Improving Diabetes Care

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NEWS FROM THE SOUTH WEST'S INNOVATIVE Partnerships for Health **INITIATIVE**

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Partnerships for Health: Innovating for better care

Diabetes is a serious and growing health problem, and a significant burden for patients, their families and primary care teams. It's clear that better prevention and management is the key. That's why Partnerships for Health (PFH) is such an important initiative for the South West Local Health Integration Network (LHIN).

PFH puts Ontario's Chronic Disease Prevention and Management (CDPM) framework into action, fostering the use of evidence-based best practices to manage adult patients with diabetes proactively. The initiative brings together key health care providers – family doctors, South West Community Care Access Centre (CCAC) case managers, diabetes educators, and others – in an integrated approach to care. Patient self-management is also a critical component. "Partnerships for Health is all about breaking out of our current paradigms and working in new and different ways," says Marg McAlister, a member of the leadership team.

PFH is funded by the Ministry of Finance, through Strengthening our Partnerships, a program designed to foster innovation and increase efficiency in the not-for-profit sector. "If there's a way we can contain spending and as a result improve patient outcomes, it's a win-win. We know that health care spending is continually trending upward," says Nancy Elliott, Senior Program Manager with the Ministry. "We saw PFH as an innovative pilot project that could be replicated across the province and with other chronic diseases."

In the first phase of the PFH initiative, three Family Health Teams (FHTs) in Strathroy, Clinton and Brockton are working closely with South West CCAC case managers and local diabetes educators. Each site team is assessing its patient profile, selecting and implementing improvements, and monitoring their successes. "There's an important role for everyone on the team," says Jennifer Blackhall, a Nurse Practitioner with the Clinton FHT. "The best part of this initiative is developing collaborative partnerships and using the experience of many partners to improve outcomes."

Ontario

The leadership team is supporting site teams through education and coaching. During the first Learning Collaborative session in late September, Dr. Stewart Harris discussed the latest diabetes care guidelines (see page 3). The session also included presentations on improvement models, integration, self-management support, measurement and reporting, and the use of information technology. "We're already starting to see some very positive results," says Barb Willis, another member of the PFH leadership team. "The success stories we're hearing from the practices are evidence that the clinical integration is working."

In January the site teams will gather again, this time to report on their efforts. Two more meetings will be held in the course of the year, culminating in an "Outcomes Congress" in October 2010.

Meanwhile, Phase Two of PFH will get under way in January, with 10 more family practices involved. Phase Three will involve up to 100 practices.

"I'm optimistic that 'Partnerships for Health' will help achieve the Ontario government's goal of creating an effective chronic disease prevention and management system – one where information is shared with the patient, the patient's family, and the care team, and where health conditions are managed proactively."

Michael Hillmer, Manager, Chronic Disease Management Unit, Ministry of Health and Long-Term Care

"There are a lot of resources in the South West to support diabetes management, but it isn't always easy to figure out how all the pieces fit together," says Kelly Gillis, Senior Director, Planning, Integration and Community Engagement with the South West LHIN. "Partnerships for Health is about providers understanding what resources exist in our communities and how best to use them."

Part of the Big Picture

Partnerships for Health is integrated into a province-wide initiative to improve diabetes care

You could say it's a case of being in the right place at the right time.

In July the Ontario government announced a $741 million Diabetes Strategy. The Strategy is based on internationally-accepted best practices and the recommendations of a Diabetes Management Expert Panel established by the Ministry of Health and Long-Term Care. "Our plan will help Ontarians living with diabetes get better access to the care they need, when and where they need it," said David Caplan, Minister of Health and Long-Term Care, in making his announcement. "By improving the way we prevent, treat and manage diabetes, thousands of Ontarians will benefit from a better quality of life."

When the Strategy was announced, Partnerships for Health was already under way in the South West. The PFH initiative called for the creation of an electronic system to support patient self-care and connect providers across disciplines and organizational boundaries. Now the Ontario government has committed to moving technology forward for people living with diabetes. Once fully implemented, electronic diabetes management tools will provide instant access to information to help patients, families and practitioners to manage care. Doctors will be able to check patient records, access diagnostic information and send patient alerts. The tools are expected to be online by Spring 2009.

That's good news for Partnerships for Health, says Barb Willis, a member of the PFH leadership team. "We've evolved from being a demonstration project to being a cornerstone of the South West LHIN eHealth strategy. Instead of developing our own solutions, we will now be focused on helping family practices prepare for the electronic solutions being developed at the provincial level."

Resources freed up will be used to expand the reach of Partnerships for Health. Originally designed to involve a total of six primary care practices, it will now involve more than 110 practices over a three-year period.

Diabetes: A growing challenge for primary care

Consider the facts:

- Today some 900,000 Ontarians live with diabetes. By 2010 the number will be 1.2 million
- Ontarians with diabetes account for 32% of heart attacks, 43% of heart failure cases, 30% of strokes, 52% of new dialysis cases and 70% of amputations
- People with diabetes are twice as likely to have depression as the general population, and the presence of depression as a co-morbid condition to diabetes is associated with poor adherence to medication regimens, greater complications of diabetes, increased numbers of emergency room visits, and poorer physical and mental functioning
- In 2001 it was estimated that diabetes cost the Ontario health system $2.5 billion per year
- 74% of diabetes care is provided by a family doctor alone
- Patients with diabetes average eight family physician visits a year
- Within two years of diagnosis, more than half of patients with diabetes have hypertension
- Half of all patients with diabetes in Canada are not at target for A1C
- For every one percent reduction in A1C, deaths from diabetes are reduced by 21%, microvascular complications are reduced by 37% and peripheral vascular disorders are reduced by 43%

As Dr. Stewart Harris, Canadian Diabetes Association Chair in Diabetes Management at The University of Western Ontario and McWhinney Chair for Studies in Family Medicine puts it, “Diabetes is not a mild disease.” At a recent Partnerships for Health learning session, Dr. Harris also noted that regardless of treatment, diabetes is progressive and lifestyle changes alone are not enough to manage it.

