



Diabetes in Manitoba

A Call to Action

May 2009

Preamble

Type 2 diabetes can be prevented through increased awareness of healthy living choices, adoption of healthy living behaviours and creation of supportive environments that reduce modifiable risk factors. Addressing physical inactivity, unhealthy eating and smoking, and gaining an understanding of the relationship between chronic disease and mental health require building capacity for healthy living in all settings. Through effective prevention policies, programs, systems and supportive environments, Manitobans can be assisted in making healthy choices easier.

Accomplishments to date and lessons learned are a strong foundation for enhanced efforts to address type 2 diabetes and other chronic diseases. National and provincial diabetes surveillance information provides a solid base for evidence-informed planning and ongoing monitoring. Expanded partnerships, along with research that examines effective interventions and identifies best practices, offer many opportunities to help prevent a continuing rise in the number of Manitobans being diagnosed with type 2 diabetes.

Background

Diabetes is a common chronic disease throughout Manitoba, as it is around the world. If untreated or poorly managed, diabetes can result in complications and disabilities, including heart disease and stroke, blindness, amputations, kidney disease and nervous system damage. The primary focus of *Diabetes in Manitoba: A Call to Action* is to prevent new cases of type 2 diabetes by addressing related risks and environmental factors.

Great strides have been made over the last 20 years to address the burden of diabetes in Manitoba. Improvements in diabetes prevention and treatment have contributed to a decrease in the annual rate of deaths associated with diabetes. As a result, the number of Manitobans living with diabetes has more than doubled between 1989 and 2006, to approximately 76,000 identified cases in 2005/06. Approximately 96 per cent of these cases are type 2 diabetes. Continuing improvements to the primary health care delivery system, enhanced prevention strategies and sustained action will be necessary to effect positive change in the burden of type 2 diabetes and other chronic diseases.

If levels of care, prevention efforts and rates of diabetes remain as they are, projections show that approximately 111,000 Manitobans will be living with diabetes by 2016, representing a projected 8.5 per cent of the population. This information, combined with an increase in the number of younger Manitobans being diagnosed with type 2 diabetes, presents both challenges and opportunities.

The cost of diabetes and its complications to individuals, families and communities in Manitoba is significant. Related health care costs are also significant. By 2010, the direct cost of treating diabetes in Manitoba is estimated to be approximately \$250 million¹. If current trends continue, projected national diabetes health care costs will increase by more than 70 per cent between 2000 and 2016.¹

This *Call to Action* goes out to individuals, families, communities and regional health authorities as well as health care providers. It is a call to re-energize, regroup and refocus our efforts to reduce the incidence of type 2 diabetes and create a healthier Manitoba.

A Call to Action

Improving the health of Manitobans by actively addressing diabetes is a provincial priority. This document is a call to:

- prevent type 2 diabetes, and
- reduce diabetes-related complications.

Actions taken will also assist in addressing other chronic diseases as their root causes are similar and potentially preventable.

Current diabetes surveillance data drives the need to identify effective ways to halt the increase of type 2 diabetes in the critical age range from birth to 49 years. A concerted effort involving an

expanded community of partners in prevention can make the difference needed to create this change. This is a call for commitment at all levels and across regions and jurisdictions to:

Develop a co-ordinated, collaborative action plan to reduce the burden of type 2 diabetes and chronic disease in Manitoba.

Working together to prevent the onset of type 2 diabetes will mean fewer days spent in hospitals and fewer visits to physicians each year. In addition, this equates to:

- fewer Manitobans admitted to hospitals for heart disease or stroke,
- fewer lower limb amputations, and
- fewer Manitobans admitted to hospital for chronic kidney disease.

The purpose of *Diabetes in Manitoba: A Call to Action* is to strengthen existing partnerships and build new ones to develop and implement a province-wide integrated and co-ordinated action plan. This *Call to Action* takes a life course approach to reduce the cumulative risk for diabetes and keep Manitobans healthier and disease-free over a longer period of life. Individuals, communities, regional health authorities, government and non-government organizations must all work together to achieve this goal.

