Moving Toward a Vascular Health System

Lessons Learned from Primary Health Care Providers

Upper Canada
Family Health Team

STROKE NETWORK
of Southeastern Ontario

Disclosures

- Nothing to disclose at this time

Objectives

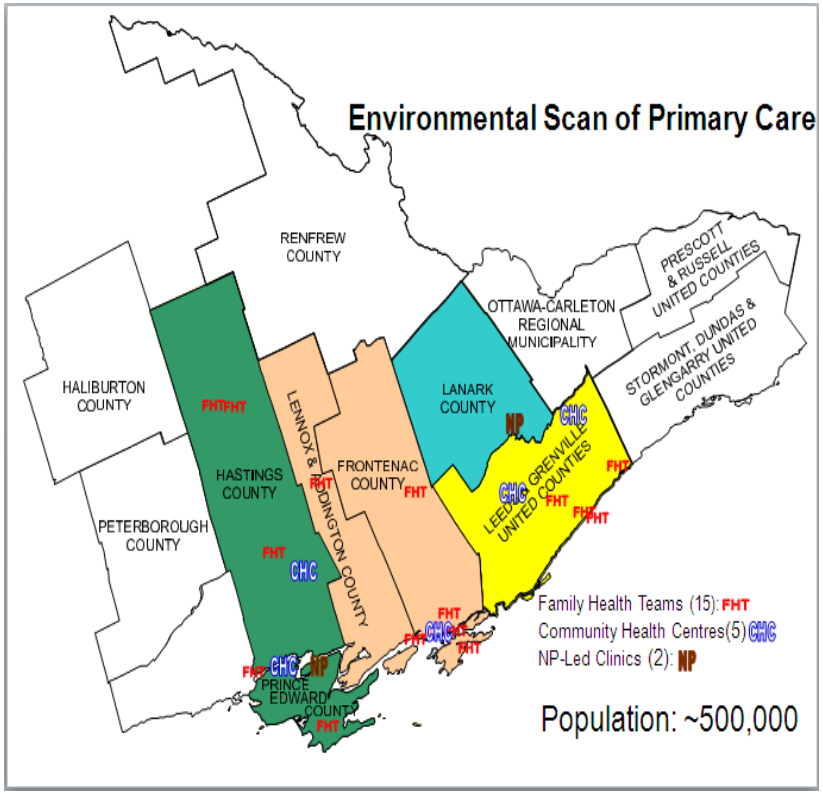
- Provide context to an integrated vascular health approach in Southeastern Ontario
- Share findings from the *Vascular Health in Southeastern Ontario (SEO): A focus on Primary Care* report and follow-up action plans with SEO Health Collaborative
- Showcase the Global Risk Reduction Program at Upper Canada FHT

Background

- SEO continues to have high rates of vascular diseases and risk factors
- SEO Health Collaborative
  - formed in Jan 2011
  - includes many partners: health networks, Primary Healthcare (PHC) organizations & public health
  - supports PHC in vascular disease risk reduction

Background

- In order to identify PHC needs and learn more about resources provided
  - Environmental scan & Think Tanks conducted



