- is based on clinical practice guidelines.
- is in alignment with the Canadian Diabetes Association Standards for Diabetes Education in Canada.
- includes components for screening for diabetes and for modifiable risk factors.
- considers lessons learned from diabetes prevention programs already in place, including Aboriginal initiatives.
- builds upon supports already in place and under revision such as the regional Lifestyle Clinics and Regional Wellness Coalition activities.

3.2. Stakeholders, with leadership from the Provincial Government and CDA, should enhance awareness and educational activities on societal, system, community, family and individual levels which:
- are in collaboration with other related activities, including provincial wellness and primary health care initiatives.
- targets children through community activities and school programs including the promotion of the Healthy Students Healthy Schools initiatives.
- considers educational activities and programs specific to Aboriginal people in partnership with the Aboriginal Diabetes Initiative.
- seeks ways to reach the senior population including the promotion of relevant aspects of the provincial Healthy Aging Strategy.
- targets other “at risk” groups, including women who have had gestational diabetes.

3.3. CDA, with media support, should inform decision-makers of the impact of diabetes on provincial, regional, municipal and personal levels through:
- highlighting the future costs to the health care system should this epidemic not be addressed.
- bringing the real picture of living with diabetes to life by engaging and enabling those affected by diabetes (CDA champions) to tell their “stories”.
- profiling the relationship between social inequities and chronic disease.
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3.4. CDA, in partnership with the Provincial Government and the Regional Health Authorities, should develop and implement a social marketing campaign to help the public to better understand diabetes, the different types of diabetes, the associated challenges and the available supports and resources.
Key Direction Four:

Enhance the resources and capacity of those affected by diabetes (those at risk, individuals with diabetes and their families and caregivers, and health care providers)

To have the best outcomes possible, people with diabetes and their families and caregivers need support on many levels. Financial support is often needed, especially to cover the cost of healthy eating and the costs of diabetes-related medications, supplies and devices. The 2005 CDA Diabetes Report confirms that Newfoundland and Labrador remains the most expensive province for individuals and families to manage diabetes. Ideally, where a person lives in Canada should not impact on diabetes-related outcomes and quality of life.

Emotional support is necessary to cope with the impact of dealing with a chronic disease, especially one as complex as diabetes. Many people with diabetes need emotional support on some level to cope. This scenario is especially true of children, teens and their families who often face significant challenges in dealing with diabetes.

People with diabetes need to have the skills and knowledge to self manage their disease. Some people can learn these skills and gain the necessary knowledge on their own. However, many people need the services of health care providers, who must also be well versed in diabetes education, management and care. This skill and knowledge acquisition needs to occur during health care provider training and continue once the health care professionals are working in their respective fields. Having consumers and health care providers who are well-informed allows health provider expertise to be aligned with consumer need.

In addition to education and skills development, people with diabetes need to be able to access information to deal with different situations, such as shift work, travel and illness as well as different life stages, such as pregnancy. As well as information, supportive environments are needed where people live, learn, work and play. To create and sustain these environments, healthy public policy development is often needed.

Community groups and organizations involved are often the driving force behind the creation of healthy public policy. Connecting groups with each other and proving opportunities to explore collaborative opportunities is important.

Current Status
There are some supports in place and initiatives in the planning and the implementation stages to enhance the resources and capacity of those affected by diabetes. One area which is currently receiving attention is diabetes-related medication, devices and supplies. Recent changes to the Newfoundland and Labrador Prescription Drug Program, as part of the Poverty Reduction Strategy, show great promise and are steps in the right direction. More efforts in this area are needed so that people with diabetes...
will never have to choose between diabetes supplies and basic living needs, such as
food or housing. It is also important that people with diabetes are aware of the various
financial opportunities which may be available. Although this information is often
provided to people by CDA as well as health care providers as part of diabetes
education, management and care, a standard means of providing updated information
is needed.

In addition to accessing information about financial support, people with diabetes
currently access diabetes information and skill development from a variety of health
care providers, such as those in the Regional Health Authorities, Aboriginal
communities and primary health care teams as well as through CDA programs. These
services are beneficial, but need to be more far-reaching in the province so that all
people have access, especially in the area of self-management.

Emotional support is also important. Primary health care teams include a variety of
health care providers who have mental health and counselling skills as do the other
diabetes teams in the Regional Health Authorities. These services are often dedicated
to individuals who need support with specific issues, although some diabetes services
do have mental health counselling as an integral component of services.

