First Nations Diabetes Care for Health and Wellness

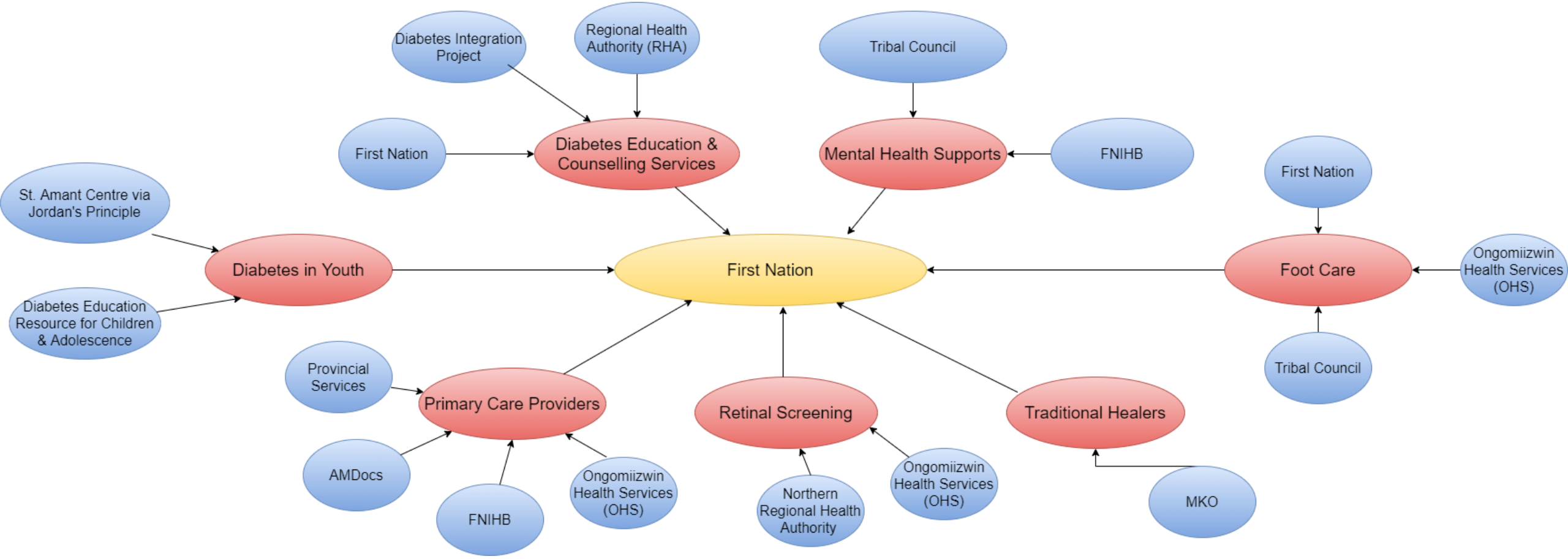
Business Case Update

March 2021

Background

- With the rates of diabetes in First Nations populations, current services being provided to address diabetes is not enough.
- Resolution passed at this table in September 2019 for the Manitoba First Nations Diabetes Leadership Council (MFNDLC) and FNHSSM to develop a business case for additional diabetes resources to prevent diabetes and to address the gaps in care and services.
- Upon completion, the business case will be presented to the Federal Ministers to designate investments for expansion of diabetes care.

Map of Diabetes Services in Community



Work to Date

The contract was awarded to EPI Research Inc. in January 2019

Preliminary work to support the development of the business case included:

- A review of the Diabetes Integration Project (DIP).
- Focus group sessions with community clients, community health staff, Manitoba First Nation Diabetes Leadership Council (MFNDLC) and key informants.
- Review of existing data and reports.
- Draft presented to MFNDLC in February 2020 further work required

Work to Date

MPH Student (August 2020)

- Engagement sessions with MFNDLC
  - November 16, 2020
  - December 14, 2020
- Asset mapping of diabetes services currently available in First Nations.
- Scan of diabetes programs in Canada.
- Draft 1 of proposed service delivery model and implementation plan.