Findings

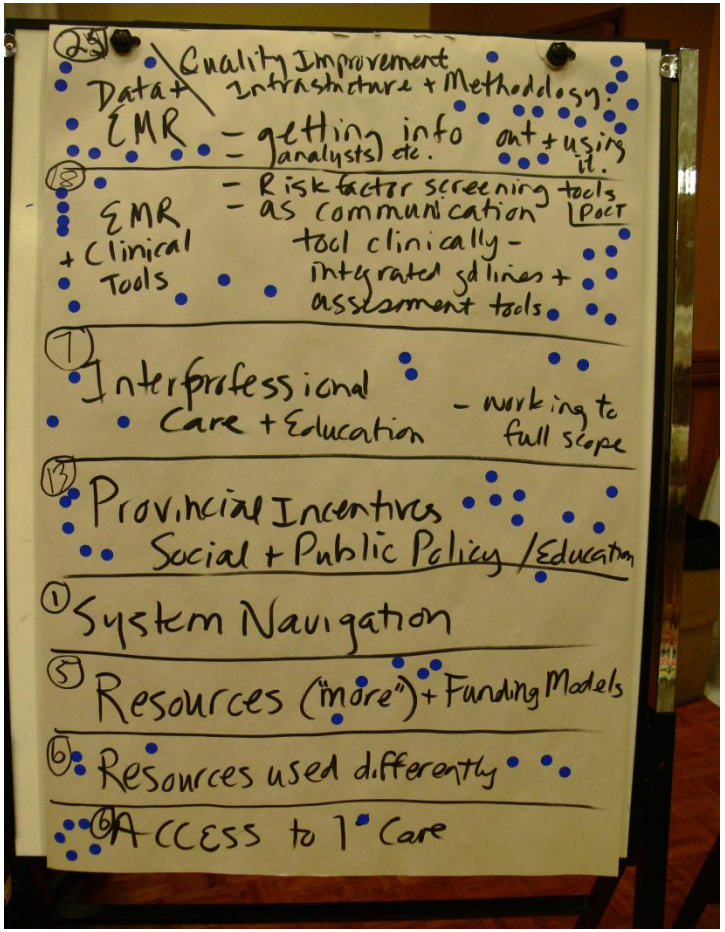
- Many vascular health services working well such as
  - Smoking cessation
  - Diabetes education and services
  - Self-management programs
  - Linking with community partners

Findings

- Sharing information between PHC organizations
- Facilitate consistency (e.g., documentation)
- Innovative ways for providing vascular health updates
- Improve connections
- Increase awareness/promotion of established resources

Findings

- Use EMR to facilitate integrated vascular health
- One integrated patient-centred vascular health service (e.g., Global Risk Reduction program at the Upper Canada FHT)



Southeastern Ontario Health Collaborative–Action Plan April 2013 - March 2014

PRIORITY	ACTION	MRP	Time line	Status
1. Use of CQI Methodology	**i. Support for SE primary health care education event in use of a common methodology for CQI**			✓
2. One vascular health integrated guideline; integrated vascular health program with Community Partnerships	**i. Foster partnerships with Health Links that have identified interests in vascular health** **ii. Promote opportunities within Health Links to trial integrated vascular guidelines and tools** • Promote C-CHANGE • Seek opportunities to pilot Ontario Integrated Vascular Health Strategy (OIVHS) tools • Promote Canadian Primary Care Sentinel Surveillance Network (CPCSSN) **iii. Encourage integrated vascular health initiatives within Primary Care Quality Improvement Plans** • Prepare examples and share at Primary Health Care Forum conference			✓
3. Sharing learning on vascular tools, programs or services, including use of EMR **Education/KT** on vascular topics	**i. Promote shared learning** • Promote at primary care events/forums/symposiums • Include shared learning as part of CQI workshop • Encourage use of Stroke Network funded "shared work day" **ii. Specifically promote shared learning on use of Electronic Medical Record (EMR) to facilitate integrated vascular health** **iii. Maintain Joint Collaborative Education Calendar**			✓ ✓ ✓ ✓
4. System Navigation – Resource Directory	**i. Prepare an inventory of SE vascular programs that are working well with contact info** **ii. Prepare an on-line community resource directory of vascular health services for each Health Link** • Investigate use of CCAC HealthLine website **(www.SouthEastHealthLine.ca)**			✓
5. Collaboration with SE Indigenous Health Council	**i. Maintain communication with and support for Indigenous Health Council (IHC) Initiatives:** **a) ICHAP (Indigenous Community Hypertension Awareness Program) and Social Cultural Circles** **b) Stanford Model of Healthy Living**			

