A Word from our Leadership Team

Our deepest thanks to the Diabetes, Obesity & Nutrition Strategic Clinical Network™ Core Committee for your enthusiastic guidance, support and vision since launch of the Network five years ago. Your enduring commitment has seen - among other achievements - the implementation of the provincial Insulin Pump Therapy Program for people with Type I Diabetes; improved recovery of patients after surgery with more effective nutrition protocols; and deeper understanding on the impact of obesity on the care of bariatric patients in hospital. We feel uniquely privileged to work with such a knowledgeable and diverse group of patient advisors and advocates, clinicians, researchers, government representatives, and scholars. Your perspectives and counsel have truly shaped our roadmap - and the health of our communities.

Over the past five years our Network has grown substantially and with that has come new challenges and opportunities to address unmet patient needs and design clinically appropriate service delivery models. Clinicians from across the province have collaborated on pathways to help people with diabetes - and their primary health care teams - identify and manage diabetic foot problems in a shared commitment to save lives and limbs. Alberta Health Services representatives from clinical and support service areas across all five Health Zones have embarked on a journey to improve glycemic management of hospital patients with diabetes – reducing complications and lengths of stay. Alberta Health continues to rely on the Network for support and advice on the appropriate use of diabetes and complications management technologies and on effective obesity prevention/management strategies. More recently we have been recognized by local and international industries as a gateway to test and inform the effectiveness of new technologies and value based health care models.

Going forward, as described in our Transformational Roadmap 2017-21, the achievement of our Vision will build from our network strength to create durable organizational partnerships: with our AHS Zone and Provincial colleagues and Primary Care Network partners to spread diabetes and obesity management initiatives provincially; with our partners in Alberta Health to work on policies that promote prevention; with Alberta Innovates, Alberta universities and industry partners to develop for the first time a provincial diabetes registry and improved health care delivery models/technologies; with other SCNs on patient care initiatives of mutual interest; and with our national colleagues to promote uptake of our work beyond provincial borders. We look forward to the next five years with great excitement. And we know our Vision is possible - with your continued support and guidance.

Petra O’Connell
Senior Provincial Director
Diabetes, Obesity & Nutrition Strategic Clinical Network™
Alberta Health Services

Dr. Peter Sargious
Senior Medical Director
Diabetes, Obesity & Nutrition Strategic Clinical Network™
Alberta Health Services
Executive Summary

Since our launch in June 2012, the Diabetes, Obesity, and Nutrition Strategic Clinical Network™ (SCN™) has grown to over 1200 active members, and has become a major stakeholder in the areas of diabetes, obesity, and nutrition in Alberta. Our network is comprised of a diverse community of patients, healthcare providers, operators, associations, government, and researchers who are passionate and knowledgeable about these three different yet interrelated clinical areas of focus. Reflecting on the past five years, this refreshed Transformational Roadmap (TRM) builds on the work that has been completed since the launch of the SCN and looks forward to the next four years.

The DON SCN follows the AHS vision of “Healthy Albertans. Healthy Communities. Together.”

In order to achieve this vision, the focus of the Diabetes, Obesity, and Nutrition SCN is “All Albertans have access to services and supports that optimize their nutritional status, prevent or reduce the risk of diabetes, obesity, and malnutrition, and enable those living with these chronic diseases to be healthy and well.”

Our mission statement, or how we will achieve this vision, is: “To bring people together to integrate research and innovation within quality care in order to promote equitable, seamless and sustainable healthcare services related to diabetes, obesity, and nutrition for all Albertans.”

To reach this vision and mission, the Diabetes, Obesity, and Nutrition SCN has identified three strategic domains and a number of corresponding priorities for 2017-2021. These strategic domains and priorities are:
Prevent the onset & progression of diabetes, obesity, & malnutrition:

- Standardizing foot care across Alberta.
- Working with AHS and Alberta Health on the identification, implementation, and evaluation of new models of care for obesity management in the community.
- Working with AHS Nutrition & Food Services to develop a Malnutrition Strategy for screening, assessment, and treatment of people with malnutrition.

Empower patients & providers to better manage diabetes, obesity, & malnutrition to live well and long:

- Improve glycemic management in hospitals to enhance health outcomes of patients with diabetes.
- People with diabetes and primary care providers learn and practice the importance of foot screening and care.
- Develop an understanding of both the impact of malnutrition in patients’ lives as well their perceived barriers to achieving a healthy diet.

Transform the Health Care System through Research, Surveillance, and Partnerships:

- Development of the Enhanced Diabetes Surveillance and Research Infrastructure that will inspire future research and new health service.
- Translation of research findings into practice e.g. “Care and Rehabilitation for Patients with Severe Obesity in Alberta's Tertiary Care Settings” (PRIHS 1) project into Bariatric Friendly Care Hospital Standards for eventual spread to Alberta hospitals.
The above noted strategic domains and corresponding priorities are intended to transform diabetes, obesity, and malnutrition care across the province by looking for ways of delivering care that will provide better quality, better outcomes, and better value for every Albertan. To achieve this, SCNs are responsible for generating innovation, implementing best evidence into practice, and utilizing change management techniques to ensure long-term sustainability and success.

**We have also developed eight Guiding Principles that serve as a foundation for our SCN and all the work we do. These Guiding Principles include:**

- We guide the building of diabetes, obesity, and nutrition capacity and capability across the health care system and other sectors in Alberta.
- We work to ensure that health care is accessible, acceptable, appropriate, safe, effective and efficient.
- From conception through to implementation, our initiatives are centered on the experiences of patients and their families.
- We improve health system value (and value for money) to ensure the sustainability of health care resources over the long term.
- Broad engagement, strong communication, and relationship-building on local, provincial, national, and international scenes are trademarks of the DON SCN.
- We promote a culture of innovation where innovation is any evidence-informed, value added service, device, technology, or model of care.
- We embed research, evaluation, and knowledge translation in all of our activities.
- We promote equitable access to care for all Albertans and communities.

By focusing on prevention, patient and provider empowerment, and system transformation at all levels of care, the Diabetes, Obesity, and Nutrition SCN is confident that the strategies identified in this four year Transformational Roadmap will help us bring Alberta to a leadership position within Canada in the areas of diabetes, obesity, and nutrition. We look forward to working together with our network partners to meet the challenges and opportunities ahead.
“Healthy Albertans. Healthy Communities. Together.”

