



The Recommendations

The Manitoba Diabetes Strategy Steering Committee recommends the following Diabetes Health Goals and Actions.

These goals and actions are inter-related and reflect the continuum of diabetes prevention, education, care, research and support.

The Committee recognizes that the implementation of these Diabetes Health Goals and Actions can be accomplished only through multi-level, intersectoral, inter-governmental and community partnering and collaboration.

Prevention

GOAL 1

Develop community-based **Diabetes Primary Prevention Programs**, particularly targeting seniors and Aboriginal people.

Actions

Include the following in the **Diabetes Primary Prevention Programs**:

- a) emphasize the role of individuals and families in making lifestyle and environmental changes and in serving as models of healthy living.
- b) encourage individuals and families to advocate change to the health

determinants that are increasing their risk for diabetes.

- c) promote an environment that supports healthy lifestyle choices for men and women of all ages and cultures.
- d) provide opportunities and encouragement for the development of diabetes prevention skills and healthy choices.
- e) involve elders, chiefs and other community leaders as positive role models.
- f) inform individuals and families about the importance of attaining and maintaining healthy weight through regular physical activity and healthy eating habits.
- g) develop comprehensive risk factor assessment tools.
- h) include assessments for individuals and families at risk for developing diabetes.
- i) ensure availability of resources for socially relevant and effective diabetes prevention activities.
- j) provide necessary resources to optimize quality of life for groups at high risk for diabetes. This refers to children, seniors and Aboriginal people.
- k) include individually and culturally relevant, sensitive, clear, accurate and consistent content in messages.
- l) disseminate messages and tools to break

- the cycle of diabetes risk factors in families and future generations.
- m) use existing community networks to disseminate prevention messages.
 - n) encourage school boards to create an environment conducive to healthy living for students and the community. For example, healthy foods as part of a school lunch program and increased physical activity for children.
 - o) include education about healthy eating and physical activity in all school curricula.
 - p) address the impact of acculturation (example, residential schools) on the development of diabetes.

Prevention

GOAL 2

Develop comprehensive community-based Diabetes Screening Programs.

Actions

Diabetes Screening Programs should include:

- a) community understanding, awareness and involvement.
- b) multidisciplinary teams.
- c) follow-up components and strategies that address case findings of both Impaired Glucose Tolerance and Diabetes.

Prevention

GOAL 3

Develop a Manitoba Nutrition Strategy to ensure the availability of nutritious foods and promote healthy food choices.

Actions

Include the following in the Manitoba

Nutrition Strategy:

- a) differential pricing, supplemented by governments, to ensure the availability of nutritious foods.
- b) supplements for individuals and families who cannot afford to buy healthy foods.
- c) establishment of programs and land for community gardens.
- d) regulation of the procurement and distribution of wild foods/game.
- e) standardized information on food labels combined with a nutrition labelling education component.

Prevention

GOAL 4

Develop a Manitoba Physical Activity Strategy to provide appropriate physical activity opportunities for all and to encourage individuals and families to incorporate physical activity into their daily lives.

Actions

The Manitoba Physical Activity Strategy must be applicable to diverse culture, heritage, abilities, experience and interests.

Include the following in the Manitoba Physical Activity Strategy:

- a) aim for the Federal/Provincial/Territorial Ministers' target of a 10% reduction in physical inactivity over the five-year period 1998-2003.
- b) seek and support local leadership as role models to promote healthy, active living within the community.
- c) support community action toward active transportation and physical environments



- that support active living.
- d) support families in the use of their own home and immediate neighbourhood as an active living environment.
- e) provide environments such as facilities, open spaces, trails, walking paths, cycle and canoe routes to support active living.
- f) seek alternative funding sources for cultural and sporting events to replace funding from alcohol and tobacco companies.
- g) co-ordination with other **Physical Activity Strategies**.

Prevention

GOAL 5

Provide **Tax Reduction Incentives** to individuals, families and communities practising diabetes prevention.

Actions

Tax Reduction Incentives require:

- a) federal, provincial, Aboriginal and municipal government collaboration.
- b) indicators and benchmarks to measure prevention practices and outcomes.

Prevention

GOAL 6

Develop a **Public Awareness Campaign** about the prevention of Type 2 Diabetes.