Provincial Vascular Health Strategy

- SEO Vascular Report was distributed to the Ontario Vascular Health Coalition
- Many areas within the SEO Vascular Report align with the Ontario Integrated Vascular Health Strategy Blueprint such as:
  - Need for an organized integrated, accessible and patient-centred approach
  - Providing primary care providers with essential tools such as an integrated vascular health guideline
  - Improving communication and collaboration with care providers such as primary care and specialists (e.g., information flow)
- Vascular Health Coalition Primary Care Working Group:
  - Vascular Flow Sheet
  - Vascular Health Resource Toolkit
- Potential to pilot the tools developed with PHC organizations in Health Links

Upper Canada Family Health Team

- Approximately 34,000 rostered patients
- Predominately Leeds Grenville and Lanark Counties
- 26 Physicians & 6 Nurse Practitioners located throughout Brockville & 1000 Islands Region (Gananoque, Seeley's Bay & Lansdowne)

UCFHT Programs

- **Global Risk Program**
  - Supportive assessment, education and management of cholesterol control, cardiovascular disease, pre-diabetes, hypertension and healthy lifestyle education, in addition to Blood Pressure and INR clinics
  - **Diabetes Program**
  - **Foot Care**
  - **Nutritional Management**
  - **Smoking Cessation Program**
- **Mental Health Program**
- **Gerontology Program**
- **Memory Clinic**

Vision and Purpose

The **Global Risk Reduction (GRR)** Program assists the patient to navigate along the full spectrum of interventions – screening and diagnosis to treatment, education, collaborative goal-setting and follow up.

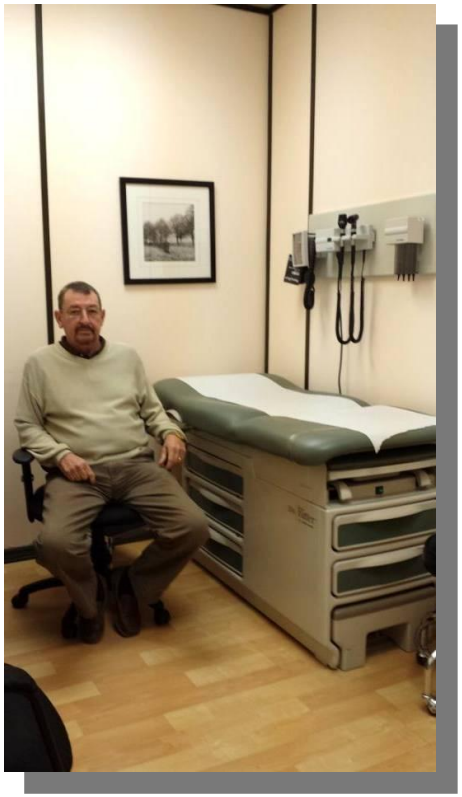
Working with UCFHT and community resources, educators provide skills and practical tools to assist patients self-manage with the goal of reducing hospital readmissions, return trips to the ED and unnecessary primary care visits.

The purpose of these resources is to provide a ***Tool Kit*** for patients at risk, with emphasis on promoting self-management towards healthy outcomes.

Mr. C

October – initial visit with physician

- 58 year old
- Newly diagnosed T2DM, symptomatic
- HbA1c – 11.3%, FBS- 27.6 mmol/L
- Past hx: nephrectomy removed d/t cancer
- Cr 129, eGFR 50, ACR-114.7
- Dyslipidemia (TC-7.08, LDL-4.12, TC/HDL ratio-7.5, TG-4.45, HDL-0.94)
- HTN BP-186/104
- New Rx: Crestor 10 mg od, Ramipril 10 mg od, ASA 81 mg od & Lantus insulin initiation @ 10 units hs & titrate
- Referred to GRR program by physician



Global Risk Reduction Intake Process

- Initial referral is received from physicians, other healthcare providers (FHT, Hospital, Community Agency) or self-referred
- Assessment is made by the RN Educator by reviewing EMR
- Initial plan of action is discussed during GRR team meeting to determine patient's point of entry

Mr. C's Initial Phone Contact from Global Risk RN

- Limited understanding of health issues, "overwhelmed" with everything, "father had diabetes"
- Unaware of dietary restrictions
- Irregular & skipping meals
- Sedentary lifestyle, no exercise
- Does not have glucometer

Phone consult provided health teaching (e.g. "no juice!"), informed of resources, reassured & scheduled for individual office appointment with RN for meter setup, health teaching & insulin initiation.

