IMPROVING INTEGRATION THROUGH COLLABORATION

Advancing Equitable Access To & Provision of Diabetes Care

2023-24 Impact Report

South Riverdale COMMUNITY HEALTH CENTRE

Toronto Diabetes Care Connect

Message from the Regional Diabetes Steering Committee

We have seen exciting developments emerge this fiscal year. The year began with a motion that was unanimously passed in the Ontario Legislature, asking for the development of a provincial framework for chronic disease. The proposed initial focus is on diabetes and is to be designed to address prevention, management and treatment. We look forward to learning more about the work of Ontario Health to move the strategy forward.

On February 29, 2024, The Honourable Mark Holland, the Federal Minister of Health, announced next steps that will be taken towards establishing national universal pharmacare which will enable universal access to diabetes medications, and a fund for access to devices and supplies for people living with diabetes. This is a significant step towards removing financial barriers that many people living with diabetes face. These medications, devices and supplies are essential to enabling diabetes management, improving quality of life and reducing the risk of diabetes-related complications. Access to primary and tertiary care are also needed to ensure timely assessment and access to these medications and supplies, and requires ongoing focus to address capacity and access challenges. Access to nourishing food is also of critical importance across the diabetes continuum, and remains an ongoing challenge for many living in Toronto Region and across the province.

There are a number of exciting initiatives happening in the province that are aimed at improving diabetes care. It is wonderful to see community members, organizations and healthcare providers across sectors brought together to collaborate. Grounded in population health management models, the OHT Integrated Clinical Pathways are being developed to address the entire patient journey, including upstream services (ie. screening and prevention), as well as management in the community and at home. By investing in upstream prevention and integrated care pathways, we not only address current health disparities but also set a precedent for sustainable, cost-effective healthcare delivery in the long term.

Two of the Toronto Region OHTs have been designated as Lower Limb Preservation demonstration project sites, tasked with improving integration of care for people at risk of lower limb complications and amputation. Across the region, healthcare providers and diabetes teams provide supports that are key to reducing the risk of lower limb amputations including education and self-management support, early identification through foot screening, and preventive foot care. Access to affordable foot care has been voiced as an ongoing concern by people living with diabetes and healthcare providers. Funded chiropody models have enabled access to care for many, though the growing need for foot care, compounded by health human resource challenges are posing ongoing significant barriers to foot care access for those who need it most. It is our hope that some of these barriers to access can be addressed through the learnings from these initiatives.

As we press forward, let the data drive our decisions and the imperative for high-quality, equitable care guide our actions. Together, we can redefine the future of diabetes management and healthcare at large. It's crucial to harness the collective wisdom across all diabetes self-management education programs and scopes, and implement support structures that enhance upstream prevention efforts, thus reducing the downstream intensity of care required. The expansion of integrated hybrid and virtual care solutions presents a game-changing opportunity to scale our understanding and management of diabetes, which is particularly salient as primary care providers navigate an increasingly complex landscape. Leveraging these technological advancements can catalyze a transition towards more proactive, preventative healthcare models, revolutionizing the way we approach diabetes care. The diabetes care continuum demands a sophisticated, interdisciplinary approach that leaves no resource or insight unutilized to help continue the work or reorient health systems to meet the needs of the populations we serve with the incredibly talented healthcare teams (Quintuple Aim). Continuing to invest in upstream prevention and integrated care pathways, we address current health disparities and set a precedent for sustainable, values-based healthcare delivery in the long term.

Toronto Diabetes Care Connect (TDCC) Strategic Pillars

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

Facilitating Linkages & Connections

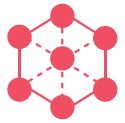
- Facilitate the coming together of partners to support meaningful discussions and strategic regional & sub-regional planning
- Facilitate connections amongst partner groups/ individuals to support coordinated care and planning
- Facilitate connections to diabetes prevention & management supports by 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

Year in review
Facilitating Connections

"TDCC unites the full scope of Diabetes expertise available within our healthcare system"

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

53
partners engaged

31
cross-organizational connections made

"... In the end, it all comes down to the foundational and fundamentals of this work, something that TDCC has been hyper-focused on to ensure that the body of knowledge, the knowledge translation, and the community of practice all continue to grow."

