Yukon Diabetes Strategy

Renewed March 2006

Supported by:

Yukon Diabetes Prevention and Promotion Project

Recreation and Parks Association of the Yukon

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The Yukon Diabetes Strategy envisions an effective response to diabetes involving the coordination of strategies, services and resources for the prevention and care of diabetes throughout the Yukon Territory. It is recognized that this response can be accomplished within the context of a chronic care model.

The Yukon Diabetes Strategy does not represent official views of any of the employers of, or groups represented by, the people participating in its renewal.

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Diabetes in the Yukon

- More than **1,520** people in Yukon had diabetes (diagnosed and undiagnosed) in 2002.

- The National Diabetes Surveillance System (NDSS) identified a 1999/2000 Yukon prevalence rate for diagnosed diabetes of 3.9 per cent for females and 3.8 per cent for males over age 20. According to NDSS, diabetes rates are likely to be 30 per cent higher as a result of people who have diabetes but do not know it (undiagnosed diabetes).

- NDSS reports that 22 per cent of the Yukon population (29,960 in 2002) is of Aboriginal descent. It is known that diabetes prevalence among Aboriginals is three to five times higher than the national rate.

Estimated Direct Costs of Treating Diabetes in Yukon[1]			
2000	2005	2010	2016
$3,000,000	$3,700,000	$4,600,000	$6,000,000

[1] The Projection of Prevalence and Cost of Diabetes in Canada: 2000 to 2016, Canadian Journal of Diabetes, June 2004

From: *Diabetes Report 2005, the Serious Face of Diabetes in Canada*
Released by: Canadian Diabetes Association on December 7th, 2005
Located at: http://www.diabetes.ca/section_advocacy/index.asp
Retrieved: January 10, 2006

Yukon Response to Diabetes

What is working well?

- ✓ The territorial **Chronic Disease Program** provides partial coverage to Yukon residents for diabetes medications and supplies.
- ✓ The **Yukon Diabetes Collaborative** runs from May 2005 to September 2006. The collaborative supports and directs system change for health professionals to build their capacity to provide best-practice chronic disease management. The Diabetes Collaborative addresses diabetes care, education, self-management, prevention and measurement.
- ✓ The territorial government supports the implementation of the **Yukon Active Living Strategy**. The Strategy promotes active lifestyles, active communities, active schools and active workplaces.
- ✓ The **Recreation & Parks Association of the Yukon** offers programs and resources that promote healthy living and diabetes prevention. Developed through the Diabetes Prevention and Promotion project funded by Health Canada (April 2001 - March 2006), On-the-Right Path, Active Rx, healthy eating resources for schools, and the Yukon Diabetes Resource Guide are legacies of this project.
- ✓ **Aboriginal Diabetes Initiative** funding provides a long-term federal commitment with ownership and decision-making about diabetes prevention and treatment to Yukon First Nations.

What requires attention?

- ✓ The **Yukon Diabetes Education Centre** requires increased funding and resources so that its team of certified part-time staff can provide programs and services to all Yukoners living with diabetes.
- ✓ **Rural community access** to diabetes education and **community outreach** require resources to deliver programming and services.
- ✓ Leadership and policy supporting a comprehensive approach to **integrating healthy eating and physical activity into all schools** is required.
- ✓ No organization is currently responsible for ensuring **a coordinated Yukon response to diabetes**. Intermittent funding for non-profit groups makes coordination amongst agencies somewhat scattered.

What opportunities exist?

- ✓ The **Yukon Diabetes Collaborative** should continue and expand. Currently, not all physicians' offices and health centres are participating.
- ✓ The Department of Health and Social Services and the Department of Education are developing a **partnership to promote health in Yukon schools**. This partnership intends to support classroom activities that encourage healthy living.
- ✓ The **Aboriginal Health Blueprint process** may have an impact on resources that could improve prevention and promotion in Yukon First Nation communities. The process may serve to improve communication and services throughout the Yukon.
- ✓ The renewal of the **Yukon Diabetes Strategy** will help organizations identify activities that can complement current programs, services and resources.
- ✓ Resources are required to ensure continuation of the legacy of **healthy living programs and resources** developed by RPAY through the Diabetes Prevention and Promotion Project.

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List of abbreviations

CDA – Canadian Diabetes Association

CDE – Certified Diabetes Educator

CDM – Chronic Disease Management

CDS – Canadian Diabetes Strategy

CYFN – Council of Yukon First Nations

DM – Diabetes Mellitus

DRG – Diabetes Reference Group

GP - General Practitioner

IFG - Impaired Fasting Glucose

IGT - Impaired Glucose Tolerance

NDSS - National Diabetes Surveillance System

NIHB – Non-Insured Health Benefits

PHCTF – Primary Health Care Transition Fund

RN – Registered Nurse

RPAY – Recreation and Parks Association of the Yukon

WGH – Whitehorse General Hospital

YDEC – Yukon Diabetes Education Centre

YHIS – Yukon Health Insured Services

YTG – Yukon Territorial Government

Introduction

Overview

The Yukon Diabetes Strategy has been developed through a collaborative effort. Reflecting the current response to diabetes in the Yukon, this Strategy is a result of the time, knowledge and expertise contributed by territorial professionals working with diabetes. Within the context of chronic care management, the Diabetes Strategy proposes an effective response to diabetes requiring:

1) Care and Treatment,
2) Health Promotion and Diabetes Prevention, and
3) Coordination and Support.

