WATERLOO WELLINGTON DIABETES

Diabetes Central Intake/Mentoring/Website

Year End Report to WWLHIN

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Improving access. Improving knowledge. Improving health.

Contents

Central Intake/Mentoring/Website

Langs receives base funding from the WWLHIN to support the regional services of Diabetes Central Intake, Mentoring and the Waterloo Wellington diabetes website. These services support residents (patients, families and health care providers) with easy access to diabetes care; the LHIN in system planning for diabetes care; and health care providers in the region to enhance their knowledge of diabetes management. Reports on the volume of referrals and referrals sources are submitted monthly and more detailed reports are submitted quarterly. This end of year report provides a summary of the activities and successes over the past fiscal year of 2014/15.

Central Intake

Central Intake (CI) continues to be successful with over 15,000 referrals (as of March 31st) being processed since its inception in 2011. Many other regions in the province continue to consult with our program seeking help in developing similar systems. We have presented our program through poster presentations at the 2014 Health Quality Ontario conference in November and the CDA National Conference. More recently, we presented to the SWLHIN and shared our reports with Champlain, North West and Toronto Central LHINs; eHealth Ontario; Ontario Renal Network and the Ontario Chiropractors. We have also done many presentations to organizations and networks in our own region.

Despite the increasing prevalence of diabetes, we have demonstrated the following successes in our region:

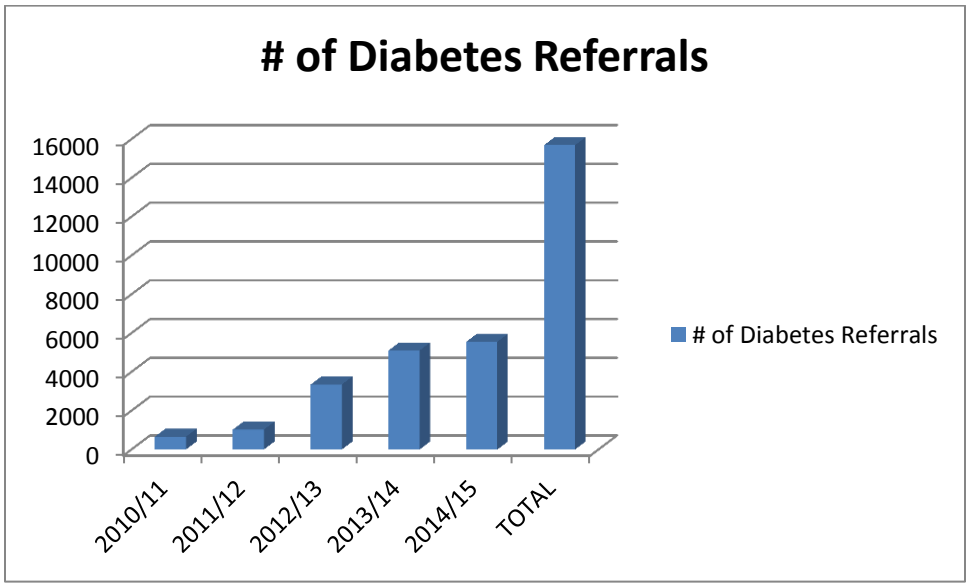
- Increased number of people referred and followed for education
- People accessing care close to home
- Increased utilization of community programs
- No-one lost in system
- Increased self-referrals
- Increased prevention
- Increased retinopathy screening
- Decreased wait-times for diabetes education programs
- Decreased diabetes related ER visits
- Streamlined access to specialists

