DIABETES SERVICE DIRECTORY

2004 Edition

Prepared by:

COLLEEN RAND RD, CDE
Diabetes Program Specialist

Winnipeg Regional Health Authority
2nd Floor, 490 Hargrave St.
Winnipeg, MB. R3A 0X7
Phone: 940-3648
Fax: 957-0884
E-mail: crand@wrha.mb.ca

October, 2004

Diabetes Education Sites in the Winnipeg Health Region

Note: The Safeway Health Promotion Program and Walmart Diabetes Program are offered at retail sites throughout the Winnipeg Health Region

Map prepared by: Population Health and Health Systems Analysis, WRHA

Diabetes Education Sites, October 2004

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WRHA DIABETES EDUCATION REGISTRY

Name of Program/Organization: **ABORIGINAL HEALTH AND WELLNESS CENTRE**

Contact Information:

Name: Dr. Barry Lavallee, Evelyn Allen
Address: Room 215, 181 Higgins Ave., Winnipeg R3B 3G1
Phone: (204) 925-3700
Fax: (204) 925-3709
E-mail: eallen@ahwc.ca
Web site:

Catchment Area (postal codes): All urban Aboriginal people

Service Charges:

☒ none ☐ fee for service

Description of Service: Health professionals work collaboratively to provide full primary care services for screening, diagnosis, medical management and education to enhance self-management regarding diabetes.

Traditional Healer: provides holistic, traditional care to those with diabetes in the areas of doctoring (including medicines), ceremonies, spiritual advice and counseling.

Referral Process:

☒ Self-referral
☒ Health care referral
☒ MD

Primary Prevention Activities: All people who attend Aboriginal Health and Wellness Centre Clinic on a regular basis are screened for diabetes regardless of the reason for attending. All programs offered at Aboriginal Health and Wellness Centre Clinic encourage healthy active living as prevention to chronic disease, specifically diabetes.

Care/Treatment Services (on-site)

	MD	RN	Traditional Healer	Mental Health/SW
Type 1	x	x	x	x
Type 2	x	x	x	x
Gestational Diabetes	x	x	x	x

* Referrals for RD services are made to other community agencies.

Brief Description of Care/Treatment Activities: Full primary care services are provided for screening, diagnosis, and medical management. Clients are referred to the nurses for education regarding diabetes self-management. There is no dietitian on site.

Secondary Prevention Activities: Complications of diabetes are monitored and treated as appropriate.

Education Services: Diabetes Sharing Circle (6 educational and peer support sessions) offered twice a year, in spring and fall, for persons with type 2 diabetes and their families.

	Individual	Group	New	Follow-up
Type 1				
Type 2	x		x	x
GDM	x		x	x

WRHA DIABETES EDUCATION REGISTRY

Name of Program/Organization: **AIKINS STREET COMMUNITY HEALTH CENTRE**

Contact Information:

Name: Beverly McKee
Address: 601 Aikins Street, Winnipeg R2W 4J5
Phone: (204) 940-2093
Fax: (204) 940-2069
E-mail:
Web site:

Catchment Area (postal codes): Point Douglas

Service Charges:

☒ none ☐ fee for service

Description of Service: The Aikins Street Community Health Centre provides comprehensive health services including public health, primary care and community mental health services.

Referral Process:

☒ Self-referral
☒ Health care referral
☒ MD

Primary Prevention Activities: Diabetes Medicine Bags are available and used for with young children and families. Blood glucose screening.

Care/Treatment Services (on-site)

	MD	RN Nurse Practitioner	RD	Mental Health/SW
Type 1	x	x		x
Type 2	x	x		x
Gestational Diabetes	x	x		x

Brief Description of Care/Treatment Activities: Any person who receives primary care services from the physicians at Aikins Street Community Health Centre will also have diabetes education services available to them from a nurse on staff. Clients, who require basic education about diabetes such as, blood glucose monitoring, basic nutrition or medication administration (including insulin) can have appointments with the nurses for this teaching.

Secondary Prevention Activities Complication Risk Factor Assessment screening and monitoring is conducted as part of each primary care visit. Referrals are made for dilated eye exams.

Education Services:

	Individual	Group	New	Follow-up
Type 1	x		x	x
Type 2	x		x	x
GDM	x		x	Mainly post partum x

WRHA DIABETES EDUCATION REGISTRY

Name of Program/Organization: **CANADIAN DIABETES ASSOCIATION**

Contact Information:
Name: Diabetes Information and Support Centre
Address: 102-310 Broadway, Winnipeg, R3C 0S6
Phone: (204) 925-3800 (Winnipeg) or 1-800-BANTING (226-8464)
Fax: (204) 949-0266
E-mail: arlene.hintsa@diabetes.ca
Web site: www.diabetes.ca

Catchment Area (postal codes): Manitoba

Service Charges:

☒ none ☐ fee for service

Description of Service:

The Canadian Diabetes Association offers: a toll-free information line that provides access to knowledgeable staff who can help with support/information/referrals; an award-winning web site; printed resources and information packages on diabetes prevention and management; books and videos for reference and loan; education events such as ANSWERS: A Diabetes Forum and Coffee with the Experts; public awareness displays; Steps 4 Health walking program and resource guide; Speakers Bureau of trained speakers who present a suite of diabetes presentations to community groups and worksites in both Aboriginal and non Aboriginal cultures; school puppetry program; children's camps; an advocacy committee (regional) and National Advocacy Council to improve the lives of people affected by diabetes; travel health insurance and credit life insurance; publications such as *Diabetes Dialogue*; cookbooks (reference and for sale) and other resources. The Association funds Canadian diabetes research through Charles H. Best Fund.

Referral Process:

☒ Self-referral
☒ Health care referral
☒ MD

Primary Prevention Activities:

The Association incorporates the diabetes prevention message into all education and public awareness activities. It also partners with several organizations to offer free presentations to the public throughout the year on Preventing type 2 Diabetes.

Brief Description of Care/Treatment Activities: No care provided.

Secondary Prevention Activities No screening or monitoring undertaken. Suite of presentations includes Seriousness of Diabetes and Living Well with Diabetes which stress prevention of complications.

Education Services:

Education consists of general diabetes education for groups through the suite of presentations (Signature Program). The Association meets individual needs by mailing out specific information (printed resources) as requested by callers. Bi-annual ANSWERS: A Diabetes Forum is a one-day educational event that provides answers to people's questions through education sessions, access to diabetes resources (experts such as diabetes educators, information on diabetes products and services) to empower and enable participants to take active steps in managing their health.

Support Activities:

Description: The Association provides empathetic and supportive staff to those who call the Diabetes Information and Support Centre. They are specially trained to listen to callers' concerns, identify needs, refer to organizations and services if necessary, and mail out information. These staff also have access to broader resources, both within the Association and outside.

Referrals to Other Programs/Organizations/Agencies:
The Association ensures, wherever possible, that those recently diagnosed and those who have lived with diabetes for years have access to a diabetes education program for education and follow up. Staff will help individuals get appointments as required.

Priorities for Future Programs and Services: ANSWERS: A Diabetes Forum will continue to be held every two years. Space has already been booked for 2005, 2007 and 2009. The Manitoba/Nunavut regional office is also planning to have a presence in Nunavut. Ongoing advocacy work with the provincial government is planned to help improve the lives of those living with the disease.

Mission: "To promote the health of Canadians through diabetes research, education, services and advocacy."

Vision: "By 2005, the Canadian Diabetes Association will be pivotal in preventing the onset and reducing the burden of diabetes in Canada and will be publicly recognized for it s role.

Our network of members, volunteers, health care professionals, partners and staff will interact with every community, achieving quality relationships with two million of the people in Canada affected by diabetes."

