Realizing Patient Goals

Aim for Nothing and You'll Hit it Every Time!

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Family Health Team

Today's agenda:

- Brief History of our team
- Needs/Gap Analysis for Type 2 Diabetics
- Clinical Goals for Diabetic patients
- Program pathway for Type 2 Diabetes Management
- Patient Flow for Diabetic Visits
- Patient Education Tools
- Metrics
- Challenges

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Team History

- Since 2007, grew from three to seven and then 11 physicians
- IHPs: 2 NPs, 4.5 RNs, 1 Social Worker, 1 Dietitian
- Situated in 3 sites and 6 different office suites
- Over 20,000 rostered patients
- Adopted EMR in 2009
- Various approaches to Diabetic patient care and chronic disease management

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TEAMWORK

Coming Together Is Beginning. Keeping Together Is Progress. Working Together Is Success.
~ Henry Ford ~

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MANAGING your diabetes

Ontario

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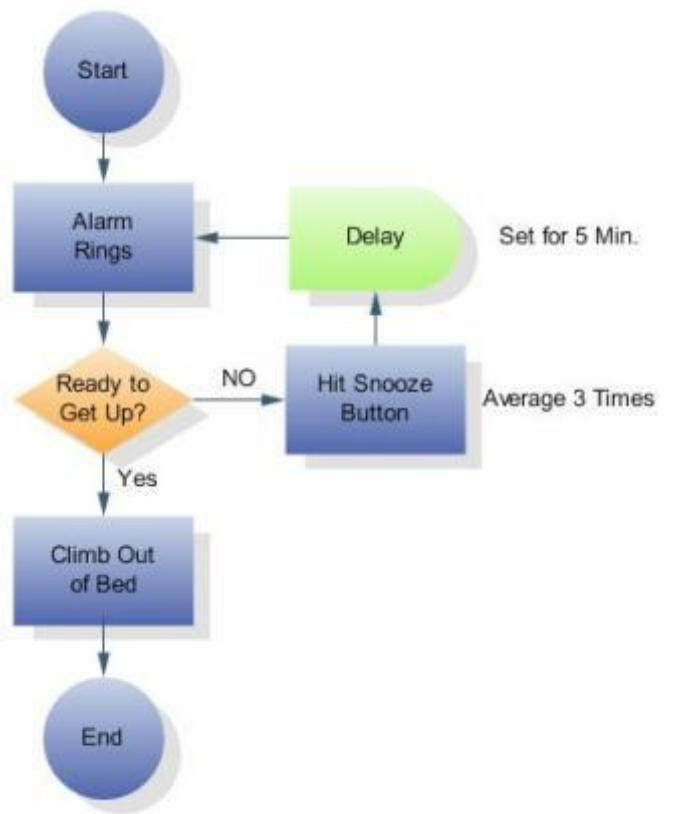
Needs Analysis

Where we started

- Variability between practice management strategies and approaches to collaborative care in the approach to Diabetes Management
  - Standardized protocols/procedures for disease management and measurement tracking are not uniformly implemented

