TAKING THE PATH FORWARD

Advancing Equitable Access To & Provision of Diabetes Care

South Riverdale COMMUNITY HEALTH CENTRE

Toronto Diabetes Care Connect

Message from the Regional Diabetes Steering Committee

As we continue to move through COVID recovery and revitalization, we have seen a gradual shift back towards resuming in-person healthcare appointments and events, providing opportunities to rekindle social connections that were sorely missed over the past 3 years.

People have been able to come back together in shared spaces to participate in learning and collaborative planning. Diabetes Canada was able to host the 2022 annual conference in person again in November, bringing together people across the country committed to improving diabetes care.

The Toronto Central Referral Service (TCRS) continues to see an increase in referrals, nearly back to pre-pandemic volumes. This fiscal year, the TCRS received 1,816 referrals. Diabetes programs continue to provide equitable access to care across the diabetes continuum, maintaining virtual appointment options while also increasing offerings of in-person appointments and groups. Programs and providers continue to report seeing health system access gaps, in particular for foot care, mental health care and community RN services within schools to support young children living with type 1 diabetes. There is desire to embed foot care, mental health and case management services into diabetes teams due to the increased patient need and limited supports available. Food insecurity continues to sky-rocket with increasing food prices. Gaps in access to medication and device coverage continue to widen.

Addressing structural barriers and focus on advancing health equity are essential in order to improve access and health outcomes for individuals living with and at risk of diabetes.

We were very pleased to hear the Ministry of Health, "The Path Forward" announcement outlining chronic disease priorities for the Ontario Health Teams (OHT), including diabetes (with a focus on lower limb preservation). Lower limb preservation has long been a top priority for the Regional Diabetes Steering Committee. Effective pathways addressing prevention, screening, escalation and treatment involve all healthcare sector partners working together. We see great potential for partnership and collaboration with diabetes teams and partner organizations within and across OHTs that will help to ensure that people living with and at risk of diabetes are connected to the right care at the right time. Aligning with Federal, Provincial and Regional diabetes strategies, we look forward to the ongoing collaborative work aimed at ensuring equitable and timely access to care for all individuals living with, and at risk of, diabetes.

Toronto Diabetes Care Connect (TDCC) Strategic Planning Framework – Role of TDCC in Sub-Regional Systems

Vision: Equitable access to and delivery of coordinated, high quality diabetes-related care across Toronto Region

Facilitating Linkages & Connections

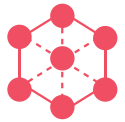
- Facilitate the coming together of partners to support meaningful discussions and strategic regional & sub-regional planning
- Facilitate connections amongst partner groups/ individuals to support coordinated care and planning
- Facilitate connections to diabetes prevention & management supports by operating the Toronto Central Referral Service (TCRS) & TDCC website with a QI lens

*Enablers 1,2,3,4,5,6

Integrating & Building Capacity

- Support development of sub-regional integrated care models that ensure access to team-based care across the diabetes continuum that leverages the full scope of diabetes educators
- Establish sub-regional communities of practice, bringing together providers across organizations and care teams to support capacity & relationship building
- Facilitate diabetes-related professional development among healthcare providers supporting individuals living with and at risk of diabetes

*Enablers 1,3,4,5,6,7



Developing Frameworks, Tools & Initiatives that Align with Regional, Provincial & National Priorities

- Support development and/or use of frameworks, tools & initiatives to ensure access to and delivery of quality care across the diabetes continuum
- Establish structures to facilitate coordination & spread of effective initiatives across OHTs

*Enablers 2,3,4,5,6

Desired Outcomes

1. Increased systems alignment with OH & OHT chronic disease strategies and National Diabetes Framework
2. Increased integration, collaboration & coordination across programs
3. Improved access to high quality care
4. Increased system capacity to deliver high quality care

Enablers:

1. Creates an atmosphere for open dialogue among key partner groups
2. Supports planning around effective use of available resources
3. Supports development of shared commitment to work together to reach common aim
4. Supports access to and delivery of person-centred care
5. Supports sharing of expertise among key partners
6. Provides relevant and useful information to key partners
7. Increases diabetes-related competence of health care providers

TDCC Strategically Supporting Regional Access to Care Across the Diabetes Continuum

Prevention & Awareness

- Diabetes Prevention Programs

Screening & Identfication

- Sub-Regional Collaborative QI Initiative Regarding Diabetes Risk Identification & Screening
- Leveraging EMR Data to Advance Health Equity

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 & Demonstration Projects
- Facilitating connections to foot & eye care

Groups & Initiatives Supported by Toronto Diabetes Care Connect

Year in review
Facilitating Connections

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

40 partners engaged

32 cross-organizational connections made

"Facilitating meaningful discussions and strategic planning post pandemic provided suggestions and solutions to worsening health of clients."

