

North West LHIN



North West LHIN Summary of Community Engagement: Ontario Diabetes Strategy

North West Local Health Integration Network



Ontario
Local Health Integration
Network

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1.0 Background

The North West LHIN was selected to be an early adopter in the Ontario Diabetes Strategy (ODS). To inform planning for this initiative, the North West LHIN conducted a number of community engagement activities from January to April 2009 with a variety of health service providers (HSPs) throughout the region. The community engagement was designed to gather information to better understand diabetes care in communities across the North West LHIN.

2.0 The Process

A variety of approaches were used to engage HSPs. Individuals were contacted by telephone, e-mail or fax and invited to share their knowledge and experience in diabetes care by participating in an interview or focus group in their community. When travel to communities was impossible due to weather conditions, videoconference focus groups or telephone interviews were conducted (see Appendices A & B for Questions). The aim was to gain a better understanding of the following:

- The face of diabetes in the North West LHIN
- Gaps in diabetes care
- Challenges in diabetes care
- Strategies to improve diabetes care
- Access to primary and specialty care for people with diabetes

The following community engagement activities were carried out as part of the ODS:

- Focus group discussions with HSPs throughout the North West LHIN
- Key informant interviews with various HSPs from across the North West LHIN
- Regular Diabetes Strategy Advisory Committee meetings with members representing local HSPs from communities throughout the region

A total of 9 focus group sessions and 30 key informant interviews were conducted from January to April 2009. Participants represented the following agencies and organizations in the North West LHIN:

- Hospitals
- Family Health Teams
- Community Health Centres
- Diabetes Education Centres
- Long-Term Care/Nursing Homes
- Ambulatory Services
- Aboriginal Health Access Centres
- Aboriginal Health Authorities
- Indian Friendship Centres
- Public Health Units
- Northwestern Health Units
- Dilico Anishinabek Family Care
- First Nation Family Physicians Group
- The Northwest Community Care Access Centre
- Northern Ontario School of Medicine

In total, over 100 people from throughout the North West LHIN participated in focus groups and interviews. In addition, the Diabetes Strategy Advisory Committee met monthly between January and May 2009. Meaningful discussions regarding positive strategies, challenges and suggestions for improving diabetes care were generated. Qualitative data collected during community engagement contributed directly to framing recommendations for expanded diabetes services in the North West LHIN.

This work was complemented by the completion of two reports by the Centre for Rural and Northern Health Research at Lakehead University: *Diabetes Management and Prevention: Environmental Scan for the North West Local Health Integration Network* (2009) and *Environmental Scan: Chronic Disease Prevention and Management for the North West LHIN* (2009). The full reports are appended (Appendices C and D).

3.0 Emerging Themes in Diabetes Care in the North West LHIN

Challenges in accessing diabetes care and the need for enhanced coordination of diabetes services were two overriding themes that emerged during community engagement.

Access

The North West LHIN encompasses a land mass equivalent to 47% of the province of Ontario and has a population of approximately 242,450 people (Integrated Health Services Plan, 2006). Northwestern Ontario is a vast geographic area with sparse population density. The health status of the population falls below that of the rest of the province on a number of indicators; creating heightened demand for services. These factors present challenges to accessing health services. Access was a key theme identified by stakeholders during community engagement; specifically, access to primary and specialty care, foot care and eye care services, community services and diabetes education.

Primary and Specialty Care

Not surprisingly, geographic isolation and the need for extensive travel were reported as factors limiting access to diabetes services for many in the North West LHIN, particularly in First Nations communities. Many people from remote First Nations communities receive diabetes care by flying to Sioux Lookout, Thunder Bay or Winnipeg, where they are seen by a physician or diabetes educator. In numerous communities outside of Thunder Bay, diabetes education programs operate on a part-time basis. Stakeholders reported that, follow-up is difficult with patients who live far from the site of care, such as individuals living in rural settings and First Nations communities.