Desired State



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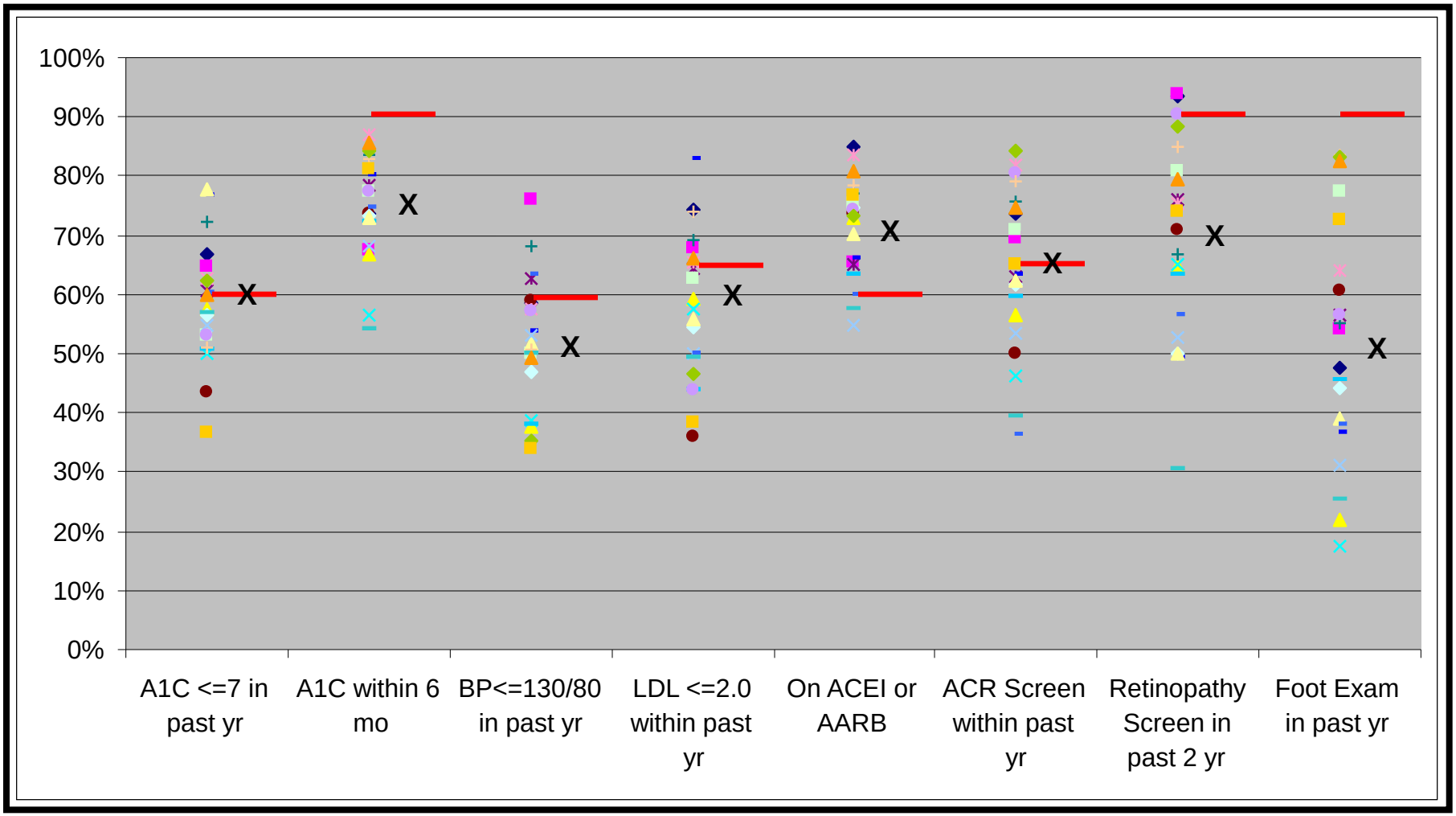
Example of FHT Diabetes Care Variability among MDs



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West Durham FHT Goals for T2DM Patients > 18 yrs

Clinical Goals
➢80% of patients reaching HbAIC goals (<7)
➢75% of patients reaching LDL goals (2 mmol)
➢80% of patients reaching BP goals (130/80)
➢80% of patients will have AIC measurement performed twice/year
➢80% of patients will have LDL measurement once/year
➢80% of patients will have BP measurement performed twice/year
➢100% of patients will have Waist Circumference measured within 12 months
➢70% of patients will have set/reviewed self management goals within 12 months
➢10% pre-diabetes screening increase for eligible patients within 12 months

Program Pathway
Type 2 Diabetes Management

Diagnosis of Diabetes:

- FPG ≥ 7.0mmol/L **OR**
- Casual PG ≥ 11.1mmol/L + symptoms of diabetes **OR**
- 2hPG in a 75g OGTT ≥ 11.1mmol/L