Actions

Include the following in a province-wide

Public Awareness Campaign:

- a) information about risk factors for diabetes.
- b) development of comprehensive risk factor assessment tools.

- c) information to encourage individuals to obtain personal risk assessments for diabetes.
- d) clear, accurate and consistent messages.
- e) communication and marketing strategies that include written, visual, audio and electronic means of communication.
- f) telephone hot-lines to allow Manitobans access to information, resources and service.
- g) co-ordination with other diabetes **Public Awareness Campaigns**.

Prevention

GOAL 7

Develop **Healthy Public Policies** that support healthy lifestyle choices, active living and health-enhancing environments.

Actions

All **Healthy Public Policies** should:

- a) be culturally sensitive.
- b) be age and gender specific.
- c) support individuals and families in their home and working environments.
- d) promote emotional well-being and build self-esteem in individuals, families and communities.
- e) support alcohol-free and smoke-free environments.
- f) emphasize the prevention or cessation of alcohol consumption and tobacco smoking/chewing.

Education

GOAL 1

Establish a **Standardized Multi-level Diabetes Education Program** to expand the pool of qualified diabetes educators from community to specialist levels.

Actions

A **Standardized Multi-level Diabetes Education Program** would include:

- a) **basic-level provider** - for peer educators, community educators and members of the general public. Training for this level shall be affordable and geographically accessible.
- b) **intermediate-level provider** - for health care providers with a partial commitment to education and/or care provision to people with diabetes.
- c) **advanced-level provider** - for health care providers dedicated on a full-time basis to health education and/or care provision to people with diabetes. The Canadian Diabetes Educator Certification Board standards will provide the basis for training at this level.

Education

GOAL 2

Develop a mandatory **Multi-level Certification Program** for diabetes educators.

Actions

A mandatory **Multi-level Certification Program** must be one that:

- a) is co-ordinated by a central agency, representing health care providers, consumers and the general public.

- b) is integrated into the existing certification program for diabetes educators.
- c) is funded for its initial set-up costs and ongoing program operation and evaluation costs.
- d) informs the general public and people with diabetes about the standards governing diabetes education.
- e) requires all individuals providing diabetes education to have evidence of current certification.
- f) requires all individuals currently providing education to obtain certification as soon as possible.
- g) conducts an annual review of the certification program curriculum based on existing evidence and standards of education and care.

Education

GOAL 3

Expand and enhance the community-based **Standardized Client Education Program** (Diabetes Education Resource Program).

Actions

The community-based **Standardized Client Education Program** must be one that:

- a) ensures timely access to community diabetes resources at initial diagnosis.
- b) emphasizes information about complications of diabetes at the time of initial diagnosis.
- c) utilizes certified diabetes educators at all levels - basic, intermediate and advanced.
- d) provides ongoing follow-up.
- e) uses teaching methods and language of instruction that are appropriate for the



intended audience.

- f) distributes appropriate educational material.
- g) provides education, care and support for individuals with diabetes and their families in their home communities, whenever possible.

Education

GOAL 4

Incorporate **Education About Diabetes** throughout the continuum of health care provider education.

Actions

Education About Diabetes must ensure that health care providers are aware of the scope of practice of all other health care practitioners. In addition, include the following in the program content:

- a) cultural beliefs of disease causation.
- b) health care provision in cross-cultural and northern/remote environments.
- c) the role of traditional and spiritual healing.
- d) prevention, education and the broader determinants of health as they relate to diabetes.
- e) issues related to seniors and diabetes.
- f) the provision of learning opportunities in community-based settings in both undergraduate and postgraduate education.

Education

GOAL 5

Develop a **Refresher Program** for all health care providers in the work force to update their knowledge about diabetes.

Actions

Include the following in a **Refresher Program** for health care providers:

- a) recommended standards of practice,
- b) inter/multi-disciplinary approach,
- c) burden of illness of diabetes,
- d) diabetes as a public health issue,
- e) holistic approaches, and
- f) health determinants.

Education

GOAL 6

Encourage all health professional associations in Manitoba to require **Continuing Education** about diabetes.

Actions

For **Continuing Education**:

- a) use a multidisciplinary approach for all continuing education, recognizing that the content of the material may be profession-specific.
- b) provide access to continuing education for all health care providers through itinerant programming, interactive distance education or, if necessary, by funding attendance at centralized or regional sites.

