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

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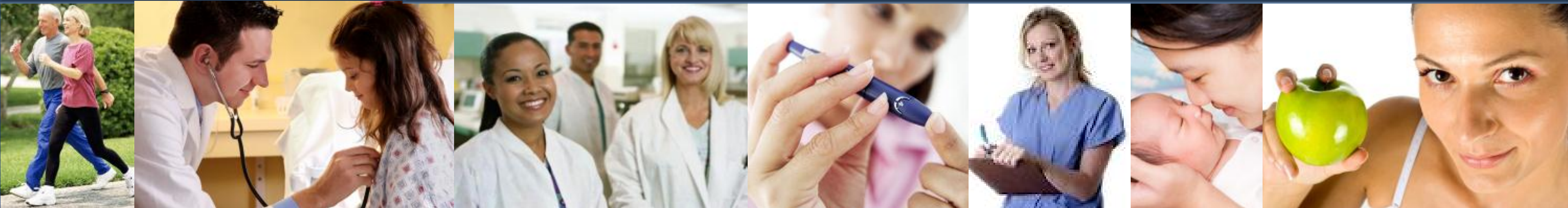

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Agenda

- 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):

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

Diagnosis Visit (MD/NP)

Halton Diabetes Education Program (3 -6 Months)

Halton Diabetes Education Program Summary Discharge

Initial Visit (RN/MD co-visit)

Allied Healthcare Professionals	Follow-up visits every 3-6 months

1 Year Follow-up Visit (RN/MD co-visit)

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
- Primary case manager: 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

MD/NP

* 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***

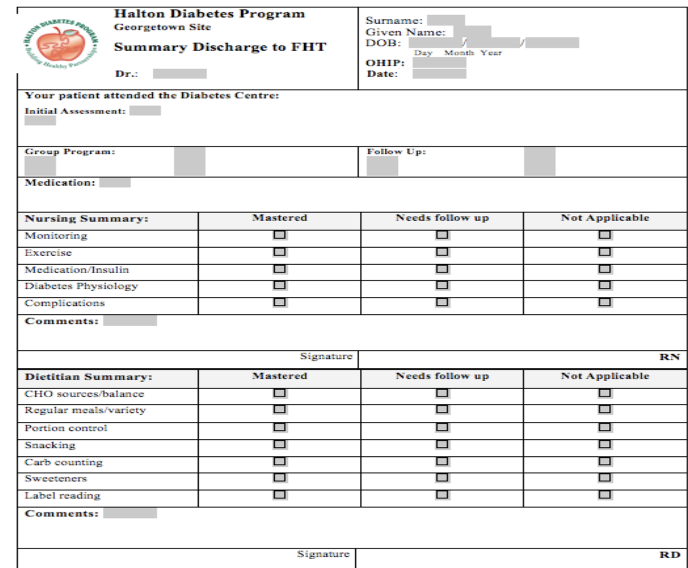
Halton Diabetes Program

- 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



Halton Diabetes Program
Georgetown Site
Summary Discharge to FHT
Dr.:

Surname:
Given Name:
DOB: / / (Day Month Year)
OHIP:
Date:

Your patient attended the Diabetes Centre:
Initial Assessment:

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

Visit # 2: Follow-Up Co-Visit

RN (20min) MD (10min)

- 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

Bunny, Bugs birth date 10/03/1969 #102

D. Examination

Wt: Ht: WC:
General «normal»
BP (target <130/80 BP:
Foot examination: «normal»

Bunny, Bugs birth date 10/03/1969 #102
Oct 29, 2009 AF

Diabetes Patient Care Flow Sheet

Every 3-6 months:

A. Review

Glycemic Control
Latest HbA1C = never done (never done)
Hypogylcemic Episodes: «no»
Diabetic Meds: see Rx

BP Control/Vascular Protection
Patient using ASA: «yes»
Patient using ACEi or ARB: «yes»

Weight Management
Waist-to-Hip Ratio (<0.9 female; <0.85 male) «reviewed»
Waist Circumference (< 40 male; < 35 female) «reviewed»

B. Counselling

Self Management
Motivational Counselling done on: «nutrition» ,«exercise», «smoking»
Collaborative Goal Setting: «dietary and exercise modifications»
Self Management Challenges: «monitor intake and exercise frequency»

Preventative Management
Advised patient to arrange annual eye exam «done»
Advised patient to have influenza immunization «done»
Advised patient to monitor home sugars «done»
Advised patient to attend DM education clinic or FU with Endocrinologist «done»

DEC
Diabetic Education Clinic (DEC) note reviewed «done»
Highlighted issues of concern:
•«no new changes»

C. Lab Investigations

Latest Cholesterol = never done (never done)
Latest LDL (< 2.0) = never done (never done)
Latest TG = never done (never done)
Latest HDL (>1.0) = never done (never done)
Latest TC:Chol (<4.0) =5
Latest Microalbumin/Creatine Ratio (<2 M; <2.8 F) = never done
Latest Creatinine = never done (never done)
Latest eGFR (>60) =never done

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Referrals to Allied Healthcare 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
- Patient confusion due to having multiple locations/organizations providing care

Risk/ Concern
Redesign would reduce physicians "buy in"

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	•Offer the program at the FHT office •Group booking and individual follow up completed by FHT RN immediately following diagnosis
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	•Referrals now gathered by FHT RN •Discharge notes provided immediately following individual follow up appointment •Clear communication paths & triggers were identified

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 reduce physicians "buy in"	Modify and evolve the existing program

Benefits

- ✓ Increased number of patients utilizing education programs
- ✓ Improved quality and efficiencies for both FHT & DEP
- ✓ Reduced patient and provider confusion
- ✓ Improved communication between diabetes educators and primary care clinicians
- ✓ 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