Streamlining Access to Diabetes Care Through a Centralized Intake Process

Issue

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.

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)

Table 1: Referrals Indicating Prevention Opportunities

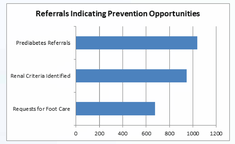
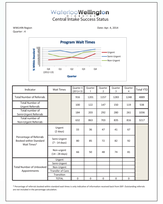


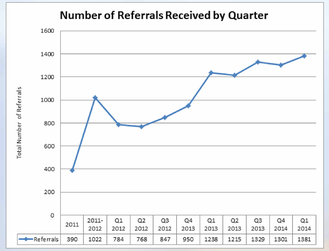
Table 2: Regional Quarterly Wait-time Report



Process measures include # of:

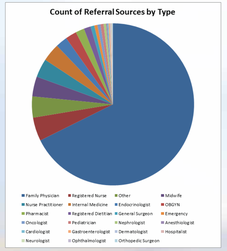
- referrals received (Table 3)
- unique referral sources (Table 4)
- EMRs with the CI uploaded referral form
- referrals to specialists
- referrals from hospitals (ER, inpt and outpt)
- "near misses" (wrong dx or wrong medication) (Table 5)

Table 3: Number of Referrals Received by Quarter



	2011	2011-2012	Q1 2012	Q2 2012	Q3 2012	Q4 2013	Q1 2013	Q2 2013	Q3 2013	Q4 2014	Q1 2014
Referrals	390	1022	784	768	847	950	1238	1215	1328	1301	1381

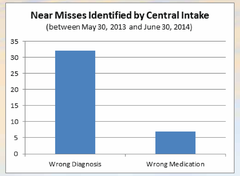
Table 4: Count of Referral Sources by Type



Balance measures include:

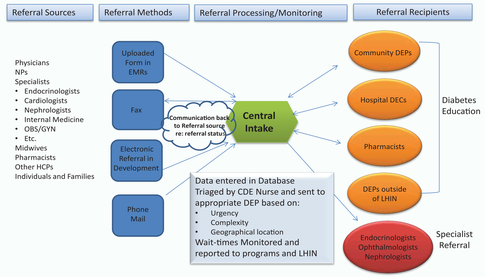
- evaluation with the referral sources (both health care provider and patients)
- evaluation with the referral recipients (diabetes education programs)
- communication and interviews with the receptionist and the health care providers

Table 5: Near Misses Identified by Central Intake

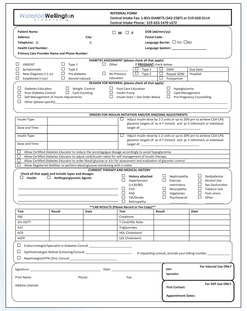


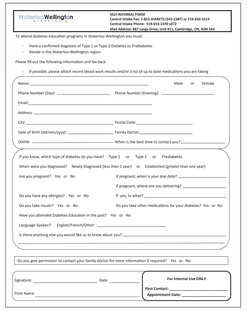
Process Planning

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.





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

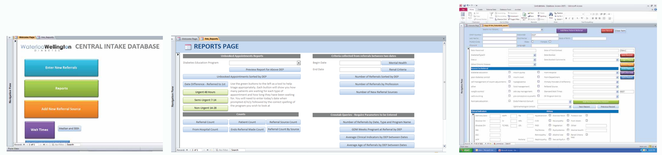
Table 6: Standards for Access to Diabetes Education

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

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.

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. CI also directs referrals to other parts of the province and country.

Outcomes & Results

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:

- Processed 12,524 referrals
- 850 unique referral sources
- 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.

Lessons Learned

The importance of:

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

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