BUILDING BACK BETTER

Supporting Equitable Access to & Provision of Diabetes Care Across Toronto Region

South Riverdale COMMUNITY HEALTH CENTRE

Toronto Diabetes Care Connect

Message from the Regional Diabetes Steering Committee

The year 2021 marked the 100th anniversary of the discovery of insulin – a discovery that saved the lives of millions of people around the world. During this pivotal year, we were excited to see the passage into law of Bill C-237, an act to establish a national framework for diabetes in Canada.

We also continued to see the mounting impacts of the pandemic for people living with or at risk of diabetes, and the health care providers and staff across the healthcare sector who have continued to provide support for those individuals. The impacts have been disproportionate for those who face systemic barriers to accessing healthcare and other basic needs required to thrive. Notably, programs are seeing significant increases in clients presenting with more urgent social and health-related needs, food insecurity, mental health challenges and barriers to accessing essential care (including mental health supports, foot care and eye screening).

Despite the ongoing required focus on COVID related efforts, diabetes programs and teams have continued their commitment to providing equitable access to care and education across the continuum of diabetes care, from prevention to screening & diagnosis, care and self-management support. Leveraging technology when accessible, maintaining in-person care when possible, and continuing home visits in the community have enabled ongoing access to care for many individuals. The Toronto Central Referral Service has also continued to operate throughout the pandemic, maintaining connection support to diabetes prevention, education and self-management programs.

As we look ahead, the Regional Diabetes Steering Committee will be mapping out priorities in alignment with the Diabetes 3600 National Framework, as well as with Ontario Health regional recovery priorities. Opportunities are arising in the areas of upstream prevention, identification of individuals at risk of diabetes and lower limb preservation, through advocacy efforts and supporting regional quality improvement initiatives aimed at improving equitable access and health outcomes. We support wholeheartedly the Lower-limb preservation strategy to help Ontarians get back on their feet, literally. We see this in our work in all health care sectors daily. Ontarians with diabetes, and without diabetes who have at-risk feet or early wounds developing need preventative Professional advanced foot care that prevents debilitation and amputation. As we move through the waves of this pandemic, we look forward to continuing to work collaboratively with our partners, OHT's and with Ontario Health towards building back better for those at risk, living with or impacted by diabetes.

Strategically Supporting Regional Access to Care Across the Diabetes Continuum Through:

1. Facilitating the coming together of partners
2. Facilitating connections to diabetes supports by operating the Toronto Central Referral Service & Toronto Diabetes Care Connect Website
3. Supporting development and/or use of frameworks, tools & initiatives
4. Supporting diabetes-related professional development

Prevention & Awareness

- Diabetes Prevention Programs
- Supporting World Diabetes Month Initiatives

Screening & Identfication

- Sub-Regional Collaborative QI Initiative Regarding Diabetes Risk Identification & Screening

Management & Education

- Diabetes Education Programs
- Hospital Diabetes Programs
- Choose Health Self-Management Program
- Supporting Healthcare Provider Professional Development

Improving Health Outcomes

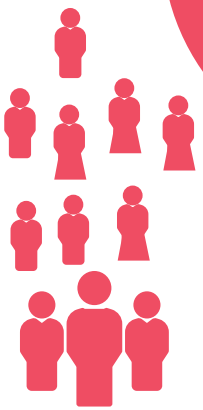
- Diabetes Eye Screening Program
- Supporting Ontario Lower Limb Preservation Strategy & potential demonstration projects
- Facilitating connections to foot & eye care

Groups & Initiatives Supported by Toronto Diabetes Care Connect

Year in review

Strategy 1

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



11 clients & **45** providers

engaged across organizations as part of a East Toronto sub-regional collaborative QI project related to diabetes screening

"The aim of this work is to be able to leverage sociodemographic data to address health equity by identifying individuals at risk of developing type 2 diabetes, and to better understand & address barriers to diabetes screening."

Strategy 2

Facilitate Connections to Diabetes Supports by Operating the Toronto Central Referral Service (TCRS) and the Toronto Diabetes Care Connect website with a QI lens

Plans are underway for the TCRS to join the expanding Ocean eReferral Network, aligning with OHT digital strategies.

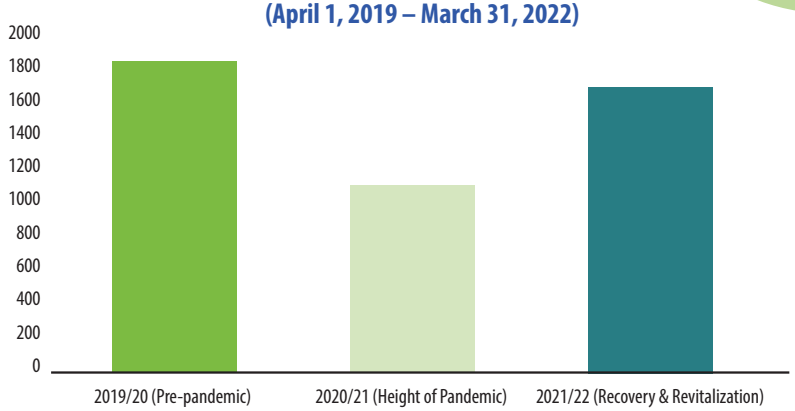
7,093 website users

Website viewed **12,998** times

1,666 referrals submitted

97% referrals resulting in connection

TCRS Referral Volumes - Recovery & Revitalization (April 1, 2019 – March 31, 2022)



The significant reduction in referrals to TCRS in 2020 reflected systemic impacts of the pandemic on access to healthcare. Seeing referral volumes nearly back to pre-pandemic levels reflects systems in recovery & vitalization.