Telemedicine was perceived to be an effective tool for improving access by many HSPs. Access to specialists such as ophthalmologists, nutritionists, and diabetes educators is enhanced in remote communities through the use of this technology. Though valuable in many cases, key informants identified the need for face-to-face interactions to complement telemedicine sessions. The limitations inherent in delivering consistent, culturally appropriate care in remote First Nations communities via telemedicine were a prevalent theme. The need to develop and maintain local health human resources within communities rather than developing dependence on external resources was also identified.

Foot Care

The need for improved access to foot care services was identified as a common concern during community engagement.

*“Foot care services are more or less non-existent, and desperately required.”
(Provider, Sioux Lookout)*

In many communities a fee for foot care services exists. Fees range from \$25 to \$50, which is evidently a deterrent for individuals on fixed incomes such as seniors. Many stakeholders shared stories of complex wounds leading to amputations, which might have been prevented with improved foot care. Limited access to advanced foot care training programs and a lack of sustained funding for programs were identified as the two greatest barriers to increasing access.

Eye Care

Access to ophthalmology services is an essential component of quality diabetes care. Many communities do not have ophthalmology or optometry services and in these instances people have to travel to larger communities to receive routine eye care. The Canadian National Institute for the Blind (CNIB) offers services on-site through the CNIB Eye Care Van mobile unit. Many stakeholders expressed support for this program, though more frequent visits were recommended.

“There is an eye van that goes out to most Northwestern communities once a year to do screening, etc. However, they do not travel from November until mid-March due to weather and road conditions.” (Provider, Thunder Bay)

In some First Nations communities, eye care is available through a tele-ophthalmology program supported by on-site ophthalmology visits. Though successful, this program is reportedly unavailable in a number of communities.

Community Supports

The North West LHIN has an aging population. Key informants identified the need for improved community supports, especially for seniors with diabetes. It was widely perceived that increased community supports would reduce diabetes-related complications for this population.

*“Older people with diabetes have mobility issues and may not be able to leave their home; (they) have to rely on other people that may not always be available.”
(Provider, Terrace Bay)*

The shortage of community services for people with diabetes was identified as a prevalent concern among HSPs. In particular, community wound care was identified as a challenge. Ambulatory clients reportedly must go to local emergency departments (ED) for wound care, rather than receiving services in their homes. The worsening condition of existing wounds was the perceived result, as some people elect not to visit EDs. Where community services for wound care do exist they are apparently well received.

Availability of Diabetes Education Centres

Limited availability of diabetes services was reported to be a significant barrier in providing quality diabetes care. In many communities throughout the North West LHIN, diabetes programs delivered through the Diabetes Education Centres apparently have long wait lists. While many HSPs felt that diabetes services in larger communities were utilised well, concern was expressed for people in more northern, rural and remote communities. Some diabetes educators travel to small rural communities to provide diabetes services once or twice per month. Many First Nation communities receive on-site services once to twice a year due to limited staffing, extensive distances and travel conditions. The need to enhance outreach to these communities was a particularly prevalent theme.

Health Human Resources

The recruitment and retention of health human resources in the North West LHIN were identified as ongoing challenges. Though many innovative programs exist to support improved recruitment and retention, shortages continue in several areas including: primary and specialty care, mental health services, home care, and foot care. HSPs reported that shortages impact access to diabetes services. Of particular concern was the lack of available health professionals serving people with diabetes in isolated First Nations communities, which is reportedly leading to compromised care in some cases.

Psychosocial support

The need for enhanced psychosocial support services for people with diabetes was expressed by numerous providers.

*“We could use mental health counselling and social workers because there are so many issues to get through before (patients) can address their diabetes”
(Provider, Red Lake)*

It was reported that few primary care practices in the North West LHIN offer psychosocial supports for those suffering from chronic diseases such as diabetes. Where mental health services are available within an interdisciplinary team, they are apparently well received and over subscribed, leading to wait lists.