¹Ohinmaa A, Jacobs P, Simpson S, Johnson JA. The Projection of Prevalence and Cost of Diabetes in Canada: 2000 to 2016. *Canadian Journal of Diabetes*, 2004.

Guiding Principles

The following principles are the foundation and lens for future consultation and collaboration on an action plan to address diabetes in Manitoba. These principles describe chronic disease across the continuum from determinants of health to end-of-life care.

Focus on health equality

A focus on building healthy living opportunities for all Manitobans, based on determinants of health and principles of equity, disease prevention and health promotion.

Shared responsibility and accountability for health

Collaboration among partners to address priority chronic disease issues and share in the achievement of common personal and population health goals. Accountability processes will ensure that actions are based on evidence that supports efficient, cost-effective programs.

Partnerships and collaboration

An “all-of-Manitoba” approach to address diabetes and other chronic diseases through the collaboration of existing and new partners within and beyond the current health and healthy living systems.

Capacity to address chronic disease

Sustainable action requires knowledge and leadership at all levels as well as shared responsibilities and resources.

Community-led and community-informed

Community assets and strengths are realized by engaging and actively listening to people affected by diabetes and chronic disease. True community support is based on an understanding of community needs and respectful, trusting relationships with individuals, families and community groups.

Cultural and linguistic relevance

Diverse cultures and traditions are honoured and acknowledged. Culturally appropriate approaches are inclusive of the historic and newest populations of Manitoba to strengthen cultural identity, provide a feeling of security, a sense of belonging and hope for the future.

Evidence-informed policy and practice

Decisions are based on the best available evidence from research, practice and/or experience.

Sustainability

Initiatives are implemented in a sustainable manner by communities, regions and governments.

Promotion of mental health and well-being

Initiatives are designed to help individuals achieve a sense of control over their lives, feel capable of making decisions, cope with life’s challenges and participate in meaningful ways.

Manitoba Solutions

The following six approaches reflect the continuum from health determinants to end-of-life care. Each of these approaches and corresponding descriptions provide a context for key examples of best and/or promising practices in Manitoba. Existing and developing initiatives are included to stimulate thinking about ways in which Manitobans can work together to prevent type 2 diabetes and its complications.

1. Advance policies, programs and systems (see page 6)

Co-ordinated action leads to health, economic and social policies that foster greater equity, making the healthier choice the easier choice for all Manitobans. Policy makers in all sectors and at all levels need to be aware of how their decisions have an impact on the well-being of vulnerable populations. Collaboration across departments and sectors, along with coherence among the policies of these organizations, will help to ensure true partnership in working together toward a consistent target.

The disparity gap in Manitoba requires shifts in what, where, when, how and to whom health services are provided. Addressing disparities means enhanced outreach of health care services to those who need them, regardless of where they reside in Manitoba. Policies, programs and approaches that address the underlying determinants of health must be developed, implemented and evaluated on an ongoing basis to prevent and delay the onset of type 2 diabetes and other chronic diseases.

2. Promote healthy choices in every setting (see page 9)

Helping Manitobans create settings that promote and support healthy living in the areas of physical activity, healthy eating and smoke-free environments will contribute to healthy practices necessary over the life course. Healthy choices and positive behaviour changes must be promoted and supported in all settings where people live, work, learn and play. This will support and enable all Manitobans to control modifiable risk factors for type 2 diabetes and achieve their fullest health potential.

3. Identify, screen and address risk factors (see page 11)

Identifying, screening and addressing common risk factors are essential to improve the health outcomes of people who are at risk of developing type 2 diabetes through unhealthy eating, physical inactivity and tobacco/smoke environments. Early detection of prediabetes will also provide opportunities to address risk factors, plan effective interventions and prevent new cases of type 2 diabetes.