Education

GOAL 7

Include information about diabetes and chronic diseases in all **School Health Curricula**.

Actions

Link with appropriate people from Manitoba Health, Manitoba Education and Training and other agencies/associations to

ensure that information about diabetes and chronic diseases is included in all **School Health Curricula**.

Education

GOAL 8

Ensure the safety and health of students with diabetes in all school settings by utilizing the Canadian Diabetes Association **School Standards of Care** (1998).

Actions

Implement **School Standards of Care** in partnerships with:

- a) Manitoba Education and Training,
- b) school boards,
- c) teachers' associations,
- d) school trustees, and
- e) consumers.

Education

GOAL 9

Increase the **Number of Aboriginal Students** participating in, and graduating from, health care provider programs (in accordance with Recommendation 3.3.16 of the Royal Commission on Aboriginal Peoples - November 1996).

Actions

To increase the **Number of Aboriginal Students**:

- a) address the need for peer and cultural support.
- b) negotiate funding issues with partners.
- c) improve geographical access.
- d) introduce flexibility for entrance criteria.

Education

GOAL 10

Include information about diabetes and other chronic diseases in the health component of the **Teacher Certification and Training Program**.

Actions

Changing the content of the **Teacher Certification and Training Program** will require multisectoral discussions with:

- a) Manitoba Education and Training,
- b) Faculties of Education in Manitoba universities,
- c) Manitoba Health,
- d) school divisions, and
- e) consumers.

Education

GOAL 11

Develop a **Public Awareness Campaign** about the complications of diabetes.

Actions

A **Public Awareness Campaign** about the complications of diabetes must be province-wide, culturally-appropriate, age-specific and targeted to people with diabetes and their caregivers. A **Public Awareness Campaign** about diabetes complications should include:

- a) clear, accurate and consistent messages.
- b) information about the risk factors for the complications of diabetes.
- c) information to encourage individuals to obtain personal complication risk assessments.
- d) co-ordination with other diabetes **Public Awareness Campaigns**.



Education

GOAL 12

Co-ordinate an annual **Diabetes Symposium**.

Actions

The **Diabetes Symposium** should be organized in collaboration with the existing diabetes education network partners and address the latest developments in diabetes prevention, education, care, research and support.

Education

GOAL 13

Develop a **Diabetes Resource Library**.

Actions

The **Diabetes Resource Library** should:

- a) focus on educational resources and teaching tools for educators and their clients.
- b) include computer access through the Internet to ensure accessibility.

Education

GOAL 14

Develop **Healthy Public Policies** that support the concept of education as a fundamental component of diabetes prevention, care, research and support.

Actions

Focus **Healthy Public Policies** on the support of education of:

- a) the public,
- b) people with diabetes and their families,
- c) the health professions, and
- d) other policy makers.

Care

GOAL 1

Develop **Manitoba Diabetes Care**

Recommendations for the care of people with diabetes, consistent with the Canadian Diabetes Association Clinical Practice Guidelines.^{(18) (19)}

Actions

The **Manitoba Diabetes Care**

Recommendations should include:

- a) a format that is concise and practical.
- b) periodic review and update.
- c) collaboration with the College of Physicians and Surgeons of Manitoba and other appropriate regulatory bodies.
- d) tools to evaluate the implementation of the recommendations and their effectiveness.
- e) a distribution plan for all health professionals and health care providers, as well as appropriate regulatory bodies and professional organizations.
- f) information relevant to the care of:
 - I. Aboriginal people with diabetes. The unique considerations of family-centred care, language and culture must be incorporated in the recommendations.
 - II. women of child-bearing age with diabetes and women with, or at risk of developing, gestational diabetes.
 - III. children with diabetes and their families. Instruction should be made available to all members of the family. Community-based care should be emphasized for Aboriginal children.

IV. seniors with diabetes. The recommendations should promote individualized care for seniors with consideration given to individual needs, associated diseases and functional status.

Care

GOAL 2

Develop comprehensive **Diabetes Complications Screening and Care Programs**.

Actions

Diabetes Complications Screening and Care Programs should include:

- a) complication risk assessment.
- b) use of multidisciplinary teams.
- c) intervention programs for eye care, foot care, kidney function, high blood pressure and heart disease.
- d) links with other Manitoba programs: for example, the Diabetes Education Resource Program, tribal council diabetes programs, Northern Medical Unit and the Manitoba Dialysis Program.

