VILLAGE FHT METABOLIC PROGRAM

DIABETES AND SERIOUS MENTAL ILLNESS

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VILLAGE FAMILY HEALTH TEAM

Located in Liberty Village in downtown Toronto

Opened January of 2012

About 12,000 patients

Affiliated with the Center for Addictions and Mental Health (CAMH)

Provides primary health care to ~1350 patients living with Serious Mental Illness (SMI) in the FHT catchment area

proud partner of camh

FAMILY HEALTH TEAM

What is a Family Health Team?

Provides primary health care to patients through a multi-disciplinary health care team

Funded by the Ontario Ministry of Health and Long Term Care as a not for profit corporation

Our FHT works with the Centre for Addiction and Mental Health, St Joseph's Health Centre Psychiatry and other Toronto based mental health agencies to improve access and quality of care for patients with mental illness living in the community

OUR TEAM

Village FHTs medical and allied health team includes:

10 Family Physicians

0.2 FTE Psychiatrists

1 Nurse Practitioner

2 Registered Nurses

1 Social Worker

1 Medical Assistant

0.3 FTE Registered Dietician

0.24 FTE Chiropodist

Access of off site publicly funded Physiotherapist

SOCIAL DETERMINANTS OF HEALTH FOR VFHT METABOLIC CLINIC PROGRAM PATIENTS

Have limited:

Financial resources. Virtually all on Ontario Disability Support Program (ODSP)

Access to healthy food choices

Access to fitness facilities

Literacy Skills

Clean and supportive housing (some)

Are Challenged By:

Social stigma attached to diagnosis of mental illness and diabetes

Lack of self-management and self-determination capabilities

May rely on Case Worker to attend appointments

Family support?

METABOLIC PROGRAM – REDUCING BARRIERS

Monitor patients with mental illness and diabetes every three months

On site blood work

Identify those with poor control and ensure more frequent monitoring based on specific needs – what % have poor control?

Identify and manage co-morbid conditions most common being???

Identify and refer for medication evaluation/change or dietary/physical intervention as needed

Identify community resources and develop partnerships

Ensure improved quality of life, increased longevity and decreased amount of hospitalizations in patients with diabetes and serious mental illness – what are the stats?

Help increase patient's understanding of their own illness

Work towards achieving Canadian Diabetes Association targets

Partnered with Optometrist and chiropodist.

CASE STUDY #1: D.C.

Male Age 27 BMI: 35 BP: 136/78

LDL: 1.9 mmol/L

Smokes 1ppd

Referred to VFHT by CAMH. New dx of diabetes while admitted for Schizophrenia

A1C of 13.1 not on any medication. Symptomatic of visual disturbances.

Family doc put on metformin and referred to MC.

HOW THE MC MET D.C'S NEEDS

- Initial assessment and blood work
- Education about diabetes and CDM one on one and in a group setting.
- Introduced to other patients in similar circumstance for peer support.
- Initiated insulin- long acting once daily plus added januvia
- Multiple f/u visits with NP to titrate insulin dosing.
- Closely monitoring borderline BP and lipids
- Encouraged weight loss and smoking cessation
- Foot assessment and rapid access to chiropody.
- At 3 month visit A1C was 6.8%

CASE STUDY #2: T.B.

Male   Age: 47   BMI: 39.2   BP: 120/87

Smoker

Housing: Boarding home/group accommodation

Education level: Partial high school

Income: <$20,000 annual

Marital status: single

Family support: none

Employment status: unemployed

Referred to VFHT by CAMH. Has had DM for >5 years.

A1C of 9.3 when pt joined our FHT.

HOW THE MC MET T.B.'S NEEDS

- Blood work and DM management done on site to limit transit costs.
- Education about diabetes and CDM one on one and in a group setting.
- Introduced to other patients in similar circumstance for peer support.
- Encouraged weight loss by providing pt with community information (gym, swimming pool access, etc) that are free of charge.
- Encouraged pt to utilize local food banks.
- BMI is now 38.5 and last A1C is 6.3%.

VILLAGE FHT DIABETES MANAGEMENT PROGRAM DESIGN

Program Logic Model – used as a guideline

Identified patients with diabetes and SMI using EMR query

Patients divided into groups of 8-10

Created a diabetes registry in the Electronic Medical Record

Establish systematic patient recall process by RNs

Use clinical flow sheets for documentation

Blood work reviewed within X days

Individualized recall process to follow up on abnormal results for one-on-one counseling and/or prompt referral in cases requiring multisystem approach

METABOLIC CLINIC FLOW

Staggered patient arrival times from 9-9:30am

Fasting blood work drawn by medical assistant

In with RN/ NP for one on one assessment (10-15min):

- Biometrics (height, weight, waist circumference)
- BP check
- Foot exam
- Review of blood glucose self monitoring results as appropriate
- Review of smoking status

~10-10:30am Group meets for healthy breakfast & education session topics/activities include:

- Conversation maps
- Interactive arts and crafts to solidify diabetes education points
- Educational videos/ games

~10:30- 11am Group adjourns

DOCUMENTATION: CLINICAL FLOW SHEET

Meet C.S. who has been participating in our Metabolic clinic since 2012.

GROUP VISIT DESIGN

Our group visit design is an evolving process

Group meetings occur every three months

Fasting blood work, blood pressure check and biometrics

- now moving towards non-fasting blood work to help further reduce patient barriers

Feet check for neuropathy, diabetic ulcers and care needs

Group meeting and breakfast (see picture of sample breakfast served)

Discussion of selected diabetes management topics

(see pictures of group in session)

(see models made in group session)

EDUCATION MODELS CREATED IN GROUP SESSION

QUALITY IMPROVEMENT PLAN

Program Objectives	Performance Measures	Performance Targets	Actual Performance
Achieve target A1C for all patients	# of patients with A1C level of 7% or lower	70% of patients achieve A1C at target within the last year	74%
Ensure foot and eye exams are up to date	Documented completion of foot screen and diabetic eye exam	95% of patients have completed eye and foot exams within the last year	Diabetic foot exam: 91% Eye exam: 86%
Increase knowledge of life style decisions and their effect on diabetes as reflected through ongoing participation	Attendance at quarterly clinic	75% of patients attend metabolic clinic on a quarterly basis	85%

FUTURE PLANS

Increase collaboration with CAMH, joint project directed towards improvement of patients' socioeconomic and daily activities needs

Moving towards patient specific and patient centered plans to ensure that they are up to date with CDA guidelines

Provide ongoing access to blood work on site.

Exploring opportunities to ensure that menus served in our patients community housing are optimal for diabetics.

Reaching out to patients to determine any new barriers, re-evaluate existing barriers

- currently in the process of creating an afternoon group session for those who are not able to fast for blood work or for those not able to make it to morning sessions

Work with EMR vendor to improve data quality – Diabetic Measures Report

Increase access for patients that are home bound to complete required Metabolic blood work.

CONTRIBUTORS TO VFHT METABOLIC CLINIC

- Many providers have assisted with the evolution of our Metabolic clinic.
- The Presenters would like to thank the following individuals for their contribution:
  - Oksana Konko, NP
  - Kerry-Anne Ross, NP
  - Marcella Fernandas, RN
  - Jordana Kashin, RN
  - Leticia Oba, Administrator

QUESTIONS