

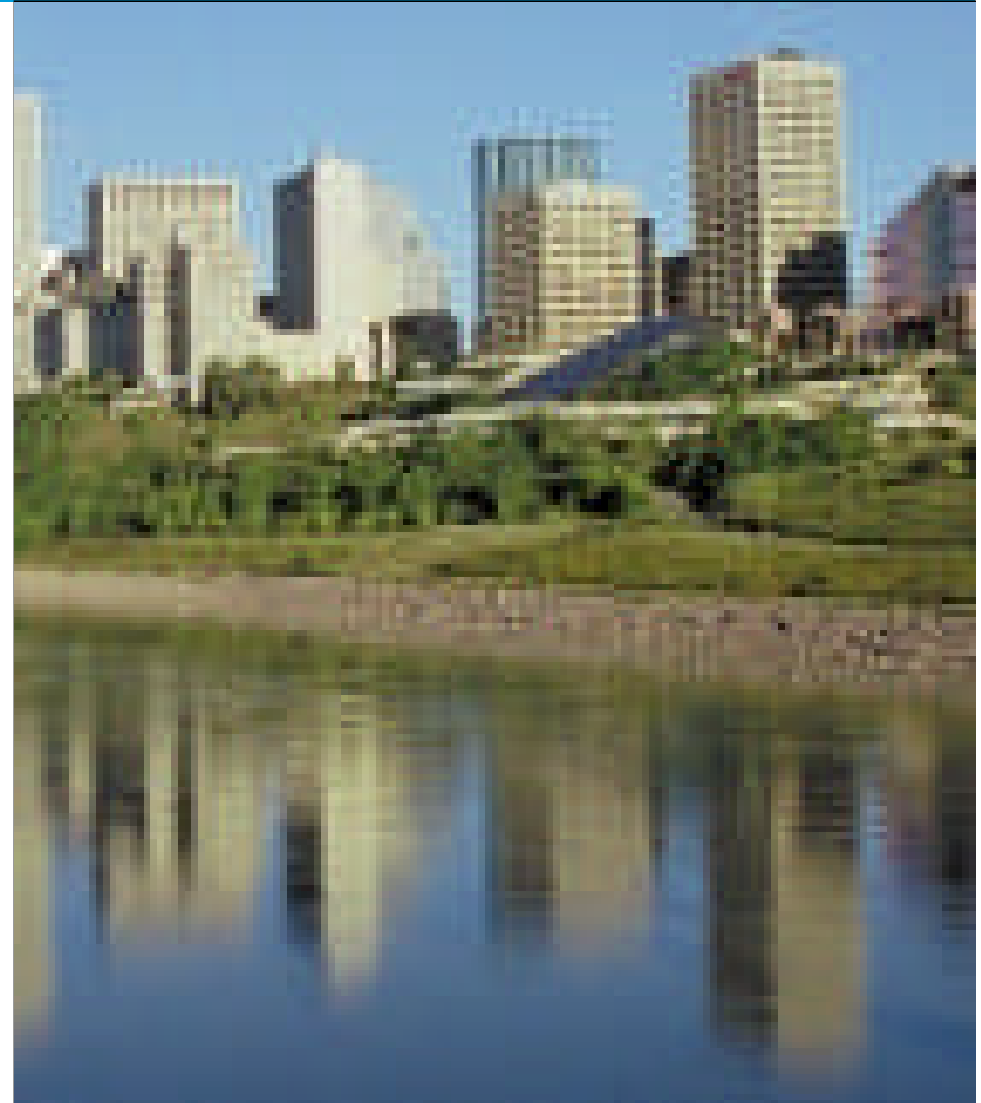


Capital Health
EDMONTON AREA

Using Teams to Support Diabetes Care in the Community

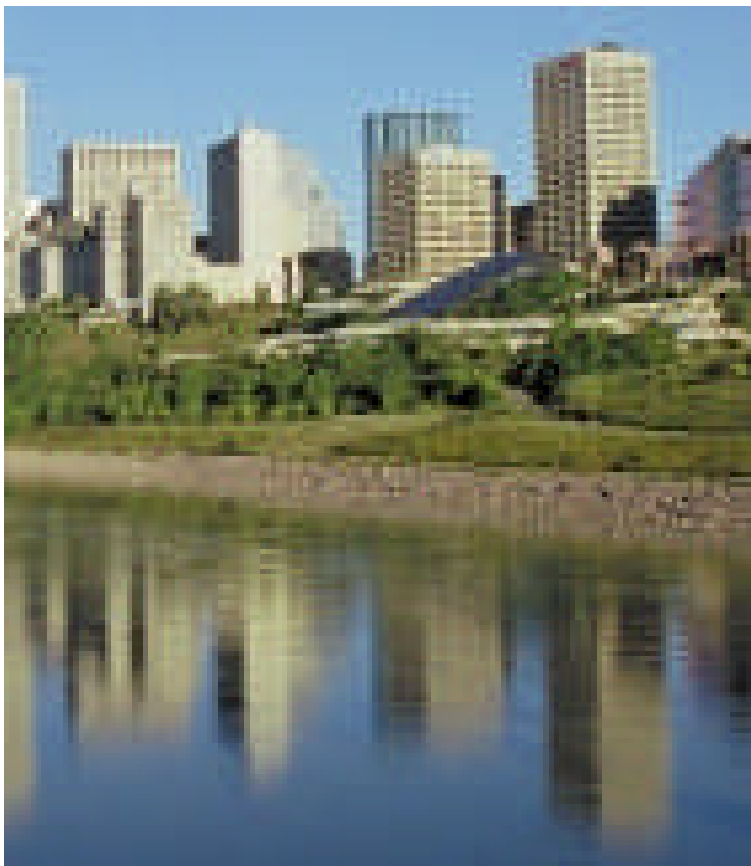
Stephanie Donaldson Kelly