Diagnosis of IFG/IGT:

- FPG < 6.1-6.9 mmol/L **AND**
- 2hPG in a 75g OGTT 7.8-11.0 mmol/L

Criteria for Triage within WD FHT Diabetes Team or Diabetes Education Centre

T2DM
- **newly diagnosed**
- **Existing**

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Newly Diagnosed
- Initial visit booked with MD/NP (*see Initial Visit notes)
- Referral to nutrition counseling group

Existing
- Well controlled patients (AIC<7.0/LDL<2.0/B.P 130/80) scheduled for DM visit with appropriate personnel every 6 mos (see Follow Up Visit notes)
- Poorly controlled patients scheduled for DM visit with appropriate personnel every 3 mos (see Follow Up Visit notes)
- Patients with poorly controlled/complicated diet/nutrition referred to dietitian: 1 on 1 counseling

Pre-Diabetes (IFG/IGT)
- **newly diagnosed**
- **Existing**

→ West Durham Pre-Diabetes Program

Newly Diagnosed
- Initial visit booked with RN for 1 on 1 counseling on nutrition/lifestyle choices

Newly Diagnosed and Existing
- Patients booked into Group Counseling session with nutritionist/dietician
- RN to contact all patients 1 week prior to session

- **T1DM**
- **gestational**
- **< 18yrs**
- **Non-responsive to FHT Management**

→ Diabetes Education Centre

T1DM/gestational/Pediatric Patients:
- Referral to Diabetes Education Centre (Charles Best for pediatric/RDDC referral process)
- Follow up information regarding patients care to be communicated by the DEC and scanned into Practice Solutions by RN and/or MOA staff

Non-responsive Patients:
- Patients with severe complications or consistently inadequate control should be referred (following case discussion with MD/NP) to DEC or direct consult with endocrinologist

West Durham FHT – DM Visit Patient Flow

Reception/ Medical Secretary

- Welcome/Check-in
- Hand-out Next Visit Tear off form for patient with instructions to bring form into exam room
- Schedule patient for next visit according to HCP recommendations (3 or 6 mos DM visit with MD/NP or Dietician)
- DM visits booked in EMR for 30 min blocks at which time patient will be seen in 15 min blocks first by RN and then MD/NP. DM visits should not be booked during the same time frame as Annual Physicals or Well-baby visits to ensure RN staffing is sufficient

RN

All information to be captured in DM Custom Form to meet flow sheet requirements and MD/NP review:

- Height/weight/BP/waist circumference
- Eye exam (ask patient when was last specialist eye exam)
- Vaccinations (pneu/flu)
- A1C Test (if required: no labs within last 6 months or high in last 3 months
- Foot Exam
- BP monitoring
- Self-monitoring discussion – glucose meters

MD

- A1C
- BP (ACE/ARB)
- Lipids
- Meds Review: adjust/add
- Insulin
- CAD Risk Assessment
- ACR (nephropathy)
- ECG
- Lifestyle Review
- Erectile Dysfunction concerns
- Self-Management Goals
- Referral as necessary (indicate special patient instructions on Next Visit Tear off form)

Dietitian

- Lifestyle Review
- Diet/Nutrition Review
- Weight/WC/BMI Review
- Complications
- Education
- Self-Management Goals

NP

- Insulin Starts/MDI adjustment
- AIC
- BP
- Lipids
- Lifestyle Review:
- Self-Management Goals
- Case Management discussion with MD for non-responsive patients for referral as necessary to DEC or endocrinologist

DEC/Endocrinologist

- Case Management and consultation for complicated and/or non-responsive patients

Initial Visit-MD/NP

- **Discuss diabetes: what it is, how diagnosis was made**
- **If previous diagnosis, discuss their understanding of diabetes current medications**
- **Discuss blood sugar targets, target A1C should be achieved within 6-12 months:**

