Upstream Solutions for Downstream Congestion

A Proactive Approach to the Use of the RN Role in Primary Care

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Background

Introduction

The role of Primary Care Nurse Clinician (PCNC) was established by the Guelph Family Health Team to target, monitor and case manage populations at risk for developing chronic disease states.

Unlike acute disease processes that focus on downstream solutions, chronic disease problems have aspects that can effectively be addressed upstream, even preventing the disease itself.

This example outlines how the PCNC role was used for patients with Impaired Fasting Glucose (IFG) / Impaired Glucose Tolerance (IGT) with a goal to prevent and or delay conversion to Type 2 diabetes (DM 2).

Research on intervention trials for patients at Risk for DM-2 reported reduced risk of progression by 60%. Therefore reduced downstream congestion.

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Process

General Process

Identify
- PCNC identifies the target population and reviewed with the interdisciplinary practice care team

Plan
- Creates individual plan of care based on Best Practice Guidelines

Implement
- Provides education and support to individual patients
  - promote healthy lifestyle
  - determine health priorities
  - review potential complications
  - promote self-management
  - identify barriers to health based on the determinants of health

Evaluate
- Monitors progress of the patient quarterly

Patient Identification Criteria

PCNC used the following Clinical Risk factors to identify suitable patients:
- Impaired fasting glucose (IFG)
- Impaired glucose tolerance (IGT)

Timely visits with appropriate interdisciplinary team member

Visits are organized with the following:
- Primary Care Nurse Clinician
- Family Physician
- Dietitian

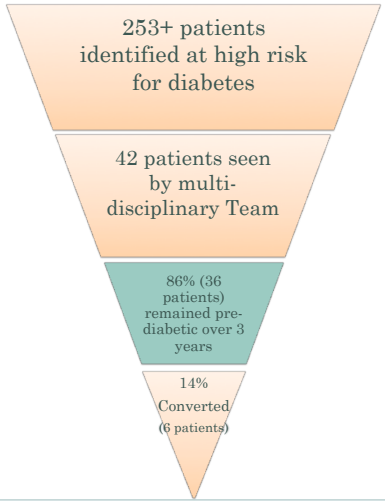
Lifestyle Counseling

- Focus on Nutrition and Activity
- Verbal and written material provided

Outcomes

Results

This is an practical example of the process executed in a clinical setting.



Conclusion

Proactive use of Primary Care RN role to identify, screen and manage populations at Risk for developing Chronic conditions such as Type 2 DM, using simple interventions and interdisciplinary team to coordinate care, delayed progression to Typé 2 DM for 86% of patients

System Leadership | ***Organizational Capacity*** | *System Navigation* | *Sustainability*