Yukon Diabetes Strategy Renewal

A Strategic Response to Diabetes

Yukon
2009 - 2012

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March 2009

A strategic response to diabetes in the Yukon involves the coordination of strategies, services and resources for diabetes prevention and care. An effective response will support the well-being of people living with and at risk of diabetes while minimizing the long-term complications and costs.

This document, A Strategic Response to Diabetes, does not represent official views of any of the employers or groups represented by the people participating in its renewal. It is a collection of ideas and opinions of those working with diabetes in the Yukon about what a comprehensive and effective response involves. No commitment of resources or effort on the part of any organization is implied.

Supported by:

Recreation and Parks Association of the Yukon

www.rpay.org

Diabetes Education Centre & Yukon Diabetes Reference Group

www.yukondiabetes.ca

Funding for this publication was provided by the Public Health Agency of Canada. The opinions expressed in this publication are those of the authors and do not necessarily reflect the official views of the Public Health Agency of Canada.

DIABETES IN THE YUKON

Prevalence of Diabetes in Yukon[1,11]			
	1999-2000	2004-05	2005-06
Population	N/A	4.3%	5.0%
Male	3.8%	4.0%	4.6%
Female	3.9%	4.6%	5.5%

Estimated Direct Costs of Treating Diabetes in Yukon[4]	
in 2000	$3 million
in 2016	$6 million

Yukon Response to Diabetes	
Strengths	**Gaps**
Yukon Diabetes Reference Group	Lack of a formal Diabetes Strategy
Chronic Disease Management Program	No allocation of funding for a comprehensive response
Diabetes Education Centre	Limited coordination for an overall response
Telehealth	Limited local capacity for prevention and care
Healthy Living project (PHAC, YTG and RPAY)	Limited access to foot care services
Yukon Health Care & Chronic Disease Program	Limited services and support for pre-diabetic clients
Yukon First Nations and Aboriginal organizations are planning and delivering diabetes activities.	Limited services for Elders/seniors, Aboriginal people, women of child-bearing age and people considered pre-diabetic
Diabetes Resources: website, Do-It-Yourself Manual, Diabetes Resource Guide (3rd edition and in French), Diabetic Foot Guide	Limited programming and support for self-care and self-management

CONTENTS

ABBREVIATIONS

ADI - Aboriginal Diabetes Initiative

AHRN-YT – Arctic Health Research Network – Yukon Territory

CCSMP – Chronic Conditions Self Management Program

CDA – Canadian Diabetes Association

CDMP – Chronic Disease Management Program

CDS – Canadian Diabetes Strategy

CPG – Clinical Practice Guidelines

CPNP - Canada Prenatal Nutrition Programs

DEC –Diabetes Education Centre

DM – Diabetes Mellitus

DRG – Diabetes Reference Group

GDM – Gestational Diabetes Mellitus

IFG - Impaired Fasting Glucose

IGT - Impaired Glucose Tolerance

NDSS - National Diabetes Surveillance System

NGO's - Non-Governmental Organizations

NIHB – Non-Insured Health Benefits

PHAC – Public Health Agency of Canada

PHCTF – Primary Health Care Transition Fund

RPAY – Recreation and Parks Association of the Yukon

WGH – Whitehorse General Hospital

YHIS – Yukon Health Insured Services

YTG – Yukon Territorial Government

UNDERSTANDING DIABETES

The Issue

Diabetes mellitus is a chronic condition and is classified by type 1 diabetes, type 2 diabetes and gestational diabetes.

Diabetes is a serious health condition that can lead to complications and premature death. Insulin is needed to create energy from sugar in the body. When insulin does not work well, or when there is not enough insulin, a person can experience significant variations in blood sugar levels. Over time this can lead to complications such as heart disease, kidney failure or blindness.

Physical activity and healthy eating leading to the maintenance of a healthy weight can minimize complications related to diabetes, help reduce the costs for diabetes care and treatment, and prevent or delay the onset of type 2 diabetes.

Type 1 diabetes is more likely to develop in childhood or adolescence. It is an autoimmune disease where the cells in the pancreas no longer produce insulin. There is no cure for type 1 diabetes which affects 5-10% of people living with diabetes. The condition is managed with insulin injections, a healthy diet and regular physical activity.

Type 2 diabetes affects about 90-95% of people living with diabetes. In this form of the disease a person's body may not respond properly to the insulin produced, or may produce very little insulin. Historically, type 2 diabetes has been diagnosed in people after the age of 40. However, it is now being diagnosed in people in their 30's, 20's and teens. Onset of diabetes earlier in life increases potential complications and costs of the disease.

Gestational diabetes mellitus (GDM) is described as high blood sugar developing during pregnancy. Affecting about 4% of pregnancies, blood sugar levels usually return to normal by six weeks postpartum. There is evidence that gestational diabetes increases the risk of developing type 2 diabetes for both the mother and child later in life.

The Current Situation

Diabetes is a global issue.

- Diabetes currently affects over 246 million people worldwide. 366 million people will be affected by 2030.[3]
- Every 10 seconds, two people develop diabetes. Each year, 7 million people develop diabetes. [3]
- Complications of diabetes are the 4th leading cause of death world-wide. 3.8 million deaths are attributed to diabetes every year.[5] One person dies every 10 seconds from diabetes-related causes. [3]

In Canada, complications of diabetes are the 7th leading cause of death.[6]

- About 2.4 million Canadians have diabetes and 200,000 new cases are diagnosed annually.[2] Every 8 minutes a Canadian is diagnosed with diabetes.[9]
- 1 in 3 Canadian children born after 1999 will develop Type 2 diabetes [9]
- 22% of Canadians aged 75-79 had been diagnosed with diabetes in 2006.[8]
- Almost 20% of First Nations adults in Canada had been diagnosed with diabetes in 2005. The prevalence of 3% among First Nations adults aged 18–29 increases to 36% among those aged 55–64.[14]
- The prevalence of diabetes is higher for Aboriginal women than Aboriginal men. The prevalence of gestational diabetes ranges from 8–18% for Aboriginal women in comparison to less than 4% for non-Aboriginal women.[7]

In the Yukon,

- The number of people over the age of 12 who reported being diagnosed with diabetes by a health professional has grown since 2003.