Recommended targets for glycemic control*			
	AIC* (%)	**FPG or preprandial PG (mmol/L)**	**2-hour postprandial PG (mmol/L)**
Type 1 and type 2 diabetes	≤7.0	4.0 – 7.0	5.0 – 10.0 (5.0 – 8.0 if A1C targets not being met)

- **Discuss tools for managing diabetes (food, exercise, medications)**
- **RN/NP to train patients on how to use blood glucose meters**
  - **measurements tested and recorded varying between PPG and FBG (1 recording/ day min)**
- **Discuss complications and need for aggressive therapy and follow-up**
- **Set Self Management Goals – introduce Diabetes Passport**
- **Introduce nutrition guidelines: *messages? i.e. portion sizes, sodium intake, etc.***
- **Encourage exercise ≥150 min aerobic activity/week**
- **Encourage patient to quit smoking – refer to a smoking cessation program**
- **Aggressively treat BP, Lipids**
- **Patient is given an appointment tear off and instructed to bring to Medical Secretary to book follow up appointment in 1 month before leaving office and a requisition form for lab work to be completed**

Canadian Diabetes Association 2008 Clinical Practice Guidelines, Canadian Journal of Diabetes, September 2008, Volume 32

Patient Instructions

Patient Name: _____

Appointment Date: _____

Follow up at: 1 month 3 months 6 months Other: _____

With: Physician Nurse Nurse Practitioner Dietician Other: _____

Instructions this visit: _____

_____

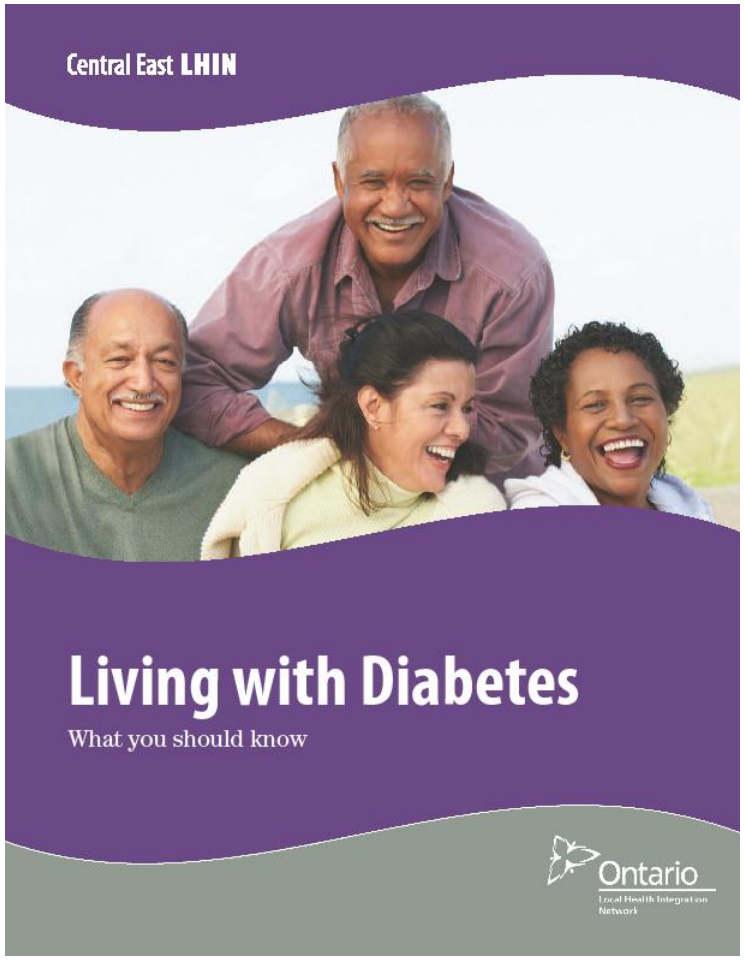
_____

For Next Visit: ☐ Blood sugar record ☐ Lab Tests 1 week before visit (Requisition)

How To Prepare:

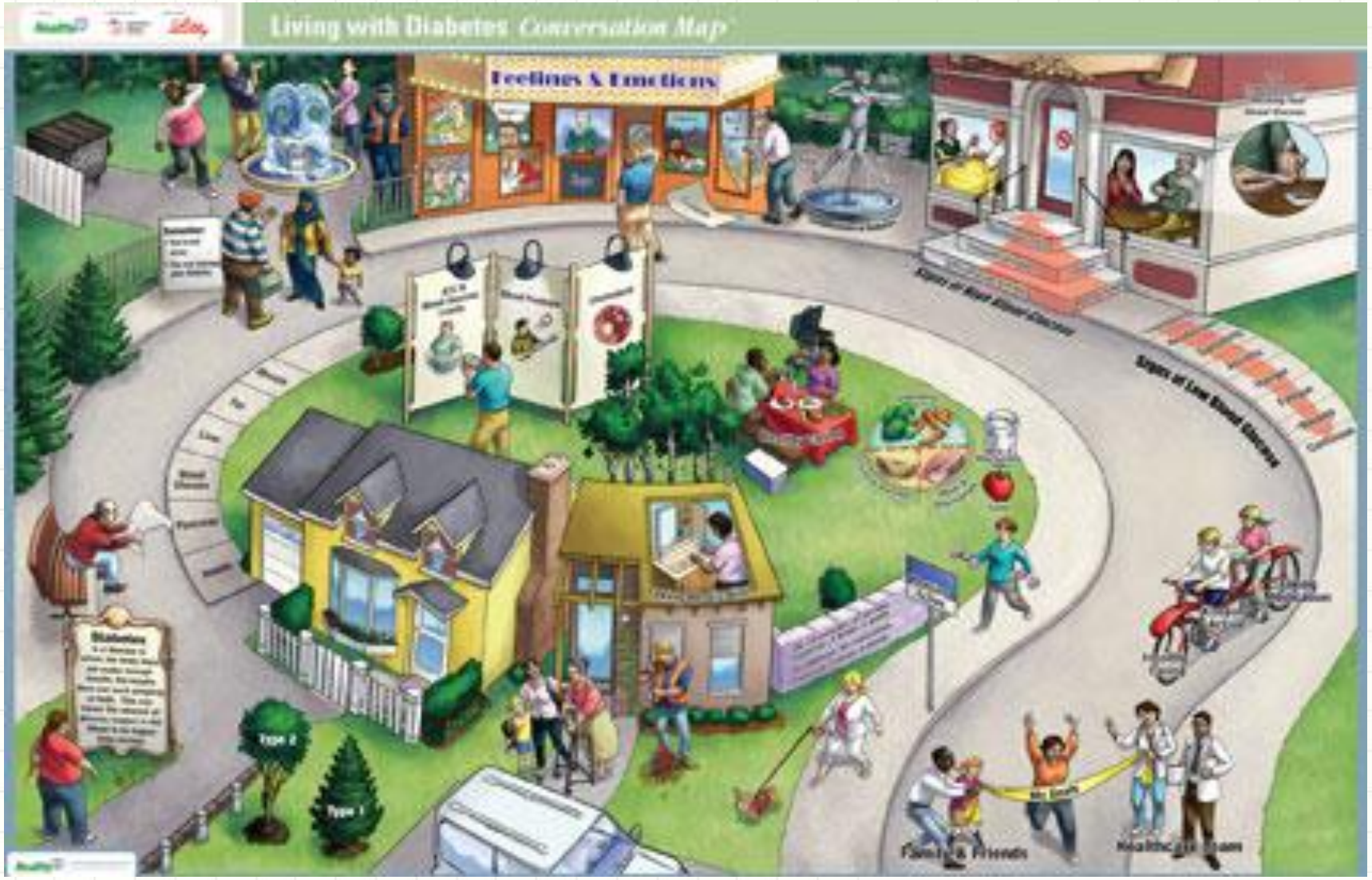
Write down a list of all your diabetes questions. Save all your non-diabetic questions for another visit – this will help your team to give your diabetes the full attention it deserves. Bring a list of all your medications and let your team know which need to be refilled.