Self-Management

The Stanford Chronic Disease Self-Management program was identified as an effective tool for supporting people to better manage their diabetes throughout the North West LHIN*. HSPs reported that peer support and access to self-management strategies are positive attributes of the Stanford program. Many providers felt that in addition to supporting people to manage their diabetes and co-morbidities, the program could also be effective in addressing other issues such as mental health.

*“People do have to be accountable. If we can get more people self-managing, it would help them and the community to reduce the burden of treatment.”
(Provider, Thunder Bay)*

* The North West LHIN has sponsored three Stanford Self-Management Master Trainer courses. There are now 75 master trainers throughout the region.

Stakeholders expressed a need for ongoing financial support to lead self-management programs. Enhanced networking and physician participation in programs were felt to be key components to make a lasting impact on the self-management of diabetes and other chronic diseases.

Education, Health Promotion and Prevention

In several communities, stakeholders commented on the lack of access to effective education and prevention programs. Although Diabetes Education Centres follow the Canadian Diabetes Association (CDA) guidelines, many providers saw the need for advanced education in diabetes for health care professionals in order to achieve consistent messaging and enhanced delivery of care. Access to primary prevention programs was clearly identified as a gap in many communities, while the poor health status of the population was a concern in all communities. Strong support for education by diabetes educators in schools and community centres was expressed as a means to address this concern.

Limited access to healthy food in many remote First Nations communities was a prevalent theme in community engagement. Many communities are faced with high costs for fresh produce; these costs combined with low incomes make healthy food choices unaffordable for many individuals. Healthy lifestyle programs exist in some First Nations communities, such as community grocery store tours and community kitchens. Although these programs take a hands-on approach, they have limited effectiveness due to the high cost of 'healthy' food versus 'unhealthy' food. For example, it was reported that a bag of oranges may cost up to \$35.00 in some remote communities.

Stakeholders also indicated that many communities in the North West LHIN do not have the infrastructure to support healthy lifestyle choices.

*Our communities are not built to encourage exercise - people walk and bike in Europe. Here, Wal-Mart is at the end of town, so everyone is forced to drive.
(Provider, Fort Frances)*

Communities with limited outdoor facilities, such as summer swimming pools and no dedicated areas for pedestrians and cyclists, do not encourage residents to get active. The current socio-economic situation is likely to exacerbate these issues as additional resources for new facilities were perceived to be unlikely.

Most key informants reported a need to increase primary prevention for children and adolescents. Other primary prevention strategies suggested include: increasing community awareness of available services, offering more education on healthy lifestyle choices and chronic disease management, and working with municipalities to create safe exercise environments for people of all ages.

Coordination

The coordination of diabetes care services was identified as a gap throughout the North West LHIN; specifically, the need for improved collaboration among HSPs providing diabetes care, improved communication, and a shared Electronic Medical Record (EMR) across the region. Where providers are collaborating, the level of diabetes care is apparently more efficient with smoother access across the continuum of care.

Collaboration

Enhanced collaboration amongst HSPs was identified as a way to provide more coordinated and comprehensive diabetes care. Many key informants felt that interprofessional teamwork and integration of services would alleviate confusion and duplication of services experienced by many diabetes patients. Gaps were also reported in services available to support people with diabetes when transitioning from hospital to community programs, especially in smaller communities. This creates fragmentation in care, especially for those living in First Nations communities. Family Health Teams involved in the Quality Improvement Innovation Partnership (QIIP) have reported tremendous success improving the quality and coordination of services in their communities. Additionally, HSPs felt that following CDA guidelines across the region would improve quality and consistency in the way diabetes care is provided and monitored.

Communication

Communication is integral to meaningful collaboration between HSPs. Inadequate inter-professional communication was reported in most communities, leading to gaps and duplication in diabetes care for some clients. In several communities, stakeholders felt that communication between HSPs was challenging for several reasons: patient information is recorded in different and/or incompatible systems; HSPs are overwhelmed by their caseloads; and clients receive services in multiple locations.