Yukoners (older than 12) diagnosed with diabetes[12]	
2003	925
2005	1,160
2007	1,238

- 495 Yukon people aged 65 and older reported to have been diagnosed with diabetes in 2007. The prevalence of diabetes in this age group is almost 21%.[12]
- 25% of Yukon's population in 2006 were of Aboriginal identity.[13] The prevalence of diabetes amongst Aboriginal Peoples is 3 to 5 times higher than the national average.[7]
- Yukon women are more likely to live with diabetes than Yukon men. The reverse is true across the provinces.[1]

Prevalence of Diabetes by Gender[1]		
2005-06	**Yukon**	**Canada**
Population	5.0%	5.0%
Male	4.6%	5.5%
Female	5.5%	4.5%

The cost of diabetes—both socially and economically—is increasing rapidly.

- The personal costs of diabetes can include a reduced quality of life and the increased likelihood of complications such as heart disease, stroke, kidney disease, blindness, amputation and erectile dysfunction.
- Life expectancy for people with type 1 diabetes may be shortened by 15 years while life expectancy for people with type 2 diabetes may be shortened by 5 to 10 years. [9]
- People with diabetes incur medical costs two to three times higher than those without diabetes. A person with diabetes can face direct costs for medication and supplies ranging from $1,000 to $15,000 a year. [9]
- By 2010, it is estimated that diabetes will cost the Canadian healthcare system $15.6 billion a year with the cost increasing to $19.2 billion by 2020. [4]
- The greatest increase in total health care costs is expected in the three territories. Total health care costs for individuals with diabetes are estimated to double in Yukon from $3 million in 2000 to $6 million in 2016.[4]

A National Approach to Diabetes

In 1999, diabetes was recognized as a national concern. The Canadian Diabetes Strategy (CDS) was established to identify and implement effective diabetes prevention and control strategies for Canada. Its goals were to develop a health promotion-disease prevention strategy for the entire population; to establish care, treatment and diabetes prevention programs for First Nations people on-reserve and in Inuit communities; and to improve national and regional data about diabetes and its complications.[10]

For ten years the CDS has been well-positioned to determine needs and gaps and to allocate diabetes resources accordingly. Many CDS initiatives have generated momentum thus ensuring that diabetes remained on the national public health agenda.

As a result, most jurisdictions in Canada have or are developing formal diabetes strategies. Strategies tend to include objectives and outcomes for prevention, care, education and surveillance; and often incorporate a specific Aboriginal component. Most jurisdictions have resources committed to the implementation of their strategy. For example, Saskatchewan, Manitoba, Ontario, Nova Scotia and PEI have government staff positions dedicated to the coordination and delivery of diabetes policy and programs; other provinces have staff responsible for broader chronic disease management and strategies[12]. The only jurisdictions without formal diabetes strategies are Newfoundland-Labrador, Quebec and Yukon. (Refer to Appendix A for more information.)

In 2009, while the CDS undergoes review, stakeholders in Canada re-emphasize the importance of a national diabetes strategy. When countries such as Finland report saving money and lives by using diabetes best practices on a national level[11], the importance of coordinating the numerous and varied diabetes programs and initiatives across Canada is clearly evident.

How have we responded?

The Yukon does not have a formal diabetes strategy. Since 1999, the response to diabetes has been a combined effort of Yukon Government departments, the Diabetes Education Centre, Aboriginal organizations, health care practitioners, NGOs, and individuals working and/or living with diabetes. An informal Yukon Diabetes Strategy was developed in 2004, renewed in 2006 and again in 2009. This informal Strategy provides guidance to groups undertaking projects; particularly projects funded through sources such as the Canadian Diabetes Strategy.

Although not affiliated with any particular organization, the Diabetes Reference Group is central to diabetes efforts in the Yukon. Membership in this group is fluid and brings together professionals working in areas of diabetes care and prevention. Originally the Diabetes Advisory Committee, this group was formed over 18 years ago to guide the emergence of the Diabetes Education Centre (DEC). It has since evolved into the Diabetes Reference Group (DRG) and has terms of reference (Appendix B) that address current tasks and priorities.

Currently, there are several components (as identified by the DRG) involved in the process of responding to diabetes in the territory. As illustrated, the response involves stakeholders—people living with diabetes, families, communities, health care professionals, NGO's and government departments. Through the DRG stakeholders share their understanding of organizations, initiatives, programs and resources presently involved in the diabetes response. From this understanding, strengths and gaps of the response can be discussed. This common understanding, combined with professional knowledge and expertise, leads to the identification of strategic actions that can contribute to a comprehensive diabetes response. In the absence of a formal strategy, the actions identified may be implemented through the collaborative effort of stakeholders when resources are available.

Certain aspects of the current diabetes response in the Yukon work well, while others require attention due to the lack of a formal strategy. Networking through the DRG has provided opportunity, when funding has become available, to collaborate and attain some of the goals of the 2004 and 2006 strategies. However, political recognition and a financial commitment are needed for a comprehensive and balanced approach to attaining all the actions described in A Strategic Response to Diabetes.

Since 2006, a number of diabetes activities and projects have been implemented. The aspects of the response that have worked well—the strengths—need to be recognized, celebrated and continued. (Appendix C offers more detail on many of the resources, organizations or initiatives listed below.)

Strengths: what has been working well?

