Interprofessional Workshop Series
Implementing Best Practices

Vancouver Coastal Health Childhood Diabetes Workshop

January 29, 2010
Vancouver BC

Final Report

CONTENTS

EXECUTIVE SUMMARY

Child Health BC in partnership with the Paediatric/Child & Youth (PCY) Council hosted the Vancouver Coastal Health (VCH) Childhood Diabetes Workshop on Friday, January 29, at the Morris J. Wosk Centre for Dialogue, Simon Fraser University. The goals of the one day workshop were to identify local and regional priorities and recommendations to optimize access to the best healthcare and community services for children with Type 1 diabetes and identify opportunities to enhance the capacity of communities to prevent the development of Type 2 diabetes among children across the region.

The workshop activities commenced with presentations on the following topics:

1. *The Health System & Constructing a "Vision" for Childhood Diabetes Prevention and Care in VCH*: This presentation was delivered by Ms. Jennifer Scarr, Co-chair, PCY Council, and provided an overview of the work of the Council and its vision for planning for the health of children and youth within VCH.
2. *Diabetes across the Continuum of Care:* Dr. Shazhan Amed, Endocrinologist, BC Children's Hospital, presented this topic which covered standards of care for Types 1 & 2 diabetes and ways in which VCH is meeting these standards. The presentation also provided information on the role of physicians and families caring for children with diabetes through the "Shared Care Model", and future directions in providing services for patients across the continuum of care.
3. *Pediatric Type 1 Diabetes Management in VCH:* Also presented by Dr. Amed on behalf of Dr. Sue Stock, focused on the successes and challenges of the North Shore diabetes clinic and the work of Dr. Stock and her team in caring for children with Type 1 diabetes in that region.
4. *Healthy Living Resources for Children in VCH:* Presented by Dr. Wharf Higgins, Research Chair, University of Victoria, provided an overview of healthy eating and physical activity resources, programs and policies available for children in the VCH geographic area.

After the presentations, participants worked with members from their health service delivery areas in a facilitated group discussion to determine services currently available, gaps in services and opportunities to improve the treatment and early identification services for children and families with Type 1 Diabetes and prevention of Type 2 Diabetes. Delegates reconvened to share their findings and collaboratively identify and prioritize regional recommendations. Participants which included Public Health Nurses, Social Workers, Educators, Community Developers, Dietitians, Community Nutritionists, Primary Care Physicians, and Pediatricians identified gaps and made a number of recommendations to improve healthcare services and support community prevention activities for children and families. Some of the recommendations put forward include incorporating a culturally sensitive approach in healthcare strategies, improving access to community-based mental health services (family and individual counseling) for children and families, enhancing current community resources that support healthy eating and physical activity, establishing and/or expanding healthy living programs and policies in schools, implementing stronger linkages and better communication between all stakeholders.

To maintain momentum and transition into next steps, local groups were encouraged to continue discussions on local priorities and move forward with the identified recommendations. The information documented during the workshop will be synthesized and circulated to each participant for review and validation. It was also suggested that a communication tool such as share point be established to facilitate continuation of dialogue and sharing of information among participants.

At the closing of the workshop Child Health BC committed to providing support for provincial communication and skill building through the continued development of diabetes resources for families and professionals available on the BCCH Endocrinology and Diabetes Unit website:
www.bcchildrens.ca/Services/SpecializedPediatrics/EndocrinologyDiabetesUnit/default.htm

INTRODUCTION

Child Health BC

Building Capacity for Infant, Child and Youth Health Services

Child Health BC, an initiative of the BC Children's Hospital, is a network of health authorities and health care providers dedicated to excellence in the care of infants, children and youth in British Columbia. BC Children's Hospital is an agency of the Provincial Health Services Authority. Our mandate is to bring together partners from the Health Authorities, the Ministry of Health Services, the Ministry of Children and Family Development, t h e Ministry o f Education the Ministry of Healthy Living and Sport and other provincial agencies and services to optimize the health of children and youth and to improve access to high quality clinical health services. Child Health BC is working to ensure children receive the right service at the right time, in the right place, by the right provider. Through many cooperative partnerships; regional subspecialty programs; education and dissemination; research; monitoring quality and performance; and developing standards, protocols and guidelines, Child Health BC is creating an integrated, standardized and accessible system of care available to all children in British Columbia.

Paediatric/Child & Youth Council

Vancouver Coastal Health (VCH) is a regional health authority of BC. Historically, the needs of children and youth have been addressed through the facilities, health centers and partner agencies as well as provincial bodies such as Child Health BC and the Provincial Health Services Authority. In addition, the services provided for children and youth were further compartmentalized in to "silos" of acute care, primary care, public health and population health. The Paediatric / Child & Youth Council was established to integrate this segregated approach into a coordinated single entity. The Council members worked together to develop a common vision statement, establish values and determine the functions for the Council. It is through these lenses that the Council will develop, recommend and evaluate strategies for population health, acute care, public health and primary care. The agreed vision is: "Children and youth will have equitable access to quality health resources they need to flourish and achieve their best health".

