Guelph Family Health Team

Advancing the RN Role in Primary Care Chronic Disease Management

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OVERVIEW

The Guelph Family Health Team's (GFHT) experience with the implementation of Primary Care Nurse Clinicians (PCNC) for Chronic Disease Management (CDM)

1. ***Why*** implement the PCNC role
2. ***How*** the PCNC role aligns with GFHTs Interdisciplinary Health Professionals (IHP)
3. ***What*** are the outcomes

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OVERVIEW

... CONTINUED

ABOUT GFHT

Physicians	72
GFHT Staff	65 +
Roster Size	100,000
Clinics	22

CDM PREVALENCE*

Diabetes	9,000
Hypertension	16,900
COPD	3,900
Asthma	13,000

* Projections based on WWLHIN prevalence data 2010

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NURSING ROLES AT GFHT

PROGRAM BASED

- Get FHT
- Diabetes Care Guelph
- INR Clinic
- Aging at Home Program
- Foot-care Clinic

CLINIC BASED

- NPs
- PCNCs
- Practice RNs

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WHY IMPLEMENT THE PCNC ROLE?

WHY THE PCNC ROLE ?

GFHT responded to health care directives and priorities:

1. Proactive and optimal chronic disease management and prevention upstream
2. Improved access to primary care
3. Improved patient self-management
4. Reduced inappropriate use of acute care and emergency department (ED) resources

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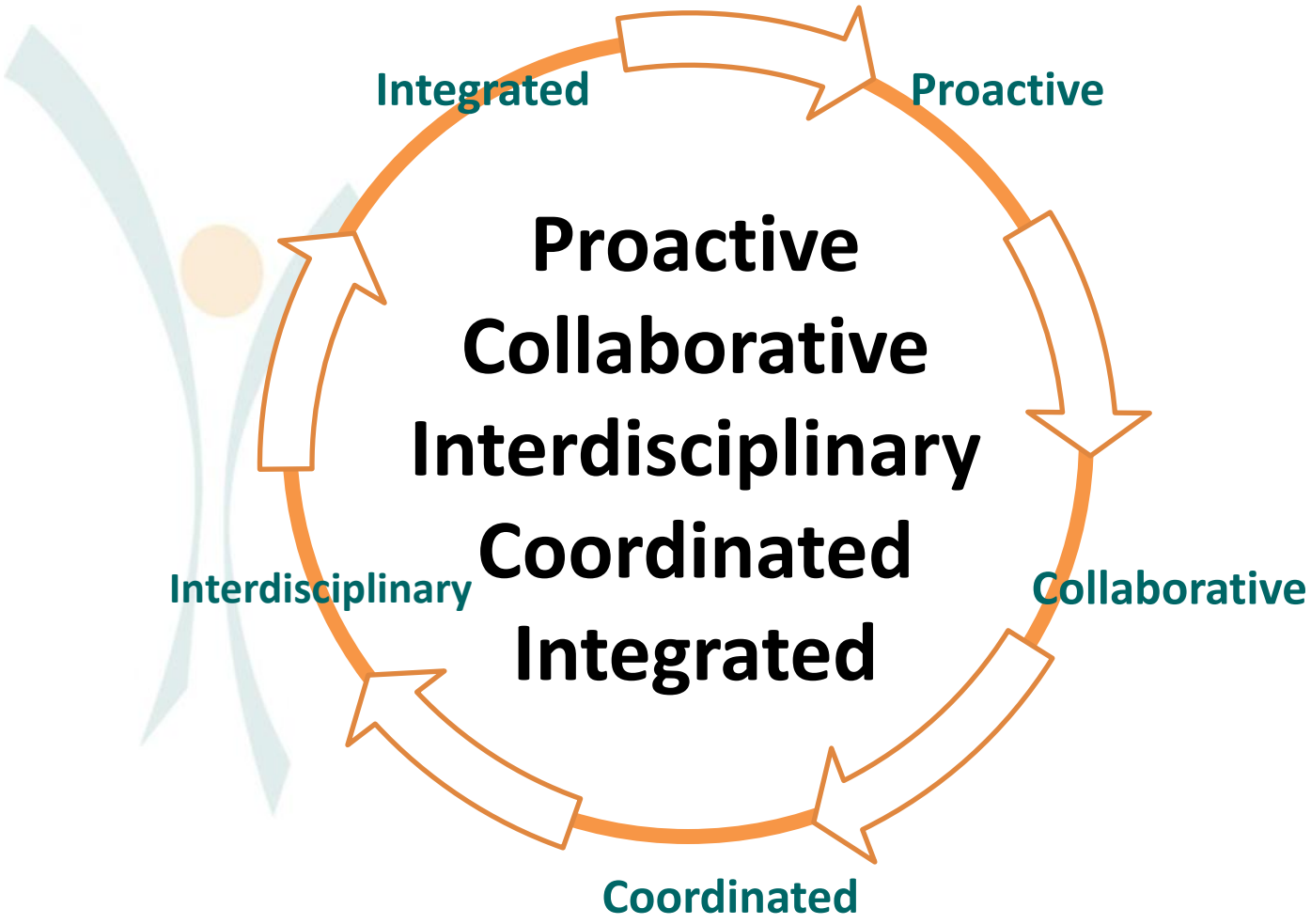
THE PCNC ROLE ALIGNMENT

