Ontario Diabetes Strategy – Newsletter

From: Alex Bezzina,
Assistant Deputy Minister
& Executive Sponsor

A newsletter for
diabetes stakeholders
Issue #7 - June 2011

New Faces

This spring has seen a number of exciting and significant changes at the Ontario Diabetes Strategy, as we continue our fight to improve diabetes care in Ontario. We would like to take the opportunity to mark the departure of two people who have provided excellent leadership to the ODS, Dr. Joshua Tepper and Sheila Banks-Switzer.

Dr. Tepper, who was Executive Sponsor of the Diabetes Strategy, assumed the position of Vice President, Education for Sunnybrook Health Sciences Centre, effective January 24, 2011. Dr. Tepper joined the ministry in September 2005 in the role of Assistant Deputy Minister (ADM) and has been a champion for the access to care agenda.

Banks-Switzer, while leaving the ODS, isn't going very far. She has agreed to take on the role of Acting Director of the Ministry's Performance Improvement and Compliance Branch.

"We will greatly miss both Joshua's and Sheila's contribution to diabetes care and the health care sector as a whole," said Saäd Rafi, Deputy Minister of Health and Long-Term Care. "Ontario has made helping people with diabetes and people at risk of developing the disease a very big priority, and thanks to the efforts of Joshua and Sheila there is a system in place for doing just that."

Leadership of the ODS shifts to Melissa Farrell, who is Acting Director of the Implementation Branch. Effective May 4th, the ODS will be integrated into that branch.

The other significant development has been the appointment of Alex Bezzina as ADM for the Health System Accountability and Performance Division to which the ODS and Implementation Branch belong. Bezzina comes to MOHLTC from the Ministry of Community and Social Services, where he was ADM of the Operations Division. He takes over from outgoing Acting ADM Ruth Hawkins.

"Change is sometimes hard, but it can also be good, and this is one of those times," said Rafi. "The ODS has benefited from dedicated leadership under Ken Deane, Joshua and Sheila, and thanks in large part to Ruth's steady guidance we had an extremely smooth transition to Alex and Melissa. The Strategy is in extremely good hands."

Baseline Diabetes Dataset Initiative

This spring will see the conclusion of the second iteration of the Baseline Diabetes Dataset Initiative (BDDI). This initiative is designed to help primary care providers in Ontario ensure that their patients with diabetes are receiving the three key tests used in managing the disease within recommended guidelines:

- the HbA1C blood glucose test, which patients should receive at least every six months;
- the LDL-C cholesterol test, which patients should receive at least every year, and
- a retinal eye exam, which patients should receive at least every two years.

Preliminary results as of May 13, 2011 show that there are over 6,100 primary care providers participating in BDDI, helping over 616,000 adult Ontarians with diabetes get the tests that they need. The third iteration of BDDI will commence in June 2011 with a public notice campaign, refreshed Diabetes Testing Reports for participating providers and the opportunity for other providers (salaried physicians and Nurse Practitioners in Nurse Practitioner-Led Clinics) to participate. *(cont'd)*

Stand up to Diabetes

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"We're very encouraged by these numbers," said Ruth Hawkins, outgoing Executive Sponsor of the Ontario Diabetes Strategy. "Ultimately we want to see every Ontarian who is living with diabetes getting tested according to recommended guidelines, and we encourage primary care providers to take part in this program."

Statistics at a Glance

46%	of adult Ontarians confirmed with diabetes are receiving tests within recommended guidelines
80%	is the Ontario Diabetes Strategy target for compliance with recommended guidelines
53%	of primary care providers receiving BDDI packages in first and second phase are participating

Centres for Complex Diabetes Care (CCDCs)

The Ontario government has established the province's first three Centres for Complex Diabetes Care (CCDCs). CCDCs are an integral part of Ontario's overall diabetes strategy, designed to respond to the particular needs of individuals with diabetes and complex health needs, including co-existing conditions (such as heart disease, kidney disease and mental health issues). The CCDC model will provide these individuals with a single point of access to specialized health care providers working together as an inter-professional team and in close collaboration with individuals' primary care providers.

"Our diabetes investments to date have focused mostly on prevention and services for people who are able to self-manage their diabetes with support from their primary care provider," said Health and Long-Term Care Minister Deb Matthews.

"These are important investments, but we know there are people who need more help than that. They need their primary care providers working together with specialists to get them the care they need, and that's what the new CCDCs are going to facilitate."