4. Detect disease and establish therapeutic strategies (see page 13)

Detecting disease and establishing therapeutic strategies are essential components of a comprehensive approach to address the impact of diabetes. Periodic assessment of Manitobans at risk of developing type 2 diabetes makes early clinical interventions possible, which in turn reduces the risk of disease onset and prevents complications.

5. Enable a comprehensive approach for services and programs (see page 14)

A comprehensive approach to services and programs can reduce the morbidity and mortality of diabetes and other chronic diseases. This includes evidence-informed decision support tools, clinical information systems, access to multidisciplinary health care teams and patient self-management.

6. Cultivate quality of life (see page 15)

This is an area that presents opportunities for ongoing development of healthy living approaches for all Manitobans in every stage of life, regardless of health status.

Manitoba Solutions

1. Advance policies, programs and systems

EXISTING

■ Housing and Health

The Cross Department Co-ordination Initiative (CDCI) is a partnership between the departments of Family Services and Housing and Manitoba Health and Healthy Living. Its mandate is to identify and review existing housing-related policies, programs and services and to propose enhancements or alternatives to improve the housing and health outcomes for seniors and individuals with mental health and homelessness issues. The focus is on creating a range of adequate and affordable housing options with related health and social service supports.

Without adequate community-based housing and support services, vulnerable populations struggle to meet their daily living needs. This frequently results in decreased health status and increased use of acute care and institutional settings. Many struggle to manage type 2 diabetes, which is compounded by inadequate housing, limited or no access to appropriate nutrition and medications and chronic stress. Stable housing and supports can improve health efficacy through access to consistent health services, medication, nutrition, quality of life and decreased stress.

■ Healthy Child Manitoba

Healthy Child Manitoba (HCM) aims to help all Manitoba children and youth be physically and emotionally healthy; safe and secure; successful at learning; and socially engaged and responsible, to their fullest potential. HCM policies and programs are long-term investments that contribute to

healthy living and chronic disease prevention through strategic action on social determinants of health. Built on research that shows the strong correlation between early childhood experiences and lifelong health outcomes, HCM focuses on evidence-based programs and policies that support positive parenting, nutrition and physical health, literacy and learning, and community capacity-building. Investments in early child development are among the most effective in reducing the escalating burden of chronic disease in adults.

■ Northern Healthy Foods Initiative

The Northern Healthy Foods Initiative (NHFI) exists to increase nutritional options and support informed healthy food choices for northern Manitobans. The NHFI assists communities in developing capacity to increase local food production, increase the availability of nutritional foods, implement strategies to lower the costs for healthy foods, increase awareness of healthy eating, leverage funding for projects and create food-based economic development opportunities.

■ National Diabetes Surveillance System

The National Diabetes Surveillance System (NDSS) is a network of provincial and territorial diabetes surveillance systems. It was created to improve information about the burden of diabetes in Canada so that policy makers, researchers, health practitioners and the general public can make better public and personal health decisions. Expansion to include surveillance of additional chronic conditions such as hypertension, stroke, cardiovascular disease, chronic respiratory disease, mental illness and arthritis is underway and scheduled for the next few years, transforming the NDSS into a Canadian Chronic Disease Surveillance System (CCDSS).

■ **Manitoba Institute of Child Health – University of Manitoba**

The Manitoba Institute of Child Health (MICH) strives to improve the health of children and youth by creating an environment that fosters excellence in research and the development and application of treatments and cures. MICH conducts the following research into type 2 diabetes prevention in Manitoba:

- Tracking physical activity rates through the use of accelerometers (an objective measure of physical activity) to determine the prevalence of risk factors among youth, including inactivity and obesity rates. This research will be used to support the Manitoba Youth Health Survey results by providing a better understanding of self-reported data.
- Comprehensive assessment of fitness, physical activity and risk factors for type 2 diabetes in 100 Manitoba youth living with and at risk for type 2 diabetes, using Magnetic Resonance Imaging (MRI) techniques to examine fat content in liver, muscle and pancreas tissue. Results will help identify why some overweight youth progress to type 2 diabetes rapidly, while others remain protected for years.
- Following a group of 2,000 youth over three years to understand the “dose” of physical activity needed to protect adolescents from becoming obese and from developing insulin resistance (a key determinant in the natural history of type 2 diabetes).
- Community intervention for high-risk youth. A fitness centre in an isolated northern First Nations community has been established to

deliver a diabetes management and prevention program every evening to Aboriginal families affected by type 2 diabetes. This project will examine the quantitative and qualitative aspects of this community-driven project on the health of Aboriginal Manitobans living with type 2 diabetes in an isolated region of the province. The results could be used for the dissemination of a similar model across northern communities with a high burden of type 2 diabetes.

- Randomized controlled trial examining the role of different doses and intensity of physical activity on risk factors for type 2 diabetes in overweight adolescents.

The following federal initiative can provide important and valuable lessons about prevention and health promotion in Aboriginal communities throughout Manitoba:

■ **Brighter Futures**

The Brighter Futures program is a community-based health promotion and ill-health prevention program for First Nations and Inuit communities. The program typically promotes health and prevents ill health through learning-related activities to increase awareness, change attitudes, build knowledge and enhance skills. The program includes five components – mental health, child development, parenting, healthy babies and injury prevention. First Nations and Inuit communities have the flexibility to choose which program component(s) are appropriate as the basis of community programs, services and/or activities.

DEVELOPING

■ **Manitoba Institute of Child Health – University of Manitoba**

Based on research findings, the following are promising future opportunities:

- A screening study for youth at risk or currently diagnosed with type 2 diabetes. The association between modifiable lifestyle factors and the risk for type 2 diabetes and its complications in youth and young adults will be examined. The data will help tailor prevention efforts and provide important empirical evidence for policies, guidelines and media campaigns centered on type 2 diabetes prevention. The study will include a large number of Aboriginal youth to understand the culturally-specific lifestyle determinants of type 2 diabetes risk and management.
- Province-wide, community-based physical activity prevention programs in high schools. Data will inform high school curriculum and community health programs in high-risk First Nations communities.
- Longitudinal follow-up of youth diagnosed with type 2 diabetes before the age of 20. Following the development of these young Manitobans and measuring modifiable lifestyle factors throughout their early adulthood may help researchers pinpoint the factors that lead to early cardiovascular complications. Data could be used to develop “cardiac rehab” style programs to prevent morbidity and mortality among the growing number of Manitoba youth with type 2 diabetes.
- Establishment of a structured, 12-week lifestyle and physical activity-based program to improve cardiovascular risk profiles for persons diagnosed with type 2 diabetes.

■ **Childhood Obesity Prevention Review**

Manitoba Health and Healthy Living is currently conducting a review related to childhood obesity prevention and mitigation strategies.

■ **Traditional Aboriginal Healing Centre**

A traditional Aboriginal healing centre will be built next to the Powerview-Pine Falls Primary Health Care Complex. The centre acknowledges the Aboriginal contribution to wellness and healing, and will provide traditional Aboriginal healing practices and modern medicine in a holistic setting. These two facilities are intended to better serve the people of the North Eastman Health Association, including First Nations communities.

■ **Healthy Living for Newcomers to Manitoba**

Manitoba Health and Healthy Living is partnering with the Public Health Agency of Canada to support a needs assessment for newcomers that investigates barriers to physical activity and healthy nutrition choices. Culturally-sensitive approaches will be developed to assist in planning healthy living strategies with newcomers.

■ **Age-Friendly Manitoba Initiative**

The Age-Friendly Manitoba Initiative supports seniors in leading active, socially engaged, independent lives that contribute to healthy aging. Through partnerships, this initiative will support community efforts that enhance the health, independence and well-being of all Manitoba seniors.