Patient Education Tools for Newly Diagnosed Diabetic Patients



Publication available through the CE LHIN/RDCC

Passports can be ordered online from:
serviceontario.ca/publications
(search phrase: diabetes passport)



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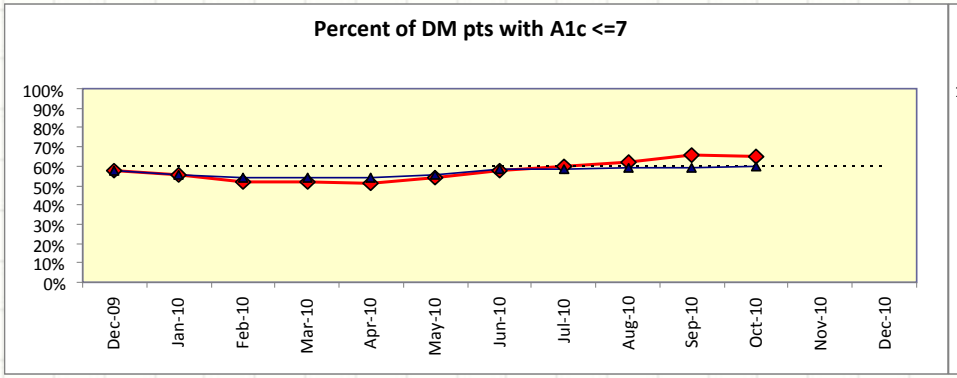
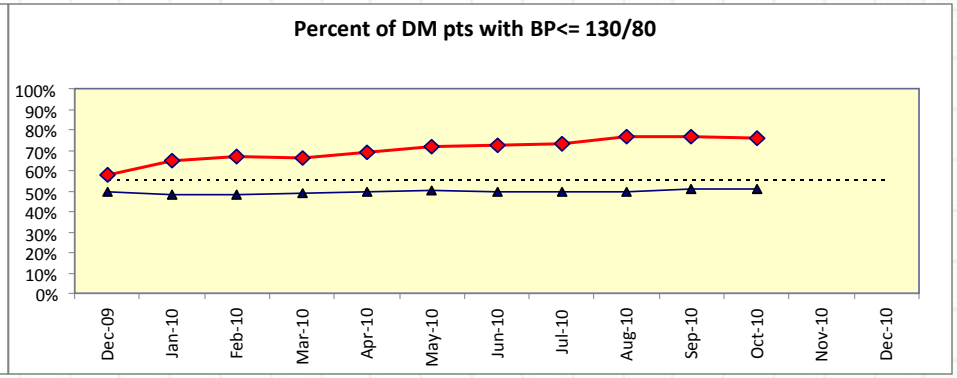
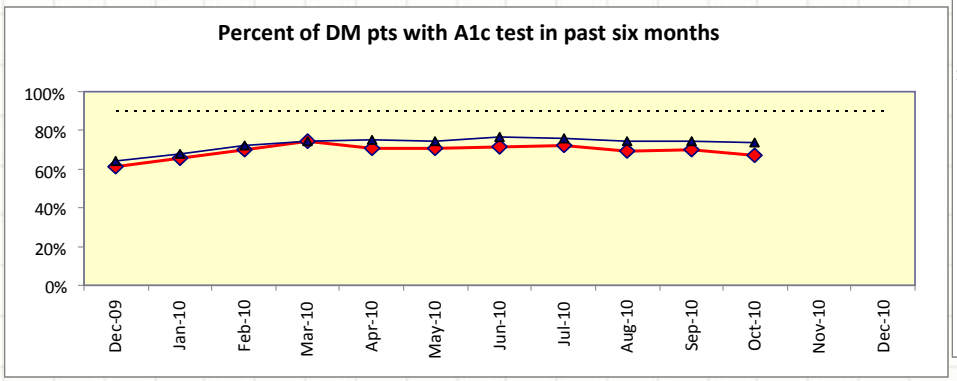
How important is the dashboard in your car?

