
Champlain Local Health Integration Network

Joint Diabetes, Heart and Stroke Chronic Disease Prevention and Management Planning Session

REPORT for THE CHAMPLAIN LOCAL HEALTH INTEGRATION NETWORK

Ottawa, ON
July 22, 2008



Prepared by:
The Intersol Group
205 Catherine, Suite 300
Ottawa, Ontario K2P 1C3
Tel: 613.230.6424
Fax: 613.567.1504

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CHAMPLAIN LOCAL HEALTH INTEGRATION NETWORK JOINT DIABETES, HEART AND STROKE CHRONIC DISEASE PREVENTION AND MANAGEMENT (CDPM) PLANNING SESSION JULY 22, 2008 – OTTAWA, ON

MEETING OBJECTIVES

The Champlain Cardiovascular Disease Prevention Network (CCPN) is a group of health and community partners dedicated to reducing the burden of heart disease and stroke in the Champlain region. The CCPN was formed in November 2005 to provide leadership for the implementation of a five-year Cardiovascular Disease (CVD) Prevention Strategy designed to eliminate disparities in CVD risk and ensure the residents of the Champlain District the most heart healthy and stroke-free in Canada. .

The CCPN is one of a number of key community of practice networks within the Champlain Local Health Integration Network (LHIN) that are keen to begin to plan a Champlain Vascular Strategy.

The Champlain Vascular Strategy aims to coordinate efforts in common areas related to heart disease, diabetes, stroke and kidney disease. To this end, stakeholder representatives met for a one day planning session on July 22, 2008 in Ottawa. The list of participants is included in Appendix A of this report.

The objectives of the planning session were:

- To develop a shared understanding of the current projects and priorities of each of the participating members of the Vascular Strategy communities of practice;
- To identify at the initiative level, where synergies exist;
- To identify priorities for action; and
- To identify the next steps to move forward.

What follows here is a report from this planning session. The report is intended as a record of the meeting, to be used by participants in planning and implementing initiatives to support the Champlain Vascular Strategy.

CURRENT INITIATIVES

A series of short presentations provided participants with background information on various initiatives currently underway in the Champlain region.

CHAMPLAIN LOCAL HEALTH INTEGRATION NETWORK (LHIN)

Karen Patzer

The Champlain LHIN is aligning its strategy with the Ontario provincial strategies: the E-Health Strategy (Electronic health record); the Diabetes Strategy; and the forthcoming CDPM Strategy. The Champlain LHIN has been selected as an early adopter LHIN for E-health and will be moving forward with the



development of a diabetes registry using portal technology. The Champlain LHIN CDPM Strategy would include the following elements: prevention and promotion; optimizing diabetes management (the Ottawa Model); the integration of self-care at each level of care; the development of a diabetes registry as an enabler; and measurement and reporting on progress. The Champlain LHIN is targeting the achievement of key milestones for the diabetes registry by April 2009.

STROKE NETWORK

Dr. Michael Sharma

In June 2000, the government adopted the report entitled *Towards an Integrated Stroke Strategy for Ontario*; the Ontario Ministry of Health and Long-Term Care (MOHLTC) provides \$30 million funding to support various initiatives such as health promotion, stroke prevention clinics, best practices for stroke rehabilitation and other programs. The development of a sodium guideline (www.sodium101.ca) represents one example of success in the area of prevention. In addition, significant progress was achieved in this region to support stroke prevention and to improve stroke management in patients.

CHAMPLAIN CARDIOVASCULAR DISEASE PREVENTION NETWORK (CCPN)

Sophia Papadakis

The CCPN was formed in 2005 to reduce the burden of heart disease and stroke in the Champlain region. The Network has 14 partner organizations and is supported by a board of directors, a project management team and five expert panels. Six priority initiatives are being undertaken in the following key areas: primary care, specialty care, hospitals, schools, workplaces and communities. The Champlain Hospital-based Smoking Cessation Network (the Ottawa Model) has been identified by Ontario as a leading practice in the area of prevention.

DIABETES NETWORK

Dr. Erin Keely

The Diabetes Network in Ottawa-Carleton was formed recently and is not currently funded; members of this network include providers and administrators. The importance of self management and self care in this area is recognized. While the Network has established priorities and a collaborative process, specific initiatives under each priority remain to be determined. Timely access to services, enhancing the availability of information about services offered, E-health, professional development for providers, effective communication between stakeholders and collaboration with other regional networks represent some of the priorities identified.

OTTAWA HOSPITAL

Dr. Jim Worthington

The Ottawa Hospital has been involved extensively in various programs of the CCPN, stroke, diabetes and chronic kidney disease networks. It also supports continuity management across the various disciplines and recognizes that supporting the primary care physicians represents a priority. The Ottawa Hospital is also looking broadly at how it can best support the Champlain LHIN.



PRIMARY CARE

Dr. Jacques Lemelin and Dr. Renée Arnold

One of the challenges in this area is that primary care represents many physicians working on their own in various communities. Other countries such as the United Kingdom and Australia have created organizations around primary care practitioners; this represents an interesting model. Obtaining funding to support E-health initiatives, ensuring that each person has a family physician and providing access to a network of specialists for primary care practitioners represent some examples of key areas where a difference can be made.