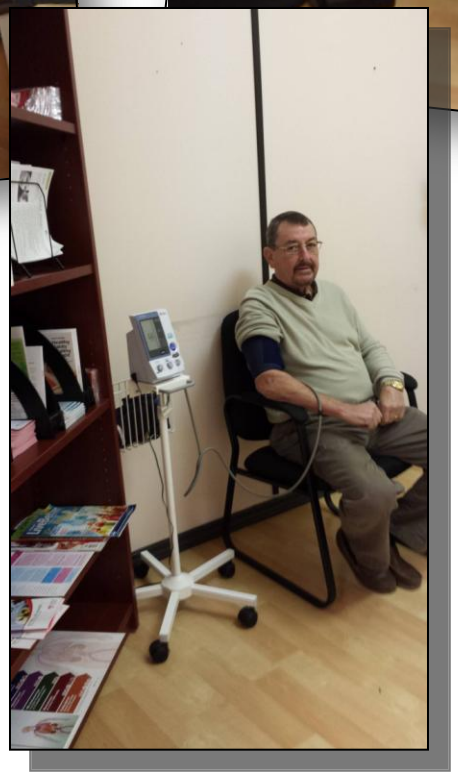
Education and Supportive Counseling for Global Risk Management

- Assessment & Health Teaching for management of Hypertension & Dyslipidemia
- Anti-coagulation clinic
- BP Clinic
  - 24 hour ABPM
- Diabetes Education and Ongoing Support
  - Diabetes & Pre-Diabetes education, assessment, treatment plan
  - Insulin initiation & supportive follow-up
  - In-hospital education prior to discharge & follow up
- Smoking Cessation: STOP Program & affiliation with OHI
- Education and Ongoing Support in both group setting & individual appointment

Self-Management Tools for Healthy Outcomes

- Group Education:
  - "Heart Smart"
  - "Living with Diabetes"
  - "Craving Change"
- Individual appointments to review, assess, teach & support patient setting self-management goals
- Hospital visits
- Home visits
- Referral to appropriate resource(s) within UCFHT and community

INR clinic



Foot Care RN

•Also provides diabetes education to the patient during their appointment – refers to others when indicated

BP Tru room – lots of educational handouts to read while waiting to have BP done!

GRR Group Education-"Heart Smart"

Target Audience:

- Hypertension
- Dyslipidemia
- Insulin Resistance
- Central Obesity

Focusing on healthy lifestyle management, this session provides an opportunity for the client to work with health educators in both a group and individual setting.

Following class, client discusses individual goals and follow up plan with educator

Mr. C

- *Office appt. with RN*: meter setup, initial health teaching, provided with handouts for home reference
- *Office appt. with RN,CDE*: Insulin initiation, titration, targets, factors affecting BG's
- *Group Education*: "Living with Diabetes" "Heart Smart"

- *Individual follow up appt's with Registered Dietitian and RN*
  - BP monitoring
  - Ongoing h/t & review with patient to provide support with self-management goals

AND….smoking cessation RN!

Mr. C's Follow Up Appointments

December:

- FBS- 5.4, HbA1c-8.3% **-lowered by 3% in < 2 months!**
- TC-3.63, LDL-2.04, TC/HDL ratio-3.8, TG-1.4, HDL-0.95
- Dr's note: "in control"
- Pt. now exercising, following dietary plan

February:

- BP on target: 122/68
- Lantus -22 units hs
- Exercising
- EMR note: "doing exceptionally well"

