Streamlining Access to Diabetes Care Through a Centralized Intake Process

SSUe

With the increasing prevalence of diabetes and increasing burden on the health care system, access to diabetes services is essential to support individuals with diabetes and their families to manage their diabetes.

Background

In the Waterloo Wellington region, prior to implementation, feedback from residents and health service providers identified:

- a difficult referral process to diabetes services
- multiple referral forms being used
- physicians and patients not knowing where to go for care or education
- competition for referrals among programs
- long wait times for some education programs, and under-utilization of other programs.

Solution

Diabetes Central Intake (CI) was developed for the WWLHIN region and has provided system improvements for patient navigation, access to care, and monitoring of outcomes.

Objectives

- To provide a single point of contact to access diabetes education and specialist consults
- To ensure individuals with diabetes are receiving the right care at the right time at the right place
- To ensure a seamless coordinated system supporting patient navigation
- To provide consistent and accurate data collection and monitoring of wait-times
- To facilitate prevention strategies by identifying and facilitating referrals for early intervention
- To identify and intervene for "near misses" including wrong diagnosis, wrong medication and incorrect dosages.

WaterlooWellington A B E T E C DI



Stand UP to Diabetes

Measures

Outcome measures include the # of referrals:

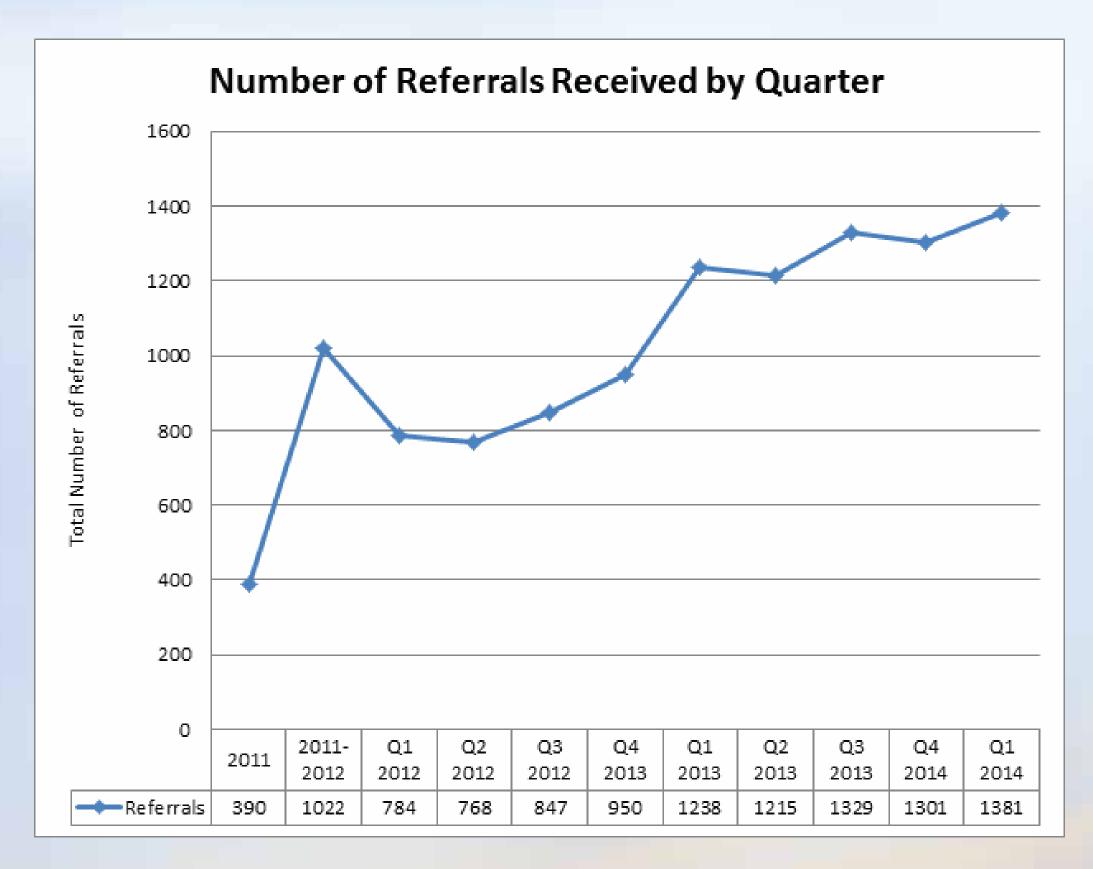
- by type, urgency, and complexity of diabetes
- indicating prevention opportunities (Table 1)
 - with prediabetes
 - meeting renal criteria
 - requesting foot care.