ALIGNMENT WITH CDM FRAMEWORK GOALS



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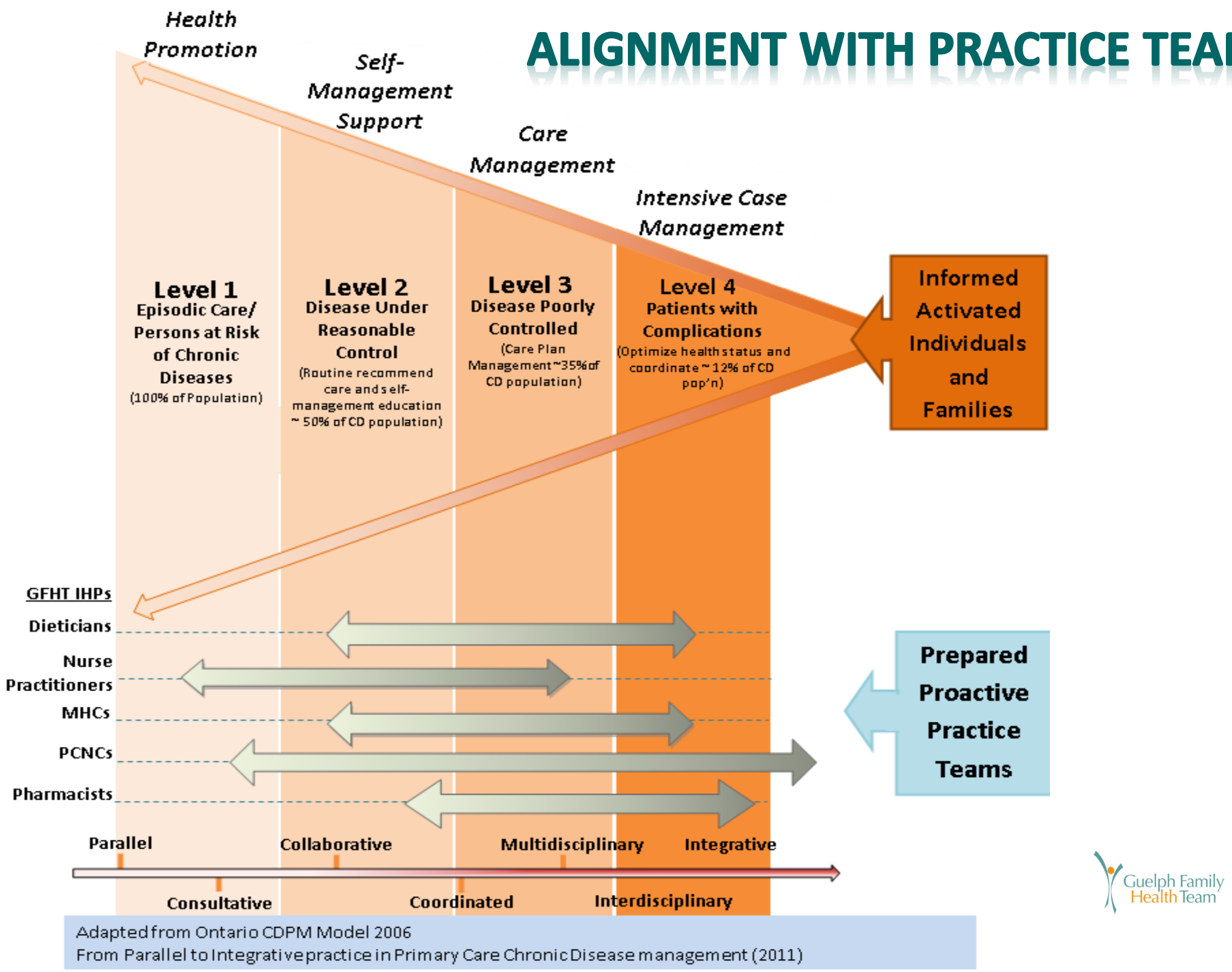
ALIGNMENT WITH PRACTICE TEAM