The Yukon Diabetes Strategy is based on the knowledge and opinions of diabetes experts. Collectively, their understanding of the current environment provides a well-rounded perspective of what is working well, what requires attention, and where the opportunities for improvement lie. This Strategy should be used by organizations and groups, involved in diabetes prevention and care, to identify opportunities for activities that will enhance services for all Yukoners. It must be noted that the Yukon Diabetes Strategy does not represent official views of any of the employers or groups of those who collaborated in its development.

Diabetes Reference Group

The initial Yukon Diabetes Strategy was developed during the winter of 2003-04 by members of the **Diabetes Reference Group** (DRG). Diabetes Reference Group members are professionals working in the area of diabetes in the Yukon. Members come from a broad range of perspectives including government, non-government, rural and urban representatives, Aboriginal people, health professionals, and people affected by diabetes. Formed over 15 years ago, this group was originally the Diabetes Advisory Committee. At that time, the specific purpose was to guide the emergence of Yukon Diabetes Education Centre (YDEC). After YDEC was established, terms of reference for the group shifted and it evolved into the Diabetes Reference Group. Membership has been fluid over time and has always been based on the tasks and priorities at hand.

Over time, Diabetes Reference Group members have shared their knowledge, opinions and unique perspectives on diabetes-related issues and projects. For example, when Canadian Diabetes Strategy funding was announced, the group reconvened to provide guidance to the Yukon Diabetes Prevention and Promotion Project. More recently (2006), members have collaborated to renew the Yukon Diabetes Strategy and to make recommendations for the second edition of the Yukon Diabetes Resource Guide.

Renewal of the Yukon Diabetes Strategy

With RPAY's five-year Diabetes Prevention and Promotion Project concluding in March 2006, renewal of the Yukon Diabetes Strategy is appropriate. It is recognized that renewal provides opportunities:

- ✓ to rebuild connections and contacts;
- ✓ to improve understanding about the current response to diabetes in the territory; and
- ✓ to look for ways to strengthen partnerships and collaboration in order to maximize resources and minimize gaps.

It is believed that a renewed Strategy will help to build bridges while being useful to a variety of organizations, individuals and communities. This Strategy has the potential to provide guidance for a coordinated response to diabetes involving: health professionals; home and community care workers; people living with diabetes and their families; the Diabetes Education Centre and Whitehorse General Hospital; Council of Yukon First Nations; groups working in the areas of health promotion, diabetes prevention and chronic conditions management; governments and departments; and the Yukon Diabetes Collaborative. (See Appendix A for information about the Yukon Diabetes Collaborative.)

RPAY has sponsored renewal of the Strategy with Health Canada funding received for diabetes prevention and promotion activities. Two consultants were contracted to facilitate the process; one an expert in planning and the other an experienced Certified Diabetes Educator. The consultants ensured that participation in the renewal process was open. Previous members of the DRG were invited to attend and invitations were sent to communities, First Nations, government departments, health professionals and other groups involved in diabetes in the territory. A process of electronic research and two facilitated meetings resulted in this document—the renewed Yukon Diabetes Strategy (2006). An updated listing (Appendix A) of all resources and

organizations involved in the Yukon's approach to diabetes is an additional outcome of the renewal process.

It is intended that the Yukon Diabetes Strategy be shared publicly. Therefore, a "user-friendly" format was deemed important. This document includes two introductory pages which provide an overview of the current situation and response to diabetes in the territory. The vision and the goals encompass the areas of Care and Treatment, Health Promotion and Diabetes Prevention, and Coordination and Support and are succinctly described. A current listing of diabetes resources is located in Appendix A and illustrates the organizations, activities and resources that are involved in the response to diabetes in the Yukon in early 2006. This listing will help maintain historical knowledge and momentum in an ever-changing environment. Furthermore, it can help uncover new and future opportunities for partnerships and collaboration. Public knowledge of this document will help to ensure that diabetes treatment, care and prevention, as well as the development of new initiatives, are efficient and streamlined; and subsequently avoid duplication of services.

The Strategy: Vision & Goals

> *The Yukon Diabetes Strategy envisions an effective response to diabetes involving the coordination of strategies, services and resources for the prevention and care of diabetes throughout the Yukon Territory. It is recognized that this response can be accomplished within the context of a chronic care model.*

The Strategy's vision emphasizes an effective response to diabetes involving the coordination of programming, resources and actions, and occurring on a continuum from diabetes prevention to the care and treatment of diabetes and secondary complications. The response to diabetes proposed in the Strategy contains components typically found in chronic care models.