Wait-times and unbooked appointments are monitored. Quarterly reports on wait times are sent to each diabetes program and the LHIN. (Table 2)

Process measures include # of:

- referrals received (Table 3)
- unique referral sources (Table 4)
- EMRs with the CI uploaded referral form
- referrals to specialists
- referrals from hospitals (ER, inpt and outpt)
- "near misses" (wrong dx or wrong medication) (Table 5)

Table 3: Number of Referrals Received by Quarter



Balance measures include:

- evaluation with the referral sources (both health care provider and patients)
- evaluation with the referral recipients (diabetes education programs)
- communication and interviews with the receptionist and the health care providers

Table 1: Referrals Indicating **Prevention Opportunities**

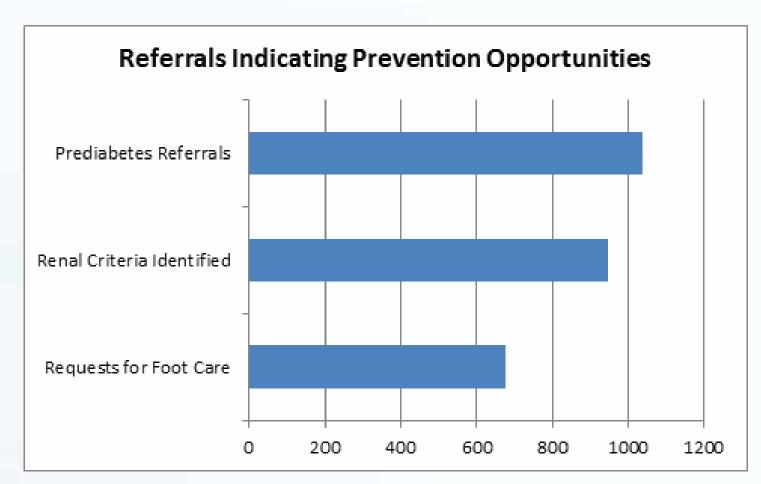


Table 2: Regional Quarterly Wait-time Report

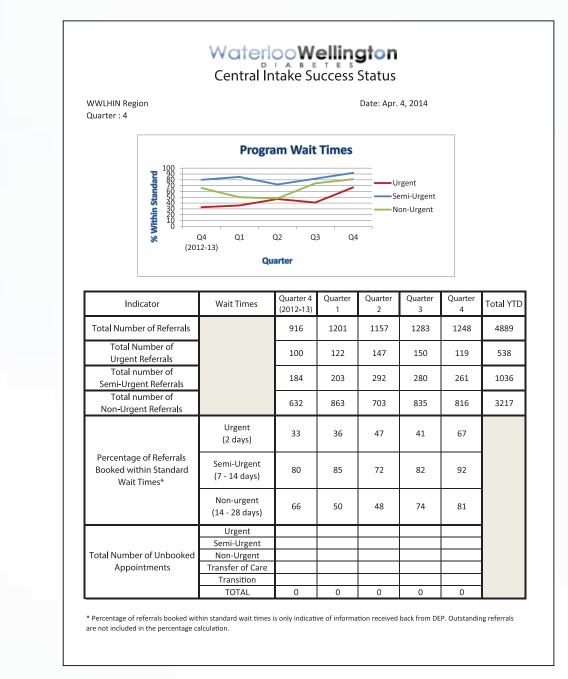


Table 4: Count of Referral Sources by Type

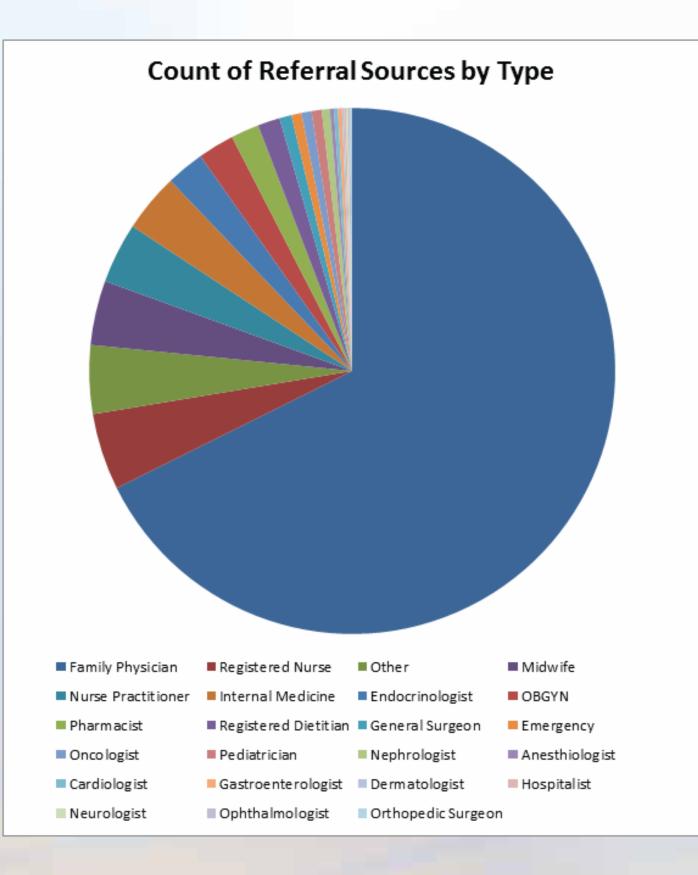
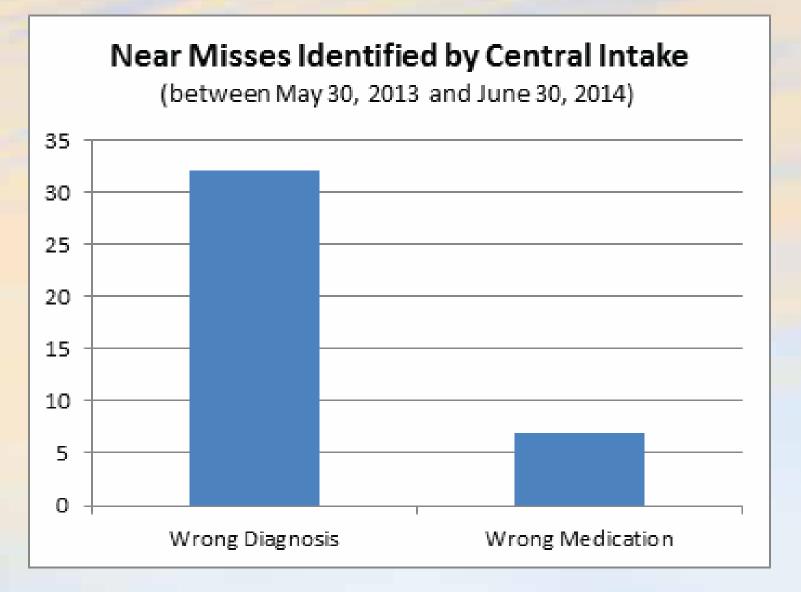
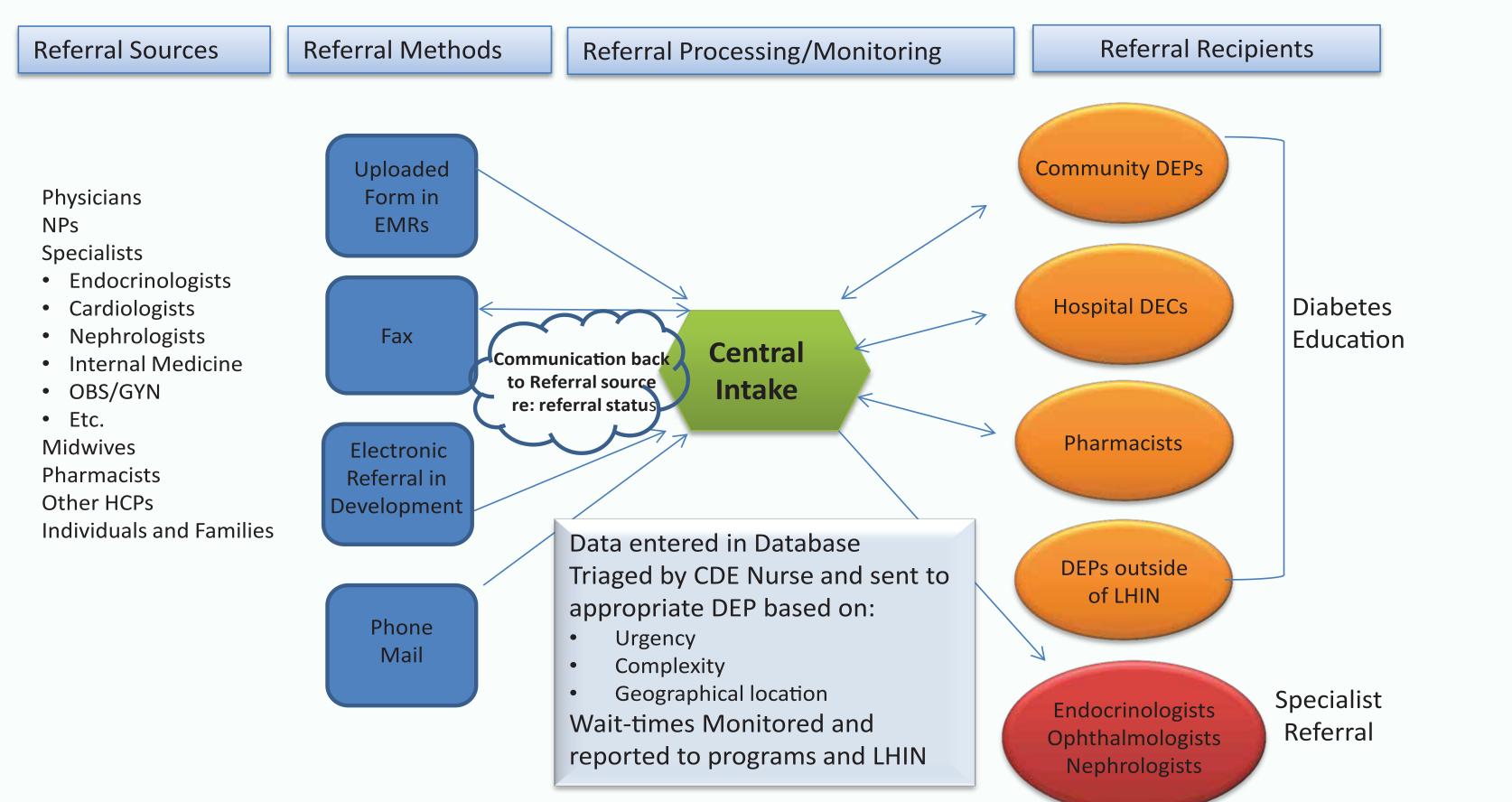