IDENTIFICATION OF GAPS AND OPPORTUNITIES

PRE-MEETING QUESTIONNAIRE

Prior to the meeting, a questionnaire was sent to participants to identify current programs and services, to solicit input to identify gaps, opportunities and priorities as well as elements that would support a joint strategy. The results of the questionnaire were compiled and are included in Appendix B of this report.

GAPS

During a plenary discussion, the following gaps were identified:

1. Lack of adequate information and the fact that the existing data is not integrated (e.g. demographic data, incidence of disease, etc.).
2. Need for integration of primary care with other sectors.
3. Training for practitioners to best assist patients across the continuum of care.
4. Giving consideration to the social determinants of health in the Strategy.
5. Resource gaps related to the current funding mechanisms, processes and criteria.
6. Coordination in the area of information and knowledge management.
7. Lack of understanding of the patient's perspective.
8. Technology to support the whole practice (e.g. patient self-management, E-health, etc.).
9. Access to allied health professionals.
10. Shared care, care pathways and access to specialists.
11. Diabetes database or registry.
12. Lack of integration of guidelines, and weaknesses in the way to best present the information.
13. Non-supportive environment.

OPPORTUNITIES

The following opportunities were identified by participants:

1. The diabetes portal may include many common risk factors for other diseases.
2. There is an opportunity to offer creative ways to incite people to use the portal.
Note: the need for information technology (IT) infrastructure may be a barrier to the uptake of the portal.
3. An opportunity exists at the project level to expand the Ottawa Model for Smoking Cessation to other areas such as diabetes.
4. Determining how to link the hospital model with other health care system interactions also represents an opportunity to build on.



STRATEGIC CHALLENGES AND OPPORTUNITIES

In light of the initiatives currently underway as well as the important gaps and opportunities identified, participants were asked to brainstorm individually which were the key challenges and opportunities for the Vascular Strategy.

13 themes emerged from this discussion; they are listed below, along with a summary of the individual inputs which were used to create each theme.

CHALLENGES AND OPPORTUNITIES

- 1. A unified voice and integrated infrastructure to support vascular health:**
Common voice for public awareness; integration of projects and services; engagement of the community; common information and resources.
- 2. Building on successes and focusing on the patient:**
Evidence-based resources; best practices models; prevention campaigns; shared care; IVR models incorporating multiple diseases; co-morbidity patient-centered approach.
- 3. Single window approach:**
Lack of an integrated approach (e.g. services availability, referral criteria) between patients, providers and health care system; opportunity to leverage the diabetes portal and existing structures and programs to develop an integrated approach; centralized communication.
- 4. Case management:**
Regional case management program; shared case management; involvement of patients.
- 5. Common approach for risk assessment and screening:**
Integration of multi-disciplinary care; prevention and systematic screening and identification of people at risk; building on existing initiatives to add a diabetes component and lifestyle changes; leveraging existing technologies; application of the Ottawa Model to other disease conditions.
- 6. Obesity as an emerging issue:**
The incidence of obesity is increasing.
- 7. Lack of lifestyle management:**
Prevention, education and support for practitioners and patients; lifestyle and self-management strategies and programs; diabetes education.
- 8. Integration of primary care:**
Primary care needs to be organized, integrated and resourced; practitioners need access to E-health, allied health professionals and a professional community; matching of resources and expertise to needs; ensuring each chronic disease patient has a primary care practitioner.
- 9. Capacity for change:**
Coordinated roll out of strategy; capacity to manage change; collaboration; sharing successes; building on examples of excellence; capacity building; multi-disciplinary perspectives.
- 10. Training, mentoring and knowledge transfer:**
Knowledge and expertise within various sectors; need for integration between primary care and specialists; team support and mentoring to increase comfort level and competence.



11. IT infrastructure:

Lack of IT infrastructure and systems; incompatibility between different information systems; lack of complete electronic health records; need for communication between points along the continuum of care and central access; the E-health project and diabetes portal represent opportunities to develop an e-system that would address the needs of providers and patients.

12. Funding and funding strategy:

Align funding with initiatives; focus on what is achievable; need resources for planning and coordination and to support involvement; being selected as a pilot site for E-health represents an opportunity; removing duplication to re-allocate funds where they are most needed.

13. Ensuring access for all:

Client-centered instead of disease focused; prevention and chronic disease management; access to healthy foods, physical activity, and transportation; ensuring patients have a primary care provider; ensuring access for the poor and uneducated.

STRATEGIC CHALLENGES AND OPPORTUNITIES TO ADDRESS AS A PRIORITY

Participants were asked to select the most important themes to address; this was conducted by voting on the areas where participants feel that the Champlain Vascular Strategy needs to achieve key results over the next three to five years in order to have the greatest impact and move forward. Each participant was given three votes.

The following three themes were given the highest priority, based on the number of votes received.

- Single window approach (17 votes)
- Common approach for risk assessment and screening (11 votes)
- IT infrastructure (9 votes)

The following two themes were given the next level of priority:

- Integration of primary care (6 votes)
- Funding and funding strategy (5 votes)

The eight other themes received three or fewer votes.

KEY RESULT AREAS

The following represents key results to be achieved over the next three to five years in each of the areas identified. Specific initiatives and projects which will support each of these key result areas will be established after this meeting.