Adapted from Ontario CDPM Model 2006
From Parallel to Integrative practice in Primary Care Chronic Disease management (2011)

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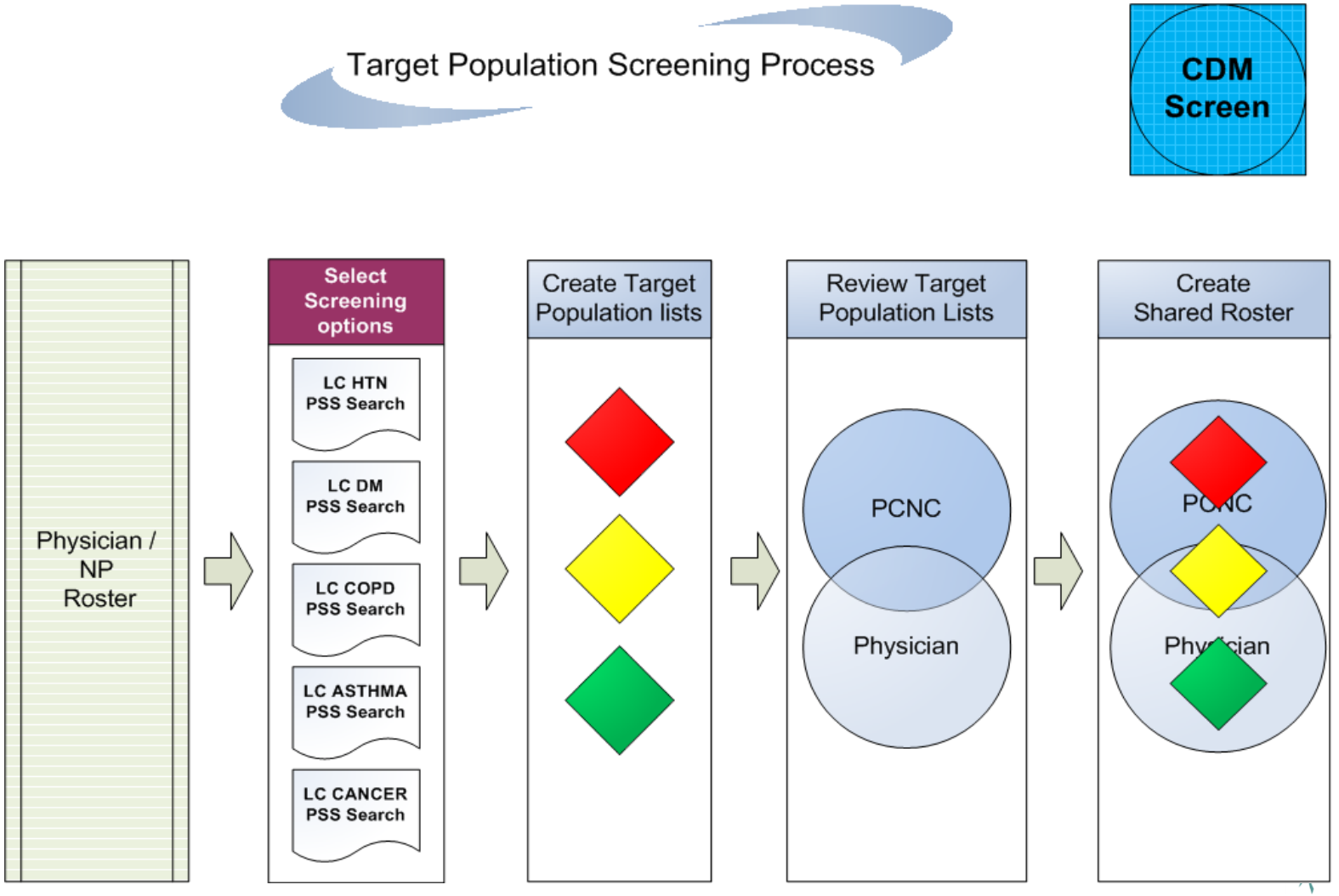
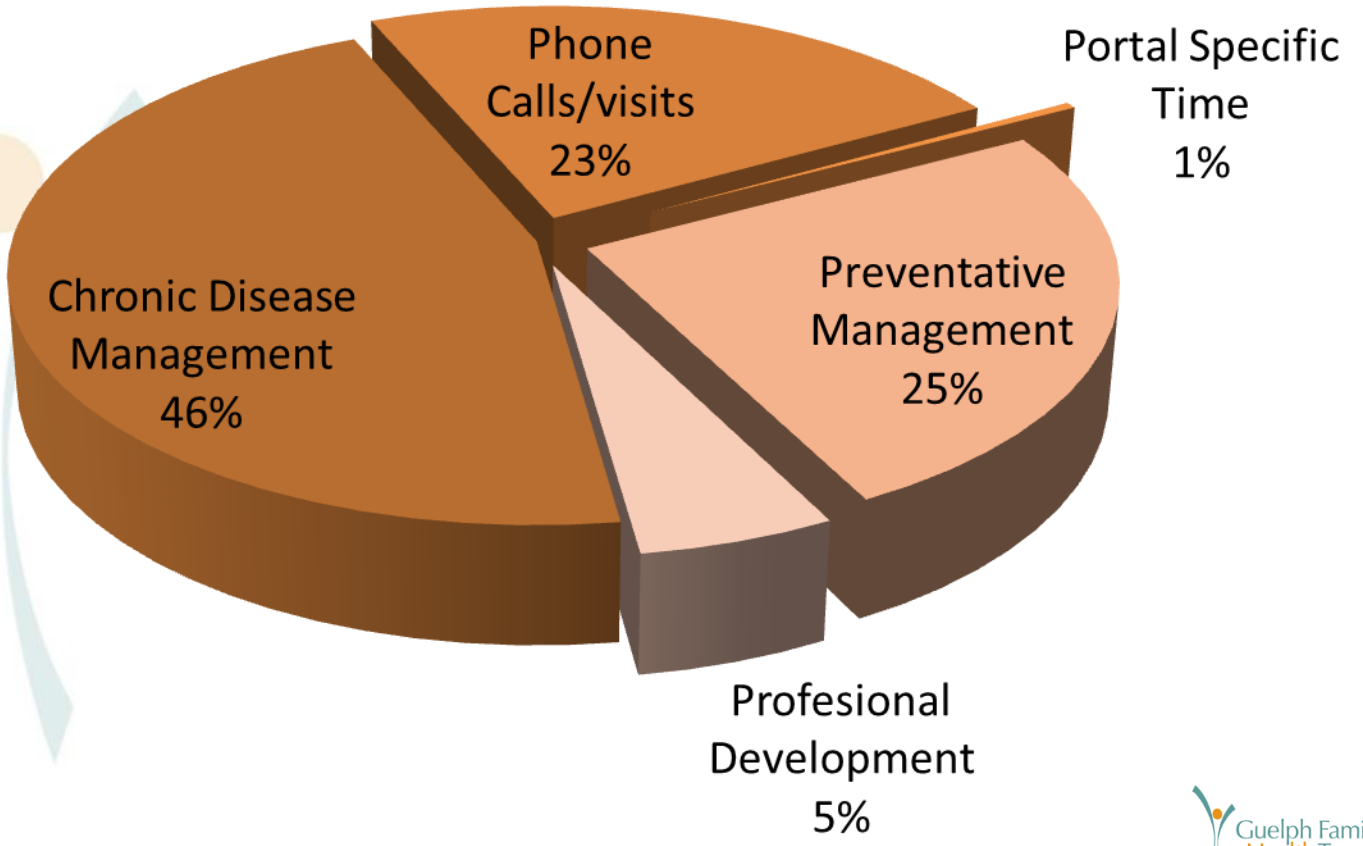
ALIGNMENT WITH POPULATION NEEDS