WRHA DIABETES EDUCATION REGISTRY

Name of Program/Organization: **CENTRE DE SANTÉ SAINT-BONIFACE HEALTH CENTRE**

Contact Information:
Name: Lucille Cenerini, RD, Diane Buissé, RN
Address: 409 Taché Avenue, Winnipeg
Phone: (204) 235-3910
Fax: (204) 237-9057
E-mail: lcenerini@centredesante.mb.ca, dbuisse@centredesante.mb.ca
Web site: www.centredesante.mb.ca

Catchment Area (postal codes): the residents of St. Boniface (R2H, R2J, R3X) and the French- speaking population of Winnipeg

Service Charges
☒ none ☐ fee for service

Description of Service: The Centre de Santé is a francophone community health centre offering bilingual primary health services to the French-speaking population of Winnipeg and to the residents of St-Boniface. Our goal is to work with individuals, families and communities to maintain or improve their health and well-being. At the Centre you can access a wide range of health services including:

- basic medical services;
- nursing services;
- nutritional services;
- psychosocial/mental health services; and
- community development facilitation.

Through a community development approach, we work closely with the community to develop and offer health education, illness and injury prevention as well as health promotion initiatives.

Referral Process:
☒ Self-referral
☒ Health care referral
☒ MD

Primary Prevention Activities: 1.) One-to-one basis ~ Clients may schedule a visit at Centre de Santé with the primary health nurse, the social worker, the mental health counselor or the nutritionist to focus on healthy lifestyle choices. To make health care more accessible for seniors, Centre de Santé has established two satellite offices in seniors' residences in Saint-Boniface. Clients from the blocks and surrounding areas can access basic medical care (as provided by nurses), nutrition and lifestyle counseling, and psychosocial/mental health services. Clients can meet health professionals individually to focus on health promotion, disease and injury prevention or health education.

2.) Health promotion sessions ~ Monthly health promotion sessions have been facilitated in collaboration with seniors in Saint-Boniface. Health promotion, disease and injury prevention and health education are the focus of these sessions. Example of topics include: foot care, stress management, nutritional health and diabetes screening clinics, etc.)
3.) Monthly blood pressure clinic ~ A health promotion program including a monthly blood pressure clinic has been developed by seniors in collaboration with the Centre de Santé.

Care/Treatment Services (on-site)

	MD*	RN	RD	Mental Health/SW
Type 1	x	generally referred to Youville DER	generally referred to Youville DER	x
Type 2	x	x	x	x
Gestational Diabetes	x	generally referred to Youville DER	generally referred to Youville DER	x

* Physicians are not currently accepting new clients. If clients already see physicians at Centre de Santé, diagnosis and management of diabetes is provided.

Secondary Prevention Activities Primary health nurses play a major role in providing health care maintenance to assist clients in managing medical conditions such as diabetes and high blood pressure. Clients are encouraged to schedule visits with nurses for a follow-up (re: blood pressure for instance) as well as health education. The nurses work closely with other professionals to refer clients to the most appropriate resource when necessary.
Blood pressure monitoring is offered by a primary health nurse at a monthly blood pressure clinic in seniors' blocks.

Education Services:

	Individual	Group	New	Follow-up
Type 1	x		generally referred to Youville DER	x
Type 2	x		x	x
GDM	x		generally referred to Youville DER	x

WRHA DIABETES EDUCATION REGISTRY

Name of Program/Organization: **DIABETES EDUCATION CENTRE (DEC)**
Health Sciences Centre

Contact Information:
Name: Nancy Edmondson RN, Unit Manager Ambulatory Care
Beverly Stephenson - Clerk
Address: GA 248-820 Sherbrook St. Winnipeg R3A 1R9
Phone: (204) 787-7852
Fax: (204) 787-3786
E-mail: bstephenson@hsc.mb.ca
Web site: www.hsc.mb.ca/placecard25.htm

Catchment Area (postal codes): Manitoba

Service Charges:

☒ none ☐ fee for service

Description of Service: At the DEC, nurses and dietitians provide comprehensive diabetes education services to all those referred by a physician.

Referral Process:
☐ Self-referral
☐ Health care referral
☒ MD
Primary Prevention Activities:

Care/Treatment Services (on-site)

<table>
<tr><th></th><th>MD</th><th>RN</th><th>RD</th><th>Mental Health/SW</th></tr>
<tr><td>Type 1</td><td>x</td><td>x</td><td>x</td><td rowspan="3">Referral</td></tr>
<tr><td>Type 2</td><td>x</td><td>x</td><td>x</td></tr>
<tr><td>Gestational Diabetes</td><td>x</td><td>x</td><td>x</td></tr>
</table>

Brief Description of Care/Treatment Activities: Many of the clients attending the DEC are referred by the HSC Endocrinologists. They work closely with these physicians to develop diabetes care plans and to provide the information necessary for people to manage their own diabetes. Community physicians may also refer to the DEC.
DEC staff receives consults from the nurses on the ward and also provides diabetes education for in-patients. Wait times are as follows:
New type 2 classes at Wellness Institute: 2-3 weeks
Seniors or complicated cases requiring 1:1: 4 weeks
Gestational Diabetes: 2 days
Insulin Starts: 2 days

Secondary Prevention Activities
Access and referral to Lipid Clinic and Hypertension Clinic.
Referrals to Renal Clinic.

Education Services: All services available at HSC, groups are offered at the Wellness Institute at Seven Oaks Hospital.

	Individual	Group	New	Follow-up
Type 1	x	x	x	x
Type 2	x	x	x	x
GDM	x	x	x	x

WRHA DIABETES EDUCATION REGISTRY

Name of Program/Organization: **DIABETES EDUCATION RESOURCE FOR CHILDREN AND ADOLESCENTS**

Contact Information:
Name: Dr. Heather Dean, Director
Address: FE037-685 William Ave. Winnipeg, R3E 0Z2
Phone: (204) 787-3011
Fax: (204) 787-1655
E-mail: rpadua@hsc.mb.ca
Web site:

Catchment Area (postal codes): Manitoba, Northwestern Ontario, Eastern Saskatchewan

Service Charges:
☒ none ☐ fee for service

Description of Service: The DER-CA a specialized regional pediatric program for central Canada, that has national DES-CDA recognition, provides comprehensive medical care and diabetes education for children / adolescents with Type 1 and Type 2 diabetes and their families.

Referral Process:
☒ Self-referral
☒ Health care referral
☒ MD

Primary Prevention Activities: Type 2 Outreach semi-annually to Aboriginal communities to provide on-site Clinics, support and education for families, nursing station staff, schools, and community (grocery tours, local TV/radio, health fairs), smoking cessation and lifestyle change.

Care/Treatment Services (on-site)

	MD	RN	RD	Mental Health/SW
Type 1	x	x	x	x
Type 2	x	x	x	x
Gestational Diabetes	Referred to Adult Service			

Brief Description of Care/Treatment Activities: 1.) Two pediatric endocrinologists and a pediatrician associate provide 4 follow-up clinics per week. A diabetes education team of two nurses, two dietitians and a social worker provide diabetes education and counseling. 2.) All children with new onset type 1 diabetes living in Winnipeg are seen at the DER-CA on the same day as referral. Initial education requires 2-3 days of comprehensive education, support and initiation of insulin. Children with type 2 diabetes are seen at the next weekly type 2 diabetes clinic. 3.) The DER-CA team works hard to coordinate all activities regarding education, care and support of families with the primary care physician and community allied health personnel.