Through a collaborative process, the Council identified several priority areas. The areas of Mental Health, Special Needs and Chronic Conditions were determined as the initial focus areas of the Paediatric/Children & Youth Council. Within the priority areas of chronic conditions, childhood diabetes, including childhood obesity, was identified by the Council as an area where there is both a significant need and an opportunity for improvement in service delivery.

The PCY Council utilized the funds provided by Child Health BC to facilitate the development of the VCH Childhood Diabetes Workshop. The information gathered during this event collaboration and knowledge sharing across BC, with the provincial program unifying pediatric diabetes care into a comprehensive provincial health care model.

WORKSHOP PURPOSE AND OBJECTIVES

Goals

To identify regional recommendations to address childhood diabetes across the continuum of care throughout VCH; standardizing care and management of Type 1 Diabetes and determining opportunities to prevent Type 2 Diabetes.

Objectives

- To optimize access to high quality health care and community services for children with Type 1 diabetes and their families in their communities
- To identify how to utilize existing community-based services to support prevention and management of diabetes in children living in Vancouver Coastal Health Authority geographic region.
- To identify opportunities and partnerships that will enhance the community's capacity to prevent Type 2 diabetes in children, specifically in at-risk children.

PRESENTATION HIGHLIGHTS

Presentations on Child Health BC Website:
http://www.childhealthbc.ca/resources/category/40-workshop-presentations-diabetes-provinical-regional-workshops

The Health System & Constructing a "Vision" for Childhood Diabetes Prevention and Care in VCH: Jennifer Scarr, Co-lead, Peadiatric/Child & Youth Council

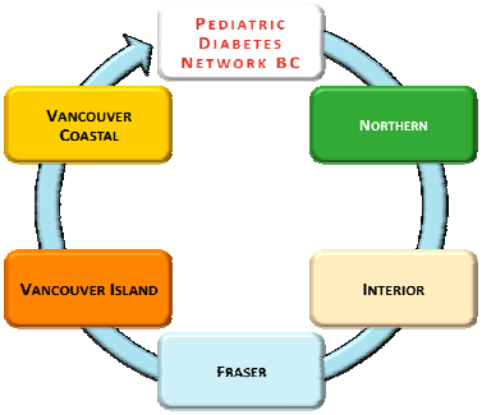
Ms. Scarr welcomed participants and thanked Child Health BC for partnering with the Peadiatric/Child & Youth Council to host the workshop. She gave a brief overview on the development, vision and work of the Council within the Vancouver Coastal Health geographic area and placed emphasis on the fact that the Council applies a child/youth lens to all of its regional strategies.

The planning of services for children and youth with chronic conditions across the continuum of care is a key initiative of the Council and childhood diabetes was selected as the issue for the priority area of Chronic Conditions. Ms. Scarr presented the Continuum of Services for Diabetes framework (see diagram below) and briefly defined and demonstrated the importance of each level/service along the continuum. The framework was used as a guide for the group's dialogue on gaps in the levels of service and to identify local and regional priorities.

<table>
<tr><th colspan="6">Continuum of Services for Diabetes</th></tr>
<tr><td rowspan="3">Primordial Prevention</td><td colspan="2">Primary Prevention</td><td colspan="3">Secondary Prevention</td><td>Tertiary Prevention</td></tr>
<tr><td>Universal</td><td>Targeted</td><td colspan="4">primary, secondary & tertiary services</td></tr>
<tr><td></td><td></td><td>Early Identification</td><td>Treatment & Management</td><td>Intensive Treatment</td><td>Intensive Treatment, Long-term Rehabilitation & Support</td></tr>
</table>

Pediatric Diabetes across the Continuum of Care: Shazhan Amed, MD FRCPC MPH, Staff Endocrinologist BC Children's Hospital, Clinical Assistant Professor University of British Columbia

Dr. Amed provided an overview on the work of the Pediatric Diabetes Network in British Columbia, which has been established to support the implementation of evidence based high quality diabetes care to all children/youth in BC and to bring together diabetes programs in each health authority for the provision of consistent high quality healthcare to children and families.



The provincial diabetes workshop which took place in November 2008 was the first step in building the network. Key goals of this event were to: build capacity in community programs, coordinate services and linkages, foster the development of communities of practice and partnerships in the province and monitor and evaluate progress. The achievements of the network to date include:

- Formation of a committee representing all Regional Health Authorities to develop an educational resource for children and their families with newly diagnosed Type 1 diabetes. There are plans to develop a similar provincial resource for children and youth with Type 2 Diabetes.
- In partnership with local pediatricians, the establishment of a pediatric diabetes clinic at Abbotsford Regional Hospital based on a Shared Care Model.
- Hosting of the Interior Health Diabetes Regional Workshop in March 2009.