AHS Vision

To this end, the Diabetes, Obesity and Nutrition SCN strives to ensure that all Albertans have access to services and supports that optimize their nutritional status, prevent or reduce the risk of diabetes, obesity and malnutrition, and enable those living with these chronic diseases to be healthy and well.

Diabetes Obesity and Nutrition SCN
# Diabetes, Obesity and Nutrition Strategic Clinical Network™

## AHS Vision

### Healthy Albertans. Healthy Communities. Together.

## Our Focus

All Albertans have access to services and supports that optimize their nutritional status, prevent or reduce the risks of diabetes, obesity, and malnutrition, and enable those living with these chronic diseases to be healthy and well.

## Our Mission

To bring people together to integrate research and innovation within quality care in order to promote equitable, seamless and sustainable healthcare services related to diabetes, obesity and nutrition for all Albertans.

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## How we’re going to get there: Our Strategic Domains and Priorities

### Prevent the onset and progression of diabetes, obesity and malnutrition:

- Standardize diabetic foot care across Alberta
- Create new obesity management models in the community
- Develop a Malnutrition Strategy for screening, assessment and treatment of people with malnutrition

### Empower Patients & Providers to Better Manage Diabetes, Obesity & Malnutrition to Live Well and Long:

- Improve hospital glycemic management and facilitate patient self-management of diabetes in hospital
- Develop an understanding of the impact of malnutrition in patients’ lives and perceived barriers to a healthy diet
- People with diabetes and primary providers understand the importance of and practice evidence-based foot screening and care

### Transform the Health Care System through Research, Surveillance, and Partnerships:

- Develop an Alberta Diabetes Registry that will inspire future research and new health service delivery models in diabetes management
- Translate PRHSG 10 research findings into standards that improve the care of patients with obesity in hospital
- Build capacity for innovation and research through new partnerships with Alberta Innovates, industry, universities, Alberta Health, Alberta Health Services
# Table of Contents

A Word from our Leadership Team ................................................................. ii
Executive Summary ...................................................................................... iii
Table of Contents .......................................................................................... viii
Introduction .................................................................................................... 1
About the Diabetes, Obesity and Nutrition SCN ........................................ 1
Our Guiding Principles .................................................................................. 2
Celebrating Our Achievements ................................................................. 3
The Challenge ................................................................................................. 4
The Journey Continues: Strategic Domains for 2017 – 2021 .......................... 7
  Strategic Domain: Prevent the Onset and Progression of Diabetes, Obesity, and Malnutrition 8
  Strategic Domain: Empower Patients and Providers with Diabetes, Obesity, and Malnutrition to Live Well and Long ........................................................................ 12
  Strategic Domain: Transform the Health Care System through Research, Surveillance, and Partnerships .................................................................................. 15
How will we know we are successful? ....................................................... 22
Communication and Engagement ............................................................. 23
Conclusion ...................................................................................................... 24
Glossary .......................................................................................................... 25
Appendix A: Strategic Clinical Network Leadership and Core Committee Members .......... 28
Appendix B: Community Diabetic Foot Care Clinical Pathway Infographic .................................................. 31
Appendix C: Diabetes Inpatient Management Infographic ............................. 32
Appendix D: Seed Grant Recipients .............................................................. 33
References ...................................................................................................... 34
Introduction

Strategic Clinical Networks™ (SCNs™) are province-wide teams that bring together patients and their families, healthcare providers, researchers, community, industry, and government and non-government agencies to improve the health outcomes of Albertans. To achieve this, SCNs are responsible for generating innovation, implementing best evidence into practice, and utilizing change management techniques to ensure long-term sustainability and success. SCNs are aligned with Alberta Health Services’ (AHS’) quadruple aim which includes the elements of patient quality and experience; health outcomes; value for money and improved health care provider experience.

About the Diabetes, Obesity, and Nutrition SCN

The Diabetes, Obesity, and Nutrition (DON) SCN launched in June 2012 and now has 1200 active members. It’s comprised of diverse communities of patients, healthcare providers, operators, associations, and researchers who are passionate and knowledgeable about diabetes, obesity, and nutrition. Our team looks for better ways of delivering care that will provide better quality, better outcomes, and better value for every Albertan. Our Core Committee has membership from all walks of life including patients, government, research, community, and healthcare providers (membership in Appendix A).
Our Mission:
To bring people together to integrate research and innovation within quality care in order to promote equitable, seamless and sustainable healthcare services related to diabetes, obesity, and nutrition for all Albertans.

Our Guiding Principles

- We guide the building of diabetes, obesity, and nutrition capacity and capability across the health care system and other sectors in Alberta.
- We work to ensure that health care is accessible, acceptable, appropriate, safe, effective, and efficient.
- From conception through to implementation, our initiatives are centered on the experiences of patients and their families.
- We improve health system value (and value for money) to ensure the sustainability of health care resources over the long term.
- Broad engagement, strong communication, and relationship-building on local, provincial, national and international scenes are trademarks of the DON SCN.
- We promote a culture of innovation where innovation is any evidence-informed, value added service, device, technology, or model of care.
- We embed research, evaluation, and knowledge translation in all of our activities.
- We promote equitable access to care for all Albertans and communities.
Over the past four years, we have:

- Successfully implemented a provincial Insulin Pump Therapy Program for people with Type 1 Diabetes. Since 2012, the number of people using a pump to control their diabetes has doubled.

- Implemented and evaluated the Enhanced Recovery After Surgery Colorectal Protocol in six hospitals in Edmonton and Calgary. The program significantly reduced post-operative complications and length of stay in hospital. The Surgery SCN is now spreading the protocol and introducing new protocols across Alberta hospitals.

- Led research on the care of people with severe obesity in hospitals; funded by a Partnership for Research and Innovation in the Health Care System (PRIHS 1) grant. Findings are being translated into hospital standards for the care of people with obesity.

- Reviewed glycemic management of patients with diabetes across all Alberta hospitals. We discovered that patients experience hyperglycemia 1/3rd of the time they are in hospital. This has led to the launch of a multifaceted Improved Glycemic Management In-Hospital Initiative.

- Developed a Community Diabetic Foot Care Clinical Pathway for patients and primary care providers in response to the rising number of preventable foot ulcers and lower limb amputations in people with diabetes.

- Initiated partnerships with Alberta industries in foot pressure mapping and wound care to improve and expedite foot care. Funded by the Accelerating Innovations into CareE Program, Alberta Innovates.

