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Integration Priority & Action Plan:

Preventing and Managing Chronic Illness

October 31, 2006



Preventing and Managing Chronic Illness

Description

While Canadians enjoy relatively good health with one of the highest life expectancies in the world, we have a high burden of chronic diseases, consuming an estimated \$80 billion in health care costs and lost productivity to the economy each year (Health Council of Canada 2005). In Ontario the economic burden of chronic disease is estimated at 55% of total direct and indirect health costs (EBIC 2002). The data within the South West LHIN suggests that the incidence of chronic disease and accordingly the related costs fall within the provincial and national patterns.

With our aging population, the demand for services will continue to increase. Jurisdictions across Canada are responding to the compelling evidence pointing to the importance of effectively managing and preventing chronic diseases, thereby reducing or delaying health system costs and most importantly, improving the quality of life for Canadians as they age.

To accomplish this goal we must shift the paradigm, and view health promotion and disease prevention as important as episodic interventions (such as an emergency room visits or hospital admissions) to treat illness. It requires a commitment by all of our partners – health care providers and consumers —to work toward measurable outcomes that demonstrate a good return on our health investment.

Defining Chronic Disease Management

A chronic condition is an illness, functional limitation or cognitive impairment that lasts (or is expected to last) at least one year, limits what a person can do, and requires ongoing care. Chronic Disease Management is a proactive treatment approach that seeks to support clients in the community to manage their illness and minimize the need for acute episodic care (CHCA 2005). Disease management has also been defined as “a systematic, population-based approach to identify persons at risk, intervene with specific programs of care and measure clinical and other outcomes” (Epstein, 1996).

The goal of Chronic Disease Management is to treat patients sooner, closer to home and earlier in the course of the disease. Primary care providers therefore play a central role. Instead of just treating illness, health care providers focus on wellness strategies and work in a coordinated manner ensuring that patients receive consistent messages and are supported to manage their own care where appropriate. The result is health care interventions that are less reactive and episodic, and more proactive and preventative.

Health care providers must be sensitive to the variation in need across the population. Individuals who face barriers to accessing the health care system due to language, poverty, or multiple health and social needs may require care that is responsive to their unique circumstances. Often



individuals from these populations require a more intensive case management approach given the daily challenges they face due to the lack of social supports available to them. However, flexibility and creativity may also be required to enable individuals to successfully adopt self-management strategies.

The key components of disease management include:

- A inter-disciplinary framework
- An emphasis on health promotion and illness prevention
- Use of evidence-informed clinical guidelines
- Evaluation and outcome measurement
- An approach that is responsive to client needs and fosters client self-management

Effective chronic disease management dovetails with Canada's primary health care strategy which has as its key pillars:

- Healthy living (including a focus on prevention and self-care)
- A team approach to patient/client care
- '24/7' access to the right services when needed; and
- Improved information sharing between health providers and expanded access to information by Canadians (through the use of tools and electronic health records and systems).

