Virtual Care in High Risk Patients With Diabetes

Objective

To develop a virtual care team focused on people with diabetes at risk for poor outcomes.

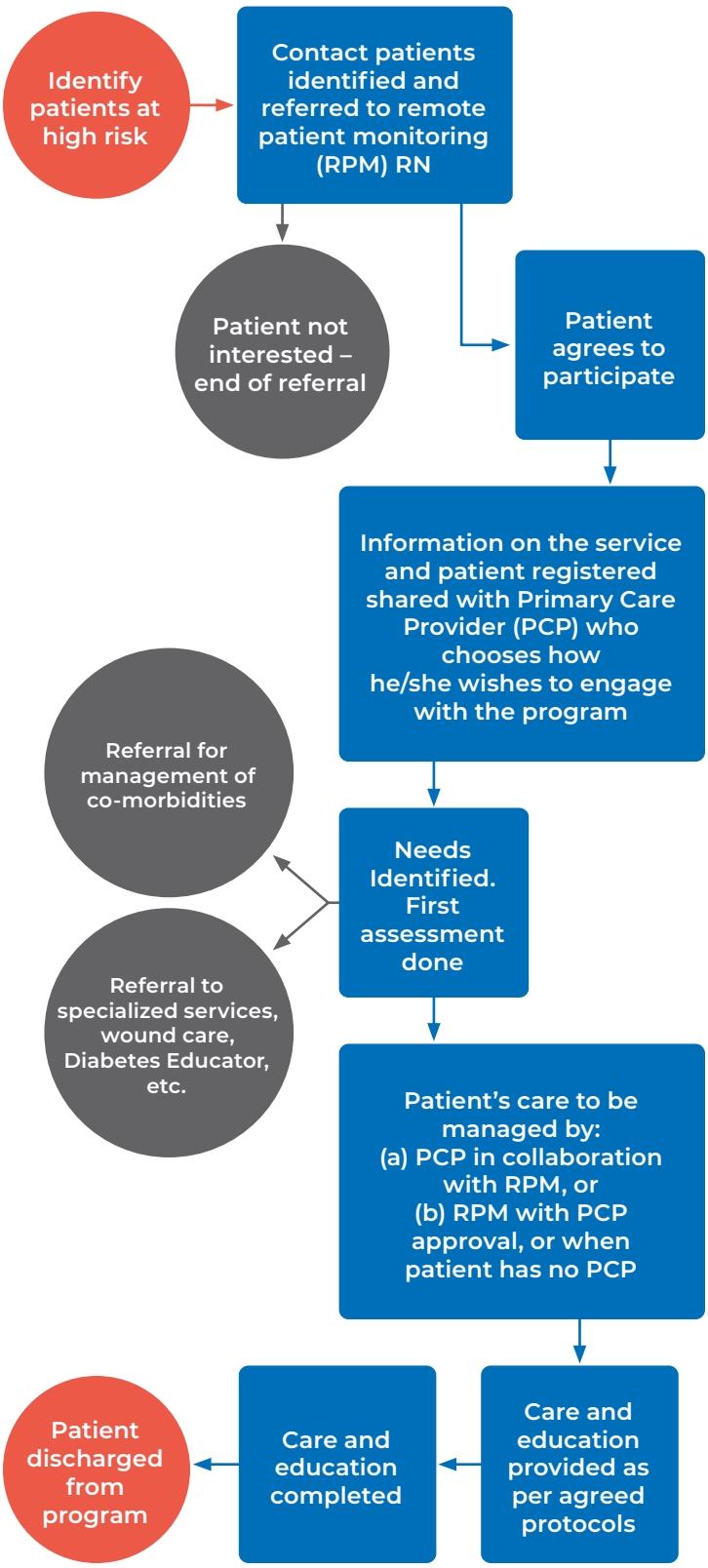
Practice Points

1. People with chronic disease often have gaps in care and challenges with self-management.
2. An effective virtual care team integrating service providers with primary care may address some gaps and support self-management.
3. Innovation is required to achieve true integration across the team and with patients.