Mr. C's Follow Up Appointments

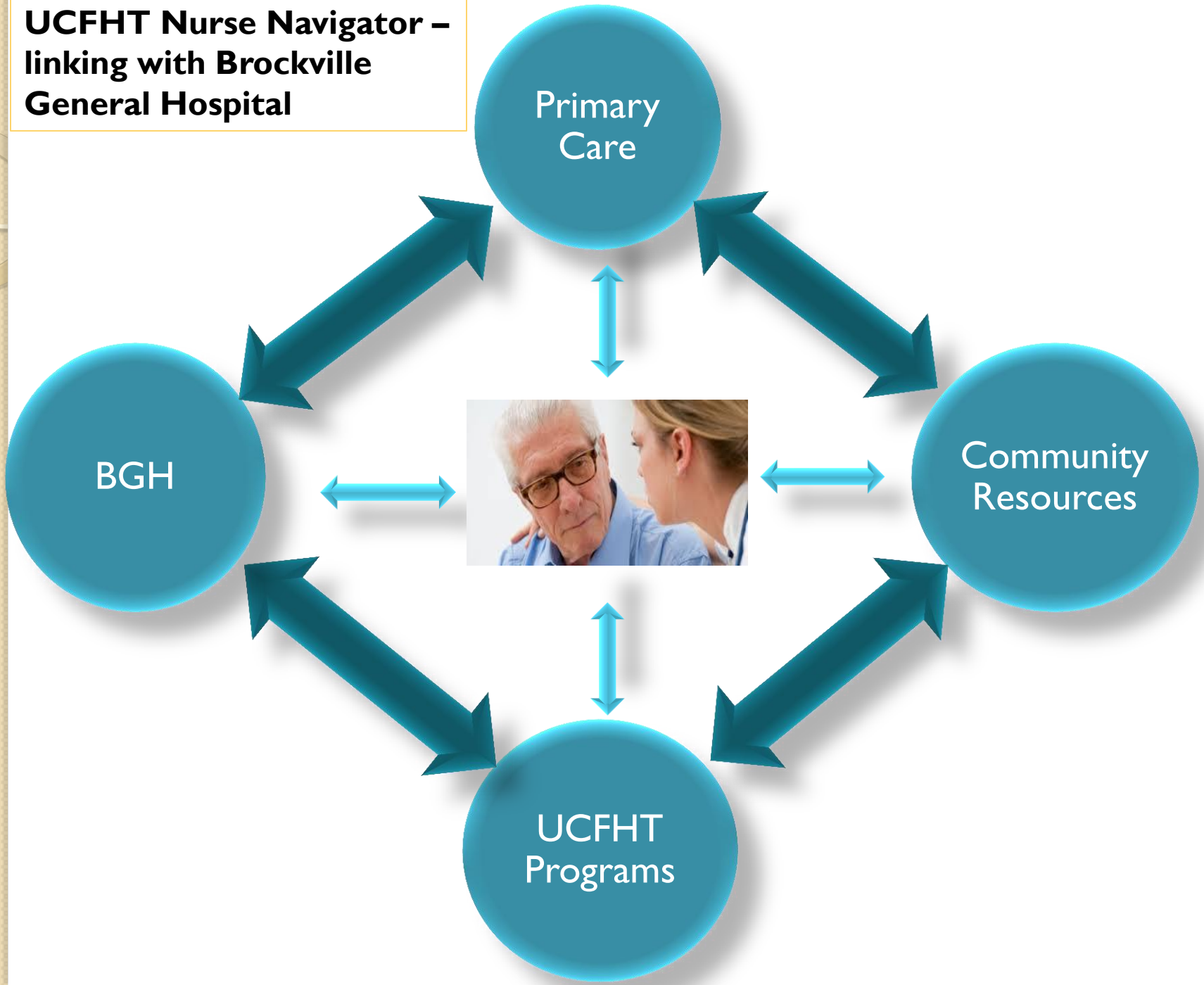
May:

- HbA1c-6.4%
- Dr's note:
  "lipids on target, all risks optimally managed"
- BP on target
- Creatinine "normal"

