



Housekeeping Items

- PLEASE have your VC on mute for the entire presentation
 - Question and answer period will be at the end of the session
 - Please refrain from sharing any personal/client stories as this session is being recorded
- If you have any personal issues you would like to discuss these can be addressed with your primary care professional
- Or
- If you have any client issues you would like to discuss these can be addressed with your local Health Care Facilitator



Community Networks of Specialized Care

Making Cents of Healthy Eating: Eat Well But Pay Less [Nutrition Focus]

CENTRAL WEST REGION in partnership with the Canadian Diabetes Association thank you for participating in today's education and training opportunity



Presenters

Sabrina Vertolli, RN, B.Sc.N, M.A. Ed., Health Care Facilitator
Central West Network of Specialized Care

and

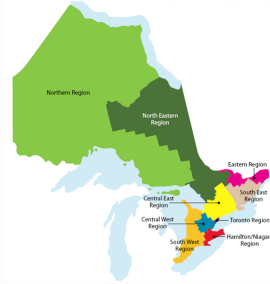
Lucy Florio, Public Programs and Services Coordinator
Canadian Diabetes Association

May 31, 2013



Establishment of Networks

The networks were established across the province by the Ministry of Community and Social Services (MCSS) as part of the transformation of Developmental Services.



****Context*



The province is split into 4 Community Networks of Specialized Care.





CENTRAL ONTARIO

Community Network of Specialized Care is made up of three Regions:



Lead Agency is Central West Specialized Developmental Services



Lead Agency is Community Living Huronia

Lead Agency is Surrey Place Centre

COMMUNITY NETWORKS OF SPECIALIZED CARE

Central West Network of Specialized Care Service Area:

- Is made up of **five counties** in total:
Waterloo,
Wellington,
Dufferin,
Halton and
Peel.



COMMUNITY NETWORKS OF SPECIALIZED CARE

A little bit about me

- Community Living of Mississauga (frontline)
- Nursing Degree
- Worked in various environments
- Masters in Adult Ed
- Most recently worked in Long-Term Care as a Clinical Nurse Specialist before coming back to the Developmental Service Sector as a Health Care Facilitator

COMMUNITY NETWORKS OF SPECIALIZED CARE

A little bit about the Health Care Facilitator (HCF) role

- My mandate is to ensure that adults with developmental disabilities receive access to primary & preventative care.
- How do I do this? It is 2 fold
- I help people navigate across sectors (Health, Mental Health and the Developmental Service Sector) **AND**
- A large part of my role is building capacity (by increasing skill & knowledge) in health care professionals/service providers through a variety of knowledge transfer activities such as training, education and support.
- Currently they are 9 HCF across the province of Ontario



Why is the CW CNSC hosting today's event?

- Increase in referrals for diabetes education in the developmental service sector d/t staff turnover, changes in care needs and changes in medication regime

AND

- We are currently in a transformation period - how diabetes service are being accessed is changing

NEW: Central Intake Programs



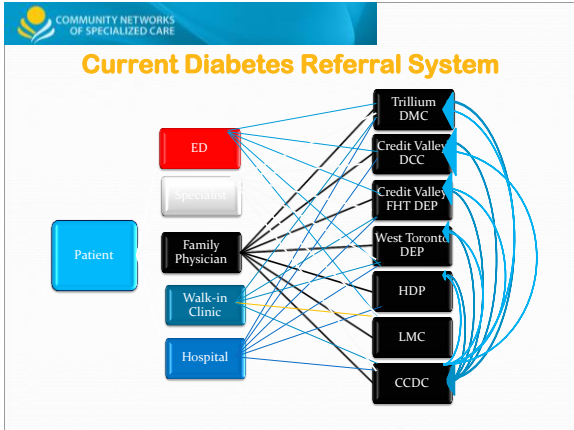
CIP Background

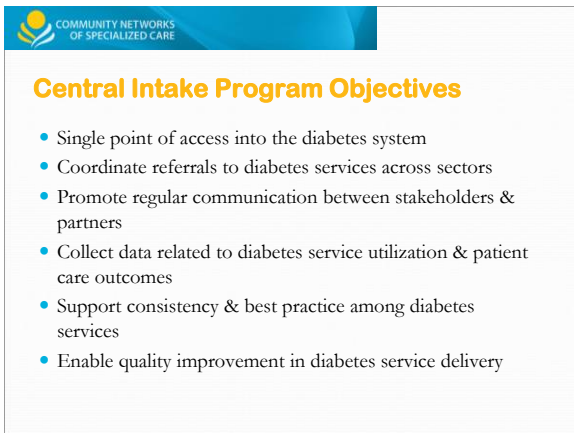
- A need was identified to
 - Reorganize and centralize the referral process for accessing diabetes services and
 - Common Referral Form
- Ministry of Health and Long Term Care (MOHLTC) approved separate Central Intake Program (CIP) funding for each Local Health Integration Network (LHINs)
 - Each LHINs will have their own CIP