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 joined the expanding Ocean eReferral Network this year.

2,503
website visitors

Website viewed
4,733
times

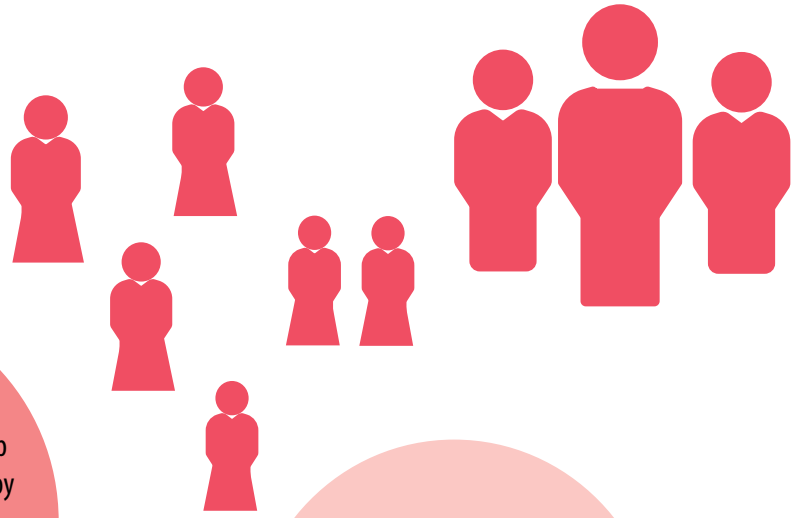
1,775
referrals submitted

98%
referrals resulting in connection

"Toronto Diabetes Care Connect efficiently connects individuals with diabetes to support services. The Toronto Central Referral Service (TCRS) streamlines access to diabetes support resources."

"Continued operation of TCRS and the website is vital for sustained accessibility and assistance."

Supporting Framework Development



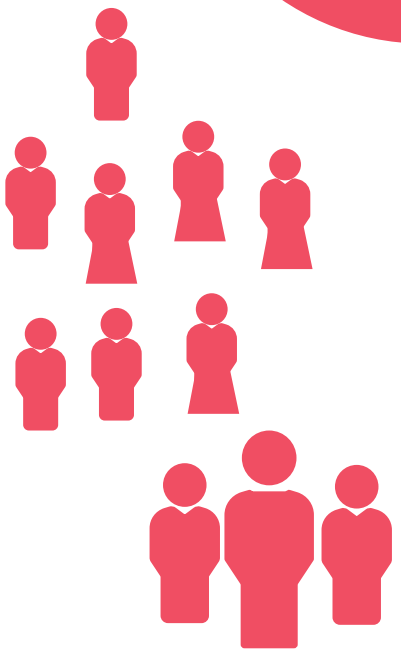
Support the development and/or use of frameworks, tools, and initiatives to support access to and delivery of quality team-based diabetes care

Supporting a regional work group aiming to advance health equity by leveraging EMR data to capture complexity of individuals accessing diabetes care at Toronto Region DEPs

Supporting lower limb preservation initiatives through facilitating connections to diabetes programs and providing implementation support