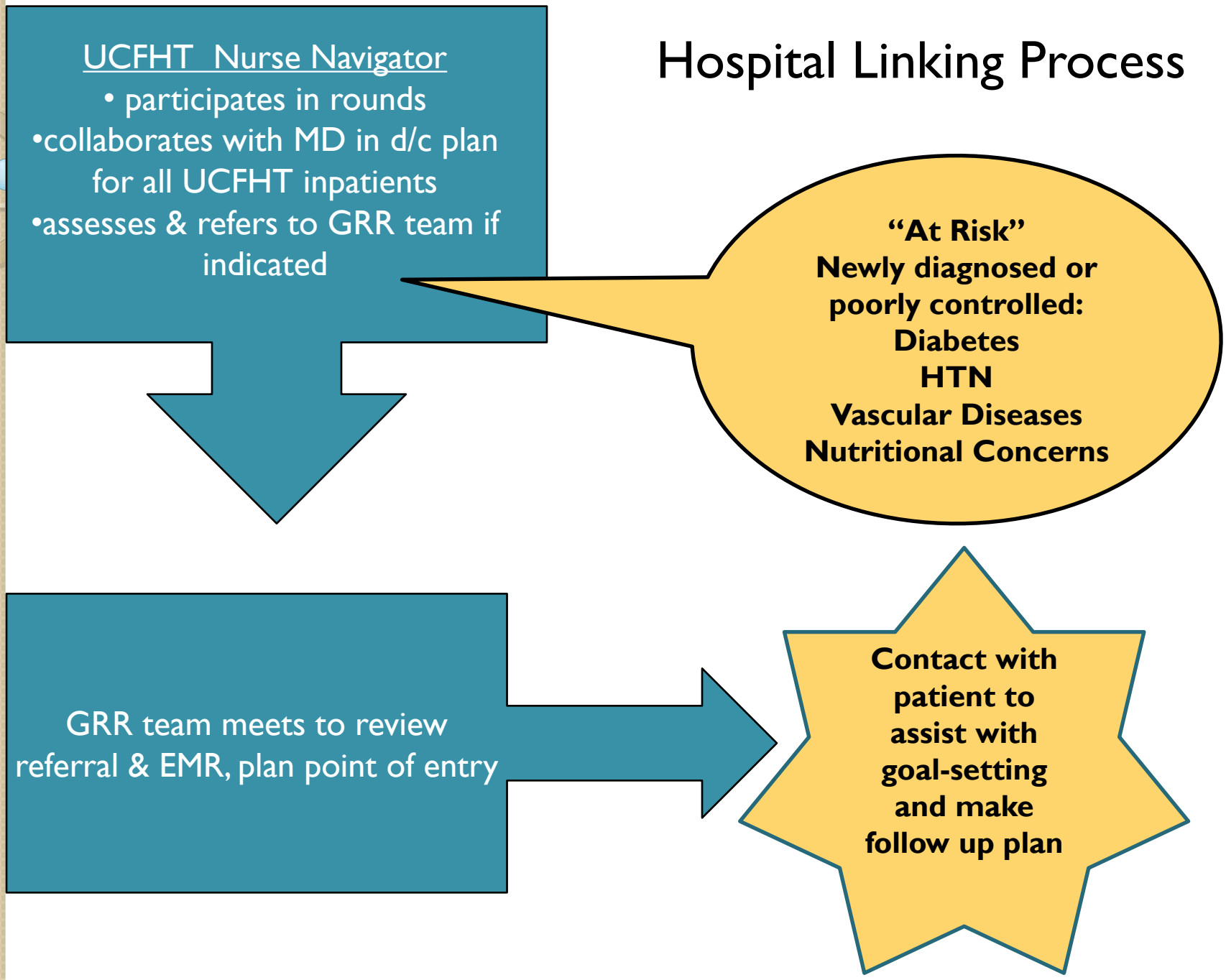
July:

- FBS- 6.4, HbA1c- 6.2%
- Lantus -30 units hs
- Exercising, weight loss goals continue
- Quarterly visits with GRR team for ongoing support

