

# Integrated Lower-Limb Preservation (LLP) CoP Webinar: *Putting Feet First*

Ontario Health's Diabetes Strategic Initiatives



November 28, 2024



# Land Acknowledgement

# Housekeeping



- Please keep yourself on mute unless you are speaking.



- We encourage you to type your questions or comments in the chat box. The chat box is monitored throughout the webinar. Questions will be addressed directly in the chat box or in the discussion following the presentations.



- We also encourage you to share any suggestions/topics for future webinars.

- This meeting will be recorded. A copy of the webinar recording, and slides will be available on the virtual CoP shared space.

# Agenda

TIME	TOPIC	NAME
8:00 am	Land Acknowledgment	Lindsay McKendrick
8:05 am	Welcome & Introductions	Mike Setterfield
8:10 am	Ontario Health's Diabetes Strategic Initiatives	Ryan Emond
8:45 am	Questions & Discussion	All
8:55 am	Wrap Up	Mike Setterfield

# Speaker

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## Ryan Emond

Program Manager, Chronic Disease  
Primary and Community-Based Care  
Ontario Health



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# Diabetes Strategic Initiatives

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Reflections on Progress and the  
Path Forward

Nov. 28, 2024



**Ontario  
Health**

# Ontario Health - Diabetes Initiatives Key Priorities

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**The Population Health and Prevention team is focused on addressing:**

- ❖ diabetes prevention,
- ❖ early detection, and
- ❖ early intervention for complications

**Key Ontario Health areas work to date include but are not limited to:**

- Diabetes Quality Standards
- Lower Limb Preservation pathways in Ontario Health Teams
- *Diabetes Education Programs*

# Background: Diabetes Education Programs



## Adult DEPs at a Glance:

Ontario Health  
funds 185  
Diabetes  
Education  
Programs (DEPs),  
including 35  
Pediatric DEPs,  
and 150 Adult  
DEPs

- ❖ **Client Population:** type 1 and type 2 diabetes, prediabetes and diabetes in pregnancy (depending on program focus)
- ❖ **Program location:** hospitals, Community Health Centres (CHCs), Family Health Teams (FHTs)
- ❖ **Team composition:** Registered Nurse (RN) - Registered Dietitian (RD) diabetes educator dyads; may include additional health professions (e.g., Registered Social Workers, Chiropractors, Kinesiologists)
- ❖ Collaborate with the client's primary care provider and/or endocrinologist to carry out the diabetes care plan; use person and family-centered care strategies, self-management principles



# Opportunities & Benefits

## Key Benefits:

- Support for patients' w/ diabetes
- Source of community care for underserved and unattached populations
- Potential to keep patients out of the ER
- Provide services virtually and other innovative practices

## Opportunities:

- ❖ Lack of a standard model
- ❖ Lack of accountability for performance
- ❖ No long-term plan
- ❖ Manual and inconsistent reporting
- ❖ Lack of connectivity with OHTs and PC



According to Diabetes Canada<sup>1</sup>, self-management education offers significant **benefits and improved outcomes for individuals and with diabetes**, including:

- ✓ Reduction of CVD episode of 20%
- ✓ **Reductions in foot ulcerations, infections and amputations**
- ✓ Reductions in all-cause mortality of 44%
- ✓ Reduction of stroke of 30%
- ✓ Reductions in glycated hemoglobin (A1C)

<sup>1</sup> <https://www.diabetes.ca/health-care-providers/clinical-practice-guidelines/chapter-7>

# 2024/ 25 DEP Initiative Goals

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## **24/25 ABP: 2.7.3 Update guidelines and program expectations for digital/virtual supports to improve access, equity and performance of Diabetes Education Programs**

*In partnership with OH Regions, improve clinical outcomes, access and equity of Diabetes Education Programs (DEPs) by building on existing expertise, tools, feedback and evidence. Initial focus is on Adult DEPs.*

# Strategic Objectives

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In 2024, our focus has been on laying the groundwork for our diabetes strategic initiatives, driven by external partners and a need for deeper engagement with FNIMUI communities.

Despite funding constraints, we've concentrated on gathering data and building strong stakeholder relationships. As we move forward, we are using what we've learned to refine our 2025/26 objectives:



**Improve access, equity, and performance of Diabetes Education Programs:**

comprehensive foot assessments, better integration with OH programs and primary care, knowledge sharing, and performance management