A Chronic Disease Framework

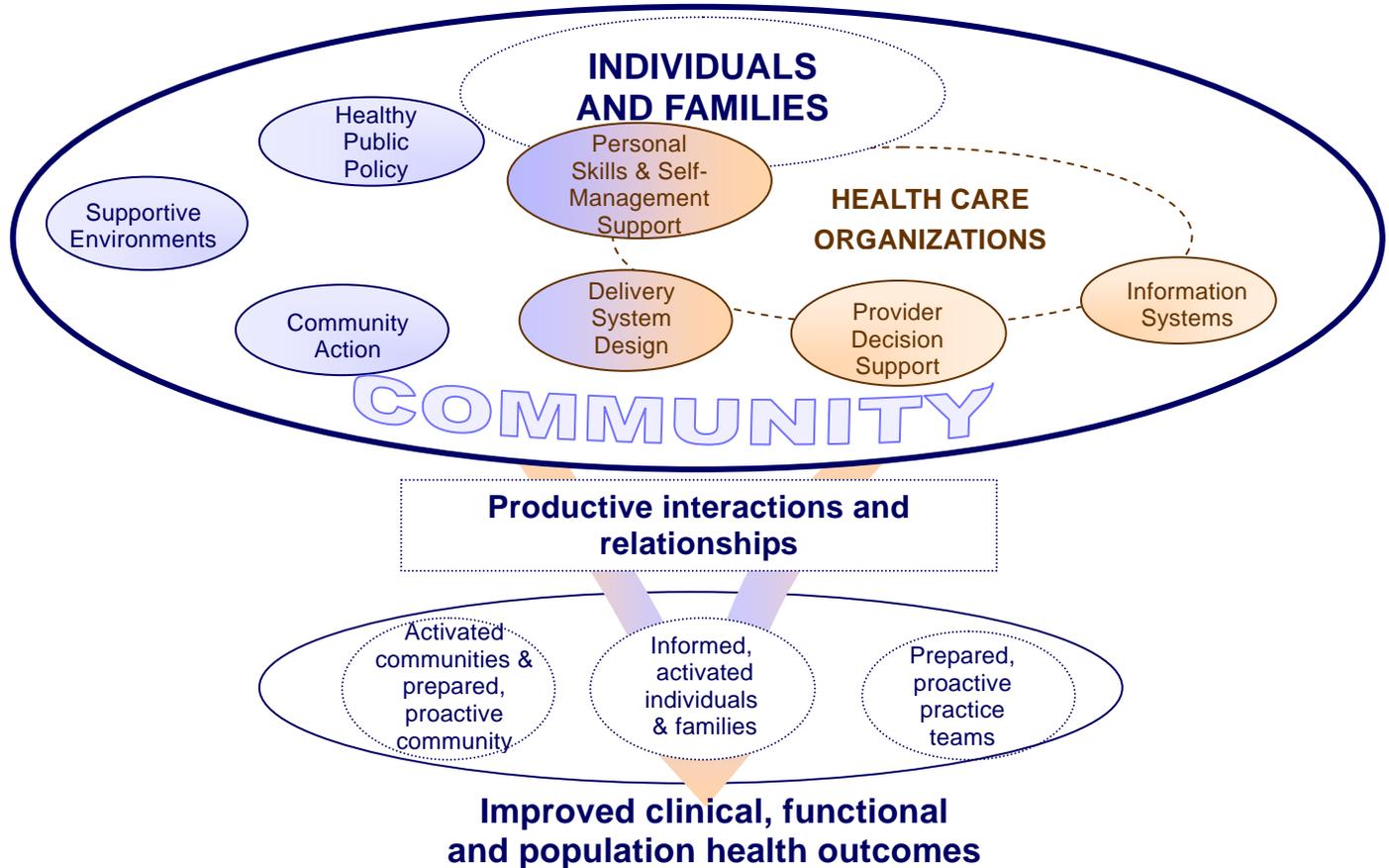
Managing chronic illness through an acute care system will only get limited results. Chronic disease management is a community responsibility managed by family physicians and the network of community-based health and social services to support patients to maximize their health and independence.

"When you leave the clinic, you still have a long term condition. When the visiting nurse leaves your home, you still have a long term condition. In the middle of the night, you fight the pain alone. At the weekend, you manage without your home help. Living with a long-term condition is a great deal more than medical or professional assistance."

Harry Cayton, Director for Patients and the Public, Department of Health (UK, 2005)

Ontario's Chronic Disease Prevention and Management (CDPM) framework is applicable and relevant for all chronic care conditions. The model illustrates that good outcomes (clinical, satisfaction, cost and function) result from productive interactions. To achieve productive interactions, the system must be seamless and provide coordinated care for individuals and their families. The community must work together to address the determinants of health through public policy and supportive environments. Ontario's CDPM framework is based on the Chronic Care Model developed at the MacColl Institute in the United States, which has been adopted in many jurisdictions across Canada and has been associated with improved clinical, behavioral and psychological indicators.

Ontario's CDPM Framework



This model shows that a health system oriented to good chronic care exists in a larger community where the environment, public policy and action influences and supports care delivery. It emphasizes the importance of addressing the determinants of health as integral to chronic disease prevention and management.

Two concepts to ensuring successful application of the CDPM Framework are an integrated delivery system and case management:

Integration

Integration is defined as “the combining and coordinating of separate parts or elements into a unified whole” (Merriam-Webster's Medical Dictionary 2002). The model depicts integration of all the traditional health care silos and the broader community to foster shared responsibility and accountability for health outcomes. Episodic intermittent care is replaced with a commitment to



supporting improved clinical, functional and population outcomes. As part of a system, providers agree to care guidelines and commit to algorithms that outline the nature of interventions by the respective partners. These result in reduced duplication and the most appropriate use of the system and health care providers, at the most appropriate time.

Interactions and relationships span primary health care and specialist services, and cut across sectors and geographies. Integration must consider opportunities to work with partners outside the traditional health care sector areas, such as municipal governments, and provincial ministries responsible for children's services, housing, and economic development.

