The Taming of the Queue:

National Invitational Colloquium on Wait Time Measurement, Monitoring and Management

Wait List Management of Diabetes

in Capital Health

Capital Health
Edmonton, Alberta

Capital Health

www.capitalhealth.ca

Capital Health

www.capitalhealth.ca

Presenter: **Marianne Stewart, Senior Operating Officer, Primary Care Division, Capital Health**

Co Authors: Dr. Richard Lewanczuk, Kathleen Ness, Michele Lahey, Angela Estey

Capital Health

www.capitalhealth.ca

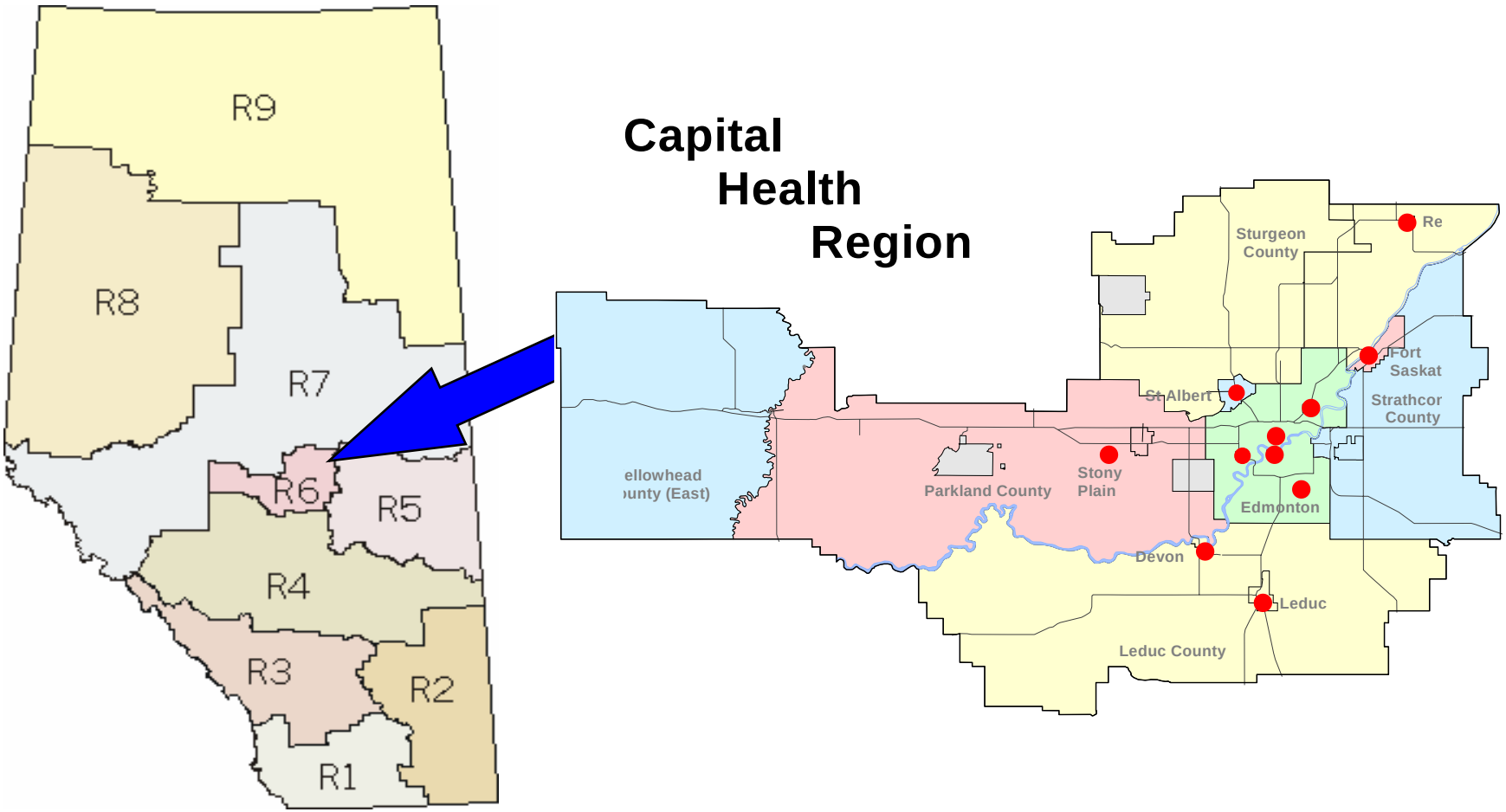
Outline

- Capital Health
- Alberta's Approach to Queues
- Wait List Management of Diabetes in Capital Health
  - Drivers of Change
  - Vision and Model for Diabetes Services
  - Outcomes
  - Next Steps: Rolling Out the Diabetes Virtual Team
- Future Direction for Chronic Disease Management

