Stand up to Diabetes

2011-2012

Waterloo-Wellington Diabetes RCC Annual Report

Executive Summary

WaterlooWellington DIABETES

Langs Community. Health. Wellness.

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Background

The Waterloo Wellington Diabetes Regional Coordination Centre (DRCC) was established in 2010 to provide regional leadership to integrate and coordinate diabetes care in the region of Waterloo-Wellington, including primary care, diabetes programs, endocrinologists, and the community. The DRCC works closely with the Local Health Integrated Network (LHIN) to provide a clear point of contact within each region for diabetes. The DRCC does not provide direct patient services, but drives the implementation of provincial priorities while monitoring regional performance. The goal for the DRCC is to improve the delivery of care for people and families living with diabetes.

In 2010, a workplan was established in the form of a logic model, using the framework of the Chronic Disease Prevention and Management (CDPM) Framework and incorporating the principles from Health Quality Ontario—"*Safe, integrated, Patient-Centred, Accessible, Equitable, Effective and Efficient*". For 2011-12, priorities were identified through an environmental scan using inventories of service with Diabetes programs, Physicians, Optometrists/Ophthalmologist, Chiropodists/Foot care nurses, Pharmacists and Dentists. Focus group interviews and patient surveys were conducted as well as numerous stakeholder meetings and data collection. Priorities focused on the following three areas:

- Quality Improvement
- Primary Care Engagement
- System Integration

Key Findings from Environmental Scan

Geographic, socioeconomic and cultural barriers from data collection:

- The highest prevalence rates (10.1%) are found in the Rural-South Grey and North Wellington subLHIN
- The WW LHIN covers approximately 4,800 square kilometers of land
- 90% of the WW LHIN's total geographic space is rural
- Immigrants represent 20.6% of the WW LHIN, 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 visible minority population is located in the Waterloo area
- Mennonite & Francophone make up 3.4% and 1.3 % respectively
- 1% of the WW LHIN population who identifies with at least one Aboriginal group (North American Indian, Métis or Inuit)
- Population in 65+ age group is projected the growth faster than the provincial growth
- Over 9% of Waterloo-Wellington residents were in the low-income bracket before taxes, compared to almost 15% for Ontario
- The WW LHIN population is engaging in less healthy behaviour

- Higher proportion of obese and overweight people 53.3% compared to the provincial average of 49.2%
- Lower percentage of the population consuming fruits and vegetables
- Lower proportion of residents participating in physical activity
- The percentage of heavy drinkers in WW LHIN (23.5%) is slightly higher than the provincial (21.7%)

Inventories of service and stakeholder meetings

Need for:

- Common data collection
- Improved navigation of the system
- Role definition of programs
- Improved distribution of patient load
- Monitoring of wait times
- Increased awareness/marketing of diabetes education programs
- Community programs to expand services to include insulin starts for Type 2 diabetes, especially basal insulin
- Extended hours; after hours support/on-call support
- Focus on prevention in particular: Gestational Diabetes, Pre-diabetes, Outreach services
- Focus on continuity of care

Focus Groups

- Each group had a slightly different focus on what they believed to be the main goal/purpose of diabetes education which reflected the characteristics of the group mostly by the stage of disease
- The physician's role was recognised as essential to the effective management of diabetes by almost all participants in both groups
- Access to information emerged as an important factor
- Participants would like to have other support mechanisms to learn and share diabetes experiences, such as support groups
- Participants often relied on friends and family for information when they could not get the desired information from their health care provider or did not understand the information given
- Access to reliable information when unable to contact healthcare team or family physician was important
- Participants suggested visual aids to improve information access
- Healthy eating was seen as the biggest obstacle to self-management and participants wanted more information such as sharing of recipes, cooking techniques, label reading etc.