THEME	KEY RESULTS TO ACHIEVE BY 2011 TO 2013
Single window approach	Patients and providers have single window access to resources: to know which services or resources are available; to access those resources; and to access educational resources.
Common approach for risk assessment and screening	We have developed a systematic point of service strategy for screening, intervention, engagement and follow-up of vascular risk factors*.



IT infrastructure	We have a comprehensive integrated health information system available at every point of service.
Integration of primary care	We have systematic support for primary care providers, as it relates to vascular disease.
Funding and funding strategy	The key results for this theme will be established after the meeting.

*Note: vascular disease and risk factors refer to these four conditions: diabetes, stroke, heart disease and kidney disease.

NEXT STEPS

The following next steps were agreed upon:

ACTIVITIES	WHO	BY WHEN
Identify a process to capture the initiatives to be pursued under each key result area.	Sophia and Karen.	
Consult the participants on suggested initiatives to pursue and seek suggestions on a process to prioritize the proposed initiatives.	Sophia and Karen will lead; all will provide input.	Input provided within 3 weeks from request.
Confirm the priority initiatives to be pursued for each key result area (primary initiatives).	Small working groups for each key result area.	Finalize by mid-September.
Draft joint strategy and plan		
Formulate project management office/structure for strategy		
Identify small teams/ working groups to lead each initiative (estimated 1 to 3 meetings per team) Draft a project charter/business plan for each initiative Including: project goals, outcomes & objectives; project scope; milestones & targets; costs & funding sources; dependencies; risks, assumptions & constraints; project organization		
Identify implementation teams		
Evaluate and finalize priorities		
Finalize strategy and plan		



APPENDIX A – LIST OF PARTICIPANTS

The following participants took part in the July 22, 2008 meeting:

Dr. Ayub Akbari – Nephrology (Chronic Kidney Disease Network)
Dr. Renée Arnold – Family Physician, President of the Ontario College of Family Physicians
Sharon Brez - TOH Advanced Practice Nurse, Endocrinology & Metabolism
Jane Brownrigg – UOHI Cardiac Rehab Program
Dr. Robert Cushman – CEO Champlain LHIN
Tracy Gierman – CHAP Program Manager
Dr. Phyllis Hierlihy – Community Endocrinologist
Dr. Sharon Johnston – Family Physician, ERBI researcher
Dr. Erin Keely – TOH Chief Endocrinology & Metabolism, Diabetes Network
Allison Lampi – Planner, Community Health Centre
Dr. Jacques Lemelin - Chair Dept. of Family Medicine University of Ottawa
Dr. Clare Liddy – Family Physician, EBRI Researcher
Kelly Lumley-Leger – Regional Stroke Program Coordinator
Jim Lumsden – Regional Stroke Program Manager
JoAnn MacKenzie – Community Diabetes Education Program
Christina Marchant – Community Diabetes Education Program
Sabine Mersmann – Pembroke Regional Hospital
Sophia Papadakis – Project Manager, CCPN
Karen Patzer – Senior Planner, Champlain LHIN
Dr. Andrew Pipe – Chair, CCPN
Dr. Bob Reid – Associate Director, University of Ottawa, Smoking Cessation Network
Lise Richard – Coordinator, Champlain Community Support Services
Dr. Michael Sharma – Chair, Regional Stroke Program
Heather Sherrard – VP Clinical, UOHI
Dr. Jim Worthington – TOH, Senior Vice-President, Medical Affairs, Quality and Patient Safety



APPENDIX B – RESULTS FROM THE PRE-MEETING QUESTIONNAIRE

16 respondents filled in the pre-meeting questionnaire.

The following represents a compilation of the responses from the pre-meeting questionnaire.

1. What programs and/or services does your organization or network provide in the following areas? Please consider inpatient, ambulatory, and community setting when responding?

Healthy Persons with Risk Factors Lifestyle

- Hospital-based Smoking Cessation Network, Blood Pressure Campaign, Healthy School Aged Children Initiative
- ambulatory care: Heart health eating group class, strong women fitness and wellbeing program nutrition counseling, CHAP, social work
- individuals with public health are members of our network, and provide community services for healthy lifestyle; community education programs for pre-diabetes; strong women's program (Shirley Greenburg Women's Health Centre)
- education programs, exercise counseling
- stroke prevention clinic provides interventions on exercise diet obesity and smoking for individuals who have not had stroke or TIA; educational programs for family members
- Cardiovascular Health Awareness Program (CHAP) presently operating in Pembroke and Cornwall
- Strong Women Lifestyle and Strength Training Program from SEG Women's Health Centre: Riverside Campus and YM-YWCA
- education, counseling, support for lifestyle change, screening
- healthy lifestyle program
- Heart Health Education Centre

Healthy Persons with Risk Factors Clinical

- Improved Delivery of Cardiovascular Care (IDOC in Primary Care), Blood Pressure Campaign
- ambulatory care: lipid clinic, PCOS clinic, post partum reminders for type 2 diabetes to women who have had gestational diabetes, new diabetes education team in family medicine programs provide ambulatory care services, referral to a community based programs
- nutrition counseling, CHAP
- postpartum reminder program for women with gestational diabetes, however no clinical intervention per se; community programs for early screening, pre-diabetes;
- education programs, risk factor modification
- interventions are irritated for hypertension, dyslipidemia and smoking
- CHAP
- Strong Women Lifestyle and Strength Training Program from SEG Women's Health Centre: Riverside Campus and YM-YWCA and Community Based Diabetes Education Program and Strong Women Program
- education, counseling, support for lifestyle change, screening and management/treatment
- chronic disease nurse - access to DEP & 2nd Stroke
- Specialty Clinics