Capital Health

www.capitalhealth.ca

Capital Health Overview



Capital Health

www.capitalhealth.ca

Capital Health Overview cont'd

Academic Health Region:

- Pop. - 1 m (referral base 1.6 m)
- $2.2 billion budget
- 20,000 staff
  - Northern Alberta's largest employer
- 2,300 physicians
- Full range of health faculties:
  - 520 medical residents/fellows
  - 6,000+ students

Capital Health

www.capitalhealth.ca

Capital Health Overview cont'd

- 13 hospitals
  - 2,600 acute care beds*
  - 110,000 separations annually
  - 450,000 emergency visits annually
- Community Care Services
- 5,700 continuing care beds/spaces
- 22 public health centres / 4 clinics
- Community Mental Health Services
- Capital Health Link (10,000 calls/wk)

** includes psychiatric and adult & pediatric ICU beds*

Capital Health

www.capitalhealth.ca

The Provincial Approach

- Alberta Waitlist Registry
  - Online registry for insured surgeries/procedures
- Booking Services
  - Centralized system to book select services
  - Begin with orthopedics followed by primary health care services via Health Link Alberta

The Provincial Approach cont'd

- Access Standards
  - To establish acceptable wait time standards for selected services:
    - » MRI/CT scans
    - » Major joint replacement
    - » Breast and prostate cancer
    - » Cardiac
    - » Children's Mental Health

Capital Health

www.capitalhealth.ca

Wait List Management of Diabetes in Capital Health

Capital Health

www.capitalhealth.ca

The Problem

- Limited number of physician specialists
- Limited health care resources
- Obesity epidemic (ballooning incidence)
- Aging population

Our current approach to the treatment of diabetes was unsustainable

Capital Health

www.capitalhealth.ca

The Problem: Access to Treatment

Delivery Approach

- **Multiple non-standardized service models**
- **Multiple entry points**
- **Inconsistent definitions and collection of wait time data**
- **No regional coordinated strategy for wait times**
- **No standards for wait times**

Resulting Problem

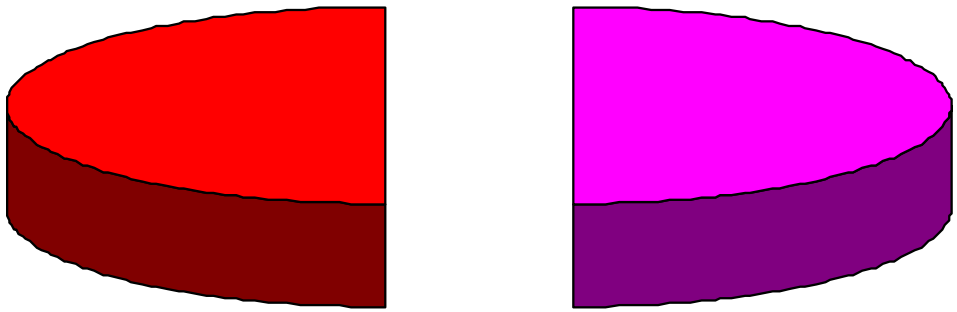
- **Long wait times for service/treatment (4-8 months)**
- **1000 waiting for service/treatment**
- **Limited access - small percent of total diabetes population being seen in diabetes centres**
- **Reached 20% of diabetic population**