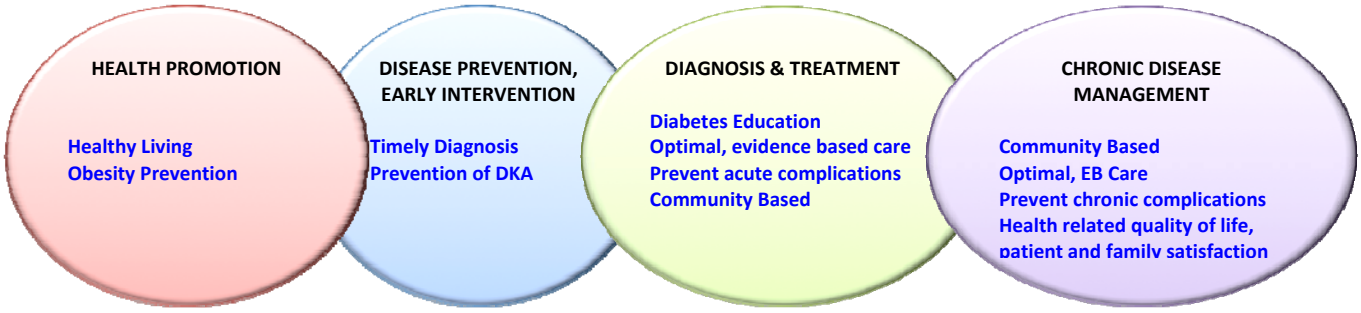
Statistical data on diabetes presented by Dr. Amed indicate that:

(Type 1 Diabetes[1])

- Approximately 60% of children living in BC prescribed an "anti-diabetic drug" (i.e. insulin, metformin) are seen at BC Children's Hospital and this percentage has not changed significantly over the last 10 years. The remaining 40% of children with diabetes may not be receiving optimal treatment and health authorities must work together to extend services and standardize care.

- In 2002, 117 children in the North Shore were on insulin and 93% of these cases were being seen at BCCH. There has been a reduction in this number as children in that region are receiving community based treatment through the pediatric diabetes clinic operated by Dr. Stock.

The following are some measures suggested by Dr. Amed to treat and manage Type 1 diabetes.



[1] *Taken from PharmaNet data in research study conducted by Metzger, Prosser, Carleton, et al (2002 & 2008)*

(Type 2 Diabetes[2])

- The incidence of Type 2 diabetes in Canada is 1.54 per 100,000 children per year or roughly 110 - 120 new cases per year. In the mid 1980s Type 2 diabetes was never seen in children therefore this represents a significant increase in diagnosed cases.

- In British Columbia (BC), the incidence is 1.20 per 100,000 children per year. Compared to other Canadian provinces BC has the third highest incidence of type 2 diabetes. Diabetes Type 2 is on the rise in BC, and more frequent screening is required to capture and record cases.

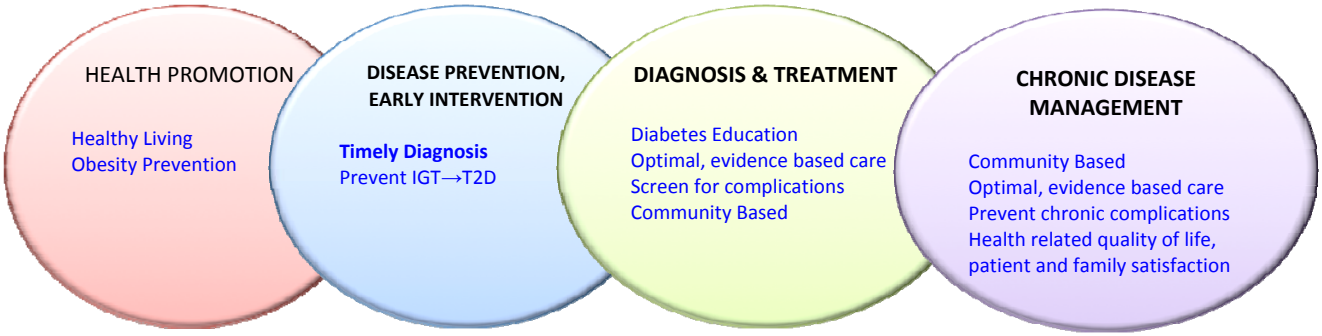
- The average age for children with type 2 diabetes in Canada is 13.7 years and in some ethnic groups, there are children 10 years or younger who have been diagnosed with this condition. Of the total number of children presented in Canada, 8% were less than 10 years old.

- 35% of the children presented had no symptoms of the disease prior to diagnosis and 74% had clinical signs of insulin resistance (i.e. acanthosis nigricans). Of the total number of children with Type 2 diabetes examined, 95% were obese - implies that obesity may be driving the onset of Type 2 diabetes in children.

- 37% of the children with a new diagnosis of Type 2 diabetes had co-morbidity at diagnosis e.g. liver disease, kidney disease, high blood pressure and high cholesterol.

- Aboriginal children represented over 40% of cases diagnosed, a quarter was Caucasian and the remaining quarter was a mix of Asian, African/Caribbean, Hispanic, Middle Eastern and other groups. This implies that all children are at risk of developing this disease and strategies to prevent the onset of this illness in children should be a priority.

Below are measures suggested by Dr. Amed that may be implemented along the continuum to prevent and manage Type 2 diabetes.



