Waterloo Wellington Diabetes Regional Coordination Centre (RCC)

November 2011

Waterloo Wellington DIABETES

Stand up to Diabetes

Langs Community. Health. Wellness.

Host Organization

Ontario

Ontario MOHLTC Chronic Disease Prevention and Management Strategy (CDPM)

- Transformation from illness focus to wellness focus
  - Self-management skills
  - Interdisciplinary care
  - Patient centered
- Focus on chronic diseases that are:
  - Preventable/preventable complications
  - Significant burden in mortality, morbidity and cost
- Diabetes identified as the lead disease in the strategy

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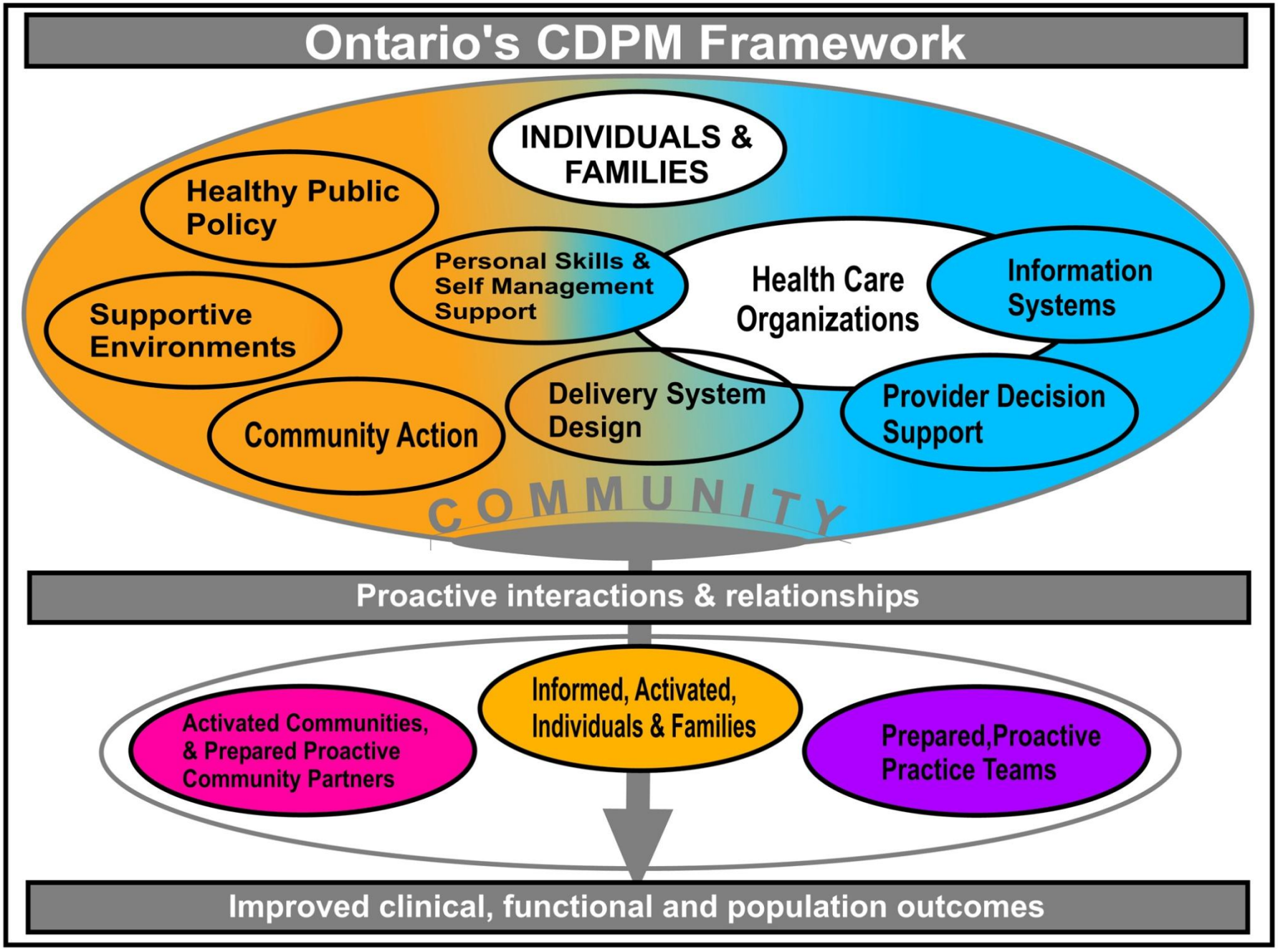
Why Diabetes?

