DIABETES CANADA

SUSTAINING MOMENTUM TO IMPLEMENT THE DIABETES FRAMEWORK (SMIDF):

PRINCE EDWARD ISLAND ROUNDTABLE

OCTOBER 2024

Summary

This grey paper provides key findings about the Sustaining Momentum to Implement the Diabetes Framework (SMIDF): Prince Edward Island Roundtable 2024.

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About Diabetes Canada

Diabetes Canada is a national health charity representing more than 4 million people in Canada diagnosed with Diabetes. Diabetes Canada leads the fight against diabetes by helping those affected by diabetes live healthy lives, preventing the onset and consequences of diabetes, and discovering a cure. It has a heritage of excellence and leadership, and its co-founder, Dr. Charles Best, along with Dr. Frederick Banting, is credited with the co-discovery of insulin. Diabetes Canada is supported in its efforts by a community-based network of volunteers, employees, health care professionals, researchers, and partners. By providing education and services, advocating on behalf of people living with diabetes, supporting research, and translating research into practical applications, Diabetes Canada is delivering on its mission. Diabetes Canada will continue to change the world for those affected by diabetes through healthier communities, exceptional care, and high-impact research.

For more information, please visit: www.diabetes.ca.

Contact

framework@diabetes.ca with inquiries about this Diabetes Canada report.

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Maleka El Naghi, MPH (Health Equity and Evaluation Officer)

We would like to thank all presenters, panelists, and attendees for their contributions to the PEI Roundtable. The insightful presentations and discussions allowed for knowledge sharing, enabling a deeper understanding of diabetes in Prince Edward Island.

Title: Sustaining Momentum to Implement the Diabetes Framework (SMIDF): Prince Edward Island Roundtable, October 2024

Project Overview: Through the Framework for Diabetes in Canada (the Framework) project, supported by the Public Health Agency of Canada (PHAC), Diabetes Canada continues to bring together key stakeholders to help identify and share best practices. This project began in 2023, and the result of this 3-year project will be an inventory of successful diabetes programs/interventions/projects and the dissemination of findings for adoption and scaling to identify and share best practices for addressing diabetes, including the identification of barriers in health equity-deserving communities.

Prince Edward Island (PEI) Roundtable

The fourth roundtable of this project was held in Prince Edward Island, Canada, in October of 2024. Participants were invited from all over the province to share, listen, and brainstorm regarding the Framework. The roundtable was a combination of presentations, group discussion/ breakout work and a panel. Presentation topics were focused primarily on interventions and programs that exist in the province including the provincial diabetes program, specialty diabetes programs, preventative diabetes foot care program, patient medical homes, unaffiliated services, and diabetes drug programs.

Location and Date: Rodd Charlottetown in Charlottetown, PEI, on October 4, 2024, from 10:00 am to 4:00 pm AST.

Meeting Objectives:

- Identify provincial programs, interventions and opportunities to optimize efforts (for those living with or working in diabetes)
- Review alignment with the Diabetes Framework in Prince Edward Island and build on the collaborative engagement with strategic partners
- Determine diabetes access and resource pathways in PEI

Framework Overview: The Government of Canada introduced the Framework for Diabetes in Canada on October 5, 2022. The Framework aims to support prevention and treatment for all types of diabetes and provide a common policy direction to address diabetes in Canada. The Framework seeks to support the identification of gaps in current approaches, avoid duplication of effort, and provide the federal government an opportunity to monitor and report on progress. In doing so, it strongly promotes the foundation for collaboration across sectors to reduce the impact of diabetes.

The Framework is comprised of six interdependent and interconnected components that represent the range of areas where opportunities to advance efforts on diabetes could be beneficial. The principles and the components (below) form a dynamic environment within which to create change in Canada. These were derived

from, and built on, contributions from diverse groups within Canada throughout the multi-year engagement process.

Cross-cutting principles:

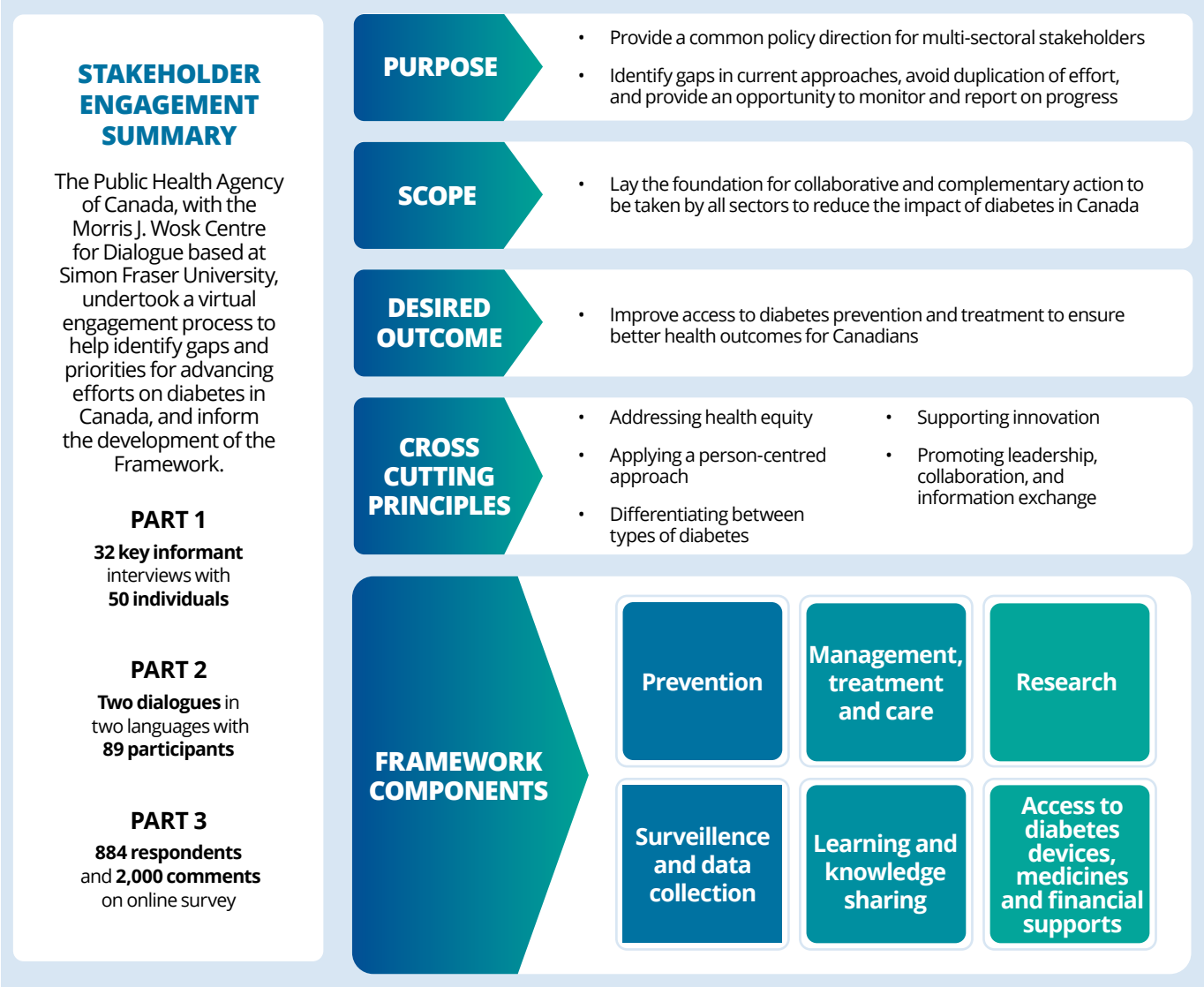
- Addressing health equity
- Applying a person-centered approach
- Differentiating between types of diabetes
- ·Supporting innovation
- Promoting leadership, collaboration, and information exchange

Framework components:

- Prevention
- Management, treatment, and care
- Research
- Surveillance and data collection
- Learning and knowledge sharing
- Access to diabetes devices, medicines, and financial supports

The Framework summary below outlines the process, purpose, scope, and overall desired outcomes.