Type 1 Diabetes Management in VCH: North Shore Perspective: Sue Stock, MD, FRCPC, Pediatric Endocrinologist

Dr. Amed presented on behalf of Dr. Stock. The North Shore multidisciplinary diabetes clinic offers community based healthcare services to children/youth living in that region. This local facility helps to reduce barriers to health care such as transportation costs and long distance travel to BCCH to access services. The clinic is staffed by two nurse educators per clinic, one back up nurse and a registered

[2] Amed S., Dean H.J., Panagiotopoulos D., Sellers E.A.C., Hadjiyanakis S., Laubscher T.A., et al. *Type 2 Diabetes, Medication-Induced Diabetes, and Monogenic Diabetes in Canadian Children: A Prospective National Surveillance Study Diabetes Care 2010*; E-published ahead of print

dietitian (there is also a back up dietitian for vacation relief). One gap in the clinic's services is the absence of a number of other key healthcare professionals on the team such as a Mental Health Clinician, Social Worker, Child Life Worker and local Pediatrician.

The care of new patients usually begins with admittance to the Lion's Gate Hospital (LGH) for stabilization and education. More in depth education takes place at the North Shore clinic every 1-2 weeks after patients are discharged from the hospital. The average length of hospital stay is usually 24-48 hours depending on the severity of presentation. Children are seen at North Shore clinic every three months and these clinics are organized by age groups to facilitate patient and family interaction. Approximately 12 to 15 patients are seen per clinic with approximately 100 patients admitted at LGH.

Through the community-based Diabetes Education Centre, families have access to support and resources between scheduled visits i.e. pediatric endocrinologist, Diabetes Nurse Educator (DNE), and Registered Dietitian and Nutritionist (RDN). The clinic continues to see an increase in the number of patients and additional physical and human resources are required to cope effectively with the growing number of patients.

Healthy Living Programs for Children & Youth in VCH: Joan Wharf Higgins, Canada Research Chair (Tier 2), Health and Society, University of Victoria

Dr. Wharf Higgins presented findings from a CIHR funded research study *on The Implementation of Healthy Living Programs for Children/families within VCH* which was conducted by the School of Exercise Science, Physical & Health Education at the University of Victoria. Thirty interviews were conducted and document review was completed by the research team to identify physical activity and healthy living programs, policies and activities available to the people living within the VCH geographic area. In addition, a web based survey of non government organizations involved in the delivery of healthy living programs was also completed.

- Research findings indicate that 30% of boys and 25% of girls in Canada between the ages of 6 and 17 are classified as overweight or obese according to the body mass index.

- The survey also showed that in BC, 23% of boys between ages 12 and 17 were inactive during leisure time and 25% were overweight or obese. For girls in the same age group, 31% were inactive during leisure time and 13% were overweight or obese. This implies that there are opportunities for public health and public recreation to work together to implement programs that promote a more active lifestyle.

- The environmental scan within VCH revealed eighty eight physical activity and healthy eating initiatives. Of this number, fifty focused on physical activity programs, twenty six on healthy eating. Seventeen were food security programs and twelve initiatives were a combination of different activities.

- Thirty two of the eighty eight programs identified specifically identified children and youth as their focus, and there were seventy programs for families. These initiatives were established through grant funding and VCH identified as a key player in approximately thirty five of these initiatives.

- **Action Schools:** This program in offers daily physical activity exercises to older children. The BC government has specified that children should participate in at least 30 minutes of physical activity, as part of the student's educational program outside of the classroom, but this is a challenge for some schools due to a lack of appropriate resources. Schools can now apply for grants to include a healthy eating component to this program.

- **At My Best:** This program is designed for kindergarten to grade 2 children and promotes the development of children's overall wellness. The program combines physical activity, healthy eating and emotional well being to support children's development. This program was developed by Physical and Health Education Canada.

- The top NGOs in the province that provide support for **physical activity programs** in the province include BC Recreation & Parks Association, 2010 Legacies Now, Smart Growth BC, BC Healthy Communities, ParticipAction, Heart and Stroke Foundation and BC Healthy Living Alliance. Examples of some initiatives supported by these organizations include the Grade 5 Active Pass, Sechelt Library Pedometer Lending Program and So Go.

- Top NGOs involved in **healthy eating programs** for children/youth include the ones listed above as well as Dietitians of Canada, and the BC Cancer Agency. Examples of initiatives funded by these organizations include Heart Smart Kids, What's For Lunch, Healthy Eating at School, and Hi 5 Living.

- Some key knowledge brokers for physical activity and healthy eating initiatives include:
    - BCRPA Communiqué e-bulletin- communiqué@bcrpa.bc.ca
    - DASH monthly newsletter – info@dashbc.org
    - First Call: BC Child and Youth Advocacy Coalition– http://www.firstcallbc.org/currentissuesannouncements.html
    - BC Healthy Communities provincial newsletter - http://www.bchealthycommunities.ca/content/resources/communications.asp and
    - the BC Healthy Living Alliance newsletter – http://www.bchealthyliving.ca

  The Canadian Health Measures Survey for children and youth is also available on the Statistics Canada website.

