



Guelph Family Health Team

The “One Stop Shop” Diabetes Program:

Engaging, Aligning, and Integrating an interdisciplinary team to
create a patient-focused program

DiabetesCare
Guelph

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Presenter Disclosure

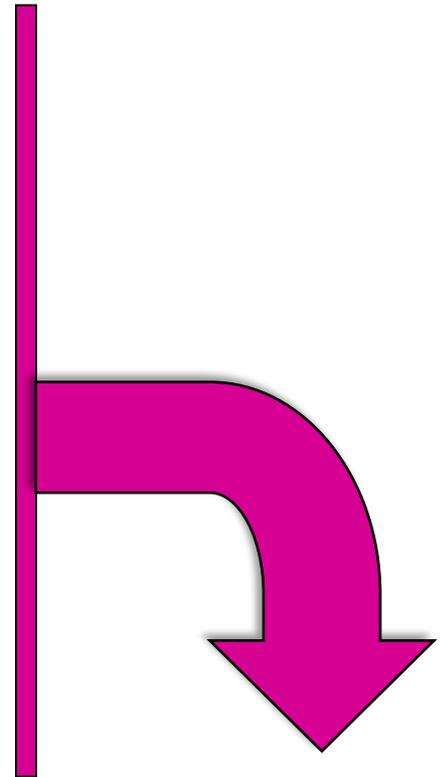
- **Presenters:** **Alicia Atkinson**
- **This program has no relationships with commercial interests**
- **This program has received no financial or in-kind support**
- **This program has no potential for conflict of interest**

The Transformation

From ...

Illness Orientation

- Prevention not a priority
- A solo provider approach
- Provider, disease centred
- Reactive and episodic care
- Limited role for individuals in management



The Transformation

To...

Wellness Orientation

- Prevention at all points of continuum
- An integrated, interdisciplinary care team approach
- Patient centered
- Proactive, complex, continuing care
- Individuals empowered for self-management and part of care team

Strategic Goals

Prevent and Promote

- Raise awareness about diabetes prevention and management
- Implement programs for reducing risk of diabetes

Identify and Attach

- Identify people with diabetes or at risk
- Ensure access to health care and self care support

Manage and Improve

- Organize, enhance and expand local access to care
- Provide education, tools and training to patients, caregivers and providers
- Expand capacity for more complex conditions ie. Insulin pumps

DCG – Who We Are

Diabetes Education Program Funded by Ontario MOHLTC under the Primary Care Branch

Interdisciplinary team Registered Nurse, Registered Dietitian, Certified Kinesiologist, Mental Health Counselor, Foot Care, Pharmacist

Administered by Guelph Family Health Team

Population Served City of Guelph and Surrounding Area

Funded for 4 FTE teams

Started January 2009. With Guelph General Hospital until 2008

DCG – Our Team



DCG – Who We See

Projected Service Volumes

– Type 2 Diabetes Mellitus

- 6% of the population
- In Guelph (114,943) n = 6,896

– Pre-Diabetes

- 10% of the population
- In Guelph (114,943) n = 11,495

DCG – Who We See

Endocrinologist
Pediatrician, OBGYN
New Diagnosis Type 1

Specialized
Clinical
Management
Service

Level 3

- Complex co-morbid conditions
- Gestational
- Pumps

- Multi-disciplinary DM Team
- Endocrinologist

Diabetes Care
Guelph
Specialized
Self-care
Support Service

Level 2

- Newly Dx
- Insulin starts
- MDI
- Self-care issues

Primary care
Physician Supported
by primary care
RN/NP/ Pharm

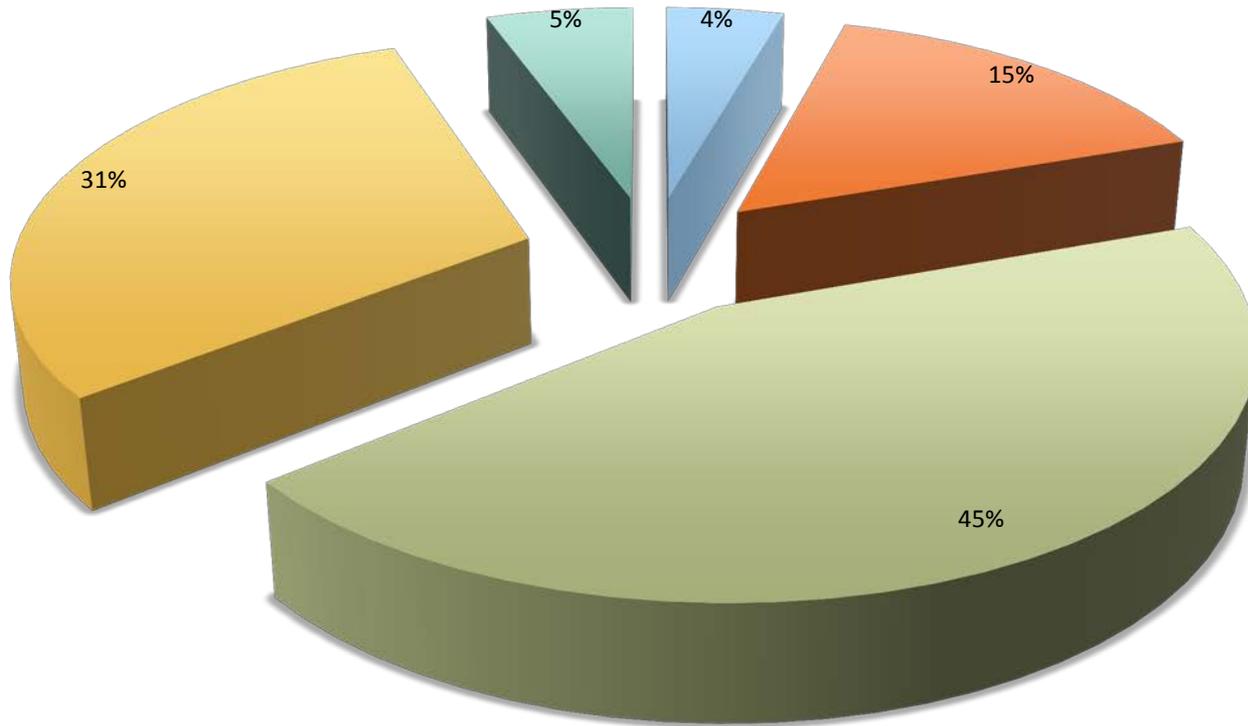
Primary Health Care
(80%)
N=6,896 (DM)
N=11,494 (Pre-dm)