Summary of the Framework[1]



Indigenous Engagement and a National Diabetes Framework: In respect to reconciliation and in recognition of Indigenous autonomy, self-determination, and sovereignty, the Public Health Agency of Canada has provided independent funding to the National Indigenous Diabetes Association (NIDA). NIDA is engaging with various Indigenous peoples, nations and organizations across Canada to develop an Indigenous Diabetes Framework. Through supporting open dialogue, NIDA sits on the Diabetes Canada/SMIDF's Pan-Canadian Action for Diabetes committee to promote mutual knowledge exchange and collaboration. For more information about NIDA, please visit their website (nada.ca).

Speakers:

- Adria Cehovin - Diabetes Canada: Sustaining Momentum to Implement the Diabetes Framework Overview
- Amanda Clinton - Provincial Diabetes Program
- Katelin Campbell, Michelle Hogan, Anna Marshall - Specialty Diabetes Programs in Prince Edward Island
- Krisandra Cairns - Provincial Preventative Diabetes Foot Care Program
- Taylor Mackenzie, Angela Blanchard, Elizabeth Smith, Diana MacLennan - Patient Medical Homes
- Michelle Smith, Emily McGuigan - The Journey of the Unaffiliated Diabetes Patient
- Martha St. Pierre - Insulin Pump Program and Glucose Sensor Program
- Beth Bradley - Prince Edward Island's Diabetes Drug Program

Diabetes in Prince Edward Island, 2024

Below are Diabetes Canada's estimates of diabetes prevalence and costs, in Prince Edward Island:

Estimated Prevalence and Cost of Diabetes - Prince Edward Island[2]

Prevalence (1)	2024	2034
Diabetes (type 1 + type 2 diagnosed + type 2 undiagnosed)	25,400 / 15%	31,800 / 16%
Diabetes (type 1 and type 2 diagnosed)	17,540 / 10%	23,030 / 12%
Diabetes (type 1)	5-10% of diabetes prevalence	
Diabetes (type 1 + type 2 diagnosed + type 2 undiagnosed) and prediabetes (includes undiagnosed)	52,130 / 30%	61,660 / 32%
Increase in diabetes (type 1 and type 2 diagnosed), 2024-2034	31%	
Direct cost to the health care system in 2024	$25 million	
Out-of-pocket cost per year (2)		
Type 1 diabetes costs, % of family income	$867-$6,085 / 3%-20%	
Type 2 diabetes costs, % of family income	$487-$4,832 / 2%-16%	

For many living with diabetes, there are often impacts both on the body and social fabric of the person. Nearly half of people with type 1 diabetes and one-third with type 2 diabetes experience diabetes distress—an emotional burden that makes it harder for people to stick to diabetes management plans and can lead to burnout[2]. In addition people living with diabetes are ***three times*** *more likely to be hospitalized with cardiovascular disease,* ***12 times*** *more likely to be hospitalized with end-stage renal disease, and almost* ***20 times*** *more likely to be hospitalized for a non-traumatic lower limb amputation compared to the general population*[2]. For these reasons and others, diabetes is an expanding priority in many provinces.

Presentations

Amanda Clinton - Provincial Diabetes Program (PDP)

Amanda Clinton, provincial diabetes program clinical lead, provided a detailed overview of the Provincial Diabetes Program in PEI. The programs specific objectives are to:

- Reduce long-term complications associated with diabetes,
- Promote self-care practices by individuals with diabetes,
- Reduce morbidity and mortality due to diabetes
- Increase awareness of clinical practice guidelines by clients, families and other health care providers

To meet these objectives, each staff member has a distinct role to play.

Diabetes educators (DE) are mainly responsible for teaching self-management skills, providing education, counselling, coaching and support to individuals living with diabetes and their support persons. DE's are found throughout the province's six primary care networks and can support general diabetes to specialty populations in settings including medical homes, primary care networks and primary care clinics. Clinton mentioned wait times to see a DE in the province differ based on location and the ratio of patients to DE. This may be in part due to staff shortages, increase in population needs, and the recent program expansion. However, efficiency and improvements are constantly sought after, as meetings are held regularly to discuss these matters.

The registered *social worker* for this program provides support in relation to diabetes distress, coping with disease burden, financial needs, access to programs and support, as well as safety and competency assessments.

Within the program, there are 2 *licensed practical nurses (LPN)* who help to support staff (i.e. nurse practitioner and DE's) and patients.

Medical office assistance (MOA) focuses on administrative tasks to support staff and maintain organized workflow, including booking, reminder calls, cancellations, etc.

The *medical director* is involved in providing guidance for policies, program improvement, quality and safety concerns and is an advocate for the PDP at the leadership level. Dr. Lenley Adams, the medical director for the program, is the only provider seeing adult patients with insulin pumps.

The *clinical lead* advocates for the needs of the program and staff, collaborates with staff to advance policies and procedures, and supports the on boarding of new staff.

Finally, a *nurse practitioner (NP)* within the program focuses on supporting unaffiliated patients with the support from an LPN. The process to see a nurse practitioner is as follows:

- Joining the provincial diabetes program via referral or self-referral
- See a DE (Registered Nurse or Registered Dietician)
- DE will do an assessment based on criteria in Figure 1
- Referral made to NP based on assessment

Criteria for referral to DE NP for unaffiliated patients from Diabetes Educators:

- Must be able to see DE NP in Charlottetown at least once yearly (and PRN if needed)
- A1C >8.0% AND one or more of the following:
  - eGFR <60
  - On max tolerated SU/ Metformin/ SGLT2/ DPP4
  - Recent insulin start or in need of insulin start
  - On MDI or pump
  - Recent treatment of DKA, nonketotic hyperosmolar hyperglycemia
  - Recurrent hypoglycemia
  - DE Social Worker/ Patient Navigator has recommended connection after other navigation interventions were unsuccessful

Figure 1. Criteria for referral to DE NP for unaffiliated patients from Diabetes Educators.

To be enrolled in the program, referral or self-referral is needed based on the diagnostic criteria as created by Diabetes Canada (Figure 2). Referrals must be accompanied by recent laboratory testing within three

months of referral including but not limited to: A1C, Random Glucose, Lipids, and Creatinine. Having up-to-date lab work is crucial as it helps to determine how quickly a patient needs to be seen. After patients are seen as stable, they are connected with the primary care (PC) RN for their ongoing follow-up.

FPG ≥7.0 mmol/L (Fasting = no caloric intake for at least 8 hours)

or

A1C ≥6.5% (in adults)

or

2hPG in a 75 g OGTT ≥11.1 mmol/L

or

Random PG ≥11.1 mmol/L

Figure 2. The diagnostic criteria as created by Diabetes Canada[3]

To determine how quickly a patient needs to be seen, the criteria in Figure 3 is utilized as set by The Standards for Diabetes Education in Canada (Figure 3).

Uncontrolled diabetes, symptomatic, with blood glucose levels greater than 20mmol/L, ketonuria greater than 1.5 mmol/L

- Newly diagnosed type 1 diabetes
- Pregnancy with pre-existing diabetes
- A crisis that severely impacts on the ability to manage diabetes
- Recent treatment for diabetic ketoacidosis/ nonketotic hyperosmolar hyperglycemia or severe hypoglycemia
    - Within 1 to 2 weeks for women with gestational diabetes.
    - In the absence of priority standards for diabetes follow up services, priority may be given to individuals with marked hyperglycemia (A1C > 8.5%), individuals with diabetes complications (such as nephropathy, neuropathy, retinopathy), pediatric patients and pregnant women based on clinical judgment.

Figure 3. Criteria as set by The Standards for Diabetes Education in Canada, 2014.[4]

It is their goal to see patients within 48 hours however, specific networks have larger wait times and patients are prioritized as able.