GROUP PROCESS

Two case stories were used by participants to identify factors affecting the care of children and youth with Types 1and 2 diabetes. Delegates were placed in small groups according to health service delivery area and through a facilitated group process they identified local opportunities/priorities for the improvement of services and care.

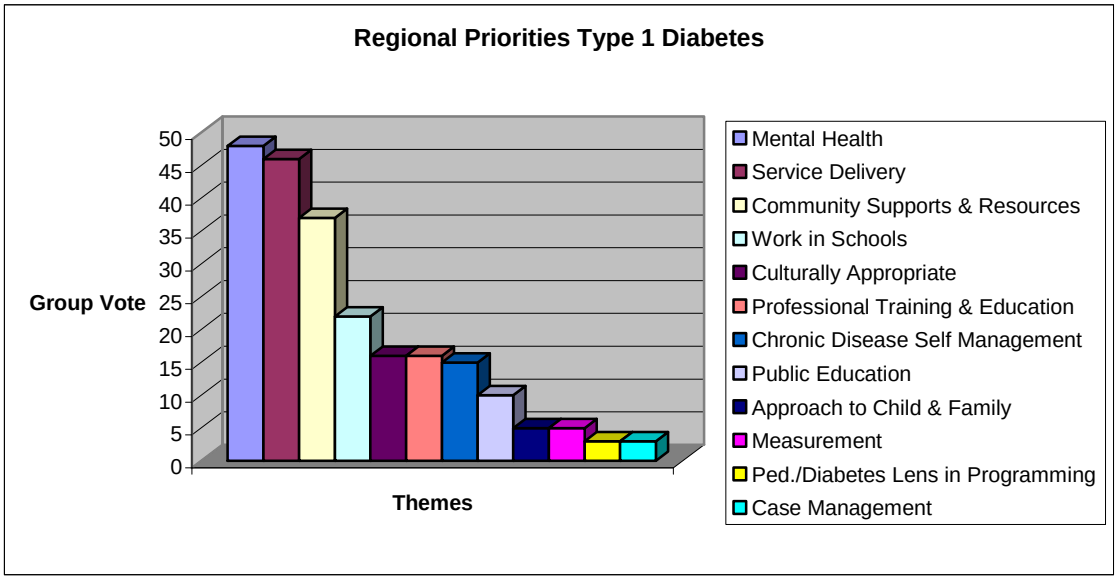
Based on small group discussions participants were invited to identify recommendations for regional strategies to improve services for children and families diabetes. These recommendations are captured in the discussion highlights and chart/table below.

Highlights form large group discussion

- *Better awareness in rural communities of accessible resources outside of BC Children's. Need one place where health care profession can contact for information on resources - a networking process.*
- *Need to build capacity by empowering people locally through connection to services. Don't necessarily need a centre of excellence.*
- *Quality of care that you would get at BC Children is the same that you would get at Dr. Stock's clinic at Lion's Gate Hospital or any other regional clinic. The Public should know that there is no defined centre of excellence. We all work together as a network to improve the care of children. Regional standard of care clinics must have multidisciplinary teams.*
- *Advocate for policy changes in schools e.g. how kids are classified to receive additional supports.*

- *How do we develop a communication system across the continuum e.g. between primary care and public health and level of the school etc? This is a barrier in getting children connected with the services that they need. Communication system often breaks down and the ability to use the existing resources that are available is lost.*
- *Communication has to be a model change.*
- *E-health is a big resource gap. Need to support different service delivery models.*
- *Education/training is also a communication issue. Need education resource in communities to assist health professionals. Education needs to recognize learner needs across health authorities.*
- *BCCH is able to connect individuals in rural communities with education resources.*
- *Could use Toronto model where there are professional development days that have the continuing education element.*
- *People need site to access information. BCCH site has amazing resources, and are working on how to make this site more accessible.*
- *Need standardization of approach across the region in service model to benefit children/families. Need culturally sensitive and safe approach.*
- *Discrepancies in boundaries between MCFD and communities. MCFD should broaden its reach, boundaries are not lining up, access and movement are hindered by the current structure.*
- *Must have mental health support on teams. Counselor needs to be a natural part of the team. Need the Bio, social, psychological, spiritual mix.*