Capital Health

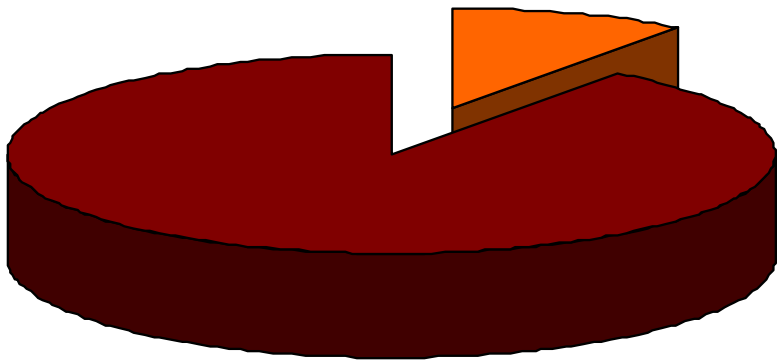
www.capitalhealth.ca

Old System for Diabetes Services

known undiagnosed



excellent care



seen not seen

Problems

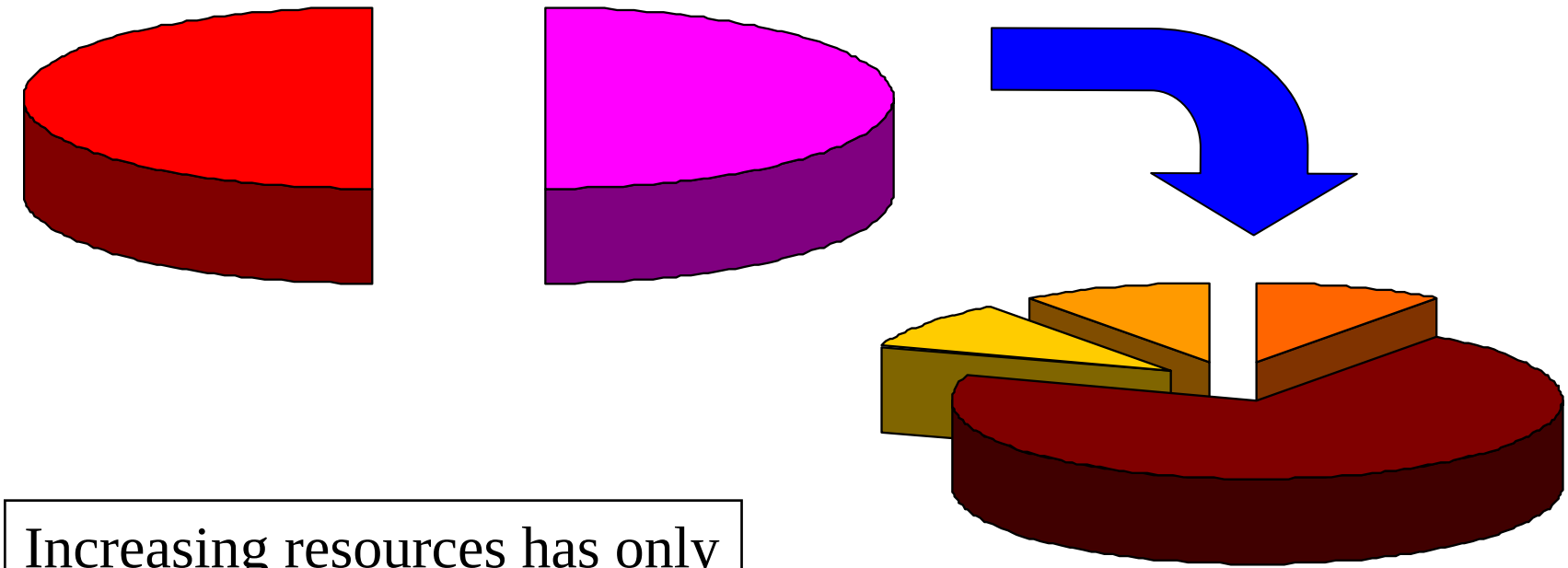
Only small proportion of diabetes population served

Capital Health

www.capitalhealth.ca

Increase Capacity of Old System

known undiagnosed



Increasing resources has only marginal impact

seen not seen

2X capacity 3X capacity

Capital Health

www.capitalhealth.ca

Tripling Capacity

In the Capital Health Region Means:

Current resources:

- 22 diabetes specialists
- 11.1 nurses
- 8.15 dietitians

Tripling capacity:

- 66 diabetes specialists
- 33.3 nurses
- 24.45 dietitians

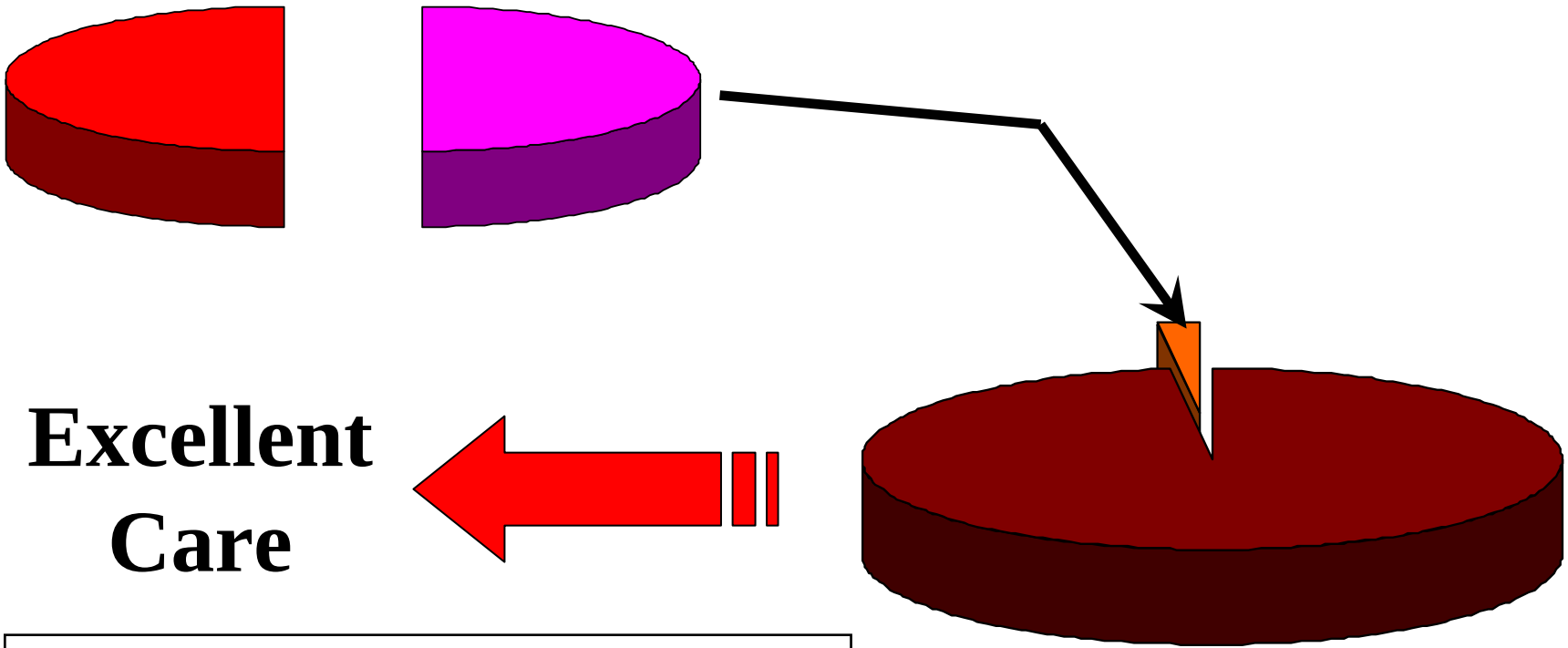
Plus: triple space, triple parking, triple clerical resources, etc

Capital Health

www.capitalhealth.ca

Our Goal

known undiagnosed



Excellent Care

Re-engineering to increase capacity

seen not seen

Capital Health

www.capitalhealth.ca

What We Did

A New Model for Diabetes First Steps

- Establishing physician leadership and involvement
- Conducted a Visioning Session:
  - Attended by key stakeholders
  - Guiding principles developed
  - Led to development of operational model