Goals for the Diabetes Strategy have been identified for each of the three core areas:

1) Care and Treatment,
2) Health Promotion and Diabetes Prevention, and
3) Coordination and Support.

The goals described in this section of the Strategy can enhance the current level of diabetes programming and services available in the Yukon. Implementation of the goals will, in most cases, require additional resources and the presentation of new opportunities. Yet, with coordinated planning and implementation of these goals, the vision described above can be achieved.

CARE & TREATMENT

Care and Treatment is identified as one of three core areas of action in an effective response to diabetes. Care and Treatment encompasses the diagnosis and management of Type 1 and 2 diabetes in order to reduce the incidence and severity of secondary complications. Care and Treatment activities aim to encourage self-care through a supportive network of professionals that includes physicians, educators, health care workers, dietitians, etc.

In order to offer comprehensive and coordinated Care and Treatment to Yukoners living with diabetes, the Yukon Diabetes Strategy recommends that:

- ⇨ The Yukon Diabetes Collaborative continues and expands to include all Yukon medical practices and health centres. This will require a commitment of funding past September 2006.
- ⇨ Electronic medical records are utilized in order that recall and screening activities occur systematically.
- ⇨ Access to screening for secondary complications—particularly in rural communities—becomes available.
- ⇨ The Yukon Diabetes Education Centre is developed as the centre of excellence for the management of diabetes in the Yukon. This will require a commitment of resources to increase the current level of services and programs that can be offered by its half-time staff.
- ⇨ Outreach programs, particularly outreach to rural residents, increases. Outreach is an essential component of care and treatment and can include education, complications screening and monitoring, and case specific support. Outreach programs are available in a very limited capacity and are virtually non-existent in rural communities.

- ➪ The use of telehealth videoconferencing increases. Where it is available in rural communities, telehealth videoconferencing provides a method to deliver follow-up support and education for diabetics and their families.

- ➪ Programs and supports that foster the growing interest in chronic care self-management be enhanced and become more available. Specific techniques for self-management have been well researched and need to be implemented in medical care. People with diabetes take care of themselves 99.9% of the time; therefore, their interest and ability to self-manage is crucial to optimizing their control.

- ➪ YTG's health care coverage through the chronic disease program continues to be made available to Yukoners living with diabetes.

HEALTH PROMOTION & DIABETES PREVENTION

Health Promotion & Diabetes Prevention is one of three core areas of action in an effective response to diabetes identified in the Yukon Diabetes Strategy. Activities in this area are targeted at all Yukoners in an effort to promote health and prevent—or at least delay—the onset of diabetes. The aim of health promotion is to encourage attitudes and practices around healthy eating, active living and stress reduction to be integrated into cultural norms, community planning and everyday lifestyles. Benefits of healthy living are not limited to any particular group of the population. Rather, the benefits of healthy living have a profound effect on the social and economic fabric of our communities.

In order to offer comprehensive and coordinated Health Promotion & Diabetes Prevention to all Yukoners, the Yukon Diabetes Strategy recommends that:

- Policy development occurs. Policies are needed to support healthy eating practices, access to healthy food choices, active living opportunities, active transportation options, etc. Policy that fosters healthy living practices must encompass communities, workplaces, schools and neighbourhoods.
- Public health education increases. Public health education needs to incorporate obesity prevention for the general population with the main focus on healthy eating and regular physical activity. To foster positive attitudes around healthy eating, education needs to include general nutrition knowledge, confidence in cooking skills, an increased emphasis on unprocessed foods, home cooking, low budget grocery shopping, and more.
- Coordination with the Yukon Active Living Strategy continues. Support to increase physical activity levels at home, in the community, at the workplace and in schools will help to prevent, delay, and manage the prevalence of diabetes.
- Community planning incorporates opportunities for active transport (e.g., paved trails, bike lanes, neighbourhood parks).

- ⇨ RPAY is encouraged and supported to continue delivery and development of its healthy living programs. An increase to available financial and human resources will ensure that programs such as "On-the-right" Path walking program, Healthy Eating Resources for schools, Active Rx, active living programs and others continue.

- ⇨ Efforts and resources to incorporate daily physical activity and nutrition education into school curriculum continue. Effective school policy is needed to set the stage for the allocation of resources and time that will create environments which value healthy eating and active living as key aspects of health in all Yukon schools.

- ⇨ Programming for IFG (impaired fasting glucose) and IGT (impaired glucose tolerance) persons who are at increased risk of diabetes is developed and implemented. This high risk group needs to be targeted as an effort to prevent, or at least delay, their advancement to diabetes.

- ⇨ Opportunities for partnering with Food for Learning are explored. Food for Learning now has dietitian support and is in a position to promote healthy eating practices throughout Yukon schools.