The PDP itself offers:

- Group classes for patients newly diagnosed with type 2 diabetes and patients with prediabetes
- Individual appointments
    - Reviewing blood works
    - Foot assessments
    - Date of last eye exam
    - Medication assessment and advocating
    - Technology supports (i.e. sensors)
    - Insulin adjustment
    - Insulin teaching (site rotation, proper injection technique etc.)
    - Mental health support (diabetes distress)
- Group education sessions
    - For health care providers
- Social work services
    - Connecting to services
    - Diabetes distress
    - Financial support
    - Cognitive assessments
- Specialized services for pediatrics, insulin pumps, and pregnancy

The PDP is committed to improving patient care through collaboration and implementation of best practices.

Katelin Campbell, Michelle Hogan, Anna Marshall - Specialty Diabetes Programs in Prince Edward Island

As part of the provincial diabetes program, Katelin Campbell, Michelle Hogan and Anna Marshall shared the specialty diabetes programs focusing on insulin pumps, pregnancy and pediatrics. Staff for this program include registered dietitians (RD) and registered nurses (RN) located in Charlottetown and Summerside, PEI. Both RD's and RN's, while unique, share similar roles within the program. Specialty diabetes educators work with clients to promote self-care, and overall disease management with the goal to enhance quality of life, reduce risk factors for acquiring further comorbidities, and to reduce the need for acute care services. RD's in the program:

- Meet with pediatric patients who are newly diagnosed with type 1 and their families in hospital, and support school management planning
- Attend clinics (insulin pump and pediatric)
- Meet with patients, their families and support persons one on one
- Meet to discuss preconception counselling and review pregnancy teaching
- Provide general nutrition counselling

Pediatrics and young adults

The Pediatrics and Young Adult Program is for individuals up to 25 years of age with type 1 diabetes, type 2 diabetes, and maturity-onset diabetes of the young. The program includes internal medicine specialists and ten pediatricians between Charlottetown and Summerside. The pediatric and young adult specialty supports insulin pump training and management as well as management using MDI and oral agents. The overall goal is to encourage continuation of adherence and compliance with diabetes management and for there to be a seamless transition from pediatrics to adult care. Marshall provided us with updates on new initiatives in the pediatrics space including the school/daycare program, Baqsimi initiative, and point of care A1C testing in Charlottetown clinics.

School/Daycare Program

- In partnership with Public Schools Branch (PSB), created guidelines and documents used to facilitate care of children while in daycare and schools.
- Allows for teachers and educational assistants to manage the care of diabetes for children in schools.

PEI is one of the first provinces to have documents in place so kids can have insulin administered while they are there, with Nova Scotia following.

Baqsimi Initiative

- New Baqsimi (glucagon, lifesaving medication in event of extreme low) in schools launched late September 2024 which provided protocols and FAQ sheets

They are the first province in Canada to have an initiative like this.

Point of care A1C testing

- Taking place In Charlottetown clinics for the young adult and pediatric population allowing patients to have their A1C tested in real time
- Aims to eliminate the need to go to additional appointments which supports caregivers and patients with their schedules

Adult Insulin Pump Program

The adult insulin pump program is a new initiative in PEI with expanded coverage to those over 25 years of age, living with type 1 diabetes. Patients are followed 4x per year in insulin pump clinics with RNs and/or RDs certified in insulin pumps and seen 2x a year by internal medicine specializing in insulin pump therapy. Additional staff include MOAs and an NP.

Pregnancy (gestational and pre-existing diabetes in pregnancy)

DE's with a specialty in pregnancy, work with patients throughout their pregnancy journey from preconception to post-partum. This population is mandated to be seen two weeks from referral, where they are provided with education and monitoring lifestyle modifications and medications by the DE's. During pregnancy, they will be followed one to two times a week to review glucose readings and for adjustments of insulin. Staff are committed to making support as easy as possible by providing text and email communication along with supplies including glucose meters and strips. Patients with gestational diabetes are contacted three months after

delivery to ensure repeat 75 gram oral glucose tolerance test (OGTT) has been completed.

In this branch of the program, staff work cross functionally with the obstetrics group throughout the patient's pregnancy journey.

The specialty diabetes program has had many firsts and milestones. As such, this program can serve as a blueprint for replication across the country to improve diabetes care for pediatric, adult, and pregnant patients.

Krisandra Cairns- Provincial Preventative Diabetes Foot Care Program

Krisandra Cairns, Provincial Skin and Wound (Diabetes) Nurse Lead, provided a summary of the Provincial Preventative Diabetes Foot Care Program in PEI. Although there are more than 17,000 Islanders and 15-25% of them will likely experience a diabetes ulcer in their lifetime, the province did not have programs to provide diabetes foot care. A complication for providing any foot care program is that there is no standardized education/certification recognized as industry standard by a nursing regulatory body. RNs and LPNs are accountable to their regulatory bodies, and PEI's LPN regulatory licensing body (CLPNPEI) has a foot care practice directive published in 2021 that PEI LPNs must follow. Special authorization is needed for an LPN to provide advanced foot care below the dermis (at the time Krisandra was unaware of any practicing LPNs with this special authorization).

Available options for foot care in PEI include:

- Long term care/community care facilities might have their own foot care RN or LPN
- Periodic offerings in the community by LPNs as primary care networks have the funding for it
- Inpatient acute care waitlist has a list provided to nurses that can provide foot care when their schedule permits it
    - Due to the current state of the healthcare system, they are often prioritized elsewhere
- Private hire has been the most consistent offering of foot care in PEI and so is highly encouraged despite financial impact
    - Recent concerns with practitioner credentials have led to worries with private hiring

With staggering statistics and lack of standardized foot care, the first pilot diabetes foot care program, launched in 2022 and ended in May 2024, focused on fall prevention. Staff within this pilot program included a physiotherapist and LPN. The goal was to provide foot care two days a week and the pilot program was able to provide care for 157 patients, with 179 on a wait list. Some challenges that arose from this program were:

- Staffing challenges
- Paper based program
- Pilot was not streamlined with other clinics within health PEI using an EMR system

