Grandview Medical Centre FHT Vascular Clinic

Serving Different Disease States in Primary Care…

Patient Population- recent search

- Large Portuguese population
- Increasing East Indian population
- 2,277 patients with diagnosis of DM
- 4,370 patients with pre-diabetes
- 4,316 patients with hypertension
- 4,646 patients with dyslipidemia
- 3,954 patients identified as smokers

Goals of the Vascular Clinic

- To educate & treat rostered patients with documented vascular risk factors so that they might improve their long-term vascular outlook.
- Improve screening, treating to target and maintaining adherence
- Chronic Disease Model of care (patient self-empowerment, proactive prevention, long-term follow-up, patient is key member of the team)

Important Factors in Clinic design

- Comprehensive risk factor identification & treatment with every referral
- Multiple access points for patients within the system
- Utilize multidisciplinary care providers with various levels of expertise
- Offer combination of classroom (6-10 pts/class) and individual counseling
- Medical Directives for providers to maximize their scope of practice
- Introduce or modify Rx in accordance with most appropriate clinical practice guidelines
- Avoid duplication of readily available services in the community
- Form community partnerships to enhance care

Personnel

- Clerical – Marlena Fernandes & Cristina Sousa
- Dietitians – April Hoover* & Nina Gauthier
- Clinical Pharmacist – Sheryl Horton-Smith*
- Pharmacist/Insulin Therapy – Andrea Main*
- Nurse – Christine Paquin
- Physician Advisors – Jeff Main & Janet Samolczyk

* Certified diabetes educator (CDE)

Access

- GMCFHT MD or AHP, patients can self-refer
- Patients who decline blood work or CV-risk assessment still offered service(s) but are not part of vascular clinic database
- Patients over 85 will be offered service(s) but will automatically be excluded from database
- Services will be offered for 1 year or until all relevant targets are met, whichever comes first
Referral Process

- Physician identifies a vascular risk
- Emails "vascular clinic" and identifies risk(s)
- Patients provided with appropriate lab requisition, baseline data collected & added to the CV Health Manager
- Vascular Nurse does individual review of risk profile with each individual patient
- Vascular Clinic referral added to problem list & sticker to help identify patient in the EMR

Disease States Managed At Vascular Clinic

- Diabetes
- Pre-diabetes
- Smoking cessation
- Dyslipidemia
- Hypertension
- PCOS

Diabetes Clinic

- Goal is A1c at target or maximum 1 yr follow-up
- Exclusion: <18 yrs of age, gestational diabetes, patients on insulin pumps
- All programs taught by personnel with CDE designation

Diabetes Protocol

- 3 classes (2 hours each) in a classroom setting taught by dietitians & pharmacists
- Individual consults available with dietitian for meal plan – encouraged to do both but patients who are not appropriate for class setting (personality, language barrier) may be seen by dietitian only
- Individual consult available for insulin start or medication adjustments (automatically includes referral to dietitian for CHO counting)

Diabetes Classes

- 1st class
  - Etiology of diabetes, lab targets, complications (macro/micro), role of meds, depression screening, SBGM
  - Covers importance of aggressive risk factor management, need for asa, statin and ACEI therapy
- 2nd class
  - Carb counting, meal plans, fibre & fat, label reading
- 3rd class
  - Hypoglycemia, foot care, preventative care, exercise

Diabetes follow up

- Pts expected to see their family doc q6 mo while attending the clinic
- If at target, discharged from vascular clinic & advised to see family doc q4 mo
- After 1 yr, every pt who has gone thru the program will be offered a “what’s new in diabetes” follow-up
Diabetes follow-up

- Every 3 months with individual appointment with dietitian & pharmacist
- Meds to be adjusted by pharmacist under medical directive of physician using latest CPGs (including smoking cessation, statins, antihypertensives, blood thinners & oral hypoglycemic agents)
- Insulin starts, adjustments will be done by pharmacist/CDE
- Rx's will be generated under family doc name by prescribing CDE
- Attached sheet demonstrating pt meets inclusion criteria & pharmacy fax
- Family physician reviews Rx and signs
- Pts advised of 48-72 hr turnover time for Rx

What about insulin therapy?

- OHAs & insulin starts and adjustments done by Pharmacist/CDE
- Pharmacist and dietitian work together with patient
- Insulin time-action profiles, technique & selection of appropriate regime (tailored to pt's individual lifestyle)
- Emphasis on self-titration (pt empowerment)
- Logbook patterning/interpretation
- Recognition & management of hypoglycemia
- Lab targets for sugars, lipids & BP reviewed

Pre-Diabetes Protocol-Revamped

- Demand is growing despite offering 2 classes per month - needed to increase the number of patients offered the program
- Single class format caused “information overload”
- Developed “core classes” which are required & “add on” classes which are optional and offered several times/month
- “Core classes” will have common denominator shared by patients referred for hypertension & dyslipidemia
- Need to ensure follow-up over several months – add in extra visit at 3 months with team and back to GP at 6 months for recheck

Smoking Cessation

- Class offered by pharmacist on twice monthly basis
- Baseline data, blood work & CV Manager risk assessment offered to each patient – not mandatory
- Consists of 45 min group class “Exploring Your Options” followed by individual appt within one week
- Rx generated if appropriate under guidance of medical directive
- Follow up at 1 week, 3 weeks and 7 weeks via phone call

Dyslipidemia

- Target group is Framingham mod/high risk
- Not appropriate for low HDL only pts
- Pts at low risk may still benefit from dietary advice
- 90 minute class taught by dietitian covers
  Types of chl & fats, trans fats, omega 3s, sources of fat in diet healthy cooking methods, fibre, physical activity, effects of smoking & alcohol
  Target levels for HDL and LDL

Dyslipidemia

- Lipid levels repeated at 3 months and if not target, patients will be given follow up appt with pharmacist to discuss medical therapy
- Medication prescribed according to latest CPGs and in accordance with medical directives
### Hypertension
- Aimed at newly diagnosed pts with HBP or pts who are having trouble maintaining control
- Usual data collection, blood work, profile assessment
- 2 hr class taught by vascular nurse covering
  - “what is hypertension” (definition, etiology, target levels)
  - review of cardiovascular risk (IHD, stroke)
  - treatment options with emphasis on DASH diet/lifestyle changes and review of various medications
- BP Tru at 1 month. If not at target, patient given follow up appt with pharmacist to discuss medical therapy
- Target BP is < 135/85 non-diabetic
  - < 130/80 diabetes
- Medication prescribed according to latest CPGs & in accordance with medical directives
- Family doc to initiate therapy prior to class if severe elevation (>180/110)

### PCOS
- Dietitian consult with emphasis on weight management & exercise
- Blood work will include sugars, thyroid function, hormone profile
- Pelvic U/S if none ordered in prior 6 mo
- Follow up with family doc

### CV Health Manager Program
- Tool provided courtesy of Pfizer based on CHIP risk assessment from McGill
- “Database” which can provide both individualized & population-based heart risk
- Estimates CV risk & cardiovascular age & can track changes in CV risk & can demonstrate how individual risk factor modification modifies overall CV risk
- Limitations of CV risk Manager program
  - Inability to identify CV risk of certain patients (pre-diabetes or metabolic syndrome, kidney disease, strong family Hx)
  - Perception of “risk minimization” by physicians

---

If you have any questions, please contact Sheryl Horton-Smith.