But the news is not all bad. “If we don’t discover anything else about diabetes in the next 30 years,” he said, “we have enough knowledge now to effectively manage the disease and prevent complications.”

Dr. Harris reviewed newly-released 2008 guidelines for management of Type 2 diabetes. Among the key guidelines:

- Measure A1C every three months to ensure goals are being met and maintained
- Maintain A1C below 7
- Add medications rapidly and move to new regimens when target glycemic goals are not being achieved or sustained
- Make reducing cardiovascular risk the first priority in the prevention of diabetes complications
- Screen annually for diabetes nephropathy
- Maintain LDL below 2, total cholesterol to HDL ratio below 4
- Maintain blood pressure at or below 130/80
- Screen regularly for peripheral neuropathy using a monofilament or tuning fork

www.partnershipsforhealth.ca for more info >>

A Fresh Look at Community Care

The South West CCAC commits support

“We’re a new organization with a revitalized mandate, and we are committed to supporting primary care better than ever before.”

That’s Sandra Coleman, Executive Director of the South West Community Care Access Centre, speaking to the first PFH learning session in late September. Coleman encouraged participants to take a second look at the CCAC and the role of case management in managing chronic disease.

She pointed to a Canadian Home Care Association study on the impact of having case managers onsite in primary care practices. The study found that case management:

- Enhanced the physician’s capacity to provide the best care
- Improved health outcomes by ensuring that patients were referred to more services sooner
- Increased client satisfaction
- Empowered clients to manage their own chronic diseases
- Reduced system costs by avoiding costly complications

Coleman outlined plans for having dedicated case managers in each county to build relationships with physicians. In some cases, including the three FHTs involved in PFH, there will be case managers working onsite on a regular basis. “Our goal is to establish partnerships, build on trust and good communication,” she said. “We want to be part of a proactive disease management approach that uses the special skills of each member of the team. Ultimately, we want to play a role in improving outcomes for patients and clients.”

www.partnershipsforhealth.ca for more info >>

Partnerships in Grey-Bruce

The Brockton Area Family Health Team is forging ahead with new approaches to diabetes care

Daphne Williams, a psychotherapist with the Brockton Area Family Health Team (BAFHT), admits that she was "dragged kicking and screaming" into the Partnerships for Health (PFH) initiative. Now she is an enthusiastic participant who sees big benefits for herself, and the whole team.

BAFHT Administrator Steve Struthers persuaded Daphne to attend the PFH pre-learning session in May and soon she was fully engaged. In fact, she is now using a technique she learned through PFH – the PDSA improvement model – with the clients in her everyday practice.

Struthers saw PFH as a great opportunity for the relatively new Family Health Team. "The initiative focuses on how to modify a practice to improve communication and teamwork, take advantage of IT and provide better patient care," he says. "We were very interested in having access to expertise in all those areas, and we're pleased with what we've seen so far."

Kim Biesenthal, a Health Educator with BAFHT, says the team was already beginning to change its approach to caring for patients with diabetes. "I thought PFH would give us the interventions and we'd come back and implement," she says. "But it is better because we've been given the autonomy to select the changes that make sense to us based on our practice and community."

Now she says the team has a whole new way of working. Instead of waiting for patients to make an appointment, BAFHT staff members call patients to check that blood work has been done and schedule follow-up appointments before problems occur. "We're not letting people fall through the cracks and in fact we are helping them manage better."

Fellow Health Educator Heather Barrett says they're also spending more time with each patient, giving them the knowledge and tools to be responsible for their own health. "We can see the patients connecting the dots," she says. "They begin to see the connection between their A1C, and their physical activity and diet, and they understand what we're testing for when we do blood work." Patients now also complete a Beck Inventory, designed to identify those at risk for depression, a common side effect to diabetes. This enables earlier detection and intervention by Daphne.

A dedicated South West CCAC case manager is available to the team and works onsite two days a week, helping to coordinate community care for patients. The hospital's diabetes educator is also working more closely with the team. Barrett says business process mapping was a big help in understanding each other's roles and identifying areas for improvement.

Although the team acknowledges that finding the time to dedicate to PFH can be challenging, the team in Brockton is excited by its potential. They are confident their participation will lead to better clinical outcomes, and a stronger sense of team both within and beyond the FHT. Says Struthers: "From my point of view the long-term benefit of this initiative is how it will affect the way we deal with other chronic diseases. I look forward to seeing all clinicians in our FHT approaching things the way the PFH team does."

Be part of Partnerships for Health

A Chronic Disease Prevention and Management Initiative

For more information about becoming a partner, please contact **www.partnershipsforhealth.ca** >>

If you are a family physician with a practice in the South West LHIN, you can join Phase Three of Partnerships for Health.

Among the benefits of participating:

- The latest in evidence-based best practices in diabetes care
- Coaching on team building and quality improvement
- Contributing to the development of new models of care

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