- Participants did not have a full understanding of the importance of tests and results (i.e. foot care, A1C, LDL, and eye-exams)

Patient Surveys

- 66.4% of respondents believe that they can support themselves in dealing with diabetes
- 73% of respondents agreed that they can motivate themselves to care for diabetes, yet results show that most of individuals are poorly following the recommendations eg. 47% of respondents never or sometimes follow exercise recommendations
- 39% of respondents believed the emotional impact of diabetes affected their life
- Majority of respondents identified family physicians and diabetes educators as main source for information or advice
- 89.3% of respondent attended diabetes education programs but 61.5% have not attended in past year
- The most common reason provided by respondents for not attending a diabetes education program was: doctor did not refer to diabetes program (36.4%) which conflicts with the physician survey response where 73% of respondents "indicated patients unwilling to attend" as highest reason for not referring
- Also indicate as common reasons for not attending: been never aware of any diabetes programs (27.3%), and times were not suitable for respondent to attend (22.7%)
- Majority (91.1%) of respondents rated their experience with diabetes education program as satisfied to very satisfied
- Only 61.5% reported having a foot inspection done in the past year
- 77% of respondents indicate they have high blood pressure and 72.2% indicate high cholesterol
- Only 56% of respondents were aware that GDM is a risk factor for Type 2 diabetes

Major Accomplishments in 2011-12

In addition to receiving feedback from an extensive environmental scan, the DRCC steering committee continued to meet bi-monthly to help guide and support the work of the DRCC. Membership on the steering committee includes representation from the whole region, including diabetes educators, managers, specialists, pharmacist, CCAC, health promotion, LHIN, and the CDA. Based on their feedback and results from the environmental scan, a work-plan was established based on the CDPM framework with the following accomplishments:

Self-Management

In the spring of 2011, funding was received from the MOHLTC through the Ontario Diabetes Strategy to support the coordination of Self-management training and programs for both individuals with diabetes as well as health care providers.

A coordinator and administrative assistant were hired to coordinate regional programming and liaise with provincial counterparts.

Coordination of Programs for Individuals with Diabetes

The "Take Charge" program was developed which included coordination of the Stanford *"Living Well with Chronic Disease"* program. This program was previously being offered by a number of organizations in the region with each organization having individual licenses. Work is underway to coordinate all of the programs through a central registration.

Other programs such as *Craving Change* is also being coordinated regionally.

Coordination of Programs Health Care Providers

The “Moving Towards Change” program was developed with 3 workshops provided and 125 Health Care Providers trained. This program is a tailored program for diabetes educators and health care professionals to gain the skill-set required to empower behavioural change and to support patients to self-manage their diabetes

- Program includes:
  - 1 ½ day training by an expert psychologist , Dr. Michael Vallis, specialized in behavioural change and diabetes
  - 5 follow-up mentorship sessions in the clinic setting by a consultant psychologist, Dr. Shannon Currie, to help build and support confidence and knowledge

Delivery System Design

Central Intake

A high priority was to develop a central intake process for improved system navigation for individuals and families with diabetes and health care providers. Objectives included:

- To develop a central intake (CI) with one common physician referral form and a self-referral form
- To develop a model of care with clear definition of the roles of each diabetes program
- To identify triage criteria to improve access to the appropriate care
- To develop standard wait-times for education
- To provide timely access to information regarding the status of referrals (pending, booked, complete, reported) for primary care providers and patients
- To monitor wait-times of programs
- To help build and maintain capacity of diabetes education programs
- To standardize data collection in order to improve quality, monitor outcomes and implement appropriate changes

The central intake process developed in the Waterloo-Wellington region, has been a very successful project to date, with achievement in all the identified objectives. The common referral form has been received well by the region, with desire to expand it further. The central intake will be well positioned for when the Ontario Diabetes Registry becomes available, as it will be one central access point for education referrals. The self-referral form is just starting to have an impact, and is anticipated to improve access as it becomes more widely known. The central intake is providing valuable data, and will be of more use when it becomes the only entry point for referrals.

Diabetes in Pregnancy

Research on diabetes in pregnancy for the region demonstrated that there is no consistency in the management and care among programs and was identified as a concern from many of the diabetes specialists in the region. Data shows poor outcomes for women with diabetes in pregnancy in the region, such as large for gestational age birth-weights, and higher rates of C-sections.

An advisory panel of endocrinologists, obstetricians, midwives, family physicians, nurse practitioners diabetes educators and managers was developed to provide guidance to the DRCC on the development of a strategic plan and pathway for diabetes in pregnancy.

