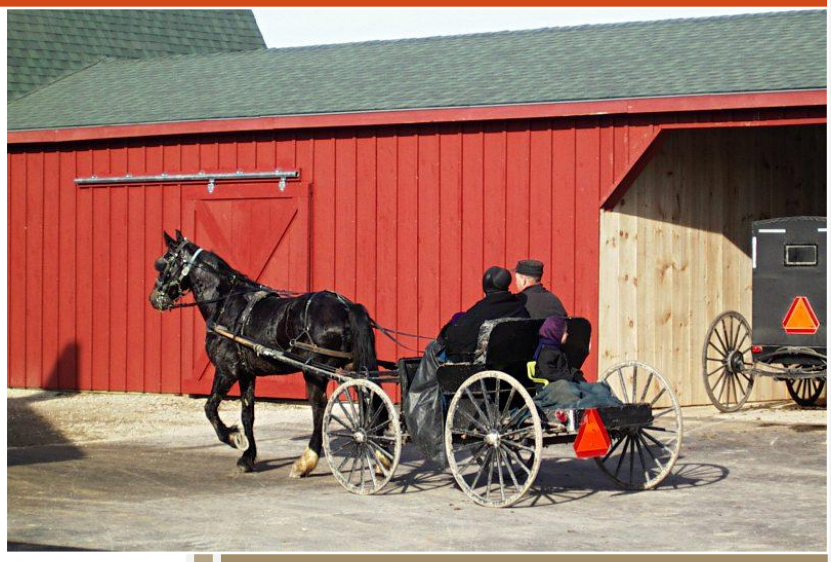
Stand up to Diabetes

2010-2011

Waterloo-Wellington Diabetes RCC Final Report

Executive Summary



WaterlooWellington DIABETES

Langs Farm Village Association
Building a Healthy Community

Debbie Hollahan, Regional Director
Waterloo-Wellington Diabetes Regional Coordination Centre

May 31, 2011

Development of the RCC

The Diabetes Regional Coordination Centre (RCC) was established in the summer of 2010, with Langs Farm Village Association as the host organization. Langs Farm Village Association entered a legal agreement with the Ministry of Health to host the RCC and provides finance, human resources, facility management and IT support, and secured space and co-ordinated leasehold improvements for the RCC. The hiring of the RCC team occurred between July and December 2010, including the director, administrative support, outreach coordinator, health information analyst, endocrinologist consultant and primary care leads. A steering committee was established in September and has continued to meet bi-monthly with the purpose of advising and guiding the work of the RCC.

Demographics

The Waterloo-Wellington LHIN (WWLHIN) covers an area of 4,800 square kilometres, with a population of 732,113 residents or 5.6% of the total Ontario population.[i] The area extends from Proton Station in the north to Ayr in the south; Clifford to the west, and Rockwood to the east. It is comprised of 4 large urban centres—Cambridge, Guelph, Kitchener and Waterloo, with almost 90% of the total geographic space being rural.

Immigrants represent 20.6% of the WWLHIN, which is slightly lower than the provincial average. The South Asian community is the largest visible minority group, followed by the Chinese and Black communities. 75% of the visible minority population is located in the Waterloo area.[ii] Other than English and French, the most common spoken languages are German, Chinese, Spanish, Polish and Portuguese. A unique aspect to this region is that it is home to a large Mennonite community, which makes up 3.4% of the population[iii].

The population is growing, and currently rates sixth in the province for growth rate. The greatest growth is in the aging population, which is faster than the provincial average.

Of concern is the proportion of the population that is physically inactive. In 2009, 4 out of 10 adults were physically inactive, which is higher than the provincial average. As well, 4 out of 10 adults were either overweight or obese, which was also higher than the provincial average, although not statistically significant[iv].

In general, residents of the WWLHIN are slightly better off compared to the province with respect to education, unemployment and income levels. Guelph and Kitchener-Waterloo have the highest proportion or residents living below the low income brackets.[v]

95% of residents have a family doctor in this LHIN.[vi] Most of the 595 family medicine physicians belong to one of the 10 FHTs or the 4 community health centres in this community.

