Terms of Reference
Central East LHIN Diabetes Sub Committee

1. Background/Context

1.1 Purpose

The Central East LHIN has identified the following Strategic Aim as a priority in the 2016-2019 Integrated Health Service Plan (IHSP)) – *Living Healthier at Home*:

- Continue to improve the vascular health of people to live healthier at home by spending 6,000 fewer days in hospital and reducing hospital readmissions for vascular conditions by 11% by 2019.

The achievement of this aim is dependent on the ability of residents of the Central East LHIN to access best practice diabetes care across the LHIN. In alignment with *Patients First Act, 2016*, the consideration of unique needs of residents in each LHIN sub-region should be taken into account.

In July 2008, the provincial government launched the Ontario Diabetes Strategy to help the growing number of Ontarians living with diabetes. The goal of the Ontario Diabetes Strategy is to improve the health and health care for Ontarians living with all types of diabetes and for those identified at high risk of developing diabetes. The Central East LHIN recognizes the importance of leveraging numerous health professionals and having an integrated service delivery model that spans the continuum of care from prevention, through primary care to specialist care management for those at risk or living with diabetes.

Within the Central East LHIN, community based diabetes care is provided at the Diabetes Education Centres (DEPs), Centres for Complex Diabetes Care (CCDCs), Self-Management Program, primary care providers, and specialists. Access to diabetes care is coordinated through the Community Diabetes Intake (CDI) department. For a full description of diabetes resources, please refer to **Appendix 1**. To support the coordination of diabetes care within the Central East LHIN, the Diabetes providers have created cluster-based diabetes networks: the North East cluster, the Scarborough cluster and the Durham cluster.

The Central East LHIN, as mandated by the Ministry of Health and Long-Term Care, will ensure coordination and alignment of a diabetes care system and models to promote the best possible health outcomes for those at risk or living with diabetes.

The Goal of the Central East LHIN Diabetes Sub Committee:

The goal of the Central East LHIN Diabetes Sub Committee is to inform the Central East LHIN of gaps between the needs of the communities served and the scope of services currently provided. The Diabetes Sub Committee will also be responsible for making recommendations regarding the organization of diabetes services, in consultation with stakeholders, based on the identification of gaps in care.

The outcome will be the development of a Diabetes Work Plan based on identified needs. The implementation of the work plan will receive support from the Central East LHIN and system stakeholders. In addition, the Diabetes Sub Committee will provide ongoing collaboration and recommendations to the Central East LHIN on system-wide planning that integrates diabetes best practice and opportunities for enhancing access to diabetes services.

The Diabetes Sub Committee will review Central East LHIN's diabetes care needs, build on the existing best practices and evidence based care within the LHIN, and give attention the specific needs of each sub-region.

This committee will review the achievement of Diabetes Best Practices across the Central East LHIN and make recommendations on sustainable care.

1.2 Scope

The mandate of the Diabetes Sub Committee is to provide recommendations regarding improved service efficiencies for patients living with diabetes.

"IN" Scope	"OUT" of Scope
• Consultation and engagement with local stakeholders, including patients and caregivers, and Indigenous and Francophone communities, to inform local planning • Review of Diabetes-related metrics and sub-regional performance data to guide development of local priorities • Undertake gap analysis of diabetes services and programs in relation to local needs • Develop annual Diabetes Work Plan • Offer recommendations to the Central East LHIN for innovative, integrated strategies to improve diabetes care • Determine the Work Groups (WGs) required to realize the Work Plan deliverables • Leverage the work of the Sub-regional Planning Tables to advance local priorities • Additional indicators of success will include reduced wait times, improved access and optimize consistent positive outcomes and patient experience	• Decision-making regarding service delivery operations and funding of individual health service providers/entities, including Central East LHIN Home and Community Care division, within the sub-region • Advancing collective action on priorities relating to diabetes care without endorsement of the Central East LHIN • Advocacy on behalf of organizational interests • Advocacy on behalf of political interests • Addressing specific patients' concerns

