Sioux Lookout
First Nations
Health Authority

SLFNHA Regional Diabetes Strategy

Final

November 2019

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INTRODUCTION

This report documents a proposed Regional Diabetes Strategy for the Sioux Lookout Area First Nations. The strategy is intended to support the Sioux Lookout First Nations Health Authority (SLFNHA), First Nations communities, leadership, health staff, tribal councils, partners and other health care providers to address diabetes in a more coordinated, collaborative and wholistic way.

The Sioux Lookout First Nations Health Authority provides a range of valued health services, including primary health care, counseling, and public health, to 33 communities in the Sioux Lookout Area (SLA) of Northwestern Ontario.

Figure 1. Map of Sioux Lookout Area First Nations

Diabetes is widely understood by health providers to be a top-priority health problem among community members in the region.[1] In Canada, age-standardized prevalence rates for Type 2 diabetes are 17.2% among First Nations individuals living on-reserve and 10.3% among First Nations individuals living off-reserve.[2] The prevalence of Type 2 diabetes in First Nations peoples is three-to-five times higher than in the general Canadian population and is accompanied by a high burden of diabetes-related complications and mortality.[3]

Alarmingly, the prevalence of diabetes has been reported as high as 45% in some Sioux Lookout Area communities.[4] First Nations people living with diabetes in the SLA also use acute care, emergency departments, and day surgery at a higher rate while often reporting challenges in accessing primary and community-based services for diabetes management and support.[5]

Against this backdrop and drawing on direction from numerous community partners and stakeholders, SLFNHA has led the development of a regional diabetes strategy on behalf of Sioux Lookout Area First Nations communities.

RATIONALE

Primary prevention, education and improved diabetes management and care is an urgent priority for First Nations in the Sioux Lookout Area. Although little formal data exists on the current prevalence of diabetes among First Nations communities in the area, it is well understood that the burden of diabetes and its associated complications contributes significantly to ill health of individuals and communities in the region. Outdated estimates of the prevalence of diabetes in the Sioux Lookout Area range from 17 to 26%.[6]

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[1] SLFNHA, 2006. The Anishinabe Health Plan. Accessed at: http://www.slfnha.com/files/4114/0007/2122/AHP-FINAL-REPORT.pdf.

[2] Chronic Disease Surveillance and Monitoring Division, Centre for Chronic Disease Prevention and Control. Diabetes in Canada: Facts and figures from a public health perspective. Ottawa, ON: Public Health Agency of Canada, 2011 http://www.phac-aspc.gc.ca/cd-mc/publications/diabetes-diabete/facts-figures-faits-chiffres-2011/index-eng.php.

[3] Canadian Diabetes Association, 2013. "Type 2 Diabetes in Aboriginal Peoples". Accessed at: http://guidelines.diabetes.ca/browse/chapter38

[4] North West LHIN, 2016. "Diabetes Prevalence North West LHIN" [date file]. Unpublished dataset

[5] SLNFNA, 2006, op. cit.

[6] Morrison, N and Dooley, J. The Sioux Lookout Diabetes Program: diabetes prevention and management in northwestern Ontario. Int J Circumpolar Health 1998, 57(Suppl 1):364-9.
Harris SB, Gittelsohn J, Hanley A, Barnie A, Wolever TM, Gao J, Logan A, Zinman B. The prevalence of NIDDM and associated risk factors in native Canadians. Diabetes Care. 1997 Feb;20(2):185-7.

Anecdotally, its known that patients who are newly diagnosed with diabetes are not accessing the education they ought to. More generally, diabetes care experienced by community members in First Nations across Canada is often poorer than elsewhere. Chart audits in 2011 demonstrated evidence of suboptimal management of diabetes in Canadian First Nation patient populations. For example, 61% of patients have an A1c greater than 7.0, 92% were overweight or obese, 55% had chronic kidney disease, and 16% of patients with hypertension were not on a hypertension drug.[7]

As evidence of an even more compelling rationale, provincial analysis done by the Institute for Clinical Evaluative Sciences (ICES) found First Nations people in Ontario living with diabetes to be 1.5 to 2 times more likely to require dialysis and 8 times more likely to require lower extremity amputation.[8]

Over the past few years, the system has experienced pressure from mounting incidence of diabetes, particularly amongst younger and younger individuals. Federally and provincially funded programs have struggled to provide quality care in-line with Diabetes Canada guidelines. Providing services for patients who require complex care is particularly difficult, particularly given the geographic challenge of providing care in the region.

Sioux Lookout First Nations Health Authority, along with Dignitas International, an internationally recognized, Toronto-based health services NGO has been collaborating the past several years on a project to establish a community health worker (CHW) program for diabetes and evaluate its effectiveness with an eye to future scale-up of the initiative across more communities.

In addition, other initiatives have been developed in recent years to address diabetes, such as investments in diabetes education centres and community-based diabetes prevention workers. The 2016 Ontario First Nations Health Action Plan also delineated diabetes programming as a key priority for investment.

While additional program investment has been welcomed, it has become apparent over time that, in order to leverage these investments and support the effectiveness of such programming, there needs to be a region-wide, comprehensive diabetes strategy.

The Chief's Committee of Health of SLFNHA, which represents chiefs of the region in health-related matters, has long expressed their desire to see improvements in diabetes prevention, education and care in their communities.

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[7] Harris SB, Naqshbandi M, Bhattacharyya O, Hanley AJ, Esler JG, Zinman B; CIRCLE Study Group.Major gaps in diabetes clinical care among Canada's First Nations: results of the CIRCLE study. Diabetes Res Clin Pract. 2011 May; 92(2): 272-9. doi: 10.1016/j.diabres.2011.02.006. Epub 2011 Mar 3.

[8] Shah BR, Anand S, Zinman B, Duong-Hua M. Diabetes and First Nations People: In Hux J E, Booth G L, Slaughter P M, Laupacis A (eds). Diabetes in Ontario: An ICES Practice Atlas: Institute for Clinical Evaluative Sciences. 2003: 13.231-13.244.

At the system level, diabetes services in the Sioux Lookout Area are currently funded by a number of different federal, provincial, and community-based programs, (see Appendix A – Diabetes Services Landscape) with each party delivering distinct programs based on disparate mandates, eligibility criteria and policies. Based on findings included in the *Diabetes Environment Scan for the Sioux Lookout Area (2017)*, community leaders and service providers reported that governance over, and coordination of, diabetes care is unclear. One service provider reported more than 50 programs providing some level of diabetes care, education or prevention in First Nations, resulting in overlap of services in some communities, while significant gaps remained in others.

This patchwork of services also gives rise to diabetes service providers operating in 'silos', communicating infrequently with other diabetes service providers. The result is a fractured service landscape in which different service providers, healthcare organizations and funding bodies may be working toward a similar goal, however, services are not patient-centred and consequently patients experience gaps in care.

In light of the inefficiencies in current diabetes care, and the high rates of diabetes in many regional First Nations communities, SLFNHA initiated a dialogue on ways that diabetes prevention and management could be improved. The overarching goal of this Regional Diabetes Strategy is to improve diabetes prevention and management efforts in the SLA through the integration of efforts, collaboration, and community-based planning and implementation.

The timeline below provides a summary of the steps taken to-date in the development of this Regional Diabetes Strategy.

TIMELINE: REGIONAL DIABETES STRATEGY PLANNING & DEVELOPMENT

The need for a regional diabetes strategy for Sioux Lookout Area communities has been expressed for many years. The 2006 Anishinabe Health Plan explicitly describes diabetes as a priority health concern and outlined actions in a number of areas including prevention, promotion of healthy lifestyles and care and management. In some respects, the development of SLFNHA initiatives, such as the Approaches to Community Wellbeing (2015), as well as the Integrated Primary Care Team, are aspects of the response needed in these important areas.

Nonetheless, SLFNHA, in its planning and coordination role, saw the need to develop a diabetes strategy which would not only encompass these new services but also include other partners and care providers. A brief timeline of the effort to carry out this work is outlined below.

1. January – March 2018: SLFNHA scopes out a plan to develop a Regional Diabetes Strategy using MOHLTC funding

2. July – September 2018: Consulting team contracted
3. September – October 2018: Environmental scan via online review
4. October – November 2018: Development of electronic partners survey and community interview guide
5. December 2018 – January 2019: Survey administration and key informant interviews with community and Tribal Council representatives
6. February 3 & 4, 2019: Regional Diabetes Strategy Forum with community health directors and Sioux Lookout Area service providers

PROCESS & APPROACH TOWARDS THE DEVELOPMENT OF A REGIONAL DIABETES STRATEGY

A brief summary of the methodology for the development of the diabetes strategy is provided in Table 1.

Table 1. Timeline of activities

Activity	Timeframe
Document review	September 2018
Online review of programs and services	October 2018
Information gathering tools development	November 2018
Electronic survey administration	December 2018
Community interviews	January 2019
In-person diabetes strategy forum	February 2019
Diabetes services map and draft strategy	March 2019

Details concerning each of the methodological steps are outlined in this section.

Project team guidance

The activities undertaken to develop the regional diabetes strategy have been overseen and supported by a guidance group comprised of the following individuals:

Janel Genge, Community Health Worker Manager, SLFNHA
Janet Gordon, Chief Operating Officer, SLFNHA

Terri Farrell, Medical Director, SLFNHA
Katie Johnson, Director, Canada Programs, Dignitas International
Sumeet Sodhi, Senior Scientist, Dignitas International

Project team check-ins

During the timeframe of the project, the consulting team leader participated in eight of the regularly scheduled project team calls to receive guidance on the methodology, approach, information gathering tools (such as the electronic survey and interview guide), participants to be recruited or invited, and the diabetes strategy forum agenda. An in-person meeting was held in Toronto in December to confirm plans for the February 5th and 6th, 2019 Regional Diabetes Strategy Forum. Co-facilitators Mariette Sutherland and Pamela Hubbard and research assistant, Beaudin Bennett were on hand for this important planning meeting.

Document review

Several important documents were reviewed to provide some background and context to this project. These included:

- Anishinabe Health Plan (2006)
- Approaches to Community Wellbeing – Model Description (2015/2016)
- Forum for Diabetes Prevention in Ontario – Preliminary Report (2012)
- Diabetes and Chronic Disease Report – A review of best practices and scan of programs available to First Nation communities (2011/2012)
- Moving Forward on Diabetes, Chiefs of Ontario Dialogue Session February 27th, 2018 Final Report (2018)
- Exploring perceptions of and experiences with diabetes care in the Sioux Lookout Area by patients, community stakeholders and service providers – Diabetes Environmental Scan for the Sioux Lookout Area (2017)
- Community Health Worker Diabetes project – Report from the Health Directors meeting, August 18-19 2015, Frenchman's Head, Lac Seul First Nation (2015)
- Northwest LHIN Regional Diabetes Plan (2016)
- Diabetes 360, A framework for a diabetes strategy for Canada, recommendations for governments (2018)
- Diabetes Canada 2018 Clinical Practice Guidelines – Chapter 38 Type 2 Diabetes and Indigenous Peoples, Lynden Crowshoe, David Dannenbau, Michael Green et al.

Secondary review of Sioux Lookout Area diabetes programs and services

With the support of the Community Health Worker Program Manager at SLFNHA, an online review of available programs and services was conducted for the Sioux Lookout Area. This consisted of identifying available program descriptions and documenting these according to the following criteria:

- Service category (e.g. complex management, care, treatment, education etc.)
- Location of service
- To whom the program provides services
- Access by, and outreach to, First Nation communities
- Program description
- Clinicians
- Portion of the population that are First Nations and diabetic (if known)
- Other partner organizations
- Additional comments

This summary has been used to generate a diabetes service map (Appendix A) that provides a visual depiction of available services and programs in the Sioux Lookout Area. The full document describing the various programs and services is also provided in Appendix B.

Electronic survey

To round out the picture of available diabetes programs and services in the Sioux Lookout Area, an electronic survey was developed to further probe for information not available in the online program descriptions. The survey was adapted from a similar survey delivered by the Northeast LHIN to health service providers in an attempt to characterize diabetes programs and issues and challenges in diabetes care conducted with Indigenous peoples of Northeastern Ontario.

The survey consisted of 12 questions concerning the following topics:

- Organization profile and demographics
- Types of education and services provided

- Current gaps and barriers in diabetes services in First Nations in the Sioux Lookout Area
- Top three current gaps and barriers
- Ways to mitigate these gaps and barriers
- Team composition
- Culturally safe care
- Partners in referral networks
- Funding source(s)
- Structured outreach to First Nations communities
- Evaluation of programs and services
- Linkage with, and contribution to, a regional diabetes strategy

The survey was reviewed by the project guidance team and, once approved, was administered from December 3rd to the 14th, 2018. (see Appendix C for the Introductory Email & Survey Questions) The survey was sent to 11 identified partner providers, organizations and contacts. Six partners and providers completed the survey and one shared an existing diabetes plan, in lieu of responding to the survey (NW LHIN). The survey was analyzed and a summary report was generated. The high-level results were shared by means of a PowerPoint presentation at the Regional Diabetes Strategy Forum in February 2019.

Community interviews

In order to gather and assess representative views and insights from First Nations communities, an interview guide was also developed (see Appendix D). The project guidance team identified the following communities as ones in which interviews should be sought from health directors and health staff involved in diabetes care. The communities included:

- Small community – Poplar Hill First Nation
- Medium sized community – Webequie First Nation
- Large community – Sandy Lake First Nation

The interviews were carried out in January 2019. Two of the three communities' health directors responded to the interview requests. Additionally, to round out these perspectives, the consulting team leader spoke to health directors and a diabetes program manager from two area Tribal Councils.

The interview guide consisted of eight questions concerning the following topics:

- Description of diabetes care and services in the community
- Diabetes care team members
- Challenges with staffing
- Perceptions on how diabetes services are integrated, from the viewpoint of the client
- Services gaps in diabetes care
- Challenges
- Principle strengths in the community
- Perspectives on cultural competency and cultural safety, as it relates to diabetes care

Highlights from these interviews were also shared at the Regional Diabetes Strategy Forum in February.