Self-management is a focus of the Provincial Diabetes Collaborative. Both the
Provincial Diabetes Collaborative Toolkit and the flow sheet promote self-management.
Primary health care teams now incorporate the diabetes flow sheet and the diabetes
toolkit into clinical services and education. In addition, self-management was the focus
of one of the provincial learning sessions.

Health provider education is important. The provision of diabetes-related health care
provider education occurs in the province through a variety of avenues. Diabetes
educators participate in and attend regional, provincial and national workshops and
conferences, including the CDA’ national professional conference and the Diabetes
Educator Section (DES) provincial workshop. Physicians access continuing education
through a variety of venues, including the participation in the Canadian Diabetes
Association Practical Diabetes Management Program. Education for professionals has
been provided by through the Diabetes Collaborative at both the provincial and PHC
team area levels. Professional association workshops and Regional Wellness
Coalitions provide opportunities for learning in the areas of chronic disease prevention.
However, the increasing breadth of diabetes knowledge and the increasing number of
health care providers involved with diabetes requires additional cost-effective
approaches which can reach more health care providers in all areas of the province,
such as telehealth. The province is currently implementing a Provincial Telehealth Plan
which embraces chronic disease prevention and management as a core program.
Additionally, the Centre for Collaborative Health Professional Education is currently
developing interprofessional education programs at the pre and post-licensure levels.
Significant efforts are needed to ensure that professional development initiatives keep
pace with the increasing rate at which knowledge, best practices, standards and guidelines which are being continually updated.

In addition to an individual focus, there have been significant efforts in recent years to provide opportunities for networking and collaboration. Through initiatives as part of the Provincial Wellness Plan, the Poverty Reduction Strategy and the Provincial Diabetes Collaborative, community groups and organizations have come together to discuss ideas and to explore partnerships. Healthy public policy has also been developed as part of current initiatives and provides a foundation on which to build diabetes-related health public policy.

**Recommended Actions**

4.1. Improved access to appropriate diabetes-related medications, supplies and devices should occur through enhancement to the Newfoundland and Labrador Prescription Drug Program (NLPDP) and with advocacy for enhanced private and group insurance coverage.

4.2. Through the further implementation of the Provincial Diabetes Collaborative, self-management of people with diabetes should be enhanced by providing general diabetes information, client-specific information and support to individuals and their families and caregivers.

4.3. The Regional Health Authorities and all other relevant stakeholders should ensure that people with diabetes and their families and caregivers have opportunities to seek emotional support as needed and on an ongoing basis through avenues such as counselling, support groups and an emphasis on mental health as part of the provision of diabetes care.

4.4. CDA should take the lead to ensure that people with diabetes and their families and caregivers are aware of the financial assistance opportunities available.

4.5. The Provincial Government and other relevant stakeholders should continue to identify and address the challenges which people with diabetes and their families and caregivers face in achieving appropriate diabetes control and achieving a reasonable quality of life, including the financial challenges.

4.6. All relevant stakeholders should collaborate with provincial, regional and community programs which target women who are pregnant or planning pregnancy.
4.7. All relevant stakeholders, with the Provincial Government, Regional Health Authorities and CDA serving as leads, should promote and further enhance linkages between community groups involved in diabetes-related activities which contribute to the development and maintenance of supportive environments.

4.8. Relevant stakeholders should ensure that provincial health provider educational programs adequately address diabetes as part of the curriculum.

4.9. The Department of Health and Community Services, in collaboration with CDA and the Regional Health Authorities, should provide diabetes learning sessions and enhance continuing education opportunities for health care providers; explore ways to reach as many health care providers as possible through means such as web-based technology which provides current recommendations and best practice.

4.10. The continuation of the investigation and incorporation of alternate methods of delivery of health information and education including telehealth should occur by all stakeholders with the leadership of the Department of Health and Community Services and CDA.

4.11. All stakeholders should promote diabetes-related healthy public policy where those at risk and people with diabetes learn, work, live and play.
Key Direction Five:

Enhance collaborative partnerships in chronic disease prevention and management and build upon relevant frameworks and strategies

The prevention and management of chronic disease has been the focus of a number of initiatives across Canada and within the province. The Provincial Diabetes Strategy is not intended to be a composite of solely new actions and the identification of partnerships which need to occur. Instead, the strategy builds upon initiatives in development and implementation as well as current partnerships. Collaborative partnerships are at the core of any successful initiative and have been the key to the successes of the diabetes strategy process, the Provincial Diabetes Collaborative and chronic disease prevention and management initiatives. As part of these processes, the areas of diabetes prevention and management which are not currently receiving attention have been identified.