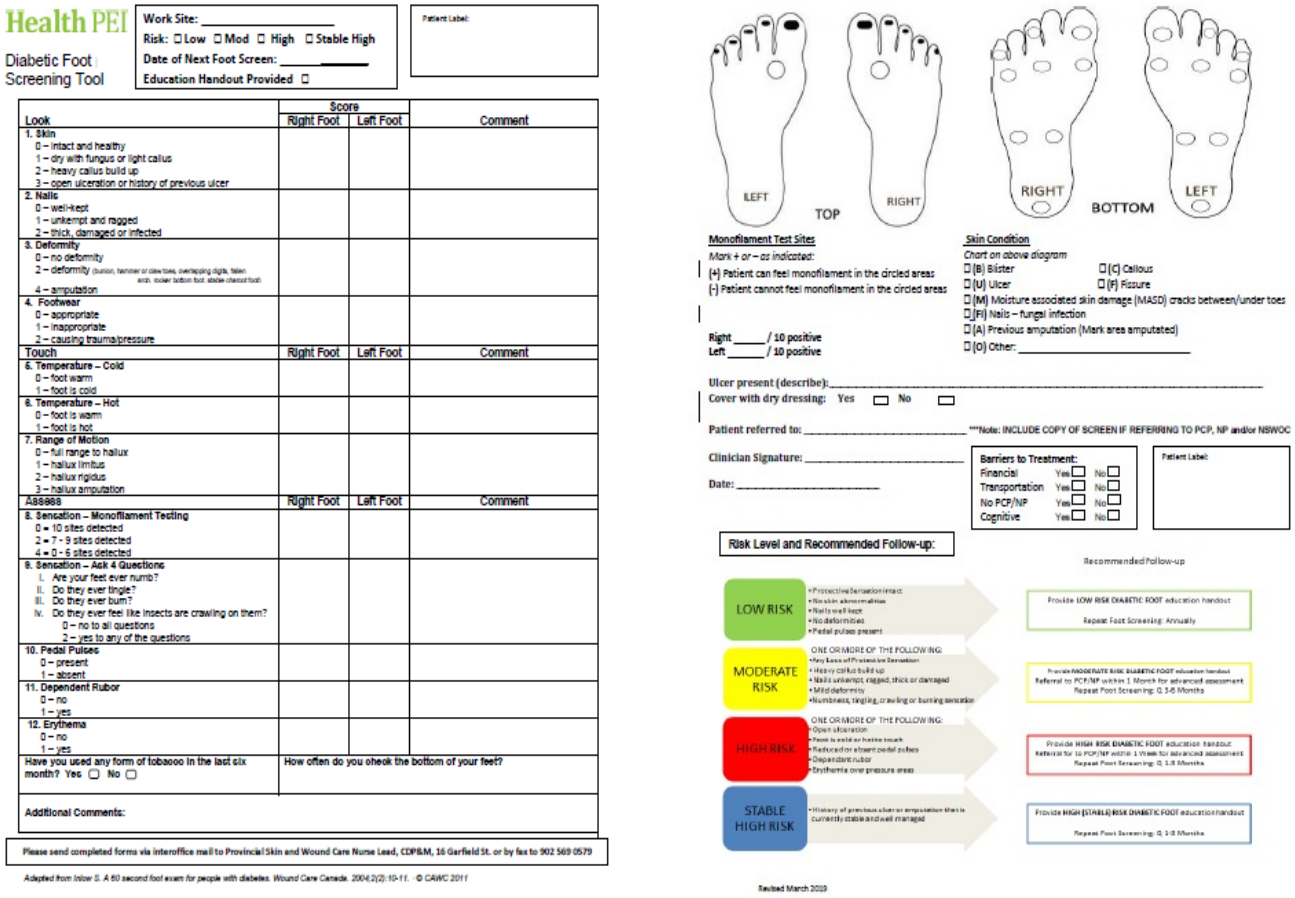
This pilot program served as the foundation for the development of the Provincial Preventative Diabetes Foot Care Program. The soft launch took place in May 2024 where the goal was to:

- Reduce risks and incidences of foot complications
- Improve quality of life for patients
- Educate and improve confidence in self-care or caregiver care of feet when able
- Provide diabetes foot care when self-care or caregiver care is not an option

With the program offering:

- Foot and nail assessments by an LPN with post-graduate training in foot care
- Nail care, callus care, and corn care
- Education and promotion of self-care or caregiver provided care
- Education to prevent common foot issues
- Professional advice on when medical attention outside the ability of the program is needed

To be referred to this program, the patient must have a diabetes diagnosis along with a completed diabetes foot screening assessment using the Provincial Diabetes Foot Screening Tool (Figure 4). This tool assigns a risk level for foot complications where a patient must be moderate, high, or stable high risk to be referred to the program. To complete this, the healthcare provider looks at skin, nails, range of motion, etc. to determine the individual's risk level, then if appropriate makes a program referral to move the individual along their diabetes foot care journey.



Health PEI

Diabetic Foot Screening Tool

Work Site: _____
Risk: ☐ Low ☐ Mod ☐ High ☐ Stable High
Date of Next Foot Screen: _____
Education Handout Provided ☐

Patient Label:

Look	Score: Right Foot	Left Foot	Comment
1. Skin 0 – intact and healthy 1 – dry with fungus or light callus 2 – heavy callus build up 3 – open ulceration or history of previous ulcer			
2. Nails 0 – well-kept 1 – unkempt and ragged 2 – thick, damaged or infected			
3. Deformity 0 – no deformity 2 – deformity (bunion, hammer or claw toes, overlapping digits, fallen arch, rocker bottom foot, elevated charcot foot) 4 – amputation			
4. Footwear 0 – appropriate 1 – inappropriate 2 – causing trauma/pressure			
Touch	**Right Foot**	**Left Foot**	**Comment**
6. Temperature – Cold 0 – foot warm 1 – foot is cold			
6. Temperature – Hot 0 – foot is warm 1 – foot is hot			
7. Range of Motion 0 – full range to hallux 1 – hallux limitus 2 – hallux rigidus 3 – hallux amputation			
A8988	**Right Foot**	**Left Foot**	**Comment**
8. Sensation – Monofilament Testing 0 = 10 sites detected 2 = 7 - 9 sites detected 4 = 0 - 6 sites detected			
9. Sensation – Ask 4 Questions I. Are your feet ever numb? II. Do they ever tingle? III. Do they ever burn? Iv. Do they ever feel like insects are crawling on them? 0 – no to all questions 2 – yes to any of the questions			
10. Pedal Pulses 0 – present 1 – absent			
11. Dependent Rubor 0 – no 1 – yes			
12. Erythema 0 – no 1 – yes			
Have you used any form of tobacoo in the last six month? Yes ☐ No ☐	How often do you ohook the bottom of your feet?		
Additional Comments:			

Please send completed forms via interoffice mail to Provincial Skin and Wound Care Nurse Lead, CDP&M, 16 Garfield St. or by fax to 902 569 0579

Adapted from Inlow S. A 60 second foot exam for people with diabetes. Wound Care Canada. 2004;2(2):10-11. © CAWC 2011

LEFT TOP RIGHT

RIGHT BOTTOM LEFT

Monofilament Test Sites
Mark + or – as indicated:
(+) Patient can feel monofilament in the circled areas
(-) Patient cannot feel monofilament in the circled areas

Right _____ / 10 positive
Left _____ / 10 positive

Skin Condition
Chart on above diagram
☐ (B) Blister ☐ (C) Callous
☐ (U) Ulcer ☐ (F) Fissure
☐ (M) Moisture associated skin damage (MASD) cracks between/under toes
☐ (Fi) Nails – fungal infection
☐ (A) Previous amputation (Mark area amputated)
☐ (O) Other: _____

Ulcer present (describe): _____
Cover with dry dressing: Yes ☐ No ☐

Patient referred to: _____ ***Note: INCLUDE COPY OF SCREEN IF REFERRING TO PCP, NP and/or NSWOC

Clinician Signature: _____

Date: _____

Barriers to Treatment:
Financial Yes ☐ No ☐
Transportation Yes ☐ No ☐
No PCP/NP Yes ☐ No ☐
Cognitive Yes ☐ No ☐

Patient Label:

Risk Level and Recommended Follow-up:

Recommended Follow-up

LOW RISK
• Protective Sensation Intact
• No skin abnormalities
• Nails well kept
• No deformities
• Pedal pulses present

Provide LOW RISK DIABETIC FOOT education handout
Repeat Foot Screening: Annually

MODERATE RISK
ONE OR MORE OF THE FOLLOWING:
• Any Loss of Protective Sensation
• Heavy callus build up
• Nails unkempt, ragged, thick or damaged
• Mild deformity
• Numbness, tingling, crawling or burning sensation

Provide MODERATE RISK DIABETIC FOOT education handout
Referral to PCP/NP within 1 Month for advanced assessment
Repeat Foot Screening: Q 3-6 Months

HIGH RISK
ONE OR MORE OF THE FOLLOWING:
• Open ulceration
• Foot is cold or hotter touch
• Reduced or absent pedal pulses
• Dependant rubor
• Erythema over pressure areas

Provide HIGH RISK DIABETIC FOOT education handout
Referral to to PCP/NP within 1 Week for advanced assessment
Repeat Foot Screening: Q 1-3 Months

STABLE HIGH RISK
• History of previous ulcer or amputation that is currently stable and well managed

Provide HIGH (STABLE) RISK DIABETIC FOOT education handout
Repeat Foot Screening: Q 1-3 Months

Revised March 2013

Figure 4. Provincial Diabetes Foot Screening Tool

If a patient is a "high" or "stable high" risk, they are automatically enrolled to the program regardless of insurance status. On the patients' end, they must consent to foot care, be able to come into the clinic and be able to go in and out of a chair as there is no access to a lift.