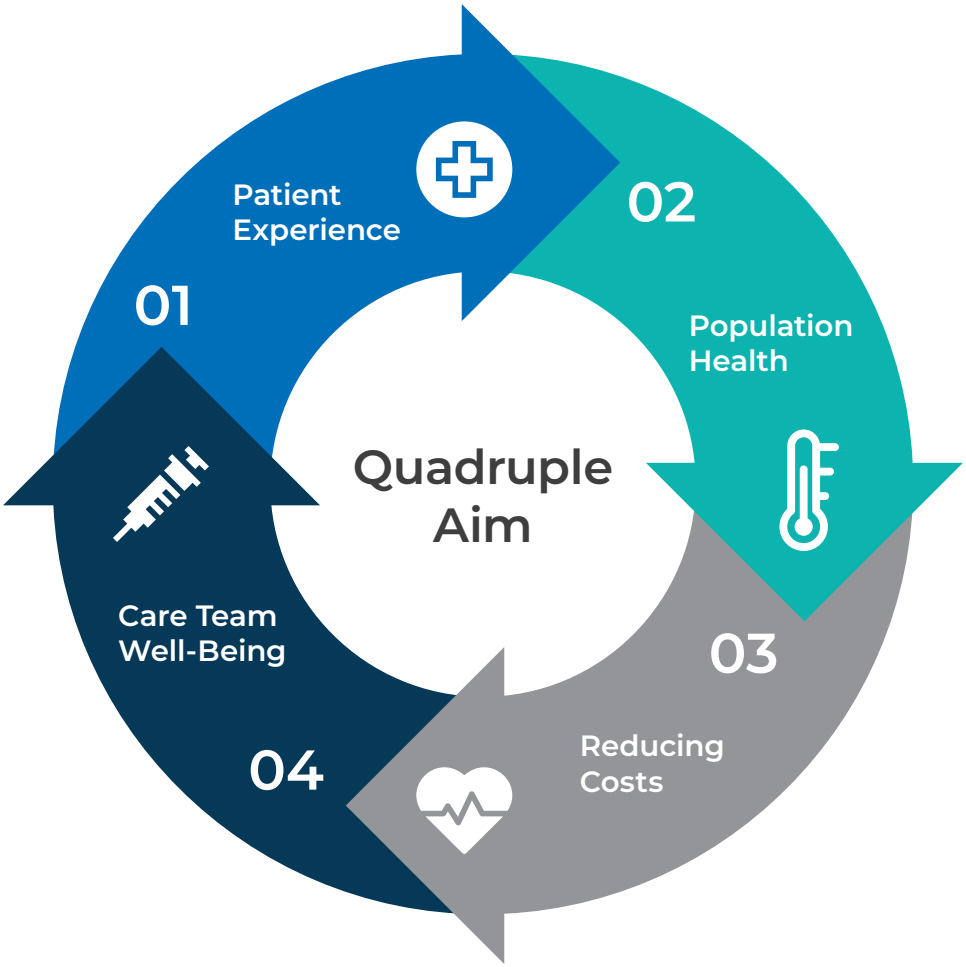
Methods (PI: Dr. B. Barrett)

1. The team will consist of existing resources linked in new ways (Remote Patient Monitoring, Diabetes educators, primary care and specialist physicians, and others such as mental health services).
2. Patients will be identified from existing databases and offered an opportunity to participate.
3. Focus will be on identifying gaps and care needs, prevention of adverse outcomes, team inter-referral and communication using tools such as the e-Health Record (EHR) and e-Medical Record (EMR).
4. Eastern Health, the NL Centre for Health Information (NLCHI) and researchers from the Faculties of Medicine and Nursing at Memorial University are involved. The hope is to expand provincially and to include other chronic diseases over time.
5. This work will be linked to the work of Diabetes Action Canada, the Strategy for Patient Oriented Reseach (SPOR) network, and will engage patients as research team members.

Patient Flow



- The program will be fully evaluated by incorporating feedback from the participants with diabetes and health care providers. The range of outcomes will include process measures, health outcomes, self-reported outcomes, and cost effectiveness.
- The evaluation will be based on the quadruple aim framework.



Conclusions

1. This program is in development and external funding is being sought. The initial pilot phase is expected to last for three years .