2. Promote healthy choices in every setting

EXISTING

■ **Manitoba *in motion***

Manitoba *in motion* is a province-wide strategy to help Manitobans make physical activity part of their daily lives for health and enjoyment. The initiative focuses on children and youth, families, adults and older adults in home and community settings such as schools, child care facilities and workplaces. Manitoba has initiated Healthy Schools *in motion*, Communities *in motion* and Workplaces *in motion*. Community and workplace physical activity grants are available to help plan and implement physical activity opportunities.

■ **Type 2 Diabetes Prevention Campaign**

Manitoba Health and Healthy Living has developed a province-wide public education campaign for people at risk of developing type 2 diabetes. The campaign, which includes television advertising and a website, will build awareness about type 2 diabetes risk factors and prevention. The website includes an interactive self-assessment tool and practical information on healthy eating, physical activity and smoking cessation.

■ **Healthy Schools Initiative**

Manitoba Education, Citizenship and Youth, Health and Healthy Living and Healthy Child Manitoba have worked in partnership to develop the Healthy Schools initiative. This initiative includes a website, targeted provincial campaigns and community resources that promote healthy living choices and behaviours.

■ **Manitoba School Nutrition Policy**

Manitoba has a provincial school nutrition policy to ensure that healthier foods are available in school cafeterias and vending machines. Key activities and resources include:

- *Manitoba School Nutrition Handbook: Getting Started with Guidelines and Policies*
- *Guidelines for Foods Available in K to 12 Schools in Manitoba*
- School Nourishment Program

■ **Breastfeeding in Manitoba Provincial Strategy and Framework**

The Breastfeeding in Manitoba Provincial Strategy and Framework reinforces the importance of breastfeeding for optimal health and development. Breastfeeding may help protect infants against developing early-onset adolescent type 2 diabetes and mothers from developing type 2 diabetes.

■ **Chronic Disease Prevention Initiative**

The Chronic Disease Prevention Initiative (CDPI) is a five-year demonstration project currently implemented in 10 regional health authorities (RHAs) in Manitoba involving 83 communities, including 21 First Nations and seven Métis communities. The CDPI is community-led, co-ordinated by RHAs and supported by two levels of government (Manitoba Health and Healthy Living and Public Health Agency of Canada). The CDPI Progress Report² provides valuable insights into these community-led approaches aimed at reducing modifiable risk factors for diabetes and other major chronic diseases.

²Manitoba Health and Healthy Living. Chronic Disease Prevention Initiative 2005-2007 Progress Report. December 2008.

■ Tobacco Control Strategy

Manitoba has been actively implementing a comprehensive provincial tobacco control strategy since 2002 and was the first Canadian jurisdiction to ban indoor smoking in public places. The strategy is based on four nationally-endorsed goals of prevention, protection, cessation and denormalization and has focused on youth to prevent tobacco addiction. Related programs and policies include legislation, media campaigns, tobacco education resources for schools, funding for the Canadian Cancer Society Smokers Helpline and support for Students Working Against Tobacco (SWAT). Given what is known about the links between smoking and diabetes in terms of negative health outcomes, it is reasonable to expect tobacco control initiatives will contribute to reducing the burden of illness.

■ Aboriginal and Northern Affairs Recreation Funding

Aboriginal and Northern Affairs provides funding to Northern Affairs communities for recreation. Funding is available for either a full-time recreation director or part-time recreation programming, depending on the size and unique needs of the community. Funding is allocated based on the discretion of community councils, all of whom submit plans at the start of each fiscal year.

■ Healthy Buddies™

Healthy Buddies™ is a pilot initiative that will be introduced to Manitoba schools in 2009-2010. Healthy Buddies™ is a comprehensive health education and health promotion program that aims to empower students to live healthier lives using an innovative peer-led and mentorship approach to promoting healthy attitudes and behaviours.