- 69% increase in diabetes in Ontario between 1995 and 2005
- Already exceeded the WHO projections for diabetes prevalence for 2030
- Co-morbidities are significant health care cost
- Increasing prevalence of diabetes is straining sustainability of health care system
- Inter-disciplinary care for diabetes well established
- Diabetes can be self-managed
- 49% of people with diabetes in Canada not at target A1C*

*Diabetes in Canada Evaluation (DICE), Dr. Stewart Harris, UWO, London, ON, 2005


Ontario's CDPM Framework
INDIVIDUALS & FAMILIES
Healthy Public Policy
Personal Skills & Self Management Support
Health Care Organizations
Information Systems
Supportive Environments
Delivery System Design
Provider Decision Support
Community Action
COMMUNITY
Proactive interactions & relationships
Activated Communities, & Prepared Proactive Community Partners
Informed, Activated, Individuals & Families
Prepared,Proactive Practice Teams
Improved clinical, functional and population outcomes

Ontario Diabetes Strategy (ODS)

Objective:

Improve health outcomes for the growing number of Ontarians living with diabetes and reduce health care costs

Goals:

- Prevent and promote
- Identify and Attach
- Manage and Improve

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Key Elements of Diabetes Strategy

Diabetes Registry	Patient and Provider access via eHealth portal
Expanded Insulin Pump Program	Coverage for insulin pumps & supplies for adults with type 1 diabetes
Expansion Team-Based Care	Aligning current services and addressing service gaps
Social Marketing Campaigns	Targeting risk factors in high risk populations, such as Aboriginal and South Asian communities
Chronic Kidney Disease Strategy	Primary/Secondary prevention as well as increased access to dialysis
Implementation Bariatric Surgery Strategy	Expansion of access to bariatric surgery
Implementation of Regional Coordination Centres (RCCs)	To coordinate and align diabetes care and promote best practices.

Regional Coordination Centres

- 1 RCC/LHIN
- Common team composition
- Accountable to MOHLTC—Implementation branch
- Established Summer 2010
- Waterloo Wellington RCC host organization: Langs Farm Village Association (CHC)

Role of Regional Coordinating Centre (RCC)

- To provide regional leadership to organize, integrate and coordinate regional programming
- Engage primary care, diabetes programs, endocrinologists and community to support diabetes care
- To work closely with LHIN
- Provide a clear point of contact within each region
  - for ODS support for MOHLTC
  - for regional program/health care provider support
- Drive implementation of provincial priorities and monitor regional performance
- Promote best practices (adoption of standards, new IT capabilities)

Waterloo-Wellington Diabetes RCC Team

- **Regional Director:** Debbie Hollahan
- **Administrative Assistant:** Kim Busato
- **Health Information Analyst:** Elena Oreschina
- **Outreach Coordinator:** Sarah Christilaw
- **Primary Care Lead:**
  - Dr. Upe Mehan (Cambridge/Kitchener/Waterloo)
  - Dr. Rob Norrie (Centre/North Wellington)
  - Jo-anne Costello, NP (Guelph/East Wellington)
- **Consultant Endocrinologist:** Dr. Nadira Husein
- **Self-management Coordinator:** Jayne Giroux
- **Self-Management Administrative Assistant:** Tracey Dodds