Secondary Prevention Activities:
Type 1: Glycosylated hemoglobin (A_1C) height, weight, blood pressure, every 3-4 months; urine albumin creatinine ratio is done every 4 months after age 12 years; thyroid stimulating hormone (TSH) every 2 years; referral for annual dilated eye exam at age 15 years; lipid profile done on a selective basis. Smoking prevention/cessation, sexual health and alcohol use also discussed with those >12 years of age at all clinic visits (every 3-4 months).
Type 2: Glycosylated hemoglobin (A_1C) neuropathy and foot examination, height, weight, blood pressure, urine albumin/creatinine, lipid profile every 3-4 months; referral for dilated eye exam on annual basis. Smoking prevention/cessation, sexual health and alcohol use also discussed with those >12 years of age at all clinic visits (every 3-4 months)

Education Services:

	Individual	Group	New	Follow-up
Type 1	x	limited	x	x
Type 2	x	limited	x	x

Education / Support Activities: Rural Outreach Program, Family Workshops, Research Day, Annual Teachers' Inservice, School /Day Care / Camp Presentations, Camp Briardale /Camp Koda training and involvement, Institutional/ Home Visits, Pre-School Parent Support Group, Newsletter, Health Professional Education
Description: All activities focus on the five components of the Manitoba Diabetes Strategy (1998): Prevention, Education, Care, Support and Research

WRHA DIABETES EDUCATION REGISTRY

Name of Program/Organization: **DIABETES RESEARCH GROUP**

Contact Information:

Name: Lori Berard
Address: HSC University of Manitoba Campus
838-715 McDermot Ave. Winnipeg, MB. R3E 3P4
Phone: 789-3433
Fax: 789-3988
E-mail: lberard@hsc.mb.ca
Web site:

Catchment Area (postal codes): All

Service Charges:

☒ none ☐ fee for service

Description of Service:
- Clinical Research program for diabetes and related disorders/complications.
- Adult and pediatric
- Provide ongoing assessment and education as well as cutting edge research

Referral Process:

☒ Self-referral
☒ Health care referral
☒ MD

Primary Prevention Activities: Type 2 diabetes, Type 1 diabetes, Cardiovascular disease, Retinopathy, Nephropathy

Care/Treatment Services (on-site)

	MD	RN	RD	Mental Health/SW
Type 1	x	x	x	
Type 2	x	x	x	
Gestational Diabetes				

Brief Description of Care/Treatment Activities:
The Diabetes Research Group is involved in multiple research initiatives for prevention and new treatment of type 1 and type 2 diabetes and their complications

Secondary Prevention Activities
As indicated – communication with primary educators as well as primary care physicians.

Education Services:

	Individual	Group	New	Follow-up
Type 1	x		x	
Type 2	x		x	
GDM				

Education only available for participants in research program.

WRHA DIABETES EDUCATION REGISTRY

Name of Program/Organization: **FAMILY MEDICAL CENTRE**

Contact Information:
Name: Peggy Murphy RD, MED / Joanne Parker RN, CNS, MScN
Address: 5th Floor - 400 Taché, Winnipeg, R2H 3E1
Phone: (204) 237-2863
Fax: (204) 231-2648
E-mail: pmurphy@cc.umanitoba.ca / jparker@SBGH.mb.ca
Web site:

Catchment Area (postal codes): No specific area – serve both urban and rural Manitoba

Service Charges:

☒ none ☐ fee for service

Description of Service: Family Medical Centre provides comprehensive health services throughout the lifespan. Interdisciplinary diabetes care is provided within a Family Medicine residency program. The team consists of primary care physicians, family medicine residents, a clinical nurse specialist, nurse practitioners, registered dietitian and a social worker. Individual education is provided currently. Diabetes group education is offered.

Referral Process:

☐ Self-referral
☐ Health care referral
☒ MD * **Only those people who are followed by the physicians at FMC are eligible for education services from health professional staff.**

Primary Prevention Activities:

Care/Treatment Services (on-site)

	MD	RN	RD	Mental Health/SW
Type 1	x	x	x	x
Type 2	x	x	x	x
Gestational Diabetes	x	x	x	x

Brief Description of Care/Treatment Activities: The Primary Care Team provides screening, detection and monitoring of diabetes. The nurse provides information and education for all aspects of self-care including insulin management. The dietitian assists in the nutritional management through education and counseling.

Secondary Prevention Activities Complications are monitored by the Diabetes Health Care Team and referrals are made to specialists (i.e. ophthalmologists, podiatrist etc.) as appropriate.

Education Services:

	Individual	Group	New	Follow-up
Type 1	x		Generally refer to St.B. GH Endocrinology	x
Type 2	x	x	x	x
GDM	x		x	x

WRHA DIABETES EDUCATION REGISTRY

Name of Program/Organization: **HEALTH ACTION CENTRE**

Contact Information:
Name: Sheelagh Smith RD, CDE
Address: 425 Elgin Ave. Winnipeg, R3A 1P2
Phone: (204) 940-1626
Fax: (204) 942-7828
E-mail: healthac@mb.sympatico.ca, ssmith2@wrha.mb.ca
Web site:

Catchment Area (postal codes): Downtown area B – R3A, R3B, R3C, R3E
Service Charges:

☒ none ☐ fee for service

Description of Service: Health Action Centre (HAC) provides primary care and health education for residents in the downtown area. The HAC utilizes the multi-disciplinary health care team of physicians, nurses, dietitians, social workers, and outreach workers to address all aspects of heath in their population.

Referral Process:

☒ Self-referral
☒ Health care referral
☒ MD

Primary Prevention Activities:
Care/Treatment Services (on-site):

	MD	RN*	RD	Mental Health/SW
Type 1	x	x	x	
Type 2	x	x	x	
Gestational Diabetes	x	x	x	

Brief Description of Care/Treatment Activities: Primary Care physicians at HAC provide medical management for clients with diabetes. Individual appointments with the dietitian for diabetes education can be arranged through the front desk.

Secondary Prevention Activities Primary care physicians provide the screening and surveillance of diabetes complications. Through health services for the elderly, limited nursing service is available for foot care.

Education Services:

	Individual	Group	New	Follow-up
Type 1	x		x	x
Type 2	x		x	x
GDM	x		x	x

WRHA DIABETES EDUCATION REGISTRY

Name of Program/Organization: **HOPE CENTRE HEALTH CARE INC.**

Contact Information:
Name: Eleanor Martens, RN, BN clinic coordinator
Address: 240 Powers St. Winnipeg, R2W 5L1
Phone: (204) 589-8354
Fax: (204) 586-4260
E-mail: emhopece@mts.net
Web site:

Catchment Area (postal codes): Point Douglas (R2W)

Service Charges:
☒ none ☐ fee for service

Description of Service: Hope Centre Health Care is a community health agency that provides a wide scope of health care services. Staff at Hope Centre includes primary care physicians, nurses, counselors, out-reach workers. All aspects of health care and education care are offered including reproductive health, pre- and post-natal, chronic disease.

Referral Process:

☒ Self-referral
☒ Health care referral
☒ MD

Primary Prevention Activities: All of the programs offered at Hope Centre include healthy living messages.

Care/Treatment Services (on-site)

<table>
<tr><th></th><th>MD</th><th>RN</th><th>RD</th><th>Mental Health/SW</th></tr>
<tr><td>Type 1</td><td>x</td><td>x</td><td rowspan="3">Referrals are made for RD service</td><td>x</td></tr>
<tr><td>Type 2</td><td>x</td><td>x</td><td>x</td></tr>
<tr><td>Gestational Diabetes</td><td>x</td><td>x</td><td>x</td></tr>
</table>

Brief Description of Care/Treatment Activities: Primary care physicians and nurses provide screening, detection and medical management of diabetes. The nurse provides information and education for self-management. For those who are interested, appointments can be made with a diabetes nurse educator (CDE), or an on-site foot care nurse.

Secondary Prevention Activities Complications are monitored on-site by the primary care physicians and referrals are made for foot care and ophthalmology. The wait time and need to travel to these appointments is considered a major barrier in the clients attending.

Education Services:

	Individual	Group	New	Follow-up
Type 1	x		x	x
Type 2	x	Occasional group activities	x	x
GDM	x		x	x

WRHA DIABETES EDUCATION REGISTRY

Name of Program/Organization: **KINSMEN REH-FIT CENTRE**

Contact Information:
Name: Martina Gornik, RD
Michelle Meade BPE, ASCM Exercise Specialist
Beverly Burton-Guindon, R.N.
Address: 1390 Taylor Ave. Winnipeg, R3M 3V8
Phone: (204) 488-8023
Fax: (204) 488-4819
E-mail:
Web site: www.reh-fit.com

Catchment Area (postal codes): None

Service Charges: The general public can access dietitian for a fee for service.