- Coordination and regular meetings of the **Diabetes Reference Group** have provided opportunities for networking, partnerships and resource sharing amongst those involved in diabetes prevention and care.
- The **Diabetes Education Centre** has increased its services and its number of clients. It has its own Telehealth site and has, since January 2008, been able to connect with all Yukon communities. Telehealth provides a valuable link to services for rural Yukoners living with diabetes.
- Over 800 people living with diabetes are involved in and tracked through the Yukon's **Chronic Disease Management Program** (CDMP) program. Many Whitehorse clinics and all Community Health Centres participate in the CDMP. Health professionals receive educational support and training through the program.
- Yukon Health Care Insurance Plan, the Chronic Disease Program and Non-Insured Health Benefits provide adequate **health coverage** and reasonable access to internists and specialists for most Yukoners living with diabetes.
- A pilot project that runs to March 2010 has funded two, three-quarter time **Community Dietitian** positions. These positions have enabled diabetes prevention and nutrition education services to be provided in rural Yukon.
- **Healthy Living programs and initiatives**, delivered in 2008-09 by the Recreation and Parks Association of the Yukon (RPAY), resulted from a bilateral agreement between the Yukon Government and Health Canada.
- **Aboriginal organizations** are involved in diabetes prevention and care. Successful initiatives are delivered by First Nation communities, Kwanlin Dun First Nation Health Centre and Skookum Jim Friendship Centre.
- **Arctic Health Research Network-Yukon** (AHRN-YT) brought together community-based First Nation health workers for Spring School 2007 and Fall School 2008. Participants created strategies for their communities related to health issues; one of which was diabetes.

- Steps have been taken to support healthy school environments. Partnerships between the Department of Education, Health Promotion Branch, Sport and Recreation Branch and NGO's (Food for Learning and RPAY) encourage the **integration of daily physical activity and nutrition education into school curriculum** using frameworks such as Action Schools B.C. and B.C. Dairy Foundation resources.
- **Canada Prenatal Nutrition Programs** (CPNP) reach many new and expectant mothers throughout the Yukon and promote health for women and young children.
- **ElderActive Recreation Association** reaches out to Yukoners over the age of 55 and encourages participation in activities that support healthy lifestyles.
- The **Yukon Diabetes Website** (www.yukondiabetes.ca) provides information, links and a current event listing for the public as well as a members-only area.
- The **Do-It-Yourself: Diabetes Prevention Activities Manual** (DIY) responds to the needs of front-line workers in Yukon First Nation communities. Training to use the manual enables front-line workers to build awareness of diabetes in their communities.
- The **Yukon Diabetes Resource Guide** is in its 3rd edition and is now available in French. The Guide supports self-care and self-management; print versions are available throughout the Yukon and electronic versions are available at www.yukondiabetes.ca.
- The **Yukon Diabetic Foot Guide**, a resource for health professionals published in 2006, aims to provide a consistent approach for foot care for people living with diabetes.
- Teaching tools and resources for diabetes prevention education are available at RPAY.

Within the approach to diabetes in the Yukon, gaps have been identified that if addressed will improve the effectiveness of the overall response. These gaps relate primarily to the lack of a formal strategy, inconsistent funding, and lack of overall coordination. Actions need to be taken to minimize and eventually eliminate these gaps.

<u>Gaps: what requires attention?</u>

- A **formal diabetes strategy** with a specific Aboriginal component would provide a comprehensive response to the growing incidence and cost of diabetes. A formal diabetes strategy should link to the current Yukon Active Living Strategy.
- Future funding through CDS and Aboriginal Diabetes Initiative (ADI) is uncertain. A comprehensive response to diabetes requires a **commitment of consistent funding**.
- Responsibility for overall **coordination of a comprehensive response to diabetes** is lacking. Although coordination has occurred through the DRG, this group does not have the mandate or the resources to assume the role.

- **Groups at higher risk** of developing diabetes and of experiencing complications related to diabetes (Elders and seniors, Aboriginal people, and women of child-bearing age) need targeted diabetes prevention and improved diabetes services.
- **Local capacity** for diabetes prevention and care is limited. Individuals, family, community members and front-line health workers need knowledge, skills and resources to enhance Yukoners' understanding of diabetes and to encourage self-care. Diabetes is a community issue; reducing the incidence and cost requires support at the community level.
- **Foot care** for Yukon people living with diabetes does not meet the standard of care outlined in the Clinical Practice Guidelines (CPG). Medical access to foot care services, and insurance coverage for these services, are not accessible to the majority of the population.
- More policy and leadership for the integration of **regular physical activity and nutrition programs** in all schools is needed. Although progress has been made, the Yukon still lags behind other jurisdictions in fostering healthy living within daily school and community environments.
- The **Canadian Diabetes Association** (CDA) is not active in the Yukon. Elsewhere in Canada, CDA branches provide education and programming such as support groups, workshops and cooking classes.
- **Public nutrition education** needs ongoing funding for community dietitian positions, coordination of effort amongst the agencies involved, and innovative services such as "dial-a-dietitian".

Actions supporting a strategic response to diabetes must consider future opportunities in order to act upon them. Networking through the DRG has increased awareness of upcoming opportunities that may positively impact the approach to diabetes in the Yukon.

<u>Opportunities: what are they?</u>

- The Canadian Diabetes Strategy is currently under review and its future unknown. Should a national form of coordination and support emerge from this review, it will foster a comprehensive response across all Canadian jurisdictions.
- Improved services and increased opportunities for professional development may arise as the Yukon's Chronic Disease Management Program shifts from a pilot to a full program.
- RPAY contracted Data Path Systems to conduct a brief survey of healthy living attitudes and behaviours of Yukoners. The initial report provides valuable information for health promotion programming and provides some baseline data from which a broader healthy living study could be conducted.
- About half the Yukon teachers using nutrition resources in schools have expressed an interest in resources to help them teach about traditional and locally-grown foods.

STRATEGIC ACTIONS FOR THE RESPONSE

Renewal of the 2006 Yukon Diabetes Strategy reinforces the need for a formal diabetes strategy and a commitment of funding. Although not a formal strategy, this section of A Strategic Response to Diabetes offers a vision and goals (strategic actions) for three core areas.

A strategic response to diabetes in the Yukon involves the coordination of strategies, services and resources for diabetes prevention and care within three core areas. An effective response will support the well-being of people living with and at risk of diabetes while minimizing the long-term complications and costs.

Care and Treatment encompasses the diagnosis and management of diabetes mellitus to reduce the incidence and severity of secondary complications. Care and treatment activities aim to encourage self-care through a supportive network of professionals such as physicians, educators, health care workers and dietitians.