UCFHT Nurse Navigator – linking with Brockville General Hospital



Hospital Linking Process



Example of GRR Program Referral from Nurse Navigator

Initial referral from NN to GRR team via an EMR office action:

- Admitted for syncope episode
- Metformin dose doubled by MD while in hospital
- HTN-194/109 on admission, 149/69 when d/c from hospital
- FBS 8.9 – 13.2
- HbA1c – 0.073
- Patient expressed questions re. foot care & areas of concern
- Provided with information re UCFHT resources
- Booked for f/u appt. with Family Physician in 1/52

Follow up…

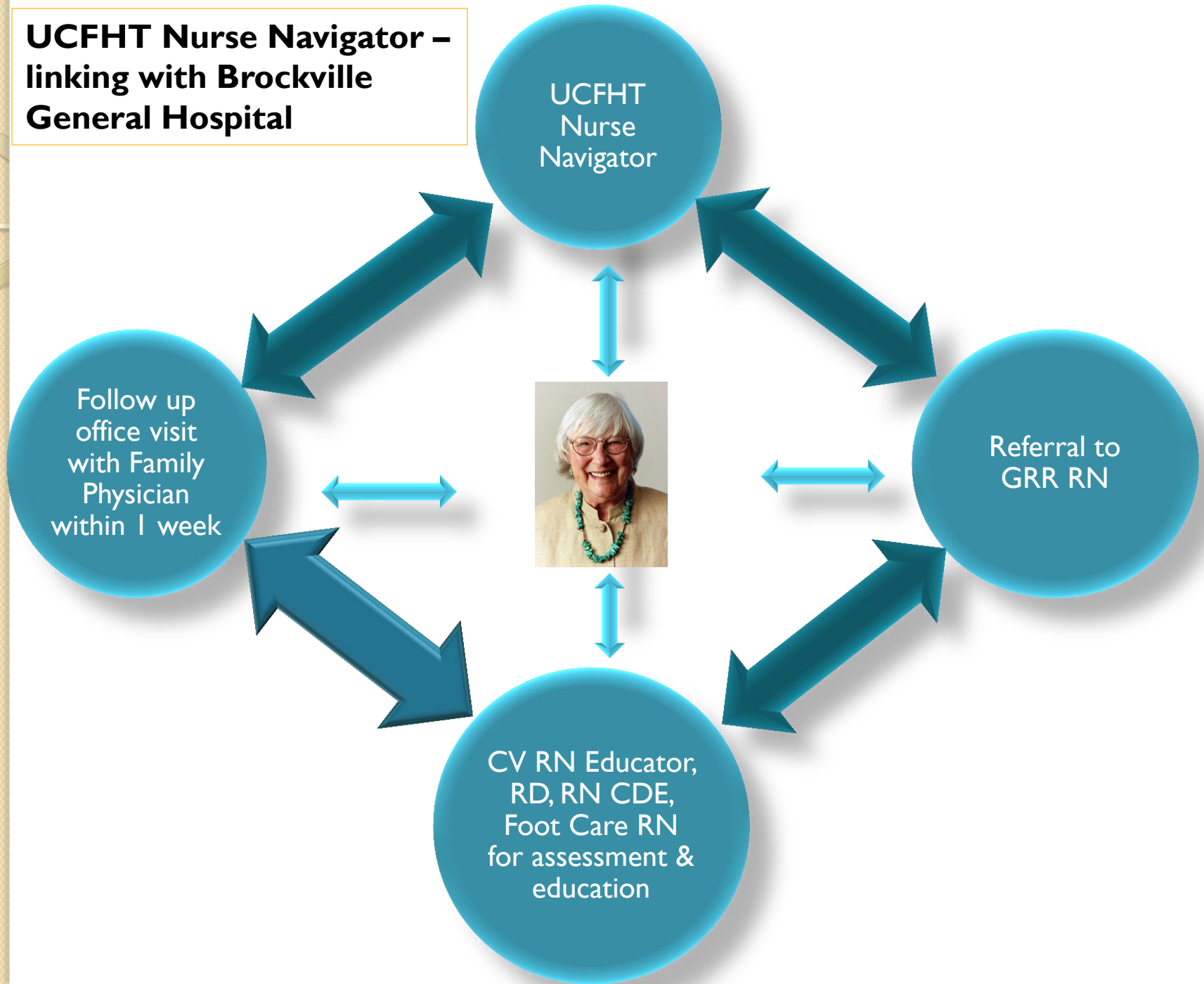
Following an initial EMR review, an initial phone call was made to patient by GRR RN within 24 hrs:

- Patient c/o intolerance to increased dose of medication- rec'd advice re titrating dose
- Reviewed recent BG's & advised re SMBG timing
- Scheduled for office appt. with RN for BP Tru check & health teaching
- Scheduled for appt. with Foot Care RN for assessment & treatment

Following initial visit with RN:

- BP Tru indicated HTN, health teaching done
- Office action to MD re BP results prior to office appt.
- Referred to Reg. Dietitian & Diabetes RN Educator for ongoing support with global risk management goals

UCFHT Nurse Navigator – linking with Brockville General Hospital



Additional Successes!

Straw Bale Gardening:

putting words into action

Our Challenges

- Identifying patients – data collection, limitations of the EMR or data entry
- Lack of awareness
- Inability to measure or document the value of our programs as we can't measure what *hasn't* happened

  E.g.

  1. A patient was prescribed an antibiotic that had severe interaction with warfarin – identified by INR Clinic RN who then notified physician & patient's pharmacy, something that a community lab might have missed, possibly averting a big health crisis!
  2. A patient just dropped by the dietitian's office to say "thanks!" – proudly announcing that he has lost 11 lb, his HbA1c & lipids have all significantly improved since his last visit with her & self-management goals "worked!"

Global Risk Reduction (GRR!) Committee

- In our continued efforts to meet patient needs, the UCFHT has further developed the GRR Program to utilize available resources by collaborating with outside partners.
- Goals promoting healthy outcomes & risk reduction benefit by a systematic approach and standardized visits.
- GRR Committee is multi-disciplinary with active participation by all members who meet on a regular basis.
- Barriers and goals are identified, sharing resources and information to assist with **standardizing patient visits and collection of identifying data**.
- By ongoing development of flow sheets and templates, patients are identified and offered timely intervention to improve global risk management.

How We are Getting There

- Provincial vision of an Integrated Vascular Strategy
- Began in 2009
- Now in implementation phase

Vision and Purpose (June 2010)

The Global Risk Reduction Program assists the patient to navigate along the full spectrum of interventions - from screening and diagnosis, to treatment, education, collaborative goal-setting and follow up.

Working with BFHT and community resources, educators provide the skills and practical tools to assist patients self-manage with the goal of reducing hospital readmissions, return trips to the Emergency Department and unnecessary primary care office visits.

The purpose of these resources is to provide a ***Tool Kit*** for patients at risk, with the emphasis on promoting self-management towards healthy outcomes.

Toolkit Challenges

- Data out
- Data discipline
- Guidelines
- Workflow
- Programming

Resources

- Canadian Cardiovascular Harmonization of Guidelines Endeavour: http://c-changeprogram.ca/
- Shaping the Future of Vascular Health: An Integrated Vascular Health Blueprint for Ontario: http://www.ontariostrokenetwork.ca/pdf/VHCBlueprint_FINAL WEB-EMAIL.pdf
- Stroke Network of Southeastern Ontario: http://strokenetworkseo.ca/
- Vascular Health in Southeastern Ontario: A Focus on Primary Care Report: http://strokenetworkseo.ca/projnewprojects

References

- Microsoft. (2013). *Clip* art. Mississauga, ON: Microsoft Office.

- Stroke Network SEO. (2012). *Vascular health in southeastern Ontario: A focus on primary care*. Kingston, ON: The Stroke Network of Southeastern Ontario. Retrieved from www.strokenetworkseo.ca

Questions & Discussion