



Success study:

Chronic disease management at New Vision Family Health Team

Situation:

New Vision Family Health Team is a busy primary care practice in Kitchener, Ontario. On average, outcomes for patients in the practice who had been diagnosed with type 2 diabetes were not meeting clinical best practice guidelines. The team realized it needed to redesign its chronic disease management system to improve care for these patients. Initially, they focused their efforts on one senior physician's roster of 70 patients with type 2 diabetes.

Aim:

Meet or exceed current diabetes clinical best practice guideline recommendations to improve outcomes for patients diagnosed with type 2 diabetes.

Measures:

See the Results section for the four process and five outcome measures New Vision used.

Changes:

- Created a care map for patients with type 2 diabetes to change the way patients engage in the management of their disease:
- Referred patients with newly diagnosed or poorly controlled type 2 diabetes or pre-diabetes to a Diabetes Education Program led by a registered dietitian
- Provided individual follow-up with a nurse practitioner and registered dietitian within one month of the group session, then ongoing follow-up as needed until patients are stable
- Scheduled appointments with a nurse practitioner or physician, on alternating visits, every three months after patients are stable
- Redesigned the custom assessment form clinical staff use to collect patient information for the EMR to trigger appropriate questions
- Created a diabetic registry to identify clients not seen in more than six months and book blood tests and follow-up appointments
- Acquired medical equipment (Neuropen®) that allowed allied health professionals within the practice to thoroughly examine patients' feet; patients were also asked to take off shoes and socks in advance, to ensure prompt foot examination
- Maintained standardized charting for all allied health professionals, enabling them to track dates of a patient's most recent eye and foot examinations and discussions about self-management goals
- Embraced a team approach to delivering care that better utilized each provider's scope of practice

QI team:

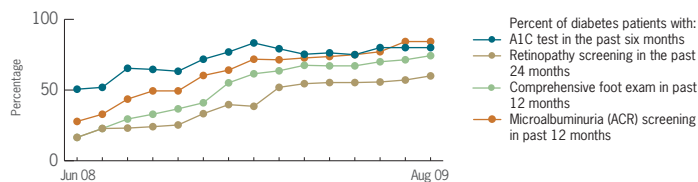
The New Vision team includes 10 physicians, two nurse practitioners, three registered nurses, three registered practical nurses, one pharmacist, one dietitian and two social workers in partnership with the Quality Improvement & Innovation Partnership (QIIP).

Results:

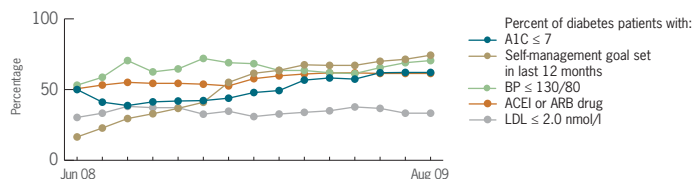
New Vision achieved improvements in all but one measure within a period of 18 months.

Percentage of diabetes patients with:	Target	Baseline	August 2009
A1C ≤ 7	>60%	50%	62%
LDL ≤ 2.0 nmol/l	>65%	17%	33%
BP $\leq 130/80$	>55%	51%	71%
On ACEI or ARB	>60%	30%	61%
Retinopathy screening in past 24 months	>90%	17%	60%
Comprehensive foot exam in past 12 months	>90%	17%	74%
A1c test in past 6 months	>90%	51%	80%
Microalbuminuria screening in past 12 months	>65%	28%	84%
Documented self-management goals in 12 months	>70%	17%	74%

Process measures of improving diabetes management, New Vision Family Health Team



Outcome measures of improving diabetes management, New Vision Family Health Team



Next steps:

New Vision will continue to work on improving clinical outcomes, including LDL levels (the one measure that did not improve), using Plan-Do-Study-Act quality improvement cycles. For example, the team is currently testing a linkage with community optometrists to facilitate communication of diabetic retinopathy screening results. The team will also focus on sustaining current changes and spreading improvements to the rest of the diabetes patient population within the family health team, as well as implementing similar models for patients at risk of heart failure.