COORDINATION & SUPPORT

Coordination & Support, the third core area of action in an effective approach to diabetes, is essential to maximizing resources and addressing the goals identified in the Yukon Diabetes Strategy. Coordination and support involves activities related to implementation of the Strategy, research and measurement, professional development, the development and maintenance of partnerships, and communication and information sharing amongst governments, departments, First Nations and other concerned organizations. Without Coordination and Support, there cannot be an effective or efficient response to diabetes in the Yukon.

Thus, the Yukon Diabetes Strategy recommends that:

- ➪ The Yukon's response to diabetes occurs in the most effective and sustainable manner possible. A Yukon response will strive to follow better and best practices in planning for implementation, policy development, coordination of service delivery, and evaluation to provide the best possible diabetes treatment and prevention Yukoners deserve. The Yukon Diabetes Strategy (2006) provides a framework from which this type of response can be initiated.

- ➪ Leadership and coordination of the overall response to diabetes in the Yukon are sought. Communication pathways need to be maintained amongst organizations in order that information sharing occurs systematically. Yukoners need to know who to access for information and to know that the information they receive will be consistent. There is neither an organization nor a position dedicated to fulfilling coordination responsibilities. Such a position would enhance communication, improve resource sharing and partnerships, assist with the implementation of new ideas, and ensure consistency.

- ➪ Funding is identified to improve coordination of the approach to diabetes in the Yukon. Resources are needed that are relevant, ongoing, and can be used to support successful and sustainable programs and initiatives.

- ⇨ Research, when conducted, is relevant, offers Yukon-based data, and is shared. Research is a key component of an approach that encompasses better and best practices. As YHIS continues to collect statistics for NDSS, a coordination position as described above could monitor research initiatives and distribute current data.

- ⇨ A position for a Community Dietitian is developed and staffed. A Community Dietitian is needed to provide overall support to the diverse programs and services which address care and treatment, health promotion, and diabetes prevention throughout the territory. Through this position, support for policy development, school programming and community programs would be provided.

- ⇨ Professional development, education and support for the implementation of the Clinical Practice Guidelines, as is taking place through the Collaborative, increases. Clinical Practice Guidelines are evidence-based and accepted standards for anyone working in the prevention and treatment of diabetes in Canada and are regularly researched, published and updated by the CDA. Increased support for the dissemination and implementation of these Guidelines will help to improve consistency and effectiveness of the Yukon's response to diabetes.

- ⇨ Professional development and education for physicians and other health professionals, as is taking place through the Collaborative, is extended throughout the Yukon. Professional development needs to relate to a chronic care model and to the opportunities to support self-care within this model.

- ⇨ Opportunities to support front-line, community workers are offered. (Opportunities may involve "train-the-trainer" workshops on topics related to diabetes care, self-management and/or prevention.)

- ⇨ Community programming is improved through resource sharing between departments (e.g., travel to communities and through an increased use of telehealth).

Conclusion

In conclusion, it is hoped that the renewal of the Yukon Diabetes Strategy will contribute to an effective and efficient response to diabetes in the territory. For those working closely with diabetes, either in care and treatment environments or in health promotion and diabetes prevention, this Strategy can help provide guidance by emphasizing where independent efforts need to be concentrated. For decision-makers, the Strategy offers direction about policy development and resource allocation to improve the Yukon's approach to diabetes. For all Yukoners, the Diabetes Resource Listing in Appendix A describes the resources and components involved in the current response to diabetes. Using this Strategy as a framework will ensure:

- ✓ that Yukoners living with diabetes receive the best care and treatment possible, and
- ✓ that opportunities for <u>all</u> Yukoners to engage in healthy lifestyles are increased.

Appendix A: Yukon Diabetes Resources

Appendix A offers information on the territorial and national components and resources involved in the Yukon's approach to Diabetes. Listings include (if available) organizational/program information and activities, contact information, and comments regarding current status of the resource.

The following resources are included in the listing:

- ⇨ Primary Health Care Access
- ⇨ Canadian Diabetes Association
- ⇨ Yukon Diabetes Educator Section
- ⇨ National Aboriginal Diabetes Association
- ⇨ National Diabetes Surveillance Strategy
- ⇨ Aboriginal Diabetes Initiative
- ⇨ First Nations Health Programs
- ⇨ Yukon Diabetes Education Center
- ⇨ Yukon Diabetes Collaborative
- ⇨ Home Care and Home Support Services
- ⇨ YTG Health Promotion & Tobacco Reduction and Control
- ⇨ Yukon Diabetes Reference Group
- ⇨ Recreation & Parks Association of the Yukon
- ⇨ Yukon Diabetes Resource Guide
- ⇨ Chronic Conditions Self-Management Program

The Yukon Diabetes Resource Listing:

Components and resources involved in a Yukon approach to Diabetes

Component / Resource	What are the Activities?	Additional Comments	Contact
Primary Health Care Access Available through: Yukon Health Care & FNIHB at Health Canada	General Practitioners and Community Nurse Practitioners provide the majority of primary care to Yukon patients. • Diabetes workshops and annual education sessions for physicians are offered twice a year. • The Clinical Practice Guidelines for diabetes are increasingly being applied in the Yukon as diabetes knowledge amongst physicians and nurses increases. Diabetes medications and supplies are partially covered when private insurance is not available thru the Yukon Government's **Chronic Disease Program**. Most diabetes medications and supplies are covered for eligible First Nations people when they are not insured elsewhere through the Health Canada's **Non-Insured Benefits Program** (NIHB).	• Community Nurse Practitioners and nursing stations are the cornerstone of health care in Yukon communities. Currently specialized diabetes training is limited for these nurses. • A shortage of physicians in Yukon can limit access to care.	Chronic Disease Program Yukon Insured Health Phone: 667-5092 1-800-661-0408, local 5092 First Nation NIHB Phone: 667-3974
Canadian Diabetes Association **CDA Yukon Chapter** is located in Whitehorse	CDA promotes the health of Canadians through diabetes research, education, service, and advocacy in over 150 branches nationally. The Yukon Chapter of CDA is strictly a volunteer organization. It does some fundraising and educational events.		1-800-226-8464 www.diabetes.ca Yukon Chapter Voicemail: 393-2329
Yukon Diabetes Educator Section **YDES** is CDA's professional section in the Yukon.	Operating in the Yukon with limited resources, this group maintains membership and supports access to continuing education for its members. • YDES currently supports the development of a Yukon-wide foot care assessment tool.	• Funding is limited at $1000/year to provide professional education opportunities to members.	Contact: CDA Yukon Chapter at 393-2329

Component / Resource	What are the Activities?	Additional Comments	Contact
National Aboriginal Diabetes Association www.nada.ca	Vision: • to address diabetes amongst Aboriginal Peoples by creating networks, and opportunities for individuals and communities within their beliefs, traditions, and values. Mission: • to be the driving force in addressing diabetes and Aboriginal people as a priority health issue by working together with people, Aboriginal communities and organizations in a culturally respectful manner in promoting healthy lifestyles among Aboriginal people today and for future generations. Our Values provide inspiration and guide our actions and decisions. We value: • Respect of diversity, culture and traditions of the people we work with. • Honour and Validation of experiences, wisdom, NADA's history, knowledge around us, and cultural differences in building relationships. • Caring And Sharing in how we approach people, families and Aboriginal communities in our work. • Integrity in the way we strive for excellence and quality in the work that we do. We are accountable in taking responsibility for all that we do, in building efficient operations and in promoting a holistic approach to our activities. • Aboriginal Community and Family are at the centre of what we do in connecting NADA with its Members and their Aboriginal communities. • Freedom to represent the best interests of diabetes and Aboriginal peoples.	Goals: 1. To support individuals, families and communities to access resources for diabetes prevention, education, research and surveillance. 2. To establish and nurture working relationships with those committed to persons affected by diabetes. 3. To inspire communities to develop and enhance their ability to reduce the incidence and prevalence of diabetes. 4. To manage and operate NADA in effective and efficient ways. 5. To be the driving force in ensuring diabetes and Aboriginal people remains at the forefront of Canada's health agenda.	174 Hargrave Street Winnipeg, Manitoba R3C 3N2 Phone: 1-877-232-6232 Email: diabetes@nada.ca
National Diabetes Surveillance Strategy	NDSS data collection is ongoing at Yukon Health Insured Services (YHIS)		Gregor Gabb, Health Information Specialist Sherri Wright, Director of YHIS

Component / Resource	What are the Activities?	Additional Comments	Contact
Aboriginal Diabetes Initiative FNIHB at Health Canada is responsible for establishing regional work plans for ADI in a collaborative process.	Nationally in 2006-07, ADI will have seven components: 1. Prevention / Community projects, 2. Screening & Care community projects, 3. Primary Prevention off reserve, 4. Promotion, 5. Capacity Building/Training, 6. Surveillance & Research, 7. Evaluation & Monitoring Some community-based initiatives focus on components such as prevention/community projects, and screening & care. Other components are coordinated at a regional or national level to support community-based programming. ADI was enhanced with a national increase of $190M over five years. In 2005/06, ADI provided $110,000 for 14 Yukon communities. Activities were community driven and included: • care and treatment, • prevention and promotion, and • lifestyle support. Yukon activities often incorporate aspects of traditional lifestyle like hunting, fishing and berry picking. Some activities involve workshops on traditional medicines and how they can be used in diabetes treatment care and prevention. Yukon ADI activities may include bringing a naturopathic doctor, a diabetes educator, or the CHIP program into the community.	• ADI will not provide services that fall under P/T jurisdiction, fund operational activities not directly related to ADI projects, or duplicate services provided through other community services. • Changes to programming and administration of ADI will occur in 2006/07. • Need increased funding to bring human resources (RD/RN) for diabetes support to the Yukon.	Myra Shilleto Program Consultant Health Canada Lori Duncan Director of Health and Social Development CYFN
First Nations Health Programs A department of Whitehorse General Hospital, **First Nations Health Programs** operates under the direction of the Council of Yukon First Nations and an advisory committee of key stakeholders	• The Traditional Diet Coordinator position is staffed by a full-time Registered Dietitian. This position is responsible for programming related to the Traditional Diet Program and co-coordinates the Yukon First Nations Dietetic Internship. Outreach to First Nations people living with diabetes is limited. • Diabetes-focused activities comprise approximately 5% of the overall workload. The Traditional Diet Coordinator does not see patients with diabetes unless requested by the Diabetes Education Centre. • The Coordinator may travel to communities for prevention activities about 3-5 times per year when time permits.	• Delivery of First Nations Diabetes Wellness Workshops has been in cooperation with DEC. Participation and demand has decreased. Provision of this workshop is being re-evaluated as part of DEC strategic planning.	Laura Salmon First Nations Health Programs, WGH Phone: 393-8891