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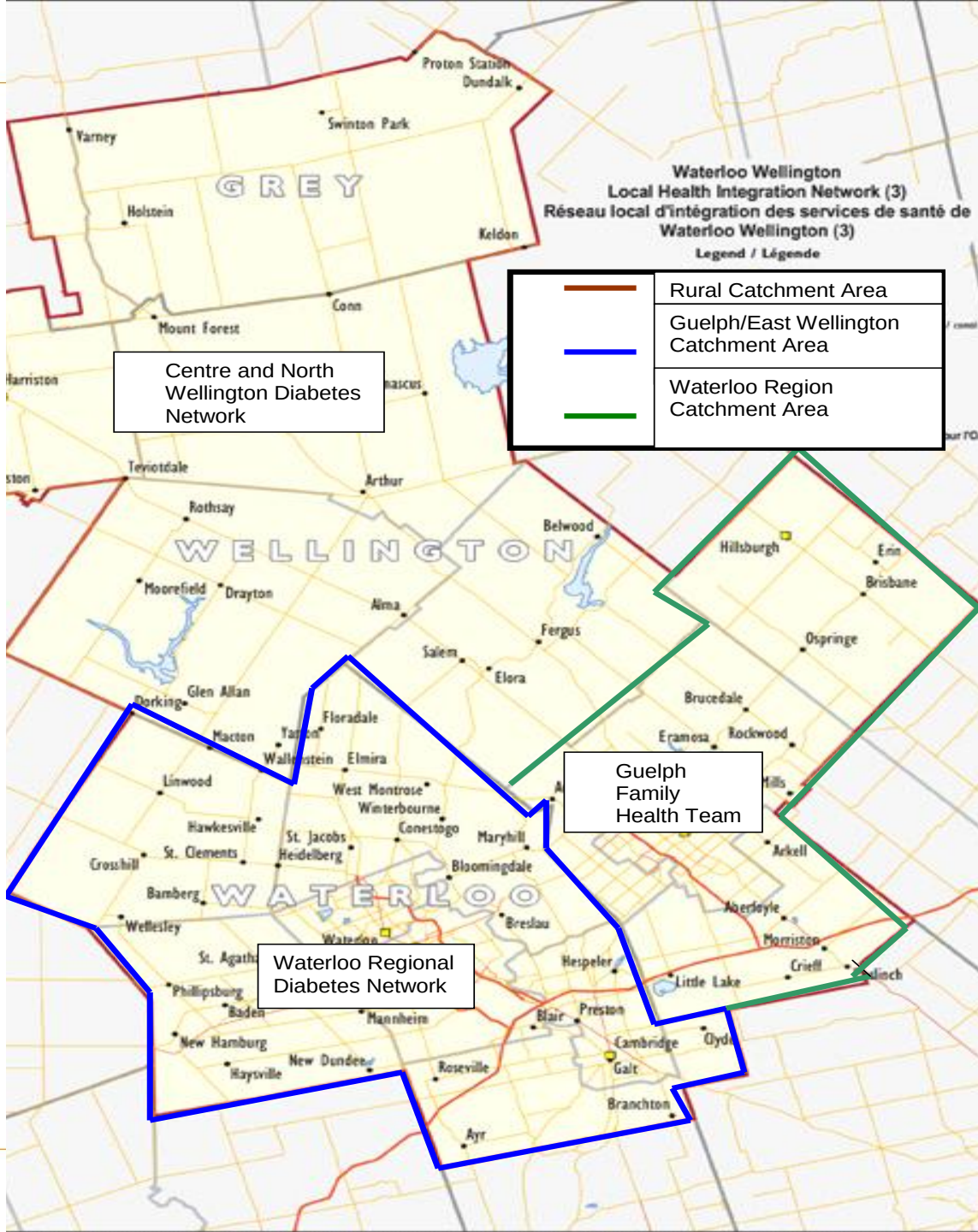
Waterloo-Wellington LHIN boundaries divided by 3 nodes



http://www.health.gov.on.ca/en/ms/diabetes/en/

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Stand up to Diabetes

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EMAIL PRINT ACCESSIBILITY

Welcome to Stand up to Diabetes

Are you living with diabetes; or know someone who is? Are you interested in diabetes prevention? Or maybe you're a health care provider treating people living with diabetes. Whatever your interest, you'll find the information you need about diabetes to help yourself and others live life to its fullest.

To get started, choose the link below that's most relevant to you.