DEVELOPING

■ Healthy Living Strategy

A Healthy Living Strategy is currently being developed through ongoing consultation with key stakeholders throughout Manitoba. This strategy is aimed at integrating existing and new healthy living initiatives.

■ Manitoba *in motion*

Approaches will be developed to support specific audiences including new immigrants, Aboriginal Manitobans, persons with disabilities and low-income children and families.

■ Eat Smart, Meet Smart

The *Eat Smart, Meet Smart Resource: How to Plan and Host Healthy Meetings, Events and Conferences* is a new support available to workplaces. The resource package provides guidance in planning and serving healthy meals and snacks, and suggests ways to promote physical activity.

■ Healthy Schools Initiative

A pilot program was launched in January 2009 to test and assess different ways to increase fruit and vegetable consumption in school settings. A follow-up nutrition survey will be conducted in spring 2009, the results of which will inform future nutrition policy and program development.

■ Chronic Disease Prevention Initiative

Sustainability of chronic disease prevention capacity and programs will be an area of emphasis in the fifth year of this five-year demonstration project. CDPI evaluation processes will provide additional information on effective reduction of risk factors and innovative approaches in

advancing chronic disease prevention efforts at provincial, regional and community levels.

■ **Mental Health Promotion Champions**

Mental health is a key element of overall health. It is “a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.”³ Mental health promotion is about supporting individual resilience, creating supportive environments and addressing the influence of the broader determinants of mental health.

Chronic diseases can have a profound impact on an individual’s mental health; in turn, mental health status affects an individual’s ability to participate in chronic disease prevention and management. Mental health promotion stakeholders partner, collaborate and plan mental health promotion strategies across sectors and programs.

3. Identify, screen and address risk factors

EXISTING

■ **Regional Diabetes Program**

A province-wide Regional Diabetes Program (RDP) was initiated in 2004 to enhance the existing Diabetes Education Resource Program. A policy framework was developed to identify expectations, activities, deliverables and potential outcomes for a population health approach to diabetes that promotes systems integration and

guides RHA implementation planning. Risk Factor and Complication Assessment was developed as one component of the RDP to educate multi-disciplinary health teams and provide tools for the implementation of screening programs. This includes the provision of periodic assessments for people at risk of developing type 2 diabetes and other preventable chronic diseases, as well as annual complication assessments for people living with diabetes. Each risk assessment includes awareness and education components to help individuals identify and plan for positive behaviour change.

■ **Prediabetes Initiative**

Upstream Screening for Prediabetes and Undiagnosed Type 2 Diabetes is a 15-month project implemented in 2008 by Manitoba Health and Healthy Living and the Brandon Regional Health Authority, with funding support from the Public Health Agency of Canada. The project developed and delivered community-based prediabetes screening and intervention to Manitobans 20 to 74 years of age with no previous diagnosis of prediabetes or diabetes. Individuals were recruited and screened for prediabetes using a risk assessment questionnaire and blood testing, and then referred to existing lifestyle education programs within the community. This initiative will enhance early detection of prediabetes and type 2 diabetes, and inform development of similar projects elsewhere in the province.

³ World Health Organization. 2005.

The following two federal initiatives will provide valuable lessons and inform future directions in diabetes prevention and management in Aboriginal communities throughout Manitoba:

■ **First Nations Patient Wait Time Guarantee**

This 18-month project was initiated in 2007 by the Assembly of Manitoba Chiefs and Saint Elizabeth Health Care, with funding from Health Canada. The project goal was to reduce the impact of foot ulcers and amputations in Manitoba First Nations communities by establishing and implementing a wait-time guarantee for the prevention, treatment and care of diabetic foot ulcers. Major barriers to foot care and community assets to address these barriers were identified by engaging key stakeholders and communities. A framework for foot care was developed with strategies for information management, partnership networks, engagement of people and a policy review. The final report will inform future directions in foot care across the province.