Design of Regional Diabetes Strategy Forum

In order to engage in more detailed discussion of the system-level issues, a regional diabetes forum was planned for February 5th and 6th, 2019 in Sioux Lookout.

This two-day in-person intensive forum hosted 30 participants. The forum was designed to further understand service coordination and operational challenges and identify community and cultural strengths upon which to base a vision of an improved future state for diabetes prevention, education and management in the region. The vision would encompass medium-term and long-term strengthening of diabetes care in the region.

As mentioned, the consulting team's co-facilitators and team members met with the project guidance team in Toronto in December 2018. At this meeting, an agenda involving key activities and discussion questions was developed. A list of potential participants was also established. An invitation to community health directors was prepared for circulation. The agenda is provided in Appendix E.

Regional forum

On February 5th and 6th, 2019, a two-day Regional Diabetes Strategy Forum was held in Sioux Lookout at the Forest Inn.

Twenty-eight individuals took part including seven community representatives, 14 partner and provider representatives including Meno Ya Win Hospital, Thunder Bay Regional Hospital, the Sioux Lookout Area Integrated Primary Care Team, Tribal Councils, an academic partner, four members of the project guidance team and three facilitators from the consulting team.

The agenda (see Appendix E) included the following key activities:

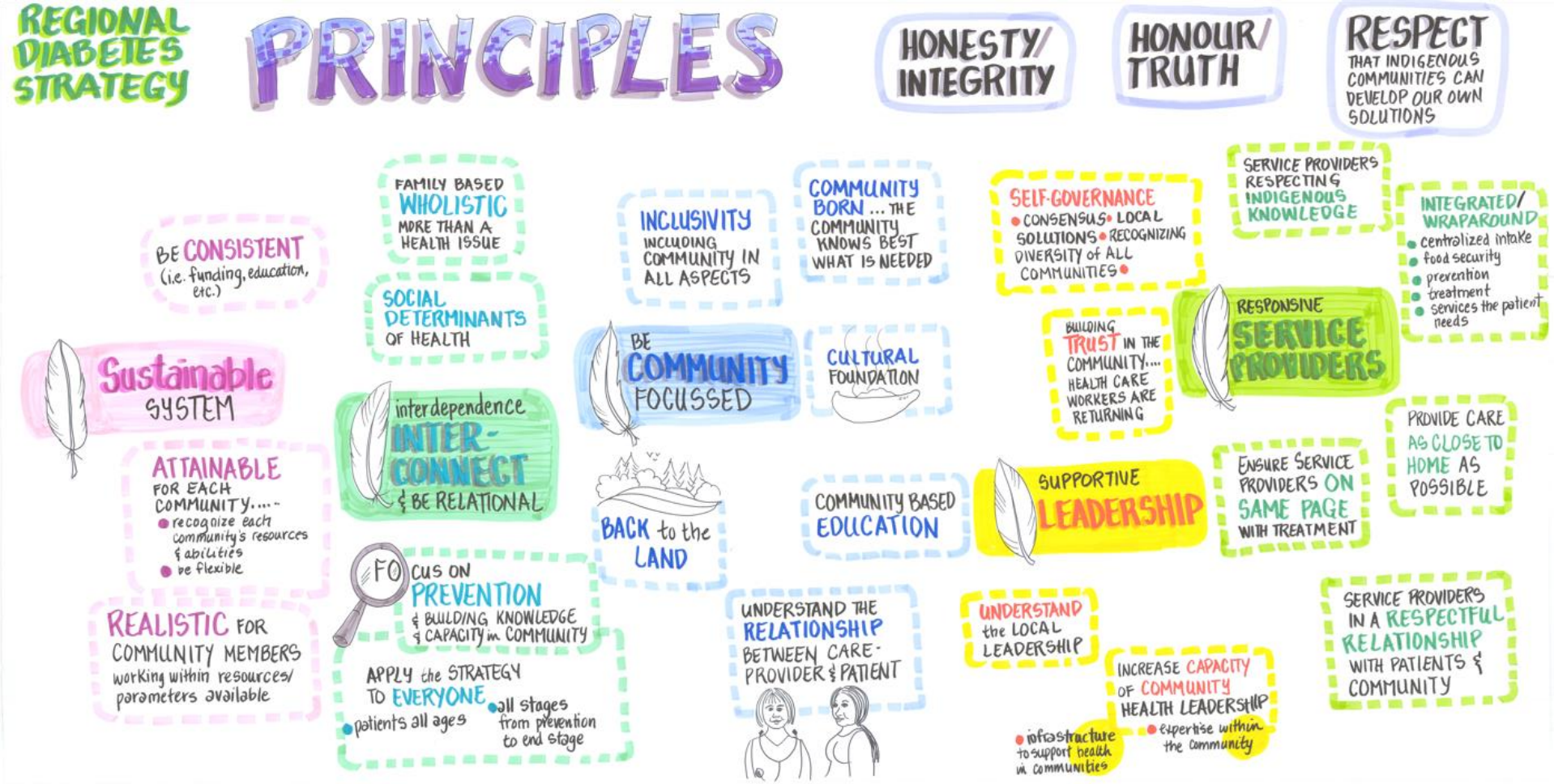
- Opening prayer and welcoming remarks
- Presentation concerning information gathered to date in preparation for the forum
- Principles and values to guide the strategy
- "Teepee talk" open-space forum to explore key topics identified by meeting participants
- "Rez café" World Café format to generate small group discussion about a vision for diabetes prevention, care and management for the region
- "Moving forward" session documenting key needs from community, SLFNHA and partner perspectives, in order to move forward on the strategy

Much of what follows in this draft strategy document derives from the dialogue conducted at this forum. In the next sections, the themes which arose at the forum will be further illuminated and linked to specific strategy directions and actions.

PRINCIPLES & VALUES

One of the first activities at the Regional Diabetes Strategy Forum was to engage in a discussion on principles that would inform the strategy. Figure 2 is a graphic depiction of these principles.

Figure 2. Regional Diabetes Strategy Principles



Forum participants dedicated a significant amount of time to describing and discussing the principles by which the diabetes strategy should be approached. Meaningful values and fundamental principles must guide the strategy and, in fact, are essential to ensure the success of a diabetes strategy. The overarching values were ***Honesty, Integrity***, ***Truth, Honour*** and ***Respect.*** Flowing from these core values were five principles upon which the regional diabetes strategy should be based:

- Sustainable system
- Interdependence, interconnectedness, inter-relational
- Community focused
- Supportive leadership
- Responsive service providers

Each of these are described in more detail in this section.

A SUSTAINABLE SYSTEM

A sustainable system is realistic, attainable for each community, and its programming efforts and funding sources are consistent.

INTERCONNECTED/RELATIONAL

Prevention and management efforts identified as part of a regional strategy are interconnected and relational in an ecological model, beginning with the individual, their family, and community, and encompassing social determinants of health.

COMMUNITY-FOCUSED

A Regional Diabetes Strategy ought to have a strong cultural foundation that emphasizes a return to the land as a key culturally-based approach to empower the communities and support physical activity, community nutrition and overall health and wellbeing. It needs to be inclusive in that it includes community in all stages of the process, and thus is born from the community, who know best what is needed and what is feasible.

SUPPORTIVE LEADERSHIP

An understanding of local community leadership, acknowledgement of self-determined health priorities and an appreciation for self-governance is critical in planning and implementation. Leadership supports, dialogue and consensus-building efforts, locally-driven solutions and the strength and diversity of all communities are foundational to the strategy's success.

RESPONSIVE SERVICE PROVIDERS

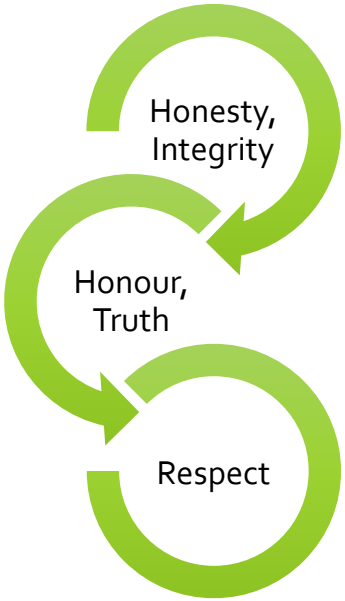
As part of a Regional Diabetes Strategy, responsive service providers work to integrate care to the benefit of the patient and 'wrap' patients in relevant and realistic supports. Further, these services are provided as close to home as possible and in a coordinated fashion, with all providers "on the same page". Finally, service providers work in a respectful relationship with patients and community and respect Indigenous knowledge.

Further detail related to each of these principles and values is provided in the following sections.

Principles driven by key values

An essential element of this strategy are key values upon which the principles can be enacted. These are interlinked and find expression in each aspect of the strategy.

Figure 3. Values important in a regional diabetes strategy



- Service providers build trusting relationships with patients and communities based on honesty and integrity.
- Service providers should honour and respect Indigenous knowledge.
- Truth is an essential starting point for acknowledging a community's history and understanding its health status.
- Respect that Indigenous communities can develop their own solutions.

SUSTAINABLE SYSTEM

Three pillars were described as being part of a sustainable system for the region. They included:

- Being *consistent* which is important in three main dimensions: a. with respect to stable and sustained funding, b. with respect to service delivery which is consistently offered in communities and c. with respect to diabetes education and messaging aimed at community members.

- Being *attainable* for each community which implies that community level initiatives and programs recognize each community's resources, abilities, and constraints while still being flexible and responsive to community needs and priorities.

- Being *realistic* for all community members which suggests that services are workable for individuals based on their context and within resources available.

INTERDEPENDENCE, INTERCONNECTED, INTER-RELATIONAL

The regional diabetes strategy must recognize the "system" in the broader context of an ecological model. An ecological model considers that an individual's health is the result of the interaction between, and the interdependence on, many factors within and across all dimension of health, in particular, people's interactions with their physical and sociocultural environments. An understanding of the system in the region is an essential premise upon which the regional diabetes strategy must be built.

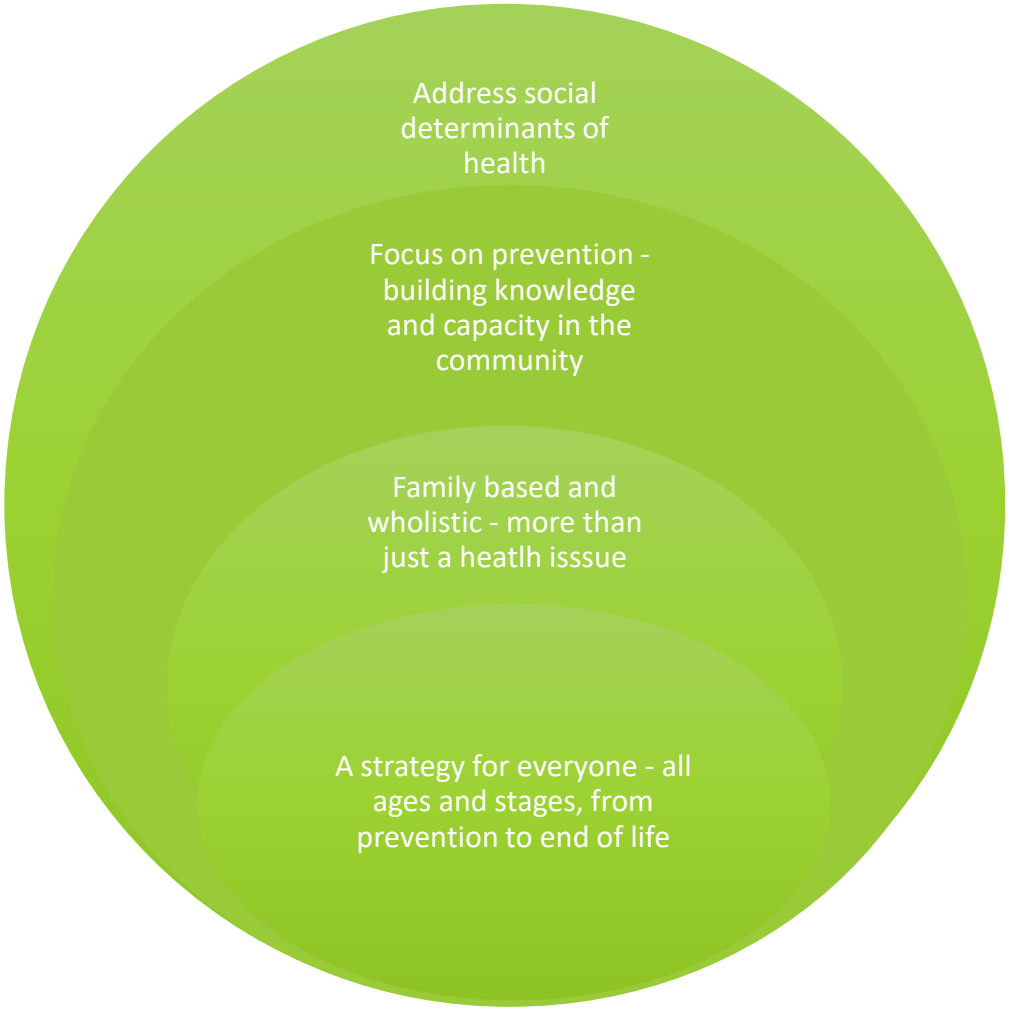
The system consists of interacting, interrelated, or interdependent elements that form a whole. Most times, a health care system is characterized as the programs, services, agencies and providers who interact within the system. However, in this case, forum participants emphasized that the system encompasses the people, their families and the community, as well as broader social determinants of health.

The following graphic (Figure 4) depicts these relationships. Beginning with the individual, the strategy would recognize their needs across the life course as well as across the spectrum of diabetes prevention, care and management. The individual is nested within the context of their family and

relationships in the community – thus the strategy must take a wider approach to education, care and prevention and bolster the system to address diabetes not only from a clinical perspective but from a community and population health perspective.

