



G. Implementing the Ontario Diabetes Strategy

Due to the high prevalence and impact of diabetes in the South East, an essential first step into chronic disease management will be to focus on this serious disease. We have opportunities to integrate diabetes care and the monitoring of management indicators. Lessons learned will drive other chronic disease management strategies.

Objectives:

- To meet expectations of this provincially required priority
- To implement Ontario's Diabetes Strategy as a first step in a broader chronic disease management model

Measures

- ❖ Percentage of people with diabetes, per year, who are unattached to a primary care provider
- ❖ Number of people who are evaluated by a qualified interdisciplinary diabetes team (education and nutrition counseling at a minimum)
- ❖ Percentage of people with diabetes who have had their LDL-C tested within past three years
- ❖ Percentage of people with diabetes who have had at least two HbA1C tests in the past year
- ❖ Percentage of people with diabetes who have had ACR and serum creatinine within an appropriate time period

Planned Actions

- ❖ Implement the Ontario Diabetes Strategy.
- ❖ Establish a regional diabetes coordination centre to provide leadership for a regional diabetes program and lead implementation of provincial priorities across the region.
- ❖ Consider reallocating existing diabetes resources to best meet population needs.
- ❖ Roll-out the provincial Diabetes Registry with the region.