DCPNS

Diabetes Centre (DC) Grant Applications
Priority Areas 2019

Note: The examples given for each of the priority areas are only that, examples. We encourage you to consider other ideas for your Zone/DC that fall within these priority areas.

***Using local evidence to effect a change in programming/approach.**
For example:

- Identify, develop, and measure:
  - The effectiveness of an intervention for a specified quality indicator (foot assessments, eye examinations, BP, lipids, BMI, etc.). For example, review the number of people who self-monitor, determine how many use their results to modify treatment, and then intervene and re-measure after a period of time. This could also be used for activity monitoring (what are people doing now, versus after implementation of the Physical Activity and Exercise Tool-kit), use of the exercise vital sign (in the Registry) to track change over time; use of the My Blood Pressure Card and related materials, etc.
  - An approach for your "complex patients". This should reflect team-based care, including access to a trained mental health therapist and/or approaches to address financial and family stressors, cognitive ability, functional ability, family supports, etc.

Note:

- We would also entertain a proposal to allow focused attention on **improved data capture for a specific population,** e.g., pump patients, individuals ages 20-30 yrs., etc. Grant money could support a student or data entry clerk to work on an area of greatest interest.

*** Preference will be given to DCs using the DCPNS Registry on-site where evaluation metrics can be accessed.**

Increasing program efficiencies and effectiveness.
For example:

- Plan, implement, and evaluate:
  - Engagement of patients/families in the evaluation/planning DC operations/services.
  - An approach to discharge patients who are able to self-manage reasonably well (for example A1C less than 7.5%, good problem solving skills, and routine laboratory measures) and encourage follow-up with their family physician and community supports.
  - A series of group medical visits with an area physician or group of physicians.
  - Group session(s) for insulin dose adjustment; use of advanced pump features; young type 1s; etc., to enhance self-care and promote independency.
  - A brief intervention for all women with types 1 and 2 diabetes in their child-bearing years (15-45) using the pregnancy and diabetes pamphlet. Assess knowledge pre and post and develop follow-up programming as indicated.
  - A video for home use to support patient education/self-learning on a topic of identified need/interest.
  - An approach for the frail elderly population that discusses with the patient and family/care givers the realities of aging and what this means to future diabetes management approaches.
  - Use of a patient-completed follow-up form (does this save time in information gathering and improve patient engagement/involvement in the visit?). Does it allow for more focused discussions on issues of interest to the person with diabetes?
  - A refined case management approach for more complex, difficult-to-manage patients attending your DC. Could you target specifically those that have an A1C > 8.5%?
  - Telephone follow-up for selected patients (for example, those who must travel a distance to attend a DC appointment). The telephone follow up time period could be during the more difficult travel months (November-March).

- Action plans (use of) and phone follow-up/coaching to determine progress in support of self-management.
- A tool to track the types of phone calls leading to areas that could be addressed through a change in practice (new group session) to encourage more self-care.
- A group session for FUV to reduce the number of individual patient visits. (May include an educational topic session, "Ask the Educator" session, patient self-measuring/monitoring stations for B/P, Wt., BG record, etc.) .
- A transition clinic/shared appointment with an adult diabetes specialist.

Modeling chronic disease management through collaboration and integrated delivery models.

- Plan, implement, and evaluate:
  - An interactive risk factor reduction module (e.g., hypertension, weight management, stress reduction, etc.) to be used in conjunction with other chronic diseases (using a shared/rotating delivery schedule).
  - A group medical visit in the office setting.
  - A partnership with the local long-term care facility, continuing care staff, VON, or physician group practice, to discuss diabetes care and aging, specifically as it relates to the frail elderly population.
  - Enhancement of the DC team through new partnership initiatives (shared expertise). For example, work with community partners to develop, implement and evaluate lunch and learn lifestyle sessions in the workplaces within the community. Work with local pharmacists to promote consistent messaging and approach to insulin initiation/adjustment, care of the frail elderly, etc.
  - A program/approach for individuals who successfully self-manage. Determine the best supportive approaches—phone/email/other contact, provision of routine requisitions, clear processes for making own appointment (vs set appointments), etc. This could be formalized phone follow-up visits in lieu of "face to face" appointments for those who continue to meet targets for A1C, B/P, lipids, etc.
  - A community-based patient-education module in conjunction with other partners (i.e., hypertension, dyslipidemia, or stress management). For example, a community-wide schedule could be established (i.e., once per month or every 2-3 months) for a session on hypertension and another session on dyslipidemia. Both sessions would be open to the community, with and without diabetes. These sessions would be advertised to physicians, other health clinics, and community locations (fire hall, radio audiences), etc. (This would be a valuable way to implement group programming in small communities where getting enough people together for a session remains a challenge).
  - A program/service to high-risk patients in a physician/group physician practice setting (case management approach).
  - A community awareness session on Diabetes Management targeting those individuals with diabetes who do not/will not attend the local DC. (Topics may include: self-care practices, need for routine monitoring, lab, eye, foot exams, BG monitoring, understanding and meeting targets, etc.)
  - A service or specific program for a marginalized and/or vulnerable population in your catchment area.
  - A prevention program aimed at high-risk populations.

Enhancing communication/engagement practices/channels (between provider and client and among healthcare providers).

- Plan, implement, and evaluate:
  - The PACIC Questionnaire (assessment of care for chronic conditions) to establish a baseline understanding of your program's approach to patient centeredness in keeping with the chronic care model (CCM). Use the findings from this survey to revisit program approaches and plan for change using the IHI PDSA cycle.
  - Patient/community engagement in Program/service delivery. Engage patients/families (or a subset thereof) in determining program direction and in the design of a specific component or intervention.
  - Client and provider tools to facilitate improved communication (client/patient passports, appointment cards) that clarify what is required at client visits; medication cards that describe why, when, and how to take the prescribed medication; forms/reports to share diabetes related information with home care or LTC facility.
  - Use of the revised hand-held record with a set of patients—does it make a difference in patient engagement, awareness, and involvement in the care plan/approach to treatment.