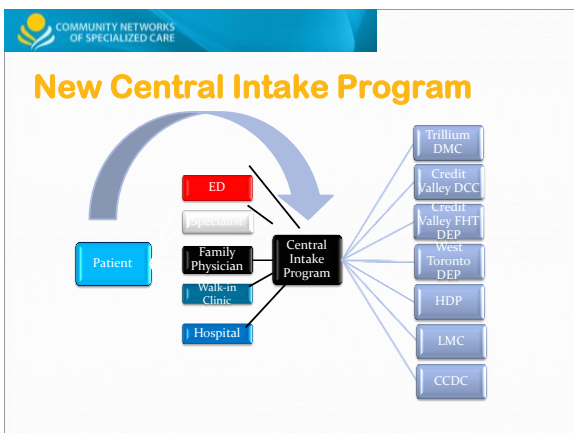


An overview of the issues that existed in the old referral model

- Duplication of services
- No tracking of patient flow
- Disconnect between primary care, speciality care and acute care services









Referral Management Process:

- All Referrals for diabetes services are sent to CIP
- Modes:** paper & fax, on-line website form, by phone
- Referrals will be triaged and routed to appropriate DEP by CIP
 - DEPs receives referrals from CIP and proceeds with appt setting and patient care as per organization protocol
 - DEP feedback will be shared with primary care providers & CIP at appointed timeframes



CIP roll out plan

1. Endocrinologists [pilot]
 2. Family Health Teams (FHT)
 3. Primary Care & Community Sector
- They will be accepting referrals from the DS sector beginning in late summer 2013



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Diabetes Specific Resources

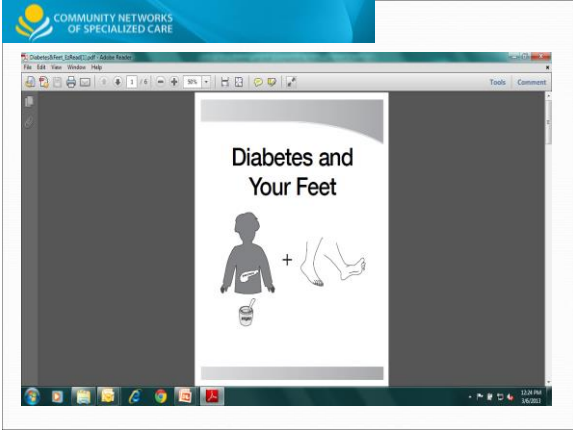
COMMUNITY NETWORKS OF SPECIALIZED CARE

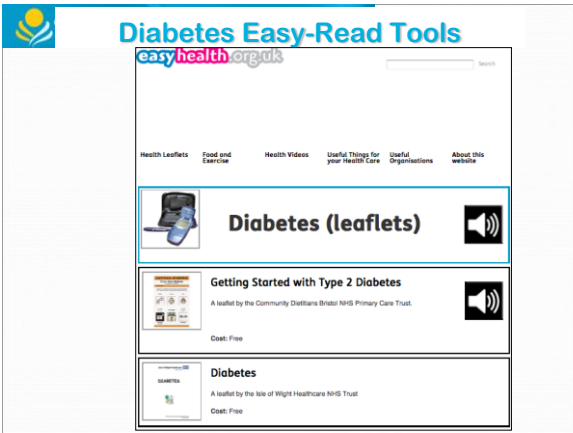
© Aphasia Institute 2010: EZ Read Resources

