System Impact of Toronto Diabetes Care Connect

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Introduction

Within the Toronto region, diabetes care is being provided across a number of programs, organizations and sectors. Regional support is required to help coordinate services, facilitate collaboration across programs, and improve awareness of and access to quality team-based care.

Toronto Diabetes Care Connect (TDCC), a program of South Riverdale Community Health Centre, was created in 2013 to help the Toronto Central LHIN provide this regional support. Here we highlight the impact of TDCC's four key strategies.

Our Clients

Primary care providers, specialists, health care providers, planners, and community members

VISION

Equitable access to and delivery of coordinated, high-quality, team-based, diabetes care within the Toronto region

OUTCOMES

Increased collaboration & coordination across programs → **Improved access to high-quality team-based care** → **Increased system capacity to deliver high-quality care**

STRATEGY #1

Facilitate the coming together of stakeholders to support meaningful discussions and strategic regional (and sub-regional) planning

35 **key stakeholders engaged to support:**

1) TC LHIN Diabetes Work
2) Diabetes Current State Analysis
3) HQO Diabetes Quality Standard Development
4) Diabetes Canada's Diabetes 360 Strategy Adoption

"Allows my voice to be heard and gives me a chance to inform planning that will hopefully result in positive changes at the system-level."

"If the steering committee ceased to exist, how would the voice of service delivery organizations be heard?"

"Allows me to meet people, learn about other services, make connections across programs, and see the perspectives of others."

STRATEGY #2

Operate the Toronto Central Referral Service (TCRS) and the Toronto Diabetes Care Connect website with a quality improvement (QI) lens

489 **referral service users**

4,359 **website users**

1,840 **referrals submitted**

90% **of referrals resulted in a connection**

"The Toronto Central Referral Service provides an easy way to find the program(s) or service(s) that meet the needs of the individual."

"I was happy I was referred to a place close to my home so I could bike after coming home from work."

STRATEGY #3

Support the development and/or use of frameworks, tools, and initiatives to support access to and delivery of quality team-based diabetes care

31 **programs** from **21 organizations** collaborated **over 6 years** to develop:

1) Recommendations for Referral System Design (2019)
2) Recommendations for Physician Engagement (2019)
3) Toolkit for Public Engagement (2019)
4) TDCC Website (2017)
5) Regional Flyer (2016)
6) Insulin Order Set (2014)

"The regional flyer and website help to minimize confusion, consolidate outreach efforts, and increase overall awareness of available supports."

"Outreach collaboration across programs increases the impacts of the empowerment, advocacy, and awareness raising efforts."

STRATEGY #4

Support diabetes-related professional development among healthcare providers working in diabetes

132 **healthcare providers** reached through New Hires Program & Endocrinology Sessions

98% reported **increase** in **knowledge, skills** and **confidence**

"Enhanced my knowledge and improved my skills to provide client-centered care to people living with diabetes."

"Increased my skills to better partner with my clients and empower them to manage their diabetes."

FUTURE CONSIDERATIONS

As health care planning moves into the Ontario Health Team (OHT) model, the need for regional coordination remains. Both the referral service and the website are well suited to support coordinated pathways in a seamless healthcare system.

Toronto Diabetes Care Connect can work closely with key stakeholder groups, planning groups, decision makers, and OHTs to meaningfully participate in system-level changes.

Developed: November 2019 with data from 2018/19 fiscal year unless otherwise stated