Care

GOAL 3

Standardize the collection and communication of clinical data about people with diabetes through the development of a **Clinical Data Form**.

Actions

Standardized **Clinical Data Forms** will:

- a) contain baseline information from the initial client assessment.
- b) contain schedules for complication screening, to form the basis for reminders

to the person with diabetes and the DHC team.

- c) allow for the documentation of screening for the complications of diabetes.
- d) be available in clinical charts and to the person with diabetes.
- e) require tools to allow the transfer of essential medical information quickly and efficiently, especially reports and recommendations from specialist consultation.

Care

GOAL 4

Improve the **Co-ordination of Services** among hospitals and communities, Regional Health Authorities and other service providers.

Actions

Improve **Co-ordination of Services** between health institutions and communities by:

- a) development of communication networks as a priority in the care plan for the person with diabetes.
- b) inclusion of hospital admission and discharge planning.
- c) post-discharge follow-up as necessary (example, for children, seniors and Aboriginal people).

Care

GOAL 5

Develop the **Diabetes Health Care team** with an interdisciplinary structure and broad mandate for the education and management of diabetes and the prevention of its complications.



Actions

- a) The **Organization** of the **DHC team** is as follows:
- I. the person with diabetes and his/her family or care provider is central to the DHC team.
 - II. responsibility for diabetes care co-ordination is assigned to one individual on the DHC team.
 - III. the core DHC team will include the primary care physician, diabetes educators and/or community health educators and health care providers.
 - IV. the expanded DHC team is flexible and may include a variety of health care specialists and providers as individual needs dictate.
 - V. DHC team members should have expertise in psychosocial, economic, spiritual and cultural issues.
 - VI. if the community size does not allow for a full-time DHC team, provision on a regional basis should be considered, with every effort to provide care in the person's home community.
 - VII. the DHC team will develop alliances among business, education, volunteer, health and other sectors of the community.
 - VIII. the DHC team will utilize Regional Health Authority Diabetes Education Resource (DER) program staff who provide core services, to act as facilitators, co-ordinators and regional "experts" for DHC team development.
 - IX. DHC team members will have appropriate training, skills and the opportunities to maintain them.

- b) The **Functions** of the **DHC team** are as follows:
- I. co-ordination of comprehensive primary health care for the person with diabetes.
 - II. education about self-management of diabetes and prevention of complications.
 - III. identification of acute and chronic complications of diabetes.
 - IV. instruction in the emergency care of acute complications.
 - V. education about self-management of chronic complications.
 - VI. co-ordination of consultation with specialists as needed.
 - VII. communication and integration with community-based prevention, education and support programs, and other sectors that affect the individual's health.
 - VIII. integration of the activities of diabetes prevention, education, care, research and support as they relate to individuals with diabetes and their families.

Care

GOAL 6

Incorporate access to **Traditional Aboriginal Healing** practices and healers for Aboriginal people with diabetes and their families, if desired by the individuals concerned.

Actions

Access to **Traditional Aboriginal Healing** practices (used in conjunction with Western medical practices) requires:

- a) resolution of jurisdictional funding issues.
- b) sensitivity to community beliefs and practices.

Care

GOAL 7

Assess the validity of all **New Therapies** proposed for diabetes.

Actions

- a) Expedite the availability of those therapies shown to be valid.
- b) Develop a communication process to explain the validity of all new therapies.
- c) Develop partnerships with communities in the assessment of new therapies.
- d) Encourage opportunities for individuals and/or communities to be part of the research into new therapies.

Care

GOAL 8

Provide **Children With Diabetes and Their Families** the care necessary to optimize their quality of life.

Actions

- a) All children must have contact with a DHC team with expertise in dealing with children, at least every six months.
- b) A specialized integrated care program for young adults (aged 18-25 years) with Type 1 diabetes would assist in transition from pediatric to adult care.

- c) A variety of intersectoral and community-based care and service organizations must be integrated into the DHC team, for example: the provincial departments of Education, Justice, Family Services and the Public Trustee.

Care

GOAL 9

Provide **Seniors With Diabetes and Their Families** the care necessary to optimize their quality of life.