■ **Diabetes Integration Project**

The Diabetes Integration Project is a mobile diabetes care and treatment services program. The project was developed by the Manitoba First Nations Diabetes Committee to improve the health status of First Nations individuals, families and communities by preventing or delaying the complications of diabetes. Its objectives include raising awareness of diabetes and its risk factors, building capacity and linkages, promoting effective self-management and co-ordinating services with other community-based and provincial programs. This project was launched in 12 First Nations communities (six northern and six southern Manitoba locations) in October 2008 with funding from First Nations and Inuit Health, Health Canada.

DEVELOPING

■ **Foot Care Pilot Project in Northern Provincial Nursing Stations**

Manitoba Health and Healthy Living is currently in the early stages of developing a foot care pilot project in the northern provincial nursing stations of Moose Lake, Grand Rapids and Easterville located in the NOR-MAN RHA. The project will conduct foot screening and provide appropriate follow-up care using innovative camera technology, telemedicine and specially-trained community personnel. Specialized cameras and foot care kits will be available for use in these communities. This initiative will build upon the capacity development approaches of the First Nations Patient Wait Time Guarantee and be linked to the Regional Diabetes Program, Manitoba Retinal Screening Vision Program, Diabetes Integration Project and Chronic Disease Prevention Initiative already underway.

■ **Risk Assessment Tool**

Manitoba Health and Healthy Living is currently in the preliminary planning stages for development of a state-of-the-art risk appraisal tool. This tool will help Manitobans assess and learn what they can do to reduce their risk of colorectal cancer and other chronic conditions, including type 2 diabetes.

4. Detect disease and establish therapeutic strategies

EXISTING

■ **Manitoba Diabetes Care Recommendations**

The Manitoba Diabetes Care Recommendations provide standards of care for diabetes prevention and management in the community. These recommendations are based on the national Canadian Diabetes Association clinical practice guidelines and are distributed to primary care physicians, diabetes educators and other health professionals and providers throughout Manitoba.

■ **Manitoba Retinal Screening Vision Program**

In 2007, the Manitoba Retinal Screening Vision Program (MRSVP) began providing mobile retinal screening, vision assessment, diagnosis and treatment for people with and at risk for diabetic retinopathy in northern and remote communities. This program has improved health system cost efficiency by reducing travel and specialist visits for 89 per cent of the more than 1,800 clients who received follow-up care from local health professionals.

■ **Manitoba Renal Program**

The Manitoba Renal Program (MRP) is made up of interdisciplinary teams of health care professionals working together to provide high-quality kidney care. The MRP promotes a holistic approach to caring for people with kidney disease, their families and their communities. Three Winnipeg hospitals, Brandon General Hospital and 12 satellite local centres in rural and northern Manitoba provide renal services. Through the Renal Health Outreach initiative, a team of renal educators, nurses, dietitians, social workers and pharmacists visit communities throughout the province providing current information and education about kidney health and kidney disease.

DEVELOPING

■ **Manitoba Diabetes Care Recommendations**

The Manitoba Diabetes Care Recommendations will be updated in 2009 to reflect the current national clinical practice guidelines for the prevention and management of diabetes in Canada.

■ **Manitoba Retinal Screening Vision Program**

An evaluation of the Manitoba Retinal Screening Vision Program is planned for 2009 and will inform future delivery throughout Manitoba.

5. Enable a comprehensive approach for services and programs

EXISTING

■ Physician Integrated Network

The Physician Integrated Network (PIN) initiative involves the collection and measurement of care in a primary care setting for people living with diabetes and other chronic diseases. The initiative is based on a multi-disciplinary team approach and the use of electronic medical records, including reminder systems and opportunistic screening.