Key to successful integration is the ability to engage in partnerships and achieve "productive collaboration". The goal for an integrated care system is to develop partnerships in which the partners are able to work with patients interchangeably, with full knowledge of the situation. The partners commit to the team and the patient and assume equal responsibility for the outcomes (St. Onge, 2004).

Collaboration is a process of knowledge exchange and decision-making among interdependent parties. It involves joint ownership of decisions, joint projects and collective responsibility for outcomes. Productive collaboration amongst the team enables:

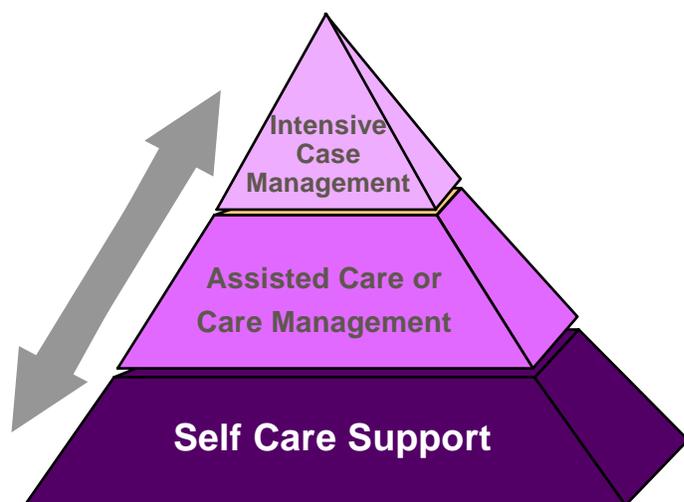
- Better, more coordinated care
- Improved leveraging of resources by bringing the right capability to serve each person's needs
- Improved use of staff on a self-initiated basis, requiring less managerial attention to coordinate the work of teams
- Learning from one another and building on each others' capabilities
- Greater trust and cohesion in serving patients
- A more satisfying work environment (St Onge, 2004)

A productive interaction requires an informed, activated patient and a prepared, proactive team. Informed, activated patients understand their disease process and are empowered self managers of care. The patients take advantage of the clinicians' medical expertise rather than assuming the clinicians will "fix" them. Family and caregivers are equally involved in the management of patient's care.

A prepared proactive practice team is one that has the right information, equipment, and personnel at the time of the visit. Appropriate decision support is easily accessible in order to deliver evidence based clinical care and self management support.

Case Management

Case management is defined as "a collaborative client-driven strategy for the provision of quality health and support services through the effective and efficient use of resources in order to support



Kaiser Permanente, 2005

the client's achievement of goals" (Canadian Home Care Association, 2005). Case management is a strategy employed by all professionals as part of their practice. Case management activities change along the health continuum. At one end, where individuals are able, they self-manage with little support from the formal health care team and social support network. Self management support is the process by which patients learn to cope with the emotional and physical changes that come with their chronic condition. The goal is for the patient to be able to carry out activities of normal daily life. To this end health care providers must understand and respect the

patient's capacity and work with them to realize their goals. Advice must be carefully given and linked to things that are important to the patient, as opposed to the traditional approach of prescribing protocols and expecting compliance. The strategy is to keep individuals informed and activated through regular assessment and problem-solving support.

Case managers / care coordinators provide system navigation and support for patients whose needs are more complex and / or who are experiencing increased health and/or social needs. The complexity of need informs the nature and level of health provider intervention and social supports required.

The features of case management critical to chronic care include:

- Regularly assessing disease control, adherence, and self-management status
- Adjusting treatment and/or communicating need to appropriate team members
- Providing self-management support
- Providing more intense follow-up
- Providing navigation through the health care process

Evidence has shown that case management can improve the quality of life and outcomes for individuals with chronic disease, reducing emergency admissions and enabling patients who are admitted to return home more quickly.

Mental Health & Addictions

Many individuals suffer from co-occurring substance abuse and mental health problems, known in Ontario as concurrent disorders (CD). According to the World Health Organization, addictions and



mental illness account for the greatest degree of disability worldwide. The Canadian Health Network states that 10% of adult Canadians report problems with their drinking and 50% report problems with someone else's drinking. Mental health and addictions are inextricably linked to physical illness. Each dollar spent on the treatment of alcohol use disorders saves between \$4 and \$12 in long-term societal, economic and medical costs.