Component / Resource	What are the Activities?	Additional Comments	Contact
Yukon Diabetes Education Center Whitehorse General Hospital	YDEC provides: • adult diabetes care for Yukon residents diagnosed and referred by a physician or community nurse practitioner • individual education, in the form of one-on-one counseling with a nurse educator and a dietitian educator • a two-day workshop covering diabetes care in a group setting • limited support to health care workers in the form of diabetes education seminars for professionals The Yukon Diabetes Education Center has a medical advisor and publishes a quarterly newsletter for health professionals.	• The current wait is about three weeks to see the nurse or dietitian and two months for group education. • There is no formal community outreach but YDEC will review each request based on available funds and human resources. • YDEC needs core funding and more resources for an outreach program for rural communities.	Phone: 393-8711
Yukon Diabetes Collaborative The Collaborative is funded until September 2006 through the Primary Health Care Transition Fund	A collaborative is a strategy to support and direct system change. The focus is on supporting health professionals to build their capacity to provide best-practice chronic disease management through the systematic adoption of clinical guidelines and subsequent practice redesign. Participants in the Yukon Diabetes Collaborative include thirteen family physicians, their medical office assistants, nurses and clerks from three Community Health Centres (Carcross, Mayo and Teslin), Diabetes Education Centre staff, nurses from the Yukon Homecare Program and from Kwanlin Dun Health Centre, and two pharmacists.	• The Collaborative model has been used nationally and internationally to improve chronic care.	Lucie Wright CDM Coordinator Health and Social Services 393-7487 Cindy Breitkreutz Family Physician Geoff Zaparinuk CDM Nurse
Home Care and Home Support Services YTG and First Nations - at a program level in Whitehorse, Watson Lake, Dawson City and Haines Junction	People with diabetes might be referred to Home Care Services, when this is needed and appropriate. The Home Support Workers (YTG) do basic foot care only on non-diabetic clients and all Home Care clients feet are assessed by a Nurse before the Home Support Workers take this duty on. In the First Nations communities, Home & Community Care Workers provide some of the support for those living with diabetes. This does not include foot care for diabetics. Home & Community Care has given their staff training in basic foot care but has emphasized liability associated with providing such care.	• RN's and LPN's may obtain specialized training in foot care.	YTG Phone: 667-5774 CYFN - Lori Duncan, Director of Health and Social Development

Component / Resource	What are the Activities?	Additional Comments	Contact
Health Promotion Unit Health & Social Services, YTG **Tobacco Reduction and Control** Health & Social Services, YTG	The Department of Health and Social Services and the Department of Education are developing a partnership to promote health in Yukon schools. School health includes: • Promoting school cultures and environments that encourage healthy lifestyle choices and decrease risk behaviours • Supporting classroom activities that support healthy living • Providing programs and materials to address priority issues (sexual health, healthy eating, tobacco reduction) • Fostering connections between schools and the community at large Reducing the use of tobacco among Yukoners of all ages is a high priority for Health Promotion. Activities include: • A mass media campaign targeting young adults ages 18-34 • Distribution of QuitPacks and Cessation Packages which contain tools and resources to help smokers reduce tobacco use • School and community presentations to encourage non-smokers to remain smoke free and to encourage smokers to become smoke free • Assistance offered to schools to reduce tobacco consumption among students • Coordinating Smoke Screening III – a media awareness program in all schools		Health Promotion Unit # 2 Hospital Rd. Whitehorse Coordinator responsible for school health: Ian Parker Phone: 667-8978 Health Promotion contact for Tobacco Reduction and Control: Susie Ross Phone: 667-8394 Daniela Meier Phone: 667-8392 Smokers' Line: 667-8393 or toll-free 1-866-221-8393
Yukon Diabetes Reference Group	YDRG members come from a broad range of perspectives including government, non-government, rural and urban representatives, Aboriginal people, health professionals, and people affected by diabetes. YDRG members have provided guidance to the development of the Yukon Diabetes Education Centre and to the Yukon Diabetes Prevention and Promotion Project as part of the Canadian Diabetes Strategy. Most recently (2006), members worked together to renew the Yukon Diabetes Strategy and the Yukon Diabetes Resource Guide.	Originally the Diabetes Advisory Committee, the group's purpose was to guide the emergence of YDEC. Afterwards, terms of reference shifted and the group became the DRG. Membership has been fluid over time and is based on the tasks at hand. • It is unclear who will coordinate this group in the absence of funding.	No contact at present.

