

PLANNED DIABETES DAYS: ENHANCING PATIENT CARE THROUGH USE OF EMR TEAM COLLABORATION IN PATIENT-CENTRED CARE

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BACKGROUND

The Owen Sound Family Health Team (OSFHT) consists of 20 physicians and 5 Nurse Practitioners supported by allied health professionals, nurses, and clerical staff, providing primary healthcare services to 35,000 patients.

Our improvement journey in the care and treatment of patients with diabetes mellitus(DM) began in 2009 with 1 Physician/NP participating in Partnerships for Health, spreading to 3 physicians at their site. Concurrently, a solo physician tested an independent project to maximize efficiencies in DM care. The current OSFHT Planned Diabetes Clinic program evolved through the study and collaboration of both approaches. Our team recognized that grouping patients into cohorts and seeing them at regular quarterly intervals by a dedicated DM trained team would ensure specialized focus, providing consistent care, support and education to patients with DM.

The success and belief in the Planned Diabetes Days model was solidified in 2011 when our multisite FHT moved into a single location. The new facility was designed with clinic areas (pods) to support multi-person clinic days for patients with DM and/or other chronic diseases.

As of 2013, all 20 physicians at the OSFHT participate in Planned Diabetes clinic days, incorporating a collaborative interdisciplinary team approach. Our Diabetes Action Team guides the services, resources and management to achieve a consistent model of care to over 2900 patients with DM.

Our poster demonstrates how clinic-wide standardization of the EMR has helped us plan, launch and sustain a successful program to manage a high volume of patients with DM.

CLINICAL GOALS

- Standardize coding and data input in the EMR to assist in the identification, recall and management of patients with DM.
- Use outcome measures to increase team members' awareness of areas for improvement and successes and develop and implement strategies to enhance performance.
- Standardize the services and resources at the OSFHT to achieve consistency in the healthcare provided to all patients with DM.

EXAMPLE OF MEASURES

- A1c Testing every 3 months
- LDL Testing every 12 months
- Retinal Eye Exam annually
- Depression Screening annually
- Self Management – at least one goal documented in EMR annually
- ACE/ARB Treatment – treated with ACE/ARB in last 12 months

METHODS OF STANDARDIZATION IMPLEMENTED TO DATE

STANDARDIZED CODING	PATIENTS CODED AS DM1 OR DM2 – Enhances accuracy of diabetic registry and facilitate data collection IDENTIFY DIAGNOSIS START DATE – Provides direction for treatment plans SNOMED CT® CODING (multilingual clinical healthcare terminology) – EMR updated for future data sharing CONSISTENCY OF DATA ENTRY – Standardized entry of all incoming reports, tests and consultations DM PATIENT GROUPING – Patients grouped according to physician roster size for future planned visits (eg. DM Group A, B, c etc.)
DM RECALL	RECALL PROCESS – Search for patients overdue for appointments. Ensuring no gaps in quarterly care. Patients are rescheduled on first available appointment
STANDARD REFERRAL	STANDARD SCREENING AND REFERRAL PROCESS – Timely referrals to appropriate allied health team members
STANDARDIZED QUARTERLY VISIT ENCOUNTER FORM	DM ENCOUNTER FORM – Encounter created by OSFHT for use on Quarterly Planned Visits. Comprehensive form incorporates links to external resources, forms and requisitions to address all components of DM visit. Improves workflow, consistency of care and efficiency
CLINIC WIDE REMINDERS	AUTO GENERATED REMINDERS – Reminders triggered at the discretion of health care provider
COLLABORATION OF COMMUNITY RESOURCES	INITIATION OF PARTNERSHIP WITH DIABETES GREY BRUCE – Supports additional individual and group diabetes education. Minimizes duplication of services, thereby increasing capacity and decreasing wait time
DIABETES COMMITTEE	DIABETES ACTION TEAM COMMITTEE – Monthly meetings to review planned visit process, identify areas for improvement based on clinical measures and discuss strategies to improve patient outcomes. Ensure standardization of care through ongoing educational opportunities. Determines quarterly clinical and education focus for Quarterly Planned Diabetes Clinic Days
PATIENT REPORT CARD	DETAILED REPORT GRAPHS – Report card shows progress and self-management goals. Empowers patients to take ownership of their health status
PHYSICIAN REPORT CARD	HEALTH CARE PROVIDER REPORT CARD – Individual report for peer-to-peer comparison of clinical process and outcome measure of established goals and CDA targets
EDUCATION PROGRAMS	GROUP-BASED EDUCATIONAL PROGRAMS – Accessible to rostered and non-rostered patients. Maximizes education resources and increases community awareness and participation

DIABETIC PATIENT STANDARDIZATION OF EMR

Patients sorted into groups for Planned Visit Days (Grouped according to roster size) Identified in EMR in Demographics as DM GROUP (A,B,C etc) in (COMMENT field) and (PERSONAL field)

In PROBLEM Field DM patients identified as DM1 or DM2

Double click to add further details:
- Diagnosis start date
- Snomed CT® Coding

DM Encounter form populates referral to Diabetes Education directly to the PERSONAL field

New OCEAN Toolbar Future plans include designing Toolbar for each chronic disease. Use consistent data entry for all DM patients