Medical illnesses such as cardiovascular disease, diabetes, asthma, and cancer are associated with mental illnesses, and the more serious the medical condition, the more likely it is that the individual will experience a mental illness. Conversely, individuals with depressive disorders are about twice as likely to develop coronary artery disease, twice as likely to have a stroke more than four times as likely to have a myocardial infarction (MI), and four times as likely to die within six months of an MI. (Sederer et al, 2006)

People with diabetes are twice as likely to have depression as the general population, and the presence of depression as a co-morbid condition to diabetes is associated with poor adherence to medication regimens, greater complications of diabetes, increased numbers of emergency room visits, and poorer physical and mental functioning. (Sederer et al, 2006). Evidence also indicates that antipsychotic medications are associated with complications such as obesity, high blood glucose levels, and diabetes. The link between medical and mental illnesses thus extends to treatments, not just the diseases. (Sederer et al, 2006)

Furthermore, mental illness left untreated results in decreased functional abilities, increased morbidity and mortality, and increased health care costs (Haslam, Takhar, 2006) Support for the family physician and indeed the entire health and social support team so that earlier interventions are provided improves health outcomes and satisfaction and increases provider satisfaction.

Rationale

What our data tells us:

Almost 80% of Ontarians over the age of 45 have a chronic condition, and of those, about 70% suffer from two or more chronic conditions (CCHS 2003). The South West LHIN has a greater proportion of people with chronic conditions than the provincial average in all conditions except asthma (7.3% vs. 8.0%). The South West LHIN ranks highest among all LHINs (a higher rank indicates a greater proportion of people with a chronic condition) for chronic bronchitis (3.3%).

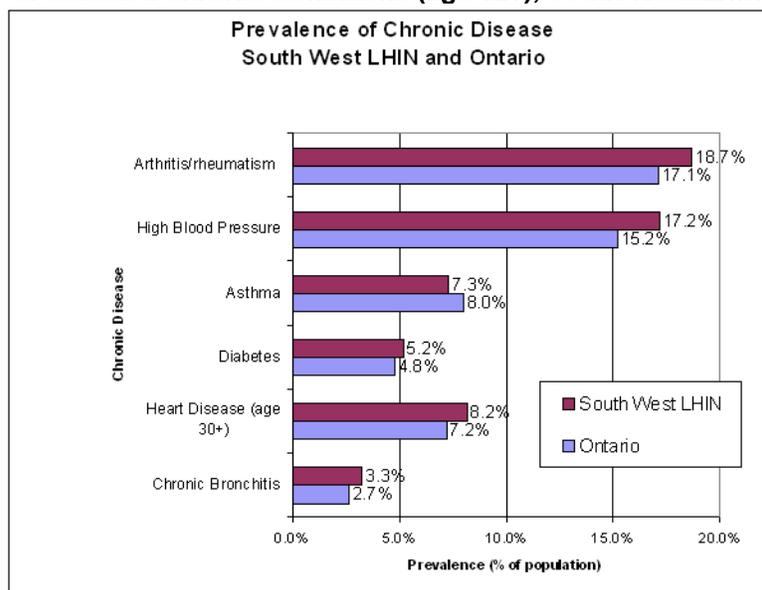
In addition, the LHIN:

- ranks 7th for the proportion of people with arthritis / rheumatism (18.7%)
- ranks 5th for the proportion of people with high blood pressure (17.2%)

- ranks 7th for the proportion of people with diabetes (5.2%)
- ranks 6th for the proportion of people with heart disease (8.2%)

The fact that the South West LHIN exceeds the provincial average in 5 of 6 conditions suggests that the South West LHIN population will need to access the health system to treat chronic conditions to a greater extent than the rest of the province (See Appendix C)

Prevalence of Selected Chronic Conditions (age 12+), South West LHIN and Ontario



Source: Canadian Community Health Survey (2003, 2005), South West LHIN Population Profile; Note: figures may under-represent the number of people suffering from these conditions, particularly among marginalized populations

The South West LHIN has a higher proportion (18.1%) of people who are obese (defined as the weighted number of people with a Body Mass Index greater than 30), when compared to the provincial average (15.1%). The percentage of daily smokers in the South West LHIN is equal to the provincial average of 20.7%. However, residents of the South West LHIN report a higher proportion that are exposed to tobacco smoke at home (8.3% vs 7.3%) and are heavy drinkers (22.0% vs 21.5%).

Mental health problems comprise approximately 30% of primary care patients (Haslam, Takhar, 2006) and mental illness is fast becoming the most common diagnosis in primary care.