Current Status
The Provincial Government has a number of strategies in varying stages of progress including the Provincial Wellness Plan, the Healthy Aging Strategy, Poverty Reduction Strategy, the Provincial Diabetes Collaborative, the provincial physical activity strategy and the provincial Food and Nutrition Framework and Action Plan. There are also a number of strategies occurring and in development on federal, regional and community levels.

Recommended Actions

5.1. Stakeholders should collaborate with relevant components of the Provincial Wellness Plan and the Provincial Diabetes Collaborative, including partnerships with Regional Wellness Coalitions and the PHC teams in the areas of diabetes prevention.

5.2. Stakeholders should collaborate with health promotion strategies that support inclusion and provide opportunities to access healthy eating and active living, including the provincial Food and Nutrition Framework and Action Plan, the provincial physical activity strategy and the Healthy Students, Health Schools Initiative.

5.3. Stakeholders should collaborate with and promote workplace wellness programs in both the public and corporate milieu with the Provincial Government and CDA serving as leads.

5.4. Stakeholders should collaborate with relevant components of the provincial strategies including the Healthy Aging Strategy and the Poverty Reduction Strategy.
5.5. Stakeholders should collaborate with federally-funded Aboriginal Diabetes Initiative programs occurring within the province.

5.6. Stakeholders should continue collaboration with federal and provincial/territorial initiatives which impact those affected by diabetes.
Key Recommendations

All of the actions in the Provincial Diabetes Strategy are important; however there are key actions which need to occur at the present time to move diabetes prevention, management, education and care forward. These key actions are summarized as the following recommendations:

1. Provincial leadership and coordination of chronic disease, including diabetes, should be formally established, enhanced and sustained by the Department of Health and Community Services.

2. People with diabetes should have timely access to new and appropriate treatment, medications, supplies and devices that can improve their immediate quality of life and diabetes outcomes.

3. Based on evaluation findings, the Provincial Diabetes Collaborative should be expanded province-wide and across the care continuum as part of chronic disease prevention and management initiatives.

4. The capacity of individuals living with diabetes should be enhanced so that they can reduce the incidence of complications and sustain quality of life.

5. The capacity of individuals who are at risk of diabetes should be enhanced so that they can prevent and delay the onset of type 2 diabetes.

6. The capacity of health care providers and organizations should be enhanced so that the needs of individuals with diabetes and those at risk are appropriately addressed.

7. Evidence-informed decision-making should be central to all processes.
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Implementation

Implementing a provincial diabetes strategy requires significant resources, time and support from all sectors and all partners. Once the consultation process is completed the provincial diabetes strategy will be finalized and it is anticipated that it will be presented to the Minister of Health and Community Services in September 2006.

Funding to implement the strategy has not been identified yet. Following the release of the provincial diabetes strategy, a comprehensive implementation plan, building upon current initiatives, should be developed, including a projection of resources needed for implementation and an evaluation component to monitor progress and recognize successes.
Conclusion

It cannot be emphasized enough the importance of effectively addressing diabetes in Newfoundland and Labrador. Diabetes is a burden on those who have the disease and their loved ones and has a huge impact on society directly and indirectly. In some academic and international circles, diabetes is now considered a pandemic as the increasing rate of type 2 diabetes spirals seemingly out of control. Preventing and delaying the onset of type 2 diabetes, early diagnosis of diabetes and preventing and delaying the complications of diabetes are critical tasks which must be addressed.

Achieving the vision of the strategy is a monumental task. However, there are already partnerships, initiatives, processes and actions occurring which provide a strong foundation of support to move forward so that all Newfoundlanders and Labradorians will have access to the supports and resources needed for diabetes prevention and management. These efforts will improve the health of the people of Newfoundland and Labrador and the overall health of the province.
Appendix A: 
Overview of the Provincial Diabetes Collaborative

The Provincial Chronic Disease Prevention and Management (CDPM) Collaborative commenced in 2004. The collaborative process supports planning, implementation and evaluation of services for chronic disease prevention and management. Through Primary Health Care teams and networks, provider teams utilize clinical practice guidelines, population health data, expanded chronic care and quality improvement models to improve services for chronic disease prevention and management. Diabetes was identified as the first chronic disease.

**Provincial Diabetes Collaborative**

In the summer of 2004, the Canadian Diabetes Association, Newfoundland and Labrador Region, was offered the opportunity to partner with the Office of Primary Health Care on a Provincial Diabetes Collaborative. Recognizing the value of this initiative to those affected by diabetes, the Provincial Diabetes Strategy Advisory Committee unanimously supported this partnership. The work plan and time lines of the development of the provincial diabetes strategy were changed to reflect the time lines and needs of the Provincial Diabetes Collaborative.