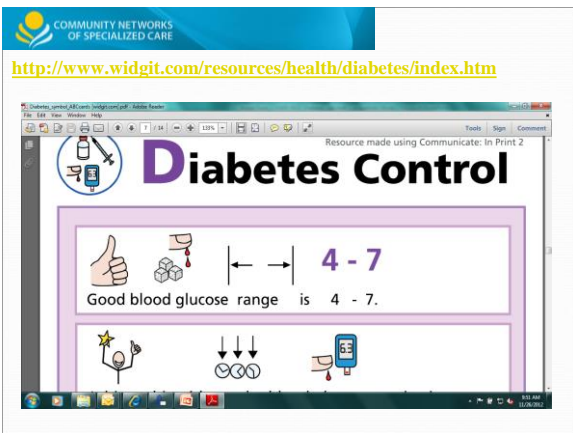
Diabetes and Testing Your Blood Sugar

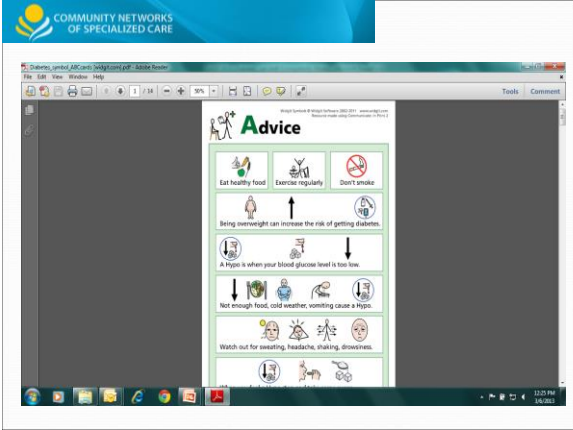
COMMUNITY NETWORKS OF SPECIALIZED CARE

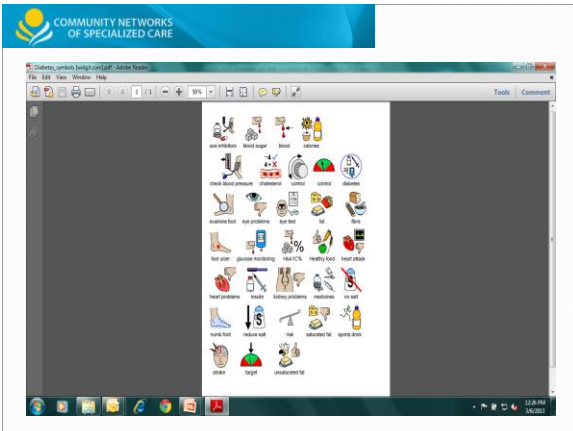
Diabetes and You

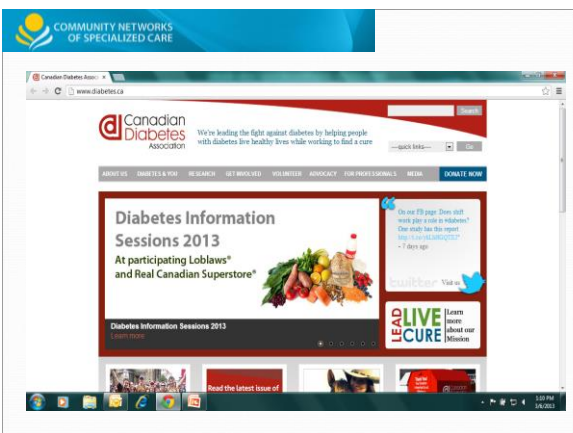


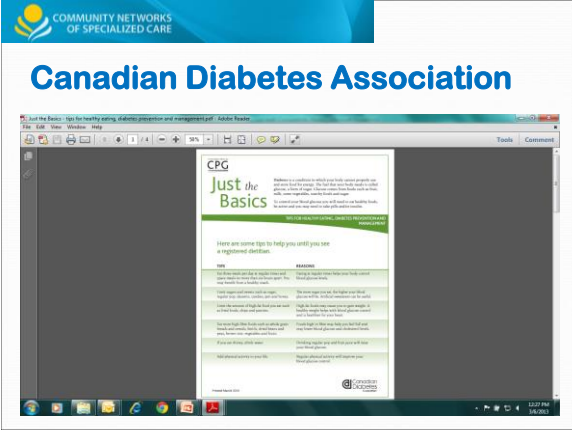


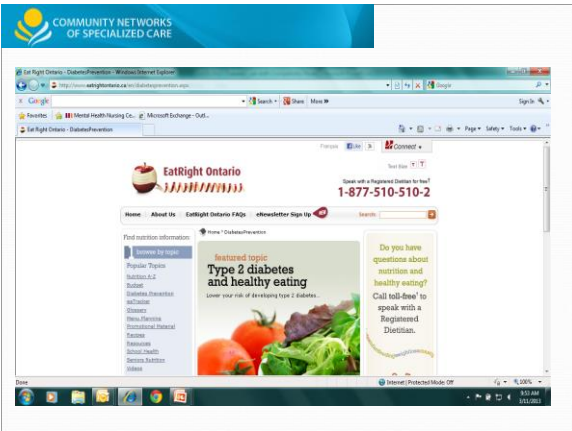




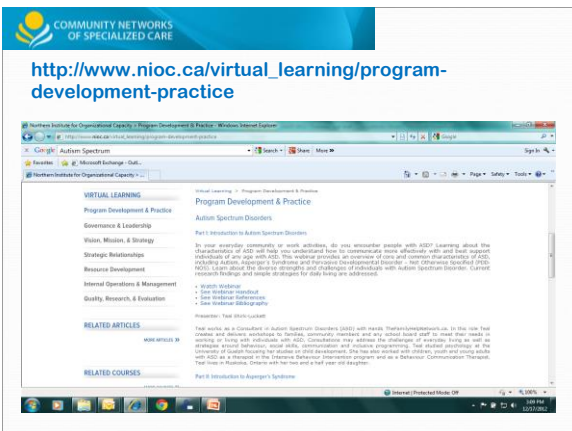
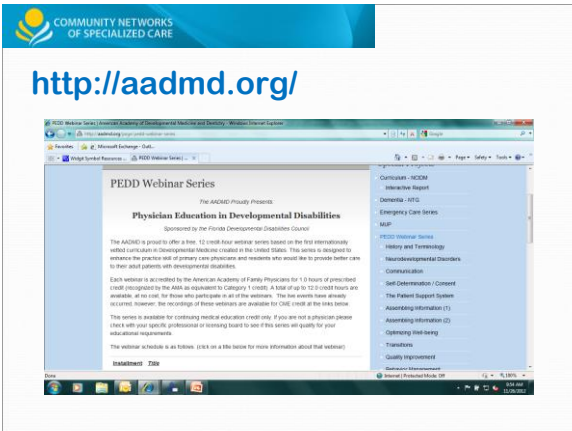
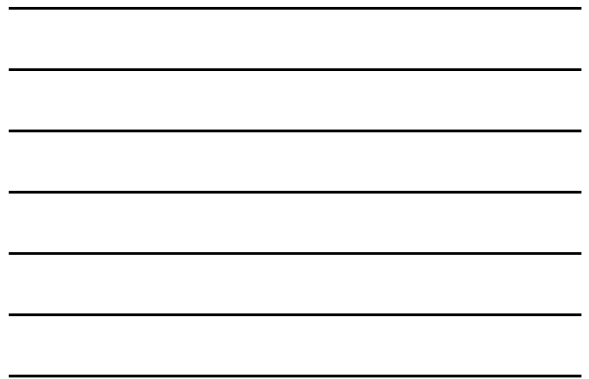
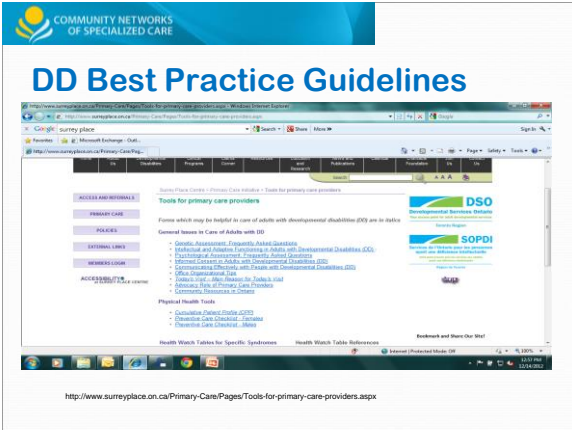












COMMUNITY NETWORKS OF SPECIALIZED CARE

Health Booklet Series

<http://www.surreyplace.on.ca/Clients-Comer/Pages/Health-Booklet-Series.aspx>

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Key Learning's

3 Things you have learned


2 Things that surprised you &

1 Thing you are going to do with this information.

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Factors that would make a client with a dual diagnosis more susceptible to diabetes are

- Diet (access and \$)
- Inactivity or limited activity
- Medications
- Mental health diagnosis



- Please complete the evaluation form for this education session
- Try scanning in the QR code on the flyer with your phone to be directed straight to the survey

OR

<http://www.surveymonkey.com/s/RXY9CKX>

- This is the last of our 4 sessions. All of the sessions have been archived and accessible on the OTN website (Steps: <http://webcast.otn.ca/>; Archived events tab; private event tab; username: cnscl & password: network1)



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Thank You!