- Presented the Community Diabetic Foot Care Pathway at the Canadian Advanced Wound Care Conference in Niagara Falls (2016).

- Utilized an Open Innovation idea-generation platform to develop ideas for the 3 for 150 Campaign. This generated ideas for development in the categories of play, walk, and create such as walking meetings, stair climbing challenges, and community gardens.
The Challenge

Diabetes

- As of 2016, **3.5 million** Canadians (9.2%) and **300,000** Albertans (7.5%) have diabetes.
- The prevalence of diabetes in Alberta has **increased by 61% since 2000**. Over the **next 10 years**, diabetes rates are predicted to **increase by 41%**.
- Diabetes rates are **3-5 times higher** in Indigenous populations than the general population.
- Diabetes costs the Alberta healthcare system **$1.1 billion** (2010); this is expected to be **$1.6 billion by 2020**.
- 20% of all patients in hospital have diabetes.

- **Hyperglycemia** contributes to delayed wound healing, and increased infections, length of hospital stays, and mortality.

- People with diabetes have a **15-25% chance** of developing a foot ulcer sometime during their life.
- Diabetes contributes to **70%** of non-traumatic lower limb **amputations**; the prevalence of these amputations has **increased 80%** in the last 5 years.
- Over **85%** of these situations could be **prevented** through regular screening and early intervention.
- There are currently **no provincial standards** for diabetes foot care, and care is uncoordinated and completely lacking in some communities.
 Obesity

- Canadian and American Medical Associations have declared obesity to be a chronic disease, confirming the need for preventative and treatment protocols consistent with other chronic disease management measures.

- The Health Quality Council of Alberta’s 2014 report Overweight and Obesity in Adult Albertans: A Role for Primary Health Care stated that 60% adult Albertans were overweight or obese.

- Albertans with obesity have an increased risk of other chronic conditions, lower quality of life, and increased use of healthcare services than adults who don’t have obesity.

- Currently in Alberta there are treatment programs for overweight and obesity but their effectiveness has never been evaluated.

- Health care professionals (including physicians, nurses, psychologists, dietitians and medical students) have been shown to hold beliefs that are consistent with weight bias. This means they are more likely to assess a person’s values, skills, abilities, and personality based on their body weight and shape.

- Many health professionals report feeling professionally unprepared when working with patients with obesity, in part due to a fear of injuring themselves.

- Patients with obesity are at significantly higher risk for injury in health care settings due to inadequate facility design, equipment, or staff competency in their care.
**Malnutrition**

- The Canadian Malnutrition Taskforce has reported that 45% of patients are malnourished on admission to hospital.
  - Hospitalized seniors are 1.4 times more likely to be malnourished than others and their average length of stay is three days longer than well-nourished seniors, which costs Canadian taxpayers $2 billion dollars a year.

- A 2013 Statistics Canada report indicated that 34% of community-based seniors were at nutrition risk.

- Recent preliminary report from Alberta has shown that 51% of seniors in homecare and supportive living environments are at risk of malnutrition or are malnourished.

- 20% of malnourished patients are readmitted to hospital one month after discharge.

- There is limited programming in Alberta to support malnourished people after discharge from hospital and its effectiveness has not been evaluated.

- The Canadian Malnutrition Taskforce recommends transition care to support malnourished patients as they move back to the community.

- Little is known why community-based seniors develop malnutrition or what supports would be best to prevent or treat this condition.
The Journey Continues: Strategic Domains for 2017 – 2021

In order to transform the healthcare system, over the next four years our work will focus on three Strategic Domains:

- **Prevent**
  - Prevent the Onset & Progression of Diabetes, Obesity, & Malnutrition

- **Empower**
  - Empower Patients & Providers to Better Manage Diabetes, Obesity, & Malnutrition to Live Well and Long

- **Transform**
  - Transform the Health Care System through Research, Surveillance, and Partnerships
Strategic Domain: Prevent the Onset and Progression of Diabetes, Obesity, and Malnutrition

“We have 400 diabetes patients in our clinic and there is nowhere to send them if they need foot care services.”

South Zone Primary Care Network Nurse

Going forward, our work will focus on building awareness of the Community Diabetic Foot Care Pathway tools and resources for patients and primary care providers. For example, plans are underway to embed the tools and referral forms into Netcare, an electronic record that is accessible to all pharmacies and primary health care providers.

For this initiative, we are working with:

- The Alberta Pharmacists’ Association to promote awareness of the importance of foot screening to individuals with diabetes,
- Alberta Aids to Daily Living (Alberta Health) to develop new foot wear eligibility criteria to prevent the development of foot ulcers,
- Primary care health providers in indigenous and remote communities and connecting them through telehealth to expert foot care teams to improve foot care outcomes,
- Seniors Health SCN on improving foot care in continuing care environments, and
- The Alberta Diabetes Foundation, who has generously supported the printing of educational resources for Albertans with diabetes.

In order to ensure the pathway will prevent diabetes foot ulcers and empower staff to provide the appropriate care, all of our work will be evaluated to determine the impact these resources are having on patient health outcomes and health care workers experience of providing care.
Did you know?

Normal Blood Sugar ≠ Healthy Feet

Over 33% of people with foot ulcers and lower limb amputations in Alberta had HbA1Cs in the normal range

"The Diabetes Obesity and Nutrition SCN has empowered me to bring about changes to attitudes, policies, and procedures that negatively affect the health of people with diabetes in Alberta. I'm involved with the DON SCN because I've found it to be a catalyst for positive change to diabetic management. I've felt that my input and the opinions and experiences of other individuals with diabetes whom I represent on this committee have been taken seriously. I'm gratified to see that many of the concerns I had for in-patient treatment of diabetes are being eliminated in a timely manner. The new pathway for diabetic foot care and the new website, iPUMPIT, are a few of the impressive achievements of this SCN."

Isabelle Emery, Patient Advisor, DON SCN Core Committee
The 2014 report “Overweight and Obesity in Adult Albertans: A Role for Primary Health Care” (Health Quality Council of Alberta), recognized that overweight and obesity were significant health issues for Albertans. However, despite the existence of a number of weight management programs in Alberta, there is a lack of information on their effectiveness. It’s recommended that a unified strategy for overweight and obesity management be developed along with an evaluation strategy. The Diabetes, Obesity and Nutrition SCN is well positioned to play a role in providing evidence-based solutions to these problems.

