Guelph Family Health Team

Moving Gestational Diabetes Care into the Community

DiabetesCare
Guelph

Presenters

- Sarah Duff RN, CDE
- Julie Goodwin RN, CDE
- Lee Kapuscinski RD, CDE

Conflict of Interest

- No conflicts of interest to disclose

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Learning Objectives

- Review of Gestational Diabetes Mellitus (GDM) transition from hospital to primary care
- Staff Training Strategies
- Program Flow
- Program Evaluation and Outcomes
- Next Steps

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Moving the GDM Program

What:

- Guelph General Hospital (GGH) and Diabetes Care Guelph (DCG) decided on a *voluntary* transfer to the community Diabetes Program

Why:

- Access to care closer to home with improved hours
- Access to interdisciplinary team (Kinesiology, Mental Health)
- Close working relationship with Endocrinologists
- Consolidation of ambulatory diabetes care for adults

Moving the GDM Program Con't

How & When:

- 2013 – Sept: Initial Meetings between GGH & DCG
  Fall: Stakeholder Consultation
  Dec: Program Transition Proposal Development
- 2014 – Jan: Meeting with LHIN and response to Clinical Transition Plan
  May: Program Proposal Approved
  July: DCG GDM Program accepting patients

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Program Transition Proposal

- Main Components included:
  - Opportunity
  - Background Information on GDM
  - Current Services
  - Proposed Services at DCG
  - Activity Statistics
  - Anticipated Outcomes
  - Stakeholder Consultation

DCG GDM Program Flow

Referral Triage Process

- Midwives, Family Physicians, Obstetricians and Endocrinologists

Intake Appointment – Within 72 hours of referral

- RN/RD for 1.5 hours

Endocrinologist Liaison

- Arranged as needed

Follow up Appointments

- In office visits with RN/RD: q 2-4 weeks for 45 minutes

Hospital Liaison

- Monthly regular updates from DCG

Postpartum Appointment
(Booked 6 weeks from EDC)

- In office visit with RN/RD for 1 hour
- Assessment of glycemic control based on SMBG and results of 75g OGTT

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Communication Plan

- Board of Directors (GGH and DCG)
  - Presentation, Email and Intranet
- Internal Staff
  - Staff Meetings and Email
- Referral Sources
  - 1:1 Office visits from DCG staff
  - Letter, Flyer and Referral Form
- Community
  - Websites, News Release, Twitter

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DCG Referral Form

- new form was created:

Urgency of Referral: ☐ Urgent Within 72 hours ☐ Within 2 weeks ☐ Within 2 Months

Reason for Referral:

☐ Newly Diagnosed Diabetes Is this person appropriate for class education? Y ☐ N ☐

☐ Gestational Diabetes ☐ EDC_________________ ☒ Referral to Endocrinologist as needed (Gestational DM Only)

☐ Special Consideration (please specify)

____

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- communication and distribution to all relevant providers

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Documentation

- EMR documentation was created for:
  - Initial Visit (Gestational and Pregestational)
  - Follow up Visit
  - Summary Letter for referral source and Endo
  - Communication Letter to Hospital
- Patient handouts were adapted from hospital use

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Staff Training

- Educational Presentations
  - Local Endocrinologist
  - Past GGH Diabetes Educator
  - Michener Institute Diabetes in Pregnancy Course
  - Diabetes Nurse Educator with expertise in DM and Pregnancy (Mount Sinai)

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Staff Training Con't

- Shadowing/ Cross Training
  - External
    - Guelph General Hospital
    - Trillium Health Care Preceptorship
  - Internal
    - Shadowing with internal staff
    - Tip of the week Emails
    - Team Rounds and consultations

GDM Program Evaluation

- Ongoing communication with GGH and DCG post transfer

DCG:

1) Chart Audits
2) Patient Surveys
3) Patient Interviews
4) Partner Surveys
5) Outcome Measures

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GDM Program Evaluation

1) **Chart Audits:** Spring 2015
   - 5 chart audits completed
   - Assessment of adherence to program flow
     - 5/5 were booked within 72 hours of referral
     - 4/5 were seen in clinic q 2-4 weeks and follow up via email/phone completed q1-2 weeks
     - 5/5 had consult summary sent to referral source post visit
     - 4/4 had communication sent to hospital at 34-36 weeks from EDD (1 had not reached 34-36 weeks at time of audit)

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GDM Program Evaluation

2) Patient Surveys

- 2 surveys completed to date
- Barriers:
  - Limited number of postpartum follow up
  - evaluation burnout from staff

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GDM Program Evaluation

3) Patient Interviews

- 6 Interviews completed
- 7-10min
- $25 gift card

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GDM Program Evaluation

3) Patient Interviews Con't:

"They made it so easy (…)I have never had so much help from a healthcare provider for anything."