Internet

100%

Performance Indicators/Outcomes

- Key performance measures:
  - A1C --at least every 6 months
  - LDL—at least every year
  - Retinal eye exam—at least every 2 years
- All people with diabetes have access to a primary health care provider

Activities to Date: Assessment of Diabetes Landscape

- Establishment of Steering committee
- Inventory of services:
  - Diabetes programs
  - Primary care practitioners
  - Pharmacists
  - Optometrist/ophthalmologists
  - Chiropodists/ Podiatrists
  - Dentists
- Networking meeting with educators
- Continuing Education event; outreach planning event
- Stakeholder meetings
- Patient focus groups
- Quarterly newsletter

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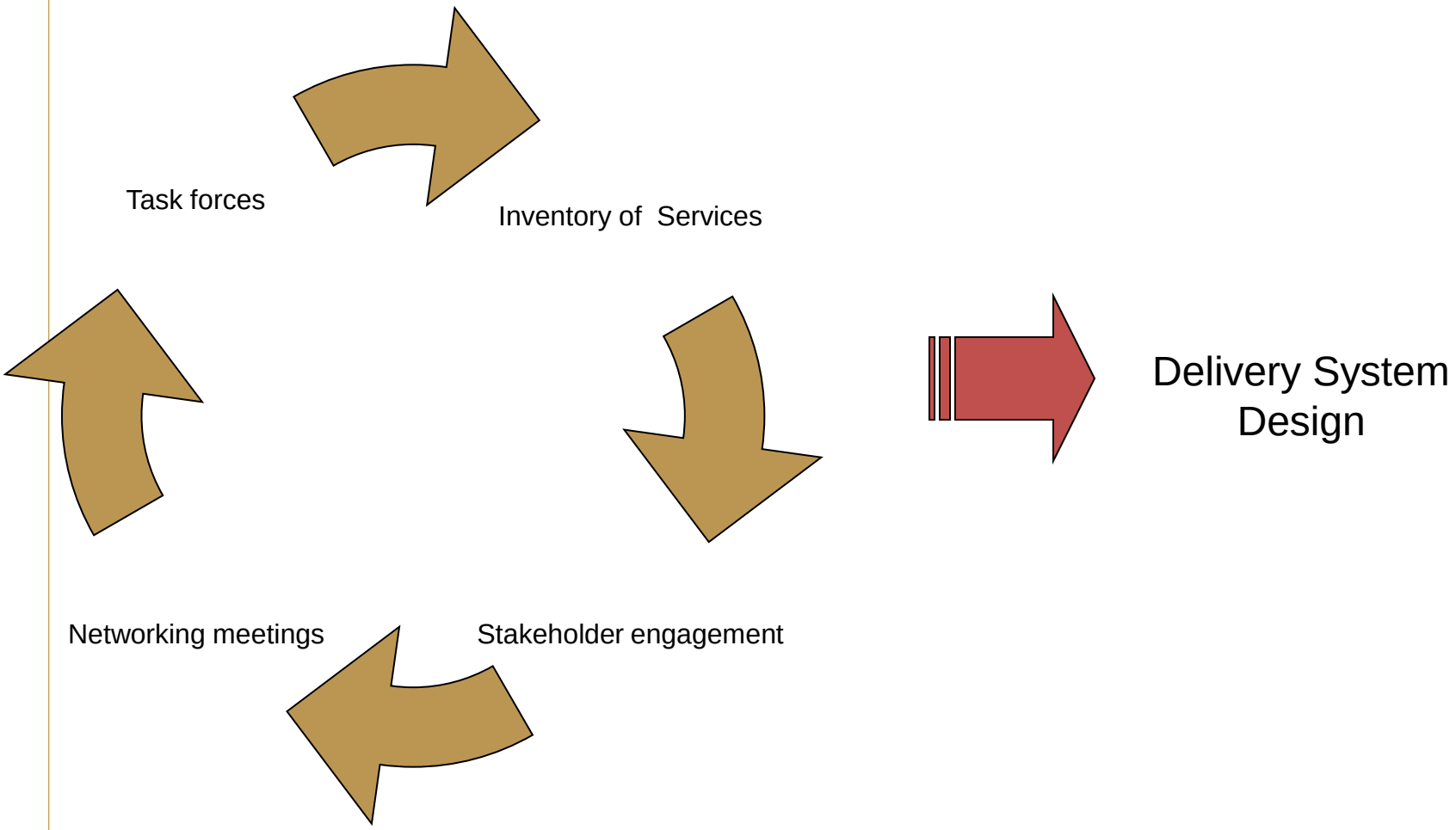
Steering Committee Members