Notwithstanding a self-rating of health status score equivalent to the provincial average, other metrics of health status indicate that the South West LHIN population is not as healthy as the province as a whole.



Community Engagement

What We Heard to Inform the Draft IHSP:

The priorities identified by the South West LHIN community partners in 2004 and again in 2006 confirm the need for an effective chronic disease management strategy. Participants described the need for a system to deal with primary and secondary prevention of chronic illnesses across the life continuum, health sectors (e.g. public health, primary health care, home care, acute care) and other sectors through a lifelong system of support (as opposed to episodic reactive interventions). Additional opportunities for improved system navigation were identified across the care continuum and recognized as necessary within chronic disease prevention and management (Summary South West LHIN Priority Assessment February 2005).

While there are a number of initiatives within organizations to improve the prevention and management of chronic disease (and mental health and addictions issues), health care providers agree that they need to:

- Improve partnerships across the health care team and social support network, adopting shared responsibility and accountability for health outcomes of individuals
- Leverage/optimize the health care team and social support network to decrease duplication within the system and use members of the network appropriately for their expertise
- Achieve greater community sector involvement to manage the care closer to home
- Create seamless transitions so that the patients are well and consistently managed
- Improve communications across the team (which includes the consumer) so that all have access to timely and relevant information
- Reach more individuals sooner so that fewer acute, reactive interventions are required in the management of chronic diseases. (Summary of Discussion at South West LHIN Forum, May 12, 2006)

There is growing interest among family physicians to work in interdisciplinary teams. The recent shift in blended payment models has helped family physicians work more cohesively with other health providers. At the May 2006 Family Health Team (FHT) forum within the South West LHIN, participants indicated that they would like more support in Interdisciplinary Team Building Information, Shared Mental Health Care, Best Practice Models (e.g. Diabetes Care, Chronic Disease Management Initiatives) and further exploration of FHT partnerships with Public Health & Community Care Access Centres (South West LHIN Family Health Team Forum, May 17, 2006).

What We Heard to Inform the Final IHSP:

The second phase of community engagement included more than 65 sessions held to gain input from the public, providers, front line workers, as well as special communities such as Aboriginals and First Nations communities, the Francophone community, people suffering from mental illness, and the deaf. The majority of participants were supportive of the South West LHIN's draft priorities,



and many of the same themes emerged from the discussion. Some of the comments and suggestions made by the participants included:

- Recognition that chronic illness occupies a significant amount of resources for acute care, as well as primary care
- The need for better information resources and better education of providers about what is available, how to address co-morbidities and care pathways
- The need to ensure the sustainability of initiatives with appropriate funding, performance management and accountability
- The importance of prevention, particularly education for youth on risk factors and healthy living
- The impact of external issues including housing, transportation, and income, particularly the costs of medication, healthy foods, and exercise facilities
- Suggestion that Aboriginal and First Nations communities had already implemented extensive education and communication programs on diabetes, but there is a need to follow up with coordinated care and better support for prevention from primary care providers
- Recognition that there are several initiatives already underway, including the Grey Bruce CDPM model, school programs and the “PRIISME” program for diabetes education, which is funded from the private sector
- Suggestion that the LHIN look to examples outside the area such as the Calgary model, smartrisk.com and Northern Ontario initiatives

Obstacles to Overcome: What We Heard

- **Challenge to “get the message out”:** Participants highlighted the importance of communications planning in order to support change across the system.
- **Adoption will depend on behavior and culture change:** Participants recognized the need for behavioral changes both by consumers and by providers.
- **Challenges of measuring success:** Some participants expressed concern about the sustainability of the priority action team’s work and highlighted challenges of measuring or monitoring success.
- **Complexity of the problem:** Participants warned about the complexity of a comprehensive chronic disease framework, both in terms of the complexity of dual diagnosis and in terms of partnership and collaboration.
- **Reaching the “hard to reach”:** Challenges of access for “hard to reach” or marginalized people were discussed, as well as challenges of reaching those who often need the services most.
- **Inter-sectoral collaboration:** Connecting across health sectors and with a broader spectrum of service providers was highlighted by participants as a significant challenge.
- **“External influences” that impact prevention and management of chronic illness:** Numerous factors outside of the traditional health care system were described by participants.
- **Human resource issues:** A range of human resource issues were identified by participants.