“When I was asked if I would like to be a part of the Bariatric Friendly Care Steering Committee, I felt it was something that I could contribute to being a Bariatric patient. I feel that this project is very necessary from a patient’s perspective. By contributing my experiences as well as that of others on their weight loss journey, I hope to be able to help change the face of how Bariatric patients are handled & treated in our medical facilities.”

June Thompson, Patient Advisor, DON SCN Bariatric Friendly Care Steering Committee
The Diabetes, Obesity, and Nutrition SCN is working with AHS Nutrition & Food Services to determine how best to prevent and manage malnutrition in hospital settings, continuing care, and in the community. This involves talking to all impacted by malnutrition including patients and their families through to health care providers. We will determine the correct assessment tools to use, the appropriate intervention and also have guidelines for transition of care between each of these environments. There will also be an evaluation plan that will monitor the impact of these interventions on rates of malnutrition, patient quality of life, and potential cost savings to the health system.

The DON SCN will also continue to work with partners such as the Population, Public, and Indigenous Health (PPIH) and Primary Health Care provincial programs and the PPIH SCN to address primary prevention of diabetes and obesity at the population health level. We will also continue to role model healthy behaviours within Alberta Health Services by supporting initiatives such as the Healthy Eating Environment policy and the sugar-sweetened beverage campaign. By focusing on modifiable risk factors and preventing obesity in particular, we will also begin to see the down-stream affects this will eventually have on other chronic diseases, including diabetes.
Strategic Domain: **Empower Patients and Providers with Diabetes, Obesity, and Malnutrition to Live Well and Long**

We recognize that it is essential for patients and providers to not only be equipped with the necessary tools to manage their own health or the health of their patients, but they also need to be empowered to use these tools on their own. Most of the work we will focus on over the next four years have patient and provider empowerment embedded within the project scope.

Our aim with the Inpatient Diabetes Management Initiative is to *optimize* inpatient glycemic control in Alberta as indicated by a decrease in the incidence of patients with hyperglycemia while in hospital.

"I have the pleasure of being part of the DON SCN, whose members are enthusiastic and committed to improving the quality of care for patients with diabetes across Alberta, both in and out of hospital. Being part of the Diabetes Inpatient Management Initiative team, I can say that care of patients with diabetes in hospital is very complex and requires collaboration among many groups and individuals, including patients and their families. The DON SCN has been instrumental in identifying care gaps and then bringing multiple stakeholders together from across the province to drive positive change, based on good evidence and best practice. I am impressed by how much work has already been done and proud to be part of this organization."

**Dr. Julie McKeen, Endocrinologist, DON SCN Core Committee Member and Medical Lead of the Provincial Diabetes Inpatient Management Initiative**
Diabetes Inpatient Management Initiative

Outcomes: Improved patient experience, improved patient satisfaction, decreased incidence of hypoglycemia and hyperglycemia, reduced medical complications, decreased hospital length of stay.
Seniors in the community, including those in continuing care environments, are at high risk for malnutrition. Alberta data indicates that up to 51% of residents in supportive living environments are at risk of malnutrition or are malnourished. While there is good understanding of medical aspects of malnutrition, there is very little known about the patient and their family’s experience with this condition. So we are going to ask seniors and their families about their experience with malnutrition and the perceived barriers to a healthy diet. We will also look to them for solutions. The information gathered will inform interventions to lower the rates of malnutrition and improve quality of life in this population.
Strategic Domain: Transform the Health Care System through Research, Surveillance and Partnerships

One of the goals of the SCNs is to transform the health care system. We intend to do this by building on our successes, using innovative approaches, and focusing on research, surveillance, and partnerships. We want to build on the success of the Open Innovation platform and consider how we can incorporate this innovative idea generation tool into our work going forward.

Scientific Office

The SCN Scientific Office, which is comprised of our Scientific Director and Assistant Scientific Director, operates to drive research and innovation in areas where knowledge gaps exist in health care prevention, services, and delivery under the expert guidance of the Research and Innovation Advisory Committee.

Our Successes

- Created and spread information in factsheets (e.g. A Look at Childhood Obesity) and newsletters that highlight findings of clinical and organizational research outcomes to engage our research community.
- Developed evaluation frameworks for the Inpatient Diabetes Management Initiative and Community Diabetic Foot Care projects.
- Secured research funding for two Accelerating Innovations into CarE (AICE) grants that are focused on improving diabetic foot outcomes through the adoption of innovative technologies.
- Developed competencies in knowledge translation through coursework and certification that have been applied to our Inpatient Diabetes Management Initiative.
**Moving Forward**

The Diabetes, Obesity, and Nutrition SCN has been instrumental in translating our research in the area of obesity in the clinical environment that has the potential to impact the way patients who live with obesity access the most appropriate and effective health care services. The connections I've made with administrators, patients, and practitioners at AHS would not be as strong without the involvement of the DON SCN. From my experience as a researcher, a major success has been the increased awareness and action plans to reduce weight bias experienced by patients throughout AHS with an emphasis on promoting safe and patient-centered care environments.

Dr. Mary Forhan, PRIHS 1 Investigator and DON SCN Broader Network Member
The SCN is leading a pilot project for **Bariatric Friendly Care Hospital Standards** at Medicine Hat Regional Hospital that will:

- provide training to improve professional competencies to prevent weight biased interactions with patients,
- ensure safe environment and equipment for patients and providers,
- empower staff by training them to proactively plan for patients’ needs
- ensure successful care transitions for patients across hospital areas and to and from the community, and
- identify measures and data requirements for performance evaluation.

35% of patients in Alberta hospitals have obesity.

Patients with obesity are in hospital 2x longer than those who don’t have obesity. This can be reduced with more appropriate care standards.
This project will create the necessary infrastructure to integrate patient reported health outcomes into a comprehensive diabetes surveillance system that will support the identification of healthcare delivery gaps and solutions, and support researchers in their quest for answers to perplexing questions.
The Diabetes, Obesity and Nutrition SCN is committed to building on existing partnerships and continuing to form new ones over the next four years, enabling us to continue to build capacity for diabetes, obesity, and nutrition within Alberta. Examples of some important partnerships that involve shared interests include, but are not limited to:

**Community-based Health Care Providers:** We work closely with Primary Care Networks, home care, community pharmacists, and others on the Community Diabetic Foot Care Clinical Pathway. We also intend to work with Seniors Support Service agencies, home care, continuing care facilities, and other community providers on our Malnutrition Strategy.