Capital Health

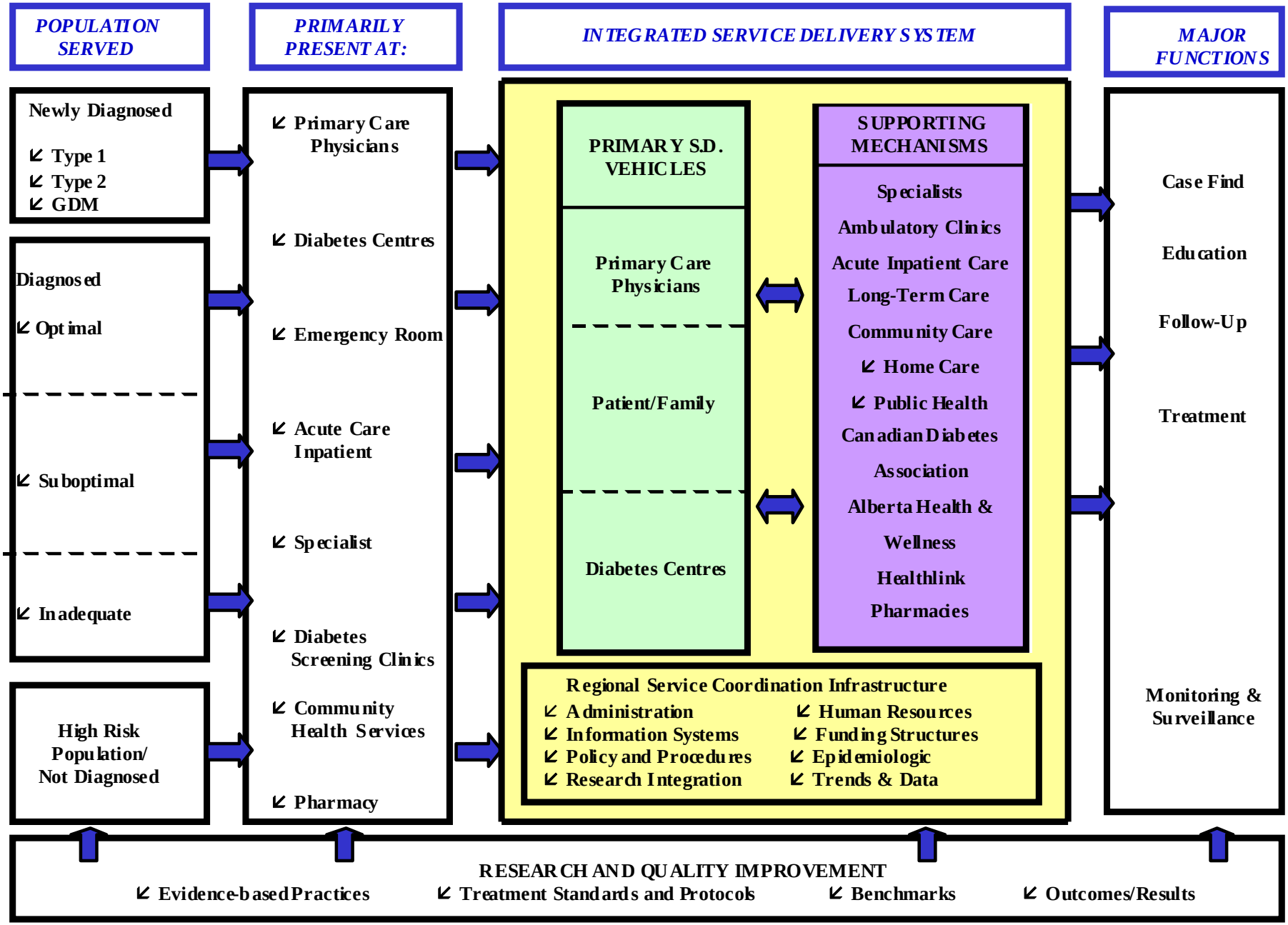
www.capitalhealth.ca

Regional Solution: A New Model for Diabetes Care

Principles

- Use best practice in diabetes management
- Build on recommendations of accreditation team
- Use integrated approach
- Include ongoing stakeholder input