Director of Operations,
Chronic Disease Management
Capital Health
Canada



Edmonton, Alberta Canada

Summer in Edmonton



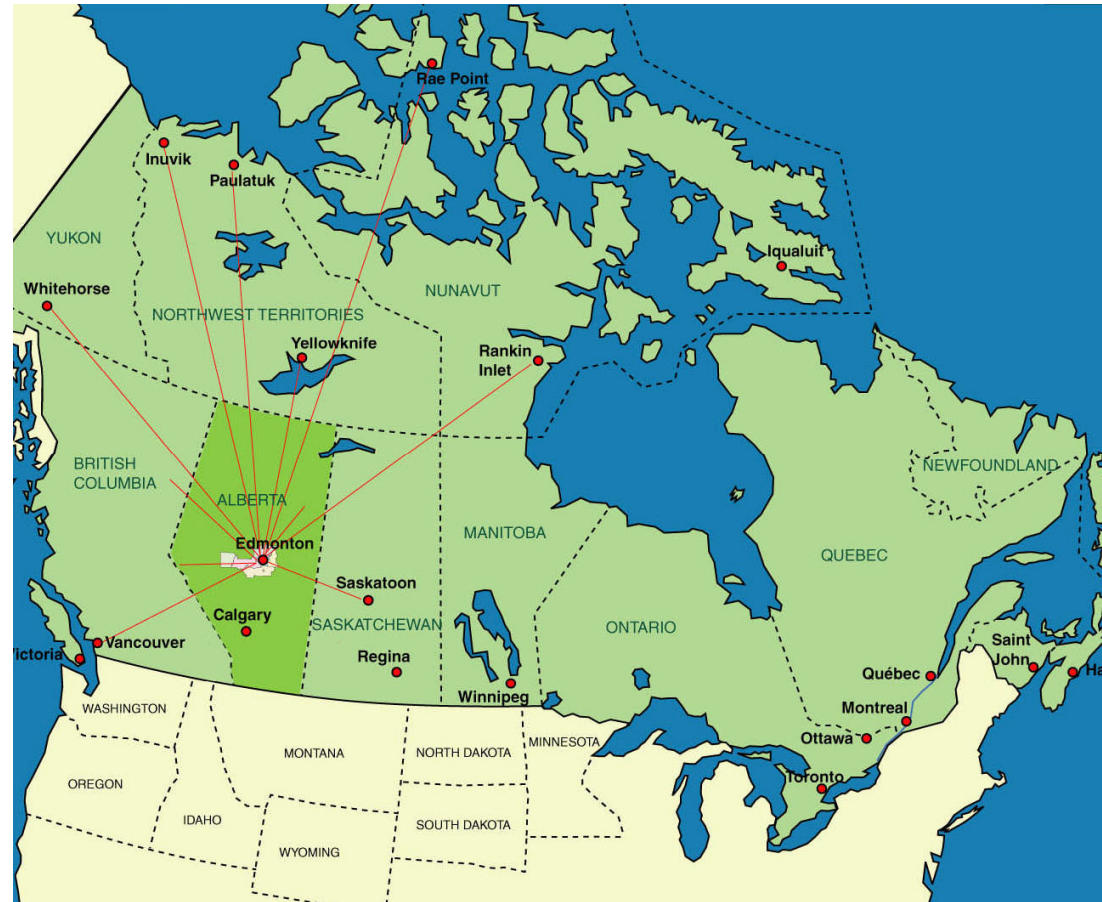
www.capitalhealth.ca

Brrr, Winter in Edmonton