■ Advanced Access to Health Care Services

Sixteen primary and specialty clinics throughout Manitoba are implementing Advanced Access so that patients, many of whom have a chronic disease, can see a physician or other care practitioner at a time and date that is convenient for them. Activities include shaping the demand and supply for appointments, determining the areas within the practice that cause delays, establishing clear roles and responsibilities for staff, and committing to work as a team to increase clinic efficiency and eliminate appointment-related delays.

DEVELOPING

■ Physician Integrated Network

During phase 2, PIN is expanding to include 65 more fee-for-service family physicians which doubles the number of participating physicians and increases the number of patients served.

■ Advanced Access to Health Care Services

A second series of learning sessions are being planned for interested primary and specialty clinics within the province. Upon completion of the second series, an estimated 200,000 patients will have better access to primary and/or specialty care. This should result in better diabetes management and increased access to appropriate health care providers.

■ CareLink – Patient Access to Quality Care

CareLink is a demonstration project jointly funded by Canada Health Infoway and Manitoba Health and Healthy Living. CareLink will focus on two projects, Chronic Disease Self-Management and After Hours On-Call, to improve patient access to quality primary health care in Manitoba.

The Chronic Disease Self-Management program will support Manitobans with chronic conditions such as congestive heart failure and type 2 diabetes by providing access to self-managed care through the Provincial Health Contact Centre (PHCC). Through telephone interventions, PHCC clinicians will provide diabetes education, symptom monitoring and management to those who meet program eligibility criteria. This program will complement existing services for Manitobans living with diabetes.

The After Hours On-Call component of this demonstration project will engage primary care providers to work in a virtual network, using technology, to help Manitobans with non-urgent health concerns access quality primary care beyond regular clinic hours. This, in turn, is expected to reduce demand for emergency department care.

6. Cultivate quality of life

EXISTING

■ **Get Better Together! Manitoba**

Get Better Together! Manitoba (GBT) is a chronic disease self-management program (CDSMP) licensed through Stanford University. This program assists participants with diabetes and chronic disease to increase activity levels, improve food choices, quality of life and health status through regular peer-led sessions.

Get Better Together! Manitoba does not replace disease-specific patient education. GBT develops self-management skills to help participants address the challenges of living with an ongoing condition. Participants are better able to manage their symptoms and limitations, increase their activity levels, improve communications with their doctors, and realize improved health status (self-reported and reduced hospitalization) as well as improved quality of life.

DEVELOPING

■ **Get Better Together! Manitoba**

Manitoba Health and Healthy Living has supported the Wellness Institute at Seven Oaks General Hospital to extend this program province-wide based on outcomes from similar initiatives in Winnipeg and rural and northern RHAs in Manitoba. Building on early successes, further development of this initiative throughout Manitoba will need to consider efficacy, sustainability, cultural relevance and ways in which peer-led behaviour change can be supported across the continuum.

Moving Forward Together

The burden of diabetes in Manitoba is both concerning and compelling. Diabetes is a complex problem that cannot be addressed effectively by any single agency or sector. It requires partnerships with stakeholders, individuals and communities to co-ordinate services and reduce fragmentation. *Diabetes in Manitoba: A Call to Action* challenges us to rethink and renew how we address diabetes and other chronic diseases in this province.

We need to find innovative ways to build on existing achievements that include:

- a robust surveillance system;
- new efforts in primary health care;
- expanded prevention programming in community and school settings;
- increased awareness of risk factors; and
- Increased use of technology.

We also need to grow our partnerships, both within the health and healthy living community as well as non-health sectors, to reduce the impact of type 2 diabetes in Manitoba. This is a call for commitment at all levels to plan across RHAs and jurisdictions in the development of an integrated, co-ordinated and collaborative plan of action to address diabetes and other chronic diseases in Manitoba.

Building on existing and developing practices will strengthen our ability to work across sectors to develop, implement and evaluate new models for the prevention and management of type 2 diabetes and other chronic diseases. Together, we can reduce the cumulative risk for chronic disease, keep more Manitobans healthier and prevent new cases of type 2 diabetes among Manitobans.