Those who are "moderate" risk were initially eligible for one visit for an assessment and education only but the criteria for accepting "moderate" risk individuals for long term program admission has become more flexible. Now, the foot care nurse can decide who and how long the patient will be in the program based on their nursing assessment. From April-June 2024 there were 906 screenings completed where 506 fell into the moderate or higher risk stratification. These 506 clients could be referred to the program.

Some challenges highlighted by Cairns regarding the program thus far have been related to staffing issues, learning the EMR CHR system, the high number of referrals as the program included waitlisted referrals from the previous pilot, and the reevaluation of the eligibility criteria of the moderate risk stratification also leading to a greater number of patients to care for.

Future plans for the program include a full launch!

Taylor Mackenzie, Angela Blanchard, Elizabeth Smith, Diana MacLennan - Patient Medical Homes

During their presentation it was shared that PEI uses patient medical homes (PMH) to deliver team-based care through a model that has been endorsed by the College of Family Physicians of Canada (CFPC). These teams provide coordinated patient-centered care and include physicians, nurse practitioners, dietitians, diabetes educators, social workers, nurses, and other health professionals. Across the province there are 18 medical homes- the majority have a developed standardized process map.

These maps provide teams with a standardized snapshot of processes and protocols. They are added to orientation materials and followed by all team members to ensure consistent care based on guidelines and best practices. Diabetes educators have provided valuable input in developing these processes. Likewise, aligning with the Canadian best practices and guidelines, EMR team works with diabetes educators to develop standardized encounter (charting) templates.

From this direct relationship, patient medical homes track vital health information, such patient profiles, preventative care and screening, consistent diagnosis codes, and information on risk factors and social determinants of health.

Diabetes Care within PMH

Diabetes Prevention, Management, Treatment and Care

- Prediabetes
- Type 1 Diabetes (>25 yrs)
- Type 2 Diabetes (>25 yrs)
- Referral/access to Diabetes Specialty Programs (Gestational Diabetes, Pediatrics, Insulin Pump Program)

Process

- Provider can send internal message to Diabetes Educator – "Hand-off"
- Based on recent A1C, health status, and/or suggested time frame the Diabetes Educator will send note to admin to arrange an appointment with a Diabetes Educator (RN or RD).
- Patient can also be offered to attend Diabetes or Prediabetes class
- *Patient can self-refer to see Diabetes Educator*

Key Components - Diabetes Care PMH

1. Coordinated Care
• **Team Approach**: multidisciplinary team • **Care Coordination**: Seamless communication among providers to manage various aspects of diabetes care.
2. Personalized Care Plans
• **Individualized Management**: tailored to each patient's needs, preferences, and lifestyle, focusing on their specific health goals. • **Shared Decision-Making**: Involving patients in their treatment decisions
3. Monitoring and Support
• **Regular follow up** • **Technology Integration**: Use of continuous glucose monitors (CGMs) and mobile health applications for real-time data and feedback.
4. Education and Support
• Patients and other Health Care professionals • Building capacity for self monitoring and self management • Navigating healthcare system to access pharmacare programs, resources and support
5. Behavioural and Mental Health Support
• Identify patients who may benefit from additional support • DEC Social Worker
6. Preventative Care and Screening
• Use of Diabetes Template to ensure patient is offered preventative care and screening as per Diabetes Canada Practice Guidelines
7. Improved Access to the appropriate care provider
• Access to care within timely manner
8. Quality Improvement and Data Collection
• EMR – Diabetes Templates • Quality Improvement (regular QI meetings and processes)

Challenges

- Still in the development stage – not all PMH have allied health support and support staff in place
- Less interaction/access to our Diabetes Educator Colleagues;
  - Training and collaboration
- Space

Benefits

- Improved communication between Primary Care Provider and Diabetes Educator
- Patient satisfaction – patient centered care
- Increased learning from other team members
- Collaborative care in timely manner
- Ability to work to full scope in a supported way
- Part of a team
- Ability to address and deal with issues earlier

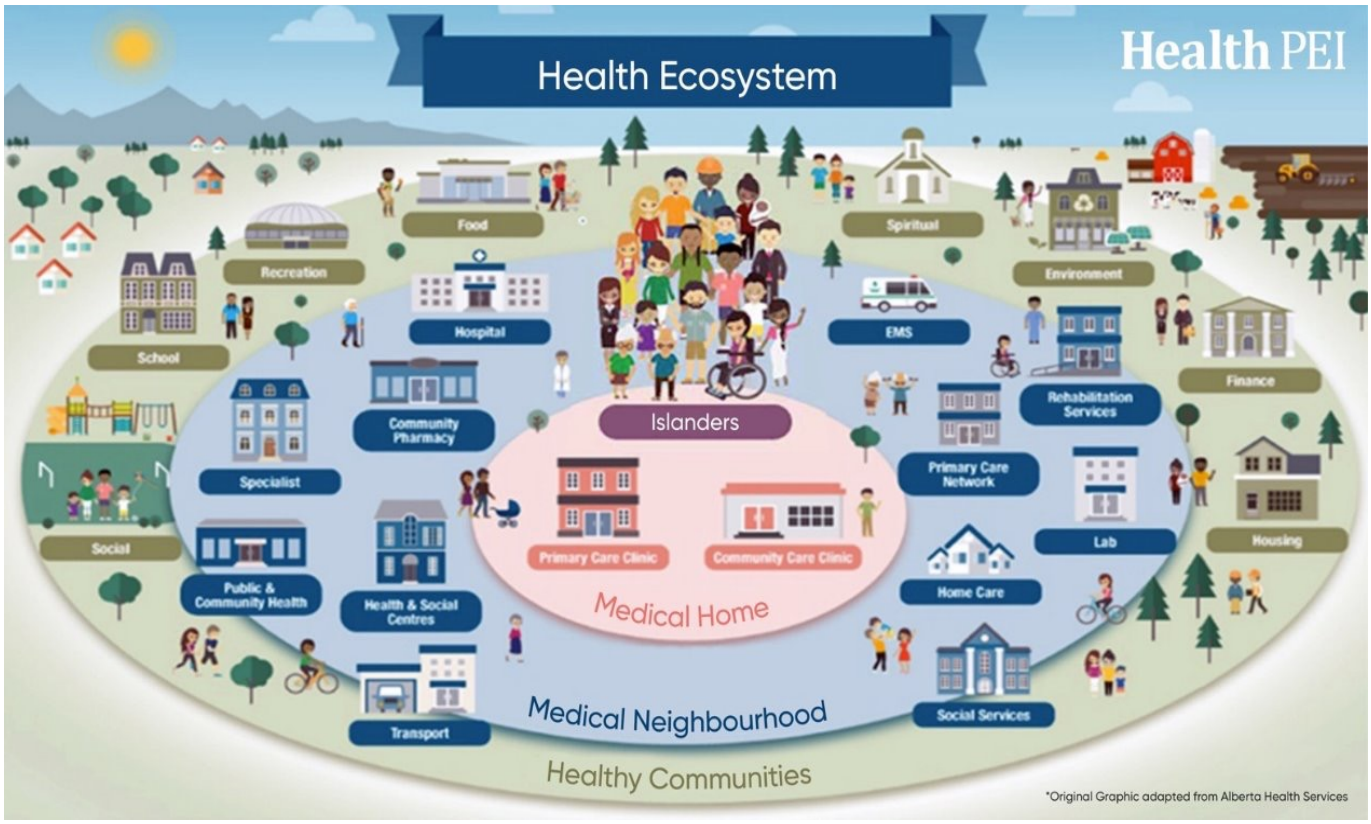


Figure 5. PEI health ecosystem

Michelle Smith, Emily McGuigan - The Journey of the Unaffiliated Diabetes Patient