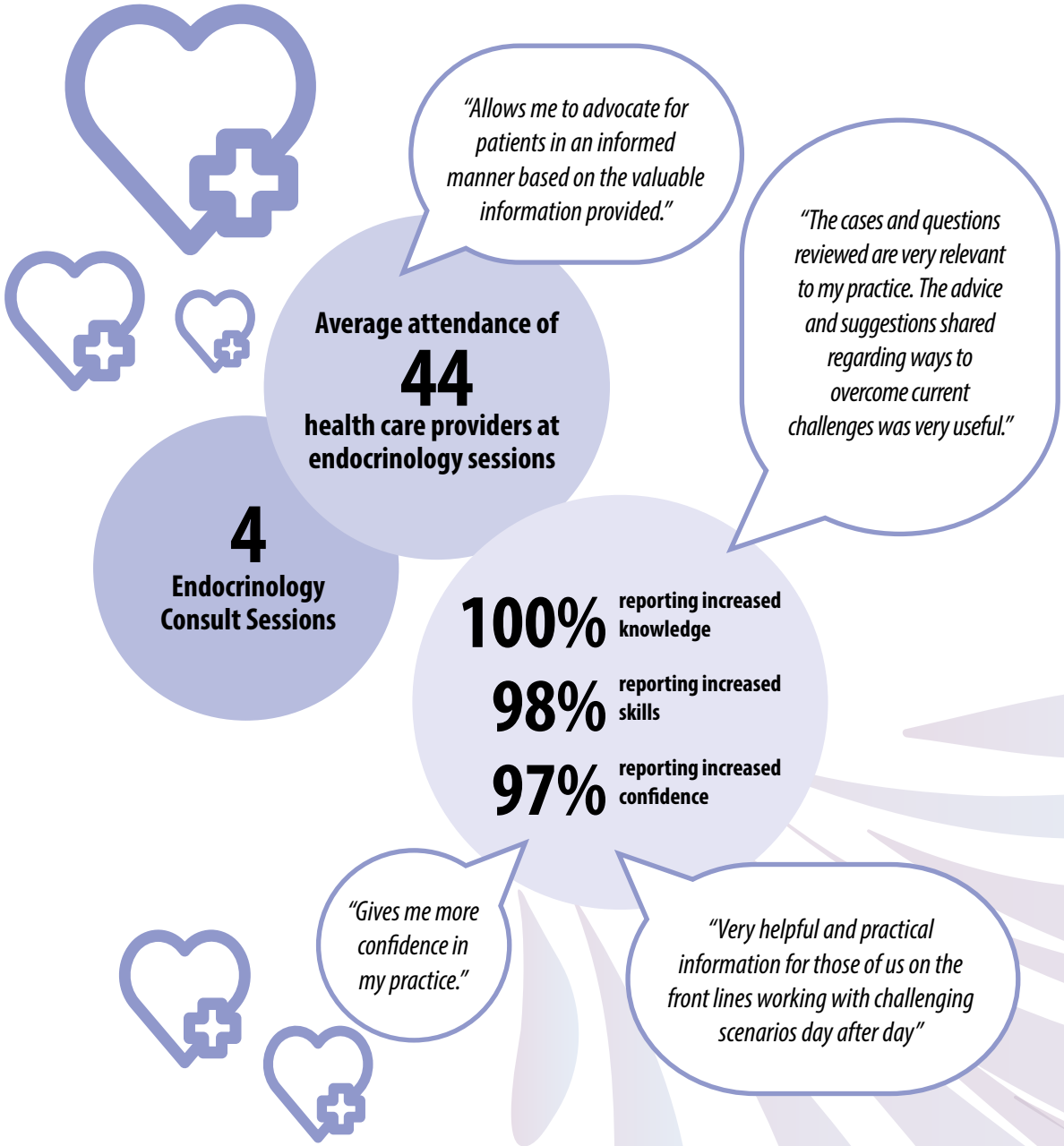
Supporting the development of data frameworks and decision-support tools to identify people at increased risk of diabetes-related complications and mental health concerns

Supporting advancement and implementation of Integrated Clinical Pathways for diabetes care



"TDCC has been a longer advocate for the strategic shift towards an integrated, team-based model than before it gained prominence."

Capacity Building - TDCC Endocrinology Sessions



As one of its core strategies since 2013, TDCC has offered endocrinology sessions to community-based healthcare providers supporting people living with diabetes. Originally, TDCC offered topic-based didactic sessions, with an aim of increasing diabetes-related knowledge of providers.