"(…) gave me they gave me their phone number for questions that pop into my head after, so if I forgot how to use [my glucometer], I don't need to book an appointment for every single question."

"I learned about high/low GI foods and how to combine foods with insulin to get the best results. I learned for me that it was best to take it 30-40 minutes before eating for it work properly."

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GDM Program Evaluation

4) Provider Surveys

- Obstetricians
- Midwives
- Family Birthing Unit

GDM Program Evaluation: Summary

What we did well:

- Supported patients
- Accessibility to providers (in office, phone, email)
- Education for GDM self management

What we learned:

- Communication between all providers is important for everyone involved

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GDM Program: Outcomes

July 2014 - Aug 2015

Referrals: 104

Delivered: 76

Lost to Follow up: 30 (39.5%)

(at any time during the program)

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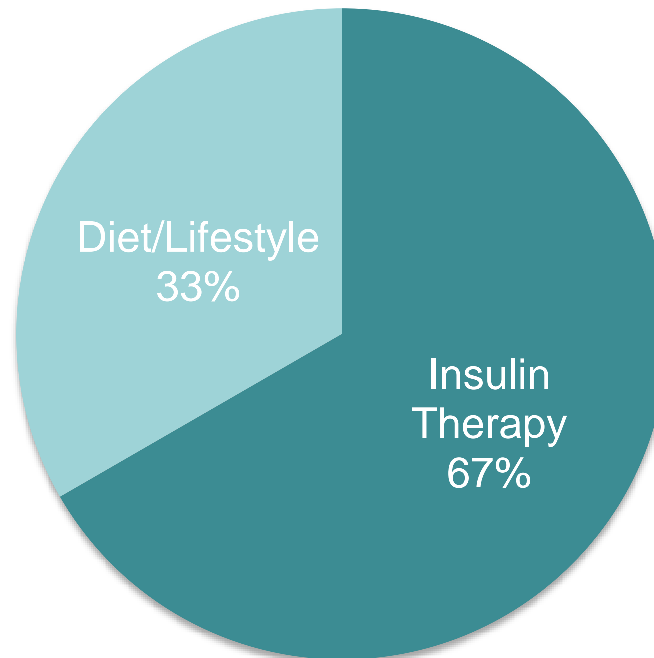
GDM Program: Outcomes

July 2014 - Aug 2015



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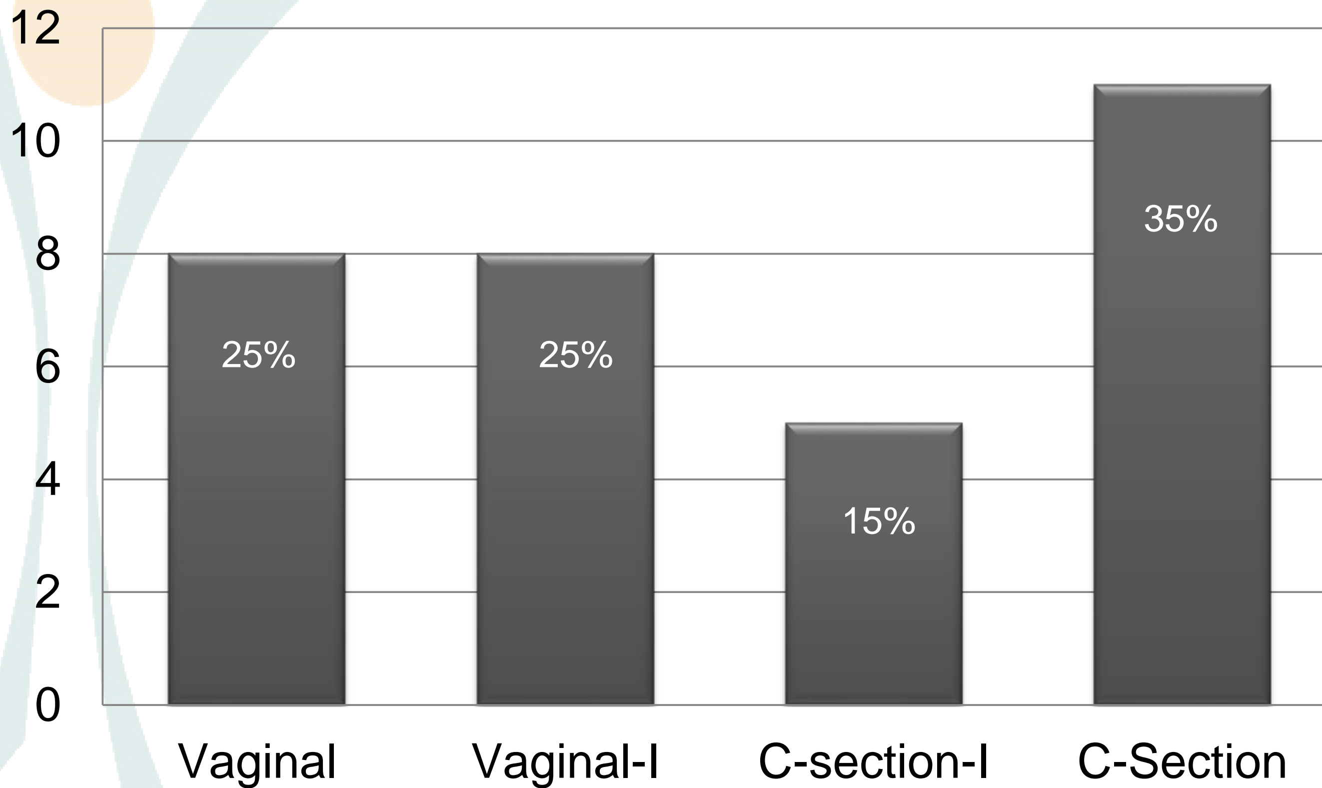
GDM Program: Outcomes
July 2014 - Aug 2015