**Other SCNs:** We are working with other SCNs including Bone and Joint Health on the development of a Clinical Assessment Tool for Hip and Knee Replacement Surgery for Obese Patients; the Surgery SCN on the development of Perioperative Guidelines for patients with diabetes to support ERAS protocols; Seniors Health SCN on development of a Malnutrition Strategy, the implementation of the Community Diabetic Foot Care Clinical Pathway within the continuing care sector, and improving glycemic management of seniors with diabetes while in hospital; and the Cancer SCN on the Alberta Screening & Prevention Initiative. We are also committed to building a relationship with the new PPIH SCN to determine how our two networks can work together to prevent diabetes, obesity, and malnutrition at the population health level.
Industry: We will continue to work with industry to bring innovative technologies to Alberta to help patients and providers. With the support of AICE grants, we have been able to initiate partnerships with two Alberta companies in foot pressure mapping and wound care to expedite wound healing and prevent the development of foot ulcers in patients with diabetes. We are also exploring other value-based health care models with global industry partners that deliver superior outcomes that matter to patients for the same or less money.

"Working with the Diabetes, Obesity and Nutrition SCN (DON SCN) has been instrumental in enabling the clinical demonstration of Orpyx Medical Technologies' SurroSense Rx device--novel smart insole technology for patients with diabetes. The 'living lab' work we are doing with the DON SCN is fundamental in getting our technology on the feet of Albertans so that together we can improve livelihoods, while saving feet and saving lives."

Dr. Breanne Everett, CEO Orpyx Medical Technologies Inc.; DON SCN Partner and Broader Network Member

Alberta Health: We are collaborating with Alberta Health to build obesity management service capacity in Alberta communities through physician Alternative Relationship Plans and to improve diabetic foot care through changes to the Alberta Aids to Daily Living benefits program. We also continue to provide support and advice on the use of Insulin Pump Therapy as new information emerges.

"The incidence of diabetes and obesity in Alberta continues to grow at alarming rates and the Diabetes, Obesity, and Nutrition Strategic Clinical Network (DON SCN) strives to improve the health and well-being of individual Albertans who are living with, and managing these chronic diseases. It is a privilege to be a member of the DON SCN Core Committee and to work with this group of insightful, resourceful, and experienced experts who are driving the activities required to transform clinical practice and improve health outcomes and healthcare service delivery, guided by evidence."

Patricia Martz, Alberta Health, Diabetes, Obesity and Nutrition SCN Core Committee Member
Academia: We are collaborating with the University of Alberta on the development of a provincial diabetes registry (Enhanced Diabetes Surveillance and Research Infrastructure Project). We will also continue to support research studies through seed grants and letters of support that advance knowledge and understanding in our three fields of interest.

Other AHS Programs/Departments: Partners including Food & Nutrition Services and Pharmacy Services have been critical to the success of our Hospital Glycemic Management initiative. The Provincial Bariatric Resource Team is a key partner in the development of the Hospital Bariatric Friendly Standards. We are also interested in continuing to build relationships with the Population, Public & Indigenous Health and Primary Health Care portfolios to assist in future work at the primary and population health levels.

National Organizations: We continue to work with Diabetes Canada and Wounds Canada to spread use of the Diabetic Foot Care Pathway and supporting educational tools across Canada. The provincial Inpatient Diabetes Management initiative will inform the 2018 update of the Canadian Diabetes Clinical Practice Guidelines and colleagues from across Canada have been referring to the Basal Bolus Insulin Therapy website. We are also involving the Canadian Obesity Network as a partner on the Bariatric Friendly hospital care initiative, with the hope of eventually spreading the learnings and products of this initiative nationally.

With our partners, we will continue to conduct research, monitor progress, and explore innovative ways to inform and implement best practices related to diabetes, obesity, and nutrition across the province, country, and ultimately around the world.
How will we know we are successful?

Inpatient Management of Diabetes
- Increase the number of patients with blood sugars in recommended target range.
- Increase the percentage of basal bolus insulin therapy being ordered for patients requiring subcutaneous insulin.
- Decrease the length of stay for patients requiring insulin.

Community Diabetic Foot Care Clinical Pathway
- Increase in capacity for diabetes foot care which will show:
  - increased rates of timely foot assessment in patients with diabetes,
  - decreased prevalence of diabetes foot ulcers,
  - decreased prevalence of lower leg amputations, and
  - reduced referral to urgent care centres.
- Better alignment with Health Benefits Program (AB Aids to Daily Living).

Malnutrition in the community
- An enhanced understanding of seniors’ experience with malnutrition, including perceived barriers to healthy eating and supports needed to improve their nutrition status.
- Development of effective, patient-centered guidelines for identification and treatment of malnutrition as patient’s transition between care environments or after discharge from hospital.

Models of Care for Obesity
- We will develop guidelines for Alternative Relationship Plans for physicians and multidisciplinary teams to more appropriately and effectively support patients with obesity in the community.

Bariatric Friendly Care Hospital Project
- Patients with obesity will feel respected and treated as partners in their health care.
- There will be fewer injuries among hospital staff attributed to patient lifts/transfer.
- Patient with obesity will experience reduced lengths of hospital stay due to more appropriate care practices.
Communication and Engagement

Communication and Engagement are essential for the success of this network. We will continue to engage with patients, families, researchers, AHS clinicians, and partners external to AHS such as primary health care providers, government, not-for-profit associations, communities, industry, and academia. Some of our achievements and ongoing activities are listed below:

- Surveyed 2000 hospital patients with diabetes on their experience
- Core Committee, Project Steering and Working Groups formed
- Surveyed 1200 network members about their work and interests in the DON SCN
- Surveying healthcare workers on their experience in caring for patients with obesity
- Championed crowd sourcing platform from AB IHE to generate ideas for healthcare improvement
- Created Insulin Pump in-Hospital Therapy (ipumpit) website
- Created DON SCN website
- Developed tools/resources to support diabetic foot care for patients & providers
- Developed Basal Bolus Insulin Therapy website (bbit.ca) for providers
- Fact sheets created and disseminated
- Produced a quarterly SCN newsletter
- Created Insulin Pump in-Hospital Therapy (ipumpit) website
- Created DON SCN website
- Developed tools/resources to support diabetic foot care for patients & providers
- Developed Basal Bolus Insulin Therapy website (bbit.ca) for providers
- Fact sheets created and disseminated
- Produced a quarterly SCN newsletter
Conclusion