A Look at Our Data

Access to Care

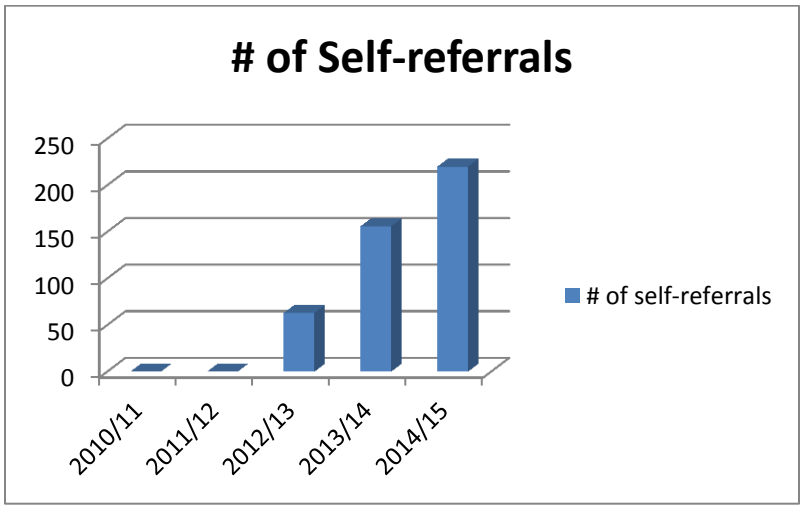
CI has increased access to care by streamlining the referral process with one form and one number to send the form. This has allowed a steady increase yearly in the referrals for diabetes care (Table 1).

Table 1: # of Diabetes Referrals to Diabetes Central Intake



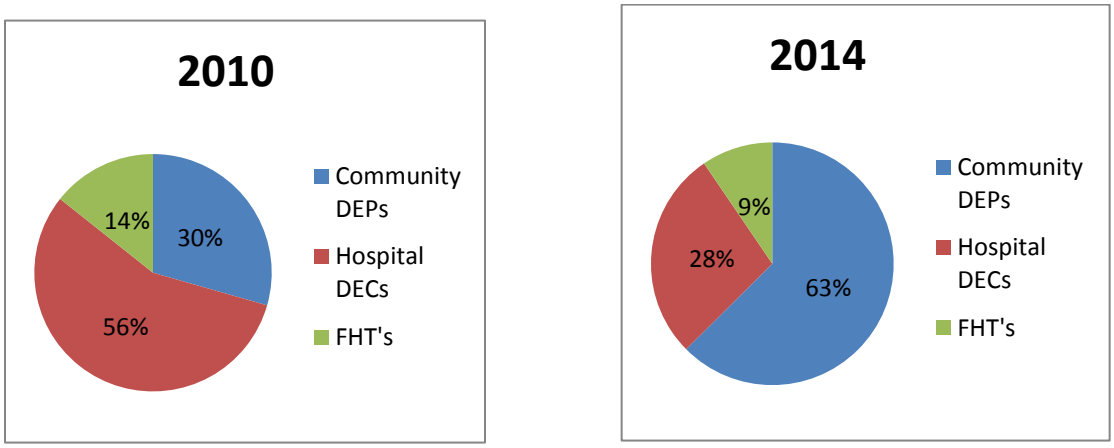
There continues to be an increase in the number of self-referrals through CI, which demonstrates easier access for people accessing diabetes care, as there previously was no self-referral option in the region (Table 2).

Table 2: # of Self-referrals



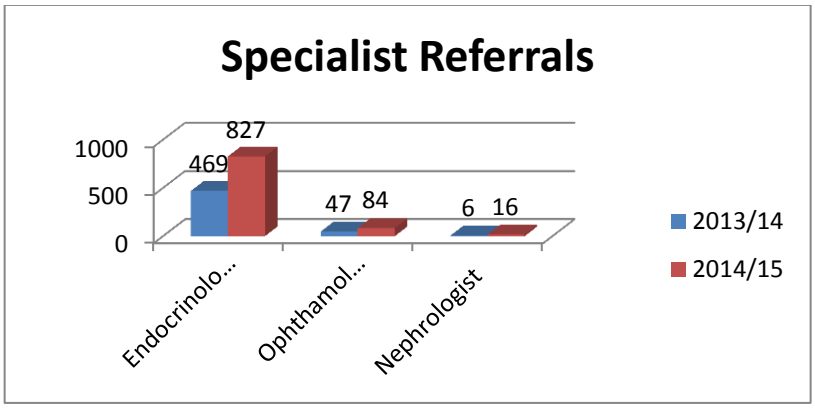
A recommendation from the 2012 Ontario Diabetes Strategy (ODS) Auditor General Report recommended increased utilization of community diabetes programs. CI allows a more equitable distribution of referrals. For example, in 2010 only 30% of referrals were seen in community diabetes programs with the bulk of the diabetes population being seen in hospital Diabetes Education Centres. With the triaging and the mentoring support, 63% of referrals are now being sent to the community programs (Table 3).

