The McMaster Health Forum convened a stakeholder dialogue on the subject of optimizing diabetes management in Ontario. With the support of the Ontario Ministry of Health and Long-Term Care, the dialogue brought together participants – three policymakers, eight stakeholders, and one researcher – from across Ontario to examine the problem, options for addressing it, and key implementation considerations.

The Ontario Ministry of Health and Long-Term Care funded the dialogue as part of a larger project – “Diabetes Tools for Ontario Patients, Clinicians and Policy Makers” – coordinated by the Li Ka Shing Knowledge Institute of St. Michael’s Hospital. The views expressed in this summary do not necessarily reflect the views of the Ministry of Health and Long-Term Care.

Deliberation about the problem

Dialogue participants focused much of their attention on the problems associated with the health system arrangements that determine access to and use of effective diabetes programs, services, drugs and devices. Within this broad category, however, their views of the problem ranged from many primary healthcare physicians not working in teams or clinics to the general lack of an organized system of diabetes care. They saw these arrangements as contributing to effective (and cost-effective) programs, services, and drugs not getting to those living with diabetes.

Participants felt that many of the building blocks for an organized system of diabetes care are in place or being put in place. However, a number of participants noted that such efforts are characterized by a lack of co-ordination, integration, evaluation and communication.
Deliberation about options

Drawing on the input from the evidence brief, their own knowledge and experiences, and the insights from the deliberations, a number of dialogue participants supported a hybrid option that includes: 1) implementing a model for optimizing diabetes management that expands nodes of expertise in diabetes management in primary healthcare (which can in turn draw on secondary and tertiary care supports) and that supports regional focal points charged with coordination and integration; 2) measuring and providing feedback on performance (and possibly establishing targets along with clear accountabilities and rewards for achieving these targets); 3) disseminating tools and resources to both patients (i.e., self-management supports) and providers (i.e., decision supports); and 4) enhancing communication among those involved in diabetes management.

Some participants also noted a transition occurring in multidisciplinary diabetes education and management centres, which increasingly accommodate a broader array of disciplines and are embedded within existing practices/clinics.

Deliberation about implementation

Participants noted two barriers to optimizing diabetes management: 1) supporting diverse ethnocultural communities is not just about translating materials into other languages, (it can also mean dealing with a vast array of lifestyle-related factors, poverty-related factors and other influences); and 2) diabetes registry implementation needs to be improved because a significant proportion of patients with diabetes are currently being missed.

Dialogue participants also recognized diabetes is the test case for a disease-based approach to strengthening primary healthcare, and observed that the initiative needs to be shown to be successful in helping people live well with diabetes. If it is not, diabetes’ “day in the sun” may well be over.

Dialogue deliverables

To learn more about this topic, consult the evidence brief that was presented to participants before the dialogue, the summary of the dialogue or the video interviews with dialogue participants. For an electronic copy of the evidence brief or dialogue summary, or to view the video interviews, visit our website (http://www.mcmasterhealthforum.com) and click on ‘Products’ along the sidebar.