☐ none ☒ fee for service: membership required for diabetes education classes

Description of Service: The Kinsmen Reh-Fit Centre offers supportive, medically monitored health and fitness services through assessment, education and exercise. The multi-disciplinary team of physician, nurse, dietitian and exercise professional delivers programs specifically designed for individuals with cardiovascular disease, diabetes, other special populations, as well as primary prevention for the healthy population. Classes are offered in a group setting, as well as individually as the need arises.

Referral Process:

☒ Self-referral for most (98%) of non-cardiac members
☐ Health care referral
☒ MD only for cardiac members

Primary Prevention Activities:

Care/Treatment Services (on-site)

	MD	RN	RD	Fitness Professional
Type 1	No primary care on site.	x	x	x
Type 2		x	x	x
Gestational Diabetes				

Brief Description of Care/Treatment Activities: Primary medical care services are not available at the Reh-Fit Centre. A physician is on staff to provide medical assessment and monitoring of cardiac health and for exercise stress testing. The nurse, dietitian and exercise specialist develops self-care plans with the members and provides follow-up education.

Secondary Prevention Activities Cardiac monitoring is conducted.

Education Services:

	Individual	Group	New	Follow-up
Type 1	x	x Limited basis		x
Type 2	x	x Limited basis	x	x
GDM				

WRHA DIABETES EDUCATION REGISTRY

Name of Program/Organization: **KLINIC**

Contact Information:
Name: Catheryn Martens, Director, Health Services
Address: 870 Portage Ave. Winnipeg, R3G 0P1
Phone: (204) 784-4090
Fax: (204) 784-4013
E-mail: cmartens@klinic.mb.ca
Web site: www.klinic.mb.ca

Catchment Area (postal codes): Polo Park to Main St., Assiniboine River North to Notre Dame

Service Charges:
☒ none ☐ fee for service

Description of Service: Klinic is a community health centre that provides a full range of health related services from medical care to counseling to education promoting health and quality of life for all.

The diabetes health care team at Klinic consists of physician, community nurses, nurse practitioner, social workers and dietitian. Counseling services are available. Klinic provides service to individuals with pre-diabetes, type 1, type 2 diabetes and diabetes in pregnancy. Basic and intermediate level diabetes self-management education is provided on an individual basis. Referrals are made to advanced diabetes self-management education programs as required. The dietitian provides group presentations within the community, focussed on the prevention and management of type 2 diabetes on request.

Referral Process:
☒ Self-referral
☒ Health care referral
☒ MD

Primary Prevention Activities: Klinic community health centre offers individual education sessions with the dietitian for individuals at risk for diabetes and for individuals with pre-diabetes.

Care/Treatment Services (on-site)

	MD	RN	RD	Mental Health/SW
Type 1	x	x	x	x
Type 2	x	x	x	x
Gestational Diabetes	x	x	x	x

Brief Description of Care/Treatment Activities: Primary care physicians at Klinic provide screening, diagnosis and medical management services for their clients (at risk for diabetes, with pre-diabetes/ diabetes). Diabetes self-management education services provided by the nurse practitioner are currently expanding for Klinic clients. Clients of Klinic and residents of Klinic's catchment area may access the dietitian by physician, health practitioner or self-referral. Clients requiring advanced diabetes self-management education are referred to advanced diabetes education programs such as Youville DER and the Health Sciences Centre Diabetes Education Resource.

Secondary Prevention Activities Complication risk factor assessments are conducted by the physicians and nurse practitioner and recorded on the *Diabetes Flow Sheet* for surveillance of diabetes complications. Self-care education is provided by the dietitian and the nurse practitioner's role is evolving. Blood pressure and foot assessments are services provided.

Education Services:

	Individual	Group	New	Follow-up
Type 1	x			x
Type 2	x		x	x
GDM	x		x	x

Referrals to Other Programs/ Organizations/ Agencies: Referrals are made to health/community agencies to expand the multidisciplinary team available to Klinic clients. This includes advanced practice diabetes education programs, foot care services, Canadian Diabetes Association, food delivery programs, and supplementary/ emergency food programs.

WRHA DIABETES EDUCATION REGISTRY

Name of Program/Organization: **MOUNT CARMEL CLINIC**

Contact Information:
Names: Kathryn Aubin, RN, BN, CDE; Nina Kudriakowsky, RD, CDE
Address: 886 Main Street, Winnipeg, MB R2W 5L4
Phone: Kathryn (204) 589-9413 - direct line, Nina (204) 582-2311 ext. 224
Fax: (204) 582-1341
E-mail: Kathryn diabetes_educator@mountcarmel.ca , Nina dietitian@mountcarmel.ca
Web site: www.mountcarmel.ca

Catchment Area (postal codes): Point Douglas catchment area – R2W postal code. Priority also given to immigrants, and refugees from all areas of Winnipeg.

Service Charges:

☒ none ☐ fee for service

Description of Service: Diabetes Education with a nurse and/or dietitian is available on a group and individual basis. Walk in visits are accommodated as schedule permits. Child care is normally available while the caregiver is attending an appointment or group session. Group education sessions occur several times each month and include basic diabetes education, and diabetes support and education. Priority appointment accommodation is made for insulin initiation and gestational diabetes, or pregnancy with pre-existing diabetes. Education occurs both in the clinic and in the community setting.

Referral Process:

☒ Self-referral
☒ Health care referral
☒ MD

Primary Prevention Activities: Mount Carmel Clinic programming has a wide scope of health and wellness activities. Using a population health perspective, emphasis is placed on health promotion and prevention activities. Some of the programs may be of interest with persons with diabetes.

- Dental care
- Foot care clinic and pedorthics services
- Immunization clinics
- Community blood pressure and blood glucose monitoring clinics
- Pre-natal program and pre-natal education
- Healthy Start – for mom and me
- Reproductive Health Education

Care/Treatment Services (on-site)

	MD	RN	RD	Mental Health/SW
Type 1	x	x	x	x
Type 2	x	x	x	x
Gestational Diabetes	x	x	x	x

Brief Description of Care/Treatment Activities: Clients are taught skills and strategies for diabetes self-management. Primary care is available for residents of Point Douglas, and is supported by laboratory, x-ray, and pharmacy services on site. For clients with physicians at the clinic, primary care is provided for diagnosis, treatment, referral and ongoing follow-up care for people with diabetes.

Secondary Prevention Activities: foot assessments, and blood pressure monitoring are provided by the diabetes nurse educator or their physician. Diabetes surveillance tests and exams (i.e. laboratory tests and referral for dilated eye exams) are made by the client's physician. Complication risk factor assessment and education are provided by the diabetes nurse educator and the physician.

Education Services

	Individual	Group	New	Follow-up
Type 1	x >18 years old	If requested	x	x
Type 2	x	x	x	x
GDM	x	If requested	x	x

Support Activities:

Advocacy
Accessing translation services

Future: Point Douglas community outreach, expansion of diabetes group education, diabetes prevention education in the local schools of Point Douglas.

WRHA DIABETES EDUCATION REGISTRY

Name of Program/Organization: **NATIONAL ABORIGINAL DIABETES ASSOCIATION**

Contact Information:
Name: Kandice Léonard, Executive Director
Address: 174 Hargrave St. Winnipeg, R3C 3N2
Phone: 927-1220
Fax: 927-1222
E-mail:diabetes@nada.ca
Web site: www.nada.ca

Catchment Area (postal codes): None, NADA is a national organization

Service Charges:

☒ none ☐ fee for service * Membership fee is $ 5 Community Member
$ 15 Health Professional
$ 25 Corporate

Description of Service: The Mission of the National aboriginal Diabetes Association is: To address Diabetes amongst Aboriginal Peoples by creating networks and opportunities for individuals, families and communities within their beliefs, traditions and values**.**

Referral Process:

☒ Self-referral
☒ Health care referral
☒ MD

Primary Prevention Activities: NADA's purpose is to take a leadership role in preventing and eradicating diabetes among Aboriginal Peoples by:
- sharing information
- educating
- empowering

Brief Description of Care/Treatment Activities: NADA's goals are:
1. To support individuals, families and communities to access resources for diabetes prevention, education and research.
2. To create working relationships with organizations committed to the prevention and management of diabetes.
3. To promote community wellness as a strategy to prevent diabetes.
4. To manage and operate in effective and efficient ways.