Persons Recently Diagnosed

- Get with the Guidelines Initiative (Acute Coronary Syndrome)
- Inpatient: diabetes RN-Endo team consultation, transitional care /discharge planning/coordination of care. ambulatory care: TOH provides continuing ed/ decision support to primary care practitioners and diabetes educators serving this population, full spectrum of diabetes services provided at Riverside Endocrinology clinics (Diabetes and lipid clinics) , individual and group education/self management support type 1, type 2
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- diabetes, telehealth clinics to rural communities, multidisciplinary clinics and education/ decision support to special populations- gestational diabetes, diabetes and pregnancy, cystic fibrosis related diabetes, transitional programs from pediatric to adult care. Community-participation in community education for consumers and for health professionals
- a wide variety of ambulatory and inpatient services as well as Community mental health
- multidisciplinary education and medical care for inpts and outpts; community and hospital based programs; education materials/advocacy through Canadian Diabetes Association
- education, cardiac rehabilitation, risk factor management
- comprehensive diagnostic and management services including prevention, rehabilitation and community reintegration
- CHAP
- Diabetes, Smoking Counselling, Dietary Advice, Training
- Inpatient and outpatient consultations by physicians. Educational services for Inpatients
- Strong Women Lifestyle and Strength Training Program from SEG Women's Health Centre: Riverside Campus and YM-YWCA and Community Based Diabetes Education Program, Strong Women Program and Community Based Diabetes Education Program
- education, counseling, support for lifestyle change, screening and
- management/treatment
- primary team & access to DEP, Cardiac Rehab, stroke
- Cardiac Rehab

Persons with well managed Disease

- Improved Delivery of Cardiovascular Care (IDOCC) in primary care
- Inpatient: provide ongoing professional development, training for hospital staff providing diabetes care, utilization of diabetes nursing BPG's in selected populations ie. reducing foot complications and insulin initiation. Amb. care: full range of diabetes services, transition to primary care provider, ongoing care type 1 diabetes, initiation of technologies to facilitate self management and clinical outcomes ie. insulin pumps, CGMS, provide access to clinical research
- Ambulatory care follow up clinics for cancer care , INR management , diabetes education , CHAP , telemedicine follow up in a variety of medical specialty areas
- a wide variety of ambulatory and inpatient services as well as community mental health
- multidisciplinary care in outpatient setting in community programs and hospital based programs
- education,
- followed until prevention regimen optimized; referrals to appropriate community resources



- CHAP
- Clinical consultation and education support for both inpatients and outpatients CBDEC's and primary care providers
- education, counseling, support for lifestyle change, screening and management/treatment
- usually family doctor office
- Cardiac Rehab

Persons with Complex or Unmanaged Disease

- - Stroke Pilot Project of Outpatient Smoking Cessation Program
- Inpatient: interdisciplinary consultation, discharge planning, transitional care and phone and clinic follow-up (approx 25% of inpatients at TOH have diabetes on any given day). Amb care: multidisciplinary clinics, individual and group self- management education, multidisciplinary clinics and education/ decision support to special populations gestational diabetes, diabetes and pregnancy, cystic fibrosis related diabetes, transitional programs from pediatric to adult care- decision support for individuals and health professionals, telehealth, Endocrine training program, clinical research
- a wide variety of ambulatory and inpatient services as well as community mental health
- multidisciplinary care inpt and outpt; hospital and community based programs
- education, cardiac rehabilitation, risk factor management
- provide acute tertiary referral services regionally; telestroke
- CHAP
- Clinical and education services for both inpatients and outpatients.
- Diabetes Clinics at Riverside and Community Based Endos, and Telehealth Clinics
- education, counseling, support for lifestyle change, screening, management/treatment and referral to specialty care as needed
- access to specialists who work with Diabetes, cardiac and stroke programs
- Cardiology, Surgery



**2. In your opinion, what are the most significant gaps in each of these areas?
Please consider inpatient, ambulatory, and community setting when responding.**

Healthy Persons with Risk Factors Lifestyle

- outpatient
- healthy schools and workplace programs (facilitated activity programs, affordable, healthy food choices), access to dietitians in non- diabetes amb care clinics; awareness, screening post gestational diabetes
- smoking cessation , management of high blood pressure , linkages between organizations and programs
- Targeted area of focus - same messages; targeted high risk population
- lack of access to intervention programs including structured nutrition and exercise programs; no "made in Ottawa" comprehensive web based education material
- public awareness, policy gaps re food, urban planning and building codes
- Programs must be community-wide, locally led and free; operate throughout the year; majority of community family physicians and other practitioners be involved; include selfBP measurement with an automated device; provide follow-up of high-risk participants; participants should receive targeted education resources and links to local programs; and, evaluation should occur for quality improvement.
- Identification of individuals. Accessible and affordable programs for lifestyle modification
- Lifestyle programs for specific groups such as women with PCOS, Metabolic Obesity, and history of Gestational Diabetes, as well as access to dietitians
- community culture and resources promoting AND facilitating healthy lifestyle
- environment not conducive, occasionally behavior specialist for mental-emotional problems - psychologist
- Supportive environment