“We are somewhat isolated in our community and feel that we are sometimes forgotten by the other larger surrounding communities. There is a lack of communication and teamwork between organizations regarding patient care because of the distance.”
(Provider, Vermillion Bay)

The need to improve communication between HSPs and First Nations communities was also identified. It was felt that this would result in improved awareness of the type and location of services in each community.

Electronic Medical Record (EMR)

A shared EMR was identified by many stakeholders as a tool for improving the efficiency and effectiveness of diabetes care, from both the patient and provider perspective, as well as a potential communication portal for enhancing consistency in diabetes care. Currently, many HSPs reported they were still working without an EMR. For those using EMRs, various incompatible programs have been adopted throughout the North West LHIN; these systems cannot interface with one another creating isolation of information. Key informants commented on the challenges of sharing lab results with multiple systems:

The hospital uses one electronic system, and then the diabetes education centre and the health access centres use a completely different one and we can’t connect to one another.
(Provider, Fort Frances)

The implementation of a shared EMR by 2015 was viewed with optimism as a tool to address several of the communication challenges reported by stakeholders. Enhanced collaboration was also advocated.

4.0 Next Steps

Information collected through community engagement by the North West LHIN is intended to illustrate current issues related to diabetes care and utilization of diabetes services, in order to identify gaps in service provision. The North West LHIN works closely with the Ministry of Health and Long Term Care in enhancing diabetes services across Northwestern Ontario. Community engagement is ongoing and the North West LHIN will continue to work with stakeholders to better understand diabetes care at the local level in communities throughout the region.

Appendix A

Northwest Local Health Integration Network Ontario Diabetes Strategy Initiative

Invitation Letter

Dear Colleague,

The North West Local Health Integration Network (NW LHIN) will participate in the Ontario Diabetes Strategy which will be implemented in the spring of 2009. As we move forward, it is imperative that we work together to more fully understand Diabetes care within our region.

The Centre for Rural Northern Health Research at Lakehead University is currently working on an environmental scan of Diabetes in our region. They will be writing a report which will help to explore diabetes prevention and management in Northwestern Ontario. In addition, the NW LHIN will also be conducting key informant interviews as well as focus group discussions regarding diabetes care.

You have been identified as a knowledgeable health care participant/provider within your community. We would like to conduct a key informant interview and/or invite you to participate in a community engagement focus group session to share your experiences and expertise. Should you not feel comfortable speaking with myself or other individuals regarding Diabetes health issues, please let me know. We will contact you with upcoming available dates, times and also community visits.

Sincerely,

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Appendix B

Northwest Local Health Integration Network Ontario Diabetes Strategy Initiative

Interview & Focus Group Questions

The North West LHIN Diabetes team travelled throughout the region to hold focus group discussions and do personal interviews with Health Service Providers in the North West. The goal of these key informant interviews and focus group sessions for the Diabetes Strategy is to improve diabetes care and ultimately chronic disease management throughout the province. The team primarily wanted to learn more about the current state of diabetes care from those working in this area, and also ideas for improving diabetes care in North West LHIN for the recommendation to the Ministry of Health and Long Term Care.

Interview Questions –

1. What specific services does your agency provide?
2. What do you see as the 3 top barriers to the delivery of quality diabetes services in your community?
 - Transportation
 - Informal support
 - Isolation
 - Health literacy
 - External locus of control
3. What solutions might you suggest to resolve these challenges?
4. Is access to primary and specialty care affecting the quality of diabetes care in your community? If so how? If not, how is it working well?
5. a) Is limited access to endocrinologist services a barrier in the implementation of the insulin pumps?

b) Is access to dialysis services an issue in your community?
6. How are the services you provide evaluated/assessed for effectiveness?
7. Other ideas, thoughts, wishes that you would like to share?

Appendix C

**Diabetes Management and Prevention:
Environmental Scan for the
North West Local Health
Integration Network
*Centre for Rural and Northern Health Research***

Appendix D

**Environmental Scan: Chronic Disease
Prevention and Management for the
North West LHIN
*Centre for Rural and Northern
Health Research***