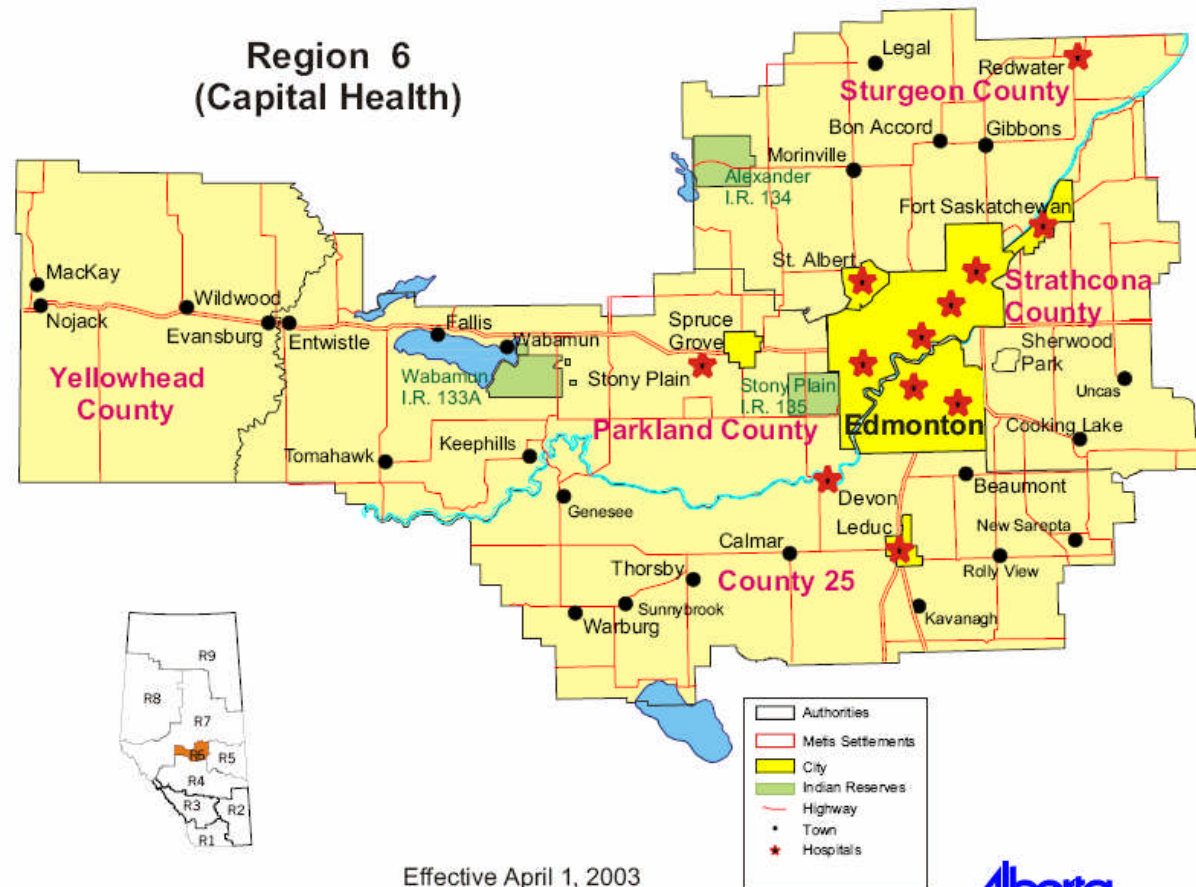
Regional Health Authority

- Referral population - 1.7 M
 - 25% of patients from outside the region
- \$2.6 B budget
- 30,000 staff (largest Alberta employer)