Finally, there is recognition that health and wellbeing, as well as illnesses like diabetes, manifest against a backdrop of social determinants of health, such as poverty and food insecurity. Moreover, Indigenous determinants of health such as accumulated stress from intergenerational trauma, are another key determinant of health which must be addressed in any diabetes strategy.

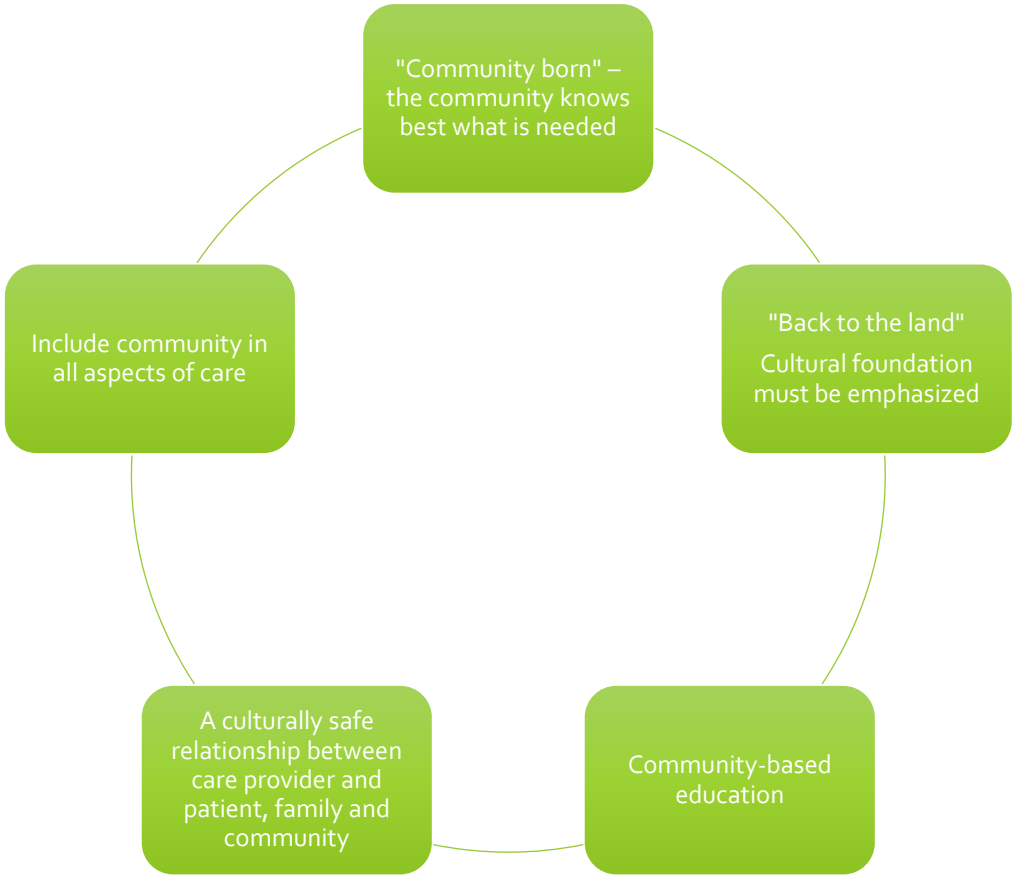
Figure 4. An ecological model for understanding health in a First Nation



BE COMMUNITY FOCUSED

Currently, an array of programs, services, providers and projects aimed at preventing diabetes and providing education and care are available in the region. To better leverage these resources, forum participants emphasized that the strategy must begin by understanding that solutions must be driven by community and recognize the community as the best source of knowledge concerning how to go about providing education and care. The approach to ensure a community focused diabetes strategy incorporates a number of elements, including the following:

Figure 5. Community is central to the strategy



SUPPORTIVE LEADERSHIP

Supportive leadership is foundational to the development of an effective regional diabetes strategy. Strategies designed to improve health must recognize and acknowledge the needs and priorities expressed by local leadership at the community level as well as the current dialogue around self-governance. Self-governance in action builds consensus around local solutions while also recognizing the diversity and autonomy of all communities. Sustained dialogue and communications around this strategy will help build trusting relationships at the community level which in turn will foster a more conducive environment for health care workers and providers.

A central focus of the regional diabetes strategy should be to increase capacity of community health leadership through the development of 1) expertise within the community related to type 2 diabetes care, prevention and management and 2) infrastructure to support health service delivery within communities.

Leadership has a significant role to play in shaping and supporting the regional diabetes strategy as well as in advocating for the necessary supports and capacities to implement the strategy.

RESPONSIVE SERVICE PROVIDERS

Forum participants spoke to a number of needs and criteria which, if met, could improve the quality of care and treatment provided to community members in the region. The theme of respect emerged as key amongst these criteria. Notably it was recommended that:

- Service providers should respect Indigenous knowledge
- All service providers should be “on the same page with treatment”
- Service providers should engage in a respectful relationship with patients and communities

In terms of an ideal service model, it was suggested that an integrated “wrap-around” continuum of services, programs and processes be developed, inclusive of:

- Centralized intake
- Food security

- Prevention
- Treatment
- Services the patient needs
- Care provided as close to home as possible.

These core principles of the strategy will be illuminated further in the diabetes strategy components.

CONTEXT– REGIONAL DIABETES STRATEGY DEVELOPMENT

As noted earlier, primary prevention, education and improved diabetes management and care is an urgent priority for First Nations in the Sioux Lookout Area. Coupled with this recognition is a clear desire amongst all involved to better collaborate on diabetes prevention and to improve coordination of diabetes services.

> *"There are multiple organizations providing diabetes care, all under different funding models. Assessing what each program is doing and the services they provide would build capacity in the system and reduce duplication of services. We need to ensure that the right providers are providing the right care for the right client. Need to develop centres of excellence to provide education and training to build capacity in the system."*
>
> *Survey respondent*

Though there are well-developed programs and services within the regional system, several structural, coordination and service gaps persist. These include: a lack of communication between service providers, travel and transportation impediments, lack of, or inadequate access, to services in community (including diabetes education and foot care, for example), lack of integration between Western and traditional approaches to diabetes, and poverty and food insecurity.

There is a need for consistency in community supports, in particular around the availability and reliability of community workers. More pressing is the need for integration of all organizations and providers who are presently working to address diabetes in Sioux Lookout Area First Nations communities.

Factors that could help address gaps in diabetes prevention and management, in addition to funding, include human resources support for community diabetes workers, improved community partnerships, and shared information management systems such as EMRs and patient registries.

> *"A collaborative approach from all the organizations/providers, in order to have a more comprehensive approach to diabetes care and eliminate some of the duplication in services. Have all the partners work on one work plan, where we all work side-by-side, regardless of funder."*
>
> *Survey respondent*

The key to a robust strategy that will improve and enhance prevention, education, care and management in the region is close coordination and collaboration as well as building upon community strengths and ensuring cultural safety.

ASPECTS OF THE NEEDED RESPONSE

The Regional Diabetes Strategy must be designed to acknowledge the context of intergenerational trauma and impacts of colonization on current health status, including the prevalence of diabetes. The strategy must also take into account the underlying social determinants of health inclusive of these Indigenous determinants of health.

To be effective, it must be framed from a cultural strengths standpoint and incorporate a wholistic approach to person-centred care, including attentiveness to mental, emotional and spiritual dimensions of health. Inter-disciplinary community-based care is needed to ensure people have access to the necessary supports for physical, mental, emotional and spiritual aspects of diabetes. In addition, it was also noted that improving diabetes care in the region requires:

- Sufficient/increased capacity of services, particularly at the community level
- Coordination of services regardless of jurisdiction
- Improved quality of services according to Diabetes Canada guidelines as well as cultural safety and competency
- Data and a robust diabetes registry/information management system

These aspects are further elaborated on in this section.

CAPACITY BUILDING WITHIN COMMUNITIES FOR CONSISTENT PROGRAMMING

Communities described a lack of supports and resources for community health workers such as training and mentorship for their workers. Inconsistent program and service delivery at the community level as well as ineffective communication has resulted in high turnover of staff due to burnout and isolation.

Capacity building within communities through the provision of the necessary training, supports, supervision and resources for community workers is needed in order for any regional strategy to be successful. Programming must also be sustainable and consistent and draw on the strengths of community, for example, by involving community members and Elders in the design of programming. More importantly, the strategy cannot impose new tasks or duties on already over-burdened community workers. Team based approaches which support working collaboratively, both within the healthcare team and alongside community will assist in reducing worker burnout and increasing retention of community health workers.

COORDINATION AND COLLABORATION AMONGST COMMUNITIES AND CARE PROVIDERS

Historically, communities and care providers have operated in "silos" based on differing mandates and accountabilities. Furthermore, each program or services has its own relationship with communities and different electronic medical records (EMR), or, in some cases, none whatsoever.

Despite knowing that "we all have the same goal, but it isn't getting reached", patients are faced with a more confusing system "when it should be getting more straight-forward." (February forum participant). Removal of barriers to care will reduce duplication of services, create efficiencies, improve care, increase patient engagement, and reduce dependency on the system. Finally, collaborating with community could result in programs that are more autonomous, realistic, specific to the needs of the patient, and culturally appropriate. True collaboration, effective communication and strong partnerships between care providers and the community are needed to create "wrap-around care".

Everyone in the regional system needs to be included in planning efforts in order to support more effective collaboration and coordination. This includes SLFNHA, Meno Ya Win Health Centre, First Nation Inuit Health Branch (FNIHB), Non-Insured Health Benefits (NIHB), patients, community members, educators, curriculum designers, the Northwest Local Health Integrated Network (NWLHIN), community leadership, tribal councils, Thunder Bay and Northwestern public health units, pharmacists and other members of the supply chain, regional diabetes programs, local lodging/hostel, wound care and other community resources.

CULTURAL SAFETY AND COMPETENCY

Communities are rich in knowledge. According to February forum participants, "Everyone has a role or gift" to contribute to community health and wellbeing. Historically, traditional day-to-day land-based lifestyle practices and activities, as well as relying on local food, medicines and fresh water was 'good medicine' and gave rise to a healthy and active life. However, over time, these practices, and the knowledge that underpinned them, were eroded and displaced by the existing medical model and mainstream systems. These systems are often judgmental and not supportive of non-Western approaches to health and wellbeing. At the same time, the quality of clinical care, when compared to clinical guidelines, is poor .[9]

Providing culturally safe and appropriate care, via a relationship of mutual respect, and finding ways to integrate traditional and Western approaches to health and wellbeing, are critically important in order to decolonize the healthcare service environment and reconcile differing conceptualizations of wellness. This can lead to healthier patients and communities and contribute to care providers being more accountable to their patients. One example shared included a 5 day hunt camp in Kingfisher Lake in which community members and health care providers participated in hands on activities which incorporated western and traditional practices. The camp was instrumental in helping to build trust, rapport and mutual respect amongst those who participated.

In order to harmonize western and traditional approaches within the healthcare environment, senior leadership, funders, policy makers, professional organizations and institutions must be involved, in equal partnership with community knowledge holders and Elders. This must be founded on sound and trusting relationships, built over time. Lastly, cultural training and cultural safety education for all health care workers and clinicians is a clear requirement in order for the strategy to be successful.

INTEGRATING DIABETES CARE

Beyond the integration of Western and traditional approaches, there is a need for more tangible and pragmatic integration across the many service providers, programs and agencies providing diabetes care, management and prevention.

[9] Harris SB, Naqshbandi M, Bhattacharyya O, Hanley AJ, Esler JG, Zinman B; CIRCLE Study Group.Major gaps in diabetes clinical care among Canada's First Nations: results of the CIRCLE study. Diabetes Res Clin Pract. 2011 May; 92(2): 272-9. doi: 10.1016/j.diabres.2011.02.006. Epub 2011 Mar 3.

Multiple actors are providing services to people living in the same region, with no central intake or electronic medical record (EMR) for these patients. At present, service providers don't always know what programs are available or who to refer to; services are not coordinated, and some services may be duplicated. Improved communication and coordination could optimize service delivery.

Patients, staff and decision makers must all be involved in co-creating the processes for intake and information sharing of this nature including:

- physicians
- nurse practitioners
- nursing station nurses
- allied healthcare providers
- health staff and administrators at Meno Ya Win Health Centre, SLFNHA, Thunder Bay Diabetes Education Program and Centre for Complex Disease Care and most importantly,
- community health workers including Aboriginal Diabetes Initiatives, home and community care and community health representatives and others.

A WIDER LENS & MORE WHOLISTIC APPROACH TO PREVENTION / MANAGEMENT OF DIABETES

Three important themes emerged from the various lines of evidence informing this strategy. They include:

- Addressing social determinants of health
- Framing efforts around a cultural, strengths-based approach
- Addressing the wholistic needs of a person with diabetes

The intersection between health and social determinants must be considered as they are central to diabetes prevention and management. Poverty and food insecurity (as mentioned earlier) are hugely influential factors in health outcomes. Current healthy eating and active living programs, such as cooking workshops, harvest week, and walking programs, are positive steps in this area. However, structural impediments persist in present levels of poverty and resulting food insecurity. Any strategy must consider a broader, multi-partner effort to address these impediments and create a long range plan to address food insecurity.

More importantly, as noted earlier, the integration of Western and traditional approaches in a respectful framework is critical. This lens can be helpful in prevention of all chronic disease, not just diabetes. Communities need a process to discuss how to develop such a framework through an inclusive process involving Elders and community knowledge holders, health workers, partners and funders. Traditional perspectives have a central role to play in diabetes prevention and management.

Finally, accumulated stress resulting from intergenerational trauma at the community and individual level must be considered. In order to support someone living with diabetes, there must be wholistic support for their mental, physical, spiritual and emotional health and supports in place to help them with coping and self-management skills.

A wider array of mental health workers and organizations, youth educators, community-based educators, support groups, and healthy babies/healthy children workers must be included alongside the usual health service providers, in order to reach and involve youth and families and begin to discuss the mental health aspects of diabetes care.