Health Promotion and Diabetes Prevention activities promote health in an effort to prevent or delay the onset of diabetes. Healthy eating, active living and stress management attitudes and behaviours need to be part of everyday lifestyles and community practices. Benefits of healthy living have a profound effect on personal health and on the social and economic fabric of our communities.

Coordination and Support maximizes resources and enables an effective and comprehensive diabetes response. Coordination and support involves communication and information sharing; research and measurement; implementation of strategic actions; development and maintenance of partnerships; and professional development.

Care and Treatment encompasses the diagnosis and management of diabetes mellitus to reduce the incidence and severity of secondary complications. Care and treatment activities aim to encourage self-care through a supportive network of professionals such as physicians, educators, health care workers and dietitians.

Strategic actions recommended for Care and Treatment:

1. Continue treatment and care provided through CDMP. Continue to provide access to screening for complications through community health centres. Increase access to eye exams for rural Yukoners without the burden of travel to Whitehorse.

2. Continue to improve and expand outreach programs, particularly those for rural residents. Outreach, an essential component of care and treatment, can include education, screening, monitoring and case specific support.

3. Maintain the Diabetes Education Centre as the centre of excellence for the management of diabetes in the Yukon. Continue to find ways to improve services and to maximize resources.

4. Maintain and expand access to services through Telehealth. Expand Telehealth programming to meet diverse needs (e.g. Q&A sessions, group sessions, health promotion workshops). Improve secure and confidential Telehealth access within rural communities.

5. Explore strategies that will increase risk factor awareness and access to testing for groups at higher risk of developing diabetes regardless of age.

6. Improve foot care services for all Yukoners living with diabetes in order to attain the Clinical Practice Guidelines for foot care. Continue foot care services at the DEC. Provide foot care coverage through Yukon Health Care and NIHB. Update the Diabetic Foot Guide and provide training to use it. Train family members and front-line workers to do foot care.

7. Improve access to specialist services. Include a Podiatrist in the specialist rotation.

8. Increase access to and promote chronic care self-management programs. Support initiatives, such as CCSMP, that are client-driven and enable the development of attitudes and skills to self-manage diabetes.

9. Continue coverage for medication and supplies through the chronic disease program. Provide similar coverage for women diagnosed with GDM.

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Strategic actions recommended for Health Promotion and Diabetes Prevention:

1. Develop territorial and local initiatives that will increase access to healthy, affordable foods and to opportunities for affordable physical activity.

2. Build local capacity to support healthy lifestyles. Expand training opportunities for front-line workers. Provide support and resources so front-line workers can help communities better understand diabetes and its relationship to physical activity and healthy eating leading to healthy weight.

3. Expand public education regarding diabetes. Promote awareness through the coordination of events for Diabetes Month, World Diabetes Day, "Walk for a Cure", etc.

4. Develop targeted messages for groups at higher risk of developing diabetes or more likely to be living with diabetes (Elders/seniors, Aboriginal people, women of child-bearing age).

5. Develop and implement programming for IFG and IGT persons who are at increased risk of diabetes. Target this group to prevent, or at least delay, their advancement to diabetes.

6. Support initiatives that promote traditional lifestyles within First Nation communities.

7. Support community-based, healthy eating initiatives (e.g. local greenhouses, community kitchens). Foster positive attitudes towards healthy eating through the development of related knowledge and skills.

8. Maintain and increase access to nutrition education for the public. Ensure Community Dietitian positions are funded when pilot funding runs out in March 2010. Implement "dial-a-dietitian" service for Yukon.

9. Expand implementation of the Yukon's Active Living Strategy. Ensure that active living messages and opportunities reach homes, schools, workplaces and communities. Support initiatives that encourage active lifestyles in Yukon's natural environment (e.g. walking, active transportation, snowshoeing).

Further actions recommended for Health Promotion and Diabetes Prevention:

10. Support delivery of ongoing territory-wide walking programs (such as On-the-right path or Walktober) to encourage regular daily physical activity. Promote participation using local program leaders.

11. Improve access to recreation centres and recreation programs for groups at higher risk of diabetes (Elders/seniors, those living with low-income). Access implies not only a reduction in fees but the provision of transportation, child care, equipment and fitness consultations.

12. Incorporate opportunities for active transportation into all community planning and development (e.g. paved trails, bike lanes and neighbourhood parks).

13. Continue integrating daily physical activity and nutrition education into school environments through partnerships. Engage school councils as well as administration, parents and communities. Support development of specific school nutrition policy. Continue to promote regular daily physical activity in all schools.

14. Promote and support classroom use of healthy living resources from kindergarten through to grade 12. Continue with training to encourage use of resources (B.C. Dairy Foundation, Action Schools B.C. and other diabetes teaching aids). Increase access to and use of Yukon resources through resource development and teacher training.

Coordination and Support maximizes resources and enables an effective and comprehensive response. Coordination and support involves communication and information sharing; research and measurement; implementation of strategic actions; development and maintenance of partnerships; and professional development.

Strategic actions recommended for Coordination and Support:

1. Lobby for a formalized Yukon Diabetes Strategy and include a component specific to Yukon Aboriginal peoples.
2. Establish a fully-funded position to provide coordination for the overall diabetes response. Enhance communication, improve resource sharing and partnerships, assist with the implementation of new ideas and ensure consistency through this position.
3. Identify ongoing funding and resources to support successful and sustainable programs and initiatives. Sustained funding is essential to ensure prevention programs gather momentum at the community level. Long-term funding will enhance the capacity to deliver consistent messaging and to foster participation in healthy lifestyle initiatives.
4. Allocate responsibility and funding for ongoing coordination and functioning of the Diabetes Reference Group. Ensure that resources are in place to review, monitor and update the document, A Strategic Response to Diabetes, as needed.
5. Continue educating community clinicians regarding diabetic standards of care. Continue professional development for implementation of the Clinical Practice Guidelines. Encourage professional development opportunities for health care and front-line workers
6. Improve Yukon-based diabetes research and dissemination within the territory.
7. Allocate funding to sustain and maintain the Yukon Diabetes website. Expand tabs to include other organizations. Add an education component (e.g. FAQs and myth busters). Improve promotion of the website throughout the territory. Strive to provide a French language version of the website.
8. Build and maintain partnerships to support an effective response to diabetes. Partnerships will enable information sharing, acquisition of funding and collaboration on initiatives.
9. Continue working closely with the Francophone Health Network to ensure resources are available in both official languages.
10. Maintain communication with AHRN-YT. Recognize diabetes-specific work of the Spring and Fall Schools as evidence of First Nation community-based strategies to approach diabetes.
11. Continue working with Aboriginal organizations to ensure that initiatives, programs and services for the care and prevention of diabetes meet the needs, interests and values of Yukon First Nation communities.
12. Lobby for improved “food security”. Access to healthy foods at a reasonable cost is needed to support healthy eating practices.