- “High needs” demographics
- Alberta’s most complex patients
- 2,650 physicians
- 13 hospitals



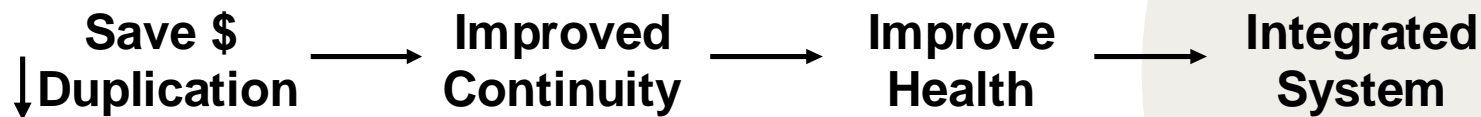
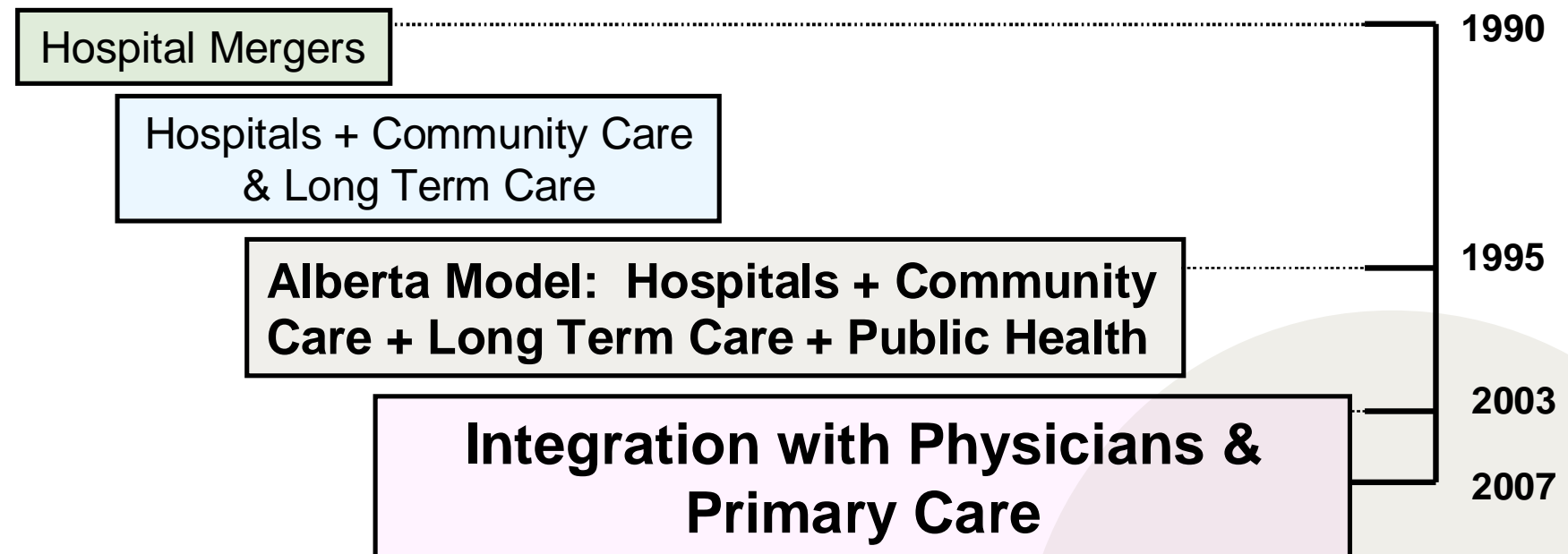
Regional Health Authority