WRHA DIABETES EDUCATION REGISTRY

Name of Program/Organization: **NOR'WEST CO-OP COMMUNITY HEALTH CENTRE**

Contact Information:
Name: Renata Cook
Address: 103-61 Tyndall Winnipeg, R2X 2T4
Phone: (204) 633-5955
Fax: (204) 632-4666
E-mail: rcook@norwesthealth.ca
Web site:

Catchment Area (postal codes): Inkster area and broader community as required

Service Charges:

☒ none ☐ fee for service

Description of Service: Nor'West Co-op Community Health Centre has a primary health team consisting of physicians, nurses, dietitian, health promoter, aboriginal health worker, shared care councillor, psychiatrist, mental health worker, diabetes educator and family violence coordinator, who work in collaboration with external partners to provide comprehensive medical care and education, health promotion and disease prevention programming for the residents of the Inkster area.

Referral Process:

☒ Self-referral
☒ Health care referral
☒ MD

Primary Prevention Activities: The Cardiovascular Health/Diabetes Program focuses on prevention of disease for at risk families or individuals and minimizing the risk of negative health outcomes for those who have CV and/or diabetes. There are many other programs offered at Nor'West that incorporate healthy living messages.

Care/Treatment Services (on-site)

<table>
<tr><th></th><th>MD</th><th>RN</th><th>RD</th><th>DM Educator</th><th>Counseling Services</th></tr>
<tr><td>Type 1</td><td>x</td><td>x</td><td rowspan="3">Referral to RD
1-3
month wait</td><td>x</td><td rowspan="3">Aboriginal councillor, health promoter, Shared care, Mental health Family violence</td></tr>
<tr><td>Type 2</td><td>x</td><td>x</td><td>x
(2 weeks wait)</td></tr>
<tr><td>Gestational Diabetes</td><td>x</td><td>x</td><td>x</td></tr>
</table>

Brief Description of Care/Treatment Activities: Primary medical care for screening, diagnosis and treatment on-site. Internal referral to dietitian, primary care nursing team, health promoter, shared care mental health, individual or family counseling.

Secondary Prevention Activities Primary care physicians provide medical screening and surveillance of complications. Referrals to on-site Foot Care Team can be made.

Education Services:

	Individual	Group	New	Follow-up
Type 1	x		x	x
Type 2	x	1-2 / year	x	x
GDM	x		x	x

WRHA DIABETES EDUCATION REGISTRY

Name of Program/Organization: **ROSE & MAX RADY JEWISH COMMUNITY CENTRE**

Contact Information:

Name: Sue Boreskie MPE, Mark Spencer BPE
Address: Suite B100, 123 Doncaster Street, Winnipeg, MB R3N 2B3
Phone: (204) 477-7510
Fax: (204) 477-7530
Email: sboreskie@aspercampus.mb.ca; mspencer@aspercampus.mb.ca
Web site: www.radyjcc.com

Catchment Area (postal codes): None

Service Charges:

☐ none ☒ fee for service – Memberships available; non-member fees are available for many programs

Description of Service: The Rady JCC is a not-for-profit community agency providing a broad range of programs and services for all age groups to meet the diverse needs of its members, the Jewish community and the community-at-large. Programs include educational, health, fitness, cultural, social and recreational activities and they serve all age groups from infant to older adult. Financial assistance is available based upon individual need and the availability of funds. Persons of all ages with a disability or special need are encouraged to participate in the programs and services offered.

Referral Process:

☒ self-referral
☐ health care referral
☒ MD – if medical problems exist

Primary Prevention Activities: All of the health and fitness programs offered at the Rady JCC are considered primary prevention for diabetes and other chronic diseases.

Care/Treatment Services (on-site)

	MD	RN	RD	Fitness Professional
Type 1				X
Type 2				X

Brief Description of Care/Treatment Activities:
Fitness Professionals work with the client to design an appropriate individualized exercise program or recommends an appropriate program. A variety of educational and mind/body programs are also available. A physician release form must be completed for those with medical problems.

WRHA DIABETES EDUCATION REGISTRY

Name of Program/Organization: **RIVER AVENUE COMMUNITY HEALTH CENTRE**

Contact Information:
Name: Sandra Marriott Silver RN, BN, CDE – Team Coordinator, Primary Care
Address: 385 River Avenue, Winnipeg, R3L 0C3
Phone: (204) 940-2000
Fax: (204) 477-5730
E-mail:smsilver@wrha.mb.ca
Web site:

Catchment Area (postal codes): River Heights (R3L, R3M, R3N)

Service Charges:

☒ none ☐ fee for service

Description of Service: River Avenue Community Health Centre is a WRHA site which has the following programs: Primary Care, Public Health and Mental Health. Our target population for these programs is the River Heights Community. The Primary Care Program takes new clients as capacity permits. If new clients are being accepted, they will receive comprehensive primary care in a collaborative model, which will include diabetes education when indicated.

Referral Process:
☐ Self-referral
☒ Health care referral
☒ MD *Only those people who are followed by the physicians at River Avenue Community Health Centre are eligible for education services.

Primary Prevention Activities: Primary prevention is integral in Primary Care. Lifestyle assessments and recognition of risk factors occurs continuously and regularly at every opportunity of meeting with clients. When issues are identified the client is directed and/or encouraged to meet with the PCN for individual education and counseling.

Care/Treatment Services (on-site)

	MD	RN Nurse Practitioner	RD	Mental Health/SW
Type 1	x	x	No RD on staff. Referrals are made to a dietitian.	x
Type 2	x	x		x
Gestational Diabetes	x	x		x

Brief Description of Care/Treatment Activities: Family physicians, a nurse practitioner and primary care nurses work collaboratively to provide full medical service for screening, diagnosis and treatment for people with diabetes. The primary care nurses, including one nurse who has obtained the CDE, provide individual counseling and education for diabetes self-management.

Secondary Prevention Activities Screening for, and surveillance of diabetes complications is provided collaboratively by family physicians, nurse practitioners, primary care nurses.

Education Services:

	Individual	Group	New	Follow-up
Type 1	x		x	x
Type 2	x		x	x
GDM	x		x	x

WRHA DIABETES EDUCATION REGISTRY

Name of Program/Organization: **SAFEWAY PHARMACY**

Contact Information:

Name: Dinah Santos
Address: 850 Dakota Street, Winnipeg, MB R3M 5R9
Phone: (204) 253-7921
Fax: (204) 256-5574
E-mail: dsantos60@shaw.ca
Web site:

Catchment Area (postal codes): None

Service Charges:

☒ None ☐ fee for service

Description of Service:

Referral Process:

☒ Self-referral
☒ Health care referral
☐ MD

Brief Description of Care/Treatment Activities:
A self referral or community referral no fee for service for Type 2 consultation offering:
- Diabetes survival skills to newly diagnosed Type 2 diabetes including physiology, testing, blood sugar goals, resources, nutrition, and medication

This program is meant to offer early access to diabetes education before patients can attend DER. I also offer this service to patients needing a review of their diabetes education. Each individual session is based on patients needs.
I work with the CDA Manitoba/Nanavut Region as a Pharmacy Consultant.
I am a Certified Diabetes Educator for Safeway Pharmacy and work with Kelly Gasmen, Health Care Consultant with the training of Diabetes Meter Technicians, pharmacy students/pharmacy interns and professional development for pharmacists.

I work with the Youville Center St. Vital as part of the Diabetes Team. (Please refer to Youville, St. Vital program description.)