Level 1

- Screening
- Risk Screening;
- Self care
- OHA
- Meter intro
- Pattern recognition
- Basal Insulin

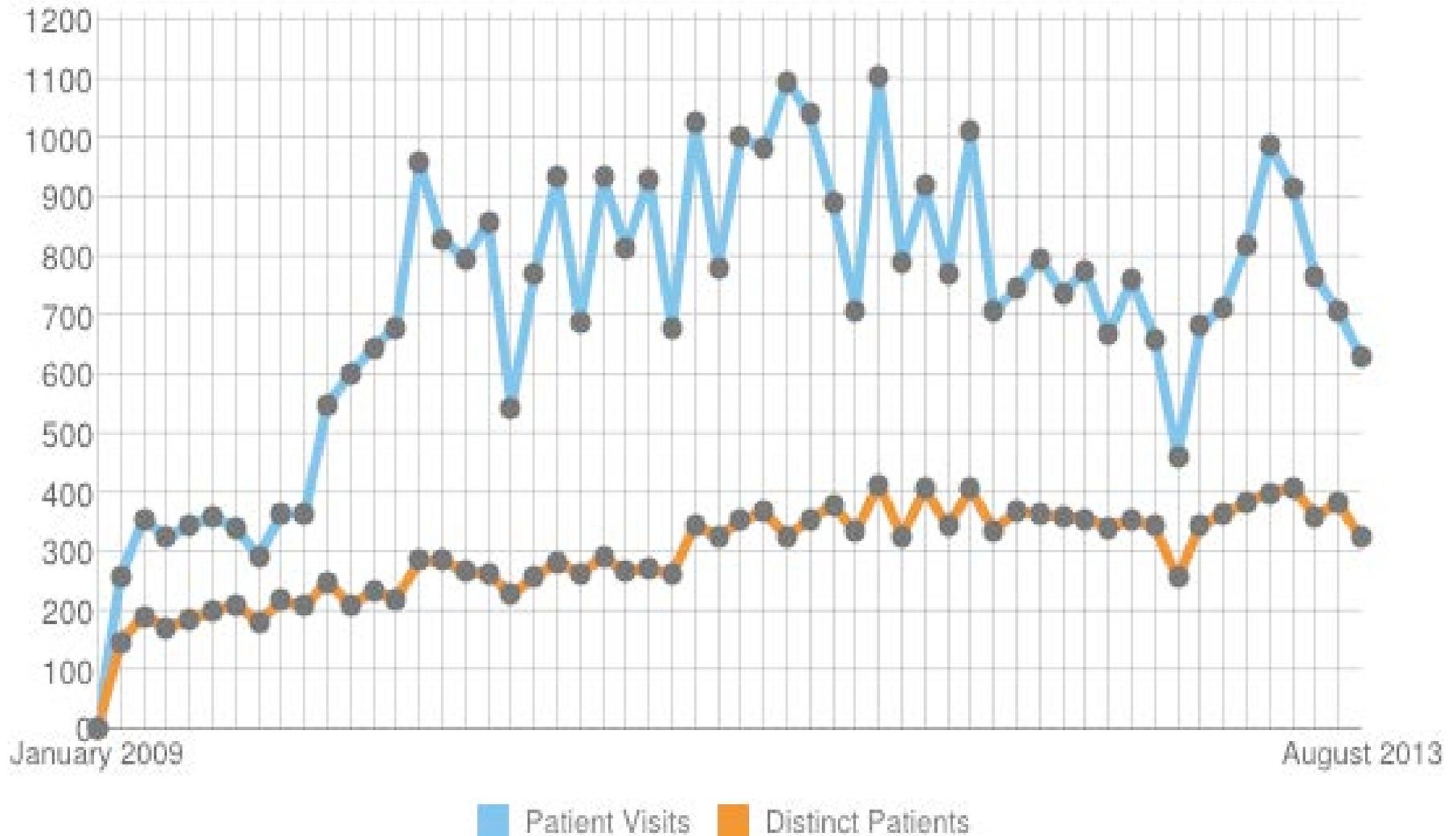
DCG – Who We See

Patient % by Presenting Problem

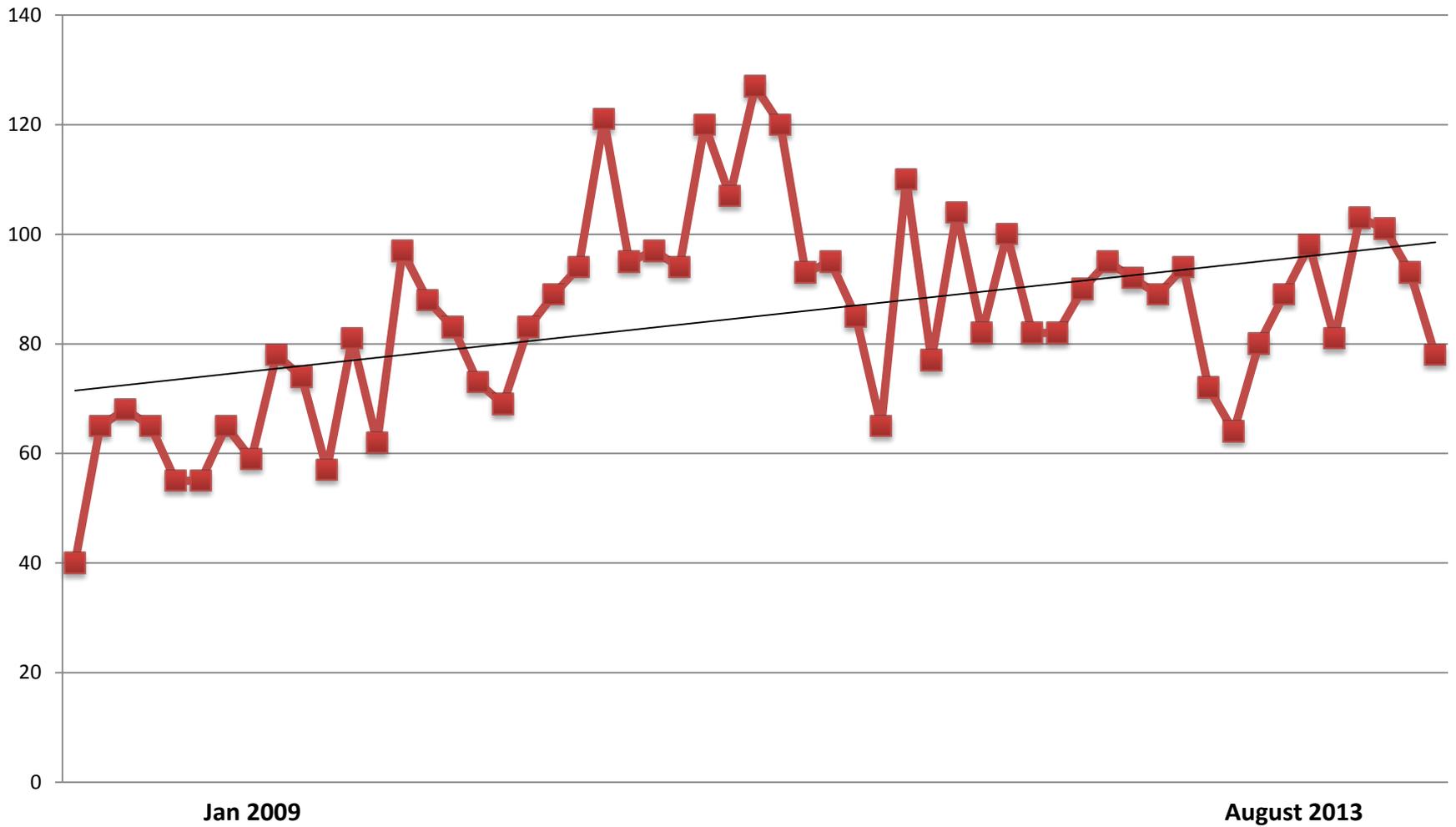


Type I Type II Diet Type II ADA Type II ADA & Insulin Type II Insulin

Number of Patients Seen - Monthly (Diabetes Care Guelph)



Monthly New Referrals



DCG – Clinic Flow

Patient Referral(HCP-SELF)

Phone call- Book appointment- Intro package mailed



Initial Intake(60 min)

RN/ RD-Assess patient needs/ Outline other services(Kin/SW/Endo/FC)



Group Seminars(Conversation Map)

Living with diabetes/Beyond the Basics/CHO counting/ Energizing fitness



Follow Up Appointments(1:1-Phone-email)

Patient preference/DCG recommendation

Referral Form

DiabetesCare
Guelph

83 Dawson Road, Guelph, ON N1H 3B3
Phone: (519) 840-1964 Fax: (519) 840-1963

Referring Practitioner: _____ Date Referred: _____

Phone: _____ Fax: _____

Patient Information:

Patient's Name: _____ DOB: _____

Address: _____

Phone: _____ Health Card #: _____

Urgency of Referral:

Urgent Within 1 Month Within 3 Months

Reason for Referral:

Newly Diagnosed
 Special Consideration (please specify)

Insulin Start (Complete insulin start order)