- Geographic area is 120km by 60 km
- 9 Primary Care Networks
- 2,900 hospital beds
- 6,719 home care clients/month
- 635,000 calls to Capital Health Link per year



Alberta's Primary Care Journey

Scope of Integration



Regional Diabetes Program (RDP)

- Adopted the Wagner model in 2003
- Implemented the regional diabetes program with 5 hospital sites and 10 community education locations in 2003, no deployment to family practice
- Standardized assessments and education
- Based on clinical practice guidelines
- Implemented Electronic Medical Record (EMR) in 2005

Regional Diabetes Program cont'd

- Diabetes Information and Advice Line (DIAL)
- Real time telephone support by diabetes nurse and dietitian educators
- For health providers in central and northern Alberta

Community Intake, Triage and Education Team



Primary Care Reform

- Alberta Initiative: Establishing Primary Care Networks
- Networks of primary care physicians and multidisciplinary teams providing primary care for a geographic area of patients.
- Chronic disease accountability

Primary Care Networks (PCN)

- Chronic disease nurses added to Family Physician offices to assume chronic disease management responsibility.
- First chronic disease to be managed was diabetes.



Collaboration and Co-ordination with Primary Care Networks

- Began extending regional diabetes services into family practise.
- Regional Diabetes staff developed a staged education program, focused on diabetes knowledge and management.
- Intended for primary care CDM nurses, and other health providers in the community.
- Two day long sessions, delivered one month apart.

Nurse Diabetes Training

- Similar in content to basic community diabetes education
- Provides basic information to help providers support their clients to manage their diabetes.
- Content based on Clinical Practice Guidelines and Canadian Diabetes Education Standards
www.diabetes.ca

Level 1

Content includes:

- Lifestyle modification
- Healthy eating
- Blood glucose monitoring
- Medications for diabetes
- Physical activity
- Self management strategies

Level 2

- In depth workshop
- Specific skills in assessment and management of type 2 diabetes
- Tools to support clients through the progressive stages of diabetes
- Includes problem solving and available community resources.

Level 2 cont'd

Content includes:

- Review of insulins and oral agents approved in Canada
- Nutrition module, Carbohydrate counting
- Co-morbidity/complication review
- Foot assessment
- Insulin start

DIAL Calls

- Use of DIAL encouraged after professional education
- Relationship building between specialty and primary care
- Link to physician specialist when required by family physician

Community Insulin Start

- Mentored insulin start in community
- Member of RDP team provides insulin start in physician office, with CDM nurse
- Returns to watch another insulin start by CDM nurse
- Short term management offered at DIAL, to teach insulin adjustment