Summary of Emerging Themes - Regional Priorities Type 1Diabetes



Regional Priorities Type 1 Diabetes

REGIONAL PRIORITIES – TYPE 1 DIABETES Coastal Rural, CU-Coastal Urban, V-Vancouver, R-Richmond, U-Unknown			
No	**Themes & Recommendations**	**Vote**	**HSDA**
1	**Approach to Child & Family**	**Total 5**	
	▪ Use a family systems approach, the current Aboriginal Model is a good example. ▪ Expand to include children	0 5	CR CR
2	**Culturally Appropriate**	**Total 16**	
	▪ Mobile and multidisciplinary education, treatment and care clinic to isolated First Nation Communities that is culturally sensitive and safe. Driven and developed by First Nation Community. ▪ Language interpretation during health care visits ▪ Education, easily accessible, culturally sensitive education materials.	9 5 2	CR CU CU
3	**Service Delivery**	**Total 46**	
	▪ Need provincial centre of excellence that is a point of entry for pediatric diabetes patients, families, care givers and health care providers (toll free number to connect or network local resources e.g. provincial HIV/AIDS centre of excellence). ▪ Equip clinics with ability to do 1 stop shop. Get A/C in 5 minutes, offer counseling & guidance. ▪ Shared Care Model with primary health care: being done with adults but we need a pediatric focus. ▪ Define a care model with roles for GP's, specialists, pediatricians. Improve methods/venues for communication across these levels of care. ▪ Communication and networking of available supports e.g. public health, schools, GPs Specialists. ▪ Advocate for communication of patient information across the continuum/sharing of information.	21 6 6 13 0 0	CR CR V V U U
4	**Pediatric/Diabetes Lens in Programming**	**Total 3**	
	▪ Any community support group should have pediatric diabetes professional attend to ensure evidence based information.	3	CR
5	**Mental Health**	**Total 48**	
	▪ Mental Health policies and resources allocated at a regional level – MCFD broadening its reach. ▪ Local mental health services for families with kids with diabetes services need have understanding of both pediatrics and diabetes.	14 34	V CR

	REGIONAL PRIORITIES – TYPE 1 DIABETES Coastal Rural, CU-Coastal Urban, V-Vancouver, R-Richmond, U-Unknown		
No	**Themes & Recommendations**	**Vote**	**HSDA**
6	**Chronic Disease Self Management**	**Total 15**	
	Chronic disease self management program expanded to include children or a class for children.	15	R
7	**Case Management**	**Total 3**	
	▪ Need case management for pediatric diabetes clients in rural Vancouver	3	CR
8	**Measurement**	**Total 3**	
	▪ Research and evaluation: link local and regional evaluators with academics and share resources to evaluate impact.	5	V
9	**Work in Schools**	**Total 22**	
	▪ Kids being classified in order to get supports, advocate for policy in schools. ▪ Healthy Alternatives in school programs, advocacy and partnership with school districts.	21 1	CU CU
10	**Professional Training & Education**	**Total 16**	
	▪ More pediatric diabetes trained dietitians. ▪ Need to focus on the multiple education needs of social workers, nursing practitioners, nutritionists. ▪ More pediatric diabetes education and training for all practitioners but especially PHN/NSS and dietitians. Think about the distance education options with education for those who need to provide support.	0 0 16	CR CR CR
11	**Public Education**	**Total 10**	
	▪ Becoming aware of what supports are available both locally and regionally. ▪ Increase public awareness and education.	7 3	R CU
12	**Community Supports & Resources**	**Total 37**	
	▪ Community Nutrition Support for special needs/chronic conditions as part of community support services. ▪ Access to supplies ▪ Access to family counseling and supports ▪ Improved access to affordable culturally sensitive healthy foods especially in remote communities. ▪ Local social supports for families with kids with diabetes.	6 3 13 7 8	CU CU CU CR CR

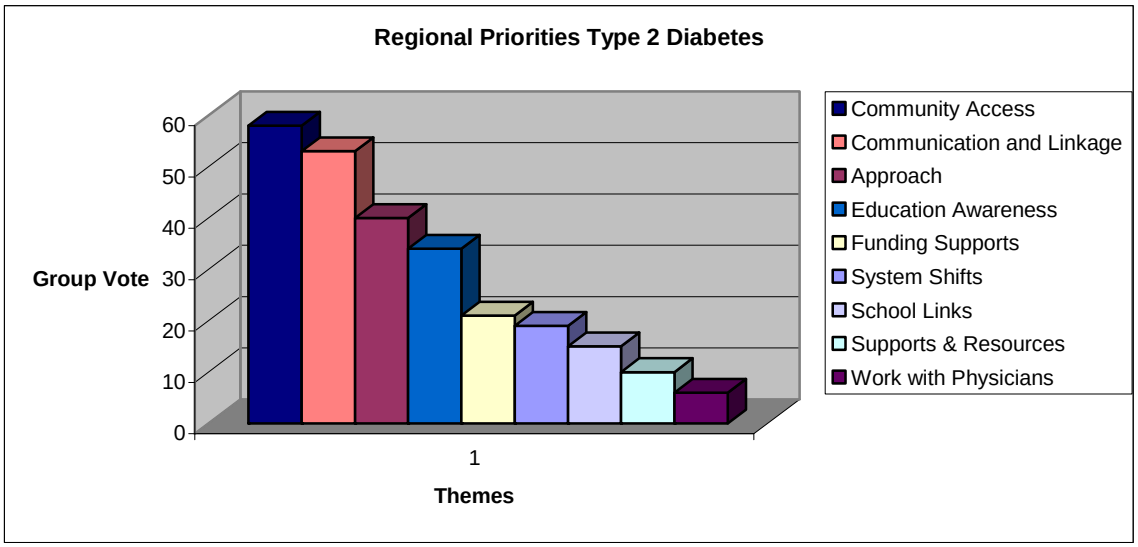
Large Group Discussion - Type 2 Diabetes

Again participants were invited to recommend regional strategies to improve services for children and families. The discussion is summarized below.