The new CCDCs will be located in existing health care facilities and will build on infrastructure and human resources already in place. In addition, the ODS has provided funding for the hiring of new staff required to meet the goals of the CCDC program. Professional staff roles will include medical specialists, case managers, nurses, nurse practitioners, dietitians and other inter-disciplinary health care providers.

In order to ensure that individuals with diabetes receive the very best care possible, CCDCs will work closely with each individual's primary care provider to ensure effective coordination and delivery of CCDC services. Those services include:

- support for individuals with diabetes who have complex health needs in a patient-centered model;
- case management for individuals as they move through the health care system, from the CCDC to primary care provider and on to community based services;
- support by specialists within or across regions. This includes provision of care through the Ontario Telemedicine Network and other innovative models;
- inter-disciplinary diabetes education and specialized management and treatment (e.g., insulin administration, mental health support/counselling, cardiovascular disease management); and
- support to primary care providers to facilitate management of individuals with diabetes and more complex needs through education, training, mentoring and/or coaching. *(cont'd)*

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"In almost every facet of health care, we are discovering that integrated care means better care," said Health and Long-Term Care Minister Deb Matthews. "CCDCs amount to a one-stop shop for integrated complex diabetes care, delivered by a coordinated team of health care providers."

Approximately 15 percent of people with diabetes are considered to be complex. As many as 6,000 people in each of the three selected CCDC regions may have the complex needs associated with diabetes that can be met through the CCDC. Over the next year, up to three additional CCDCs will be approved to serve other regions of the province.

Dr. Tara Kiran

Providing first class diabetes care is not an easy undertaking. Coordinating diabetes care across a province the size of Ontario is a difficult challenge. The Ontario Diabetes Strategy (ODS) has created 14 Regional Coordination Centres (RCCs), one located in every LHIN, to address this challenge. Supporting the RCCs, and providing clinical advice to the ODS, will be Dr. Tara Kiran, the recently appointed Provincial Clinical Lead for the Ontario Diabetes Strategy.

"Diabetes is a growing problem worldwide, in Canada and here in Ontario," said Dr. Kiran. "It is one of the most complex chronic diseases to manage, and Regional Coordination Centres were created to help ensure that Ontarians everywhere are receiving the best possible care and advice. My job is to support the RCCs."

Dr. Kiran will be working with primary care and specialist leaders in each RCC, and with the Ontario Diabetes Strategy to ensure that there is a consistent vision and approach right across Ontario.

"The challenge we face right now is that our primary care system was built to deal reactively with acute diseases and problems," said Dr. Kiran. "In order to provide proper care to people suffering from diabetes and other chronic diseases, we need to shift the focus towards a more planned proactive care model."

Dr. Kiran brings an ideal combination of skills and experience to the role of Provincial Clinical Lead. Hers has been a career dedicated to quality improvement. She has worked as a family and emergency room doctor in many small communities across Ontario, from Orillia to Sioux Lookout. In 2006, she established a practice at the Regent Park Community Health Centre (CHC) in Toronto. She led the CHC's quality improvement team and, in partnership with the centre's diabetes education program, helped implement an interdisciplinary diabetes clinic at the centre.

Dr. Kiran completed medical school at the University of Toronto and her post-graduate training in family medicine at McMaster University. In September 2008, she completed her Master's degree in Public Health at the London School of Hygiene and Tropical Medicine in London, England. She has done research on the quality of diabetes care in Ontario and is currently a researcher at the Li Ka Shing Knowledge Institute of St. Michael's Hospital in Toronto. In 2009, she was the Diabetes and H1N1 Primary Care Lead for the Toronto Central Local Health Integration Network. She joined the St. Michael's Hospital Academic Family Health Team in February 2011 where she continues to see patients and do research.

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Self-Management

When the Ontario Diabetes Strategy (ODS) was created in 2008, supporting self-management of diabetes was identified as a key priority. "A great deal of the work in managing diabetes has to be done by the people living with the disease," says Ruth Hawkins, outgoing Executive Sponsor of the Ontario Diabetes Strategy. "The ability of people to self-manage their diabetes 365 days a year has a powerful impact on their overall health."