Table 3: Percentage of clients being followed by Community DEPS versus Hospital DECs



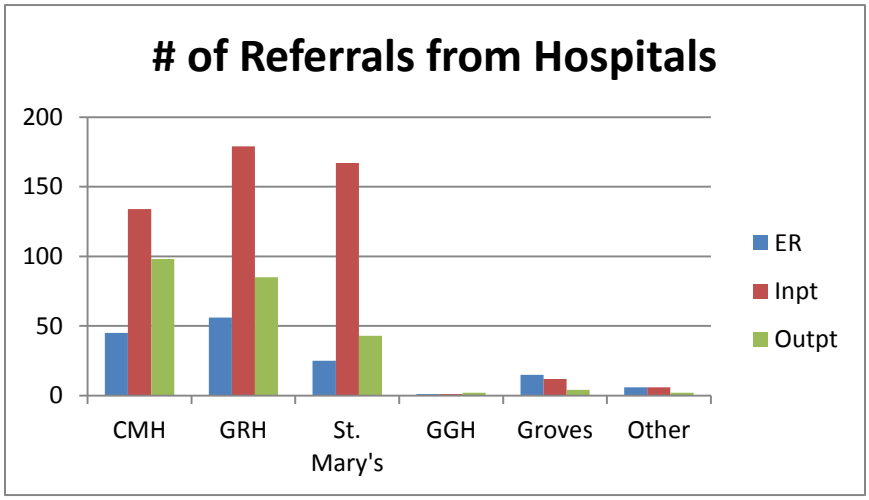
Another recommendation from the 2012 ODS Auditor General Report recommended improved coordination among diabetes care providers and access to specialized diabetes care. CI receives referrals to specialists including endocrinologists, ophthalmologists and nephrologists. CI also receives and directs referrals for chiropody and pharmacists. CI directs referrals in a rotational pattern or to the requested specialist. CI does not currently monitor wait-times of specialists, but we do stay informed of their next average available appointments and their vacation schedules. CI also facilitates urgent referrals to specialists, for example, if it is a newly diagnosed person with type 1 diabetes, we will arrange an urgent appointment with the endocrinologist. As new specialists have started practices in the region, CI has facilitated building up their practices and increasing awareness of their practice to primary care. The following table provides a record of the volume of specialist referrals (Table 4).

Table 4: # of Referrals sent to Specialists



CI has the referral form in all hospitals, except for Guelph General Hospital, which facilitates transition of residents from hospital to diabetes education programs. The following table illustrates the breakdown of ER, Inpt and Outpt referrals from each of the hospitals (Table 5).

Table 5: # of Referrals from Hospitals



CI also continues to direct and receive referrals outside of the WWLHIN (Table 6).