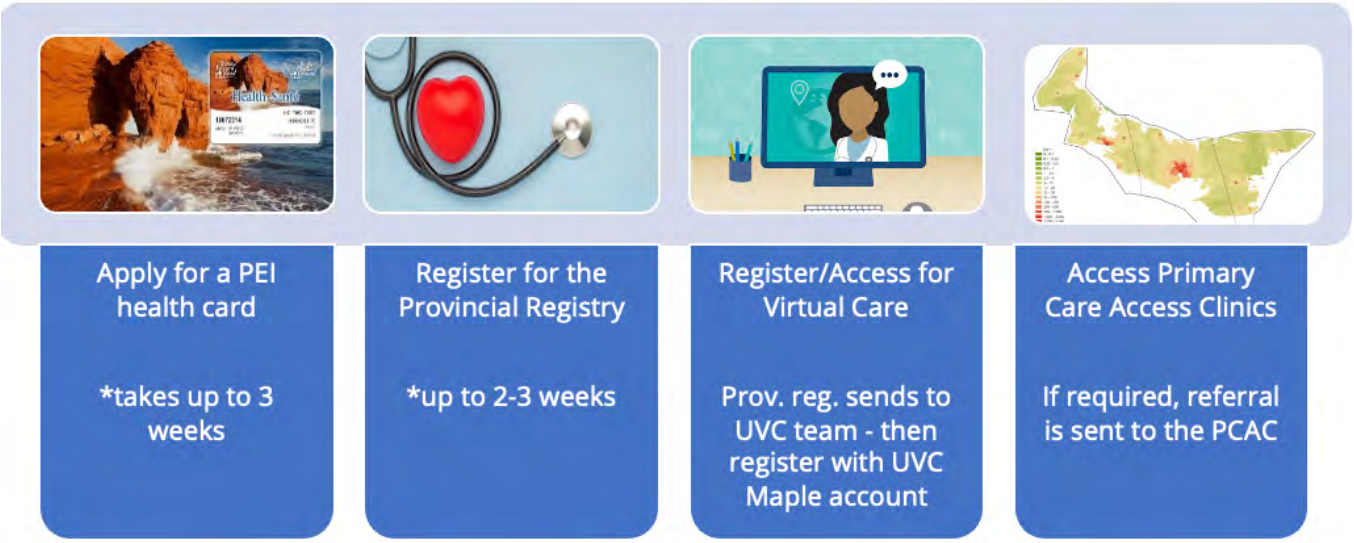
For those who live in PEI without a family doctor, and unable to be seen virtually on the UVC Maple app, they have the option of going to Primary Care Access Clinics (PCACs) for in-person care. This option "strengthen a community of practice across all primary care networks in PEI." Included in these PCACs is a team of medical doctor, nurse practitioner, RN – chronic disease management, RN – diabetes education, RD – diabetes education, social work, pharmacist, physiotherapist, Intraperitoneal Nutrition, and medical office assistant.

The pathway to unaffiliated care is highlighted below

In addition to the UVC Maple app and PCACs, there are also Health PEI Patient Navigators. These people help individuals and families "access resources within the health care services, community support organizations and other resources regardless of where you live in PEI or where you are within your health care journey. Health PEI Navigators specialize in helping people find the most appropriate access points to meet their health care needs."

Future collaboration across PEI includes possible connection to #211, library outreach, and #811 – 24-hour access to non-urgent health information via a registered nurse over the phone to:

- Help you determine if emergency or non-urgent medical attention is required;
- Provide current, reliable information related to health issue;
- Offer helpful guidance about health services available in the province



Martha St. Pierre - Insulin Pump Program and Glucose Sensor Program

Insulin Pump Program

As of September 2024, the PEI Government has expanded insulin pump coverage, regardless of age, for those medically eligible residents with type 1 diabetes. This revised PEI Insulin Pump Program "provides financial assistance to eligible residents to help offset the cost of their insulin pump and related supplies," regardless of age.

What Devices are Covered?

The following supplies from a government-approved vendor (Medtronic, Omnipod (Insulet Canada), and Tandem) are eligible for coverage:

- Insulin pump from a government-approved vendor (one pump every five years)
- Infusion sets (maximum 140 sets per year)
- Reservoirs (maximum 140 per year)
- Site inserts (maximum one replacement device per year)
- Skin adhesive wipes (maximum 150 per year) and
- Sterile transparent dressings (maximum 200 per year).

The program does not cover out-of-pocket expenses for any extra blood glucose test strips where required, lancets, or pump batteries. Also, Glucose Sensors are covered under a separate provincial program. The application process for the PEI Insulin Pump Program is listed below:

1. Complete the "Are you Ready to Pump Self-Assessment" (website)
2. Complete the online calculator to understand the estimated cost. (website)
3. Contact your diabetes care team to complete an intake assessment.
4. As you progress in your diabetes self-management, you will work with your insulin pump team to complete any additional training prior to applying to the program.
5. When ready, you will be provided with an IPP application by the team
6. Complete and submit by mail to address on the application
7. You will be given a pump start appointment date by your insulin pump educator.
8. Once program registration is complete, you will receive notification from the program administrator. At that time, you can order your pump and pump supplies from your chosen vendor.

Glucose Sensor Program

In 2022, a Glucose Sensor Program was announced by the PEI government. This program outlined, through pharmacy engagement, reduces the cost to support real-time continuous glucose monitoring (rtCGM) and intermittently-scanned glucose monitoring (isCGM) systems.

Eligibility for this program is as follows:

Diagnosed with diabetes

- PEI resident with a valid PEI Health Card
- Filed your most recent income tax return
- Rely on an insulin pump or three or more daily injections of insulin

To apply to the program, the following steps must be complete:

- Complete the Glucose Sensor Program Initial Application Form via website
- Physician, NP or diabetes educator will need to complete and sign a portion of this form.
- Submit your completed form to the Glucose Sensor Program Administrator

Marsha Cusack, Beth Bradley - Prince Edward Island's Diabetes Drug Program

Eligible Island residents can access PEI pharmacare to assist (partially or fully) with the cost of eligible prescription medications, certain medical supplies, and pharmacy services.

Eligibility criteria

- Be a PEI resident as defined by the Drug Cost Assistance Act;
- Have a valid PEI Health Card;
- Qualify for one of the drug programs;
- Have your medication listed on the PEI Pharmacare Formulary; and
- Have your medication dispensed at a participating PEI community pharmacy.

Drug Cost Assistance Act includes the following elements:

Definition of "resident": means a resident as defined in the regulations under the Health Services Payment Act R.S.P.E.I. 1988, Cap. H-2, but does not include persons who are resident pursuant to a temporary resident visa, study permit, work permit or other similar visa or permit issued by Citizenship and Immigration Canada;

Payor of last resort: Where, in respect of a benefit, an eligible person is covered by third-party insurance or a prescribed benefit plan or program not established under this Act, the Plan shall be the payor of last resort.

Figure 6. PEI Pharmacare Drug Programs

PEI Copay Program

If you have been diagnosed with diabetes and require diabetes medication(s), you may be eligible for coverage of approved medications and supplies through the Diabetes Drug Program.

The Diabetes Drug Program provides assistance toward the cost of approved medications and supplies including insulin products, oral medications, urine-testing materials, and blood strips.

How much will I have to pay for my medication?

- Your coverage will begin when PEI Pharmacare receives your physician referral. Under the current co-pay schedule, you will pay the following:
  - $10.00/10 mL vial or $20.00/5 x 3 mL cartridges of insulin (*);
  - $11.00 per oral medication prescription (*);
  - $11.00 per prescription for 100 test strips every 25 days (if you have taken insulin within the past 5 months).
  - $20.00 per glucagon device (maximum of 2 per year if you have taken insulin within the past 5 months).

(*) As part Prescription Care

- Copays for eligible insulins are $5 per vial or box of cartridges and
- Copays for eligible oral diabetes medications are $5 per prescription

As presented, since June 1, 2023, under the joint federal-provincial Prescription Care Initiative, copays for >80% of commonly prescribed, eligible medications have been reduced to $5 for residents in the Diabetes Drug program. Medications eligible for the $5 copay are identified in the formulary with a ⑤ preceding the non-proprietary or generic name. This brings the cost of many eligible medications used in the management of diabetes to $5 for residents of PEI.