"Enhances the DEPs efforts, strengthens connection and presents the team as one and solidly empowers us to voice our clients' needs and challenges."

"Helpful to connect with other DEPs for regional planning, connecting clients to other supports when out of our catchment."

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

The TCRS will be joining the expanding Ocean eReferral Network shortly, aligning with OHT digital strategies.

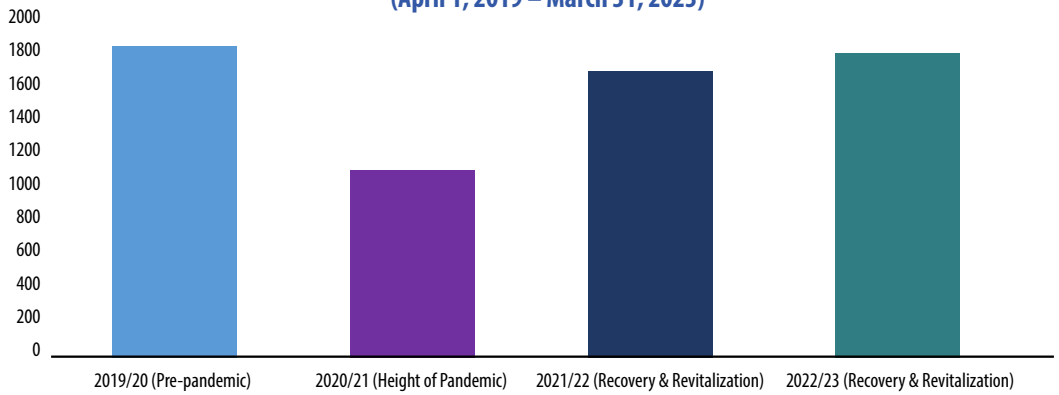
7,267 website visitors

Website viewed **9,399** times

1,816 referrals submitted

97% referrals resulting in connection

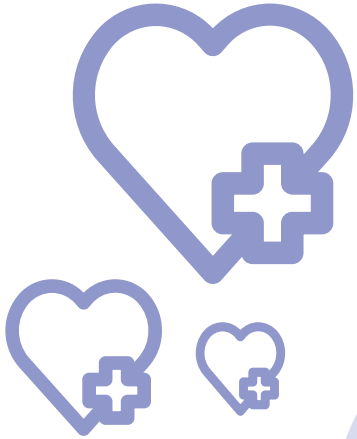
TCRS Referral Volumes - Recovery & Revitalization
(April 1, 2019 – March 31, 2023)



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.

Supporting Framework Development

Capacity Building



Support diabetes-related professional development among healthcare providers

5
Endocrinology individual consults facilitated

178
health care providers reached

96% reporting increased knowledge,

91% reporting increased skills,

91% reporting increased confidence

4
Endocrinology sessions

"I use this information daily in my practice when providing education and care to patients with diabetes."

"Learning about the different ways to teach [had the greatest impact on my practice]. I enjoyed the presentations from specialists in their field such as foot care, nutrition, physical activity, etc."

"Beneficial to hear an endocrinologists' perspective and thought process regarding decision making."

"It boosts my confidence."

"I feel I have changed my overall approach to be one of more of a collaborative, individual goal setting, from one that checks things off the list and relays certain information. I am glad to have participated in this program [New Hires] early in my role, to improve my nursing practice right from the start."

"This program's greatest impact [New Hires] was to motivate me to develop my motivational interviewing skills, and the importance of having the client's perspective/goals at the centre of my practice."

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.

- Alliance for Healthier Communities
- Anishnawbe Health Toronto DEP & DPP
- Banting & Best Diabetes Centre - University of Toronto
- 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
- Ontario Ministry of Health & Long-Term Care
- 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)
- Ontario eServices Program
- Regional Diabetes Steering Committee
- SCOPE
- South Riverdale Community Health Centre – DECNET
- 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

What Has Support for People Living With and At Risk of Diabetes Looked Like Over the Past Year?

Toronto
Diabetes
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