Healthy Persons with Risk Factors Clinical

- Public Awareness Campaign
- access to pre- diabetes/CV disease programs, awareness of risk factors, active decision support) behaviour change strategies in primary care, access to bariatric interventions (medical and surgical)
- smoking cessation , management of high blood pressure , linkages between organizations and programs
- More of a emphasis on services for people with comorbidities - making it easier for people to access; implementation of screening and identification of people at risk; self management tools, programs and services; orphaned patients
- lack of systematic tracking, screening, reminders to help individuals get timely intervention both in pt and outpt setting, eg postpartum flu of gestional diabetes, admitted patients with stress hyperglycemia
- long term follow-up
- integration of services, best practices, lack of Primary Care in region
- Identification of individuals, timely and appropriate access to appropriate services
- Lifestyle programs for specific groups such as women with PCOS, Metabolic Obesity, and history of Gestational Diabetes, as well as access to dietitians. Would like to develop
- diabetes Prevention Clinic and expand capacity of Strong Women Program



- community culture and resources promoting AND facilitating healthy lifestyle
- environment not conducive, occasionally behavior specialist for mental-emotional problems - psychologist
- Screening

Persons recently diagnosed

- inpatient access to confident, knowledgeable health care providers and electronic systems able to assist with care planning, system navigation, information access, decision support related to treatment options. no curriculum for standardizing education programs, wait times and educational resources used in all diabetes education programs. Access to bariatric interventions (medical and surgical). registry of persons with diabetes. Identification of key-leading indicators of successful care practices and outcomes to support evaluation
- - primary care , specialists consults , access to ambulatory care with interdisciplinary specialty teams , timely access to service
- Orphaned patients; access, monitoring and follow-up across the region
- tools to enable pts to navigate system, referral-consultation process between provides/disciplines haphazard/lack of standardization of programs, triaging of pt to most appropriate, closest to home program; lack of educational/nutritional resources to deal with burden of disease
- integrated management, long term follow-up
- inadequate regional system to identify, triage, manage and track patients
- Insufficient resources to reach effectively all patients
- Timely access to self-management education for chronic disease management
- Lifestyle programs to integrate nutritional and physical activity recommendations in safe and user friendly environment
- Time to do assessment of patient's complex needs with new diagnosis and time to educate and plan with patient
- no significant gaps in my community except children
- Regional programming

Persons with well managed Disease

- lack of long term self-management supports
- standardized processes of care, forms to support decision making and evaluation. Uninsured costs of medications and self monitoring supplies. Very limited peer support
- Coordination and Access
- facilitation of transition between providers - between disciplines (RN<RD<MD), community/hospitals, FP's/specialists
- long term followup,
- integration of services, best practices, lack of Primary Care in region; absence of a system to manage transitions across phases of care
- Inadequate capacity in the community around all aspects of longterm management
- timely access to specialist care if need arises
- same for those who are not active; also followup diabetes education services as relapse common after first introduction
- communication with e-health
- Long term follow up



Persons with Complex or Unmanaged Disease

- lack of regional case management model
- Inpatient: insufficient resources to provided clinical consultation to complex cases requiring turgent clinical and self management support and transitional care (transplants, MI's cardiac surgery, revascularization/amputations, stroke, Chemo, DKA, psychiatric disorders, reduced cognitive functioning etc.). e-health record and e_MAR with built in clinician decision support. Standardized care protocols across institutions. amb care: transitional support between health care sectors, timely access to specialist teams for urgent care, fragmented care due to ineffective communication/integrated care planning between disciplines and specialties in the face of multiple co-existing chronic diseasesdisease focused care vs. patient focused care.
- Dedicated Case management; system navigation; transitions of care
- lack of case managers/self management support to help people navigate system;lack of "multidisease" nurse specialist to be able to assist self-management in comorbidities; for inpt lack of ability to see opportunity to impact less acute illness , lack of interdisciplinary clinic (eg vascular clinic with cardiology, endo, nephro, foot clinic)
- long term followup, integrated management
- insufficient supply of specialized services for complex disease including human and techincal resources (eg: telestroke, acute phase and rehab)
- Present system inadequately resourced and not optimally organized or linked timely access to specialist care
- more rapid access to specialsty clinics which is dependent upon increased number of diabetes educators: wait times too long; short-of staff to educate and followup on patients with diabetes admitted to tertiary care facilities. could benefit from case managers.
- time to review cases and discuss cases with specialist for feedback
- shared care model with specialists-no payment funding for mentoring
- Access to physicians/GPs and specialists



3. In your opinion, what criteria should be used to determine priorities for a joint diabetes, heart and stroke strategy for Champlain?