Table 6: # of referrals Sent To and Received From Inside and Outside of WWLHIN

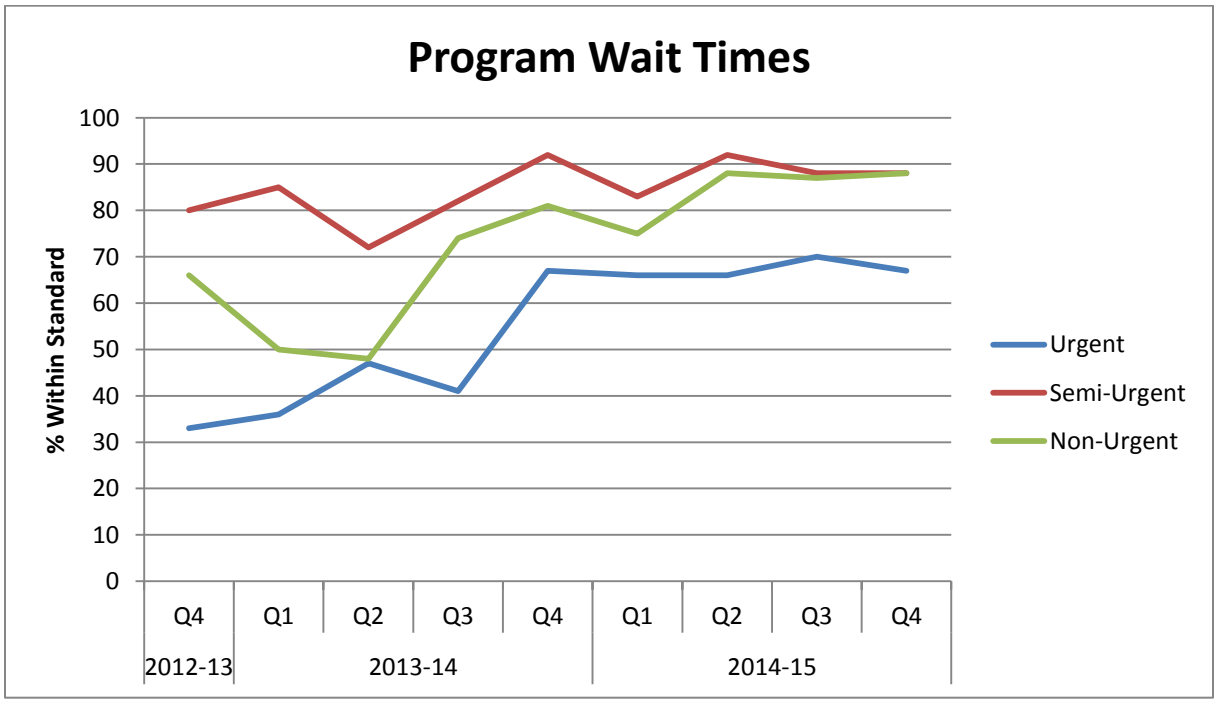
Waterloo Wellington Diabetes Central Intake Data as of Mar 31, 2015			
Ontario		# referrals sent to	# referral sources from
LHIN #	**LHIN name**		
1	Erie St. Clair	7	1
2	South West	168	37
3	Waterloo Wellington	15129	798
4	Hamilton Haldimand Niagara Brant	82	37
5	Central West	10	18
6	Mississauga Halton	14	38
7	Toronto Central	7	26
8	Central	3	12
9	Central East	1	8
10	South East	0	0
11	Champlain	1	1
12	North Simcoe Muskoka	7	2
13	North East	1	0
14	North West	1	0
Alberta		2	
Nova Scotia		1	
		15434	978