2. Roles and Responsibilities

2.1 Roles and Responsibilities

1. Development of a Diabetes Work Plan that addresses priorities across the continuum of diabetes care.
2. Monitoring the implementation of the Diabetes Work Plan, related action plans, identifying key success factors, risks, challenges, and mitigation strategies.
3. Establish a framework for planning, implementation and evaluation that includes:
    - Objectives and targets for success
    - Key evaluative metrics
    - Partnerships development and engagement strategies
    - Building on current provincial and national initiatives and work underway including:
        - Diabetes Canada Clinical Practice Guidelines
        - Wound Canada
        - Patients First Act (December 2016)
        - Other, as appropriate

2.2. Accountability

The Diabetes Sub Committee will be accountable to the Vascular Health Steering Committee. The Vascular Health Steering Committee will guide, monitor and provide oversight to the work of the Diabetes Sub Committee in relation to its work plan.

The Diabetes Sub Committee will achieve its mandate by:

- Actively and transparently involving and communicating with key stakeholders. All materials, discussions and recommendations will be provided in an open and comprehensible manner.
- Striving to improve the quality and cost effectiveness of health services provided in the Central East LHIN through the use of evidence and clinical best practices. The primary objective will be to optimize positive outcomes and experiences for residents/patients of the LHIN, while striving to minimize negative impacts to the system. All recommendations will incorporate the concept of accountability.

- Ensuring that all work has a patient-centred outcome. Work will consider the full continuum of care and how patient services flow from one sector of care to another in the Central East LHIN.

3. Membership of the Central East LHIN Diabetes Sub Committee

3.1 Membership

The Diabetes Sub Committee comprises an action-oriented core team of equal members who are experts in diabetes care.

Co-Chair: TBD

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Core Membership:

1. Patient and/or Caregiver
2. Program Directors for the community DEPs (one per cluster: Durham, North East and Scarborough)
3. Program Directors for CCDCs (one per cluster, there might be overlap with DEP representatives)
4. Director, Central East LHIN (Home and Community Care)
5. Senior Manager, Central East LHIN (Home and Community Care- Self Management Program)
6. Primary Care Physician
7. Central East LHIN Vascular Strategy Physician Lead (ex officio)
8. Director Central East LHIN (Health System Strategy Panning and Performance (HSSIPP)- Vascular Portfolio Lead) (ex officio)
9. Wellness Worker, Indigenous Diabetes Health Circle
10. Other member, as appropriate

Other key Central East LHIN staff will support the Cardiac Sub Committee as appropriate (e.g., Decision Support).

3.2 Recruitment

Committee members will be recruited based on their expertise in provision of diabetes services across the continuum of care.

3.3 Role of Co-Chairs

Responsibilities for the Co-chairs includes:

- Reviewing/shaping the meeting agendas;
- Leading the meeting in a way that ensures advancement of the agenda within the timelines allocated for specific agenda items;
- Ensuring that input is solicited from the committee members and each member has an equal voice;
- Seeking and building consensus, including deciding that a matter should be resolved by vote rather than consensus;
- Willing to act as a spokesperson;
- Providing direction when appropriate on emerging issues requiring an immediate response; and
- Attend periodic meetings with other stakeholder groups on behalf of the committee (i.e., Vascular Health Steering Committee).

3.4 Roles of the Diabetes Sub Committee Members

The Diabetes Sub Committee will bring their knowledge and experience from their organization and/or sector to support the achievement of the goal/purpose as opposed to representing their respective organizations.

The committee members will:

- Regularly attend meetings;
- Participate fully in the exchange of information and identification of issues of relevance to the participants;
- Fulfill action items that result from meetings in a timely and efficient manner; and
- Respectfully notify the chair in advance of their absence to attend meetings.

3.5 Reporting Relationships

The Central East LHIN Diabetes Sub Committee will report to the Vascular Health Steering Committee.

3.6 Duration of Service

It is recognized that a longer term is necessary to accommodate the time required to develop relationships, processes, tools and plans. As such, inaugural members of the Central East LHIN Diabetes Sub Committee will be appointed for a two or three-year term,

subject to review and mutual agreement to continue at the end of year one. Members will be eligible to serve two terms, and these terms need not be sequential.

4. Logistics and Processes

4.1 Frequency of Meetings

The Central East LHIN Diabetes Sub Committee will generally meet monthly, with no fewer than eight meetings per year. Additional meetings will be held at the call of the Co-Chairs.