OUTCOMES

PCNC ACTIVITY LOG OVERVIEW
OCT 2010-SEPT 2011



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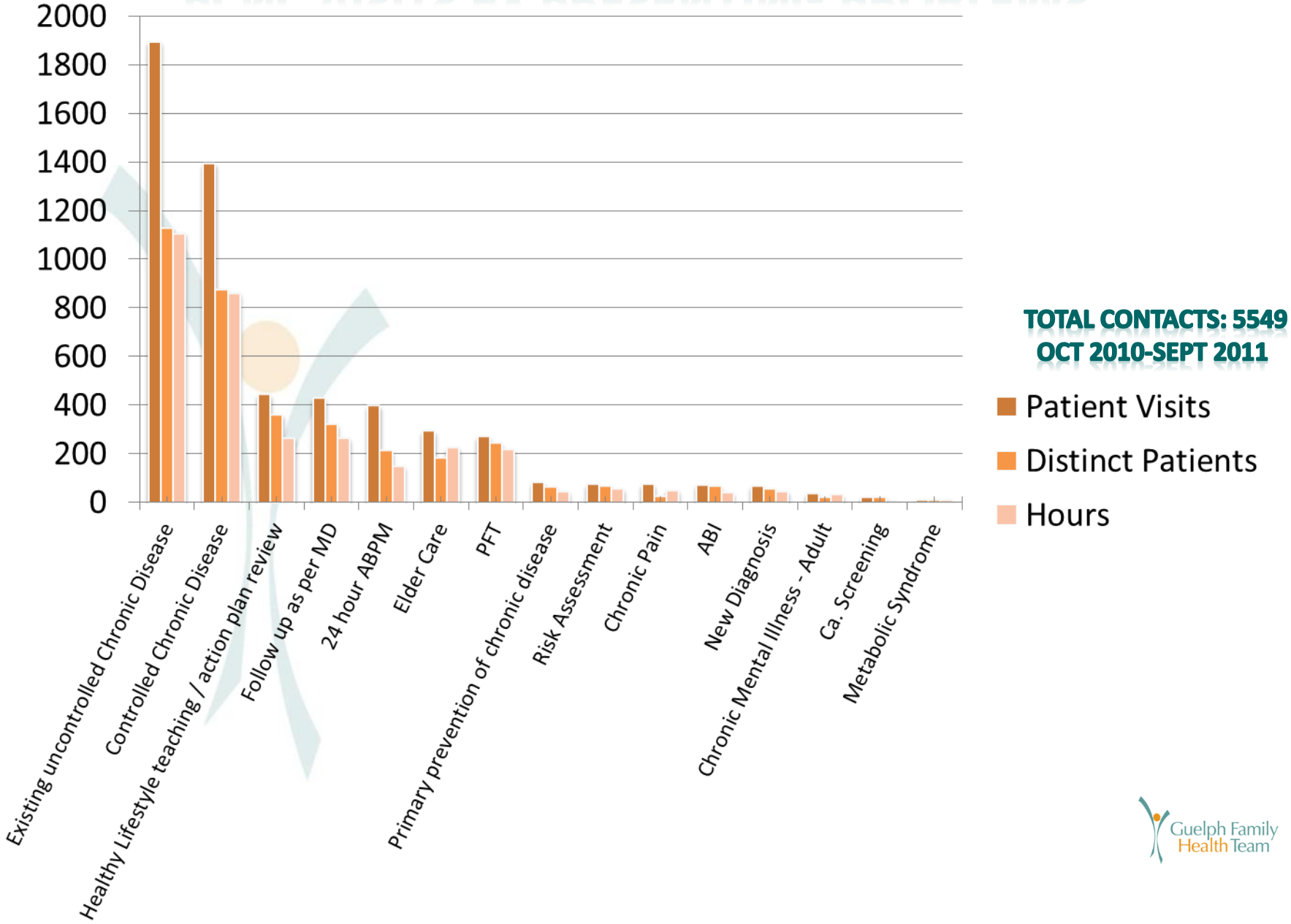
PCNC VISITS BY PRESENTING PROBLEMS