Actions

- a) Health care providers must be experienced in the care of elderly people.
- b) A variety of community-based care and service organizations must be integrated into the core DHC team for seniors: for example, Manitoba Family Services and the Public Trustee.
- c) Access to care, including foot and eye care, should be provided in the senior's home community, utilizing services such as the Victorian Order of Nurses (VON) and Home Care.

Care

GOAL 10

Develop **Innovative Ways of Funding** the expansion of diabetes care services.

Actions

- a) Develop intergovernmental and intersectoral partnerships to effect a co-ordinated approach.
- b) Seek partnerships with the private sector and non-government organizations.



Care

GOAL 11

Develop **Healthy Public Policies** that address standards of care, barriers in accessing care and continuity of care.

Actions

Healthy Public Policies should consider:

- equitable access to diabetes services in Manitoba,
- cost,
- geography,
- cultural and linguistic issues, and
- the provision of care for people with diabetes in their home communities, whenever possible.

Research

GOAL 1

Develop a **Manitoba Diabetes Surveillance System**.

Actions

The **Manitoba Diabetes Surveillance System** will:

- provide data to monitor and evaluate diabetes prevention, education, care, research and support in Manitoba and by each Regional Health Authority.
- provide data to continue the economic impact of diabetes study.

Research

GOAL 2

Develop **Indicators, Benchmarks, Outcomes and Standards** for diabetes prevention, education, care, research and support.

Actions

To develop **Indicators, Benchmarks, Outcomes and Standards**, utilize:

- Manitoba Diabetes Surveillance System data,
- Canadian Institute for Health Information data,
- best practice literature,
- census data, and
- Canadian Diabetes Association (CDA) standards.

Research

GOAL 3

Evaluate community-based interventions and initiatives in prevention, education, care, research and support.

Actions

This **Evaluation** shall be specific to groups at high risk for diabetes and its complications.

Research

GOAL 4

Increase the **Diabetes-Specific Funding for Research** to make it proportional to the cost of diabetes care in Manitoba (**Appendix D**).

Actions

Increasing **Diabetes-Specific Funding** will require:

- partnering between governments, the private sector and non-government organizations.
- analysis of the costs of diabetes.
- national comparative studies.

Research

GOAL 5

Establish a **Manitoba Centre for Diabetes Research**.

Actions

The **Manitoba Centre for Diabetes Research**:

- a) must provide an infrastructure for evaluation and research about diabetes.
- b) shall encourage Manitoba researchers to advocate special competitions by national funding agencies, to benefit diabetes research in Manitoba.
- c) shall be actively involved in national/international research networks for Type 1 and Type 2 diabetes. This includes participation in multi-centre clinical trials, collaboration on individual research projects and communication about results.
- d) shall maintain an inventory of diabetes research in Manitoba.
- e) shall seek partnerships with other Western region researchers.
- f) shall provide leadership to increase public awareness of ongoing diabetes research.

Research

GOAL 6

Develop a **Code of Ethics** for community-based diabetes research.

Actions

To develop a **Code of Ethics**, it is imperative that researchers:

- a) work with communities and people with diabetes.

- b) partner with other provincial, national and international researchers.

Research

GOAL 7

Develop **Research Skills and Experience** for health care providers.

Actions

To enhance **Research Skills and Experience**, provide:

- a) formal training at the undergraduate and postgraduate level,
- b) continuing education courses,
- c) mentorship programs with established researchers, and
- d) access to current research information and results on an ongoing basis.

Research

GOAL 8

Establish a **Manitoba Diabetes Information Warehouse**.

Actions

The **Manitoba Diabetes Information Warehouse** will:

- a) provide current, comprehensive, culturally- and community-appropriate information regarding all facets of diabetes prevention, education, care, research and support.
- b) update diabetes information regularly.
- c) meet criteria to ensure the accuracy and security of the information.



Research

GOAL 9

Produce an annual **Diabetes in Manitoba** report.

Actions

The **Diabetes in Manitoba** report will include:

- a) latest data on incidence and prevalence of diabetes and its complications by RHA, age, gender, postal code, Status and general populations.
- b) analysis of the significance of the data.
- c) demographic projections.
- d) economic impact data.

Research

GOAL 10

Inform the Public about the research process through a public campaign by researchers and non-government organizations.

Actions

Reports of research to **Inform the Public** should be distributed in a format and language that can be easily understood.

Research

GOAL 11

Develop **Healthy Public Policies** that support diabetes research in Manitoba.