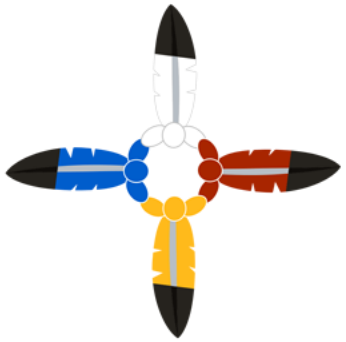
Options Explored

1. Status quo
2. Diabetes and education counselling be a services covered by Non-Insured Health Benefits (NIHB).
3. Scale up current DIP services to all communities to support those living with diabetes in First Nations.
4. Provide all services needed to prevent and manage diabetes in First Nations populations throughout the lifespan.

Suggested Direction

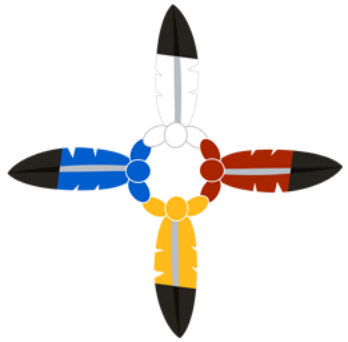
4. Provide all services needed to prevent and manage diabetes in First Nations populations throughout the lifespan.

Approach to planning diabetes programming



- Every Nation is sovereign therefore programming will look different in each.
- Ensure best practice approaches were used to inform care.
- Development of a framework to guide work in communities.

Key Considerations



Anti-Racist and Decolonized Approaches to Care

Interconnectedness

Decentralized Approach

First Nations Led

Workforce Development

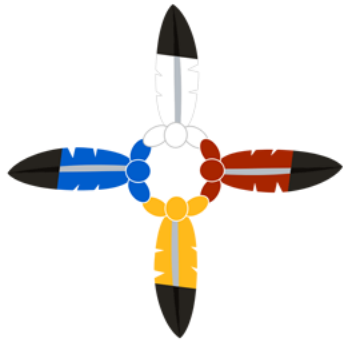
Holistic

Goal & Objectives

Goal:

Prevent diabetes and the complications due to diabetes in First Nations peoples to, at minimum, reach health parity with non-First Nations people in Manitoba within 10 years.

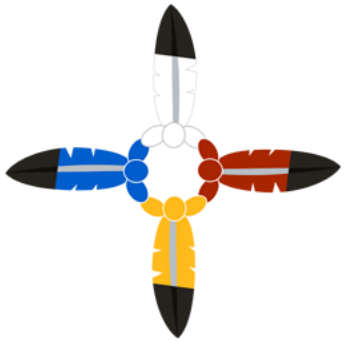
Objectives



Objectives:

- Increase access to diabetes care for First Nations people.
- Identify diabetes and diabetes-related complications early to help with management to improve quality of life.
- Promote healthy communities by increasing health promotion in other sectors in the community.
- Incorporate traditional practices and Indigenous ways of knowing into all aspects of diabetes prevention and care.
- Improve diabetes care and case management services for those living with diabetes.
- Create environments and policies that support individual healthy behaviour change.
- Implement a data management system in all diabetes programs to improve client quality of care and inform programming decisions.

Framework Development

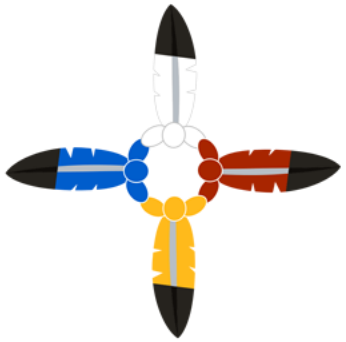


- Considered the needs across the lifespan.
- Competencies were developed as they relate to medicine wheel*: mental, spiritual, physical, and emotional*.
- Identified what care providers could meet those competencies.
- Competencies are to be met by community or Tribal Council to maintain a standard of care.

