

Ontario Diabetes Strategy – Newsletter

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A newsletter for diabetes
stakeholders

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Over the past two years of implementing the Ontario Diabetes Strategy, the government has built on existing investments in prevention and care initiatives at each level of the health system to build capacity, make it easier for people to get the services they need and improve the overall quality of diabetes service and care in Ontario. The Baseline Diabetes Dataset Initiative (BDDI), launched last Spring, is one of the best examples of this.

Through BDDI, physicians are provided with information about the numbers and proportion of diabetes patients in Ontario who have received three key tests, blood glucose control (HbA1C), cholesterol¹ (LDL-C), and a retinal eye exam within the intervals recommended by clinical practice guidelines. The Diabetes Testing Reports helps inform primary care providers about their own patients' compliance with the three key tests, letting them know which of their patients might need to be reminded. Previous estimates indicate that the majority of Ontarians living with diabetes have not had these tests within the recommended time period. The government is committed to addressing this issue and since the introduction of BDDI, recent analysis shows an increase in the number of Ontarians who have.

On November 19, 2010 the second phase of BDDI began with an online and print media public notice campaign. This was followed by updated Diabetes Testing Reports for over 5,500 providers who are participating in the program, who have more than 570,000 confirmed patients with diabetes. For those providers who have not yet enrolled, the ministry will be issuing an invitation to participate in January 2011, by sending out Diabetes Patient Lists for validation. In addition, there will be opportunities for primary care providers who do not bill OHIP to participate. BDDI represents a firm commitment by the Ontario government to providing family physicians with the information they need to support their patients, in preparation for the implementation of the Diabetes Registry. More details about this initiative and other information about the Ontario Diabetes Strategy can be found at ontario.ca/diabetes

Measurable Indicators of the Ontario Diabetes Strategy

Two of the targets that Ontario has set as part of the Diabetes Strategy are ensuring all people with diabetes have access to a primary health care provider,

¹ We are only able to examine HbA1C and LDL-C tests done in community labs.

and ensuring that 80 percent of people with diabetes, aged 18 and older, have the three diabetes tests within the recommended guideline period. To help track progress on these and other goals, we are monitoring a core set of measurable indicators. These indicators provide information on risk factors for diabetes, access to care, management of care according to clinical practice guidelines, and intermediate and long-term outcomes of care for Ontarians aged 18 years and older.

Results for these indicators are summarized below²:

Indicator	Result
Diabetes prevalence in Ontario population (age 18+)	9.3% (961,204)
Modifiable Risk Factors for Diabetes	
Percent of Ontarians who are physically inactive	51.2%
Percent of Ontarians who are overweight/obese	51.7%
Measures of Access to Care	
Percent of Ontarians with diabetes who have a regular primary health care provider	96.4%
Number of Ontarians with diabetes registered with Health Care Connect	4,768
Number and percent with diabetes referred to family doctors by Health Care Connect	2,852 (59.8%)
Clinical Management Measures	
Percent of Ontarians with diabetes receiving a blood glucose control (HbA1C) test in the past six months	55.9%
Percent of Ontarians with diabetes who received a cholesterol (LDL-C) test in past year	68.2%
Percent of Ontarians with diabetes who received a retinal eye exam in the past two years	66.1%
Percent of Ontarians with diabetes who received all three tests within the guideline periods	37.8%
Complications, Outcomes of Care per 100,000 Ontarians with diabetes	
Emergency visit rate for hyperglycemia or hypoglycemia	1,111
Renal replacement therapy rate	780
Hospitalization rate for infections, ulcers and amputations	3,244
Hospitalization rate for heart attacks (acute myocardial infarctions)	1,163

² NOTE: HbA1C and LDL-C test result percentages only reflect tests conducted in community labs where a fee-for-service claim was submitted.

SOURCES:

- Prevalence: BDDI as of August 2010.
- Risk factors: 2009 Canadian Community Health Survey.
- Access to Care: 2009/10 Primary Care Access Survey, 2009/10 Health Care Connect.
- HbA1C, LDL-C, Retinal eye exam: Lab claims (for tests in community labs), and Optometrist/Ophthalmologist claims for services provided up to March 31, 2010.
- Emergency visits: 2009/10 National Ambulatory Care Reporting System.
- Other outcomes of care: 2008/09 National Ambulatory Care Reporting System and Discharge Abstract Database.

The Ontario Diabetes Strategy (ODS) introduces a Diabetes Passport and Goal Card

The Diabetes Passport and accompanying Goal Card were created to support patients' management of diabetes. These self-management tools were adapted from existing resources used by the Quality Improvement and Innovation Partnership (QIIP) and Trillium Health Centre.

In partnership with their health care providers, Ontarians with diabetes can use the *My Diabetes 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. The Passport and Goal Card support the Ontario Diabetes Strategy's objective of improving management of diabetes and diabetes-related complications.