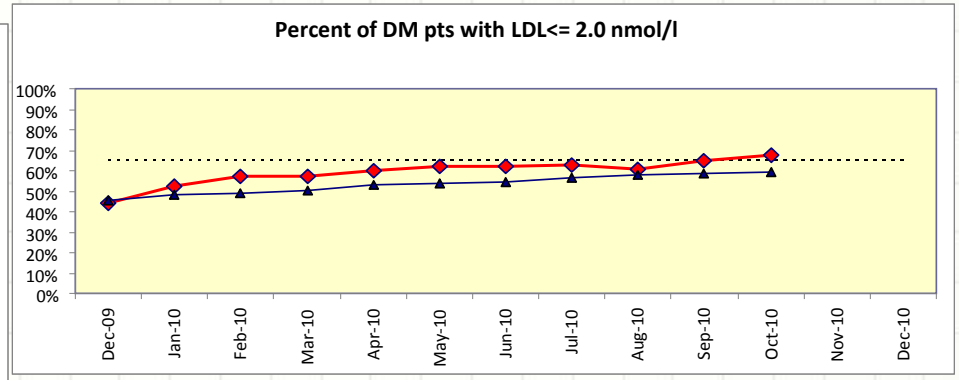
Data and measurement systems support quality improvement and mitigate risks