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TOWARDS IMPROVED TARGETS-HYPERTENSION

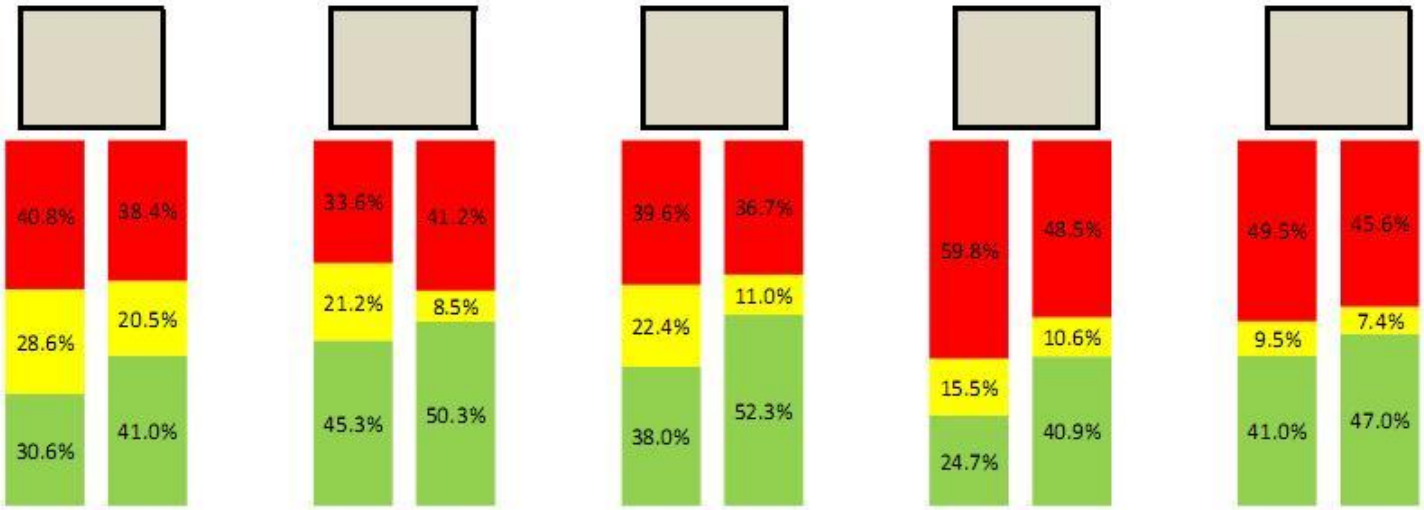
Guelph FHT

PSS Query Data Summary

Red: No documented BP in the last 365 days **AND** BP >140/90 in the last 60 to 365 days

Yellow: BP >140/90 in the last 60 days

Green: Documented BP <=140/90 in the last 365 days



Total HTN Query	100% **229**	100% **153**	100% **474**	100% **198**	100% **338**
Total Pt. in Practice	1,227	966	2,211	2,183	1,801
Total % Query Pt.	**18.7%**	**15.8%**	**21.4%**	**9.1%**	**18.8%**