VISION

At the February Regional Diabetes Strategy Forum, participants described a compelling vision for addressing diabetes and improving community health encapsulated by a number of descriptive statements and concepts. These concepts and ideas are captured in the following graphic depiction.

Figure 6. Vision for a Regional Diabetes Strategy

Each of these key concepts is elaborated as follows:

WE HAVE A WELLNESS MODEL

- Communities have found a way to deal with trauma, addictions and crisis
- We're in a prevention and early intervention mode
- Our communities are healthy and diabetes-free
- Youth are hopeful and empowered
- Everyone lives a healthy, active lifestyle

COMMUNITY TAKING OWNERSHIP OF ALL ASPECTS OF THEIR HEALTHCARE.

- People have access to housing and safe drinking water
- People use sustainable energy sources
- We use traditional practices for our babies and children
- Communities have reclaimed their traditional practices, medicines, food, parenting and land-based activities

FOOD SECURITY

- Community owned and managed stores
- Regional food distribution network
- Community gardens
- Year-round greenhouses
- Affordable, culturally appropriate harvesting
- Preserving food
- Teaching youth

YOUTH

- Educated youth are returning to the community
- Youth are leaders
- Integration of knowledge and bridging of traditional ways of healing
- Stability and consistency in healthcare workers

HEALTHCARE & INFRASTRUCTURE

- Clients needs are met
- There are enough health workers to serve the community
- Health care workers are paid adequately, supported and mentored
- Patients have a support system when they return home
- Households and family members are informed and make good choices

INTERNAL/EXTERNAL PARTNERSHIPS (HARMONIZED CONVERSATION) & COLLABORATION WITHIN AND BETWEEN COMMUNITIES REGARDING SERVICES ANDPROGRAMS

- Programs and services do not exist in “silos”
- Strong relationships are fostered, trust is built, and services are accessible, thus benefiting the continuum of care
- Infrastructure is available to support health workers and patient care
- Health care workers have a stable workplace situation and provide consistent services.

A VISION STATEMENT

Taken together these concepts can be further distilled into the following draft Vision Statement, which is an articulation of the aspirations and hope for a healthier future for Sioux Lookout Area First Nations communities:

> “Empowered communities have ownership of their health which enables them to address diabetes through coordinated, wholistic, culturally safe and appropriate prevention, education, care and management.”

DIABETES STRATEGY COMPONENTS

The February Regional Diabetes Strategy Forum was an opportunity to describe a number of ways that a regional strategy should be framed. A visual representation of the key elements of the strategy is depicted in Figure 7. Each of these will be described further and include recommendations relating to each domain.

Figure 7. Insights and ideas to inform the development of a regional diabetes strategy

Key concepts identified included:

- A community-driven model of care
- Community based health care focussed on removal of barriers and access to care
- Acknowledgement of the history of colonization and Indian Residential School (IRS) experiences
- Land-based, lifestyle approach based on the Anishinabe way using knowledge from the Elders
- Community workers are connected, supported and learning from one another
- Communications are improved and contain less medical language
- Health information systems and tools are used consistently and collaboratively

An attempt to incorporate these key insights and build upon the principles and values shared by the forum participants yielded the following as a proposed over-arching framework for the Regional Diabetes Strategy.

- Diabetes prevention
- Diabetes education and management
- Integrated care
- Early detection and screening

This incorporates a wholistic, person-centred and culturally based approach which has been described as critical to the strategy's success.

Figure 8. Regional Diabetes Strategy elements

DIABETES PREVENTION PROGRAMMING UNDER THE LEADERSHIP OF APPROACHES TO COMMUNITY WELLBEING

Diabetes prevention programming should be coordinated by Approaches to Community Wellbeing. In this regard, emphasize and amplify efforts within Approaches to Community Wellbeing (2015), under the Healthy Living pillar, which outlines interventions, policies and teachings that promote a healthy lifestyle and equip people and communities with the abilities and resources to make healthy choices. ACW will coordinate, harmonize, and leverage efforts within community health centres. This would include:

ADVOCACY & POLICY EFFORTS

Children, adolescents and young adults in the First Nations communities encounter many social and environmental conditions which give rise to increased risks for developing type 2 diabetes. The context in which they are living, unresolved trauma in communities and underlying social determinants of health are difficult challenges to navigate in order to have a healthy life. For this reason, increased advocacy and supportive policies are needed to help address and prevent these risk factors.

"Primordial prevention" which seeks to prevent and mitigate risk factors focusses on the home, school and community environment in order to make the healthy choice the easy choice. Policy level changes need to occur that decrease barriers to healthy choices. This would entail a process of engagement and dialogue within communities involving leaders, health and education, elders and community members.

It is critically important to adopt a "whole community" approach as efforts undertaken within the context of the health centre alone cannot work in isolation. Community recreation, daycare and school staff including teachers, cooks and other team members must be engaged and see their roles reflected in this strategy. Moreover, one of the strategy's overall directions advises incorporating traditional approaches to healthy living, physical activity and nutritious diets. This needs to be supported through strong policy and advocacy efforts particularly to secure the necessary resources.

WORKING WITH COMMUNITIES TO SUPPORT FOOD SECURITY

Primary prevention efforts must be situated within, and respond to, a key social determinant of health - food insecurity. This could be partly addressed by subsidizing healthy foods, as well as making healthy foods more affordable by supporting community-owned and operated stores, community gardens, community greenhouses, or hydroponic facilities. Teaching about nutrition including learning about healthy diets, cooking,

preserving, etc. form part of this effort. Using traditional foods in health programming and introducing these foods to families, children via community kitchens is recommended. Linked with this effort, as noted earlier is the need for advocacy around supportive policies, for example, limiting access to sugar sweetened beverages in community events and settings.

TRADITIONAL FOODS AND HARVESTING PRACTICES

Indigenous food sovereignty is another equally important mechanism to enhance food security by reestablishing traditional diets and practices. The harvesting and processing of locally available wild game, fish, berries and plant medicines should be encouraged as an alternative to store bought and processed foods.

These efforts to increase access to traditional foods and emphasize food sovereignty by supporting the inclusion of food from the land and wild game, fish and traditional food ways and stories align with and are a key part of the effort to increase food security. Teaching and reintroducing community members, children and youth to harvesting and food preserving practices are also an important aspect of this effort.

PROMOTING PHYSICAL ACTIVITY THROUGH LAND-BASED AND CULTURAL APPROACHES

Strengthening community members' relationship to the land and to traditional practices of harvesting, hunting, fishing, preparing and preserving food teaches valuable skills that have been lost as a result of processes of colonization such as Indian Residential Schools. Reclaiming these historical and traditional skills, knowledge and teachings reinforces community and cultural pride and enhances not only nutrition but physical activity and connection to the land and territory.

Efforts aimed at encouraging healthy physical activity and maintaining a healthy body weight should incorporate land-based physical activity in the design and reflect an understanding of how cultural strengths such as connection to land and traditions are important dimensions of physical activity.

In particular, as noted earlier, the focus should be on youth and children both in emphasizing traditional approaches to healthy active lifestyles and nutritious diets.

BUILD COMMUNITY CAPACITY

In keeping with ACW's approach to building community capacity, ensure adequate supports, supervision, and mentorship for community health workers through close connection and collaboration with the existing SLFNHA/Dignitas community health worker training program and model. Continue to support Aboriginal Diabetes Initiative workers, as they engage with community and health staff in the design of prevention programs in a cultural/strength-based approach.

Build capacity amongst community workers to promote and incorporate land based physical activity and traditional diets in prevention and education efforts by providing customized training in these areas, assisting in identifying community resources and knowledge holders and providing an overall programmatic framework and policies to support this approach.

WITHIN AN OVERALL LIFE COURSE APPROACH, EMPHASIZE PREVENTION EFFORTS WHICH FOCUS ON PEDIATRIC AND YOUTH POPULATIONS

Though the regional diabetes strategy is framed around an overall life course approach, emphasis needs to be place on designing prevention campaigns which take into account youth voices and target the needs of children and youth. This will require a participatory process involving youth workers and community youth, to ensure the messaging and content is appropriate and oriented to youth. In addition, parents must be engaged in the design of programming aimed at children in order to stem the alarming trend of diabetes diagnosis at younger ages. A specific focus on prevention, education and care for pregnant women should also be explored, particularly in relation to those diagnosed with gestational diabetes.

DIABETES EDUCATION & MANAGEMENT

Diabetes education and management programming should be enhanced through an wholistic, cultural strengths-based approach. A number of key measures should be taken including:

Cultural safety and competency training

In order to optimize care and ensure a person-centred, respectful relationship between care provider and community members, there is a need to ensure all providers undertake training in cultural safety/competency.

The Aboriginal Nurses Association of Canada defines **cultural competence**[10] as skills and behaviors "built upon self-awareness" that help a practitioner provide "quality care to diverse populations.

Cultural safety[11] was a concept coined by Maori nurses which means that there is no assault on a person's identity or esteem. An environment or encounter is defined as **culturally safe** when the individual feels mentally, physically, spiritually, socially and emotionally safe within their identity and needs they are expressing.

A cultural safety lens and culturally competent providers can create a pathway to improve First Nations peoples' experience of diabetes care. An understanding of the experiences and perspectives of patients helps to highlight the interconnection between health care provider, health care system, and larger structural drivers of health inequalities which are rooted in the socio-political experiences of colonialism. This understanding can be cultivated by having: (1) health care professionals seeking contextual knowledge about their community, culture and circumstances (social drivers/determinants) in order to better understand their patient's needs and limitations; (2) ample time in the clinical encounter to build trusting relationships with health care providers; and (3) structured opportunities for training to enhance cultural safety and competency. There are ample training resources and opportunities to build cultural competency and engender cultural safety in care.

Integrate traditional and cultural strengths into programs and services

Knowledge about traditional practices held by community Elders can instill increased pride in community members, especially children and youth and restores the essential connections between culture and healthy living.

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[10] Hart-Wasekeesikaw, F. (2009). Cultural competence and cultural safety in First Nations, Inuit and Métis nursing education: An integrated review of the literature. Ottawa, ON: Aboriginal Nurses Association of Canada.

[11] Williams, Robyn. (1999). Cultural safety - What does it mean for our work practice?. Australian and New Zealand journal of public health. 23. 213-4.

To explore the integration of traditional and cultural strengths within Western-based programming in a respectful manner, a process involving the following is suggested:

- Include Elders and community knowledge holders in the design of programs and services. This may take the form of an advisory group or Elders council to give advice as design and planning discussions are held.
- Focus on cultural values and culturally grounded approaches when designing lifestyle/behaviour modification activities.
- Develop or adapt educational resources so that they are customized to local context and culture.

Include social factors and mental wellness in diabetes care

Diabetes care, education and management should ensure mental wellness needs are tended to in wholistic, person-centred care. Examples from other jurisdictions[12] highlight the need for care providers to consider not only the person's presenting physical concerns but the whole context in which they are living, including household and family situation, access to nutritious food, food preparation knowledge and skills, lifestyle and behaviours.

A program of wholistic care should be designed to include the following elements:

- Incorporate resilience/coping skills in a trauma-informed approach to build an element of mental health care into diabetes programming. Include Elders and traditional counselling as part of the interventions.
- Design interventions that take into account community "story" – history, culture, language, land – emphasizing community and individual agency, self-determination and hope for the health of the people. Support community members and youth to learn about, and find their way back, to their historical and traditional practices that support and promote health and wellbeing.
- Emphasize family, extended family and community social support in diabetes care and management.
- Consider formalizing social supports as an element of the care plan, via structured referrals to local, non-clinical services intended to enable a patient to access a wider array of social supports on their wellness journey[13]. This could be an important value-added role of community health workers.

[12] New Mexico Community Outreach and Patient Empowerment (COPE) https://www.pih.org/sites/default/files/2018-08/COPE-AnnualReport-2016.pdf

[13] Social prescribing is an approach to ensuring wholistic person-centred care addressing social and other care needs through structured referrals to other programs, supports and partners. https://quorum.hqontario.ca/en/Home/Posts/New-Social-Prescribing-Pilot-Comes-to-Ontario

INTEGRATED CARE ACROSS ALL SETTINGS

A starting point for closer integration could be linking Meno Ya Win programs, such as the Centre for Complex Diabetes Care and the Diabetes Education Program, with SLFNHA's Approaches to Community Wellbeing, integrated primary care team and diabetes programming. It would also be important to invite First Nations community health workers (CHWs)to participate in this process. To begin the dialogue required for this to occur, the following are some recommended steps:

- Establish a dedicated advisory structure for this strategy, and the integrated care component, with the involvement of all care providers and community members/leaders who demonstrate an interest.
- Engage with LHIN level steering committees and tribal councils who have developed or are developing their own diabetes strategies to ensure coordination and connection within these plans and strategies.
- Clarify team roles and responsibilities in cooperation with community health leadership so that there is shared understanding of what a renewed and integrated system of care would look like. This would entail a review of the multiple programs, services and partners to identify any gaps and duplication as well as determine ways to address such gaps and eliminate overlap.

The goal of this component of the strategy would be to support closer collaboration between “everyone in the system” including community health staff and regional care providers to enable “wrap around”, team-managed care premised on the following elements:

- A central intake
- A mechanism to allow communications and information sharing via a common interface amongst EMRs such as Mustimuhw which many communities are beginning to implement, OSCAR which NPs and RNs use as well as other hospital and community based information systems is needed
- Information sharing and data collection processes for client specific information as well as clear accountabilities and a custodian for this data, such as SLFNHA. This will need to be discussed in coordination with communities and must adhere to and respect OCAP principles
- Reviewing and focusing on key aspects of the Diabetes Canada clinical guidelines and instituting a tracking mechanism to determine if care improves over time.
- Ongoing accountability and coordination through designated team leads as well as cultural competency training for providers
- Consistent communications with all community members and stakeholders.
- Integration meetings to network share information, coordinate and streamline access to services provided and develop new initiatives in response to gaps.