There was lively discussion around the topic of copay at the roundtable, it was recognized that many patients might have more than one drug to pick up per month, let alone more than one drug per family per month and that the copay amount overall could still add up to a considerable amount. This coincides with broader discovery research on the impact of copay to a person with diabetes' budget.

Breakout Discussions

In addition to the presentations, structured breakout group sessions were implemented. Elements of the Appreciative Inquiry Approach were used to guide discussions. Attendees were divided into four groups to discuss the topics based on the programs/interventions shared in the presentations being:

- Specialty Diabetes Programs
- Patient Medical Homes
- PEI Diabetes Drug Program
- Unaffiliated Services

Addressing the following questions:

- **Define:** What is working, what are gaps in the program?
- **Dream:** What should meaningful diabetes care look like for this program?
- **Design:** What policies, initiatives, programs, or interventions, are needed to support this adjustment/dream?
- **Deliver:** How can we deliver on this vision? Consider: Who will or needs to champion this work? What conversations need to be had? What groups need to form, or be further supported? What organizations/departments need to collaborate?

The following two pages highlight the breakout session responses from the attendees.

Summary of First Breakout Session Group Work

Specialty Diabetes Programs	

Define	What's working:
	• Collaborative team model
	• Insulin pump clinics part of the insulin pump program
	• Have a clear working plan
	• Expanded coverage and financial supports
	Gaps:
	• Single points of failure in specialty services
	  • Only three certified pump trainers
	  • Minimal cross coverage and support
	• Incentives to be diabetes education/ specialist
	  • Extensive competency requirements for staff
	  • Minimal access to education and support in PEI
	• Inconsistent collaboration across PEI with specialists
	• Multirole positions
	• Administrative support
	  • Lots of back and forth
	• Long wait times and heavily working staff when transitioning to a specialty program
	• Difficult to find supports for those who are not PEI residents (i.e. newcomers)

Dream	• Embed pharmacy services into provincial diabetes program
	• Onboarding supports
	• More physicians supporting specialist
	  • have one physician specialist supporting adult patients with pumps
	• Space
	  • Proper space for collaboration between teams
	  • Creating complex care clinics
	• Data supporting allocation of services and staff positions
	• Staff to attend conferences to expand competency, develop networks and supports

Design	• Reevaluation of financial coverage related to pharmacare costs • Recruitment and retention of staff • Mental health support for patients • Have a diabetes patient navigator • Collaboration with other Atlantic provinces • Sharing resources, education etc. • Increase awareness of specialty programs
Deliver	• Point-of-care A1C testing • Work-life balance • Improve collaboration with leadership and front-line staff

Patient Medical Homes	
Define	What's working: • CHR • Team collaboration Gaps: • Staff shortages • Limited space • Inbox management • Patient and diabetes educator ratio • .50 vs 1.0 FTE
Dream	• All patients are identified, stable and well managed • All patients are connected to patient medical homes, have access to affordable medications and equipment • Continuity of care • Funds to help with self-management • Food security • Appropriately triaged • Easily tracked, screened and monitored • Have all patients aware of resources • Upstream approach to diabetes care • Full staffing to reach and manage all patients • Patient centered care to meet patients where they're at • Group classes
Design	• Work-life balance and wellness policies • Manageable caseloads ratios
Deliver	• Clear FTE ratio for patient population • Improve CHR analytics

Diabetes Drug Program	

Define	What's working:
	• Drug coverage
	• Change to copay ($5 compared to $11-$20)
	• Removal of age restrictions
	Gaps:
	• Copay for life-saving treatment (insulin, glucagon)
	• No cap on co-payment under the Diabetes Drug Program
	• Coverage for needles, lancets, and test strips
	• Lack of appropriate diabetes foot care and coverage for footcare
	• No maximum cap on co-pay
	  • Household cap for multiple family members living with diabetes
	• Ease of access
	  • Internet access, health literacy, communication of programs

Dream	• Universal coverage
	  • $0 copay for pumps and diabetes supplies
	• No gaps or differences between provinces
	  • Coverage is the same regardless of where you are in the country
	• Provincial no-cost foot care program
	  • Coverage for footwear
	• Improved drug coverage for new type 2 diabetes drugs that protect the heart and kidneys
	• Less profit driven focus by pharmaceutical companies
	• Remove the legislative barrier (federally and provincially)
	• Obesity pharmaceutical coverage
	  • Upstream prevention

Design	• Expanding diabetes drug program
	  • More drugs and coverage
	• Standard foot care program
	  • Low barrier foot care and footwear
	• National pharmacare program
	• Diabetes supply program
	  • Test strips, needles etc.

Deliver	• Better advocacy and lobbying for better drug coverage • Open communication between all parties • i.e. provincial, federal, and partners • Better job at identifying cost burden and understanding cost burden across provinces with types of diabetes • Consistent funding to sustain drug cost coverage • Diabetes Canada presence in PEI to support Islanders

Unaffiliated Services	
Define	What's working: • Primary Care Access Clinics (PCAC) as an access point • LPN support for DE NP • Collaborative team members Gaps: • No DE NP in Summerside • Flow of PCAC has barriers • Challenges to access virtual care • Need internet to access PCAC • PCAC as episodic care vs chronic care • Spatial restrains
Dream	• Equitable care for all, affiliated and unaffiliated getting equitable care • Kinesiologists and pharmacist within program • Increased mental health supports like a psychologist • Library as a facilitator + access • 811 and 211 to increase access • Mobile clinics for those with issues to accessing clinics • MOA for NP • DC office in PEI for unaffiliated patients to access • Diabetes Canada office in PEI
Design	• Union collective agreement • Group medical visits • Virtual appointments facilitated within LPN; hybrid model for rural areas
Deliver	• Improved analytics to see where we are currently at • Where communities have the highest needs • Leveraging existing staffing to support backlog • Move patients out of DENP and into primary care • Conversations around improving access into PCAC

Panel Discussion

To further understand diabetes management and care interventions in PEI, a panel discussion was created. Six questions were asked to the panel from the moderator, however questions and feedback from the entire group was encouraged.

Our panelists:

Martha St Pierre, RN, BScN, CDE, PEI Department of Health and Wellness Chronic Disease Consultant
Lenley Adams, MD FRCPC FACP, Medical Director Provincial Diabetes Program, Internal Medicine Queen Elizabeth Hospital
Alanna Young, RSW Provincial Diabetes Program/Primary Care Queens East Social Worker

Below is a summary of the questions asked along with the answers from the panelists and audience.

What is your favourite diabetes intervention/program? What are the specific elements that are most efficient/engaging about the intervention/program?		
Social worker perspective	**Government (department of health and wellness) perspective**	**HCP perspective**

• Glucose sensor program
  • More equitable as it's based-on household income
• Insulin pump program
  • More equitable now that age limit is opened
	• Insulin Pump and glucose sensor program
	  • The access to technology
	• Adding insulin degludec (Tresiba) to the provincial Pharmacare formulary as open benefit
	• Improved drug coverage
	• Bringing safer drugs to pharmacare coverage
		• Provincial diabetes program having a clinical lead is a great addition
		• Availability and accessibility of glucose sensors + ability to monitor patient virtually

What diabetes intervention/program could use more attention? Is there a program which would benefit from an adjustment or evolution for greater uptake? Is there a program that could use greater marketing?		
Social worker perspective	**Government perspective**	**HCP perspective**

• Diabetes drug program
  • More specifically focusing on diabetes medication and supplies not covered in the diabetes drug program (i.e. needle tips approx. $40-50/box, test strips $80)
  • There is a high level of referrals for individuals not being able to afford monthly costs of their diabetes medications/supplies
  • Patients rely on samples available at diabetes education centres and medical homes
  • Consider refugee status and support availability for financial coverage for supplies
  • Have individuals deciding between medication and food/other expenses
	• Diabetes drug program
	  • Continue to expand the program by implementing improved drug coverage for type 2 diabetes that protect the heart and kidneys
		• Provincial diabetes program
		  • Provide greater mental health supports
		  • Hire more social workers (currently 1 in the program) and psychologists
		• Diabetes drug program
		  • Being the first province to have provincial obesity drug coverage
		• Implement a program with cognitive behavioural therapy