Table 5: Near Misses Identified by Central Intake



Process Planning

Waterloo Wellington Diabetes Central Intake Process



A regional task force was formed to develop one health care provider referral form and one self-referral form for the region.

Waterloo Wellington	REFERRAL FORM Central Intake Fax: 1-855-DIAB		9-650-3114	Waterloo Wellington	SELF-REFERRAL FORN Central Intake Fax: 1-	ለ 855-DIABETS (342-2387) or 519-650-3114
	Central Intake Phone: 519-653	-1470 x372		DIADEIES.Ca	Central Intake Phone	
Patient Name:	□ M □ F DOB (dd/r	mm/yy):				ngs Drive, Unit #11, Cambridge, ON, N3H 5K4
Address: City:	Postal Co			To attend diabetes education programs in Wat	terloo-Wellington you must:	
Telephone: D: E:		Barrier: YES NO		- Have a confirmed diagnosis of Type 1 d	or Type 2 Diabetes or Predial	hetes
Health Card Number: Primary Care Provider Name and Phone Number:	Language	Spoken:)	- Reside in the Waterloo-Wellington reg		
URGENT Type 1	S ASSESSMENT (please check all that app Other If <u>PREGNANT</u> che			Please fill out the following information and fa	ax back	
Symptomatic Type 2 New Diagnosis (<1 yr)	No Previous Type 2		ue Date: ospital:	- If possible, please attach recent blood	d work results and/or a list of	up to date medications you are taking
	FOR REFERRAL (please check all that app			Name:		Male or Female
 Diabetes Education Poor Diabetes Control Self-Management of Insulin Adjustments 	 Foot Care Education Insulin Pump Insulin Start – See Order Belov 	 Hypoglycemi Lipid Manage Pre-Pregnand 	ement	Phone Number (Day):		
Other (please specify)				Email:		
	FOR INSULIN INITIATION AND/OR ONGO			Address:		
Insulin Type:	Adjust insulin dose by a glycemic targets of ac			City:	Postal Code:	
Dose and Time:	target of:			Date of Birth (dd/mm/yyyy):		
Insulin Type:	Adjust insulin dose by 2 glycemic targets of ac				1 1 1 1 1 1 1	
Dose and Time:	target of:			OHIP#:	When is the best	time to contact you?
Allow Certified Diabetes Educator to reduce the secreta						
Allow Certified Diabetes Educator to adjust carb/insulin				If you know, which type of diabetes do you h	have? Type 1 or Type	2 or Prediabetes
 Allow Certified Diabetes Educator to order blood glucos Allow Registered Dietitian to perform blood glucose mo 		or giveenic control		When were you diagnosed? Newly Diagno	osed (less than 1 year) or	Established (greater than one year)
CURRENT	THERAPY AND MEDICAL HISTORY			When were you diagnosed: Newly Diagno	used (less than I year) of	
Check all that apply and include types and dosages I Insulin Antihyperglycemic Agents	History attached	Nephropathy	Dyslipidemia	Are you pregnant? Yes or No	If pregnant, whe	en is your due date?
	Hypertension (>130/80)	Exercise restrictions	 Alcohol Use Sex Dysfunction 			
	🗆 CVD	Neuropathy	Tobacco Use		If pregnant, whe	ere are you delivering?
	PAD	VegetarianPsychosocial	Foot ulcersOther	Do you have any allergies? Yes or No	If ves. to what?	
	TIA/Stroke Retinopathy			, , , , , , , , , , , , , , , , , , , ,		
LAB RE	ESULTS (Please Record or Fax Copy)			Do you take insulin? Yes or No	Do you take oth	er medications for your diabetes? Yes o
Test Result Date		sult	Date	Have you attended Diabetes Education in the	ne nast? Ves or No	
FBS	Creatinine					
2hr OGTT A1C	T Chol/HDL Ratio Triglycerides			Language Spoken? English/French/Other:	·	
ACR	HDL Cholesterol					
eGFR	LDL Cholesterol			Is there anything else you would like us to kr	now about you?	
Endocrinologist/Specialist in Diabetes Consult						
Ophthalmologist Retinal Screening/Consult	If requesting co	nsult, provide your billir	ng number			
Nephrologist/HTN Clinic Consult				Do you give permission to contact your family	ly doctor for more informatio	n if required? Yes or No
	Date:	DEP:	For Internal Use ONLY			
Signature:	Vald.	Specialist:				
Print Name: Phone:	Fax:)	Signature:	Date:	For Internal Use ONLY
Address (stamp):		First Contact:	For DEP Use ONLY			
		First Contact:		Drint Norses		First Contact:
		Appointment Date	es:	Print Name:		Appointment Date:

Standard wait times were developed providing targets to measure outcomes. (Table 6) Mapping of programs was completed along with a communication plan.