RCC: Team
CDA: Heidi Fraser (CDA)
CCAC: Jim Dalgleish (CCAC)
LHIN: Melissa Kwiatkowski(LHIN)
Public Health: pending
Guelph: Jo-Anne Costello (Primary Care--FHT)
Centre/North Wellington:
Dr. Peter Clarke (Endocrinologist)
Corinne Malette-Wolter (DNE)
Kitchener/Waterloo/Cambridge:
Lynda Kohler (Primary Care--CHC)
Dr. Nadira Husein (Endocrinologist)
Heather Camrass—(Manager G-R DEC)
Karen Sonnenberg (DNE)
Anka Brozic (Coordinator/)
Andrea Main (Pharmacist)

Information Gathering—Diabetes Education and Management



Key Findings from Inventories

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

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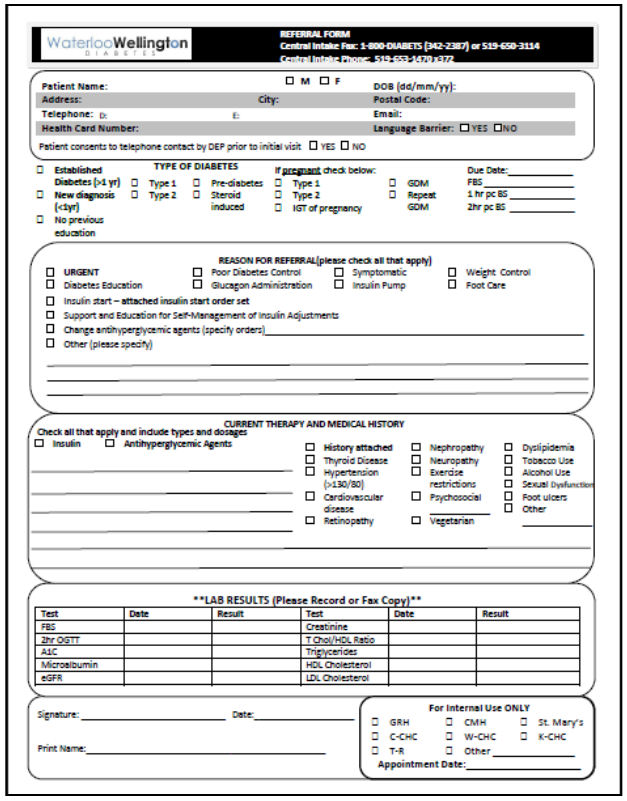
Central Intake

- Why?
  - Improve navigation of the system
  - Improve data collection
  - Monitor wait times
  - Improve patient load distribution
- What?
  - Common Referral Form
  - 1-866-DIA-BETES (342-2387)
  - Triage criteria
  - Role definitions for existing programs



WaterlooWellington DIABETES

REFERRAL FORM
Central Intake Fax: 1-800-DIABETES (342-2387) or 519-650-3114
Central Intake Phone: 519-650-3670 x372

Patient Name: ☐ M ☐ F DOB (dd/mm/yy):
Address: City: Postal Code:
Telephone: D: E: Email:
Health Card Number: Language Barrier: ☐ YES ☐ NO
Patient consents to telephone contact by DEP prior to initial visit ☐ YES ☐ NO

TYPE OF DIABETES
☐ Established Diabetes (>1 yr) ☐ Type 1 ☐ Type 2 ☐ Pre-diabetes ☐ Steroid induced
☐ New diagnosis (<1yr)
☐ No previous education
If pregnant check below: ☐ Type 1 ☐ Type 2 ☐ IGT of pregnancy ☐ GDM ☐ Repeat GDM
Due Date:_____ FBS_____ 1 hr pc BS_____ 2hr pc BS_____

REASON FOR REFERRAL(please check all that apply)
☐ URGENT ☐ Diabetes Education ☐ Poor Diabetes Control ☐ Glucagon Administration ☐ Symptomatic ☐ Insulin Pump ☐ Weight Control ☐ Foot Care
☐ Insulin start – attached insulin start order set
☐ Support and Education for Self-Management of Insulin Adjustments
☐ Change antihyperglycemic agents (specify orders)_____
☐ Other (please specify)