Basal Insulin Start Order: Type: <input type="checkbox"/> Lantus <input type="checkbox"/> Levemir <input type="checkbox"/> NPH Sig: Start at 10 units at bedtime and increase by 1 unit every night until fasting blood sugar between 5-7 mmol Mitte: 1 box with 1 repeat <input checked="" type="checkbox"/> Permission for RNs at DCG to titrate by 20% of total daily dose and dispense samples of ordered insulin	Other Insulin Start Order: Type: _____ Sig: _____ Mitte: _____
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Diabetes Management:

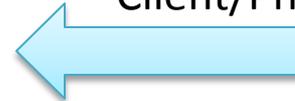
RN/RD order labs (fbs, HbA1C, OGTT, Lipid profile, Kidney Functions)
 RN write prescription for supplies related to capillary blood glucose monitoring and insulin administration

Signature: _____ Date: Sep 20, 2013

In the interest of efficient service, please ensure the following are included with the referral:

- 1) Lab Data Required from Initial Diagnostic Values and Follow-Up Values
a. (A1C, FBG, OGTT, Lipid and Kidney Functions)
- 2) Most recent History and Physical or Cumulative Patient profile (with meds listed)

Client/Physician demographics



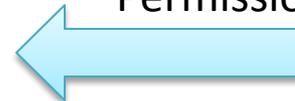
Urgency of appointment



Insulin start orders



Permission for lab req to be issued



Recent lab work requested



Role of Registered Nurse

- Initial Assessment:
 - Review of past and current health concerns
 - Current medication review
- Continuous follow up with blood work every 3-6 months through Medical Directives
- Change management support: reviewing and revising patient progress and SMART goals along the continuum
- Evidence based education and management recommendations after allowing 3-6 months for lifestyle changes if possible

Role of the Registered Kinesiologist

- Support, education and counseling one on one and in groups.
- Individualized fitness plans tailored individual strengths and limitations with modifications for specific medical conditions.
- Supervise individuals and facilitate groups in onsite fitness facility.
- Create accessible links with for physical activity within the community

Individualized Exercise Plans

Patients are screened for CDV and MSK limitations and under go stress testing as indicated.



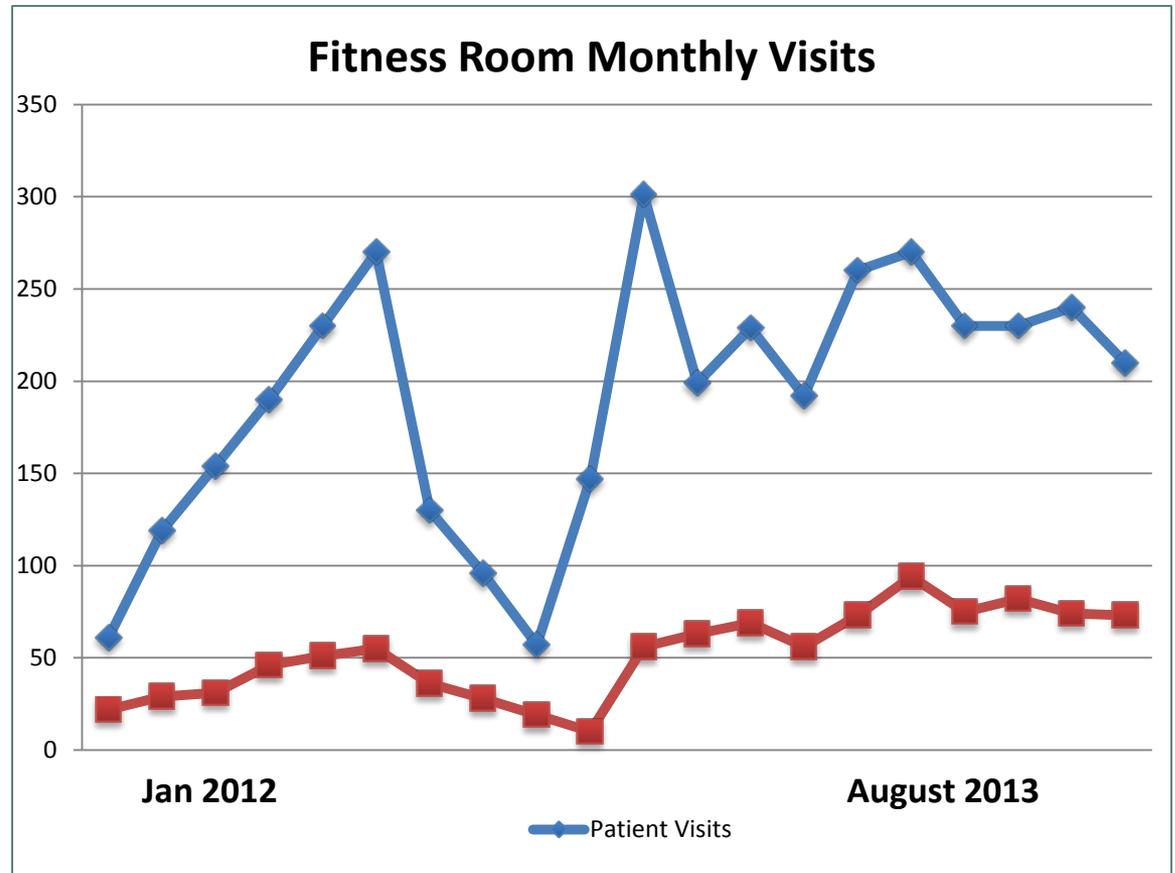
Programs are developed from stress test results to meet individual goals.