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APPENDICES

A. Summary of Provincial and Territorial Diabetes Strategies

B. DRG Terms of Reference

C. Diabetes Resource Listing

Appendix A: Summary of Provincial and Territorial Diabetes Strategies

P / T	Diabetes Strategy Details
Canada	The Government of Canada pledged $115 million over five years (1999 -2004) for the Canadian Diabetes Strategy (CDS). This was extended to 2009 with $18 million annual funding. The CDS is currently under strategic policy review.
Yukon	Yukon has no formal diabetes strategy. A strategy has been developed by members of the Yukon Diabetes Reference Group but has not been adopted by the territorial government.
Northwest Territories	An NWT department representative has indicated that NWT are "developing a strategy as well designed and laid out as Manitoba". In Spring 2007, a contractor was hired to write NWT's diabetes strategy. As of February 2009, it was anticipated that NWT's Strategy will be tabled to the Minister in the near future.
Nunavut	Nunavut's *Diabetes and Prevention Strategy* was released in 2005. It aims to develop a territory-wide program of diabetes education and care in three regions of Nunavut in order to reduce the burden of diabetes (as people typically must travel outside Nunavut for care). Goals for 2005 – 2010: • enhance prevention & lifestyle support • expand into care and treatment • facilitate professional development • engage linkages & collaboration • achieve ADI goals & objectives

Nunavut	Integrated service activities: • community based care & treatment • promotion & prevention (lifestyle support) • coordinated approach (chronic disease initiatives, resource development, human resources, communication) *Nutrition Framework for Nunavut* states that all Nunavummiut newly diagnosed with diabetes will be seen by a dietitian within 3 months of diagnosis (to be implemented April 2010).
British Columbia	*Responding to Diabetes* targets diabetes prevention and management within a multi-sector approach. Its objectives and outcomes relate to diabetes prevention, care, education, research and surveillance. Since October 2002 funding has been ongoing with no time limitation. B.C.'s Diabetes Care Guidelines were updated in 2008. People with diabetes who have received care are tracked according to the CPG guidelines.
Alberta	Alberta Health and Wellness launched its strategy in May 2003 with a ten-year time frame and funding commitment. Alberta's strategy addresses the prevention, care and management of diabetes in a coordinated and comprehensive manner and contains specific goals to reach aboriginal populations.
Saskatchewan	Saskatchewan's strategy (2003 – 2013) includes objectives and outcomes related to diabetes prevention, care, education and surveillance. It has a formal implementation plan with $650 000 annual funding and two dedicated positions of Provincial Diabetes Coordinator and Aboriginal Diabetes Consultant to assist with its implementation.
Manitoba	*Diabetes: A Manitoba Strategy* was implemented in 1998 with ongoing funding and no time limitation. The Strategy addressed prevention, education, care and surveillance. Manitoba is also involved with: • The Western Health Information Collaborative which (along with AB, BC, YT, NT and NU) has developed and used information systems that support management of diabetes. • A Regional Diabetes Program which provides a comprehensive plan to reduce the diabetes burden. • The Diabetes Care Project which is an ongoing study that links province-wide administrative data sets to evaluate the MB Diabetes Care Recommendations.

Ontario	From 1992 to 2008, Ontario followed an internal government document stating objectives and outcomes related to diabetes prevention, care, education, research and surveillance. Ontario's Aboriginal Diabetes Strategy was released in March 2006. It engages provincial and Aboriginal communities in developing an integrated and coordinated approach for diabetes prevention and management and includes prevention, care and treatment, education, research and coordination components. In July 2008 a $741 million funded public strategy for 2008-2012 was announced. This Strategy, which aims to to prevent, manage and treat diabetes, supports Ontario's two top health-care priorities of improving access to care and reducing emergency wait times. The Strategy includes: • An on-line registry to enable better self-care. • Increased access to insulin pumps and supplies for adults with type 1 diabetes. • Expanded chronic kidney disease services (access to dialysis services). • A strategy to expand access to bariatric surgery. • Education campaigns to prevent diabetes by raising awareness of diabetes risk factors in high-risk populations. • Increased access to team-based care closer to home by aligning services and addressing service gaps.
Quebec	There is no provincial strategy in place for diabetes or chronic disease.
Nova Scotia	*Diabetes Care Program of Nova Scotia* has been secured with ongoing funding and no time limitation since 1991. It includes objectives and outcomes for diabetes prevention, care, education and surveillance.
Prince Edward Island	PEI's strategy has been in progress since 2005. The strategy will have stated objectives and outcomes for diabetes prevention, care, education, governance and accountability for diabetes services.
New Brunswick	Diabetes is included in the province's overall chronic disease management strategy.
Newfoundland and Labrador	NL has no formal diabetes strategy.

Appendix B:

Yukon Diabetes Reference Group

TERMS OF REFERENCE

Purpose:

The purpose of the Yukon Diabetes Reference Group is to act as a Community Resource to promote an effective response to Diabetes in the Yukon by sharing information, networking, and developing partnerships. From time to time, the DRG acts in an advisory role for various diabetes-related projects when requested and determined appropriate by the Group.

