Streamlining Access to Diabetes Care Through a Centralized Intake Process

**Outcomes**

- Developing a Diabetes Central Intake (CI) for the Waterloo Wellington Health Region.
- Streamlining access to diabetes care through a centralized intake process.
- Improving wait times and giving timely access to care for patients with diabetes.
- Implementing a referral system that allows for consistent and accurate data collection and monitoring of wait times.

**Objectives**

- To facilitate prevention strategies by identifying and facilitating referrals for early diagnosis and management of diabetes.
- To provide consistent and accurate data collection and monitoring of wait times.
- To address long wait times for some education programs and under-utilization of other programs.
- To improve the referral process for diabetes services.

**Solution**

- Diabetes Central Intake (CI) was developed for the Waterloo Wellington region and has been expanded to include referrals to endocrinologists/specialists, ophthalmologists, nephrologists/HTN clinics.
- 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.
- Process measures included referral rates, EMRs with the CI uploaded referral form, referrals from hospitals (ER, inpatient, and outpatient), and unique referral sources.

**Process Planning**

- A regional task force was formed to develop one health care provider referral form and one self-referral form for the region.
- Table 1: Referrals indicating prevention opportunities.
- Table 2: Regional Quarterly Wait-time report.

**Waterloo Wellington Diabetes Central Intake Process**

- Process 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).

**Implementation**

- 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.
- As of Sept 2014, CI has:
  - Processed 12,324 referrals
  - 850 unique referral sources
  - Directed 919 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.

**Outcomes & Results**

- 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 forms are available for EMRs and are currently uploaded to 183 EMRs. The forms are also available on our local web-site www.waterloowellingtonondiabetes.ca

**Lessons Learned**

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

**Waterloo Wellington Diabetes Central Intake Process**

- Table 7: Referrals indicating prevention opportunities.
- Table 3: Number of referrals received by quarter.
- Table 4: Count of referral sources by type.
- Table 5: Near misses identified by central intake.
- Table 6: Standards for access to diabetes education.

**Issues**

- 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.
  - Long wait times for some education programs.
  - Under-utilization of other programs.
  - Competition for referrals among programs.

- 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.

**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).

**Development**

- 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 project 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.