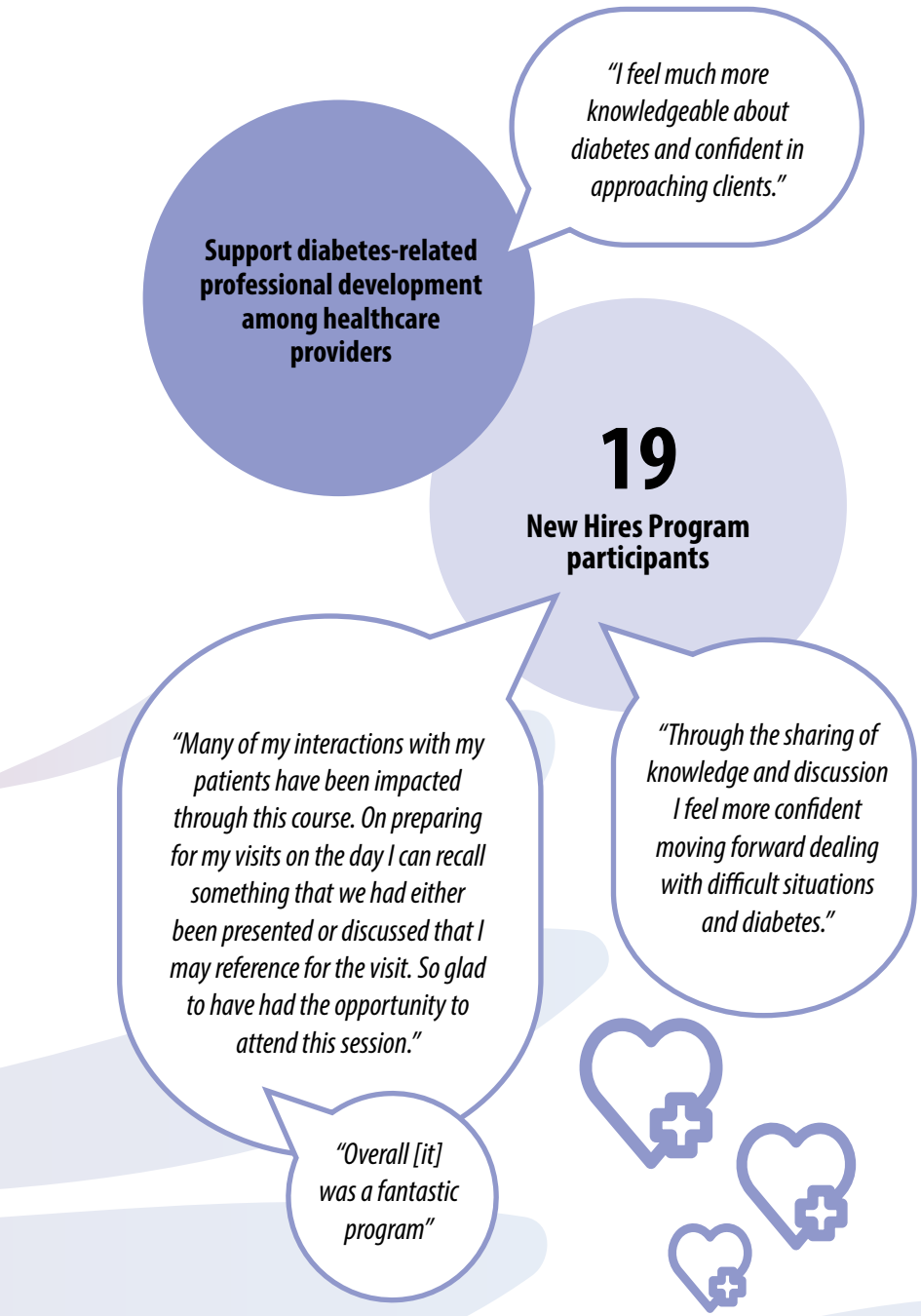
In 2014/15, through evaluations and key partner interviews, it was discovered that there was an unmet need for community-based healthcare providers to informally connect with and benefit from the expertise of an endocrinologist. In response, TDCC chose to offer case-based discussions to primary care teams and the diabetes educators they work with, and to the CDENT group (The Community Diabetes Educator Network of Toronto).