- Emphasize community capacity building and task shifting within a proactive, interdisciplinary team approach involving community health workers (CHWs), community health nurses (CHNs) and physicians. Include CHWs in client appointments to facilitate follow up when providers are not within the community.

EARLY DETECTION AND SCREENING

Throughout the information gathering process there were numerous calls to ensure that individuals across the life course and, in particular, the pediatric and youth population are reached with screening, prevention and education to empower their healthy choices into the future. Moreover, it was noted as critical that patients be tracked to ensure that, once screened, they are linked to appropriate education, care and management.

- As a starting point, establish policies to support screening per clinical practice guidelines for high risk populations - Type 2 Diabetes and Indigenous Peoples.
- Screening strategies should be designed, planned and implemented with health and community leadership, as well as persons who are living with diabetes, Elders and community leaders/builders.
- Access to standard laboratory tests is preferred, in the absence of this, point of contact screening can be considered on the condition that quality control expertise is made available in the region.
- Monitoring & follow up should be conducted using standardized tests based on Diabetes Canada guidelines, for example consider vision monitoring via a retinal photography screening program.
- Ensure continued focus on screening pregnant women, which extends to post-partum (within 6 weeks to 6 months).
- Prioritize local, social and cultural context, and community "ways of knowing" in the development and implementation of screening campaigns. For example, communities may wish to extend targeted outreach to those with a family history of diabetes or to those under 12 years of age. Screening within the regional high schools may also be considered provided parental consent and clear referral pathways are established.
- There is a need for a diabetes registry and follow up system which is robust, responsive and complete.[14]
- Ensure ample community capacity in terms of community health worker staffing at the community level to follow up with those who are screened.

[14] As an example, the Nuka model in South Central Alaska has their diabetes care teams do A1Cs on their "customer-owners" and have an associated EMR to support this.

FOUNDATIONAL SUPPORTS

Foundational supports describe the needed components – such as information management, research, evaluation and planning – that would underpin each of the four strategy areas described earlier. These are outlined in turn throughout the following sections.

INTEGRATING CULTURAL STRENGTHS INTO PREVENTION, EDUCATION AND CARE

Communities are seeking approaches to health promotion and prevention of diabetes that builds upon their community and cultural strengths.

- Establish a process for the development of and identification of community knowledge holders who can support cultural congruency in prevention, education and management supports and intervention.
- Develop a strengths-based framework to support individual and community agency – this means that communities must be recognized as the holders of valued knowledge in traditional and cultural ways that contribute to health.
- Place paramount importance on respecting community receptivity and readiness and most importantly, individual choice, as to whether cultural supports are included or offered.
- Work to establish guiding principles concerning the incorporation of cultural and traditional strengths and approaches, and ensure they are used to guide strategy efforts.

IDENTIFY AND FOSTER RESEARCH THAT SUPPORTS IMPROVED DIABETES CARE AND PREVENTION

There are many distinct and innovative research projects which have been undertaken in the Sioux Lookout Area concerning diabetes in the communities. It is recommend that a research working group comprised of community representatives as well as health system and research professionals be convened to:

- Conduct a full inventory of diabetes related research projects underway in the region beginning with the identification of research organizations and data sources such as SLFNHA, NOSM, the Anishinaabe Bimaadiziwin Research Program, Centre for Indigenous Health Research, Diabetes Action Canada, etc.
- Support the development of a community driven set of priorities for diabetes research inclusive of those which consider wholistic and cultural approaches
- Ensure effective knowledge translation so that important research findings can be mobilized in policy and programming and put into action for the benefit the communities
- Evaluate service yearly, according to selected Diabetes Canada guideline indicators

DATA

As noted earlier, there is need for a clear understanding of the diabetes prevalence and incidence within communities, as well as the level of access to services and programs. With this in mind, it is recommended that SLFNHA and the strategy proponents:

- Establish a data working group comprised of community health directors, staff and providers, managers and health administration leaders and ACW epidemiologist and interested community members with lived experience
- Work with the Approaches to Community Wellbeing epidemiologist to develop baseline prevalence, incidence and diabetes burden within Sioux Lookout Area First Nations, as well as Indian Registry System linked information reports about diabetes care in the region.
- Work with selected EMR provider(s) to develop and include decision support systems such as patient registries, clinician and patient reminders, performance reporting, simple diagnostic and therapeutic algorithms.
- Identify and track Diabetes Canada indicators and link this to responsibility and accountability of care providers.
- Develop health status reports to identify and track trends
- Support community level data collection concerning diabetes and mental wellness
- Build capacity of communities and providers to consistently gather, manage and analyze such data and information as to support diabetes care and prevention planning. Such capacity building should include the development and sharing of presentations based on data reports, as well as the provision of community workshops e.g. how to use Excel; OCAP.
- Consider engagement with community members and health staff rto contextualize the data reports with qualitative insights as well as inclusion of stories for contextualizing the data reports.

PLANNING

Beyond this strategy's further development work there is a need for annual collaborative planning to ensure the effective implementation of the strategy's components:

- Work with communities and partners to prioritize annual collaborative planning and goal setting, with an emphasis on establishing overarching strategy indicators, especially around population outcomes - screening, prevalence and incidence, access to education and other programs and clinical care according to established guidelines
- Link outcomes, reporting & accountability across all services & programs mandated to deliver diabetes prevention, education and care in the region regardless of jurisdiction

OVERSIGHT AND GUIDANCE

Though there are numerous organizations and community programs delivering diabetes prevention, care and management services, presently, there is no one entity which is responsible for the system's effective functioning and coordination of programs and services. The strategy once adopted would benefit from a Working Group involving all partners who would meet regularly to collaboratively plan for the strategy's implementation. In this regard, there is a need to:

- Establish a dedicated Working Group structure to define roles and implementation needs within the integrated care component of the strategy. The Working Group would include all care providers, including Sioux Lookout Meno Ya Win Health Centre and SLFNHA partners, as well as community representatives and leaders who express interest in being involved.
- As a first task, the Working Group would develop their terms of reference and begin developing an implementation work plan for the strategy.

ACCESS

Access to providers and specialists could be improved through leveraging technological options. Additionally, any issues or impediments to community members acquiring needed supplies, services or supports should be addressed.

- Explore and enhance current application of Ontario Telemedicine Network and telehealth applications in diabetes care and consultation.
- Continue advocacy to improve access to benefits, supplies, medicines, devices and technologies.

FUNDING & CAPACITY

Funding for this strategy will need to be delineated within an implementation work plan. As a starting point there is a need to:

- Identify current funding sources and the necessary human and financial resources implied
- Cost out expansion of existing diabetes prevention, care and management programs and services such as expanding capacity at the Centre for Complex Diabetes Care at Meno Ya Win based on available information concerning service demand
- Increase access to community-identified services based on a needs and gap assessment. For example, there is a need for ample foot care services delivered within communities.

- Infrastructure and equipment both within communities and program sites is not adequate. Identify clinical space, program space, office and accommodation needs. It will be important to align efforts with other strategies in order to address infrastructure and accommodation challenges as these have been described as community challenges for the provision of many health services.

- Identify additional human resources and capacity building that will be needed in order to deliver the various components of the strategy, for example, the development of capacity and expertise in diabetes care for pediatric populations, land based physical activity and traditional nutrition and food harvesting, etc.

- Explore opportunities to leverage technology to support care provision as well as data collection to support the strategy's implementation via a common interface to allow communications and sharing of information via various MIS and EMRs in use in the region.

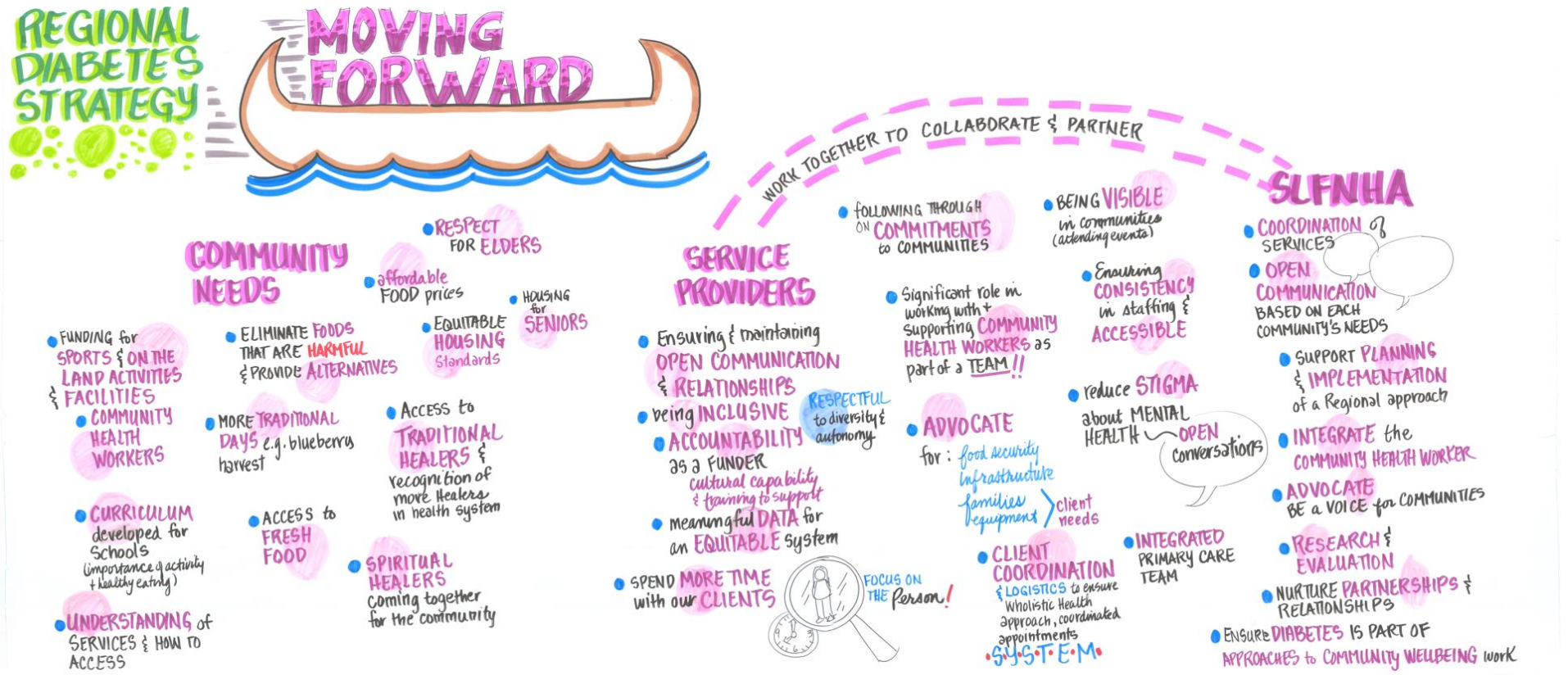
- Based on the forgoing, advocate for an adaptable, sustainable and comprehensive funding model to support the strategy which breaks down silos emerging from funding envelopes and accountabilities associated with the various programs and services

Working groups will need to be convened to map each of these aspects out further.

MOVING FORWARD

Forum participants expressed a number of essential directions in moving forward with this strategy's development. Figure 9 depicts the various moving parts, players and their respective needs in order to advance and further develop the strategy. These are described from the perspective of communities, service providers and SLFNHA.

Figure 9. Moving Forward



COMMUNITY NEEDS

From a community standpoint, a clear priority to stem increasing rates of diabetes and improve health includes addressing underlying determinants of health such as housing and food insecurity. Physical infrastructure including community facilities and resources to promote physical activities on the land are also required. Community education and awareness, training and capacity building for community health workers and culturally-based approaches to wellness are also key to an wholistic approach to health promotion and diabetes prevention. Thus part of the strategy includes advocating for food security, community infrastructure, facilities, equipment, and community based services to address client care needs.

SERVICE PROVIDERS

In order to move forward on a regional diabetes strategy, a key commitment expressed by service providers includes establishing and maintaining open communications and developing trusting working relationships with community workers in a team approach to care. This should be enabled by a number of facilitators including cultural competency training for providers, accessibility of services, consistent staffing and scheduling, and team processes to coordinate and integrate care. Gathering data to support service planning and quality care as part of the strategy is also required.

SLFNHA

A number of roles were identified for SLFNHA in moving forward with a regional diabetes strategy including:

- Communicating, advocating and being a voice for communities
- Supporting planning and implementation of a regional approach
- Nurturing partnerships and relationships
- Coordinating services based on each community's needs
- Supporting integration of the community health worker role into the coordinated care approach of the overall diabetes strategy.
- Strengthening and expanding diabetes prevention through "Raising our Children and Preventing Chronic Diseases" programming components of Approaches to Community Wellbeing.
- Conducting research and evaluations in collaboration with communities

Though succinctly described, each of the needs, commitments and roles mentioned by communities, service providers and SLFNHA imply a significant effort in planning and resourcing. There are several next steps which need to be mapped out in a more detailed implementation work plan.

ONGOING COMMITMENT AND NEXT STEPS

Though much has been learned, the journey to create a fulsome and community-endorsed regional diabetes strategy continues. As a regional health organization responsible for planning and coordination, SLFNHA commits to ongoing communications and coordination so that this draft strategy is shared, discussed and further refined. A key first step was the presentation of this draft strategy for validation by communities. This session was held on October 8th, 2019 and key refinements were incorporated in this document.

An essential first step involves SLFNHA leading advocacy efforts for the necessary resources required to fulfill the strategy's implementation work plan. A steering committee will be structured to guide and advise in the implementation of the strategy. They will liaise and communicate with community leadership, tribal councils and the Chiefs Committee on Health. A terms of reference for this Steering Committee will need to be developed to delineate the purpose and role of the Steering Committee as well as its accountability and communications with key decision makers and stakeholders.