4.2 Decision-Making Process

The decision making process will follow the guidelines as written in the Central East LHIN Decision Making Framework.

4.3 Quorum Requirements

To constitute a formal meeting, a majority of members plus one of the co-chairs must be in attendance.

In-person meetings are preferred; however, videoconferencing, webinars, and teleconference meetings are an acceptable alternative to in-person meetings.

4.4 Delegates and Other Attendees

Alternate attendees for absent members must be approved in advance by the Co-Chairs.

4.5 Meeting Materials

Meeting Agendas and related meeting materials will be prepared and distributed by the Co-Chairs in collaboration with the Central East LHIN-Director (HSSIPP, Vascular Portfolio Lead). Agendas will be approved in advance by the Co-Chairs. Minutes will be prepared and distributed by e-mail within one week of the meeting.

4.6 Review

The Terms of Reference will be reviewed annually by the Central East LHIN and updated as required to reflect modifications or additions (e.g., Annual Minister's Mandate Letter to LHINs, update to reflect new IHSP).

Appendix 1: Descriptions of Diabetes Resource in the Central East LHIN

***This resource list does not contain external stakeholder groups (i.e., independent facilities, primary care models, endocrinologists, pharmacists)

Centre for Complex Diabetes Care (CCDC)		
Definition:	• CCDC is a program in the continuum of care for those patients living with complex diabetes, for patients that need more contact, more resources and more follow-up across health care and social services systems. • Focus on Self-Management and reduction of Emergency Department (ED) visits and hospitalizations. • A shared model of care that includes an inter-professional team consisting of nurse practitioners, registered dietitians, social workers, registered nurses and pharmacists. • Transition/discharge planning with primary care providers and Diabetes Education Programs (DEPs).	
Sub-region:	Scarborough North and South	• Scarborough and Rouge Hospital
	Durham North East and Durham West	• Lakeridge Health
	Peterborough City and County	• Peterborough Regional Health Centre

Diabetes Education Programs (DEPs)		
Definition:	• Provide basic to intermediate level diabetes education and management services through a model that is needs-based and community-based. • Develop a standard approach to care and management of diabetes, including screening, based on the current Diabetes Canada's Clinical Practice Guidelines. • Establish effective community-based approaches to prevent and manage diabetes- related complications. • DEPs are staffed by a multidisciplinary team of trained health professionals that includes Registered Nurses and Registered Dietitians.	

Sub-region:	Scarborough North and South	• TAIBU Community Health Centre
		• Scarborough and Rouge Hospital
		  • General Site
		  • Birchmount Site
		  • Centenary Site
		• Scarborough Centre for Healthy Communities

	Durham North East and Durham West	• Carea Community Health Centre
		• Lakeridge Health
		  • Whitby
		  • Ajax/Pickering Site
		  • Bowmanville
		  • Port Perry
		• Uxbridge Health Centre
		• Charles H. Best
		• Brock Community Health Centre

	Peterborough City and County	• Peterborough Regional Health Centre
	Northumberland County	• Port Hope Northumberland Community Health Centre • Campbellford Memorial Hospital
	Haliburton County – City of Kawartha Lakes	• Ross Memorial Hospital • Haliburton Highlands Health Services

Centralized Diabetes Intake (CDI)	

Definition:	• Centralized Diabetes Intake (CDI) provides accessibility to both health care providers and those living with or at risk of developing diabetes through a single phone call or faxed referral.
	• Care Coordinators assess for client eligibility and provide access to:
	  • 18 DEPs and three CCDCs; and
	  • Other Services: Cardiac Rehabilitation and Secondary Prevention (CRSP); Home and Community Care services; Community Support Services; Health Care Connect and the Central East Self-Management Program.

Self-Management Program	

Definition:	• A variety of workshops and educational opportunities that are designed to empower individuals and/or caregivers with chronic disease to optimally manage their conditions through the use of resources, materials, and training.
	• Educatonal programs are offered in a variety of workshops, including:
	  • Living a Healthy Life Workshop (Chronic Pain, Chronic Condition, Diabetes) (6 week program);
	  • Powerful Tools for Caregivers (6 week program); and
	  • Getting the Most from your Health Care Appointment (1.5 hour workshop).