Education Services:

	Individual	Group	New	Follow-up
Type 1				
Type 2	In store and at Youville Center St. Vital (self referrals as well as elderly clients not able to attend Diabetes group education classes	Youville Center St. Vital location, member of Diabetes Team	Self-referrals for individuals seeking immediate source of information before they can attend DER	Offer follow up to those clients seeking individual sessions
GDM				

WRHA DIABETES EDUCATION REGISTRY

Name of Program/Organization: **SAFEWAY PHARMACY DIABETES HEALTH CENTRE**

Contact Information:

Name: Kelly Gasmen
Address: 920 Jefferson Avenue, Winnipeg, MB R3L 1W3
Phone: (204) 694-3718
Fax: (204) 697-9015
E-mail: kelly.gasmen@safeway.com
Web site:

Catchment Area (postal codes): None

Service Charges:

☒ none ☐ fee for service

Brief Description of Care/Treatment Activities:

A self referral no fee for service for Type 1, Type 2 and Gestational offering:
- selection of a new blood glucose meter with training
- how to use existing blood glucose meter
- how to take an accurate blood glucose reading
- protocol for handling an inaccurate meter
- obtaining other blood glucose monitoring supplies
- discussion of less painful ways to test
- pump supplies
- survival skills for the newly diagnosed
- will travel to all Winnipeg Safeway Pharmacy locations

Diabetes resource person for Safeway Pharmacy for the province of Manitoba including staff training (Diabetes Meter Technicians at most pharmacy locations), pharmacy students/pharmacy interns and professional development for pharmacists. Coexist with Dinah Santos, CDE at Safeway Pharmacy @ 850 Dakota Street

Conduct presentations on the Universalities of Self Blood Glucose Monitoring (Technology Specific) as part of DEC programming at Youville Centre St. Vital, Victoria General Hospital and Health Action Centre.

WRHA DIABETES EDUCATION REGISTRY

Name of Program/Organization: **SENIOR'S HEALTH RESOURCE TEAMS: DOWNTOWN SENIORS HEALTH RESOURCE TEAM**

Contact Information:
Name: Gail Pradel RN, BN
Address: Health Action Centre, 425 Elgin, Winnipeg
Phone: (204) 957-7216
Fax: (204) 957-0929
E-mail: gpradel@wrha.mb.ca
Web site: www.wrha.mb.ca

Catchment Area (postal codes): Seniors 55+, Downtown Area

Service Charges:

☒ none ☐ fee for service

Description of Service: The Seniors' Health Resource Team holds drop-in clinics for health concerns at 12 apartment buildings in the downtown area. Diabetes education counseling by appointment.

Referral Process:

☒ Self-referral
☒ Health care referral
☒ MD

Primary Prevention Activities: Health history, risk factor assessment and discussion regarding healthy lifestyle choices.

Care/Treatment Services (on-site)

	MD	RN	RD	Mental Health/SW
Type 1				
Type 2		x		
Gestational Diabetes				

Brief Description of Care/Treatment Activities: Basic diabetes care and self-management education. Blood glucose monitoring for those who do not do so independently, blood glucose meter education instruction, basic nutrition information, review of medications for diabetes.

Secondary Prevention Activities: Blood pressure monitoring, encourage regular eye exams, foot screening (refer to foot-care nurse).

Education Services:

	Individual	Group	New	Follow-up
Type 1				
Type 2	x			x
GDM				

WRHA DIABETES EDUCATION REGISTRY

Name of Program/Organization: **SENIOR'S HEALTH RESOURCE TEAM: RIVER EAST**

Contact Information:
Name: Sonja Lundstrom RN, BN / Eleanor Stelmack OTM
Address: 755 Henderson Hwy. Winnipeg, R2K 2K5
Phone: (204) 940-2114
Fax: (204) 940-3629
E-mail: slundstrom@wrha.mb.ca or estelmack@wrha.mb.ca
Web site: www.wrha.mb.ca

Catchment Area (postal codes): River East area residents.

Service Charges:

☒ none ☐ fee for service

Description of Service: The Seniors Health Resource Team – River East is made up of a registered nurse and an occupational therapist. Together, they bring health resources and community support closer to home for River East area residents, age 55+. This is done through home visits, health clinics, support groups, health education seminars and getting involved in community projects like Apartment Gardens, Millennium Gardens, the Friendly Neighbour program and Walk 'n Talk Groups.

Referral Process:

☒ Self-referral
☒ Health care referral
☒ MD

Primary Prevention Activities: The Team organizes education sessions, screening and special clinics, support groups and community programs dealing with a variety of topics, including weight reduction, nutrition and diabetes management education. All of the programs have healthy living and wellness messages, promoting self care, helping one another and building the capacity in the community for a healthy environment.

Care/Treatment Services (on-site)

<table>
<tr><th></th><th>MD</th><th>RN</th><th>Occupational Therapist</th><th>Mental Health/SW</th></tr>
<tr><td>Type 1</td><td></td><td></td><td></td><td rowspan="2">Clients are referred as required.</td></tr>
<tr><td>Type 2</td><td></td><td>x</td><td>x</td></tr>
</table>

Brief Description of Care/Treatment Activities: Diabetes Check up on an individual basis and the facilitation of the Seniors Diabetes Education and Support Group once a month in the River East Community.

Secondary Prevention Activities: Foot-care information and resources, blood pressure check, glucose monitoring, healthy weights, exercise programs and referral for dilated eye exam.

Education Services:

	Individual	Group	New	Follow-up
Type 1 (very rare)				
Type 2	x	x	x	x

WRHA DIABETES EDUCATION REGISTRY

Name of Program/Organization: **SENIOR'S HEALTH RESOURCE TEAMS: ST. JAMES ASSINIBOIA SENIOR CENTRE**

Contact Information:
Name: Laurie Green RN, CDE / Liz St. Godard RD
Address: 2109 Portage Avenue, Winnipeg
Phone: (204) 940-3261 (L. Green), 940-2683 (L. St.Godard)
Fax: (204) 987-8856
E-mail: lgreen@stjasc.mb.ca or estgodard@stjasc.mb.ca
Web site: http://groups.msn.com/StjamesAssiniboiaSeniorCentre

Catchment Area (postal codes): St. James/Assiniboia (R3J / R3K / R2Y) Seniors 55+

Service Charges:

☒ none ☐ fee for service

Description of Service: St. James-Assiniboia Seniors Centre offers a variety of health and social services to area residents 55 years and older. The Seniors Health Promotion Resource Team organizes education sessions, clinics, support groups and programs dealing with a variety of health topics. The team also holds free health clinics for tenants age 55+ who live in apartment complexes in the area.

Referral Process:

☒ Self-referral
☒ Health care referral
☒ MD

Primary Prevention Activities: The team organizes group presentations, health fairs and one on one counseling. All programs have healthy living and wellness messages. "Clinic on Wheels" at 8 housing complexes and in various other community locations.

Care/Treatment Services (on-site)

	MD	RN	RD	Mental Health/SW
Type 1 (uncommon)		x	x	Clients are referred to service as required
Type 2		x	x	

Brief Description of Care/Treatment Activities: Any person age 55 or older can arrange appointments with the Primary Care Nurse and Registered Dietitian for individual diabetes education and follow-up including basic diabetes care and self-management.

Secondary Prevention Activities:
Blood pressure monitoring. Encourage regular eye exams
Referral to on-site foot care nurse (fee for service).
Referral to volunteer pharmacist for individual medication counseling.

Education Services:

	Individual	Group	New	Follow-up
Type 1	x			x
Type 2	x	Will be offered	x	x

WRHA DIABETES EDUCATION REGISTRY

Name of Program/Organization: **ST. BONIFACE GENERAL HOSPITAL DEPARTMENT OF ENDOCRINOLOGY**

Contact Information:

Name: Chris Everhardus, RN, CDE
Address: C5-109, 409 Taché, Winnipeg, MB R2H 2A6
Phone: (204) 235-3305
Fax: (204) 233-7154
E-mail:
Web site:

Catchment Area (postal codes): All Manitoba, referrals accepted from NW Ontario and North West Territories

Service Charges:

☒ none ☐ fee for service

Description of Service: Patients are referred primarily from family or community physicians to the specialist service of the endocrinologists. Patients are booked for appointments with the endocrinologist, nurse and dietitian during clinic times. A large percent of the people referred to the endocrinology service have complications of diabetes or other co-morbidity's. Follow-up appointments are made on an individual basis.