Optimized for patients to fit patient lifestyles.

Fitness Area

Patients have access to an onsite fitness facility with drop in hours aerobic, strength and balance equipment for up to 12 months



Supervised Group Exercise Classes

- 2x1.5 hour sessions/week for 6 weeks.
- Circuit based class with aerobic, strength and balance components. In addition participants are counseled in topics including: initiating and sustaining cardiovascular and resistance programs, nutritional concerns and tackling barriers related to exercise.



FitStart with the YMCA

Free 6 week program transitional partnered with the YMCA of Guelph. Every 3-4 months 8-15 participants join the program.

Participants receive:

- Instruction and familiarization with fitness equipment and classes
- 1:1 support with YMCA personal trainers and fitness instructors.
- Free day and class passes for the duration of the program.
- Joining fees waived, and first 3 months fees cut by 50%
- 2/3 of respondents increased their number exercise days. The remainder maintained existing levels.
- 50% of participants joined the YMCA following completion of the program.



Nordic Poling Walking Group



100% of participants agree or strongly agree they received the necessary knowledge and skill to continue their own Nordic Pole walking routine

Role of the Registered Dietitian

- Complete nutrition assessment
- Education on relationship between metabolic syndrome and nutrition
- Work with client to develop nutrition plan and assist client with SMART goal setting
- Resources and tools: carb counting, online food journals, portion sizes and recommended number of servings per day, label reading, recipe sharing

Nutrition Assessment and Plan

1. Evaluate Nutrition Status

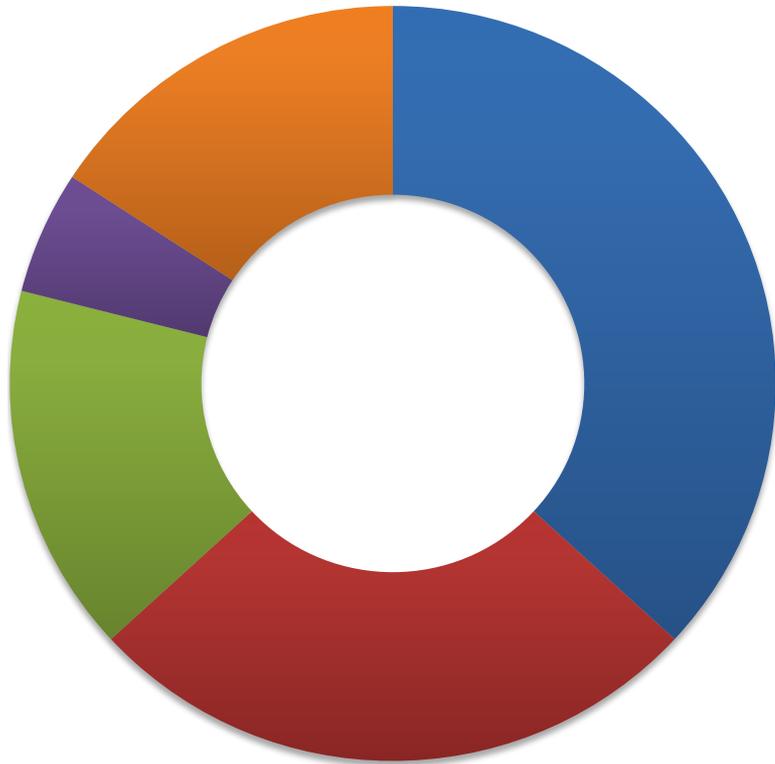
1. Plan: Medical Nutrition Therapy

- Specifically tailored nutrition plan
- Reduce the risk of developing complications

2. Follow-up

Nutrition Education

Most Common at DCG



- Diabetes Basics (plate method, meal timing, sources of carbohydrate, heart healthy eating)
- Beyond the Basics (Carbohydrate Counting, carb targets at meals)
- Diabetes + Co-morbidities
- Pre-conception/ Type 2 Pregnancy
- Insulin/Carbohydrate Ratios

Appointments

- One-to-one
 - Individualized health coaching
 - Prioritization of goals
- Group
 - Facilitation of learning
 - Experiential learning
 - Supportive, safe environment

Education through Conversation Maps

- Used in group seminars for the past 2 years
- Goal: actively engage participants with the information they learn and help them make workable plans for achieving their personal health goals
 - Face to face interactions
 - Visuals and education tools
 - Interactive conversations
 - Participants share personal experiences and knowledge



Better Access

“Dawson”
5days/w

Central
Booking/Triaging

RN/RD (CDE)

Social WORKER

Kinesiology

Fitness Room

Endocrinology on-
site

Group Education

“Surrey”
5days/w

RN/RD (CDE)

Foot Care Services

Endocrinology on-
site

Satellite 1
“CHC”
2.5days/w

RN/RD (CDE)