Example of ongoing measurement



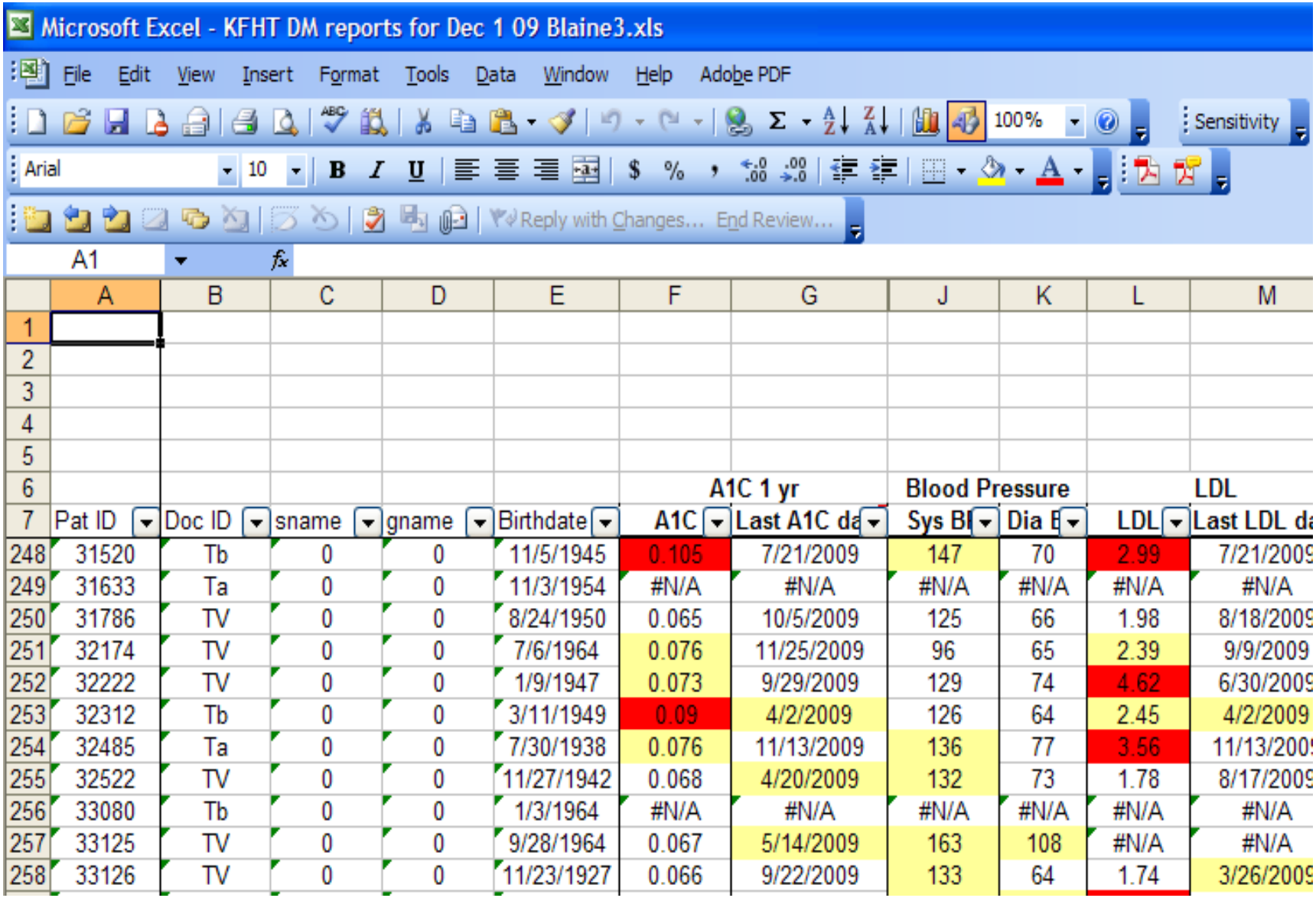






Team Individual

Patient Level Data by Provider



Microsoft Excel - KFHT DM reports for Dec 1 09 Blaine3.xls

File Edit View Insert Format Tools Data Window Help Adobe PDF

Arial 10 100% Sensitivity

Reply with Changes... End Review...

A1

	A	B	C	D	E	F	G	J	K	L	M
1											
2											
3											
4											
5											
6						A1C 1 yr		Blood Pressure			LDL
7	Pat ID	Doc ID	sname	gname	Birthdate	A1C	Last A1C da	Sys Bl	Dia B	LDL	Last LDL da
248	31520	Tb	0	0	11/5/1945	0.105	7/21/2009	147	70	2.99	7/21/2009
249	31633	Ta	0	0	11/3/1954	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A
250	31786	TV	0	0	8/24/1950	0.065	10/5/2009	125	66	1.98	8/18/2009
251	32174	TV	0	0	7/6/1964	0.076	11/25/2009	96	65	2.39	9/9/2009
252	32222	TV	0	0	1/9/1947	0.073	9/29/2009	129	74	4.62	6/30/2009
253	32312	Tb	0	0	3/11/1949	0.09	4/2/2009	126	64	2.45	4/2/2009
254	32485	Ta	0	0	7/30/1938	0.076	11/13/2009	136	77	3.56	11/13/200
255	32522	TV	0	0	11/27/1942	0.068	4/20/2009	132	73	1.78	8/17/2009
256	33080	Tb	0	0	1/3/1964	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A
257	33125	TV	0	0	9/28/1964	0.067	5/14/2009	163	108	#N/A	#N/A
258	33126	TV	0	0	11/23/1927	0.066	9/22/2009	133	64	1.74	3/26/2009

Challenges

- MISSING PATIENTS - Proactive follow up strategy:
  - Individual physician reports run to identify patients at risk
  - Patient recall determined by case review
  - Patient contacted to schedule Diabetes Visit (lab work requisitioned/ office AIC machine installation)
  - Follow up visit scheduled as per Diabetes Visit care path
- Program Time required
- Provider buy-in
- Patient preference for same provider, not team
- Additional time required for patient to attend appointments

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Benefits

- Improved patient outcome
- Appropriate scheduling of diabetes- focused appointments
- Increased incentive billing for completion of flow sheet requirements
- Improved provider satisfaction
- Better picture of diabetic care provided to patients
- Improved accountability with established program goals

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