Further coordination with SLFNHA programs such as Approaches to Community Wellbeing, the integrated primary care team and other programming that may be implicated is also a key next step. It is possible that intersectoral / interprofessional technical working groups will need to be created to carry out some of the activities described in the strategy.

The strategy provides direction to guide a fulsome, coordinated, community and culturally appropriate effort aimed at improving diabetes prevention, education and care in the Sioux Lookout area. It identifies ways to enhance service coordination, ensure the provision of culturally safe services and programs, and provides advice on policy change that can enhance diabetes prevention, education and care outcomes. Most importantly it recognizes the region's unique context and community aspirations, enabling the adaptation, optimization and improved alignment of diabetes programs and services in order to stem the tide of diabetes and restore community wellness.

We are thankful to all who participated in the information gathering efforts to date and the many important conversations initiated around this critically important topic.

APPENDIX A: DIABETES CARE SYSTEM

Regional diabetes services landscape

As part of the development of this strategy, an environmental scan of available diabetes prevention, education, care and management programs and services was completed. This is depicted in Figure 1. Diabetes Services Mapping for Sioux Lookout First Nations Health Authority.

Services in the region include community based workers and programs, regional health services such as those provided by SLFNHA including the primary care team and Approaches to Community Wellbeing and area physicians and hospitals.

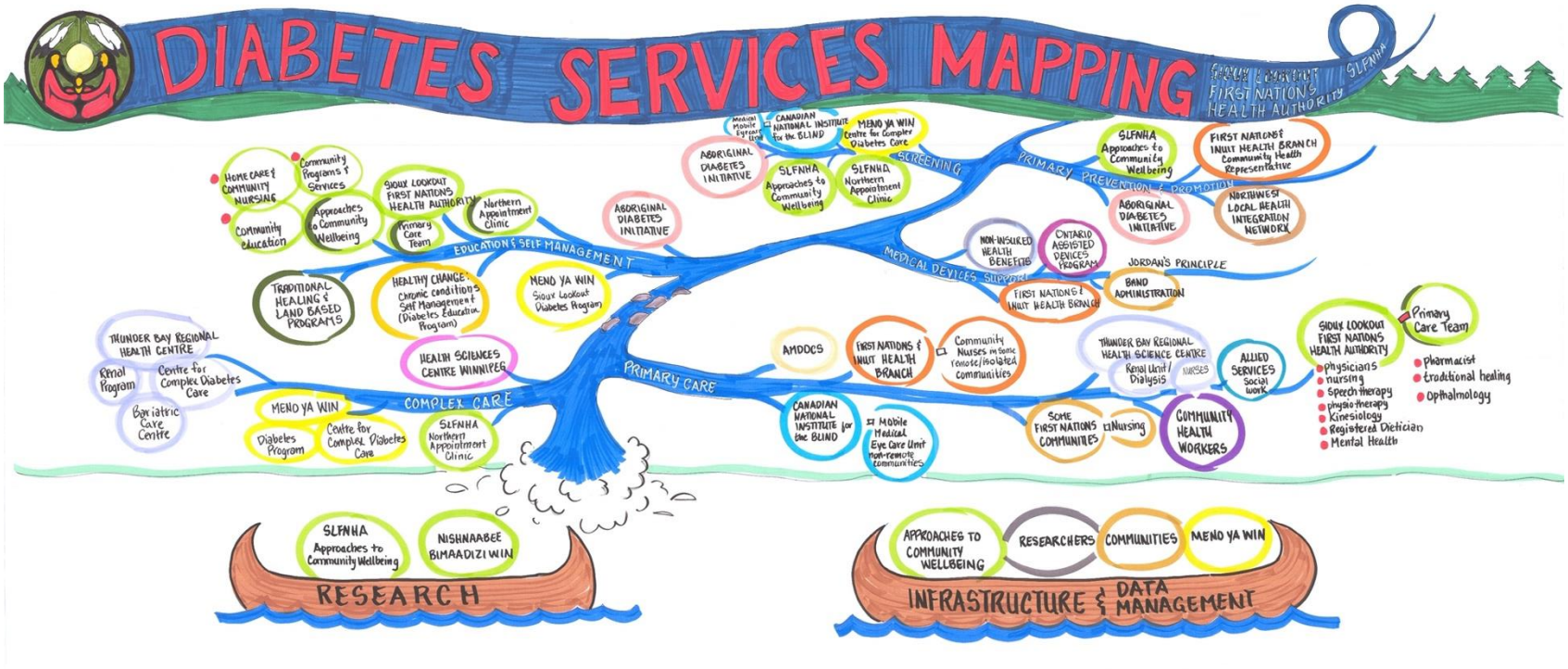
The diabetes programs and services range across a broad continuum and grouped in each "branch" of the visual as follows:

- System supports such as research, infrastructure and data management
- Primary care services for care, treatment and management
- Medical devices
- Primary prevention and health promotion
- Screening
- Education and self-management
- Complex care

It should be noted that some of the provider organizations fulfill multiple roles across the continuum of care. For example, Meno Ya Win Health Centre provides complex care for diabetes patients but also provides the Sioux Lookout Diabetes Program for patient education and self management. Similarly, SLFNHA's Approaches to Community Wellbeing is involved in community screening programs as well as diabetes prevention and promotion of healthy living. Primary care and complex care are offered as well by Thunder Bay Regional Health Sciences Centre which provides dialysis, renal program and bariatric care centre as well as acute care.

The services across the spectrum of care needs are depicted in the graphic below.

Figure 1. Diabetes Services Mapping for Sioux Lookout First Nations Health Authority



APPENDIX B: DIABETES PROGRAMS & SERVICES IN THE SIOUX LOOKOUT AREA

Meno Ya Win - Diabetes Program								
Category	Location	Who Do They Serve	Access to FN communities	Program Description	Clinicians	Portion of the population that are First Nation and have Diabetes	Other partner organizations	Additional Comments
The Program is divided into two programs **(1)** Centre of Complex Diabetes Care (CCDC) **(2)** Sioux Lookout Diabetes Program (SLDP or SLMHC Diabetes Program).								
Meno Ya Win ***CCDC***								
Complex Management Care and Treatment Education	Sioux Lookout	SLZ	Do not travel to community, but have ability to bring patients down to Sioux for care.	It's an interdisciplinary team that utilizes a case management model to provide coordinated, advanced care to patients over the age of 18 with complex diabetes needs, including: vascular disease, renal failure, impaired vision, mental illness or recurring diabetic emergencies. The additional services offed: • Advanced foot care and wound care • Chiropody (foot specialist) • Smoking cessation • Intensive insulin and medical management • Advanced meal planning • Teleophthalmology (eye screening) • Psychosocial support	-1 RD -1RN -1 RSSW - funding for 1 NP (still vacant)	serve roughly 30,000 people across 28 First Nations reserves, plus Sioux, Pickle Lake, Hudson. %FN -80-85% (verbal estimate)	Thunder Bay Health Unit (provides Dialysis support) main partners are NIHB, FNIHB and most recently PCT with SLFNHA regularly get asked to do outreach work for various organizations, including schools, Sunset Women's Shelter, friendship centres, etc. They are partnered with Reliq Health	NIHB support patient travel to Sioux Lookout for treatment and counselling with the diabetes program

				• Access to traditional programming The CCDC assists patients in accessing and navigating the health care system with strong patient advocacy and collaboration. ***The goal of CCDC*** is to assist patients in attaining the highest level of health within their own health continuum. Once patients are stable and self-managing, they are discharged from CCDC to the community Diabetes Program. CCDC is accessible by physician referral or nurse practitioner referral to outpatients and inpatients of Sioux Lookout Meno Ya Win Health Centre.			Technologies and the Ontario Centres for Excellence for iUGO remote monitoring.	
Meno Ya Win ***SLDP***								

Primary Prevention Management Education	Sioux Lookout	SLZ	Travel to communities, but do not have ability to bring patients to Sioux for care.	The interdisciplinary team provides education, support and guidance to adults and children with Type 1 or Type 2 diabetes, gestational diabetes, or those at risk for diabetes. They provide direct patient care to 28 communities in North Western Ontario. The clinicians travel to these remote communities on a monthly basis. The Program is open to referrals from any source, including self-referrals. They Provide: • Diabetes education • Medication counseling & insulin teaching • Basic/advanced foot care & assessment • Dietary consultation - cooking classes, grocery store tours, meal planning, nutritional assessments • Exercise therapy • Patient Navigation: assist clients with social determinants of health; community resources; financial or housing support • Individual, family, or group sessions • Pediatric services • Prenatal education	-2 foot care RPNs -2 RNs -2 RDs -1 RKin -1 patient navigator	serve roughly 30,000 people across 28 First Nations reserves, plus Sioux, Pickle Lake, Hudson. %FN -80-85% (verbal estimate)	main partners are NIHB, FNIHB and most recently PCT at SLFNHA regularly get asked to do outreach work for various organizations, including schools, Sunset Women's Shelter, friendship centres, etc. They are partnered with Reliq Health Technologies and the Ontario Centres for Excellence for iUGO remote monitoring.	Funded by Health Canada to travel to community. Unfortunately the entire team is NOT allowed to travel due to restrictions with HC (Ie. Kinesiologist are not funded to travel). As well, although a team approach is desired, when travelling this program cannot travel as a team. In most cases they travel alone

				• Community capacity building, programming and outreach projects • Education and training for those employed in diabetes related fields • Smoking cessation • Access to Traditional Programming & medical interpreters • OTN and PCVC services				
Sioux Lookout First Nations Health Authority								
Category	Location	Who Do They Serve	Access to FN communities	Program Description	Clinicians	Portion of the population that are First Nation and have Diabetes	Other partner organizations	Additional Comments
The health authority has more than one department that works with the diabetic population (1) Primary Care Team (2) Northern Appointment Clinic (3) Approached to Community Wellbeing								
Primary Care Team								

Education Primary Prevention Management Care & Treatment	Sioux Lookout	SLZ	Clinician services offered both in SLFNHA communities and Municipality of Sioux Lookout The PCT also has a telemedicine program that would help provide clinical support and consults to patients in community with c;linicians in Sioux Lookout as well as specialist in other areas (ie. Sick Kids Children's Hospital)	Implementation of this program is in the beginning stages and SLFNHA will be working with key partners, including communities, funders and other service providing organizations to further develop the service delivery model to ensure it meets community needs. Funded by the Ministry of Health and Long Term Care (MOHLTC). Currently still actively recruiting for many positions and have just begun providing services. The SLAPCT will operate in a team environment, to provide wrap-around services and seamless primary care. The model will involve smaller teams responsible for a cluster of communities which will travel to those communities on a regular basis to provide collaborative care.	-Nursing (Registered Nurses, Registered Practical Nurses, Nurse Practitioners) -Speech Therapy -Occupational Therapy -Physiotherapy & Kinesiology -Registered Dietician -Mental Health (Social Work and Psychology) -Pharmacist -Traditional Healing -Community Health Workers** *currently do not have all these within the team, but positions have been created and posted already for most.	100% FN % DM - ?	Funded by the Ministry of Health and Long Term Care (MOHLTC) Speech Works (Ottawa) KOE Health (telemedicine)	In addition, SLFNHA has also received a capital planning grant to support the capital needs associated with providing their service. A Steering Committee will lead the process of development of a business plan and capital plan, that will assist in identifying the primary care needs of each community, which may include various approaches such as new builds or retrofits of existing buildings. Funding to bring patients to Sioux Lookout can be covered by Jordan's Principal (JP) for children. For adults, if referred to the PCT NP they are covered by NIHB
Northern Appointment Clinic								

Primary Prevention Management Education Complex Management Screening	Sioux Lookout	SLZ Northern Communities	Only patients from Northern Communities are seen here	Patients from northern communities come to Sioux Lookout for follow-ups with Physicans and/or Nurse Practioner for more complex care needs, but they also continue to do education and assessments on patients.	-Nurse Practioner -Physicians	100% FN % DM (no formal stat but verbally said ~90%)	-Pelican Falls First Nation High School	Funded by Health Canada to travel to community. Unfortunately the entire team is NOT allowed to travel due to restrictions with HC (Ie. Kinesiologist are not funded to travel). As well, although a team approach is desired, when travelling this program cannot travel as a team. In most cases they travel alone
Approaches to Community Wellbeing								
Research Primary Prevention Screening	Sioux Lookout	SLZ	They support and provide programming for all Sioux Lookout and Sioux Lookout Communities	Previously known as "public health", through community engagement, and working with Tribal Council and community representatives, it was determined that the term public health was not the right term for the communities and the name Approaches to Community Wellbeing was born. The mission is to develop integrated, sustainable, and community-owned approaches to community wellbeing. The approach will be rooted with the traditional teachings of our people and will promote healthy	-Physician (public health and preventative medicine Specialist) -Registered Nurses -Epidemiologist -Mental Health Specialist	100% FN % DM ?	The four program areas are supported by the **Regional Wellness Response Program**	The Approaches to Community Wellbeing, at Sioux Lookout First Nations Health Authority, includes four main program areas: Healthy Living, Raising our Children, Safe Communities, and Roots for Community Wellbeing.

				lifestyles, active leaders, and positive Anishinabe people. • The Goals of ACW are: • - To improve approaches to community wellbeing, which are integrated, wholistic, sustainable, and proactive. • - Increased community ownership over our health and health system - More people leading the way who are committed to healthy communities • - Safer communities - More people making healthy choices - More children are being raised to be healthy community members - Increased connection to the teachings of our people				
North West LHIN								
Category	Location	Who Do They Serve	Access to FN communities	Program Description	Clinicians	Portion of the population that are First Nation and have Diabetes	Other partner organizations	Additional Comments

North West LHIN Regional Diabetes Plan file:///C:/Users/JanelG/Downloads/NW%20LHIN%20Regional%20Diabetes%20Plan%20(1).pdf								
Research Education Prevention	Thunder Bay	NWO	serves the largest geographic area, covering approximately 47% of the province's land area. The North West LHIN region has the largest proportion of Aboriginal people of all Ontario LHINs, with 21.5% of the population being of Aboriginal descent (Statistics Canada, 2011 National Household Survey).	non-profit organization established in June 2005. Extending from Hudson Bay in the North to the United States border, and from the Manitoba border to just west of White River, the communities of the North West LHIN are spread across 458,010 kilometres. Work with health care providers, communities and the public to set priorities and plan health services oversee the integration and coordination of local health services to make it easier for clients/patients to access the care they need. Also responsible for allocating funding for the following health services in NWO: • Hospitals	A variety of health care professionals, researchers, etc involved as this is a plan to work with others in the area	21.5% FN 14.5% DM for those 18years and older 24.6% DM for those 60 to 69 years of age	Recommendations of the Regional Diabetes Plan are aligned with Ontario's Action Plan for Health Care, Ontario's Diabetes Strategy, and the North West LHIN's Integrated Health Services Plan 2016-2019 and Health Services Blueprint. The service delivery model proposed for diabetes care aligns with the North West LHIN Health Services Blueprint by outlining elements for implementation at the Local Health Hub (LHH), Integrated District Network (IDN), and Regional levels.	North West LHIN Regional Diabetes Strategy North West LHIN Sub-region Profiles • District of Thunder Bay Sub-region • District of Kenora Sub-region • ***Northern Sub-region**** • District of Rainy River Sub-region • City of Thunder Bay Sub-region

				• Community Support Service Organizations • Long-Term Care Homes • Community Health Centres • Community Mental Health and Addictions Agencies Goal: improving the quality and accessibility of health care for all residents of Northwestern Ontario through better integration and coordination of health services.				