Component / Resource	What are the Activities?	Additional Comments	Contact
Recreation & Parks Association of the Yukon RPAY's Diabetes Prevention & Promotion Project was funded from April 2000 - March 2004 through the **Canadian Diabetes Strategy.** The current diabetes project is cash managed by Northern Secretariat and concludes March 2006.	RPAY offers a broad range of programs and services promoting healthy living. Some of RPAY's programs include: • "On-the-Right Path" Walking Program • Active Rx • Programs to meet goals outlined in YTG's Active Living Strategy: Active Schools, Active Workplaces and Rural Active Living Coordinators • Diabetes Prevention & Promotion resources and newsletter • Yukon Diabetes Resource Guide • Healthy Eating Resources for Yukon Schools • Healthy Living modules for facilitating workshops Go to www.rpay.org for a full listing of programs and services. Click on "Healthy Living Resources" for available resources. RPAY's staff includes an Executive Director, a Healthy Living Coordinator and an Active Living Coordinator.	• RPAY's role in the approach to diabetes has been driven through the nature of initiatives such as the Canadian Diabetes Strategy and the Yukon Active Living Strategy. • There is a need for ongoing coordination of activities related to the Yukon Diabetes Strategy. It is not likely that this is a role RPAY could fill without the allocation of specific funding.	509 Hanson Street, Whitehorse www.rpay.org Executive Director 668-3010 rpay@klondiker.com Active Living Coordinator 668-2328 active@klondiker.com Healthy Living Coordinator 668-3012 healthy@klondiker.com
Yukon Diabetes Resource Guide	This Guide provides a detailed description of the resources available for those living with diabetes in the Yukon. It also offers healthy living tips (healthy eating, active living, smoking cessation and foot care). It was written by YDES and RPAY, with input of the YDRG, and was initially released in the spring of 2004. • The Guide can be downloaded from RPAY's website.	• A second edition of the Guide will be available in late April 2006.	For copies, contact RPAY 668-3010 Or download your copy by clicking on "healthy living resources" at www.rpay.org
Chronic Conditions Self-Management Program Health Promotion Unit, YTG	**CCSMP** is an educational program designed to support and increase the skills of people living with a chronic condition. It promotes self-management skills (e.g., symptom management, effective communication with health care providers), healthy living (physical activity, nutrition), and coping with the social, emotional and psychological consequences of chronic illness • This is a peer led program which can be supported by health care providers. Training opportunities have been available in the Yukon. This program has been active in Whitehorse and Yukon communities since 1998. RPAY housed the program from April 2002 until March 2005.	• Research is underway to identify a range of evidence based services, programs and strategies to support self-management. • A permanent "home" for CCSMP is being sought. One with stronger ties to services for persons with chronic conditions will enable more consistent and predictable referrals.	CCSMP Voicemail: 393-2201

Appendix B:
Yukon Diabetes Collaborative

Vision:

Community and health care providers working together with each other and with people who have a chronic disease to support them to be as well as possible.

Purpose:

Primary Health Care Transition Fund will support health care providers to work together with people who have a chronic disease and with community services to provide best practice care.

Yukon Diabetes Collaborative:

A collaborative is a strategy to support and direct system change. The focus is on supporting health professionals to build their capacity to provide best-practice chronic disease management through the systematic adoption of clinical guidelines and subsequent practice redesign. Chronic Disease collaboratives have been held across the US, UK, BC and other parts of Canada.

The Yukon Diabetes Collaborative began in May 2005. The initial focus is on health professionals in Whitehorse and in community health centres in Carcross, Mayo and Teslin. It is anticipated that in the next phases we will be expanding into more communities with more chronic disease conditions.

