Sharing is Caring: Our model for dividing FHT patients among diabetes services in Barrie

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Background

- BCFHT came to fruition in 2006. At that time, there were 48 family doctors, and 98,984 patients in the first year of rostering patients.
- The BCFHT has since grown rapidly and now includes 89 family doctors, 60 IHPs and 137,043 enrolled patients.
- The Diabetes Management Centres that service Barrie and surrounding areas joined together to create a committee named the Barrie Area Diabetes Collaborative (BADC).
- Groups represented in the BADC include the following Diabetes Management Teams:
    - Barrie and Community Family Health Team
    - Barrie Community Health Centre
    - Royal Victoria Hospital
    - LMC Endocrinology
    - Orillia Soldier's Memorial Hospital
- In 2016, the BCFHT served 949 diabetes patients.

Purpose

An algorithm was created to share diabetes patients among the region's diabetes services. The main goals of the algorithm were to:

- Ensure continued funding to each of the programs
- Reduce wait times for the patients
- Prevent the duplication of services
- Allow for continuity of care for patients already receiving diabetes education services.

Development

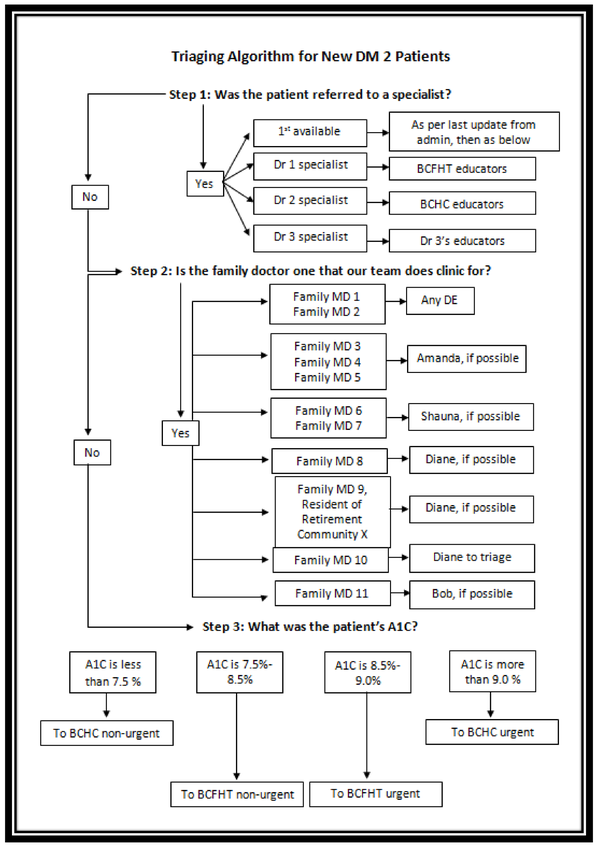
The algorithm for sharing the region's diabetes patients was created with the aforementioned goals in mind.

The focus was around creating a positive experience that catered to the needs of the patient.

Patients with a FHT physician or NP can be referred to the FHT Diabetes Management program.

When a referral is received, the educators will assess it and determine where the patient is to be seen.

- Any patients with a ongoing history of diabetes will be seen at BCFHT.
- Any Gestational Diabetes will be seen at LMC.
- Any patients with a new diagnosis of diabetes will be triaged using the following algorithm:



Outcomes

- Patients have access to individual counselling with their diabetes educator, plus group classes including:
    - Food and Diabetes 101 with the FHT Diabetes RDs
    - Carb Counting 101 with the FHT Diabetes RDs
    - Cooking classes with a RD in a grocery store
    - Kitchen Conversations program run by BCHC RD and RN diabetes educators.
    - Individual Mental Health counselling and Wellness Groups through the FHT Mental Health program. Some of the available groups include:
        - The Anxiety Series
        - Mind Over Mood
        - Self Esteem
    - Other nutritional information groups run by the FHT dietitians such as:
        - Grocery Store Tours
        - Hypertension
        - Label Reading
        - Craving Change
- There are short wait times across the collaborative, with same day appointments available for urgent referrals.
- Patients are able to receive localized care with their diabetes nurse educator, and family physician for patients whose doctors run diabetes clinics with a member of our team.

Next Steps

- The BADC continuously meets to discuss wait times, patient flow and satisfaction.
- At regular meetings, the Diabetes Management teams report on any changes with the number of patients they have seen over the period. If the number is increased or decreased, we can modify the algorithm to ensure continued dispersion of patients so the goals of the collaborative continue to be met.