How to use the Diabetes Passport and Goal Card

Patients are advised to take this Passport and Goal Card to every health care appointment. Continuous tracking of goals, completion of key diabetes tests and self-management education and skills training will help individuals better manage their diabetes in collaboration with their health care team.

The Passport and the Goal Card are enclosed in a plastic sleeve designed to fit into a purse or a pocket. Print copies of the Diabetes Passport and Goal Card are available in English and French and can be ordered from ServiceOntario (order instructions are in the orange call out box).

Electronic versions will be available in various languages on the *Stand up to Diabetes* website at ontario.ca/diabetes in upcoming months.

A tool for education

In addition to helping patients manage their diabetes, the Passport is an excellent tool for educating and raising awareness of diabetes. Diabetes Education Programs will use the passport as a teaching tool, Regional Coordination Centres will use it to promote best practices, and LHINs can use the Passport as a means of increasing provider and public awareness about diabetes and the importance of self-management.

Early in the New Year, copies will be sent to physicians across Ontario, and broader dissemination plans are being finalized.

Print copies of the Diabetes Passport and accompanying Goal Card, in English and French, can be ordered one of two ways:

1) Online through Service Ontario:
serviceontario.ca/publications
(search phrase: diabetes passport)

2) By Phone: Call ServiceOntario Publications:
Monday to Friday, 8:30 AM to 5:00 PM
1-800-668-9938 Toll-free
1-800-268-7095 TTY Toll-free

HealthAchieve Booth

A critical component of the Ontario Diabetes Strategy is raising awareness. The strategy aims to prevent diabetes and improve diabetes care in Ontario, and to do that successfully it must get the word out to Ontarians as well as health care leaders and stakeholders.

This past summer's community tour reached out successfully to patients and other members of the public in ten cities across the province. Last month, the Stand up to Diabetes booth at the HealthAchieve conference in Toronto successfully targeted health care leaders, educators and other stakeholders.

Stand up to Diabetes

“HealthAchieve is one of North America’s largest health care conferences and exhibitions,” says Dr. Joshua Tepper, Executive Sponsor of the Ontario Diabetes Strategy. “It brings together thousands of the top leaders, the best thinkers and most influential stakeholders. In addition to talking to patients one-on-one, these are the people we have to reach.”



And reach them it did. The booth occupied a central location at the Metro Toronto Convention Centre. Hundreds of people stopped by, collecting brochures, talking with Ministry of Health and Long-Term Care staff, and looking at patient tools like the Diabetes Passport, which helps individuals record, track and monitor important information as they manage their disease.

Sheila Banks-Switzer, Project Director for the Ontario Diabetes Strategy, says the feedback received was extremely positive. “We had doctors stopping by, people with diabetes who had heard about the strategy but wanted to know more, and people who were unfamiliar with the strategy but were really impressed by what they saw. People who are well versed in health care know that we are on the right track with the Ontario Diabetes Strategy, and they are going to help us get the word out.”

It was the same story in late November at the 48th Annual Scientific Assembly, also in Toronto. The event, organized by the Ontario College of Family Physicians, included family physicians, residents, medical students, family practice nurses and other healthcare professionals from all over the province.

Many of the sessions focused on diabetes prevention, management and care. That made it a perfect venue for the distribution of information about the Baseline Diabetes Dataset Initiative (BDDI).

Through BDDI, physicians are provided with ongoing information about whether their diabetes patients have received three key tests within the intervals recommended by clinical practice guidelines. This initiative provides valuable information to physicians to support more effective management of their patients’ testing needs.

Banks-Switzer says it is particularly important that people understand how comprehensive and wide ranging the strategy is. BDDI is just one of 23 current individual projects designed to reduce the risk and prevalence of diabetes, support people in the management of the disease, and improve the quality and accessibility of diabetes services and care in Ontario. The 23 projects are aligned to seven key themes, which are:

- Prevention initiatives
- Specific population-based programs
- Coordinating care/best practices
- Improving diabetes management
- Leveraging information to improve health outcomes
- Expanding diabetes programming and
- Expanding medical interventions.

“We want Ontarians with diabetes to know that we have their backs,” says Banks-Switzer. “This disease affects more than eight percent of the population, and is a significant cause of heart attacks, strokes, amputations and other health complications. But it is often preventable, and it is very manageable, and the Ontario Diabetes Strategy is a big part of the diabetes solution in this province.”

Happy Holidays

This newsletter will be the last for 2010. All of us at the Ontario Diabetes Strategy would like to take this opportunity to wish our partners, stakeholders, colleagues and friends all the best for the holiday season and the New Year to come. 2011 will be a busy year as the Diabetes Strategy continues to roll out initiatives intended to prevent diabetes and improve diabetes care, and we look forward to working with you.

Happy New Year!

Stand up to Diabetes