Sample Competencies in Physical Realm

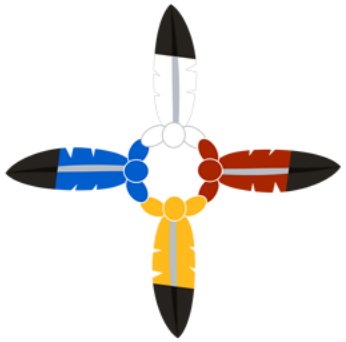
Competency	Description	Potential Service Providers to meet competency
Case Management and Care Coordination	Ability to plan and coordinate for person with diabetes, refer to appropriate specialist, and liaise with provincial health care systems.	Nurse, Dietitian
Diabetes Education	Ability to deliver advance education to person with diabetes and provide expertise in programming and resource development. Point of care testing for complications and diabetes.	Nurse, Dietitian, Footcare Nurse, Pharmacist, Nurse Practitioner, Mental Health Worker, Certified Diabetes Educators
Activity/Movement	Ability to facilitate or organize group exercises for all age groups and abilities, build community capacity to increase activity in community settings, and promote activity encouraging environments. Ability to provide individual activity prescriptions to improve health outcomes.	Physical Activity Specialist, Physical Therapist, Land-based Educators.
Regulation of care standards	Ensure care providers are following best practices and quality controls to provide.	Nurse, Certified Diabetes Educator

What does this look like?



- In alignment with clinical care transformation…
- Tribal Councils and Independent communities will provide service delivery and health promotion to address diabetes prevention, care, and management.
- FNHSSM will provide regional supports to those working in communities.

What will it look like?

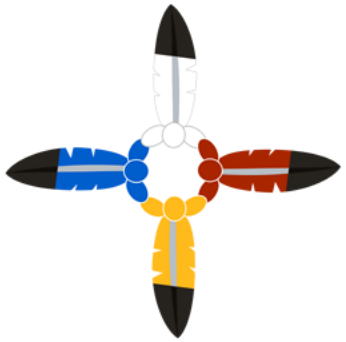


- At a Tribal Council and community level:
  - Influx of care providers.
- Wraparound services to prevent and manage diabetes.
  - Diabetes screening.
  - Diabetes complication screening.
  - Diabetes education and counselling.
  - Health promotion activities including land-based education, ceremonies, community education, physical activity, etc.
  - Changes in environment to support healthy behaviour change including food security initiatives.
  - Workforce training and development.
  - Etc.

What will it look like?

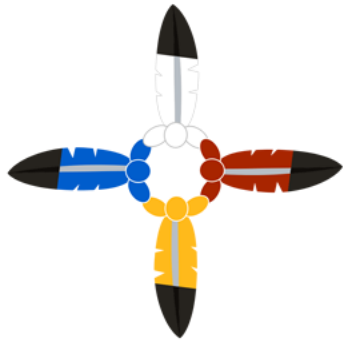
- At a Regional Level (FNHSSM):
  - Lead implementation for expansion
  - Policy development
  - Information and data management
  - Program & Clinical Care Standards and Quality Assurance
  - Research

Implementation Plan



Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10
•5% Staffing Capacity •Engagement, Planning and Development •Continue with current DIP services	•10% Staffing Capacity •Finalization of plan •Community Relationship building. •Continue with current DIP services	•20% Staffing Capacity •Implementation •All TC and independent communities have trained health professionals to provide diabetes care and management. •Transfer of DIP teams.	•35% Staffing Capacity •Capital Investment.	•50% Staffing Capacity •Transfer of training from FNHSSM to Tribal Councils. •Implement Workforce Development Strategies.	•60% Staffing Capacity	•70% Staffing capacity	•80% Staffing Capacity	•90% Staffing Capacity.	•100% Staffing Capacity •**Centre of Diabetes excellence at each Tribal Council and Independent community.**

Implementation Plan



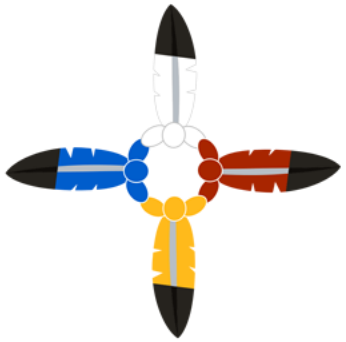
- Regional Implementation Project Manager
  - Aid in the Tribal Council and community planning and implementation of expansion of programming.
- Business Analyst
  - to help translate needs of communities into information management system.
- Tribal Council and community leads to work with implementation team to coordinate implementation regionally.

Investment Needed

10-year implementation plan = **$1.9 billion**

Ongoing annual funding after 10 years = **$360 million**

Next Steps



- Calculate potential costs saving from programming.
- Present proposed framework and implementation plan to Manitoba First Nations Diabetes Leadership Council for input and draft revisions.
- Final draft to be completed and presented by Fall of 2021.