



#### A Business Model for Integrating Community Diabetes Resources in Your Primary Care Practice

Nicole Fowler King, Primary Care Engagement Coordinator Mississauga Halton Diabetes Regional Coordination Centre Heather McAlpine, Executive Director, HHFHT



## Agenda

- Background information
- Diabetes Care Pathway Halton Hills FHT
- Review and the Challenges faced
- Development of Shared Care Model
- Process Changes
- Critical Success Factors
- Benefits
- Implementation Issues
- Recommendations





# Mississauga Halton Diabetes Regional Coordination Centre

#### **Diabetes Regional Coordination Centres (DRCC):**

- <u>Coordinate</u> diabetes services
- Identify and address challenges in diabetes service
- <u>Facilitate</u> adoption & integration of best practices/guidelines in diabetes care
- <u>Support</u> ODS initiatives & provincial priorities
- <u>Monitor</u> & improve health outcomes
- <u>Share</u> information & best practices with RCCs

#### **Primary Care Engagement Coordinator**

- Engage with Primary Care physicians in the community to;
  - Adopt Best Practices in Diabetes Management, including patient teaching, self management skills
  - Increase the usage of DEPs specifically
  - Connect Primary Care to other diabetes related resources





# **Halton Hills FHT**

- Based in Georgetown, ON
- Wave 1 FHT
  - 22 doctors
  - 27,000 patients
  - Approximately 1,600 diabetics
  - 15.1 FTE IHPs, spread over three sites
- Diabetes Care Program evolved based on experience
  - Initial program developed early 2010
  - Revised Program 2012







# **Challenges faced**

- Limited RN resources
- The risk of DEP reduced referrals due to FHT program

# **Solution:** Partnership!





## **Program Development**



# **Program Summary**

**Goal:** Provide high quality and efficient care in screening, treatment and management of Type 2 Diabetes

**Phase 1:** Only open to newly diagnosed Type 2 Diabetes patients

- Partnership with DEP– Georgetown Site
- <u>Primary case manager</u>: Registered Nurse (consult with NP)
- RN to consult with MD throughout program as a co-visit or via EMR message after each patient visit
- Developed following Canadian Diabetes Association: *Clinical Practice Guidelines for the Prevention and Management of Diabetes* 
  - Used QIIP tools process mapping, PDSA
  - Assessed resources
  - Bootcamp to help educate RNs







# Diagnosis Visit

- \* Patient is newly diagnosed with Type 2 Diabetes
  - FPG, casual PG, OGTT
- Handout: CDM Referral Diabetes
- ✓ Introductory Letter
- ✓ Just The Basics
   (Canadian Diabetes Association)
- ✓ Referral to Halton Diabetes Education Program (DEP) – Georgetown site
- ✓ Lab requisition

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		Parts & (D00)-OP			Eat more high fibre foods (whole grain and cereals, lentils, dried beans and p- rice, vegetables and fruits).	n breads peas, brown	Foods high in fibre may help you feel full and may lower blood glucose and cholesterol levels.
					If you are thirsty, drink water.		Drinking regular pop and fruit juice will raise your blood glucose.





# **Halton Diabetes Program**

- 3-6 months
- Group Education + Individual Consults

#### Skills for Success 1:

- ✓ After the Diagnosis
- ✓ Blood Glucose Monitoring
- ✓ Exercise
- ✓ Medications
- ✓ Healthy Eating
- ✓ Goal Setting & Action Planning
- ✓ Complications
- ✓ Management (foot care, smoking, dental)
- ✓ Review

Discharge Summary Form

Georgetown S Summary Dr.: Your patient attended the Di Initial Assessment:	Discharge to FHT	Surname: Given Name: DOB: Day Month Year OHIP: Date:		
Group Program:		Follow Up:		
Medication:				
Nursing Summary:	Mastered	Needs follow up	Not Applicable	
Monitoring				
Exercise				
Medication/Insulin				
Diabetes Physiology				
Complications				
Comments:	Signature		RN	
	-			
Dietitian Summary:	Mastered	Needs follow up	Not Applicable	
CHO sources/balance				
Regular meals/variety				
Portion control				
Snacking				
Carb counting				
Sweeteners				
Label reading				
Comments:				
	Signature		RD	





### **Discharge Summary Review** MD/RN

- Review Discharge Summary written feedback and determine gaps in education that requires follow-up
- RN to re-enter patient into FHT Diabetes Program
- RN/MD to review the Summary Discharge Form
- RN to confirm current blood work has been completed
- Book RN/MD Co-Visit # 2: Follow-Up to Halton Diabetes Program within 1-2 weeks







- Use Diabetes Patient Care Flow Sheet stamp
- Provide education based on learning gaps identified in Discharge Summary
- Complete Diabetes Knowledge Pre-Test
- MD to assess patient's health
- Determine next follow-up visit
- Refer as necessary to Allied Healthcare Professionals
- Issue blood work requisition
- Provide patient with Diabetes Passport

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B. Counselling			
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# Referrals to Allied Healthcar Professionals

- Pharmacist
- Dietitian
- Health Educator
- Mental Health
- Group Education Program







# Subsequent Follow-Up Visits q 3-6 Months for 1 yr PRN

RN (20min) MD (10min)