Highlights from large group discussion

- *Better support in schools to monitor children. Need a policy that links health and schools. School is an integral part of the process but it is difficult to get all the players at the table.*
- *Need a community participatory approach to Type 2 diabetes prevention. Community engagement and identification of priorities to develop action plan. Communities should be allowed to own and take responsibility for process. This approach has been successful in France and the United States.*
- *Advocacy for responsible food marketing*
- *Mandate public health to do all immunization, will result in better monitoring of children – primary care and public health need to talk.*
- *Standardize regional approach we need to look at best system approach to make things better for children across the province.*
- *Need to get conversation going among different levels of service*
- *E-health resource needed to follow children*
- *Increase physical activity for children*
- *Better mental health support for children*
- *Need to concentrate on prevention. Must look at trajectory of intervention over time.*
- *How does a child cope and manage this disease, how do you get kids involved in social marketing campaigns?*
- *Difficult to monitor children in schools as there is no specific medical alert process for diabetes.*
- *North Shore and West Vancouver have suggested policy that is awesome. Need work to standardize this in schools*
- *How does school and health work together? School is an integral part of the process but getting all players to the table is overwhelming*
- *Prevent stigma associated with obesity, should be included in training of health professional as there is bias towards these children.*
- *Adopt system in Austria of using school doctor 2 to 3 days a week to check children's weight, height, ears, etc. in schools.*
- *On the North Shore school health newsletters are used to educate families, this is a good way to link with families about topical issues and it reaches a broad audience. Should this be regional or local?*

Summary of Emerging Themes - Regional Priorities Type 2 Diabetes



Regional Priorities Type 2 Diabetes

REGIONAL PRIORITIES – TYPE 2 DIABETES * CR-Coastal Rural, CU-Coastal Urban, V-Vancouver, R-Richmond, U-Unknown			
No	**Themes & Recommendations**	**Vote**	**HSDA**
1	**System Shifts**	**Total 19**	
	• Mandate Public Health to do all immunizations to allow for screening and electronic tracking	6	R
	• Primary care and specialists will accept public health nurse referrals	0	R
	• Support for health to be engaged at community level in community planning for active and healthy living	7	CU
	• Need community process for intake, education and support of child and family of Type 2 diabetes	5	CR
	• Each local area needs dedicated pediatric dietitian support	1	CR
2	**Approach**	**Total 40**	
	• Responsible food marketing policy specifically towards children	21	U
	• A community based participatory approach to childhood obesity prevention for example the SCOPE project being piloted in Abby and Prince George	18	U
	• Speak the youth's language i.e. on website, through social media etc.	1	U
3	**Funding Supports**	**Total 21**	
	• Funding for programs ongoing and sustainable	8	CU
	• Funding for each local area for childhood obesity and Type 2 screening, treatment and support via multidisciplinary team	13	CR
4	**Supports & Resources**	**Total 10**	
	Cooking for your life and cooking skills for families continued for long term	5	R
	Upstream determinants, antenatal & prenatal care- (i.e. education for new and potential mothers), education and care for the 0-5 years focusing on early development	5	U
5	**Work with Physicians**	**Total 6**	
	• Supporting family physicians/healthcare providers on identifying kids early	3	V
	• Family physicians clinical practice guidelines diagnosis plus treatment pathways for overweight/obesity	3	CU
6	**Communication and Linkage**	**Total 53**	

REGIONAL PRIORITIES – TYPE 2 DIABETES * CR-Coastal Rural, CU-Coastal Urban, V-Vancouver, R-Richmond, U-Unknown			
No	**Themes & Recommendations**	**Vote**	**HSDA**
	• Stronger linkage with public health, collaboration to support child and family • Better communication between primary health care and public health (strengthen relationships) i.e. VCH to put together a strategic group around obesity prevention. Public health providing education to GPs etc.	18 35	CU U
7	**Education Awareness**	**Total 34**	
	• Increased education for families and multidisciplinary professionals on Type 2 diabetes • Social marketing campaign on healthy lifestyles e.g. food, physical activity, screen time • Training and better dissemination of existing resources e.g. Sip Smart, LEAP. Find a way to continue to use these resources • Social marketing campaign geared to parents/parenting and children & youth • Education to prevent stigma associated with obesity, anti bullying policies in school • Public awareness and education	2 19 2 1 1 9	R R U U U CU
8	**School Links**	**Total 15**	
	• Implement standardized nutritional curriculum in schools too many different messages • Accessing parents in PAC • Mandated school lunch programs similar to the United States	15 0 0	U CU R
9	**Community Access**	**Total 58**	
	Free physical activity programs for all children Encourage and support connections between school, recreation and health. After school activities, healthy active lifestyle Free active play sessions at community level for all families Increase access to community kitchens for pre diabetes and diabetes families	26 21 8 3	CU CU CR CR

WRAP UP AND NEXT STEPS

To maintain momentum and transition into next steps, local groups were encouraged to continue discussions on local priorities and moving forward with the identified recommendations. The information documented during the workshop will be synthesized and circulated to each participant for review and validation. It was also suggested that a communication tool such as share point be established to facilitate continuation of dialogue and sharing of information among participants.