Project Elements:

The Diabetes Collaborative involves the following elements:

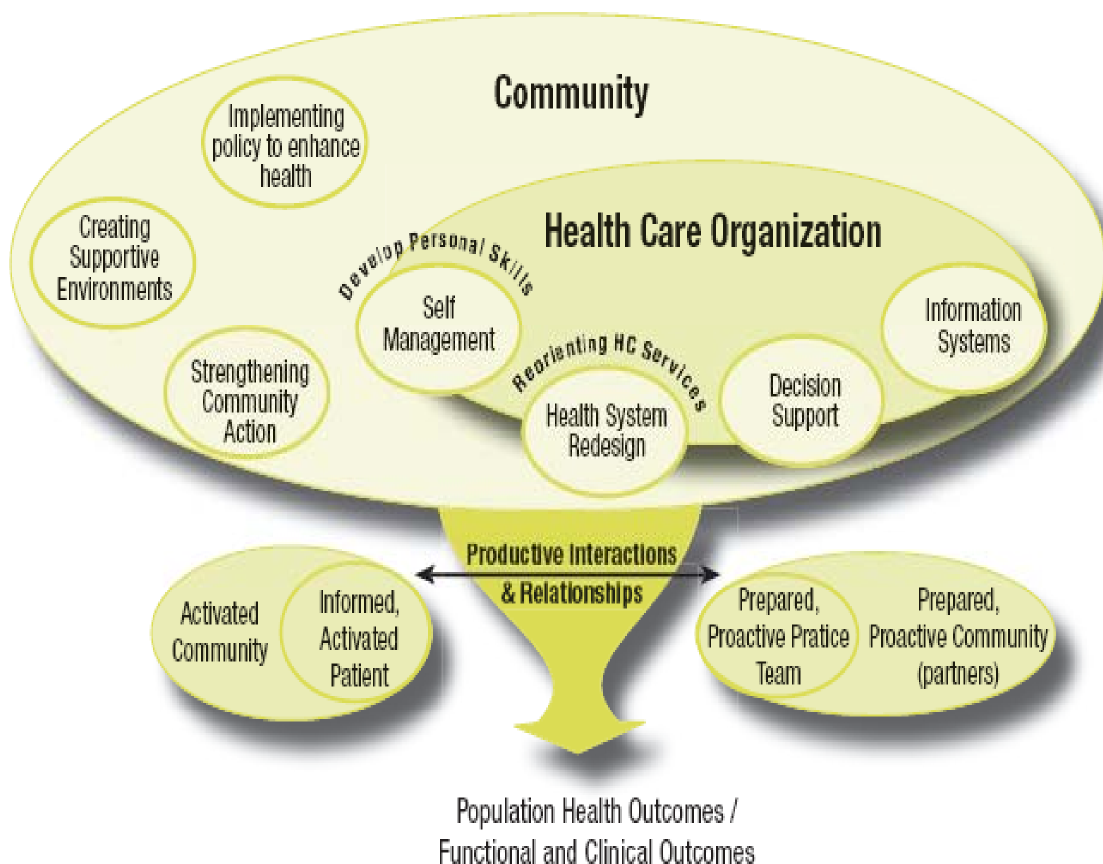
(a) Expanded Chronic Care Model

The Chronic Care Model (CCM) developed by the Group Health Cooperative and the Institute for Healthcare Improvement. The Expanded CCM was developed at Vancouver Island Health Authority. The ECCM focuses on improving outcomes for people with diabetes and population health outcomes through ‘productive interactions and relationships’ between ‘informed activated patients and prepared proactive teams’. In turn, the way to achieve these interactions and relationships is by addressing key elements of both chronic care and population health promotion. The elements are identifies in figure 1 overleaf.

(b) Learning Sessions

A collaborative comprises a series of learning sessions and action periods. The learning sessions provide opportunities for multidisciplinary teams to share learning and experiences and to set targets to improve quality of care.

The initial, orientation learning session was held in May 2005. Over the following 16 months 3 one-day learning sessions will be held (in October 2005, January and May 2006) followed by a closing congress in September 2006. Learning sessions are attended by Diabetes Collaborative participants – family physicians, medical office assistants, community nurse practitioners, health centre clerks, pharmacists, Diabetes Education Centre staff, Home Care nurses, and nurses from Kwanlin Dun Health Centre.



(c) Action Periods

The action periods, between each learning session, provide opportunities for teams to work towards meeting their own targets and to test out ideas for their achievement.

The Model for Improvement is used as a model for quality improvement. This model uses PDSA (Plan-Do-Study-Act) cycles to improve quality of care.

(d) CDM Toolkit

The Chronic Disease Management (CDM) Toolkit is a web-based electronic tool to support CDM in primary care. It is structured around clinical practice guidelines. It was developed by the Ministry of Health Services in BC. The Yukon is in the process of setting up an agreement with the Ministry in BC for access and for data storage.

The Toolkit enables to practitioners to:

- To generate a list/register of patients with diabetes
- To gather information about each diabetic patient as per clinical practice guidelines on an electronic flow sheet
- To monitor individual and aggregate care and practice redesign
- To recall patients for diabetes care
- To share individual patient's flow sheet information with other health professionals who have access to the toolkit

Facilitating Change:

The Diabetes Collaborative provides the following personnel to support participating health professionals:

- CDM Coordinator (Lucie Wright)
- CDM Clinical Support Nurse (Geoff Zaparinuk)
- CDM Toolkit Support person (Mike Tribes)