1. continue to support our successes (e.g. hospital smoking network)
 2. it will make it easier for end user (patient or health partner) if we work together
 3. it is more cost effective to delivery services together
 4. MOHLTC priority areas
 5. There is a gap in service delivery
-
1. reflect priorities of MOHLTC and funding opportunities
 2. address problems where effective interventions are known and a measurable impact on outcomes likely
 3. address issues of shared concern
Consider quick wins, buidling on existing strengths
-
1. Alignment with Provincial CDPM/Diabetes Strategy
 2. Feasibility of implementation
 3. Improve outcomes for patients/populations
 4. Applicability across the geography
 5. Cost
-
1. alignment with opportunities for funding
 2. potential for impact on lives of LHIN residents
 3. addressing major gap that is relevant to all
 4. identify a quick win based on recent successes
 5. something we are passionate about
-
1. Shared risk factor management issues
 2. Integrated long term followup
 3. Enhanced self-managment strategies
-
1. impact on human outcomes: death and disability
 2. efficient use of resources
 3. leveraging programs or strengths of current initiatives
 4. complimentary activites
 5. common infrastructure for management, data acquisition and reporting
-
1. - it is community-wide, locally led and free; it operates monthly; the majority of community family physicians and other practitioners are involved; includes self-BP measurement with an automated device; provides follow-up of high-risk participants; participants receive targeted education resources and links to local programs; and, evaluation occurs for quality improvement.



1. Impact on greatest number
2. Effectiveness of intervention clinically
3. Cost effectiveness of intervention
4. Likelihood of success
5. Ease of implementation

1. Common issues between stroke, heart, and diabetes

1. ability to impact with prevention initiatives: education and lifestyle programs
2. potential for secondary prevention with both vascular protection measures and attention to diabetes management which is often neglected in excitement of acute events and interventions; ie link a vascular protection clinic to Stroke Unit and Heart Institute
3. Case management approach to follow up high risk individuals; ie PVD, retinopathy, CRF, CAD
4. More access to preventive foot and limb care initiatives
5. identification and referral of all individuals with HbA1C >7%; obligatory access to physicians and health care providers as opposed to "cherry picking" which may occur

1. ability of strategy to address needs of complex patient with multiple chronic conditions
2. ability of strategy to build on existing strengths and resources and address identified needs
3. ability to promote integration of care rather than parallel silos

1. same risk factors - environment support
2. more collaboration - shared care with specialists
3. communication - e-health with outcomes
4. rehab for cardiac, stroke and lung with safe community settings for active reintegration
5. above probably not a criteria but what the heck!

1. Population impact
2. Common risk factors
3. Anti obesity strategy
4. Merging resources
5. Evaluation



4. In your opinion, what are the most significant opportunities for the Champlain Region in each of these areas? Please consider both the inpatient, ambulatory, and community setting when responding?

Healthy Persons with Risk Factors Lifestyle -

- Expansion of smoking cessation model to outpatient settings, Large mass media campaign for healthy blood pressure
- advocate for and model healthy school and workplace programs (health food choices, activity promotion, smoking cessation).
- Build on strengths/initiatives already in place
- public awareness campaign through joint effort; including public forums, advocacy; consider partnering with YMCA; pilot structure intervention programs eg. strong women's program
- Common messaging; "public" educational opportunities; environment and policy changes
- unique educational initiatives at the population level
- it is community-wide, locally led and free; it operates monthly; the majority of community family physicians and other practitioners are involved; includes self-BP measurement with an automated device; provides follow-up of high-risk participants; participants receive targeted education resources and links to local programs; and, evaluation occurs for quality improvement.
- community screening, development of more programs through Y, recreation centres, etc such as "Heart Wise" certification, nutrition and lifestyle interventions in schools, workplaces
- strong links between subspecialty (cardiac) policy makers and public health in Cardiovascular Network
- awareness, environment supportive for change, team-based healthy lifestyle programs
- Regional social marketing

Healthy Persons with Risk Factors Clinical -

- Expansion of Ottawa model to diabetes screening and triage
- Implement post gestational type 2 diabetes screening program. Develop integrated CV/diabetes risk assessment centres/programs, utilize CCAC resource centres and other community venue
- practice guidelines already developed;
- systematic identification, screening
- common messaging; "public" educational opportunities; consistent clinical approaches to identification and management
- CCPN IDOC program , smoking cessation program, integrated information management system
- disease registry
- widespread adoption of smoking cessation approaches implemented by Heart Institute and SEGWHC
- guidelines including behavior modification and support
- Regional screening

Persons recently diagnosed -

- Expansion of Get with the Guidelines to diabetes and other patients populations; Joint cardiac rehabilitation program
- Develop education programs for health professionals to assist them to effectively support patient decision making, behaviour change and self management; develop diabetes data base; develop disease management information portal for patients; develop; develop "basic training programs" for diabetes educators
- Diabetes Registry to be developed



- enhance guideline uptake through current programs (iDOCCC), use web based resources to improve provider and pt navigation through system
- consistent clinical approaches to management and followup; opportunities for self-management
- expansion of urgent clinics to community hospital setting; rapid access to in and outpatient rehabilitation through a common referral process (RITTS)
- Opportunity to set the patient on the right course from the time of diagnosis Disease registry
- Increase availability and awareness of resources available
- all patients have a family doctor and access to education
- Facilitate early link to rehab via telehealth

Persons with well managed Disease -

- Diabetes Registry and Specialty Care Reform to make consultation and communication more efficient
- Building on regional expertise- implement best practice guidelines (RNAO and others) in primary care practices (eg. foot ulcer risk reduction, smoking cessation, hypertension, muslin therapy); establish standardized chronic disease management documentation elements and critical indicator tracking across the LHIN
- Diabetes Education programs; use of IVR
- facilitate care in family practice through specialist (MD and other HCP) support when needed, improve self-management through pt access to resources
- consistent, integrated approach to management and followup; opportunities for self-management
- integrated access to ongoing prevention
- Disease registry
- registry of patients with diabetes; LHN website for exchange of information re network, updating opportunities, educational resources
- % of total population as indicator
- Best practice guidelines