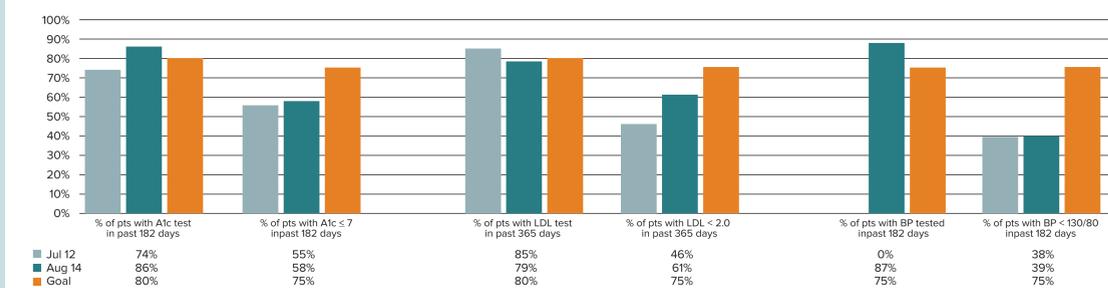
DM reminder window for all DM patients showing Diabetes Education History.

Clinic-wide reminder window for all patients 18 and old (linked to stamp

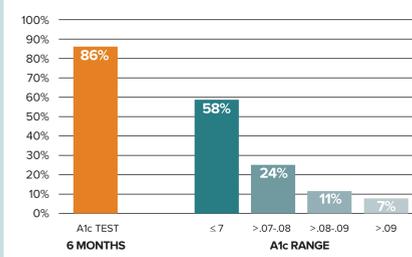
Reminders can be set for clinic-wide use or individualized by physician preference

RESULTS

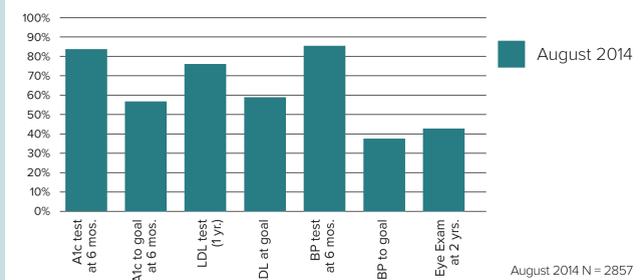
DIABETIC PATIENTS > AGES 18



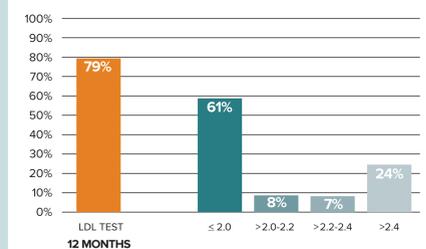
A1c TESTING & A1c OUTCOMES BY RANGE FOR ALL DM PTS



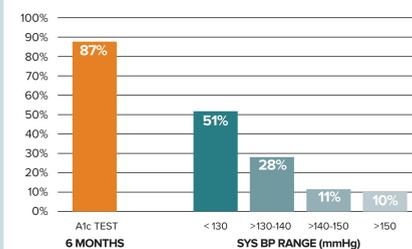
ROSTERED DIABETIC PATIENTS AGES 18-100



LDL TESTING & LDL OUTCOMES BY RANGE FOR ALL DM PTS



BP TESTING & BP OUTCOMES BY RANGE FOR ALL DM PTS



CONCLUSIONS

The physician-led Planned Diabetes Clinic Days format is supported by a multi-disciplinary team, including clinic and program nurses, allied health, and clerical staff. This format allows the team to provide comprehensive DM care.

The Planned Diabetes Clinic Days have resulted in improved patient adherence to therapy, additional opportunities to monitor health conditions and reinforce health teachings. However, failure to improve some outcome measures has identified the need to modify our current programming to focus on hard to treat patients. Additionally, clinical inertia in treating to CDA recommended targets will be addressed through an audit process to improve accountability.

Improvements in our process measures are attributed to standardizations of EMR data and DM recall process. With increased efficiency of healthcare delivery, all

aspects of patient care are addressed at regular visit intervals. This equates to improved patient satisfaction as current needs are met in one visit.

We have adopted a philosophy of positively empowering patients to use self-management skills in the management of their chronic condition. Surveys done in 2013 and 2014 have affirmed the acceptance of our program as evidenced by positive patient experiences and increased patient interest in self-management.

The OSFHT is assessing how the concept of Planned Diabetes Clinic Days can be spread to other chronic disease management programs (COPD, CHF, HTN).

NEXT STEPS

Further standardization of DM reminders to flag patients not currently treated to target for A1c, LDL and BP. As reminders are added to the EMR we will provide learning opportunities to increase staff awareness.

Develop a resource manual for new staff (clerical, nursing, allied health professionals and physicians) with processes of standardizations of data entry to patient profile, as well as for consultations, test and lab reports. Manual will be accessible in printed and pdf format on staff intranet portal.

Increase awareness of programs and services available to patients. Create information pamphlet for newly diagnosed patients with DM. Offer calendar of upcoming events through a patient newsletter in printed version and on OSFHT

website. The recent introduction of electronic tablets will expand our capacity to gather patient data and feedback.

Plan to engage physicians and nurses within each pod to review process and outcome measures, and identify barriers and solutions to achieving CDA recommended targets.

Improve communication between the Diabetes Action Committee, the Owen Sound Medical Associates Board and the clinic-wide team.

Create a patient advisory committee and host patient and provider focus groups to incorporate patient experiences into our planning and implementation of DM education and management.

ACKNOWLEDGEMENTS

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