COMPARISON DATA BY PRACTICE: FEBRUARY 11,2011 AND SEPTEMBER 26, 2011

TOWARDS IMPROVED TARGETS-DIABETES

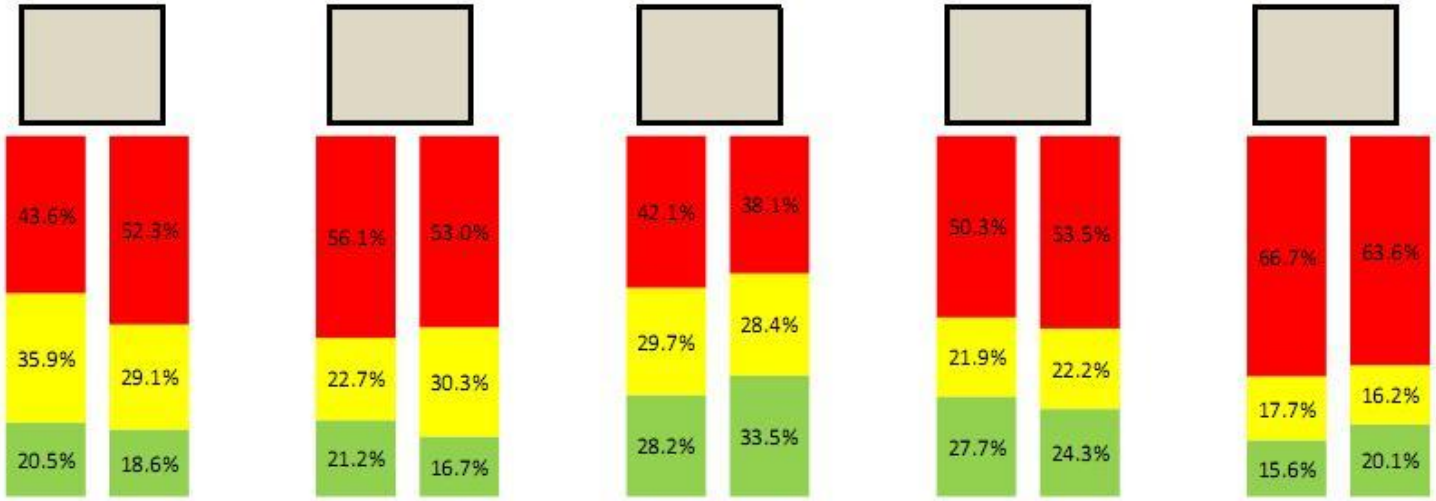
Guelph FHT

PSS Query Data Summary

Red: No documented HbA1C in the last 3 months

Yellow: Documented HbA1C >7% in the last 3 months

Green: Documented HbA1C <=7% in the last 3 months



Total DM Query	100% **86**	100% **66**	100% **197**	100% **144**	100% **154**
Total Pt. in Practice	1,227	966	2,211	2,183	1,801
Total % Query Pt.	**7.0%**	**6.8%**	**8.9%**	**6.6%**	**8.6%**

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COMPARISON DATA BY PRACTICE: FEBRUARY 11,2011 AND SEPTEMBER 26, 2011

CHALLENGES

- Historical office practice nurse role
- Evolving role of FHT in Chronic Disease management
- Perceived competing IHP roles in CDM
- Efficient system for consistent outcomes tracking, monitoring and reporting process

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LESSONS LEARNED

- Physician engagement
- Role marketing and public education
- Start slow - takes a while for people to ‘get it’
- Role customization based on practice need
- ‘Patience is a virtue’

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FUTURE DIRECTION

- Formal evaluation of role effectiveness
  - Patient satisfaction
  - improved clinical targets
  - Improved functional targets
  - Improved patient self-management
- Advocate for:
  - role expansion in primary care
  - recognition as best care delivery model for CDPM
- Improved systems for outcomes tracking and reporting

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Q&A

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