Persons with Complex or Unmanaged Disease ---

- Case managed program with IVR and E-health supports
- Persons with Complex or Unmanaged Disease - enhance access to inpatient diabetes consult teams and chronic disease (CV and diabetes) case managers to support transitional care. Develop strategies to provide early assessment and treatment of diabetes and vascular ulcers (a multi-disciplinary foot ulcer management referral clinic)
- Look at current resources directed to case management, opportunities for more specialist/primary care interface identified
- build capacity through different ways of doing business - AVR for flu of inpts, e-consultation for pts followed in primary care, multidisciplinary clinics; build capacity through coaching, mentoring, education of providers
- consistent clinical approaches; enhanced clinical resources/integrated referral opportunities/optimized community-based clinical resources for follow-up
- expansion of acute telestroke and increase in specialized human resources for acute care
- Opportunity to improve inpatient management, transition back to the community and co-management of patient by family physician and other community provider and the specialist
- Disease registry
- Identification of "at risk" individuals, report cards on how we are doing via registry, review of centralized data base (OHIP, Labs, hospital visits)
- shared care with specialists, EMRs tracking high risk
- Outpatient services



5. In your opinion what should the priorities of a joint heart, stroke and diabetes network include?

1. Support Hospital Smoking Network and Expansion to Outpatient Settings (Hospitals and Primary Care)
 2. Primary Care Collaborative (Create more organized system for Regional Planning; IDOCC; Diabetes Registry; Smoking Cessation)
 3. Case Management Program for Heart Failure, Diabetes
 4. Healthy Blood Pressure Campaign
 5. Expand Ottawa Model for Diabetes Screening in Hospitals and Expansion of Get with the Guidelines to Other Diseases
-
2. advocate and participate in development of an interdisciplinary professional education/training programs for health professionals to develop competencies required to support self management and behaviour change in chronic illness (currently not part of basic education /training for most disciplines and will be critical to successful implementation of self management programs)
 3. share and build on successes with technologies, looking for transferable processes of care
 3. promote risk factor awareness, create a visible partnership between diabetes and CV disease within the community
 4. identification of shared interests, development of 3 year plan
-
1. Prevention & Health Promotion to reduce risk factors
 2. Mgmt - Insulin; BP: Role of GP & specialists
 3. Mgmt - Complex Cases - Case mgmt
 4. Self-management
 5. Diabetes ReEgistry
-
1. improved navigation through system for pt through education, self management, coaches
 2. improved communication/collaboration between inpt/outpt, specialist/generalist through innovative communication eg. AVR, portals, telemedicine, ie. improve transition, sharing of care
 3. systematic identification - don't let things fall through the cracks on hospital admission - identify, intervene, communicate
 4. reduction of risk factors eg. smoking cessation, lipid/htn control
 5. obtain funding
-
1. Consistent approaches to identification and management of common risk factors and health behaviours
 2. Enhanced identification of those at risk and enhanced ability to initiate treatment and ongoing care
 3. information system development
-
1. common patient management and information system
 2. integration of primary and secondary prevention services to offer a unified patient experience
 3. implementation of integrated best practices in primary care
 4. seamless information flow across transitions
 5. common referral process to maximize use of regional resources while decreasing wait times
-
1. it is community-wide, locally led and free; it operates monthly; the majority of community family physicians and other practitioners are involved; includes self-BP measurement with an automated device; provides follow-up of high-risk participants; participants receive targeted education resources and links to local programs; and, evaluation occurs for quality improvement.



1. Identification of patient population
 2. Identify and implement most effective
 3. Strategies for the greatest number
-
1. Government Lobbying, Facilitating integration between programs to prevent duplication of services and address gaps in health services delivery
 2. Timely access to coordinated, evidence based care for all
-
1. education and opportunities for prevention
 2. one number to call type approach to access resources available via website, etc
 3. ability to match those at risk and those in need with appropriate level of provider
 4. ongoing feed back re achievements and prioritized needs
 5. up to date data re roadblocks in system, whether it be referral to specialist, investigation, or intervention
1. integration of care
 2. prevention
 1. Prevention - community supportive
 2. high risk - access to therapy- \$ not a barrier
 3. Access and collaboration between primary care and specialty care
 4. Access to education programs-teams integrated in primary care - model of payment of physician not a barrier to access teams
 5. rehab and social reintegration
 1. Prevention of disease
 2. Linking resources
 3. Referral of clients
 4. Screening
 5. Best practice guidelines



6. What leadership roles and responsibilities should each of the following section play in the rollout of a joint strategy?