Functions of the YDRG:

- To facilitate information sharing related to diabetes prevention/treatment programs and initiatives in the Yukon
- To network with others where possible and appropriate in order to share information or resources
- To provide history & background of diabetes initiatives in the Yukon
- To promote partnerships and collaborative approaches and to share resources when/where possible and appropriate
- To act in an Advisory capacity on funded projects when the YDRG is asked to do so and the YDRG deems appropriate
- Members of the YDRG may be involved in writing and updating the Yukon Diabetes Strategy

Concepts that Guide the Group:

- The YDRG is fluid and dynamic in nature, and its members are passionate and committed to the overall prevention, care and treatment of diabetes in the Yukon Territory
- The YDRG is not ultimately responsible for implementing the Yukon Diabetes Strategy, however it strives to support initiatives that advance the Strategy's goals and objectives

Membership:

YDRG members are people working directly or indirectly in the area of diabetes prevention and/or care in the Yukon, and come from a broad range of perspectives including non-government and government, rural and urban, Aboriginal persons, older adults, health professionals and others working in areas such as Active Living, Healthy Eating, Health Promotion, etc. Membership on the YDRG shall be by invitation from existing members. Members of the YDRG shall respect the confidentiality of information and documents provided in confidence at meetings. Members are encouraged to make every effort to send an alternate if they are unable to attend a meeting.

Membership Conflict of Interest:

Members of the YDRG shall avoid real or perceived conflicts of interest in the conduct of the Group's activities. A member who identifies or suspects a real or perceived conflict of interest shall immediately disclose the conflict to the YDRG and shall then remove him/herself from any further discussion or decision making process relating to the matter.

Structure:

The YDRG has no formal structure. Members select a Chair from within its membership, based on considerations such as the nature of current projects or initiatives. The projects/initiatives that the YDRG chooses to support are selected by consensus of the group members. The YDRG may establish sub-committees as it sees fit.

Coordination of YDRG:

Coordination of the group is done primarily via email communication regarding regular and special meetings, distribution of agendas and minutes of meetings.

Meetings:

YDRG meetings shall be held quarterly at a minimum, and also as required from time to time by members of the group.

Authority:

The Yukon Diabetes Reference Group has no formal authority and exists only in an information sharing and advisory capacity.

Responsibility and Accountability

Currently the YDRG has no responsibility and/or accountability to any entity other than to its own membership. The YDRG may have an implicit obligation to support the accountability of funding projects with which it is involved.

Decision Making:

In its deliberations, the YDRG will strive for consensus. However, when consensus cannot be reached, a decision will be deemed to have been made if supported by a simple majority of the members present.

Deliverables:

Deliverables of the YDRG include internal documents such as Agendas and Minutes of Meetings and information sharing documents. If the YDRG is supporting a funded project, it may provide documentation as such.

Terms of Reference Review:

The YDRG Terms of Reference shall be reviewed every two years at a minimum. More frequent reviews may be appropriate should the scope of the YDRG change.

Accepted by the YDRG on: March 26, 2008

Next Review Date: March 2010

Appendix C:

The 2009 Yukon Diabetes Resource Listing

Components involved in a Yukon approach to diabetes

Diabetes in the Yukon involves an approach supported by a variety of components, resources, organizations and other structures. An understanding of these components enables networking and coordination thereby strengthening the overall response territorially. The components included in the 2009 Yukon Diabetes Resource Listing have been identified by the Diabetes Reference Group. This Listing is designed to be added to and changed as resources or organizations shift. Please provide updates directly to the DRG.

Specific information on the following components is included in the 2009 version of the Resource Listing:

- Aboriginal Diabetes Initiative
- Arctic Health Research Network – YT
- Canadian Agency for Drugs and Technologies in Health
- Canadian Best Practices Portal for Health Promotion and Chronic Disease Prevention
- Canadian Diabetes Association
- Chronic Disease Management Program
- Diabetes Education Center & Telehealth Videoconferencing
- Do-it-Yourself: Diabetes Prevention Activities Manual
- Health Promotion Branch
- Home Care and Home Support Services
- Juvenile Diabetes Research Foundation
- National Diabetes Surveillance Strategy
- Primary Health Care Access
- Recreation & Parks Association of the Yukon
- World Diabetes Day
- Yukon Diabetes Reference Group
- Yukon Diabetes Resource Guide
- Yukon Diabetes Website
- Yukon Diabetic Foot Guide

General information on the components listed below can be found in the Yukon Diabetes Resource Guide. This Guide, now in its 3rd edition (2008) and published in French, is available in print from the Yukon Diabetes Education Centre or on-line at www.yukondiabetes.ca.

- Canadian Diabetes Association
- Chronic Conditions Self-Management Program
- ElderActive Recreation Association
- First Nations Health Programs
- Kwanlin Dun Health Centre
- National Aboriginal Diabetes Association
- Skookum Jim Friendship Centre's programs
- Weight Management programs
- Yukon Diabetes Education Center & Telehealth Videoconferencing
- Yukon Government's Tobacco Reduction Strategy

Aboriginal Diabetes Initiative	
In Yukon, 8 First Nations have transferred ADI responsibilities and resources under self-government Programs and Services Transfer Agreements (PSTAs). The other 6 Yukon First Nations continue to receive ADI funding via contribution agreements and are undertaking activities such as walking clubs, nutrition workshops, diabetes screening events, diabetes education workshops, and partnering to deliver Meals on Wheels. Skookum Jim Friendship Centre (SJFC) currently receives ADI funding through MOAUIPP (the Métis, Off-reserve Aboriginal and Inuit Prevention and Promotion Program) which is managed at the national level. SJFC's project focuses on traditional foods and gaining skills for harvesting and preserving foods including a berry harvest and a fish camp. Other activities include community kitchens, active living and train-the-trainer workshops.	Call your local First Nation's Health Department for more information. SJFC Reception Phone: 633-7680

Arctic Health Research Network – YT	
AHRN is the first Canadian tri-territorial health research network linking northern regions. The network includes health research centers based in the Yukon, Northwest Territories and Nunavut. To work towards its mandate to improve health outcomes through research, this network is and must be a community-driven, northern-lead, health and wellness research network that facilitates the identification and action on health research priorities in the three territories. In the Yukon, AHRN-YT is focussing on working with community priorities, particularly within Yukon First Nations communities. One of these priorities is diabetes, which guides the organization's search for opportunities to contribute to diabetes work in the Yukon.	Jody Butler Walker Phone: 668-3393 jody@butlerwalker.ca Norma Kassi Phone: 668-4442 nkassi@whtvcable.com AHRN-YT fax: 668-5543