- Develop a responsive monitoring system to drive decision making
- Incremental, planned approach to service change

INTEGRATED DIABETES SERVICES DELIVERY MODEL FOR CAPITAL HEALTH



Capital Health

www.capitalhealth.ca

Regional Solution: A New Model for Diabetes Care

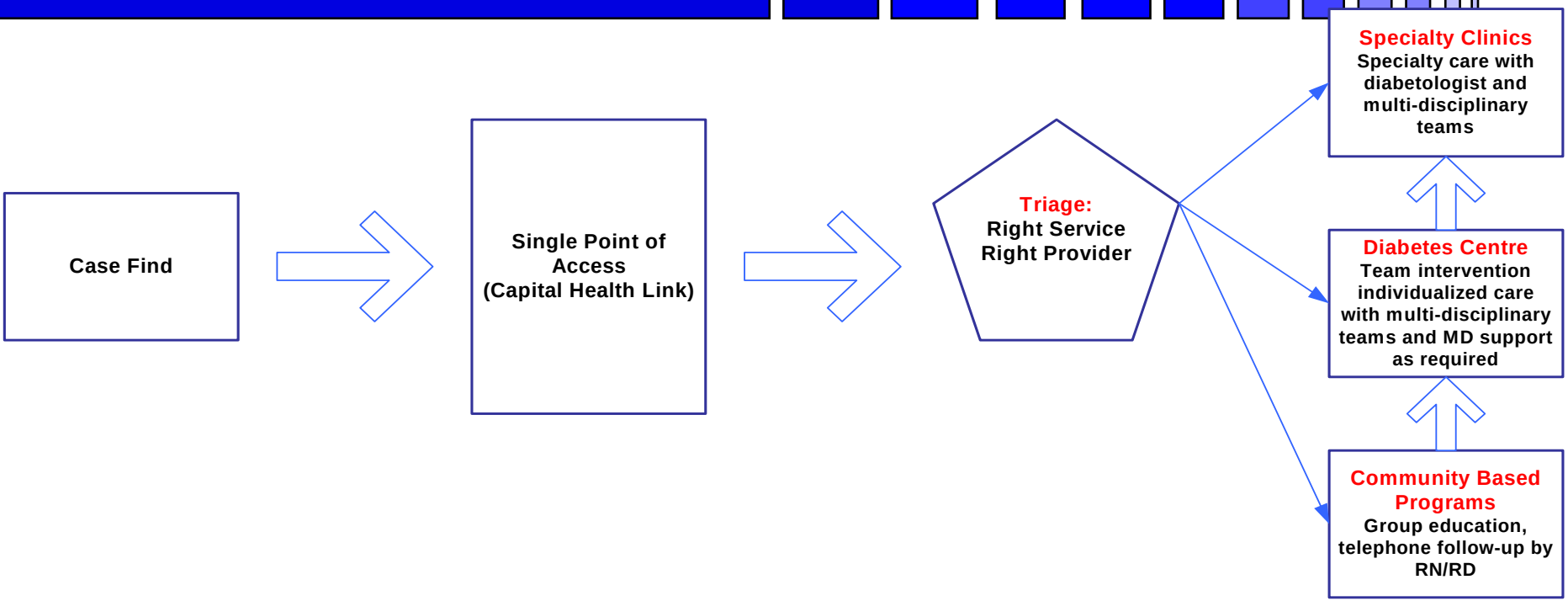
Wait Time Strategies:

- Single point of entry through Capital Health Link
  - Standardized referral process
  - Evidence-based triage criteria for new referrals; developed by clinicians to ensure right provider, right time, right place
- Triage team to ensure integrity/adherence of process (at Capital Health Link)
- Regular monitoring of waitlist - diversion of referrals and waitlist balancing

Capital Health

www.capitalhealth.ca

Chronic Disease Service Delivery Strategy of Progression of Care



Capital Health

www.capitalhealth.ca

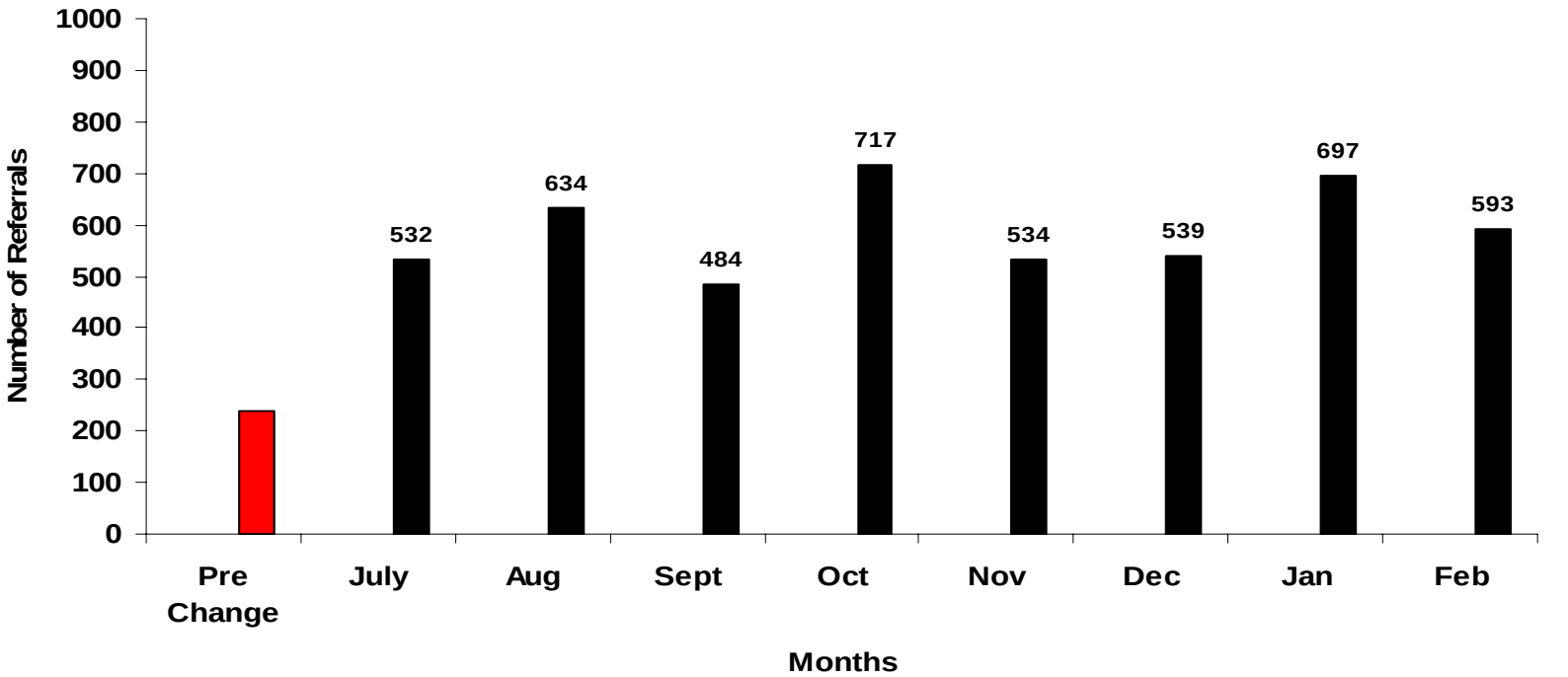
Outcomes

- Reduced wait times
  - Wait times dropped from 4-8 months across the region to 2 weeks
- Increased access
  - From 20% of diabetes population to projected 35% of entire diabetes population in first year
- Tracking costs

Capital Health

www.capitalhealth.ca

Outcomes cont'd



Outcomes cont'd

- Increased capacity:
  - Redirected physician specialists time to focus more on specialty clinics
  - Redirected staff time to provide more comprehensive follow-up of all patients
  - Established a community based diabetes team from existing resources

Outcomes cont'd

- Process
  - Single point of entry - easier access for primary care physicians and patients
  - Standardized processes
  - Evidence based decision making
  - Standardized, timely data

Capital Health

www.capitalhealth.ca

Outcomes cont'd

From the physician perspective:

- Physicians report "they are reassured" patients are now prioritized and seen in timely manner
- More time to do diagnosis and treatment plans
  - Nurses managing the follow-up
- Referring physician commented she was "thrilled" with only one number to call"

Outcomes cont'd

From the physician perspective:

- Appreciate the value of process re-engineering rather than adding resources to an existing system
- "Late adopters" are now suggesting new innovations in diabetes health delivery
- Physicians frequently comment that they would not return to the old system

Capital Health

www.capitalhealth.ca

What We Have Learned

- Plan and monitor change management strategies from the beginning
- Extensive stakeholder involvement is essential when designing waitlist management strategies
- Need strong physician champion

What We Have Learned cont'd

- Need process to deal with existing patients when shifting to new system
- Centralized referral/booking system allowed re-distribution of waitlists between sites and decreased wait times
- Waitlist required - most patients need a few weeks notice for appointment
- Principles to guide decisions are important

Capital Health

www.capitalhealth.ca

Next Steps: Rolling Out the Diabetes Virtual Team

What is the Virtual Team?

- Primary care physicians and providers will have access to a virtual team of diabetes specialists
  - Team includes Physician Specialist, Registered Nurse, Dietitian
    - » With access to pharmacy and social services
- For health regions in central and northern Alberta
- Launching summer 2004

Capital Health

www.capitalhealth.ca

Next Steps: Rolling Out the Diabetes Virtual Team cont'd

- Functions of the Virtual Team
  - Will provide direction, consultation, and promotion of evidence-based clinical management
  - Direct care - registered Type 2 diabetes patients

- Roles of the Team
  - Physicians - diagnose and create treatment plans
  - Other team members:
    - » follow-up and monitor required action between physician visits
    - » refer to other services and programs
    - » refer back to physician if further assessment required

Capital Health

www.capitalhealth.ca

Next Steps: Rolling Out the Diabetes Virtual Team cont'd

- Enabling the Team:
  - Electronic Health Record - access to lab data, discharge summaries, event histories, pharmacy information
  - Soprano software
    - » patient registration
    - » best practice guidelines embedded in the software
  - Symposium Telephony software

- Where is the Virtual Team?
  - Based at Capital Health Link
  - Providing Single Point of Entry