Sessions are facilitated by the TDCC Endocrinology Lead and Regional Facilitator. The sessions are interactive and case-based with content linked to emerging research and best practice, that is informed by areas of interest expressed by the participants. In addition to case studies discussed, recent topics addressed include diabetes and fasting, interpreting Libre reports, new medications, chronic kidney disease, and diabetes remission. Prior to the COVID pandemic, these sessions happened in person at various locations across Toronto Region. TDCC was able to continue to offer these sessions throughout the pandemic by leveraging virtual meeting platforms.

Participants have shared that they appreciate the opportunities for interactive participation and discussion, and that the cases, topics and updates presented are relevant to their practice. We also heard that shifting to virtual sessions has made it easier and more convenient for participants to join from across the Region.

Moving forward, TDCC plans to continue to offer these sessions, applying a continuous quality improvement lens to ensure we remain responsive and adaptable to the emerging needs of healthcare providers and teams. As OHTs move ahead with their diabetes related initiatives, TDCC plans to explore how this model may be leveraged within sub-regional systems.

New Hires Program



Background

In 2011, a survey of community based diabetes education programs in Toronto revealed an overwhelming need for improved access to training for newly hired diabetes educators. Identified needs among new educators were more knowledge, mentorship and networking with experienced educators in order to increase their confidence and skill. With the increasing complexity in diabetes management and a wealth of opportunity to learn from more experienced diabetes educators in the Toronto region, the New Hires Diabetes Training Program was developed. The program was developed in partnership with the Toronto Central Diabetes Regional Coordination Centre (TDCC), The Leadership Sinai Centre for Diabetes and SUNDEC.

Program Design:

Content was based on the competencies that were deemed necessary for working as a diabetes educator at an entry level. Participatory learning opportunities included the use of a scavenger hunt for local resources, practice teaching sessions and case studies. The interprofessional faculty is comprised of nurses, dietitians, pharmacists, chiropodists, endocrinologists, kinesiologists and registered social workers.

The program was initially offered in person, and was adapted to be provided virtually during the Covid-19 pandemic. This shift enabled the program to continue to run throughout the pandemic, and expanded reach that facilitated participation of diabetes educators outside of Toronto Region.

Desired Outcomes:

To increase the competence and confidence of new diabetes educators working in community settings by providing an overview of the field of diabetes and diabetes self-management education and introducing, through interactive presentations, self-management approaches that are effective in supporting people living with diabetes in achieving positive outcomes. Emphasis is on experiential learning and application of knowledge.

Program Impact:

As with any education program, the evaluation process is a key component. Participants are asked to reflect on whether their knowledge, skill and confidence in supporting people with diabetes has increased as a result of participating in the program. Results in each of these areas have demonstrated consistent impact. Qualitative feedback has highlighted the following themes: effective programing, positive participant experience and efficient program delivery. Participant feedback is integral to shaping future program design.

For additional information, please visit the TDCC website New Hires Program page.

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
- Black Creek CHC DEP
- Carefirst FHT DEP
- Centre Francophone de Toronto DEP
- Choose Health Self-Management Program
- 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
- Home & Community Care Support Services
- Humber River Health Diabetes Education Clinic
- 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)
- North York FHT DEP
- North York General Hospital Diabetes Education Centre
- Ontario Health - Toronto Region
  & Toronto Region Ontario Health Teams
- Ontario Ministry of Health
- Parkdale Queen West CHC DEP
- Regent Park CHC DEP
- Rexdale CHC DEP
- Scarborough Centre for Healthy Communities DEP
- Scarborough Health Network
- 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)
- 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
- TAIBU Community Health Centre 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
- Women's College Hospital Centre for Integrated Diabetes Care
- Women's Health in Women's Hands CHC DEP
- Wounds Canada

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