BAFHT Chronic Disease Prevention and Management Program Explanation of Services

The Chronic Disease Prevention and Management Program is offered by BAFHT Allied Health Providers (Dietitians, Nurses, Kinesiologists). The program provides disease prevention, disease management, and health promotion education and support.

BAFHT Allied Health providers work with your primary care provider (physician/nurse practitioner) to offer a collaborative approach to care. By using a shared Electronic Medical Record, your BAFHT provider(s) and primary care provider can access your health information and communicate about your care.

We strive to create an environment of trust, safety and meaningful connection with our patients. We understand how care rooted in compassion, curiosity and understanding can help people to heal and stay well.

Patients referred to the Chronic Disease Prevention and Management program will be contacted by a BAFHT administrative staff member to schedule an initial appointment. As a courtesy to your provider and other patients waiting to access our services, we ask that you provide 24-hour notice of cancellation when unable to attend your appointment. This notice allows us to offer your appointment to another patient. As all programs and services offered by the BAFHT are funded by Ontario Health, there is no direct charge to patients to access.

Please be aware that due to privacy limitations, we do not communicate patient health information by e-mail. If you need to contact us, please call our office.

Reason for Referral: Chronic Disease Prevention and Management (heart disease, osteoporosis, fatty liver, PCOS, kidney disease).

The Allied Health Provider will complete a thorough assessment, review any relevant test results and provide evidence-based recommendations to support you to achieve your health goal(s).

Patients can expect a 45-60 minute in-office, video, or phone initial appointment, followed by up to four 30-minute appointments that generally occur over six-months.

Patients who would benefit from or are interested in more extensive nutrition education can consider participation in one of our group programs (i.e. the CHANGE program). Patients with a chronic disease such as diabetes or cardiovascular disease will continue with their regular appointments with their primary care providers in addition to their appointments with BAFHT allied health providers.

Reason for Referral: Diabetes (adults with prediabetes or at risk of developing diabetes, new diagnosis of type 2 diabetes, sub-optimal control of type-2 diabetes)

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The role of the Diabetes Nurse Educator is to provide education, self-management support, and routine monitoring to adults who have diabetes or who are at risk for developing diabetes. Although diabetes is a chronic and progressive disease, with proper management, short and long-term complications due to the disease can be delayed and, in some cases, prevented.

The Diabetes Nurse Educator will complete an assessment, review recent laboratory tests, complete a family history, and identify risk factors for diabetes. They will explain how lifestyle changes, medications, monitoring blood glucose, and regular follow-up can help to improve health and minimize complications. They will work with you to create an individualized plan and focus on your health goals.

Patients can expect a 45-60 minute in-person initial appointment, followed by up to four in-person, virtual, or phone 30-minute follow-up appointments over 12 months. More frequent appointments may be required when blood glucose levels are unstable, or treatment changes are being implemented.

Reason for Referral: Gestational Diabetes
The role of the Diabetes Nurse Educator will meet regularly with the patient to support them in the management of blood glucose levels during pregnancy. They will provide education about the benefits of optimal blood glucose readings for the mother and the baby, healthy eating, carbohydrate awareness, physical activity, blood glucose testing, and optimal blood glucose levels.

Patients can expect a 60 minute in-person initial appointment, with telephone, video, or in-person follow-up appointments scheduled as necessary. Weekly blood glucose readings will be sent to the nurse for monitoring.

Preparing for your appointment with the Diabetes Nurse Educator:
Please note that laboratory testing should be completed prior to the appointment so that results will be available for review.
Please bring an up-to-date medication list including non-prescription medications and bring or upload your recent glucose monitoring results.

Reason for Referral: Nephrology Clinic
The OTN Nephrology Clinic is a specialized clinic that allows patients to be virtually assessed and followed by a Nephrologist to manage chronic kidney disease and other acute kidney concerns, without having to travel to large city centers.

Nephrology Clinic Process
- After receiving a referral from your primary care provider, a Nurse Educator will contact you to book a Nephrology Clinic appointment.

- You will be required to complete bloodwork one to two weeks prior to your appointment and will be asked to bring a list of your current medications to your appointment.
- At your appointment, you will first be assessed by the nurse educator, which may include measuring your blood pressure and weight, reviewing medications, and assessing other relevant symptoms you may be experiencing. You will then meet with the Nephrologist over a video screen for approximately 10-20 minutes.
- Appointment follow-up will be determined by the Nephrologist and coordinated by the BAFHT Nurse Educator.
- Your primary care provider will receive a consultation note from the Nephrologist after each visit and will follow-up with you as recommended.