Table 6: Standards for Access to Diabetes Education

ability to manage their diabetes

ER discharge follow-up

Urgent (within 48 hours) | Semi-Urgent (7 to 14 days) | Non-Urgent (14 to 28 days) Uncontrolled diabetes **Gestational Diabetes** Pre-diabetes Type 2 Diabetes Newly diagnosed Type 1 diabetes Inpatient discharge follow-up **Established Diagnosis Type 1 Diabetes** Pregnancy with pre-existing diabetes Steroid Induced Diabetes **Recent treatment for DKA** Hypoglycemia Insulin pump therapy Crisis that drastically affects individuals Type 2 insulin initiation

Transition Change: Following the evaluation of the pilot, the CI was rolled-out regionally. After 1 year of success, CI was expanded to include referrals to endocrinologists/specialists, ophthalmologists and nephrologists/HTN clinics which further improved access to care. Cl also directs referrals to other parts of the province and country.

The CI process was evaluated by referral sources and diabetes programs, comparing the new system to the previous system. Feedback noted a marked improvement in the referral process, wait-times, and access to care. The referral form and database were evaluated (structure) to determine effectiveness and completeness and revised accordingly.

As of Sept 2014, CI has:

- 850 unique referral sources

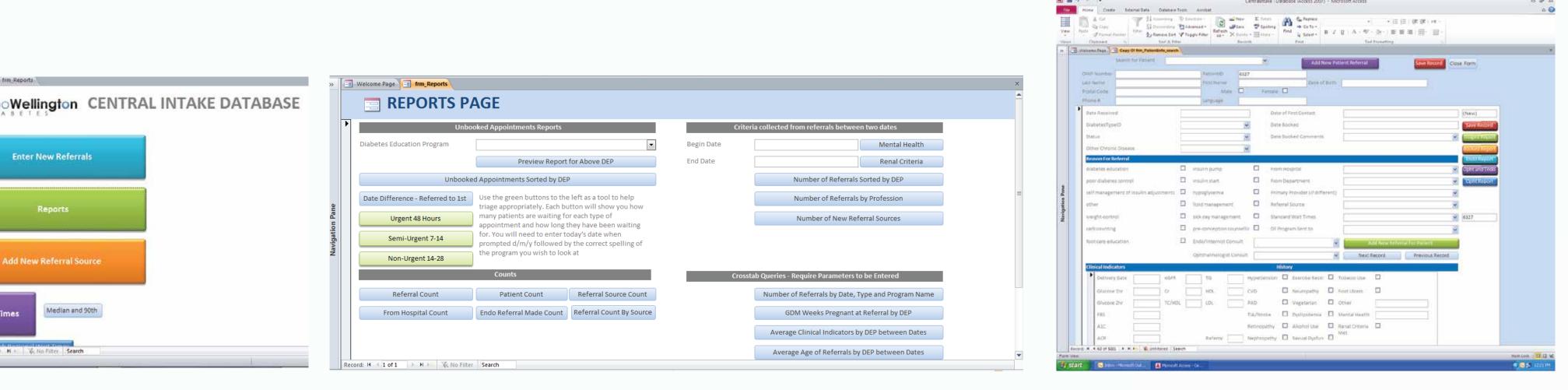
Lessons Learned

- Gaining "buy-in" from all stakeholders
- Listening to users of the system, including reception staff Maintaining regular communication and updates
- Utilizing change management strategies

Development

Performance metrics were developed to track and monitor data over time. A database was developed to monitor the number and type of incoming referrals, reason for referral, clinical indicators and appointment dates.

The form is available for EMRs and is currently uploaded to 183 EMRs. The forms are also available on our regional web-site www.waterloowellingtondiabetes.ca



Implementation

Stakeholder Engagement: There was extensive collaboration among individuals and families with diabetes, diabetes educators, community and hospital programs, family physicians, nurse practitioners, endocrinologists and other specialists.

Champions Identified: The process was piloted with a selection of high-referring physicians.

Outcomes & Results

- Processed 12,524 referrals
- Directed 938 referrals to specialists
- Received 540 referrals from area hospitals
- Sent 153 referrals to other regions
- Received 25 to 35 referrals per day

Wait-times have improved markedly, from a 16 week wait time to meeting the standards for semi-urgent and non-urgent referrals this past quarter.

The importance of:

Having a solid understanding of current system and challenges