Canadian Agency for Drugs and Technologies in Health (CADTH)	
CADTH Liaison Officer for the territories is located in Whitehorse. The Liaison Officer facilitates access to CADTH resources. CADTH delivers credible, impartial and evidence-based information about the effectiveness of drugs and other health technologies. CADTH core programs: • Health Technology Assessment (HTA) • Common Drug Review (CDR) • Canadian Optimal Medication Prescribing & Utilization Service (COMPUS)	**Dawn Priestley,** **CADTH Liaison Officer** 101A Wilson Drive, Whitehorse, YT Y1A 0C9 Phone: 334-1602 Fax: 633-5750 dawnp@cadth.ca www.cadth.ca

To help users access our wealth of resources related to the treatment of diabetes, CADTH has created a virtual library at www.cadth.ca/diabetes. You can also visit www.cadth.ca and search for any topic by using the search option at the top of the homepage. CADTH diabetes management resources include: 1. Health Technology Assessments and other reports designed for health policy and purchasing, service management, and clinical practice decision makers. 2. Reviews of the clinical and cost-effectiveness of drugs, formulary listing recommendations to the publicly funded drug plans (except Québec). 3. Recommendations, reports, and tools to support the optimal prescribing and use of: • insulin analogue therapy, • blood glucose test strips (rollout of clinical and cost-effectiveness reports underway), and • antidiabetes pharmaco-therapy after failure of metformin monotherapy in patients with type 2 diabetes (launch of project protocol 2010)	Stay informed about new reports, products, and services by subscribing to a variety of CADTH e-newsletters.

Canadian Best Practices Portal for Health Promotion and Chronic Disease Prevention	
The Public Health Agency of Canada's Best Practices Portal is available for health professionals interested in a variety of health-related projects and services delivered throughout Canada.	http://cbpp-pcpe.phac-aspc.gc.ca

Canadian Diabetes Association Best and Promising Practices in Diabetes Education	
CDA has recently identified best and promising practices in diabetes education, developed an assessment tool to identify these practices, and published findings for diabetes educators, health professionals and funders of diabetes education programs. There are 18 best practices and 27 promising practices available within the document.	Boyanne Young is the CDA contact for Northern BC and Yukon. Phone: 250-561-9284

www.diabetes.ca/files/Best-or-Promising-Practices-Catalogue.pdf

Canadian Diabetes Association Yukon Diabetes Educator Section	
YDES is the Canadian Diabetes Association's professional section in the Yukon. Operating in the Yukon with limited resources, this group maintains membership and supports access to continuing education for its members.	CDA Yukon Chapter Phone: 393-2329

Chronic Disease Management Program (formerly Yukon Diabetes Collaborative)	
The Chronic Disease Management Program (CDMP) aims to improve care for people with a chronic condition using the Expanded Chronic Care Model. This model takes a systems approach to quality improvement of chronic disease prevention and management. Currently, the CDM Program is funded to March 31, 2010 by YG through the Territorial Health Access Fund. Most physicians' clinics in Whitehorse and all Community Health Centers are participants in the program, along with other nurses, pharmacists and dietitians. There are currently two Chronic Disease Management Clinicians, a nurse and a physiotherapist providing guideline-based chronic care and self-management support to patients in their physician's clinic. Over 800 people with diabetes are involved in the program so far. Their care is tracked on the CDM Toolkit – an electronic database framed around clinical practice guidelines and a care flow sheet. The program provides educational support to participating health professionals in relation to clinical care, practice change and patient self-management support. The program began in 2005 as the Diabetes Collaborative and has now expanded into the CDM Program with the addition of flow sheets for other chronic conditions including COPD, hypertension and CHF. These will be introduced in 2009.	Lucie Wright Chronic Disease Management Coordinator, YTG Health and Social Services Phone: 393-7487 Cindy Breitkreutz Family Physician Adviser, CDM Program Terice Reimer-Clarke CDM Clinician, CDM Program Phone: 335-2974 Geoff Zaparinuk CDM Clinician, CDM Program Phone: 335-2254

Diabetes Education Center & Telehealth Videoconferencing	
The DEC provides education and support services to adults diagnosed with diabetes. The Centre is staffed with Certified Diabetes Educators (a Registered Nurse and a Registered Dietitian). Services are available to those with a referral from their physician, Community Health Nurse or Yukon Home Care. The Centre provides one-on-one and group diabetes counselling and education as well as educational workshops on various diabetes related topics for adults with diabetes and their families. The Centre also collaborates with First Nation Health Programs to provide workshops designed to accommodate groups who choose to travel from the communities. TeleHealth Videoconferencing is used for one-on-one and/or group sessions for clients in the communities. It is free of charge and is available through all Yukon community Health Centres. The DEC has about 700 active clients as of January 2009. The Diabetes Education Centre also collaborates with the National Canadian Diabetes Association and participates in various activities including Diabetes Month.	Phone: 393-8711

Do-it-Yourself: Diabetes Prevention Activities Manual	
This project was started in response to training needs of front-line workers in Yukon First Nations communities. The result is a manual that transforms key messages (what diabetes is and how to prevent it) into a learning tool appropriate for community users. Basic training that is accessible, flexible and enduring is offered. The manual can be used by a variety of facilitators (front-line health workers, community people or health professionals). Training sessions are interactive, culturally-relevant, feasible and fun. There are 20 different diabetes prevention learning activities to use alone, in combination, and in settings such as health fairs, community gatherings or staff meetings. Participants learn by interacting with materials and creating visual displays; build facilitation skills by presenting messages to peers; and increase confidence by practicing in a safe environment with the easy-to-use tool at their fingertips. Each evidence-based topic is divided into 3 sections: 1. SHOW IT contains clearly worded instructions on creating a visual display using easily found or bought items. 2. TELL IT provides a readable script to guide sharing key messages and doing the activity. 3. KEY MESSAGE provides the important piece of knowledge and rationale for the topic.	For copies contact: Laura Salmon, First Nations Health Programs Phone: 393-8891 Laura.Salmon@wgh.yk.ca For an electronic version: www.yukondiabetes.ca