Strengths to Build On

- ***What We Heard:*** Examples of successful initiatives included:
 - CDPM model currently being developed in Grey Bruce, which could be the basis for a larger LHIN-wide effort
 - “PRIISME” Program for diabetes education (funded through the private sector)
 - Healthy Sugars diabetes education program
 - Community Services Coordination Network (CSCN)
 - Interdisciplinary model of FHTs
 - Diabetic education program at CHC (mental health program)
 - Interdisciplinary team for juvenile diabetes in London
 - VON Meals on Wheels and foot care program
 - Diabetes Education Centres in Huron Perth
 - Ingersoll Cardiac Rehabilitation Program
 - Betty Cardno Centre, which supports a community interested in health
 - WSIB (Toronto) interdisciplinary model
 - Calgary model
 - End-of-life Strategy
 - Mental Health and Addictions directory registry
 - Smartrisk.ca risk and prevention agency

South West Networks

- **Regional Renal Program:** Chronic Kidney Disease is often the result of other chronic illnesses such as hypertension and diabetes. The LHSC Regional Renal Program provides disease-specific education to patients in early stages of chronic renal failure. but prevention through education and lifestyle change before kidney damage occurs is the best solution. The Program sponsors delivery of the “Living a Healthy Life with a Chronic Disease” Program.
- **Regional Cancer Services Alliance:** Cancer fits many of the characteristics of a chronic disease: once a person has had cancer, there are ongoing risks and management strategies that need to be deployed to prevent and monitor the risk of recidivism. The RCSA has completed its environmental scan and established strategic priorities and action plans, and is in a position to apply chronic disease prevention and management principles and strategies to its cancer services initiatives.
- **South West Addiction Services Network:** The South West Mental Health and Addiction Coalition was established with a mandate to provide leadership, stewardship and a unified voice for the addiction and mental health system regarding policy, planning and funding issues that may impact on addiction and mental health services in the South West LHIN. The organization has offered to participate in and act as an information resource for the Priority Action Team.
- **Southwestern Ontario Stroke Strategy:** Beginning steps have been taken through pilot projects with hospital and community partners, including the Blood Pressure Education Pilot Program, the LHSC TIA and Cardiac Rehabilitation pilot project, and integration of other specialty areas into secondary prevention clinic programs. For example Chatham Kent cardiac and stroke nurses work together to provide consistent resources and education in each others’ clinics. Four of the



South West region's stroke centres have partnered with local public health/heart health initiatives in demonstration projects that will demonstrate a systematic approach to evidence-informed practice in primary prevention of stroke. Efforts are underway to establish and support self-help groups, which may evolve into self-management groups.

Other Relevant Evidence

Readiness and willingness to move toward a chronic disease prevention and management model of care with productive collaboration through meaningful partnerships has been identified through formal and informal meetings with health care leaders within all health care sectors across the South West LHIN. Individuals and their organizations recognize the value in changing the way they currently operate and in many cases are willing to see funding shift and to give up a little autonomy in pursuit of more effective care for individuals who have chronic illnesses.

In fact, many organizations have begun to implement chronic disease management initiatives within their organizations and are reaching out to strengthen the partnerships with other members of the health team. However, regulation, funding and uncertainty about whether such activity will be approved currently compromises this agenda.

Overview of Action Planning

The goal of the South West LHIN is a proactive approach to address chronic disease that promotes health among all age groups and supports individuals in managing their illnesses. Our priorities for planning therefore include:

- Achieving improved linkages across the health care continuum and social support network
- Redesigning the system with a shift to long-term support of individuals with chronic illness that is directed toward improving health outcomes
- Adoption by health care practitioners and social service professionals of best practice guidelines
- Achieving improved health outcomes

We will need to involve partners across the social and health care continuum, including those involved in prevention and health promotion, primary and community care, rehabilitative care, and acute care. Coordination will also be needed across the system to avoid “disease silos” in the implementation of a chronic disease prevention and management framework, and to find the appropriate balance between strategies focused on risk factors (e.g. smoking, obesity) or specific diseases (e.g. heart disease, asthma).

Input from providers to date has suggested the need for a dual approach which balances a focus on specific conditions or diseases with an emphasis on risk factors and prevention. While it was recognized that the biggest impact in the short term might be among those currently suffering from

chronic illness or with a high potential for re-occurrence, it was understood that the greatest long-term benefits would come from prevention initiatives. The Priority Action Teams will need to examine both approaches in detail and identify opportunities to have an impact in the short, medium and longer term

Action planning will build on work that is already underway, both provincially and locally. Implementation will be introduced in a phased manner, leveraging local partnerships and ensuring alignment with the provincial agenda of the Ministry of Health and Long Term Care (MOHLTC) and the Ministry of Health Promotion (MHP). The South West LHIN will work towards coordination across disease strategies with the following two action plans:

1. Develop and implement a comprehensive chronic disease prevention and management program across the South West LHIN.
2. *QUICK START*: Implement a chronic disease management program for individuals with diabetes including those with mental health co-conditions, through a selected number of “pilot initiatives” across the South West LHIN.