"TDCC is such a valuable service. The referral service is effective and allows many doctors to connect their patients to diabetes care easily."

"TDCC were leaders in [all four program strategies]. Very helpful and always effective as a means of promoting [professional development] among [diabetes] educators. "

Strategy 3

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

39
partners engaged

12
cross-organizational connections made

"The facilitation of the [Diabetes Program Leaders] meetings has allowed for [diabetes programs] across Toronto to coordinate and share ideas and concerns through the pandemic."

"It's been very helpful to connect with partnering organizations to understand everyone's current state within their diabetes programs during the pandemic. It felt very supportive and a sense of relief that we were all going through similar situations with clients."

"[TDCC has been] fully supportive of these initiatives; it brings cohesion, engagement, coordination and collaboration to the next level and provides direction informed by active [partners]."

Strategy 4

Support diabetes-related professional development among healthcare providers

6
individual consultations with TDCC Lead Endocrinologist

138
health care providers reached

"I always find it helpful to keep up with diabetes care information and to discuss cases."

"Session[s] provided me with practical information I can use when questions arise with health care providers I work with when discussing diabetes management cases."

96% reporting increased knowledge,

98% reporting increased skills,

98% reporting increased confidence

5
Endocrinology sessions for teams

"The coordination of regular diabetes rounds provides a great space for diabetes educators to discuss hard cases and get questions answered and connect with each other."

"I think more than anything it reinforces that what we are seeing, feeling, doing with our patients/ their families is validated amongst us as diabetes educators/practitioners. This pandemic is stretching our 'elasticity' in healthcare to the maximum, we need to stay connected."

Thank You & Acknowledgements

Toronto Diabetes Care Connect (TDCC) would like to extend a sincere thank you to all of the healthcare providers, program leaders & staff, and partner organizations for their ongoing commitment to providing support to people living with and at risk of diabetes and for their contributions to the work of TDCC.

- Anishnawbe Health Toronto DEP & DPP
- BBDC QUEST Committee
- Centre Francophone de Toronto DEP
- Choose Health Self-Management Program
- CorHealth Ontario
- Diabetes Eye Screening Program (Teleopthalmology)
- East End Community Health Centre
- East Toronto CHC Network
- Diabetes Action Canada
- Diabetes Canada
- Flemingdon Health Centre - Don Mills DEP & South Asian Diabetes Prevention Program
- Home & Community Care Support Services
- LAMP CHC-West Toronto DEP
- LMC Healthcare & Canadian Diabetes Prevention Program
- McMaster University - Aging, Community and Health Research Unit
- Michael Garron Hospital/Toronto East Health Network
- New Hires Program Planning Partners (Gail MacNeill & Leigh Caplan)
- Ontario Health - Toronto Region & Toronto Region Ontario Health Teams
- Parkdale Queen West CHC DEPs
- Regent Park CHC DEP
- Sherbourne Health Centre DEP
- SickKids - The Hospital for Sick Children
- Sinai Health Systems - Bridgepointment FHT DEP
- Sinai Health Systems - Mount Sinai Academic FHT DEP
- Mount Sinai Hospital - Leadership Sinai Centre for Diabetes (LSCD)
- Ocean eReferral Network Project Management Team
- Regional Diabetes Steering Committee
- SCOPE
- South Riverdale Community Health Centre
- St. Joseph's Health Centre Diabetes and Education Clinic
- Sunnybrook Academic FHT - SUNDEC - Sunnybrook DEP
- Taddle Creek FHT DEP
- Toronto Central Referral Service Administrators & Team Lead
- Toronto Diabetes Care Connect Endocrinology Lead (Dr. Jeremy Gilbert, MD, FRCPC, Endocrinologist at Sunnybrook Health Sciences Centre, Associate Professor, University of Toronto)
- Toronto Public Health - Diabetes Prevention Strategy
- Unison Health & Community Services DEP & DPP
- Unity Health - St. Michael's Academic FHT DEP
- Unity Health - St. Michael's Hospital Comprehensive Care Program
- University Health Network Diabetes Program
- Vibrant Healthcare Alliance - Mid-Toronto DEP
- Waterloo Wellington Central Diabetes Intake
- Women's College Hospital Centre for Integrated Diabetes Care
- Women's Health in Women's Hands CHC DEP
- Wounds Canada

Rising to the Challenge – Addressing Impacts of the Pandemic & Ensuring Equitable Access to Diabetes Care

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