Cooking Classes

Satellite 2
GWSA
Community
Centre
1day/w

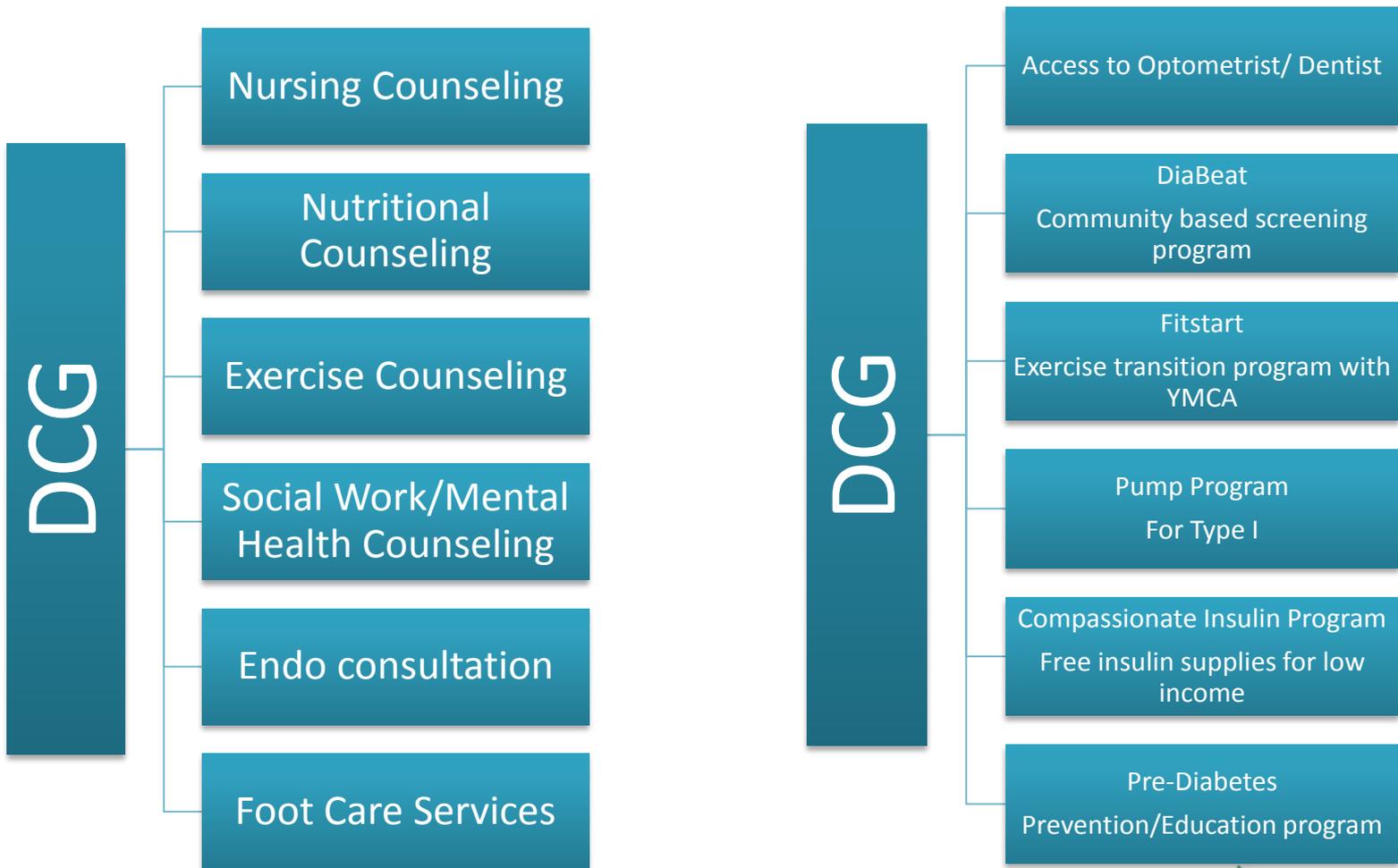
RN/RD (CDE)
Diabetes
Support Group

Food tasting events

Satellite 3
Local
YMCA/YWCA
1/w x 6 w

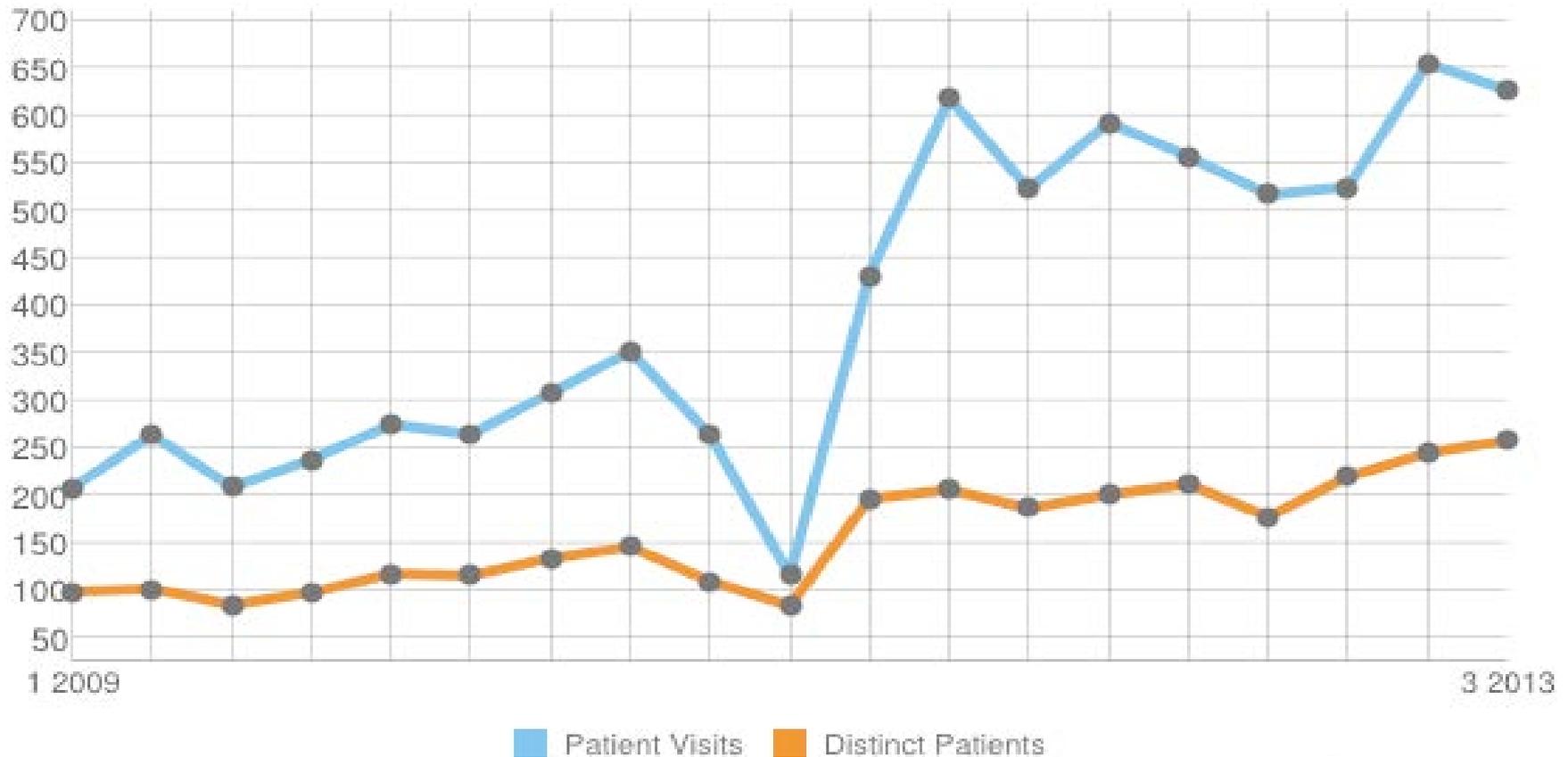