By focusing on prevention, patient and provider empowerment, and system transformation,

the DON SCN believes the strategies in this Transformational Roadmap will put Alberta in a leadership position within Canada in the areas of diabetes, obesity, and nutrition. We look forward to working together with our network partners to meet the challenges and opportunities ahead.
## Glossary

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<thead>
<tr>
<th>Term</th>
<th>Description</th>
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<tr>
<td>3 for 150</td>
<td>An online crowdsourcing interface that allows users to propose, respond to and combine ideas, stimulate and exchange information, and make decisions. The 3 refers to the categories of play, walk and eat while the 150 refers to Canada’s 150th birthday.</td>
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<tr>
<td>Accelerating Innovations into CarE (AICE)</td>
<td>A program provides funding support to generate real-world evidence in a clinical setting for new technologies developed by SME innovators that have the potential to address priority needs of Alberta’s health system</td>
</tr>
<tr>
<td>Alberta Aids to Daily Living</td>
<td>AADL provides funding for Albertans basic medical equipment and supplies to meet clinically assessed needs</td>
</tr>
<tr>
<td>Enhanced Diabetes Surveillance and Research Infrastructure (EDSRI) Project</td>
<td>A joint effort between AHS and the Alliance for Canadian Health Outcomes Research in Diabetes to integrate existing diabetes data sources, and introduce a new data collection mechanism.</td>
</tr>
<tr>
<td>Alberta Innovates, formerly Alberta Innovates Health Solutions (AIHS)</td>
<td>Provincialy-funded Corporation tasked with delivering on the research and innovation priorities of the Government of Alberta</td>
</tr>
<tr>
<td>Alternative Relationship Plans</td>
<td>Is an AB Health program that develops compensation strategies to remunerate physicians for providing defined program services.</td>
</tr>
<tr>
<td>Basal Bolus Insulin Therapy (BBIT)</td>
<td>BBIT is a way of ordering multiple daily injections of subcutaneous insulin that better replicates how our body naturally produces insulin. It is an alternative approach to sliding scale insulin orders</td>
</tr>
<tr>
<td>Change management</td>
<td>The controlled identification and implementation of required changes within a system.</td>
</tr>
<tr>
<td>Continuing care</td>
<td>Is a system that provides AB with the health, personal care and accommodation services they need to support their independence and quality of life. Occurs in 3 settings: home living, supportive living and facility living.</td>
</tr>
<tr>
<td>Diabetic Foot Care Clinical Pathway (DFCCP)</td>
<td>A clinical pathway to help guide and standardize care for diabetic foot ulcers. The goal of the pathway is to improve early detection and treatment of diabetic foot problems, thereby reducing the need for amputations.</td>
</tr>
<tr>
<td>Enhanced Recovery After Surgery</td>
<td>An international program aimed at improving patient’s recovery time after surgery, reducing complications and decreasing hospital length of stay. ERAS provides researched and tested protocols on what works best for improving patient recovery such as enhanced nutrition and getting patients mobile more quickly after surgery as well as electronic tools to ensure it happens every time, with every patient.</td>
</tr>
<tr>
<td><strong>Equitable/equity/equitable access</strong></td>
<td>Every Albertan must have equal access to health care, based primarily on medical need, no matter who they are, what they do or where they live.</td>
</tr>
<tr>
<td><strong>Foot pressure mapping</strong></td>
<td>A system that uses sensors to measure and analyze pressure distribution on a person's foot for research and product development</td>
</tr>
<tr>
<td><strong>Glycemic Management</strong></td>
<td>Regulation and maintenance blood glucose levels within normal ranges.</td>
</tr>
<tr>
<td><strong>HbA1Cs</strong></td>
<td>Hemoglobin A1C – a form of hemoglobin that is used to measure blood glucose control over a three month period.</td>
</tr>
<tr>
<td><strong>Healthy Eating Environments</strong></td>
<td>Is an AHS level 1 policy that focuses on the establishment of healthy eating environments in AHS as well as the promotion of healthy eating to staff, leaders, physicians, patients, volunteers and visitors</td>
</tr>
<tr>
<td><strong>High Risk Foot Care Teams</strong></td>
<td>A multidisciplinary team of health care professionals with expertise in: diabetic foot assessment and management, wound care and advanced vascular assessment and includes an AADL prescriber for therapeutic and custom foot wear.</td>
</tr>
<tr>
<td><strong>Hyperglycemia</strong></td>
<td>High blood glucose, usually in excess of 10 mmmol/L (for the purposes of the Inpatient Diabetes Management Initiative)</td>
</tr>
<tr>
<td><strong>Idea generation</strong></td>
<td>The process of creating, developing, and communicating ideas which are abstract, concrete, or visual.</td>
</tr>
<tr>
<td><strong>Inpatient Diabetes Management Initiative</strong></td>
<td>A provincial SCN initiative with the goal of improving and standardizing how patients with diabetes are cared for in Alberta’s hospitals.</td>
</tr>
<tr>
<td><strong>Inpatient glycemic control</strong></td>
<td>Achieving blood glucose (sugar) levels that are within the recommended range for patients that are in an acute care facility</td>
</tr>
<tr>
<td><strong>Insulin Pump Therapy Program</strong></td>
<td>This Program funds an insulin pump and supplies for adults and children with Type 1 Diabetes who meet the eligibility criteria developed by AHS. This project helps standardize care for insulin pump therapy and ensure effective, safe and appropriate use for those Albertans who will most benefit from this type of therapy.</td>
</tr>
<tr>
<td><strong>Knowledge Translation</strong></td>
<td>A dynamic and iterative process that includes synthesis, dissemination, exchange and ethically-sound application of knowledge to improve the health of Canadians, provide more effective health services and products and strengthen the health care system.</td>
</tr>
<tr>
<td><strong>Malnutrition</strong></td>
<td>Lack of proper nutrition</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Modifiable risk factors (if suggested wording is used)</td>
<td>Modifiable risk factors are conditions that increase someone’s risk of developing a disease that can be changed</td>
</tr>
<tr>
<td>Partnership for Research and Innovation in the Health System (PRIHS)</td>
<td>Grants awarded to SCNs™ and researchers from Alberta Innovates</td>
</tr>
<tr>
<td>Perioperative</td>
<td>Refers to the three phases of surgery: preoperative, intraoperative, and postoperative</td>
</tr>
<tr>
<td>Quadruple aim</td>
<td>The four aims in the AHS Health Plan which includes improving health of the population, being patient centered, staff centered and reducing costs.</td>
</tr>
<tr>
<td>Quality improvement/QI</td>
<td>A formal approach to the analysis of performance and systematic efforts to improve it.</td>
</tr>
<tr>
<td>Scientific Office</td>
<td>Consists of the Scientific Director and the Assistant Scientific Director of the SCN.</td>
</tr>
<tr>
<td>Strategic Clinical Networks™ (SCNs™)</td>
<td>AHS networks of people who are passionate and knowledgeable about specific areas of health, challenging them to find new and innovative ways of delivering care that will provide better quality, better outcomes and better value for every Albertan</td>
</tr>
<tr>
<td>Strategic domains</td>
<td>The three high-level areas of focus the DON SCN has chosen to focus on for 2017-2021. There strategic domains are:</td>
</tr>
<tr>
<td></td>
<td>• Preventing the Onset &amp; Progression of Diabetes, Obesity, &amp; Malnutrition</td>
</tr>
<tr>
<td></td>
<td>• Empowering Patients &amp; Providers to Better Manage Diabetes, Obesity &amp; Malnutrition to Live Well and Long</td>
</tr>
<tr>
<td></td>
<td>• System Transformation through Research, Surveillance, and Partnerships</td>
</tr>
<tr>
<td>Sugar-sweetened beverages campaign</td>
<td>Efforts to reduce the consumption of sugar sweetened beverages (e.g., pop, high sugar juice) either through removal or taxation</td>
</tr>
<tr>
<td>Surveillance</td>
<td>The ongoing systematic collection, analysis and interpretation of health data, essential to the planning, implementation and evaluation of health practice.</td>
</tr>
<tr>
<td>Telehealth</td>
<td>The provision of healthcare remotely by means of telecommunications technology</td>
</tr>
<tr>
<td>Transformational Roadmap (TRM)</td>
<td>All components of vision, current-state and future-state efforts come together to form an actionable plan to achieve meaningful transformation in healthcare in Alberta.</td>
</tr>
<tr>
<td>Weight bias</td>
<td>Negative attitudes toward a person because he or she is overweight or obese</td>
</tr>
</tbody>
</table>
## Appendix A: Strategic Clinical Network Leadership and Core Committee Members