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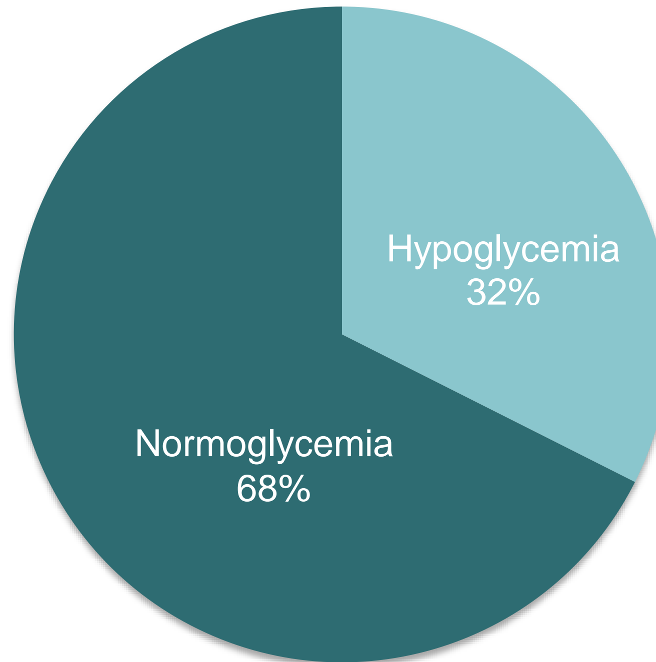
GDM Program: Outcomes
July 2014 - Aug 2015