Major Accomplishments in 2010/11

Assessment of Landscape

To assess the diabetes landscape in the region of Waterloo-Wellington, as well as to determine gaps and redundancies in the region, inventories of service, numerous stakeholder meetings, and a networking day for diabetes educators were conducted.

Inventories of service

Inventories of service were organized and delivered, with an initial focus on diabetes education programs. There was a 100% response rate from this inventory, providing key findings for identifying priorities for system design. Surveys are still in progress for primary care practitioners, ophthalmologists/optometrists; pharmacists; chiropodists/foot care nurses and dentists to further assess diabetes care in the region.

Key findings from the diabetes education programs included:

Need for:

- common data collection
- improved navigation of system
- role definition of programs
- improved distribution of patient load
- monitoring of wait-times
- increased awareness/marketing of diabetes education program
- need for community programs to expand programs to include insulin starts for Type 2 diabetes
- need for extended hours; after hours support/on-call support

Networking Day for Diabetes Educators

A successful regional networking meeting with diabetes educators was held in November, with the purpose of including them in the system design of diabetes care in the region. The goals of the meeting were as follows:

- To provide an overview of the Ontario Diabetes Strategy and the role/direction of the RCC
- To view a sampling of current initiatives and work being done in the region
- Identify key issues and gaps in our region using Open Space Technology
- To strategize how the RCC can work with you to enhance and complement the work currently being done by your program

There were 70 attendees at the event with active participation, and excellent feedback. From this meeting, a number of task forces were identified with participation from educators throughout the region.

Task Forces

Task forces were identified, and included participation from educators throughout the region. These task forces included central intake; medical directives, insulin pumps and insulin order sets. These task forces are actively in progress.

Central Intake Process/Common Referral Form

The central intake task force has produced a common referral form, as well as triage criteria and process for the central intake. The process and common referral form received approval from the steering committee and support from the various stakeholders and is currently being piloted by 3 physicians in the Cambridge/Kitchener/Waterloo region. Included in this pilot, is the central intake process, which includes an established fax line (1-866-DIABETS) as well as a triaging process and dashboard for monitoring wait times.

Communication

To date, 2 RCC newsletters have been distributed to keep health care professionals informed. Numerous presentations have been given to primary care physicians, LHIN representatives, and leadership and executive positions with community health centres, hospitals and family health teams. A logo has been developed for Waterloo-Wellington, which includes the international symbol for diabetes. A web-site is being developed with support from the self-management program, as well as the diabetes education programs in the region.

Stakeholder Engagement

A total of 122 stakeholder engagements occurred in the 10 months of operation, to assess the diabetes landscape in the region of Waterloo-Wellington, as well as to determine gaps and redundancies in the region. These meetings include primary care practitioners, diabetes programs, CCAC, Mental Health, specialists, and the LHIN to name a few. The RCC team have presented at a number of Continuing Medical Education (CME) events, Diabetes Educator meetings, and organization meetings to increase the awareness of the RCC, and to encourage improved diabetes care. Further communication is underway, including grand round presentations at the various hospitals. Mail-outs went out to all primary care practitioners, encouraging participation in the BDDI.

Regular meetings occur with the LHIN to ensure the RCC activities align with the LHIN and ODS priorities. These meetings include reviewing the LHIN CDPM; planning for future eHealth strategies; sharing the RCC workplan and activities and discussing challenges and barriers to diabetes care. Meetings have also offered additional opportunities to meet and to link with other system planners in the region. For

example, work with the renal network has resulted in plans for enhancing diabetes care to the renal population; connecting with community support services has offered ideas for our central intake.

Partnerships

Much attention has been focused on developing relationships and partnerships between organizations. Plans for a "partnership award" are underway, which includes developing criteria for selection; the award plaque, as well as the award process. The plan is to award this recognition yearly during diabetes month to acknowledge effective partnerships.

Guelph: Work has been done in the Guelph area, resulting in Diabetes Care Guelph (DCG) offering a team to the Community Health Centre, starting in May. DCG are also working to further enhance education to the pre-diabetes population, which is currently only available to rostered patients of the FHT. Additional work is underway to further develop their gestational program, to be a "one-stop shop" for women with gestational diabetes. This would involve moving the gestational program in to the community, where women will see the endocrinologist, obstetrician, diabetes nurse and dietitian all in one visit. An event is currently being organized by the RCC for physicians to enhance their knowledge of the research on gestational diabetes.