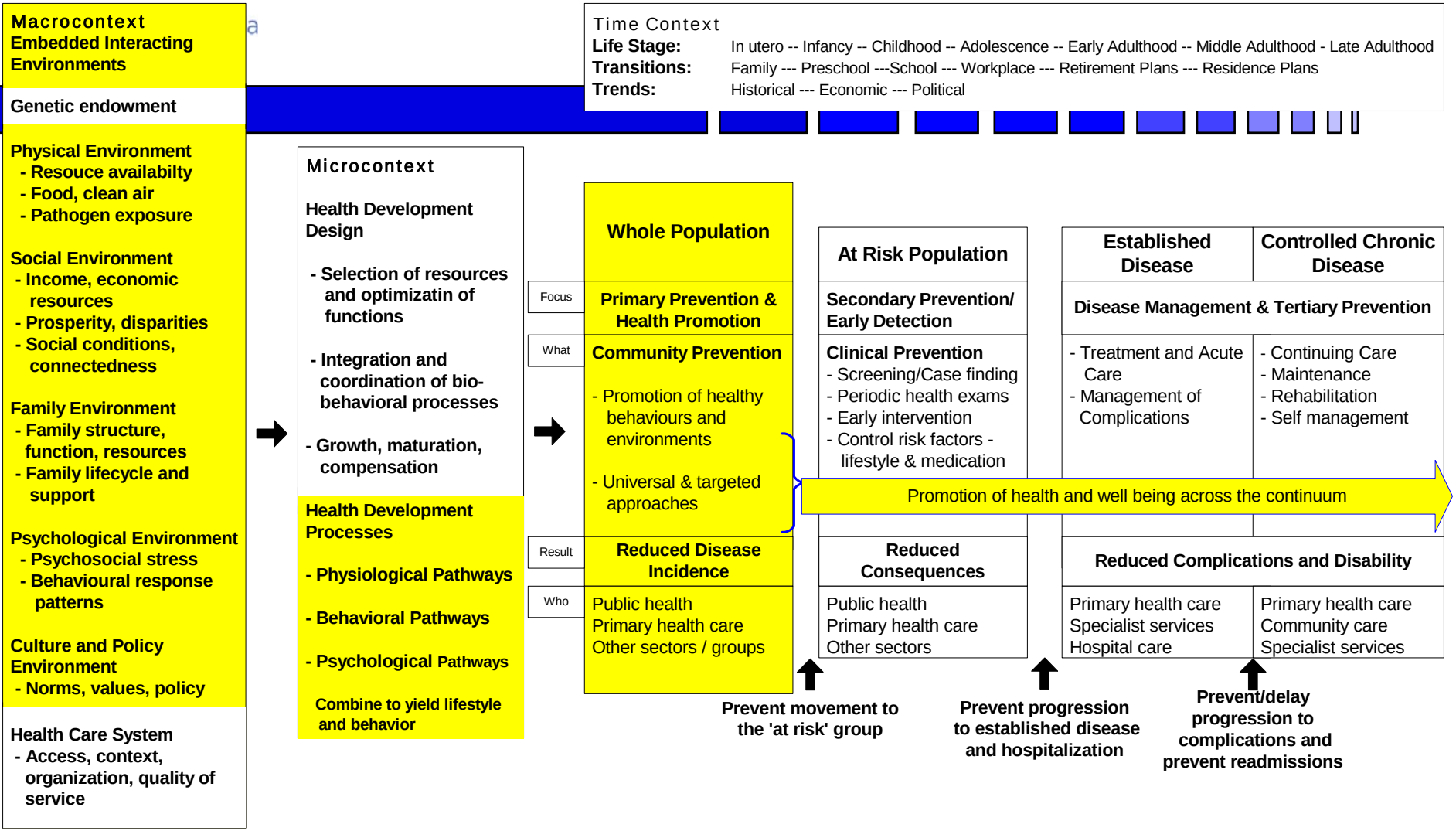
Capital Health

www.capitalhealth.ca

Future Directions

- Physician offices to remotely register patients, can view bookings via Electronic Health Record
- Patients to self-register for education via web
- Rolling out the new Chronic Disease Model

Integrated Chronic Disease*
Prevention and Management Model



*For the puposes of this model Chronic Disease is defined as "characterized by complex causality, multiple risk factors, a long latency period, a prolonged course of illness, functional impairment or disability, and in most cases the unlikelihood of cure."

Reference: Public Health Division, 2003. This model has been adapted from the Australian model referenced in: National Public Health Partnership (2001). Preventing Chronic Disease: A Strategic Framework. Background paper, pp. 4, 9-35 and from Halfon N & Hochstein M. (2002) Life Course Health Development: An Integrated Framework for Developing Health, :Policy, and Research. Milbank Quarterly 80(2).

Capital Health

www.capitalhealth.ca

Future Directions cont'd

Applying the Chronic Disease Model to :

- Cardiac Services
- Orthopedic
- Stroke

Capital Health

www.capitalhealth.ca

Discussion