AMDOCS Inc. (Anthon Meyer Doctors, est. 2003) http://www.amdocshealth.com								
Category	Location	Who Do They Serve	Access to FN communities	Program Description	Clinicians	Portion of the population that are First Nation and have Diabetes	Other partner organizations	Additional Comments
	Head Office located in	As of 2006, Pikangikum, Big Trout	AMDOCS works (exclusively?) in FN communities	Organization that provides primary care physician services in	SLRPSI and	100% DM%?		

Primary care physician services	Winnipeg, MB	Lake, Muskrat Dam, Sioux Lookout (according to AMDOCS site) & According to healthline.ca KI & Lac Seul also served by AMDOCS	in NW Ontario and northern Manitoba	remote and northern communities. Physicians working with AMDOCS work as Practice Consultants in support of RNs functioning in an expanded role. Physicians also deliver telephone on-call services to designated stations. There is also a weekly Home Visit Clinic, for patients with chronic conditions, however, there is no information on whether or not this is offered in all communities.				
Health Canada/Government of Canada								
Category	Location	Who Do They Serve	Access to FN communities	Program Description	Clinicians	Portion of the population that are First Nation and have Diabetes	Other partner organizations	Additional Comments
Non-Insured Health Benefits (NIHB); Aboriginal Diabetes Initiative (ADI); First Nations and Inuit Health Branch (FNIHB) (including gov't of Canada nurses); Health Services Integration Fund (HSIF)								
NIHB https://www.canada.ca/en/indigenous-services-canada/services/first-nations-inuit-health/non-insured-health-benefits/benefits-information.html								

Eye and vision care benefits; blood glucose test strips (# of strips covered varies depending on how you are managing your diabetes); prescription drugs for diabetics i.e. canagliflozin, metformin etc.	N/A	First Nations living in Canada	N/A	"The Non-Insured Health Benefits (NIHB) Program is a national program that provides coverage to registered First Nations and recognized Inuit for a specified range of medically necessary items and services that are not covered by other plans and programs"	N/A	100% DM% ?		
ADI (Phase 1999-2004; Phase 2 2005-2010; Phase 3 2010-2015) **https://www.canada.ca/en/indigenous-services-canada/services/first-nations-inuit-health/diseases-health-conditions/diabetes.html**								
Health Canada diabetes initiative for Indigenous peoples, intended to support health promotion, prevention, screening, care mgmt.	N/A	First Nations residing in traditional First Nations communities ADI targets people of all ages. **"Time-limited"** funds available for First Nations and Inuit living outside of their traditional communitie		***The goal of ADI*** to reduce type 2 diabetes among Aboriginal people by supporting health promotion and primary prevention activities and services delivered by trained community diabetes workers and health service providers. **Phase 1** (1999-2004) received $58 million which was intended to allow for "a foundation of awareness to be built in order to implement health promotion and primary prevention programming in Aboriginal communities."	N/A	100% DM 100%	Part of Health Canada's **Chronic Disease Prevention Division** **Phase 1:** A subsidiary of the Canadian Diabetes Strategy (CDS) **Phase 2 & 3 funding separate from CDS**	

		s and Metis living anywhere in Canada		**Phase 2** (2005-2010) had four components: • Health promotion and primary prevention; • Screening and treatment; • Capacity building and training; and • Research, surveillance, evaluation and monitoring. **Phase 3** (2010-2015) focus shifted to: • Initiatives for children, youth, parents and families; • Diabetes in pre-pregnancy and pregnancy; • Community-led food security planning to improve access to healthy foods, including traditional and				

				market foods; and • Enhanced training for health professionals on clinical practice guidelines and chronic disease management strategies				
Category	Location	Who Do They Serve	Access to FN communities	Program Description	Clinicians	Portion of the population that are First Nation and have Diabetes	Other partner organizations	Additional Comments
First Nations and Inuit Health Branch (FNIHB) (including Gov't of Canada nurses)								
supports the delivery of public health and health promotion services on-reserve provides drug, dental and ancillary health services to First Nations primary care services on-reserve in remote and isolated areas, **where there are no**	N/A	First Nations and Inuit		• Chronic Disease and Prevention Division of FNIHB oversees the ADI (described above) • **Health Canada (FNIHB) nurses (based in**	?	100% DM %?		

<u>provincial services readily available.</u>				**nursing stations and health centres):** • visit new parents and facilitate new baby care • provide immunization • encourage physical activity • facilitate community education sessions • provide primary care services for common conditions during scheduled clinics • attend to emergency needs (e.g. trauma, obstetrical emergencies, cardiac conditions)				

Health Services Integration Fund (HSIF) (est. 2010)								
Federal initiative to improve First Nations and Inuit health care collaboration/integration	N/A	First Nations and Inuit		Health Services Integration Fund (HSIF) is a five-year initiative supporting collaborative planning and multi-year projects aimed at better meeting the health-care needs of First Nations and Inuit. **Through HSIF, Health Canada is working with other Provincial, Territorial and First Nations and Inuit organizations to:** improve the integration of federally-funded health services in First Nations and Inuit communities with those funded by the provinces and territories; build multi-party partnerships to advance health service integration; improve First Nations and Inuit access to health services; and	N/A	100% DM% ?	Provincial, territorial, First Nations and Inuit organizations	

				increase the participation of First Nations and Inuit in the design, delivery, and evaluation of health programs and services.				

Provincial programs and services (ON & MB)								
Category	Location	Who Do They Serve	Access to FN communities	Program Description	Clinicians	Portion of the population that are First Nation and have Diabetes	Other partner organizations	Additional Comments
Ontario Assistive Devices Program; Healthy Change: Chronic Conditions Self-Management (Diabetes Education Programs); Health Sciences Centre Winnipeg; CNIB mobile van								
Ontario Assistive Devices Program								
	N/A	Ontario residents w/ valid Ontario health card & a disability requiring the equipment		support and funding to Ontario residents who have long-term physical disabilities and to provide access to personalized assistive devices	N/A	FN %? DM %?	Diabetes Education Program (DEP) Canadian Diabetes Association	

Medical devices support		or supplies for six months or longer	?	appropriate for the individual's basic needs. Devices covered by the program are intended to enable people with physical disabilities to increase their independence through access to assistive devices responsive to their individual needs ADP covers: prostheses; wheelchairs/mobility aids and specialized seating systems; enteral feeding supplies; **monitors and test strips for insulin-dependent diabetics (through an agreement with the Canadian Diabetes Association)**; hearing aids**; insulin pumps** and supplies; respiratory equipment; orthotic devices (braces), pressure				

				modification devices for burns and lymphedema (garments and pumps); visual and communication aids; home oxygen therapy. ADP pays up to 75 per cent of the cost of equipment, such as artificial limbs, orthopaedic braces, wheelchairs and breathing aids. With regard to needles and syringes for seniors, the ADP pays a grant directly to the person. For diabetics ADP covers: • 100% of the ADP price of an insulin pump • $2,400 a year for supplies used with an insulin				

				pump, paid to you in $600 installments every three months; any amount over $2,400 to be paid by patient **If you have Type 1 diabetes** and are not having success with multiple daily injections, ADP helps cover costs of insulin pumps and supplies used with them (e.g. infusion sets, cannulas)				
Healthy Change: Chronic Conditions Self-Management (Diabetes Education Programs) **http://www.healthychange.ca/what-are-healthy-change-workshops**								

Chronic conditions self-management	Based in Thunder Bay but also offered in Red Lake, Sioux Lookout, Kenora & Dryden, Fort Frances, Fort Hope, Geraldton, Nipigon, Schreiber, Terrace Bay, Vermillion Bay	adults of all ages with diabetes, arthritis, stroke, depression, fibromyalgia and other long-term conditions.	No (unless via videoconferencing ?)	**6-Week Chronic Conditions Self-Management Workshop** The workshop is free for adults and their caregivers • Participants meet once a week for a 2.5 hour class over a 6-week period • Two trained leaders facilitate workshops of 8-16 participants. • Workshops take place in community settings such as senior centres, churches, libraries and health care facilities or via videoconferencing **(access to remote communities?)** • The program is offered throughout the year in Northwestern Ontario communities	Volunteer-run program	FN %? DM %?	North West LHIN & St. Joseph's Care Group	

				Healthy Change Workshop Topics Include: • Coping techniques for pain & fatigue • Developing action plans & problem solving skills • Exercise and nutrition • Coping with difficult emotions • Managing Medications • Making informed treatment decisions • Working with your health care team				
Category	Location	Who Do They Serve	Access to FN communities	Program Description	Clinicians	Portion of the population that are First Nation and have Diabetes	Other partner organizations	Additional Comments
Health Sciences Centre Winnipeg http://www.hsc.mb.ca/								
Comprehensive medical care		the community surrounding the hospital and in the core area of Winnipeg, as well as to	?	clinical programs include: Adult Emergency Adult Mental Health Anesthesia Child & Adolescent Mental Health		FN %? DM %?	NW Ontario, Nunavut	

	Winnipeg, MB	**Indigenous peoples across Manitoba, northwestern Ontario and Nunavut.**		Child Health Clinical Health Psychology Critical Care Diagnostic Imaging **Dialysis** Medicine Oncology Rehab Geriatrics Surgery Women's Health				
CNIB Medical Mobile Eye Care Unit (information listed drawn from the NW LHIN vision care plan 2014 or website https://www.cnib.ca/en/programs-and-services/live/eye-van?region=bc)								
Mobile primary care	Longlac, Geraldton, Schreiber/Terrace Bay, Manitouwadge City of Thunder Bay IDN - District of Kenora, Ear Falls, Red Lake, Dryden, Pickle Lake/Osnaburgh, Ignace **According to website, in 2018, van does not travel west of Schreiber/Terrace Bay (?)**	Road accessible communities in the NW LHIN	According to the NW LHIN Vision Care plan for 2014, the CNIB van does not travel to remote FN communities	The van is a fully equipped mobile eye care clinic with a visiting ophthalmologist providing visual exams, treatment, minor surgeries and recommendations for care. Primary care providers make referrals to the van and volunteers book appointments at the community level.	25 ophthalmologist	FN %? DM %?		**NW LHIN vision care plan 2014:** Stakeholders report the most satisfaction when the services are coordinated at the local level by a primary care provider such as a Family Health Team Communities take the opportunity to provide diabetes education and screening activities during the mobile team's visit.

		But not in 2018?						The mobile van is seen as a highly valuable service in communities. Communities that are not currently serviced have expressed some concern that there is no opportunity to access this program within the current funding envelope. In communities receiving service, it is difficult to refer new patients if the caseload is at capacity. Where there is no apparent relationship with a primary care provider or no optometry available in the community there may be some frustration in responding to the recommended treatment plan laid out by the visiting ophthalmologist. The

								CNIB suggests some form of **pre-screening with teleophthalmology**, for example, would be helpful.