- ✓ Assess patients health status
- ✓ Review lab work
- ✓ Review self-management
- ✓ Continue Diabetes education
- ✓ At 1 yr:
  - ✓ Re-administer Diabetes Knowledge Post-Test
  - ✓ Administer CDM Program Evaluation
  - ✓ Review lab work





# **Evaluation Tools**

- Diabetes Knowledge Test (Pre/Post)
  - Assess improvements in Diabetes Knowledge
- Chronic Disease Program Evaluation
  - Assess patient's satisfaction with the program
- Quantitative indicators outlined in stamps to be tracked via EMR scan of program documentation

DM Core Measures
Total DM Population
Percent of DM pts with A1c <=7
Percent of DM pts with A1c test in past six months
Percent of DM pts with documented Self-Management goals in last 12 months
Percent of DM pts with BP<= 130/80
Percent of DM pts on ACEI or AARB
Percent of DM pts with LDL<= 2.0 nmol/l
Percent of DM pts with retinopathy screening in past 24 months
Percent of DM pts with comprehensive foot exam in past 12 months
Percent of DM pts w microalbuminuria (ACR) screening in past 12 months





#### **Phase 1: Critical Success Factors**

- Full and visible support of the FHT Board
- Committee input from physicians, RN/NPs, and allied providers
- Acceptance by all to move to a standardized program with common forms, stamps, EMR terminology, and resources.
- Utilization of QI processes (mapping, PDSA) in program development
- Clear understanding and agreement by the FHT and DEP on program curriculum
- Establishment of metrics
- Optimal utilization of all FHT allied providers
- Detailed program rollout





# **Program Challenges**

- Patients Access Issues
  - Cost barriers
  - Scheduling difficulties
    - Insufficient information to effectively group patients
    - Difficulty managing scheduling
- Communication between DEP and FHT
  - Referral sent to DEP patients didn't always attend- loss of communication to FHT
  - Lack of consult notes to repatriate patients to FHT

- No opportunity for FHT resources to increase knowledge of how to help manage patients with Diabetes – need for further mentorship
- No processes for complex/unstable patients

**Risk/Concern** 

Redesign would reduce

physicians "buy in"

 Patient confusion due to having multiple locations/organizations providing care





# Phase 2 Same Program: Integrated delivery

# **On – Site DEP Education**







# **Process Changes**

Challenge	Solution	
Patients Access Issues •Cost barriers •Scheduling difficulties •Insufficient information to effectively group patients •Difficulty managing scheduling	<ul> <li>Offer the program at the FHT office</li> <li>Group booking and individual follow up completed by FHT RN immediately following diagnosis</li> </ul>	
Communication between DEP and FHT •Referral sent to DEP – patients didn't always attend- loss of communication to FHT •No triggers to repatriate patients back to FHT •Lack of consult note	<ul> <li>Referrals now gathered by FHT RN</li> <li>Discharge notes provided immediately following individual follow up appointment</li> <li>Clear communication paths &amp; triggers were identified</li> </ul>	





# **Process Changes**

Challenges	Solution
No opportunity for FHT resources to increase knowledge of how to help manage patients with Diabetes – need for further mentorship	Onsite Diabetes Team allowed for ad hoc mentoring on a patient by patient basis - Enabled in house resources to extend skills and prepare for CDE exam
No processes for complex/unstable patients	Re- referral process created -Ongoing care due to complexity -Stabilize and discharge to FHT

Risk	Solution		
Redesign would in"	reduce physicians "buy	Modify and evolve the e	xisting program
Halton Hills Family Health Team	www.Maximize www.Haltoni	•	Maximize

YOUR HEALTH

# **Benefits**

- ✓ Increased number of patients utilizing education programs
- $\checkmark\,$  Improved quality and efficiencies for both FHT & DEP
- ✓ Reduced patient and provider confusion
- ✓ Improved communication between diabetes educators and primary care clinicians
- $\checkmark\,$  More effective support for complex cases
- ✓ More timely and accurate information
- ✓ Increased capacity within the Family Health Team
- ✓ Enhanced knowledge and skills in diabetes management





## **Implementation Issues**

- Resistance to change
  - DEP to provide charting and reports in a timely manner
  - Physicians to effectively use and refer to outside resources
- Booking issues Onsite education or not?
  - Patient has two options now, which affects who/how/where the appointments are booked.





## **Next Steps**

- Expand the program to two other sites
- Investigate after-hours options to accommodate working patients
- Develop an Excel-based patient registry to track the level of usage





#### **Phase 2: Critical Success Factors**

- Design solutions based on patient experiences
- Strength of partnership between FHT and Diabetes Education Program
- Identify challenges faced by each party
- Agreement from both parties of the curriculum to deliver to patients
- Clear communication to both physicians and patients
- Incorporate metrics into your program
- Addressing concerns regarding change
  - Using outside resources
  - Changes to work process





# **Recommendations**

- Develop a chronic disease team within the FHT
- Identify relevant community resources (DEP Teams etc.)
- Ask FHT physicians which populations is a priority group
- Deploy a consistent program in your FHT (e.g. every physician utilizes the same stamp and naming conventions)





## Questions