Neonatal Glycemia n=37



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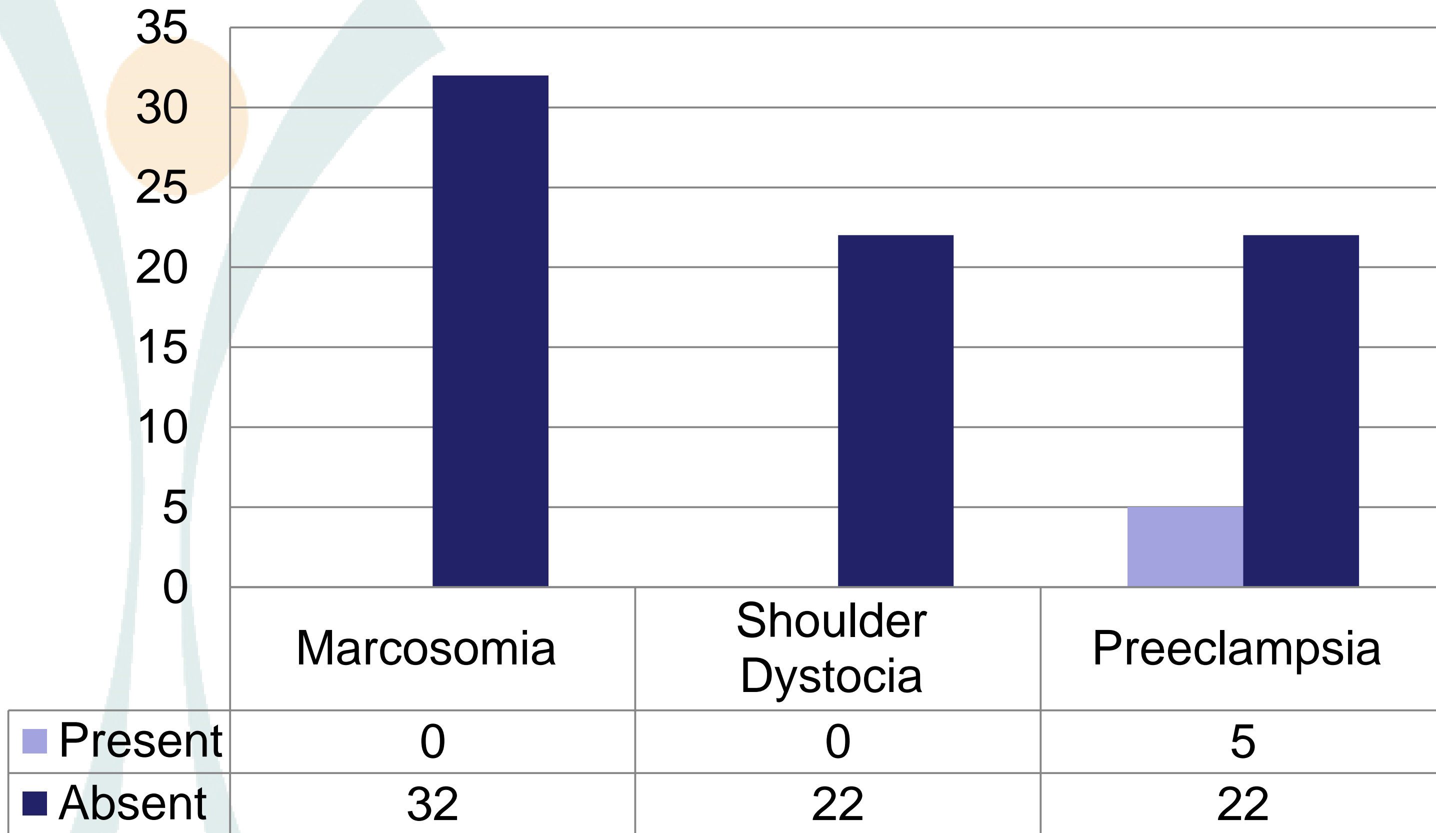
GDM Program: Outcomes

July 2014 - Aug 2015



	Marcosomia	Shoulder Dystocia	Preeclampsia
Present	0	0	5
Absent	32	22	22

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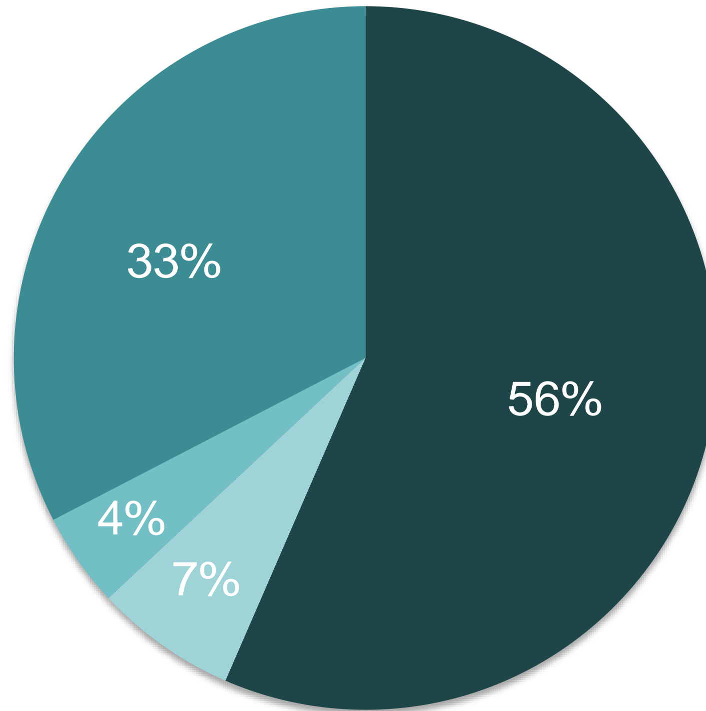
GDM Program: Outcomes

July 2014 - Aug 2015



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Ongoing Quality Improvement

- Provider Surveys
  - Currently in Progress
- Chart Audits
  - Yearly in Quarter 2 & 4
- Patient Surveys
  - Yearly in Quarter 4
  - Will look at online tools/resources

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GDM Program: Next Steps

- Communication and Integration of Regional Care pathway (Waterloo Wellington Diabetes)
- Community Network group for ongoing improvement work for GDM (Key stakeholders to be invited)
- Improve communication at discharge from hospital back to DCG
- Evaluate ways to improve postpartum follow up appointments

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GDM Program:Next Steps Con't

- Build medical directives for GDM population to further improve care

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Thanks for your help!