FitStart Program
Collaboration and
on-site support for
group Exercise

Enhanced Services



Better Access

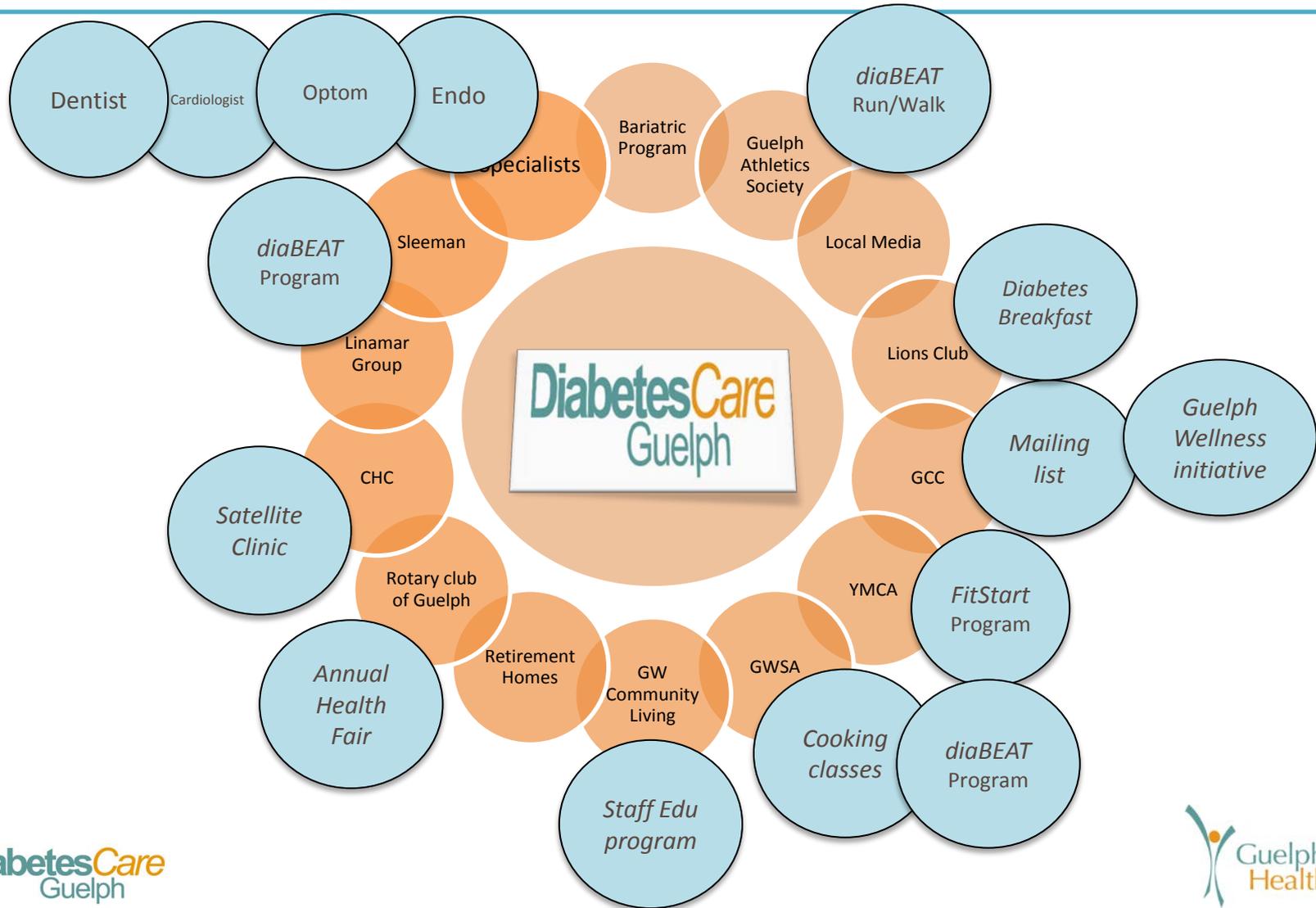
Number of Telephone Contacts - Quarterly
(Diabetes Care Guelph)