North Wellington: Meetings have occurred to build on the process between the family health team multi-disciplinary teams and the diabetes education centre. The diabetes network have received funding from the Public Health Agency of Canada (PHAC) to develop a gestational/post-partum program and care pathways, with which the RCC will be assisting. The Mount Forest FHT has also been identified as the recipients of provincial funding to develop a diabetes prevention program.

Kitchener/Waterloo/Cambridge: The work in this area has focused on enhancing the skill-set of the diabetes educators in the community programs. A mentoring program has been facilitated between Cambridge Memorial Hospital (CMH) and the community diabetes program to improve the knowledge of educators with respect to insulin initiation and management. Work has started on developing a guide/framework for the community programs to provide outreach services. A workshop is being organized to further support them in this work. Outreach services have also been facilitated between the diabetes programs, primary care and specialists in the area to facilitate knowledge transfer and access to diabetes services.

Summary

Key lessons learned to date from the above activities, is that diabetes care is being provided throughout the region in "silos" with little to no coordination. Some challenges identified include:

- Numerous referral forms to diabetes education programs
- long wait times with some programs and no wait times with others
- physicians not referring

- inconsistent data collection
- "rules for referral" such as catchment area boundaries and physician privileges barriers
- Community programs not doing insulin initiation/management
- Minimal focus on prevention strategies/programs
- Endocrinologists/specialists lacking support for complex diabetes care

The workplan for the WW RCC has been developed in the form of a logic model, using the framework of the Chronic Disease Prevention and Management Framework, with a focus on system design for the first year. These priorities/strategies include:

- Improved navigation of the system
  - central intake with common referral form with dashboard for wait-times
  - support from LHIN re: eliminating "boundaries"
- Common data collection
  - development of common data collection form/system
- Role definition of programs
  - development of standards of care for primary care clinics/community diabetes programs/hospital based management programs based on "Kaizer-Permanente risk categorization pyramid"
  - improved distribution of patient volume
  - seeking opportunities to support specialist/complex diabetes care
- Increased awareness/marketing of diabetes education programs
  - web-site;
  - brochure development;
  - improved communication to primary care practitioners
  - partnering with CDA on initiatives such as diabetes expo; directory of services
- Community programs to expand services to include insulin starts for Type 2 diabetes, especially basal insulin
  - mentorship programs
  - development of core competencies for educators; insulin certification exam
- Outreach services
  - Development of a framework for outreach
  - Offering a workshop for programs to assist with their outreach planning and services.
- Self-management
  - coordinate self-management programs to individuals with diabetes, as well as to support health care providers in the required skill-set
- Primary care engagement
  - continue to build on relationships; support with outreach teams; enhance knowledge of BDDI; billing codes
- Prevention programs
  - Pre-diabetes programs;
  - Gestational diabetes/post-partum follow-up and education
- Patient Focus groups

Longer term plans are identified in the RCC workplan, focusing on vulnerable populations and community partnerships. The continuity of care from acute episodic events in hospital to primary care is also a focus, with the plan to analyze discharge data; develop care pathways; and enhance the knowledge of inpatient health-care providers. The knowledge level of care providers in long-term care homes, and CCAC will also be explored and supported.

---

[i] Ontario Ministry of Health and Long Term Care, Provincial Health Planning Database (IntelliHEALTH Ontario). Statistics Canada. 2006 Census: Canada's population estimates.

[ii] Statistics Canada. 2006 Census: Canada's population estimates.

[iii] Waterloo Wellington LHIN, Working Together for a Healthier Future. Integrated Health Services Plan, 2010-2013. Statistics Canada. 2006 Census: Canada's population estimates, 2006.

[iv] Statistics Canada. Canadian Community Health Survey (CCHS) Ontario Shared file, 2008 & 2009.

[v] Statistics Canada. 2006 Census: Canada's population estimates.

[vi] Waterloo Wellington LHIN, Working Together for a Healthier Future. Integrated Health Services Plan, 2010-2013.