Results

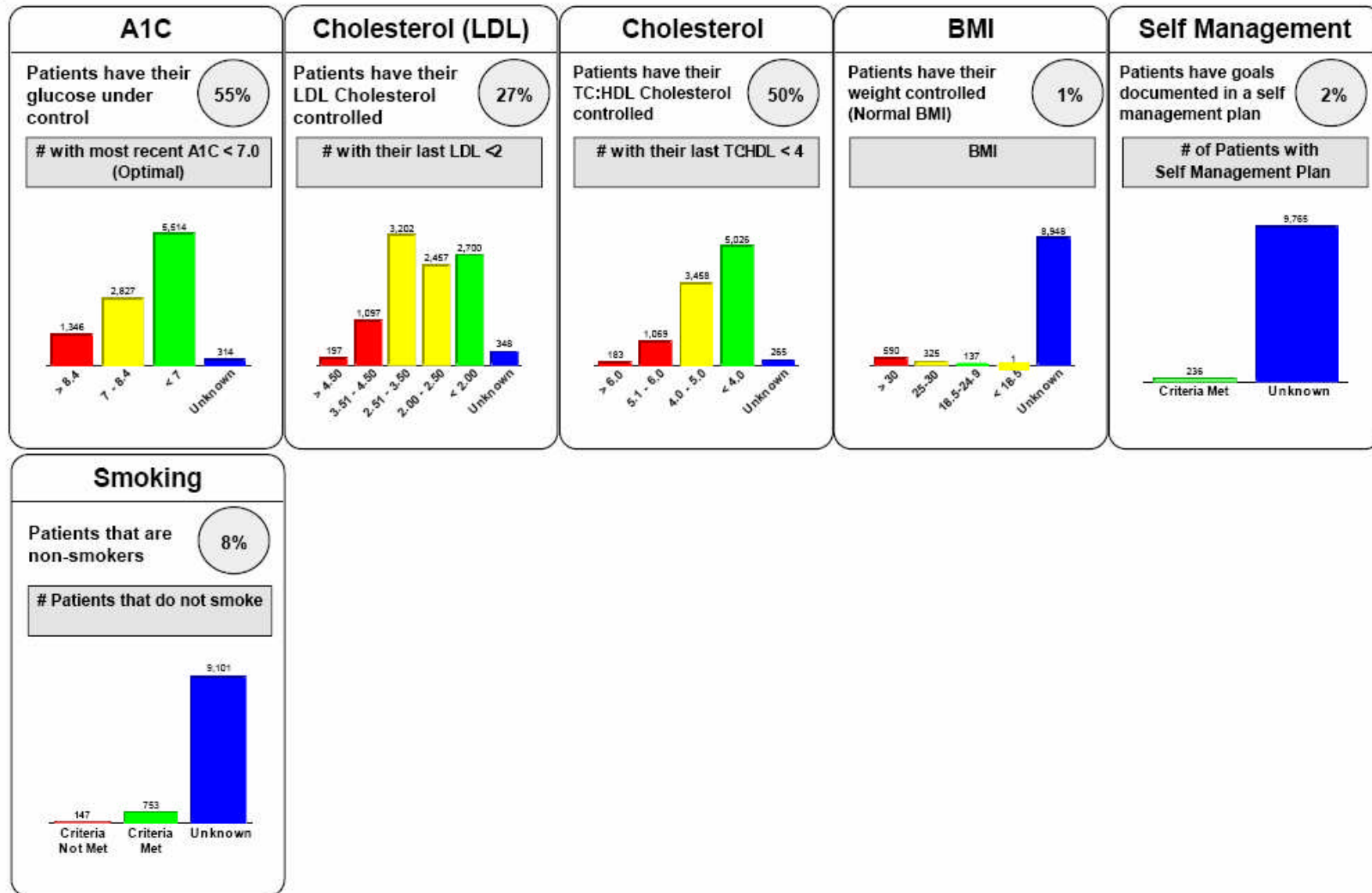
- 80% of CDM family practice nurses have attended level 1 and level 2
- PCN nurses demonstrate increased ability to initiate and adjust insulin, reduced referrals to regional program
- Provider calls to DIAL increased 40%
- Diabetes care is in the community following CDM guidelines.
- Positive health outcomes from this approach are noted in literature.

CDM PCN Registry Disease Management Indicators

Capital Health Region

April 03, 2008

Based on most recent CDM PCN Form, distinct count of patients: 10001



Conclusion

Staged education and support from specialty services provides Primary Care nurses the ability to manage and follow diabetes patients.

Thank you

For more information, please contact:

Dorothy Smolek

Operations Manager, RDP

Capital Health

Dorothy.Smolek@capitalhealth.ca

Stephanie Donaldson Kelly

Director of Operations, CDM

Capital Health

Stephanie.DonaldsonKelly@capitalhealth.ca