With this in mind, the ODS Self-Management Project was established to help individuals with diabetes assume greater control and responsibility for daily health care decisions, including:

- addressing behaviours and choices that may exacerbate their condition or increase the risk of complications (e.g., exercise, diet, smoking);
- taking medications appropriately;
- monitoring and managing the signs and symptoms of disease; and
- maintaining regular contact with health care providers.

One of the earliest ODS tools to support self-management of diabetes was the Diabetes Passport and Goal Card, introduced last year. Ontarians with diabetes can use the Passport and Goal Card to record, track and monitor important information such as key test results, medications, diabetes education sessions, personal goals and planned activities to assist in self-management of their diabetes.

In 2010-11, the achievements of the ODS Self-Management Project included:

- dedicated resources to establish a consistent, provincial standard of self-management support that served as a foundation for application to all chronic diseases;
- evidence-based self-management education and skills training for 550 health care providers across multiple sectors who in turn can provide self-management support and intervention to over 175,000 individuals with diabetes or at risk of developing diabetes;
- mentoring support for trained health care providers to assist with the integration of self-management skills and techniques into daily practice;
- evidence-based self-management education and skills training workshops for 350 patients with diabetes or at risk of developing diabetes;
- local strategies to ensure that training is offered in an appropriate manner to a diverse range of communities and socio-economic groups; and,
- local communications/outreach strategies to increase awareness of self-management principles, resources, activities and practices across each region.

"At the end of the day, it's about building confidence and ability," says Hawkins. "It's about teaching individuals how to take care of themselves in partnership with their health care providers."

The infrastructure and investments established by the ODS Self-Management Project during the past year will support the expansion of self-management education and training across the province in 2011-12.

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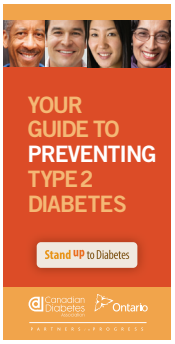
Type 2 Diabetes Prevention Guide

When it comes to type 2 diabetes, the case for prevention is clear. The number of Ontarians with diabetes has increased by 69 percent over the last 10 years – an estimated 1.169 million people in this province have now been diagnosed with type 1 or type 2 diabetes. Treatment for diabetes and related conditions such as heart disease, stroke, and kidney disease currently costs Ontario over $5 billion each year. By 2020, it is estimated that 734,000 new cases will be diagnosed and the cost will increase to $7 billion. In the face of these numbers, the Ontario Diabetes Strategy (ODS) takes helping Ontarians prevent or delay type 2 diabetes seriously.



Ontario has released its latest tool to help Ontarians accomplish this goal. "***Your Guide to Preventing Type 2 Diabetes***" was developed by the Ministry of Health Promotion and Sport (MHPS), the Ministry that develops prevention initiatives under the Ontario Diabetes Strategy. The Guide is intended for both providers and patients; it helps Ontarians who are at risk for type 2 diabetes understand what they can do to improve their chances of avoiding the disease.

"The Guide assists Ontarians to self-identify as being at greater risk for developing type 2 diabetes. The Guide presents five steps that individuals at higher risk can take to improve their health and reduce the chances of developing type 2 diabetes", says Margarett Best, Minister of Health Promotion and Sport.

Prevention Guide

The five steps for people at risk are as follows:

Eat right – What, when and how much you eat are very important

Get moving – Every bit of activity counts

Achieve a healthy weight – Physical activity is a key to good health

Record your progress – Writing down what you eat and how much you exercise will help you achieve your goals

Get help – You are not alone. Talk to your doctor. Get support from family and friends

The Guide also includes a list of risk factors and warning signs, so it can serve as a "one stop" resource for the prevention of type 2 diabetes.

The Canadian Diabetes Association reviewed the Guide and their name and logo appear on the front cover of the Guide.

"Ontarians need to understand they can take steps that dramatically reduce the risk of developing type 2 diabetes," said Ruth Hawkins, outgoing Executive Sponsor of the Ontario Diabetes Strategy. "And for providers, now a simple tool is available they can use to efficiently and effectively communicate the risks of the disease and the steps needed to reduce those risks."

"Your Guide to Preventing Type 2 Diabetes" will initially be distributed in professional publications such as the Canadian Journal of Diabetes, the Canadian Medical Association Journal and the Ontario Medical Review.

It is also available on **Stand up to Diabetes**, the Ontario Diabetes Strategy website at **ontario.ca/diabetes** where it can be downloaded or copies ordered for delivery free of charge to any Ontarian.

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