Thunder Bay Regional Health Science Center								
Category	Location	Who Do They Serve	Access to FN communities	Program Description	Clinicians	Portion of the population that are First Nation and have Diabetes	Other partner organizations	Additional Comments
(1) Center for Complex Diabetes Care (CCDC) **(2)** Renal Program/Unit **(3)** Bariatric Care Center **(4)** Orthopaedics								
(1) Center for Complex Diabetes Care (CCDC)								

Education Primary Prevention Management Care & Treatment Complex Management	Thunder Bay	Any outpatients or inpatients with Diabetes In Thunder Bay Area Same program as CCDC with Meni Ya Win		The Centre for Complex Diabetes Care (CCDC) provides enhanced support to patients with diabetes and related, collective health issues that require more intensive treatment strategies. Specialized interprofessional teams within the CCDC use a coordinated approach to diabetes management and treatment to meet each patient's individual needs and that of their families. The Centre for Complex Diabetes Care provides a single point of access to this type of care.	Does not say on website (assuming approval for the same clinicians as Meno Ya Win)	% FN ? 100% DM		SLA patients only cared for in TBay if got sick in Tbay or moved either direction elemedicine plays a vital role in helping to overcome the difficulties in delivering care to patients across Northwestern Ontario to provide closer-to-home care. Wherever possible, Telemedicine technologies are used to reduce the need for patients to leave their home communities to access CCDC services. This includes eye exams which are so crucial to detecting diabetic retinopathy early when it is most treatable. Teleophthalmology is a web-based screening program that allows patients to get their vision exams faster and closer to home. The unit is portable so it

								can travel to the patients rather than vice-versa. The digital images are sent securely to ophthalmologists in Thunder Bay for review via the Internet, resulting in faster, more timely care for patients in the region.
(2) Renal Program/Unit								

Education Primary Prevention Management Care & Treatment Complex Management	Thunder Bay			Renal Program provides a wide range of services to people living in Northwestern Ontario with kidney disease. This includes education, decision making support and treatment provided in the Kidney Clinic, in the dialysis units, as well as pre and post transplant, and living kidney donation care. The goal is to provide the right care at the right time for our patients, knowing that their needs will change at the different stages of kidney disease.	Nephrologist (Kidney Specialist) Nurse Practitioner Biomedical/Dialysis Technologist Dietitians Renal Pharmacist Renal Pharmacy Technician Social Workers Indigenous Navigator Patient Educator/Navigators Dialysis Access Coordinator / Body Access Coordinator Independent Dialysis Coordinator Clinical Nurse Specialist Volunteers Reception Clerks	% FN ? % DM ?		SLA Patient start hemodialysis here, option to transfer to SLMHC if space
(3) Bariatric Care Center								

Education Management Complex Care	Thunder Bay			one of several centres across Ontario that provide treatment for obesity. The RBCC assesses and treats patients of Northern Ontario, following evidenced based strategies, standards and protocols recommended by the Ontario Bariatric Network (OBN) and approved by the Ministry of Health and Long-Term Care. Eligibility: • 18 years of age and older • BMI greater than or equal to 40 • BMI greater than or equal to 35 but less than 40. With at least one of the following co-morbidities (as determined by your primary care provider: o Coronary heart disease o Type II diabetes mellitus o Hypertension o Diagnosed sleep apnea o Gastroesophageal Reflux Disease (GERD) RBCC also provides a meal replacement/behavior based program. The focus of the program is to help patients achieve medically acceptable weight loss in order to improve obesity-related health		% FN ? % DM ?		SLA patients names go through here with referrals

				conditions and quality of life. The goal is to help patients achieve a healthier state of wellness by providing knowledge and life skills to change their eating and coping behaviours, and develop alternative lifestyles that promote healthy eating, physical activity, and healthy living.
				
				Eligibility:
				• 18 years of age and older (allow referrals at age >= 17.5 years)
				• BMI greater than, or equal to 35
				• BMI greater than or equal to 30, but less than 35. With at least one of the following co-morbidities (as determined by your primary care provider):
				  ○ Complicated Type II diabetes mellitus
				  ○ Idiopathic intracranial hypertension
				  ○ Poorly controlled hypertension				

(4) Orthopaedics								

Complex Care Care & Treatment	Thunder Bay			The program will provide appropriate, timely and equitable access to orthopaedic specialist care for patients and primary care providers through a user-friendly, centralized referral intake process and a regionally coordinated assessment mechanism		% FN ? % DM ?	The Health Sciences Centre worked in partnership with the NW LHIN, as well as Dryden Regional Health Care, Riverside Health Care in Fort Frances, and Lake of the Woods District Hospital in Kenora. One of the main goals of the program is improved access and a standardized level of care for patients throughout the region.	SLA patients can have amputations done here. Also done in SLKT, won't usually refer out unless vascular issue, or for general anaesthetic, or already there, MD referral Residents of Northwestern Ontario face a higher than average prevalence of musculoskeletal disease and require higher than average use of orthopaedic surgical services in the region

Sioux Lookout Regional Physicians Services Inc. (SLRPSI, established in 2010)								
Category	Location	Who Do They Serve	Access to FN communities	Program Description	Additional Comments	Staffing Complement	Referral Networks	Population served: Diabetes, First Nations etc.
Committee/Corporation representing physicians	Sioux Lookout	Sioux Lookout & 32 First Nations SLRPSI physicians work in the clinic, ER, as hospitalists, and have the option of working in remote FN communities	SLRPSI physicians have the option to travel to 32 FN communities in NW Ontario	SLRPSI website describes themselves as: "Sioux Lookout Regional Physician Services Recruitment and Retention Committee." **"SLRPSI is a corporation founded to plan, govern and manage physician services in the Sioux Lookout area.** The corporation was established in January 2010." Retrieved from: http://nationtalk.ca/story/new-funding-structure-for-physicians-in-the-sioux-lookout-area		nine member board, with 1/3 representation from the Sioux Lookout First Nations Health Authority (SLFNHA), 1/3 representation from SLMHC (Meno Ya Win) and 1/3 representation from physicians." Retrieved from: http://nationtalk.ca/story/new-funding-structure-for-physicians-in-the-sioux-lookout-area	N/A	SLRPSI serves 32 FN communities in NW Ontario, no data provided on diabetes

APPENDIX C: INTRODUCTORY EMAIL AND SURVEY QUESTIONS

Introductory email:
Good afternoon, on behalf of Sioux Lookout First Nations Health Authority, I am inviting you or your staff members to complete the following online survey. The purpose of this survey is to gather information to support the development of a regional diabetes strategy to improve diabetes prevention, care and treatment for First Nations in the Sioux Lookout area.

Building upon a recent Community Health Worker pilot project aimed at improving diabetes care and developing locally customized approaches to implementation, evaluation and quality improvement, Dignitas International in partnership with the Sioux Lookout First Nations Health Authority wishes to undertake an expanded and more comprehensive approach to diabetes care in the Sioux Lookout region.

A coordinated regional diabetes strategy would be built upon community readiness and participation, partnership with regional care providers, leveraging the CHW model of care and participation in a data management and reporting system.

This survey represents an important step to round out the information gathering. Steps taken to date include document review and an environmental scan of existing diabetes programs and services in the region. A series of key informant interviews amongst partners and communities is also planned.

This survey asks for information about the current services and programs available for diabetes care in the region. It comprises 11 questions and will take approximately 25 minutes to complete.

For information about this survey and the project being undertaken to develop a regional diabetes strategy, please contact: Consulting team lead: Mariette Sutherland (705) 869-7773 and email mariettesutherland@hotmail.ca or Janel George at (807) 737-1802 email: janel.genge@slfnha.com

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1. Name of organization, respondent and email/phone.

2. Does your organization provide diabetes education and care services?

   Yes/No

If yes, which type of services do you provide:

- Healthy eating/nutrition counselling or workshops
- Physical activity/Exercise support or classes
- Monitoring blood glucose
- Pharmacological management
- Insulin therapy
- Prevention of hypo/hyperglycemia
- Planning for pregnancy
- Management of diabetes in the community
- Coping with diabetes
- Diabetes and mental health
- Traditional healing
- Alcohol and diabetes
- Smoking cessation
- Diabetic foot care
- Prevention of complications
- Home visits
- Outreach visits
- Other

3. In your experience, please list some of the current gaps and barriers in diabetes services for First Nations:
    a. Lack of communication/coordination between providers
    b. Poverty and food insecurity
    c. Lack of information/knowledge on healthy lifestyle behaviours
    d. Lack of interest/motivation from clients
    e. NIHB coverage not harmonized with Ontario Drug Benefit
    f. Cultural competency training for providers
    g. Travel/transportation for care
    h. Lack of access to services in community including diabetes education
    i. Lack of information/support for traditional or cultural approaches to care

j. Lack of integration between western and traditional approaches to diabetes
k. Lack of data (diabetes prevalence, incidence, trends etc.)
l. Access to foot care
m. Other?

4. In your experience what would help mitigate any identified gaps/barriers in diabetes services for First Nations people?

a. Funding (for staffing, training, program resources)
b. Traditional/cultural approach to programming
c. Diabetes training for community workers
d. Navigators for transitions between care settings
e. Extended transportation
f. Improved community partnerships
g. Enhanced outreach (from Diabetes Education Program, Centre for Complex Diabetes Care)
h. Enhanced funding to primary care teams
i. Cultural sensitivity training for providers
j. Better use of technology
k. Enhanced funding foot care (NIHB or provincial)
l. More promotion / prevention
m. One EMR
n. Better NIHB coverage

5. How many members are there in your team/agency?

6. Members of your team include:
   a. NP
   b. RN
   c. RPN
   d. RD
   e. Physicians

f. Mental health worker
g. Social worker
h. Health promoter
i. Exercise specialist
j. Traditional resource
k. Other

7. How does your organization demonstrate a commitment to culturally safe care?

8. Who are some of the other partners you work with in your referral networks?

9. Where does the majority of your agency/organization's funding come from?

10. How are you structured to do visits and outreach to communities/ or are services offered in your clinic setting predominantly?

11. Has your organization completed an evaluation of programs or services if so, what are some areas in which your organization is evaluated?

APPENDIX D: INTERVIEW GUIDE

Interview Guide SLFNHA Diabetes Strategy

Preamble:
On behalf of the Sioux Lookout First Nations Health Authority, I am speaking with you today about your perspective on diabetes care in your community or with your organization. This is part of our current work to collect information in support of the development of a regional diabetes strategy intended to improve diabetes prevention, care and treatment for First Nations in the Sioux Lookout area.

A coordinated regional diabetes strategy will be built upon community readiness and participation, partnership with regional care providers, leveraging the Community health worker model of care and participation in a data management and reporting system.

For information about this survey and the project being undertaken to develop a regional diabetes strategy, please contact: Consulting team lead: Mariette Sutherland (705) 869-7773 and email mariettesutherland@hotmail.ca or Janel Genge at (807) 737-5693 janel.genge@slfnha.com

Participation in the discussion is completely voluntary and will not affect your relationship with funders, partners of SLFNHA.

We will not attribute anything you say to you personally, but we will take notes and report back on the general themes that were discussed in this and other sessions in a final report.

We appreciate the time you are taking to share your experience! Thank you!

Do you have any further questions before we start the interview?

Interview Questions:

1. Please tell me about the diabetes care and services in the community

   (Probes: What services are provided locally? Which services are provide on a regional basis? How far do clients have to travel for specialist services?)

2. What are the diabetes care team members?

   (Probes: which staff members are locally employed, which staff members are visiting, how often)

3. What are some of the challenges with staffing?

   (Probes: HR, recruitment, retention, supervision, cultural safety, funding, training, etc.)

4. How well do you think are the different diabetes services seamlessly integrated form the perspective of clients?

Probes: fed/regional resources/service providers; local team, primary care team, physicians, NPs, specialists, other regulated health professionals, traditional/cultural providers, community health promotion)

5. Which services are missing in diabetes care?

   (Probes: services provided by local team, primary care team, physicians, NPs, specialists, other regulated health professionals, traditional/cultural providers, community health)

6. Are there any other challenges to care?

   (Probes: transportation, language, NIHB policies, SDOH)

7. What do you see as the main strengths in the community

   (Probes: People, leadership, elders, land and foods, camps on the land, traditional practices, informal support in the community, community, infrastructure, cultural)?

   How can these strengths help to support community-based diabetes care*?*

8. What is your perspective on cultural competency and cultural safety as it relates to diabetes care?

   (*Probes: Do you think the services are culturally safe? What is the approach with respect to teaching local and visiting staff? What could be done to improve cultural safety further? Are Language, stigma, judgement a factor?)*

SLFNHA Regional Diabetes Strategy Planning Session

Tuesday, February 5 and Wednesday, February 7, 2019
8:30 am – 4:30 pm
Forest Inn Sioux Lookout

AGENDA

Tuesday, February 5th

8:30 am – 9:00 am	Coffee & light breakfast
9:00 am - 9:15 am	Opening Prayer – Elder TBD Introductory remarks – Janet Gordon
9:15 am - 9:45 am	Icebreaker & introductions – Mariette Sutherland & Pamela Hubbard
9:45 am - 10:30 am	Information gathering & models Interactive presentation – Mariette Sutherland
10:30 am – 11:30 am	Guiding Principles – Mariette Sutherland & Pam Hubbard What essential values or principles should your regional diabetes strategy be built on?
11:30 am – 12:00 pm	Teepee Talk – Open Space and how it works – Pam Hubbard

	Choosing Teepee Talk topics
12:00 – 1:00 pm	LUNCH (provided)
1:00 pm – 2:00 pm	Teepee Talk – Session 1 (involving 4 topics from the morning)
2:00 pm – 3:00 pm	Teepee Talk - Session 2 (involving 4 additional topics)
3:00 pm – 4:00 pm	Teepee Talk Room Share What are your key takeaways from the discussion topics? What emerged from your conversations; what stood out for you as ideas or approaches that should be included in your diabetes strategy?
4:00 – 4:30 pm	Wrap up and overview of Day 2 – Mariette & Pam

Wednesday, February 6th

8:30 am – 9:00 am	Coffee & light breakfast
9:00 am - 9:15 am	Opening Prayer - Elder Recap of Day One – Mariette & Pam
9:15 am – 9:30 am	Visions in a Rez Café – an introduction to the principles and techniques of World Café to animate discussion of Vision
9:30 am - 10:30 am	Rez Café Round 1 – Three 20 minute conversations

"It is the year 2030, and your regional diabetes strategy has been in place 10 years. What does it look like… in the communities…. in Sioux Lookout; in the wider region? how are the people and places working together; what has made it effective; innovative; different?"

10:30 – 11:00 am Room Share - what did you discuss in your Rez Café? What are the main things that need to be emphasized in the vision?

11:00 am – 12:00 pm Rez Café Round 2 – Three 20 minute conversations

12:00 pm – 12:30 pm Round 2 Report Back

12:30 – 1:15 pm LUNCH

1:15 pm – 2:30 pm Moving Forward – small group discussion

- Communities - What do communities need to support them in bringing the strategy's vision to life?
- Service providers – how can you support communities in a culturally appropriate way in line with the vision?
- SLFNHA – how can Approaches to Community Wellbeing, Primary Care, Mental Health – contribute and be even more supportive of the vision of the diabetes strategy?

2:30 pm – 3:00 pm Group/room share

3:00 pm – 4:00 pm Process moving forward

What needs to happen?
What would you see as key milestones?
Who needs to be involved and how?
What do you see as viable model options for moving the strategy forward?

4:00 pm - 4:30 pm Wrap up and next steps
Closing Prayer