**Provincial Diabetes Collaborative Key Components**

The key components of the collaborative are as follows:

- Improving diabetes care through the development/enhancement of interprofessional teams who use a management process which meets the *Canadian Diabetes Association 2003 Clinical Practice Guidelines for Diabetes Prevention and Management in Canada*.
- Preventing type 2 diabetes, based on provincial and regional wellness direction, through the local leadership and involvement of the PHC Community Advisory Committees. Diabetes prevention could include a reduction of any of the risk factors for diabetes (e.g. poverty, obesity, physical inactivity).
- Educating health providers, persons with and at risk for diabetes and the community at large.
- Educating all who participate in Diabetes Collaboratives through a variety of venues including Provincial Learning Sessions, regional and community based programs.
The Provincial Diabetes Collaborative was rolled out in 2005 in eight primary health care areas in the province as part of the Provincial Chronic Disease Prevention and Management Collaborative.

**The Primary Health Care Chronic Disease Prevention and Management (CDPM) Working Group**

The Primary Health Care (CDPM) Working Group was formed, with representation from Provincial Diabetes Strategy Advisory Committee and other key stakeholders, to act as steering committee for the planning, implementation and evaluation of provincial chronic disease collaboratives, including the Provincial Diabetes Collaborative. As part of the planning process for the Provincial Diabetes Collaborative significant efforts were made to ensure that the components, activities, and tools used as part of the Provincial Diabetes Collaborative were in alignment with standards and clinical guidelines including the *Canadian Diabetes Association 2003 Clinical Practice Guidelines for Prevention and Management of Diabetes in Canada*.

**Primary Health Care Areas**

The Office of Primary Health Care supported interprofessional teams in each of the eight primary health care areas to facilitate development and implementation of the Provincial Diabetes Collaborative. In addition, newly formed Community Advisory Committees for each area advised and supported planning, implementation and evaluation of primary prevention intervention. In each area a primary health care facilitator, in cooperation with a physician lead and coordinator, supported the organization and coordination of the interdisciplinary team activities, coordinated the implementation of interventions, facilitated collation and interpretation of data collected, facilitated regular discussions among team members and supported evaluation activities.

Primary health care teams identified individuals with diabetes. Using an interprofessional approach, the collaborative developed and implemented clinical services and education enhancing self-management strategies for diabetes. The Provincial Diabetes Collaborative Flow Sheet is central to this approach. This tool informs practice as well as tracks clinical indicators in diabetes care. The data collected is diabetes management information based on the *Canadian Diabetes Association Clinical Practice Guidelines for the Prevention and Management of Diabetes in Canada*. A flow sheet is required to be completed on each individual with diabetes who is part of the Primary Health Care Diabetes Collaborative (PHCDC) as data from the flow sheet is used to guide and evaluate clinical practice as well as serves as the primary evaluation tool for the Provincial Diabetes Collaborative.

**Provincial Support**

Provincial leadership has been provided to the primary health care areas by the Office of Primary Health Care personnel through a variety of activities and services. As part of the primary health care provincial process, education and
support in team development and scope of practice was provided to interdisciplinary team members.

Specific to diabetes, and in partnership with CDA, a Provincial Diabetes Collaborative Toolkit was developed which provided support for the Provincial Diabetes Collaborative Flow Sheet and includes an array of professional and consumer tools. Recognizing the importance of professional development and networking, provincial learning sessions for health and consumer representatives and involved in the Provincial Diabetes Collaborative and other stakeholders were organized. The learning sessions focused on social inequity and chronic disease, diabetes self-management and chronic disease prevention. The Canadian Diabetes Association’s *Practical Diabetes Management* Program was delivered to each primary health care team. Additionally, the Internal Medicine Consultant to the Office of Primary Health Care delivered in each team area, provincially relevant evidence informed review of potential impact of guideline adherence on provincial and regional diabetes services and complications.

**Provincial Implementation**
The intent of the Provincial Diabetes Collaborative is to expand this initiative to all areas in the province. Currently, an extensive evaluation process is underway. The evaluation results will inform further provincial implementation processes. It is anticipated that the Primary Health Care Diabetes Collaborative will form the basis of the provincial chronic disease management strategy and the provincial diabetes strategy. It will benefit persons with diabetes and other chronic diseases in Newfoundland and Labrador.

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Office of Primary Health Care  
August 2006
Appendix B: Provincial Diabetes Strategy Advisory Committee Members

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Primary Health Care
Central Health

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