What are the most distinct small barriers (ex. redundant forms, prolonged processes, communication barriers, systematic elements etc.		
Social worker perspective	**Government perspective**	**HCP perspective**

• Patient level barriers
  • Individuals' level of literacy
  • Ability and access to use technology
  • Language differences
  • Race/ethnicity and cultural differences
  • Unaffiliated population and access to care with regards to diabetes management
• Socioeconomic status
• Ability to afford medication supplies and food
• Impacts of stress and mental health in diabetes management i.e. depression and low mood impacting overall personal care motivation and attending medical appointments
	• Do not have a provincial type 2 diabetes screening program
	  • Have well established screening programs for breast cancer, mammography, colorectal cancer but not for type 2 diabetes, hypertension, or cardiovascular disease
	• Wait times to access specialist i.e. diabetes educators
		• Wait times for primary care access
		• Lots of referrals (to NP and specialists) including those who do not have access to primary care
		• Prescription renewals

What strategies can be implemented to ensure there is ongoing supports available for people with lived experience throughout various life stages?		
Social worker perspective	**Government perspective**	**HCP perspective**

• Peer support groups
  • Speaking with individuals with diabetes directly is a great starting point to see what type of supports they need for each life stage because each person with diabetes is very diverse.
• Collaborating with other community and government organizations
  • I.e. home care, nursing, geriatrics teams
  • Food banks to see if we can get diabetes-specific foods available
  • School food programs for younger population, meals on wheels for senior population or anyone living with disability that's not able to cook for themselves
	• Increase public consultation by Diabetes Canada whether virtual or in person to support people with lived experience through various life stages with diabetes
	• Build linkages with community / neighborhood partners
	  • Leverage supports in community-based pharmacy, local university / colleges and fitness facilities
	• Implement patient satisfaction surveys with care provided so Health PEI can receive feedback from patients with diabetes as to how services/programs are provided, and what can be improved- need to hear from patient
	• Peer led groups/ support groups
		• Patient portal to improve self-management
		• Adequate staff support to support people living in rural areas and seasonal workers

What are you looking for from research to help better understand diabetes care and management (including interventions, programs etc.) and how can these be prioritized to improve outcomes?			
Social worker perspective	**Government perspective**	**HCP perspective**	**Audience**

• Mental health
  • Psychosocial aspect
  • Stress and impact on diabetes management
  • Fear of hypoglycemia
  • Accessibility to mental health supports
• Food insecurity
• Cost of living and its effects on diabetes management
	• Prevention of type 2 diabetes
	  • Amplification that type 2 diabetes can be prevented/ delayed through lifestyle changes and pharmaceutical agents
	• Updated guidelines that reflect the ever-changing research-based evidence seen with newer agents (GLP1/SGLT2i)
	• Communication of guidelines changes
	• Have less industry involvement/bias
		• Have clinician involvement in research provincially
		• Specifics around high type 1 diabetes rates in PEI
		  • Use this research to guide best practice
			• The impact of social media/ media in general in raising awareness about the importance of preventative measures and screening
			• Research on how social media/media impact the way we are receiving information these days
			  • From a knowledge translation perspective

What interventions/programs are available for families and caregivers in the management of diabetes to enhance support systems for people with lived experience? What types of interventions/programs should exist?			
Social worker perspective	**Government perspective**	**HCP perspective**	**Audience**
• Pediatric and young adult clinic that would work closely with families and caregivers • More access to family and caregiver education and support would be beneficial across life stages	• Diabetes camp organized by a non-profit for type 1 diabetes • Help to navigate funding opportunities (Disability Tax credit, drug programs, social assistance etc.) • Increase community-based supports outside of the health care system including access to peer support, healthy nutrition, physical activity, smoking cessation, alcohol reduction • CPHO released a Live Well action plan that has targeted approaches to support healthy living in PEI through public initiatives, provincial legislation etc.	• Mental health support for parents/ caregivers especially when child is transitioning from pediatrics to adulthood	• No specific program but diabetes camp for kids available • Looking to create a mentorship program where young adults mentor pediatric patients

Prince Edward Island and the Framework

PEI is committed and continues to put a great deal of effort into their diabetes initiatives. As seen in the alignment table below, the PEI Diabetes Strategy and the Framework have many overlapping elements/themes.

The Framework	Prince Edward Island
Addressing Health Equity	• Support action across all levels of government on addressing inequalities within the social determinants of health
Prevention	• Implementation of a diabetes prevention program (or as part of a larger Health PEI risk reduction approach)
Management, Treatment and Care	• Increase access to self-management education • In collaboration with provincial Mental Health and Addiction services examine opportunities to create linkages and expand supports for people living with diabetes
Surveillance and Data Collection	• Establish data indicator (lab criteria) and report provincial screening rates

Learning and Knowledge Sharing	• Awareness campaign with public (including social media, newspaper, physician offices, primary care clinics):
	  • Increasing provincial prevalence rates
	  • Type 2 diabetes can be prevented / delayed
	  • How to reduce risk
	• Education to health care providers to increase awareness of screening guidelines and to promote the need for early identification of type 2 diabetes and prediabetes

Access to diabetes devices, medicines and financial supports	• Examine opportunities for new medication and supply coverage under PEI Pharmacare's Diabetes Drug Program
Source: Framework For Diabetes in Canada, Public Health Agency of Canada	Source: PEI Roundtable Presentations and Health PEI. (2020). Health PEI Diabetes Strategy 2020-2024. https://www.princeedwardisland.ca/sites/default/files/publications/diabetes_strategy_2020_2024.pdf

As the Health PEI Diabetes Strategy 2020-2024 is ending, we look forward to learning the plan for the years ahead!

Event Feedback

Based on the feedback provided and collected for this event, it can be summarized that the event was received with enthusiasm and a desire for greater learning. The PEI roundtable became a key event for knowledge exchange, learning and bringing important discussion topics to the forefront. We are grateful for the time and support the participants contributed and progress that PEI collectively continues to strive for in diabetes care. From presentations to discussions, the event supported knowledge sharing and collaboration. Many individuals felt they had gained value from this event, with attendees sharing the following when asked what discussions and/or themes resonated with them the most:

"Patient Medical Homes; Lennox Island is in the process of becoming a Patient Medical Home so it was beneficial to hear from those already operating in this way."

"Improving care for unaffiliated populations - this is near and dear to me and felt the conversation around how to improve was fruitful and we were able to come up with tangible solutions"

"I enjoyed the roundtable conversation around unaffiliated services in PEI. As a result of this discussion, we have created connections and improved access for those living with diabetes without a primary care provider. This was very valuable."

"I really enjoyed the afternoon group discussion. It was interesting to see the gaps and trends were common throughout all the discussion points (tables) as were the solutions."

"I was really interested in learning about the Provincial Diabetes Program and all its services. Also I was pleased to have the opportunity to understand how the patient medical homes fit into the equation."

Conclusion

The SMIDF Project is an instrumental initiative by Diabetes Canada and PHAC. The Prince Edward Island Roundtable 2024 aimed to encourage further attention and engagement with diabetes in PEI. As the fourth roundtable of this project, it serves as a beacon for fostering collaboration, identifying barriers, and promoting a more equitable approach to diabetes care, thereby positively impacting public health outcomes in the region.

The roundtable met the mentioned meeting objectives and beyond through:

- Identifying provincial programs, interventions and opportunities to optimize efforts (for those living with or working in diabetes)
- Reviewing alignment with the Framework in Prince Edward Island and build on the collaborative engagement with strategic partners
- Determine diabetes access and resource pathways in PEI

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