Monitoring of Data

Wait times

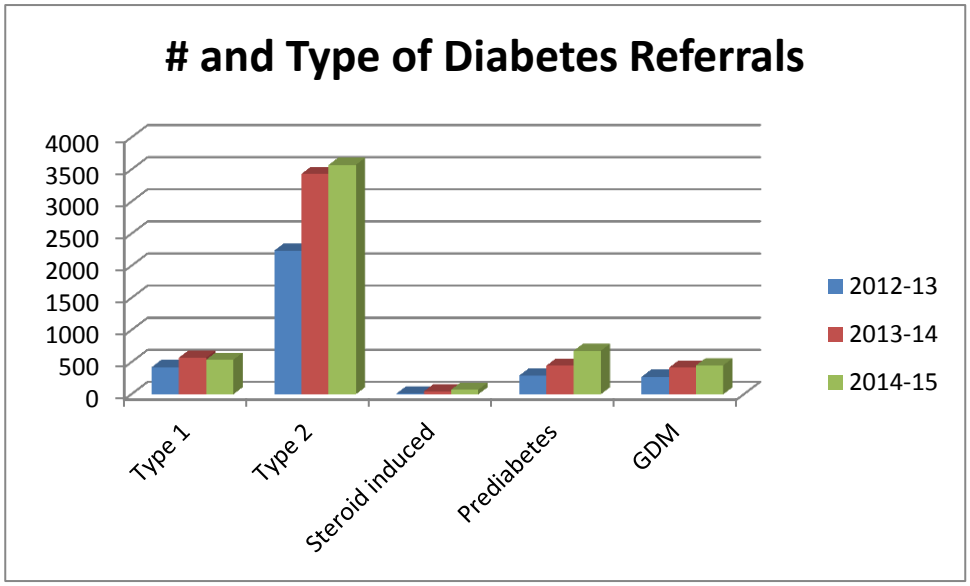
The ODS Auditor General Report recommended that there be timely and equitable access to diabetes services. CI monitors wait times for diabetes education programs and reports to the LHIN quarterly. Prior to CI, wait times were up to 16 weeks in length and many patients were lost in the system. Wait times are now 80% within the standard. Urgent referrals are not quite within standard although the trending is downwards (Table 7). The 48 hour urgent standard wait time is a difficult standard to achieve given that DEPS offer Monday to Friday hours. For example, if an urgent referral comes in Friday afternoon, and the patient is booked in on Monday, they are still outside the urgent wait time standard. The addition of pharmacies accepting referrals has helped with after-hours support.

Table 7: Program Wait Times for WWLHIN



The 2013 Auditor General report on the Canadian Diabetes Strategy recommended reporting on the different types of diabetes separately as this is not currently captured. In our region, CI is able to capture the various types of diabetes being referred (Table 8).

Table 8: # and Type of Diabetes Referrals

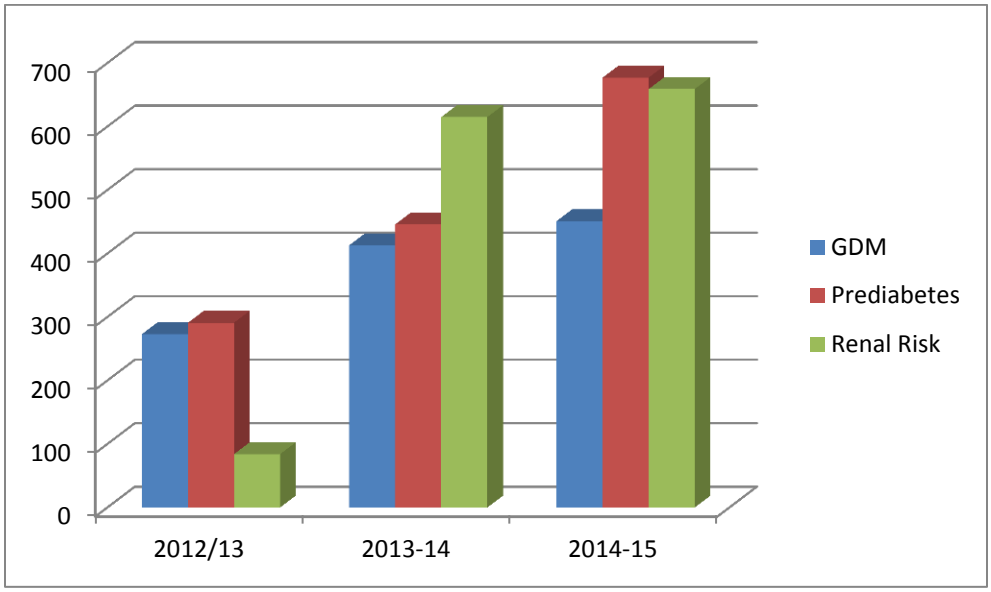


Prevention

In support of the 2012 Auditor General Report of the ODS, CI continues to focus on prevention efforts. The diagnosis of gestational diabetes provides an opportunity to intervene to prevent the onset of type 2 diabetes in both the mother and the baby. CI supported GRH in developing a high risk pregnancy clinic which offers women with diabetes and pregnancy to have a "one-stop shop" for their care. They see the nurse, dietitian and endocrinologist all in one visit. Further efforts are taking place to include the obstetrician in these visits. Additional one-time funding was used to complete the core-content binder for all diabetes education programs to ensure consistency of care across the region. We continue to disseminate the clinical pathway and tools at various events and meetings. The number of referrals for diabetes and pregnancy continues to increase, indicating improved screening and referral (Table 9).