Actions

Healthy Public Policies for research need to include the following components:

- a) community involvement in all aspects of research.

- b) research practices that are culturally sensitive and appropriate.

Support

GOAL 1

Develop holistic and community-based diabetes **Support Systems** that address cultural, emotional, spiritual and physical health issues and needs.

Actions

The development of community-based diabetes **Support Systems** should include:

- a) language concerns.
- b) cultural preferences, particularly with respect to food and activity.
- c) cultural sensitivity training for support workers.
- d) quality of life issues (example, community transportation and wheelchair accessibility for people living with disabilities).
- e) the establishment of community kitchens and walking programs.
- f) partnerships with schools, community centres and shopping malls.
- g) federal/provincial/Aboriginal/community partnerships.

Support

GOAL 2

Increase the number of **Community Diabetes Workers and Health Care Providers** from Aboriginal and other cultural, age and linguistic groups in which there is a disproportionate prevalence of diabetes.

Actions

Emphasize the following for **Community Diabetes Workers and Health Care Providers**:

- a) integration with other DHC team members.
- b) establishment and maintenance of standards of practice for community diabetes workers.
- c) develop training for support workers/providers for seniors with diabetes.
- d) develop training for support workers/providers for children with diabetes.
- e) develop federal/provincial/Aboriginal/community partnerships.

Support

GOAL 3

Address the inequities in **Access to Support Services** across the province.

Actions

- a) Seek financial, housing and transportation services for northern and rural residents who must relocate to urban centres for management of their diabetes and its complications.
- b) Develop diabetes support services for those individuals who are temporarily absent from their home community. This refers to First Nations individuals in particular.
- c) Establish partnerships with non-government organizations (NGOs): for example, Canadian Diabetes

Association (CDA), National Aboriginal Diabetes Association (NADA), Heart and Stroke Foundation, Canadian National Institute for the Blind (CNIB) and the Kidney Foundation of Canada.

- d) With these partners, develop a cohesive support system for individuals living with the long-term complications of diabetes, including visual impairment, lower limb amputation, kidney failure and/or heart disease.

Support

GOAL 4

Address **Jurisdictional Issues**.

Actions

- a) Continue partnerships that have been established by the *Manitoba Diabetes Strategy* process.
- b) Encourage the federal, provincial, municipal and Aboriginal governments to work together toward the common goal of preventing diabetes and improving access to diabetes services.

Support

GOAL 5

Inform **Leaders** at all levels and throughout the province, about the *Manitoba Diabetes Strategy*.

Actions

Inform **Leaders** through release of the *Manitoba Diabetes Strategy* in partnership with NGOs by various means, including public presentations, schools and local media.


Support
GOAL 6

Develop **Psychosocial Supports** for people with diabetes.

Actions

In conjunction with mental health programs, NGOs and communities, develop **Psychosocial Supports** that:

- a) build self-esteem in individuals with diabetes and their families.
- b) address the issues of living with diabetes on a daily basis.

Support
GOAL 7

Develop **Peer Counselling Support** services in all communities.

Actions

The development of **Peer Counselling Support** systems should include:

- a) people with diabetes and their families,
- b) the DHC team,
- c) health care workers,
- d) community health workers, and
- e) NGOs and other community organizations.

Support
GOAL 8

Develop **Advocacy Programs** for special-needs groups, including children, seniors and Aboriginal people.

Actions

Advocacy Programs will be developed in partnership with CDA and NADA to address specific issues (example, the cost of diabetes supplies for individuals with fixed incomes).

Support
GOAL 9

Expand **Pharmacare Programs** to increase coverage for diabetes medications and supplies.

Actions

- a) Assess new pharmacologic and non-pharmacologic technology.
- b) Provide affordable supplies for the management of diabetes.
- c) Maintain an inventory of supplies used in the care of diabetes and its complications.
- d) Ensure sufficient quantities of supplies are available to everyone with diabetes.
- e) Consider bulk contracts with manufacturers as a way to minimize costs.

Support
GOAL 10

Develop **Healthy Public Policies** that support people living with diabetes and its complications, their families and communities.

Actions

- a) Identify diabetes support needs within the community.
- b) Initiate policies that will promote the development of community support systems for people with diabetes and their families.
- c) Encourage the active participation of individuals with diabetes in the planning of community support systems.