Two meetings have been held to date with the advisory board, as well as numerous working meetings with individual health care providers. The development of a pathway is in progress, along with supporting documents, such as pre-printed orders for labour and delivery and a patient passport.

Further meetings and development of the pathway are planned for the following year, with a dissemination plan for distribution and education.

Pre-diabetes Education

Concerns were identified with the quality and availability of pre-diabetes education in Kitchener/Waterloo/Cambridge area. Work with the community diabetes education programs resulted in repositioning pre-diabetes education with the programs, in partnership with the local YMCA. There are now programs offered in Kitchener and Cambridge alternating monthly.

Provider Decision Support

Mentoring Support

With many newer educators in community programs, they did not have the opportunity to learn from other more experienced educators. A mentoring program was developed through an educational grant from NovoNordisk to build the knowledge, skill and judgment of newer diabetes educators to manage more complex diabetes patients while gaining the ability to initiate and adjust insulin therapy. An experienced certified diabetes educator (CDE) was hired to support educators in their own clinic setting. In a very short time, this program has made a positive impact on the quality of diabetes care being provided to patients. It creates a sustainable system, by building on the knowledge of educators already in the system.

Educational Events

3 educational events were held to support educators, with representation throughout the region.

The first event, *"Delving deeper into the complications of diabetes and discovering new tools for screening and education",* focused on how to manage complications and where to refer once identified.

The second event, was an "*Outreach Planning Day*", with representation from a variety of organizations in the region, with a focus on health literacy, and planning outreach services. A framework for developing outreach services was developed and shared with the group attending as a tool to support them in designing programs.

The third event, was focused on pharmacists, *"Diabetes Management in your Pharmacy"* , which offered a presentation in the form of a game-show to educate them about the role of the RCC, as well as diabetes management.

The DRCC partnered with the CDA to provide educational sessions to the public through Ontario Telehealth Network (OTN). 2 sessions were delivered province wide on Health Literacy and Nutrition, with a 3rd session on foot care planned for the spring.

Clinical Support

Insulin order sets were created to support diabetes educators in initiating and adjusting insulin within their scope of practice. A policy is currently being developed to support patients keeping their insulin pump on during hospital admission.

Quarterly Newsletters

Newsletters are developed and distributed every 3 months to health care providers in the region, keeping them informed of activities in the region, and clinical practice issues.

LTC Care

Several meetings have been held with LTC pharmacists to discuss opportunities for improved diabetes management in LTC homes, which may include standardized order sets, flow-charts etc. More detailed work to follow.

Additional Support

Promotional banners were developed for Diabetes Education programs in the region to help support them in promoting their services when they are out in the community.

Information Systems

Web-site

The Waterloo-Wellington Diabetes website www.waterloowellingtondiabetes.ca was developed and launched on November 14th to commemorate World Diabetes Day. This site provides a resource to both individuals and families with diabetes as well as health care providers working with diabetes.

Community Action

Diabetes Expo

A successful Diabetes Expo was provided in partnership with the CDA. This event was held in November, and had >250 people attend. Attendees were treated to an inspiring presentation from Dr. Ian Blumer, as well an interactive session with an expert panel, including endocrinologist, dietitian, optometrist, and chiropodist. A trade show was provided offering additional information to attendees.

Renal Program

Regular communication and participation on the regional renal steering committee have offered opportunities to explore further integration of services between diabetes and renal services. The DRCC participated at the Renal Education Day offered to primary care physicians in November.

Summary

Extensive work was done, in the form of inventories of service, stakeholder meetings, focus groups, patient surveys and steering committee meetings to assess the needs and priorities of the region. Participation and enthusiasm from all stakeholders with the desire for system improvement was instrumental in supporting the DRCC to achieve significant accomplishments.

The successful implementation of central intake has provided a streamline approach for diabetes education referrals. The launch of the website provides a very effective method of communication as well as a resource for both individuals with diabetes and health care providers. The educational events for health care providers have received excellent feedback and reviews. The mentoring program has offered support to educators and organizations resulting in improved diabetes care. Work is in progress to improve diabetes in pregnancy as well as LTC homes. Future work will involve looking at inpatient processes as well.