Referral Process:
☐ Self-referral
☒ Health care referral (in-patients can be referred by ward nurses)
☒ MD

Primary Prevention Activities: All women with previous GDM and others with high risk for diabetes are counseled regarding prevention of type 2 diabetes.

Care/Treatment Services (on-site)

	MD	RN	RD	Mental Health/SW
Type 1	x	x	x	Referral to psychologist as needed
Type 2	x	x	x	
Gestational Diabetes	x	x	x	

Brief Description of Care/Treatment Activities: Medical and education appointments are usually conducted on the same day during clinic time, or can be made separately if more convenient. Correspondence is sent to the referring doctor with information to the patient to attend Youville clinic DER or the DER in the region of residence, as needed.

Secondary Prevention Activities A complete complication risk factor assessment is conducted with patient teaching re: same.

Education Services:

	Individual	Group	New	Follow-up
Type 1	x		x	x
Type 2	x		x	x
GDM	x		x	x

WRHA DIABETES EDUCATION REGISTRY

Name of Program/Organization: **VICTORIA GENERAL HOSPITAL DIABETES EDUCATION CENTRE**

Contact Information:
Name: Kelly-Lynn Bekar RN, BN, CDE / Aimee Krupanszky RD
Address: 2340 Pembina Highway, Winnipeg MB R3T 2E8
Phone: (204) 477-3305
Fax: (204) 275-1376
E-mail:
Web site: www.vgh.mb.ca

Catchment Area (postal codes): Primarily South Winnipeg, but all referrals accepted.

Service Charges:

☒ none ☐ fee for service

Description of Service: Those referred for diabetes education are invited to attend two scheduled all day classes, held two weeks apart. Classes are held every Thursday. Approximately 98% of referrals are out-patients. Participants are encouraged to attend with a spouse or partner. The waiting time is several months. The nurse and dietitian conduct all group classes. Individual assessment and follow-up are done during the class day. An endocrinologist is available for individual consults at the request of a referring MD.

Referral Process:
☒ Self-referral
☒ Health provider referral
☒ MD

Primary Prevention Activities: There are no primary prevention activities that are conducted for the general population, however there is a prevention component with VGH staff education and promotion of the service.

Care/Treatment Services (on-site): Primary diabetes care is not available at the VGH Diabetes Education Centre

Brief Description of Care/Treatment Activities: Clients are taught skills and strategies for successful diabetes self-management.

Secondary Prevention Activities During the second day of diabetes education classes, a comprehensive session on complications of diabetes-prevention and treatment is provided.

Education Services:

	Individual	Group	New	Follow-up
Type 1	x	x with type 2 group	x	x
Type 2		x	x	x
GDM	x		x	x
IFG (Impaired fasting glucose)		x	x	

WRHA DIABETES EDUCATION REGISTRY

Name of Program/Organization: **WAL-MART DIABETES PROGRAM**

Contact Information:

Name: Carol Lezack
Phone: 257-8020 (St. Vital Wal-Mart)
Fax:
E-mail:lezack@mts.net
Web site:

Catchment Area (postal codes):

Service Charges:

☒ none ☐ fee for service

Description of Service:
Advice and information regarding living with diabetes, including choosing and using blood glucose monitor.

Referral Process:

☒ self-referral
☐ health care referral
☐ MD

Community Activities: Annual WAL-MART sponsored Diabetes Information Day. Booths, displays, prizes and guest speakers are offered.

WRHA DIABETES EDUCATION REGISTRY

Name of Program/Organization: **WELLNESS INSTITUTE AT SEVEN OAKS HOSPITAL**

Contact Information:
Name: Lisa Skrypek, Administration Assistant
Address: 1075 Leila Avenue, Winnipeg, MB R2P 2W7
Phone: (204) 632-3927
Fax: (204) 694-2712 (Wellness – RD counseling)
E-mail: lskrypec@sogh.mb.ca
Web site: www.wellnessinstitute.mb.ca

Catchment Area (postal codes):

Service Charges:

☒ none - There are no service charges for the Introductory Class or the Management series (with HSC-Diabetes Education Centre Program fax # 787-3786)
☒ fee for service for RD, CDE individual nutrition / meal-planning counseling at the Wellness Institute. Clients may have third party reimbursement for this service

Description of Service: At the Wellness Institute, the services of a CDE dietitian are available to provide nutrition counseling to individuals and groups.

The Diabetes Education Centre at the Health Sciences Centre holds classes on diabetes at the Wellness Institute. Please refer to 'Diabetes Education Centre' in this directory for more information.

Referral Process: Physicians refer clients to the HSC-DEC for diabetes education. Those residing in the north part of Winnipeg are scheduled for classes at the Wellness Institute.

☐ Self-referral
☒ Health care referral (HSC-DEC) and for Dietitian at the Wellness Institute
☒ MD

Primary Prevention Activities:

Many 'wellness' and healthy living groups are offered at Wellness Institute at Seven Oaks General Hospital. Brochures available at the front desk or check www.wellnessinstitute.mb.ca
Preventing Type 2 Diabetes (offered through Positively Healthy brochure)
Are you at risk for Type 2 Diabetes? Do you have impaired fasting, impaired glucose tolerance, a family history, or had diabetes during a pregnancy? Come and learn how Type 2 diabetes can be prevented! Offered at the Wellness institute by Canadian Diabetes Association, MB and Nunavut Division.

Care/Treatment Services (on-site): Not available.

Brief Description of Care/Treatment Activities
No primary care available for diabetes. Individuals may access the services of the dietitian for diabetes meal-planning at the Wellness Institute.

Secondary Prevention Activities
"Managing Complications" is one class in the management series offered in the Diabetes Education Centre series.

Education Services (for Wellness Institute Dietitian)

	Individual	Group	New	Follow-up
Type 1	x		x	x
Type 2	x		x	x
GDM	x			

WRHA DIABETES EDUCATION REGISTRY

Name of Program/Organization: **WOMEN'S HEALTH CLINIC**

Contact Information:
Name: Ann McConkey RD/ Cathy Wilke MD
Address: 419 Graham Ave. Winnipeg, MB R3C 0M3
Phone: (204) 947-1517
Fax: (204) 943-3844
E-mail:
Web site: www.womenshealthclinic.org

Catchment Area (postal codes): All Manitoba

Service Charges:

☒ none ☐ fee for service

Description of Service: Primary care physicians provide comprehensive medical management for existing clients. The physician makes referrals for specialist care (endocrinology/cardiology), off-site diabetes education, foot-care. No new referrals are being accepted for primary care. Physicians may see new clients for a one-time consultation (second opinion) but will not take on care. Diabetes education services – RD available, RN unavailable. Referrals for RD services can be made by any physician, health professional or self-referral. Less than 5% of RD services are spent on diabetes education.

Referral Process

☒ Self-referral
☒ Health care referral
☒ MD

Primary Prevention Activities
All of the programs offered at WHC incorporate a healthy living message. With some in-servicing regarding diabetes type 2 prevention, inserting a diabetes prevention message in regular programming would be possible.

Care/Treatment Services (on-site)

	MD	RN	RD	Mental Health/SW
Type 1	x	* referrals have been made to other services or to professionals in the private sector.	x	x
Type 2	x		x	x
Gestational Diabetes	x		x	x

Brief Description of Care/Treatment Activities:
See description of service.

Secondary Prevention Activities
Done by primary care physician with referral for eye examination.

Education Services

	Individual	Group	New	Follow-up
Type 1			x	x
Type 2			x RD ONLY	x
GDM			x	x

WRHA DIABETES EDUCATION REGISTRY

Name of Program/Organization: **WRHA HOME CARE NURSING UNIT**

Contact Information:
Name: Carole Arbez, RN, BN, CDE
Address: 3rd floor 831 Portage Ave.
Phone: (204) 940-3272
Fax: (204) 940-3282
E-mail: carbez@wrha.mb.ca
Web site: www.wrha.mb.ca

Catchment Area (postal codes): Winnipeg Health Region

Service Charges:

☒ none ☐ fee for service

Description of Service: The Home Care Nursing Program is a service focused on clinical intervention to assist the individual, family and community to achieve maximum independence and health.