At the closing of the workshop Child Health BC committed to providing support for provincial communication and skill building through the continued development of diabetes resources for families and professionals available on the BCCH Endocrinology and Diabetes Unit website.

The recommendations from the workshop will be used to inform the quality improvement plan for Childhood Diabetes. This plan will be used to standardize the care and management of Type 1 diabetes and support the implementation of community-based activities to prevention Type 2 diabetes for children within the Vancouver Coastal Health region.

APPENDIX

VCH Diabetes Workshop Evaluation

VCH Diabetes Workshop Evaluation		29-Jan-10				
No.	Particulars	Excellent	Good	Improvement needed	Did not meet expectation	Total
		4	3	2	1	
1	Achievement of program objectives	82%	18%	0%	0%	100%
2	Effectiveness of workshop methodology and techniques	86%	14%	0%	0%	100%
3	Organization of content	82%	18%	0%	0%	100%
4	Usefulness of program materials, handouts, etc	59%	41%	0%	0%	100%
5	Opportunity for discussion or group involvement	90%	5%	5%	0%	100%
6	Effectiveness of the presenters/moderators	95%	5%	0%	0%	100%
7	Appropriate setting for learning	90%	10%	0%	0%	100%
8	Your overall rating of the workshop	86%	14%	0%	0%	100%
	*This evaluation represents 22 responses from a group of 37 participants.					

What worked well for this workshop?

1 Working in local groups to identify local priorities and then coming together for regional priorities.
2 Working in our local groups, written materials from our local groups
3 Connecting with players within our own area - dialogue interesting we all said similar things about barriers/blocks in communication process between programs.
4 Group discussions.
5 Great facilitator.
6 Conversations.
7 The multi-disciplinary discussion.
8 The group facilitators were excellent.
9 Small group discussions, intro info, large group dialogue.
10 Great facilitation - really opened an avenue for participants input and engagement. Congrats Sue!
11 Sue was a great facilitator, good organization of group work and reconvening.
12 Small group discussions.
13 Excellent facilitators - Sue, Jennifer, Non judgmental / non defensive dialogue.
14 Small group discussions. Case studies looking at both forms of DM.
15 One of the best I have attended. Worked well, achieved results, good consensus.
16 Facilitators, focus on topic.
17 Small group breakout into HSDAs.
18 Organized with appropriate time constraints.
19 The dialogue we all shared in was spirited, connected and informative.
20 All the group discussion. Nicole was a fabulous facilitator and kept us focused on topic.

How will this workshop apply to your work and improve pediatric health outcomes?

1 Will meet with local participants again.
2 Increase communication and collaboration.
3 If we can continue to engage organizational players on an ongoing level then outcomes will most likely improve - more seamless for families and better follow up.
4 We will see which ideas of the workshop will be implemented.
5 We will see.
6 ?????.
7 Very motivated to work and collaborate with others.
8 I learned about resources in my community that I was not aware of.
9 Communication and sharing of resources in HSDA.
10 Regional team has been formed and is preparing future work together.
11 Hopefully move forward - some interesting ideas.
12 Provided arena for networking with community / public health practitioners.
13 Increased awareness of community resources for kids at risk for T2DM.
14 Plans to go forward with suggestions.
15 Move forward with childhood obesity planning.
16 Advocate for needed services.
17 I have been able to focus on some excellent recommendations and plan to make connections in community and interdisciplinary teams.
18 Hopefully more support will be coming for Rural Coastal with more defined process for managing diabetes in remote communities.

What questions remain unanswered for you?

1 My mind is now blank! But thank you for asking.
2 Funding dollars is always an issue at the provincial level to filter down . The need for more support to children with chronic health conditions (Type 1 /2).
3 Who will pay for all our good ideas (i.e. programs, food, free children's activities etc.)?
4 Need more people at the table (acute).
5 Is it possible to effect the change in care model?
6 Will we have a strong voice and that ideas will be support not only in concept but also in funding dollars?
7 Still in early stages.
8 When can we make it happen?!?
9 Will this be a help to Aboriginal people - non "professionals" poorly resourced but rich in wisdom? How well this lines up with what they already hold and carry?
10 The process of care for a child with Type 2 Diabetes who does what, what do they need as support in the community?

What other comments do you have about this workshop?

1 I enjoyed Sue's graphics and colors.
2 I hope all ideas will become a reality.
3 Great place.
4 Very relevant to my community work.
5 Overall, the workshop was excellent.
6 Great opportunity.
7 Thanks for getting us in one room.
8 Fantastic work of bringing together practitioners from across the continuum!
9 I really enjoyed being here, thank you.
10 As a region we don't seem to share communication/resources very easily or consistently.