Performance Outcomes and Measures

These outcomes and indicators are preliminary and will be discussed and refined by the Priority Action Team. The indicators *italicized* are not represented in the Ontario Local Health System Scorecard and should be viewed as developmental until further work is complete and a determination of their ability to measure is made.

Short Term Outcomes (1 to 3 Years)	Medium Term Outcomes (4 to 5 Years)	Long Term Outcomes (6+ Years)
<ul style="list-style-type: none"> ○ Increased consumer and family awareness of the availability of CDPM services ○ Increased provider awareness and knowledge of CDPM practices and services ○ Increased number of and access to PHC teams delivering CDPM 	<ul style="list-style-type: none"> ○ Increased coordination across consumers, physicians, and allied health professionals ○ Increased application of evidence-informed practice guidelines ○ Reduced unnecessary hospital admissions ○ Reduction of CDPM “disease silos” 	<ul style="list-style-type: none"> ○ Adoption of common CDPM care pathways across the LHIN ○ Increased community-based care delivery ○ Increased involvement by the health team in health promotion



Short Term Performance Indicators	Medium Term Performance Indicators	Long Term Performance Indicators
<ul style="list-style-type: none"> ○ Number primary health care teams delivering CDPM ○ Number of patients registered in PHC groups that focus on CDPM ○ Number of Service Level Agreements with CDPM focus ○ Percentage of Emergency Department visits that could be managed elsewhere ○ Percentage of cases being treated according to CPGs (diabetes specific) ○ <i>Awareness indicator for Consumers</i> ○ <i>Knowledge indicator for Providers</i> 	<ul style="list-style-type: none"> ○ Improved A1C ○ Risk factors for chronic disease ○ Readmissions rates ○ Percentage of cases being treated according to CPGs ○ <i># orphan patients with chronic diseases</i> ○ <i># patients reporting seeing a regular allied health professional for CDPM</i> 	<ul style="list-style-type: none"> ○ Readmission rates for selected chronic conditions ○ Regular provider of diabetes care ○ <i>Health team involvement in health promotion</i>



Action Plan #1

Objective

Develop and implement a comprehensive chronic disease prevention and management program across the South West LHIN.

Description

Using Ontario's CDPM framework, design the chronic disease prevention and management South West LHIN service delivery model with an emphasis on partnering and redefining organizational scope to enable effective community-based care for consumers with chronic disease. Recommendations will identify formal and/or informal arrangements and agreements that clarify leadership, membership, roles and responsibilities of all sectors within the health care team and social support network in order to provide effective chronic disease prevention and management.

The development of a CDPM service delivery model will:

- Make use of the academic health science centres as a resource to inform the health and social service community of leading practices within chronic disease prevention and management.
- Foster adoption of evidence-informed practice guidelines throughout the South West LHIN by disseminating new knowledge and acting as a resource to the broader health and social service community.
- Identify opportunities for coordination and collaboration in order to prevent the development of “disease silos”
- Incorporate ongoing evaluation and a commitment to clinical and other best practice improvement within the model.
- Support healthcare practitioners to promote patient empowerment and the acquisition of self-management skills

Information technology will be an important enabler of an effective chronic disease prevention and management strategy in the South West LHIN. The service delivery model should include the strategy for implementing electronic solutions that reduce variability in process and paperwork to ultimately reduce workload and gain efficiency of process, access to information and communication across the network.

Deliverables – Years One to Three

Year 1 Deliverables:

- Establish a cross-sectoral Priority Action Team with wide representation from across the health system to provide leadership and enable innovative thinking as it:
 - Conducts a detailed environmental scan and analysis, including a:

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- Needs assessment and analysis of current services that enables leveraging current excellence in service delivery
 - Review of existing programs and services to identify duplication and opportunities for improved efficiencies and effectiveness
 - Gap analysis by geographic area
- Engage providers, consumers and the public in order to get a detailed understanding of the strengths, challenges and issues facing this target population and their caregivers
 - Conduct any further research to ensure the most appropriate service delivery model recommendation
 - Develop recommendations for the chronic disease prevention and management service delivery model, including:
 - Implementation strategy
 - Communications plan to enable and support collaboration across providers
 - Opportunities for inter-Ministerial collaboration or coordination
 - Develop recommendations for the first two areas of focus (conditions, chronic diseases, groups of diseases or risk factors) to be jointly addressed by the recommended service delivery model.