<table>
<thead>
<tr>
<th><strong>LEADERSHIP TEAM</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Peter Sargious, Dr.</td>
<td>Senior Medical Director</td>
</tr>
<tr>
<td>Petra O’Connell</td>
<td>Senior Provincial Director</td>
</tr>
<tr>
<td>Cathy Chan, PhD</td>
<td>Scientific Director</td>
</tr>
<tr>
<td>Carolanne Nelson, PhD</td>
<td>Executive Director</td>
</tr>
<tr>
<td>Glenda Moore</td>
<td>Clinical Network Manager</td>
</tr>
<tr>
<td>Naomi Popeski, PhD</td>
<td>Assistant Scientific Director</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>CORE COMMITTEE</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Angela Dumoulin</td>
<td>Dietitian, Nutrition &amp; Food Services. Lacombe Hospital &amp; Care Centre, Central Zone</td>
</tr>
<tr>
<td>Angela Ezra</td>
<td>Manager, Red Deer Bariatric Specialty Clinic, Central Zone</td>
</tr>
<tr>
<td>Arya Sharma, Dr.</td>
<td>Professor, Division of Endocrinology, Medical Director of Weight Wise &amp; Scientific Director of CON</td>
</tr>
<tr>
<td>Ashton Michael Fernando</td>
<td>Patient Advisor, Program Director FeelGood Calgary</td>
</tr>
<tr>
<td>Carlota Basualdo-Hammond</td>
<td>Executive Director, Provincial Nutrition Services</td>
</tr>
<tr>
<td>Carol Brzezicki</td>
<td>Manager, Edmonton Zone, Aboriginal Health Program</td>
</tr>
<tr>
<td>Cheryl Andres</td>
<td>Chief Zone Officer, South Zone</td>
</tr>
<tr>
<td>Chris Barnsdale, Dr.</td>
<td>Family Physician, Sundre</td>
</tr>
<tr>
<td>Cyrene Banerjee</td>
<td>Patient Advisor, Patient and Community Engagement Research (PACER)</td>
</tr>
<tr>
<td>Daniel Van Schalkwyk, Dr.</td>
<td>Family Physician, Whitecourt</td>
</tr>
<tr>
<td>Name</td>
<td>Position/Institution</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>----------------------------------------------------------</td>
</tr>
<tr>
<td>Daniele Pacaud, Dr.</td>
<td>Endocrinology &amp; Metabolism, Alberta Children’s Hospital</td>
</tr>
<tr>
<td>Isabelle Emery</td>
<td>Patient Advisor</td>
</tr>
<tr>
<td>Jackie Morissette</td>
<td>Director Allied Health, Ambulatory Care, QEII Hospital</td>
</tr>
<tr>
<td>Jane Ballantine, Dr.</td>
<td>Family Physician &amp; Medical Director, Calgary West Central Primary Care Network</td>
</tr>
<tr>
<td>Julie McKeen, Dr.</td>
<td>Physician, Endocrinology &amp; Metabolism, Internal Medicine, Calgary Zone</td>
</tr>
<tr>
<td>Karen Johnston</td>
<td>Nurse Practitioner, Pediatric Diabetes Education Centre</td>
</tr>
<tr>
<td>Laura McLeod, Dr.</td>
<td>Medical Officer of Health, Population, Public and Aboriginal Health</td>
</tr>
<tr>
<td>Laura Tkach</td>
<td>Interim Senior Operating Officer, Nutrition, Food, Linen &amp; Environmental Services</td>
</tr>
<tr>
<td>Leah Gramlich, Dr.</td>
<td>Professor of Medicine, Gastroenterology, Royal Alexandra Hospital; Provincial Medical Advisor, Nutrition – AHS</td>
</tr>
<tr>
<td>Mary Jetha, Dr.</td>
<td>Assistant Professor, Pediatric Endocrinologist – University Alberta Hospital</td>
</tr>
<tr>
<td>Mary Jo Harland-Gregoire</td>
<td>Manager, Nutrition &amp; Food Services, Covenant Health</td>
</tr>
<tr>
<td>Melanie Snider</td>
<td>Nurse Practitioner, Home Care, Brooks, South Zone</td>
</tr>
<tr>
<td>Patricia Martz</td>
<td>Manager, Wellness, Equity and Literacy, Primary Prevention and Wellness Unit Health, Alberta Health</td>
</tr>
<tr>
<td>Peter Senior, Dr.</td>
<td>Professor and Division Director; Endocrinology, Division of Clinical Sciences</td>
</tr>
<tr>
<td>Rena LaFrance, Dr.</td>
<td>Physician - Stollery Children's Mental Health</td>
</tr>
<tr>
<td>Sara Jordan</td>
<td>Executive Director, Population, Public &amp; Aboriginal Health</td>
</tr>
<tr>
<td>Scott McRae</td>
<td>Regional Director, Alberta/Northwest Territories, Canadian Diabetes Association</td>
</tr>
<tr>
<td>Rose Yeung, Dr.</td>
<td>Physician – Medicine &amp; Assistant Professor - Endocrinology, Division of Clinical Sciences</td>
</tr>
<tr>
<td>Name</td>
<td>Position</td>
</tr>
<tr>
<td>-----------------------</td>
<td>------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Tammy McNab, Dr.</td>
<td>Physician - Endocrinology &amp; Metabolism, Internal Medicine &amp; Associate Professor - Endocrinology, Division of Clinical Sciences</td>
</tr>
<tr>
<td>Wendy McLean</td>
<td>Executive Director, North Zone Primary Care, CDM &amp; Family Health</td>
</tr>
</tbody>
</table>