Partnership



Partnership



Research Projects

- **University of Western Ontario” Brescia”**

Evaluating the impact of two different forms of diabetes self-management education on knowledge, attitude and behaviours of patients with Type 2 diabetes mellitus

- **University of McMaster” School of Nursing”**

Feasibility, Acceptability and Effects of an Interprofessional Community-Based Health Promotion Intervention on Self-Management in Older Adults with Type 2 Diabetes and Comorbid Chronic Conditions: A Pilot Study

Focus Group

- February 2011
- 9 participants
- The following were assessed:
 - Participant reaction and satisfaction
 - Learning
 - Life application
 - Community impact
 - Outcomes
- March 2013
- 9 participants
- The following were assessed:
 - Access to care
 - Respect for patient values, preferences and expressed needs
 - Coordination of care and integration of services
 - Involvement of family and friends
 - Transition and continuity

Recommendations

1. Increase community awareness
2. Increase Physicians awareness and info
3. Lack of consistency around handouts/materials
4. Increase program awareness
5. Prevention plan(Pre-Diabetes)
6. Overview of DCG service at Visit 1
7. Improved Follow-ups (phone/mail)
8. Longer hours
9. Additional counseling on Alcohol/smoking
10. Specialized programs, foot care screening, social work

Recommendations

1. Increase awareness of the Diabetes program
2. Increase awareness of existing services
3. Incorporate family and friends in a more intentional way
4. Diet planning program has been successful, however physical activity needs to be increased
5. Extend care through digital services and support
6. Improve communication and exchange of information between physicians and clinic staff
7. Develop a tool for ongoing education reminders
8. Improve location surroundings of the Guelph CHC

Program Promotion/Awareness

- Key Elements:
 - Radio, ads, articles, posters, newsletters (for both Patients and Physicians)
 - Intrigue media TV network, signage for DCG in all locations, branded communication tools
 - Promotion through GP, Specialist and Pharmacy visits.
 - Education and screening events at Retirement homes, School boards, University, Senior's centre and factory organizations

Physician Survey

Please indicate which FHT services are a priority to you for your practice?

	More Helpful	Less Helpful
• Nurse Practitioner	71.4% (25)	28.6% (10)
• Primary Care Nurse Clinician	75.7% (28)	24.3% (9)
• Aging at Home Nurses	84.6% (33)	15.4% (6)
• Foot Care Nurse	57.1% (20)	42.9% (15)
• Spirometry/ABl/24-hour BP	69.4% (25)	30.6% (11)
• INR Clinic	95.0% (38)	5.0% (2)
• Diabetes Care Guelph	92.5% (37)	7.5% (3) #3 service appreciated
• GetFHT	61.5% (24)	38.5% (15)
• Registered Dietitian	86.5% (32)	13.5% (5)
• Mental Health Counsellor	97.6% (40)	2.4% (1)
• Pharmacist	86.8% (33)	13.2% (5)
• Kinesiologist	17.6% (6)	82.4% (28)
• Psychiatry	88.1% (37)	11.9% (5)
• Groups and Classes	38.9% (14)	61.1% (22)
• Business and IT support	61.8% (21)	38.2% (13)

Measuring Outcomes

- Hb A1c
- Blood Pressure
- Waist Circumference
- LDL

DCG – Centre of Excellence

The Standards Recognition Review Committee of the Canadian Diabetes Association is pleased to grant the Diabetes Care Guelph Team recognition as a Diabetes Education Centre that successfully meets the majority of Standards for Diabetes Education in Canada (2009). The review findings indicate the Centre delivers superior diabetes education services for people in the communities it serves. (2012)

- **Notable Commendations**

- Focus on "One Stop Shopping" which enables your team to provide client access to a wide scope of services
- Extensive and varied community partnerships and linkages.
- Many opportunities exist for both primary and secondary prevention
- Work with long term care communities is impressive
- Involvement in diabetes research.

CDA Recommendations

- Enhance programming to better meet client cultural and spiritual needs.
- **Consider the development of a CQI committee to direct all of your evaluation work.**
- Utilize your identified plans as a base for program development and Diabetes
- Education Standards Re Recognition
- Community representation, as well as other multi-disciplinary diabetes professionals would be an asset to sit on the Board of Directors and Advisory committee



Guelph Family
Health Team

THANK YOU