Year 2 Deliverables:

- Develop detailed action plans for implementation of the chronic disease prevention and management model
- Determine the most appropriate approach to handle each of the following:
 - A detailed review of the transportation implications of the proposed model
 - Team building and educational support to clinical teams and partners (privately and/or publicly-funded) regarding the specific population targeted
 - Development of a framework for expert panels that will be responsible for the establishment of practice guidelines, minimum data sets and algorithms
 - Expansion of the participation of family physicians partnering with home and community care
 - Clarification of the roles of the broader health care team and social support network and securing their commitment to participate
 - Obtaining commitment to adopt the care guidelines and algorithms across the LHIN
- Identify new chronic conditions on which to focus the model
- Initiate educational support for the broader health care team across the South West LHIN on effective strategies that foster the self-management of a chronic disease
- Identify information management and technology needs which will enhance service delivery and management.
 - Link to appropriate Steering Committee to address e-Health needs going forward.



Year 3 Deliverables:

- Execute detailed implementation plans as appropriate
- Implement system-wide performance management program
- Enhance the disease specific wellness programs to achieve integration and collaboration on prevention initiatives
- Add two new chronic conditions to the chronic disease management program
- Conduct a comprehensive evaluation of the program
- Bring the physician engagement in the program to 50%

Performance Outcomes and Measures

The Priority Action Team will develop specific outcomes and indicators for this Action Plan building on the preliminary scorecard for the priority and the work of the Preventing and Managing Chronic Illness Expert Panel held on October 2, 2006.



Action Plan #2

Objective

QUICK START: Implement a comprehensive chronic disease management program for individuals with diabetes including those with mental health co-conditions, through a selected number of “pilot initiatives” across the South West LHIN.

Description

A quick start program for diabetes will leverage existing work in South West LHIN, across Canada and beyond. There is momentum, interest and initiative being undertaken amongst the providers within the South West LHIN to more effectively support individuals with chronic disease. Building on this good work and applying the lessons learned by the Canadian Home Care Association’s National Home Care and Primary Health Care Partnership Project will allow providers and most importantly clients to experience positive results quickly.

At least one of the selected pilot initiatives should focus specifically on strategies to support diabetes patients with co-morbid mental health condition. People with diabetes are more likely to suffer from depression, and this has been associated with poor adherence to medication regimens, greater complications of diabetes, increased numbers of emergency room visits, and poorer physical and mental functioning.

Deliverables – Year One to Three

Year 1 Deliverables:

- Establish ‘Quick Start’ Priority Action Team to focus on:
 - Educational support to clinical teams regarding diabetes, team building and chronic disease management
 - Commitment for home and community care to support people with diabetes
 - Development of partnerships between family physicians and CCAC case managers achieving at least one partnership within each pilot location
 - Clarification of the roles of the broader health care team and commitment to participate
 - Comprehension of practice guidelines for diabetes care and establishment of care algorithm for initiative
 - Functioning partnerships between family physicians and CCAC case managers
 - Increased use of clinical practice guidelines by all participating providers
 - Adoption of care algorithms, workflow processes and forms across all teams involved in the diabetes quick start program
 - Clearly understood expectations by providers and individuals living with diabetes
 - Agreement to standardized forms amongst local teams
 - Leveraging of professionals so they spend time on the work they are trained to do

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- Objective evidence of improved compliance to care guidelines and health outcomes
 - Focus on the 'whole' consumer and deal with co-morbid conditions – diabetes and mental health
 - Evaluation indicators and plan

Year 2 Deliverables:

- Priority Action Team continue to focus on:
 - Development of a framework for expert panels which will be responsible for establishment of practice guidelines, minimum data sets and algorithms
 - A comprehensive evaluation of the initiative including measurement of practice against clinical practice guidelines
 - Dissemination across all organizations within the South West LHN of the established clinical practice guidelines and care algorithms for people living with diabetes
 - Establishment of a reporting framework
 - Commitment to adopt the care guidelines and algorithms across the LHIN

Performance Outcomes and Measures

The Priority Action Team will develop specific outcomes and indicators for this Action Plan building on the preliminary scorecard for the priority and the work of the Preventing and Managing Chronic Illness Expert Panel held on October 2, 2006.