Referral Process:

☐ Self-referral
☒ Health care referral
☒ MD

Primary Prevention Activities: Home Care nurses provide assessment and teaching about health maintenance and health promotion to all clients as well as teaching regarding risk factors for developing type 2 diabetes and recommended screening.

Care/Treatment Services (on-site)

	MD	RN	RD	Mental Health/SW
Type 1		x		
Type 2		x		
Gestational Diabetes		x		

Brief Description of Care/Treatment Activities: Home Care nurses complement the education that individuals receive at diagnosis. They support and reinforce the diabetes self-care plan for individuals in their home. Home Care nurses may also provide the only education service for individuals and family members learning to manage diabetes. Clients are given information about all aspects of diabetes care including medication administration, BGM, general nutrition and activity. Home care nurses can assist with insulin initiation for clients with type 2 diabetes. They provide short and long-term care for individuals in their homes.

Secondary Prevention Activities Home Care nurses monitor BP, condition of feet, etc. and provide teaching regarding self care.

Education Services:

	Individual	Group	New	Follow-up
Type 1	x		x	x
Type 2	x		x	x
GDM	x		x	x

WRHA DIABETES EDUCATION REGISTRY

Name of Program/Organization: **YOUVILLE CENTRE DIABETES EDUCATION RESOURCE**

Contact Information:

Name: Diabetes Education Resource Team
Address: 33 Marion Street, Winnipeg, MB. R2H 0S8
Phone: (204) 233-0262
Fax: (204) 233-1520
Email: slaliberte@youville.ca (address correspondence to DER Team)
Web site: www.youville.ca

Catchment Area (postal codes): Winnipeg Region

Service Charges:
☒ none ☐ fee for service

Description of Service: Centre Youville Centre a community-based health resource, offers a variety of health promotion services, including a coordinated approach to the delivery of self-management diabetes education at two sites. The St. Boniface Youville offers a comprehensive self-management education program for adults affected by Type 1, Type 2 diabetes and for those who are pregnant with diabetes. Referrals are also accepted from other diabetes education program for clients requiring advanced self-management education. Interactive group and individual education sessions are offered by nurses, dietitians and a counselor onsite or in partnership with other agencies. Sessions are Monday through Thursday 9-9pm and Friday 9-5pm. French language service is available. Youville Centre is accredited by the Canadian Council on Health Services Accreditation. This organization meets national standards of quality for health services set by Council. This accreditation award has been achieved through the combined efforts of the entire organization and those it serves.
See also Youville St. Vital for additional information

Referral Process

☒ self-referral
☒ health care referral
☒ MD

Primary Prevention Activities: Youville Centre and The Canadian Diabetes Association partner to provide the public with information that can help prevent the onset of type 2 diabetes. Diabetes Association staff and volunteers from both organizations deliver a one-time group presentation based on the Association's Signature Program. The Signature Program is directed at adult audiences and covers several aspects of diabetes. *Preventing type 2 Diabetes* is the focus of the Youville presentation. Family/significant others are encouraged to attend the Grocery tour offered as part of the regular program. A "You Ville" Love it cooking series is offered monthly.

Care/Treatment Services (on-site)

	MD	BN	RD	Mental Health/SW
Type 1	Not on-site	x	x	On-site access
Type 2	Not on-site	x	x	On-site access
Gestational Diabetes	Not on-site	x	x	On-site access

Secondary Prevention Activities A complication risk factor assessment is done by the health professionals, and recorded for surveillance of preventative health care behaviours and diabetes complications. Self-management education is provided by dietitians, nurses, and counselor. Blood Pressure assessment, Self Blood Glucose Monitoring, foot assessment are services provided. Foot care service is also available, additional cost may apply.

Education Services

	Individual	Group	New	Follow-up
Type 1	x		x	x
Type 2	x	x	x	x
GDM	x		x	x

WRHA DIABETES EDUCATION REGISTRY

Name of Program/Organization: **YOUVILLE CENTRE (St. Vital)**

- Living Well with Diabetes: A Health Information Series for Persons with Type 2 Diabetes
- *Ask the Nurse*

Contact Information:
Name: Sherri Cheropita, RN, BN, CDE
Address: 6-845 Dakota Street, Winnipeg, MB. R2M 5M3
Phone: (204) 255-4840
Fax: (204) 255-4903
Email: scheropita@youville.ca
Web site: www.youville.ca

Catchment Area (postal codes): R2M, R3M

Service Charges:
☒ none ☐ fee for service

Description of Service: Centre Youville Centre a community-based health resource, offers a coordinated approach to the delivery of self-management diabetes education at two sites.

Living Well with Diabetes is a health promotion education series that is part of the Chronic Disease Management Program provided through Centre Youville Centre Community Health Resource, St. Vital. **Living Well with Diabetes** provides diabetes self-management education for adults affected by Type 2 diabetes, family and support persons. The program provides interactive group and individual sessions. Participants are invited to attend follow-up sessions. Nurses, dietitian, and counselor collaborate with community pharmacists and other agencies to provide local and timely diabetes education, care and support in the community of St. Vital.

Ask the Nurse program is a primary health care initiative through Centre Youville Centre Community Health Resource, St. Vital. **Ask the Nurse** program can be a point of entry and provides assistance to navigate access to diabetes education, care support and referral within the larger community of Winnipeg. The community has access to nurses who can address immediate concerns related to the individual's health and diabetes. A partnership is maintained with the Nurse Practitioner at St. Vital, and the St. Boniface Diabetes Education Resource nurses and dietitians for expert consultation and/or referral.

Youville Centre is accredited by the Canadian Council on Health Services Accreditation. This organizations meets national standards of quality for health services set by Council. This accreditation award has been achieved through the combined efforts of the entire organization and those it serves.

Referral Process

☒ self-referral
☒ health care referral
☒ MD

Primary Prevention Activities: Youville Centre and The Canadian Diabetes Association partner to provide the public with information that can help prevent the onset of type 2 diabetes. Diabetes Association staff and volunteers from both organizations deliver the Canadian Diabetes Association's Signature Program. The Signature Program is directed at adult audiences and covers several aspects of diabetes. *Preventing type 2 Diabetes* is the focus of the Youville presentation. In St. Vital, presentations are held at Youville Centre and at various community locations.

Care/Treatment Services (on-site)

	Clinical Primary Health Care	BN	RD	Mental Health/SW
Type 1	Nurse Practitioner provides assessment, intervention, follow-up and/ or referral	Refer to Youville St. Boniface	Refer to Youville St. Boniface	Refer to Youville St. Boniface
Type 2	Nurse Practitioner provides assessment, intervention, follow-up and/or referral	X	X	On-site access
Gestational Diabetes	Nurse Practitioner provides assessment, intervention, follow-up and/or referral	Refer to Youville St. Boniface	Refer to Youville St. Boniface	Refer to Youville St. Boniface

Secondary Prevention Activities: A complication risk factor assessment is provided by the health professionals, and recorded for the screening of preventative health care behaviours and diabetes complications i.e, blood pressure monitoring, foot screening, blood glucose testing, referral for dilated eye exam, etc. Self-management education is provided by nurses, dietitian, pharmacist and counselor. Foot care service is also available, additional costs may also apply.

Education Services

	Individual	Group	New	Follow-up
Type 1	Nurse Practitioner, Triage Nurse, and/or referral	Not available	Nurse Practitioner or Refer as necessary	Nurse Practitioner or Refer as necessary
Type 2	Nurse Practitioner, Ask the Nurse, Triage Nurse, and/or referral	Interactive Group	Interactive Group	Interactive Group
Gestational Diabetes	Nurse Practitioner, Ask the Nurse, Triage Nurse, and/or referral	Not available	Nurse Practitioner or Refer as necessary	Nurse Practitioner or Refer as necessary

For additional information, please see Youville St. Boniface.