Intervention at the prediabetes stage can prevent the progression to diabetes. CI monitors the # of prediabetes referrals. This number continues to rise (Table 9). CI also continues to monitor the # of referrals with criteria indicating higher risk for renal disease (Table 9) and we are working with the regional renal program to identify further opportunities for earlier intervention.

Table 9: # of Referrals Focusing on Prevention



Education and Mentoring

The mentoring program, which is unique to this region, continues to offer support to health care providers throughout the region. This program offers an experienced Certified Diabetes Educator (CDE) who travels to the various workplaces, enhancing clinicians' knowledge, confidence and skill-set in managing diabetes. Our mentor also provides review sessions for those educators writing their CDE exam as well as lunch and learns on various topics. This year, she offered many of the sessions by webinars allowing even more people to access the service. The mentoring program has made a positive impact on the quality of diabetes care being provided to patients in this region. There are currently 95 CDEs in this region.

Educational needs for primary care were identified through CI, resulting in a ½ day educational conference offered in October called, "An Ounce of Prevention is Worth a Pound of Cure". The event was accredited through the Ontario College of Family Physicians and resulted in 70 primary care attendees with excellent feedback, requesting an annual event.


Invitation

An Ounce of Prevention is Worth a Pound of Cure

Website

Our regional website continues to be well received. It offers education, information on upcoming events and local resources. It also offers easy access to referral for diabetes care. This year additional pages were added to the website including: Older Adults and Sick Day Management. A Search button was also added to help people find information easier. Additional resources for HCPs were added including: mental health assessment tools, financial resources and presentations. A twitter account is now active @wwdiabetes, which helps to market the website. The following table describes the volume and reach of our website (Table 10).

Table 10: Waterloo Wellington Diabetes Website Data

	# of visitors	# of page views	# of regions in province	# of countries
2014-15	5495	18766	14	81

Other Projects

One-time funding from the WWLHIN allowed us to partner with the Canadian Diabetes Association to revise and update the Diabetes Directory of Community Resources ("directory"). This directory was initially developed in 2012 as a 48 page hard copy of diabetes community services available in the Waterloo Wellington region. It is widely used by both patients and health care providers throughout the Waterloo Wellington region, with requests for more copies.

Two staff were hired on contract to research, update, validate and edit the information in the directory. They worked closely with Waterloo Wellington Diabetes (WWD) and the Canadian Diabetes Association (CDA) and completed the directory by March 31st, 2015. This version is now 63 pages in length. It will be disseminated through a medical courier to physicians throughout the region, as well as through all the Diabetes Education Programs, pharmacies and community centres. WWD and the CDA will also maintain stock to have for community exhibits and events throughout the year.

Expansion of Central Intake

Considerable work was done on the electronic expansion of Central Intake with one-time funding from 2012-13, reported on last year's final report. This work is on hold now while the regional Easy Coordinated Access (ECA) strategy is developed. CI continues to work with the ECA steering committee and CDPM working group to identify a coordinated approach for the whole region and align our work with the regional direction and approach.

Summary

Waterloo Wellington Diabetes, hosted by Langs, continues to be successful, providing an excellent service to residents living or working with diabetes. We continue to be consulted by other regions of the province on how to design and deliver centralized intake for diabetes services. Our mentoring program has helped increase capacity of experienced educators in the region. Our web-site provides education and support to people not only within but also outside our region. Our collaboration with the CDA has helped revise the regional Diabetes Directory of Community Resources.