**Support Members (Non-voting)**

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Edwin Rogers</td>
<td>Senior Analyst, Clinical Analytics, D.I.M.R.</td>
</tr>
<tr>
<td>Jennifer Green</td>
<td>Senior Communications Advisor, Communications</td>
</tr>
<tr>
<td>Jessica Lamb</td>
<td>Senior Consultant, Engagement &amp; Patient Experience</td>
</tr>
<tr>
<td>Kathy Dmytruk</td>
<td>Senior Advisor</td>
</tr>
<tr>
<td>Linda Juse</td>
<td>Senior Practice Consultant, Health Professions Strategy and Practice</td>
</tr>
<tr>
<td>Rhonda Roedler</td>
<td>Clinical Practice Leader, Pharmacy</td>
</tr>
<tr>
<td>Richard Wallington</td>
<td>Senior Consultant</td>
</tr>
<tr>
<td>Sue Yi-Austin</td>
<td>Business Relationship Partner, Information Technology</td>
</tr>
<tr>
<td>Susan Sobey</td>
<td>Senior Planner, Planning &amp; Performance</td>
</tr>
<tr>
<td>Ted Pfister</td>
<td>Health Technology Assessment Analyst, Health Technology Assessment and Adoption</td>
</tr>
</tbody>
</table>
Appendix B: Community Diabetic Foot Care Clinical Pathway Infographic

Why Now?

- 288,000+ Albertans have Diabetes
- 7,000+ present with a Foot Ulcer each year
- Lack of Coordinated care
- No Provincial Standards

What Are We Doing?

- Foot Risk Assessment Form
- Triage referral form
- Referral/Followup Algorithm
- Patient Self Management Guide
- Health Provider Guide + Video

How Are We Doing It?

- Province-wide Rollout Strategy
- Standardized Diabetic Foot Care

Expected Outcomes

- Community based HIGH RISK FOOT TEAM
- More knowledgeable and better supported HEALTH CARE PROVIDERS
- Patients as proactive partners in the care of their feet
- Decreased Wait Times
- Increased patient safety
- Increased patient quality of life
- Decreased emergency visits and hospital admissions
- Prevention of Ulcers

Provincial Goal: Standardized Diabetic Foot Care

- Significant Annual Increase in lower limb amputations
- 819 in 2017/18
- 560+ Million Annually
- 85% Preventable
Appendix C: Diabetes Inpatient Management Infographic

1 in 5 has diabetes.

In Alberta hospitals, patients with diabetes are hyperglycemic 1/3 of the time.

 Patients with diabetes spend on average 5 days in hospital compared to 3 days for non-diabetic patients.

In-hospital blood sugar target range 5–10 mmol/L.

Supporting patients to maintain their blood sugar targets.

Expected outcomes:
- More satisfied patients
- Reduced rates of hyperglycemia and hypoglycemia in hospital
- Fewer medical complications and infections
- Smoother transitions – community to hospital, hospital to community
- Shorter length of hospital stay

1/2 bed day saved per patient could result in 22,000+ days returned to the system per year.
Appendix D: Seed Grant Recipients

Below is the list of awardees of our Seed Grant, which was launched in 2016. This initiative provides awards of $10000 to research projects in the area of diabetes, obesity or nutrition.

2016

*Preterm infants risk of overweight at three years of age, after controlling for important determinants* (Dr. Tanis Fenton, University of Calgary)

*Improving the accuracy of measuring oral food and fluid intake of adult patients in acute care.* (Melani Gillam, Alberta Health Services)

*The link between gestational diabetes and perinatal depression: the role of nutrient status.* (Dr. Brenda Leung, University of Lethbridge)

*Care guide for patients with high risk diabetes-development of a novel intervention.* (Dr. Kerri McBrien, University of Calgary)

*Weight bias research: moving beyond raising awareness and creating change!* (Dr. Arya Sharma, University of Alberta)

*Breaking the cycle: understanding diabetes in pregnancy in aboriginal women* (Dr. Ellen Toth, University of Alberta)

2017

*Internalized weight bias retraining* (Dr. Tanya Berry and Dr. Geoff Ball, University of Alberta)

*Metabolomics profiling of metabolic function in pregnant women: assessing an innovation for precision medicine* (Dr. Brenda Leung and Dr. Nicole Letourneau)

*Working Together to Improve Diabetes and Cardiovascular Health* (Dr. Sonia Butalia and Dr. Maria Santana, University of Calgary)

*Beyond Body Mass Index: Sarcopenia Screening and Risk Assessment in Patients with Osteoarthritis and Obesity* (Dr. Mary Forhan and Dr. Carla Prado)

*Building Partnerships to Improve Care for Obese Patients with Osteoarthritis* (Dr. Deborah Marshall, Petra O’Connell, and Dr. Behnam Sharif)
References


Overweight and Obesity in Adult Albertans: A Role for Primary Health Care” (2014) Health Quality Council of Alberta.