**Improve early detection in diabetes:**

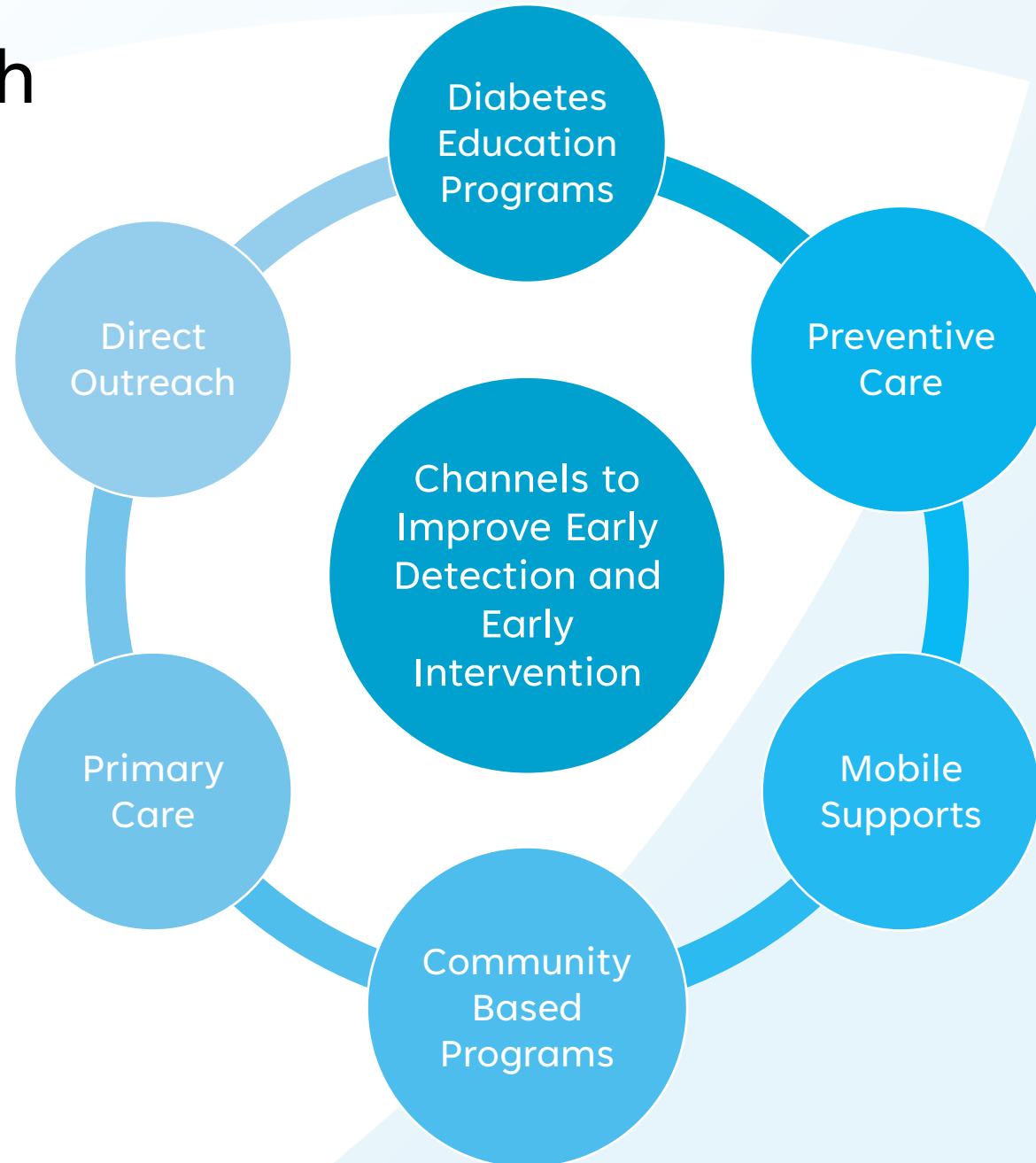
Including an initial phase of diabetes complications screening program, starting with retinopathy



**Engage with First Nations, Inuit, Métis and Urban Indigenous partners:**

To support planning and implementation of chronic disease prevention and management initiatives

# Ways to Reach



# Our Partners

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# Discussion



- How can we strengthen the integration of limb loss prevention strategies within community-based models (such as DEPs) to improve prevention and management outcomes for patients?



# Questions & Discussion

Join the...

# Integrated Lower-Limb Preservation Community of Practice

## Joining is as easy as 1,2,3

- 1 Visit the [OHT Shared Space](#) and click “SIGN UP” to create your account.
- 2 Visit the [Integrated Lower-Limb Preservation CoP](#) and click the “JOIN GROUP” button. You will receive an email notification when you’ve been accepted into the group.  
*Note: You are automatically accepted into the “[General Discussion](#)” Group.*
- 3 Don’t forget to click on the “Subscribe to Updates” button once you’ve been accepted into your CoP!

**Integrated Lower-Limb Preservation CoP**

This CoP is for all providers of LLP care and their system partners to work together and leverage the OHT model to deliver a full and coordinated continuum of care to improve outcomes and experiences for patients at risk for non-traumatic major lower-limb amputation.

This CoP brings together local and regional interprofessional teams including, but not limited to, clinical leads, change management leads, project managers, and front-line clinicians from primary care, home & community care, and acute care, as well as patients and caregivers with lived experience, using a collaborative approach to accelerate integrated, LLP care in Ontario.

This CoP is facilitated by the Ontario Health provincial LLP team, in collaboration with the OH Regions, and will be operationalized via this interactive online space that includes a discussion forum, document library of tools and resources, and a member directory for networking. The CoP also includes live touchpoints (i.e., interactive webinars) relevant to either the larger LLP community and/or subgroups within the CoP.

210 MEMBERS Mon Jan 09 2023 ESTABLISHED

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Aiman Mohammad



Any questions/concerns? Contact the OH ICP Project Team at [OHTSupport@OntarioHealth.ca](mailto:OHTSupport@OntarioHealth.ca)



# **Thank You**



OH ICP Project Team