CURRENT THERAPY AND MEDICAL HISTORY
Check all that apply and include types and dosages
☐ Insulin ☐ Antihyperglycemic Agents
☐ History attached ☐ Thyroid Disease ☐ Hypertension (>130/80) ☐ Cardiovascular disease ☐ Retinopathy ☐ Nephropathy ☐ Neuropathy ☐ Exercise restrictions ☐ Psychosocial ☐ Vegetarian ☐ Dyslipidemia ☐ Tobacco Use ☐ Alcohol Use ☐ Sexual Dysfunction ☐ Foot ulcers ☐ Other

LAB RESULTS (Please Record or Fax Copy)

Test	Date	Result	Test	Date	Result
FBS			Creatinine		
2hr OGTT			T Chol/HDL Ratio		
A1C			Triglycerides		
Microalbumin			HDL Cholesterol		
eGFR			LDL Cholesterol		

Signature:_____ Date:_____
Print Name:_____

For Internal Use ONLY
☐ GRH ☐ CMH ☐ St. Mary's ☐ C-CHC ☐ W-CHC ☐ K-CHC ☐ T-R ☐ Other _____
Appointment Date:_____

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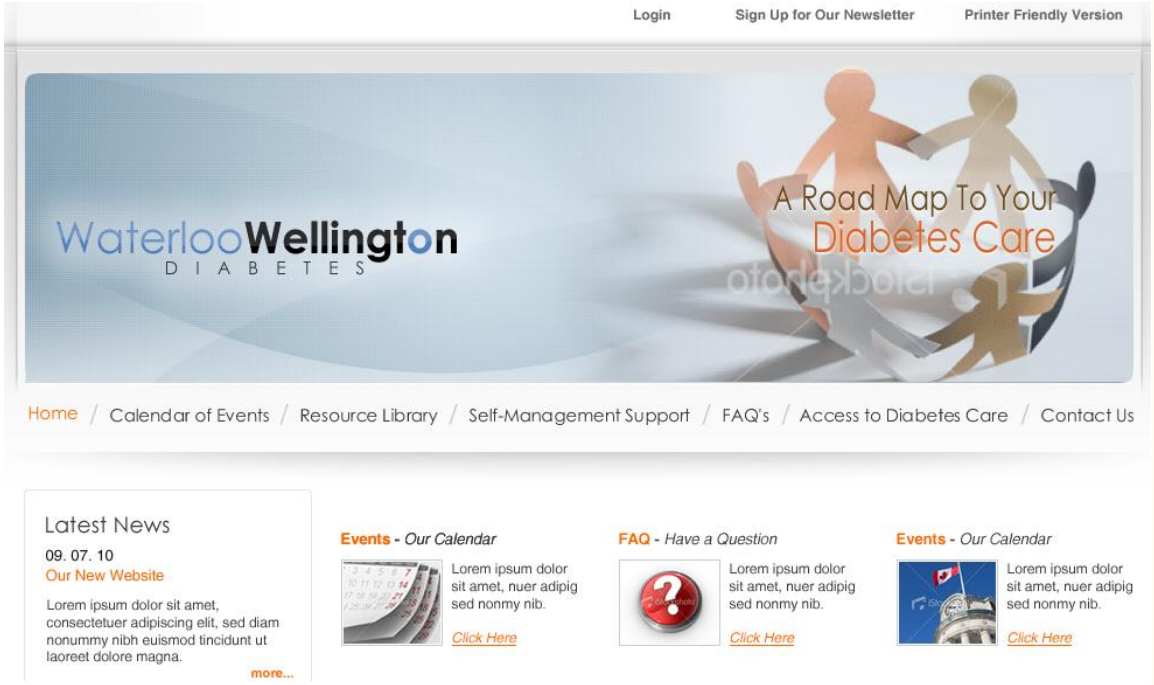
Communication

- Newsletters
- Website: available Nov 14th, 2011
- Brochures/Fact Sheets
- Updates



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Summary

- Priorities for the RCC (based on CDPM framework):
  - Delivery System Design
    - Central intake
      - Common Referral Form
    - Role Definition
    - Continuity of Care
      - Flow of patients from acute episodes to primary care
  - Provider Decision support
    - Consistency of care
      - Common medical directives
      - Common pathways
    - Knowledgeable health care providers
    - Tools for data collection
  - Personal Skills and Self-management Support
      - Coordination of self-management programs
      - Coordination of outreach programs