Health Promotion Branch, Yukon Health and Social Services	
Health Promotion provides or supports evidence-based, targeted health promotion and illness prevention programs and activities. Activities include public awareness campaigns, skill development workshops and activities, providing or supporting professional development and collaboration among health providers, social service professionals, educators, and others; building healthy public policy; creating supportive environments.	For Health Promotion information email: health.promotion@gov.yk.ca

Home Care Program	
The Yukon Home Care program provides services to keep people independent in their homes. Support for clients with diabetes can be provided through a multi-disciplinary team of RN, OT, PT and Home Support Workers. Nurses from the Home Care program offer general foot care clinics on a monthly basis for Seniors in Whitehorse, Watson Lake, Haines Junction, and Dawson City. These clinics offer basic foot care for non-complex conditions. Home Support Workers (YTG) do basic foot care only on non-diabetic clients and all Home Care clients feet are assessed by a Nurse before the Home Support Workers take this duty on. In the First Nations communities, Home & Community Care Workers provide some support for those living with diabetes. This support does not include foot care for diabetics.	YTG Phone: 667-5774 CYFN contact is Lori Duncan, Director of Health and Social Development

Juvenile Diabetes Research Foundation	
JDRF is Canada's leading charitable funder and advocate for research to cure Type 1 diabetes and its complications. The Yukon annual "Walk for a Cure" is run by local volunteers. JDRF's B.C. Chapter supports activities in the Yukon. Information packages can be requested by phoning the B.C. Regional Office.	www.jdrf.ca B.C. JDRF Regional Office Phone: 1-877-320-1933

National Diabetes Surveillance Strategy

NDSS data collection is ongoing at Yukon Health Insured Services (YHIS). Yukon statistics* provided from NDSS are based on physician coding for office visits.

2005-06: 1500 Diabetics
2006-07: 1700 Diabetics
2007-08: 2000 Diabetics

*These are approximate numbers only and may not represent a true increase. The increase may be attributed to an increase in diagnoses and/or improved screening methods.

Primary Health Care Access

Yukon Health Care Insurance Plan - Chronic Disease Plan - Non-Insured Health Benefits

General Practitioners and Community Nurse Practitioners provide the majority of primary care to Yukon patients.

- Diabetes workshops and annual education sessions are offered.
- The Clinical Practice Guidelines for diabetes are increasingly being applied in the Yukon as diabetes knowledge amongst physicians and nurses increases.

Diabetes medications and supplies are partially covered (when private insurance is not available) thru the Yukon Government's **Chronic Disease Program**.

Most diabetes medications and supplies are covered for eligible First Nations people (when they are not insured elsewhere) through the Health Canada's **Non-Insured Benefits Program** (NIHB).

Chronic Disease Program
Phone: 667-5092 or 1-800-661-0408, local 5092

First Nation NIHB
Phone: 393-6761 or 393-6777

Recreation & Parks Association of the Yukon

RPAY became involved in diabetes prevention and health promotion through the **Canadian Diabetes Strategy** funded Diabetes Prevention & Promotion Project beginning in April 2000**.** Assistance for the Project was also provided by YTG Sport and Recreation Branch. Over the years of the project, RPAY produced and assembled a wide variety of diabetes prevention, health promotion and healthy living resources.

More recently, RPAY's health promotion and prevention activities have expanded with support from Health Canada, YTG Sport and Recreation Branch and YTG Health Promotion Branch through the Healthy Living Bilateral Agreement.

Information on RPAY's projects, resources and services can be found at www.rpay.org.

Executive Director
Phone: 668-3010
rpay@klondiker.com

Active Living Coordinator
Phone: 668-2328
active@klondiker.com

Healthy Living Coordinator
Phone: 668-3012
healthy@klondiker.com

Healthy Eating Coordinator
Phone: 668-2389
healthyeating@klondiker.com

World Diabetes Day	
World Diabetes Day is a birthday celebration on a global scale. It was created to raise awareness of the diabetes epidemic which now affects 246 million people and their families around the world. November 14th is also the birthday of Canadian Sir Frederick G. Banting, the co-discoverer of insulin.	www.worlddiabetes.ca

Yukon Diabetes Reference Group	
The DRG is a territorial coalition of multidisciplinary individuals and groups who are directly or indirectly involved with diabetes prevention and management. Members of the DRG include specialists in diabetes education, health promotion and community development. DRG members have provided guidance to the development of the Diabetes Education Centre and to the Yukon Diabetes Prevention and Promotion Project as part of the Canadian Diabetes Strategy since 1999. Members have also contributed valuable insight into a comprehensive approach to diabetes in the Yukon since 2004.	Angeline Rollins Diabetes Education Centre Phone: 393-8711 View YDRG meeting minutes at: www.yukondiabetes.ca

Yukon Diabetes Resource Guide	
This Guide provides a detailed description of the resources available for those living with diabetes in the Yukon. It also offers healthy living tips on topics such as healthy eating, active living, smoking cessation, stress management and foot care. The Guide is now in its 3rd edition and is available in both official languages.	Print copies are available from: Angeline Rollins Diabetes Education Centre Phone: 393-8711 For an electronic version in either English or French: www.yukondiabetes.ca

Yukon Diabetes Website	
The website was created by the Yukon Diabetes Reference Group to coordinate and provide local information about diabetes as well as to tell Yukoners about available diabetes services and resources. Check the website often as news and information about upcoming events is regularly posted and updated.	www.yukondiabetes.ca

Yukon Diabetic Foot Guide	
The Yukon Diabetic Foot Guide is a resource complied by the Chronic Disease Program. The purpose of the guide is to achieve a consistent approach to assessing, referring, monitoring and promoting evidence-based self-management strategies for diabetics in regards to protecting their feet. This approach is intended to be used in the Yukon across the care continuum by a variety of clinical disciplines. The guide aims to assist by maintaining optimum diabetic foot health, identifying potential limb-threatening states, and intervening before amputation is necessary.	For more information, contact the DEC. Phone: 393-8711