Champlain LHIN

- Funding for Initiatives; Support Project Management Office; Support Analysis and Planning; Support Populating Report Card; Support Establishment of targets/benchmarks for regional sector specific indicators
- Assure provision of admin support and standardized funding to partially offset Network participation costs. Timely input regarding MOH priorities and funding proposal opportunities. Establish and communicate and make transparent criteria for determining recourse allocation
- Help set direction; ensure alignment with MOHLTC strategy; performance monitoring and reporting to the MOHLTC; Integration & community engagement; funding and reallocation of resources
- administrative and financial support, communication of MOH strategies/priorities
- Resources, endorsement, identification of priorities
- information management, data acquisition and analysis, verification of deliverables, funding and resource allocation
- no in house expertise/resources minimal expectations
- Overall strategic goal setting and direction
- Government Lobbying
- funding for planning a coordinated approach, facilitating coordination umbrella organization - leadership
- Create the macro network

Diabetes Network

- support project management offices; specialized clinical support; ensure leadership from
- as equal participant identifying shared concerns, providing leadership and expert advice for diabetes related initiatives or concerns, differentiating issues of interest to the joint strategy group from those more appropriately addressed by the diabetes Network, Sharing information from the Network and back to the Network members
- identification, sharing of priorities; support of network initiatives
- enhancing the capacity of the diabetes community to coordinate approaches to the identification and management of prediabetics; serve as the intellectual home of approaches/policies re the management and followup of diabetes
- Establishing priorities and linkages in diabetes care
- Support to patients and families to cope and navigate thru disease
- - Leadership in providing coordinated, accessible diabetes care
- access to DEP for all- communication electronic with primary care
- Service delivery

Diabetes Community;

- Identify partner orgs to co-lead diabetes specific initiatives

Stroke Network

- co-lead stroke initiative?; report card indicators
- intellectual home of the policies and approaches to the integrated management of those with TIA and CVA
- Establishing priorities and linkages in stroke care
- Support to patients and families to cope and navigate thru disease
- Leadership in providing coordinated, accessible stroke care
- insure stroke strategy implemented throughout region
- Regional programs



Primary Care

- Identify Performance Indicators; Creation of Primary Care Collaborative to Facilitate QI Initiatives in the Region
- support the introduction of consistent approaches to an integrated approach to the identification and management of those with risk factors for, or expressed cardiovascular, cerebrovascular or diabetic disease
- establishment and implementation of best practices in the primary care setting
- Develop capacity amongst and within the family physician
- leadership in chronic disease prevention and management of multiple chronic conditions
- key role in first contact and continuity of care - every patient needs a PHC provider Referral

Community Hospitals

- Commit to set of performance standards and indicators for Heart, Stroke, Diabetes; Implement Chronic Disease Navigator Model; Implement Hospital Smoking Model; Implement Diabetes Screening Model; Implement Get with the Guidelines Expansions
- develop consistent, integrated approaches to the identification and management of risk factors and expressed cardiovascular, cerebrovascular or diabetic disease; expressing clear institutional commitment to the delivery of integrated approaches/best-practice; participating in the governance of the joint approach
- become better integrated into regional care management
- Develop effective inpatient capacity and linkage to community
- information and service access to primary care - some have protected funding for programs
- Education programs

Community Specialists

- Work more closely with Primary Care and support reform in methods in which specialists interact with community based clinicians
- serving as champions of an integrated approach; providing intellectual and clinical leadership in their communities; participating in the governance of the joint strategy
- develop integrated referral systems
- - Increase their capacity to see and manage patients
- shared care with primary care
- Telehealth their services

Academic Centres

- Support evaluation activities
- professional development, program evaluation, best practice guideline development, knowledge translation, mentoring and consultation
- evaluation, formulate and develop research questions; clinical/education expertise
- intellectual and clinical leadership; leadership in evaluation and research undertakings; providing clear, unequivocal support for the approach; providing intellectual leadership to all clinical endeavours; adopting a regionalized perspective to the delivery of care and program development
- coordinate tertiary care activities and shared responsibilities for educational activities
- Provide insight and understanding to best practices, Develop guidelines, Be involved and evaluate all aspects of new intervention strategies, Provide leadership overall to the progress
- Leadership in promoting research and educational initiatives
- research and training
- Evaluation



Others (Specify):

- CCPN -- has a framework for governance, structure that already involves collaborative approach between and among sectors, institutions and communities
- Heart Institute: Establishing priorities and linkages in cardiac care
- Community organizations with organizational capacity and keeness to take the lead public health/education- prevention
- cardiovascular network plays an important role



7. What type of system level support would be required to enhance the impact and/or support the implementation of a joint strategy?

Regional Scorecard, Institution/Sector Specific Performance targets, Shared Governance System, Project management office (for Heart, Stroke and Diabetes) could be virtual, EHealth Systems

dedicated funding

EHR, Diabetes Registry, performance targets and measurement, data, case managers, teams, primary health and public health involvement, dedicated funding, integration, community engagement

dedicated funding with support for individual's time -appropriate administrative support' - IT support including integrated information, AVR, reminders -endorsement from LHIN, MOH - enhanced human resources to provide clinical care/intervention required to reach targets

All of the above 21st century information systems; Resource commitments from province/LHIN; Integrated evaluation system; Formalized training/professional development capacities; Patient registries?

dedicated funding, patient management information system, performance improvement system, clearly defined governance structure

it is community-wide, focally led and free; it operates monthly; the majority of community family physicians and other practitioners are involved; includes self-BP measurement with an automated device; provides follow-up of high-risk participants; participants receive targeted education resources and links to local programs; and, evaluation occurs for quality improvement.

Dedicated funding Commitment to targets Information systems

First EMRs for all primary care practices who voluntary want them- access to teams for all family doctors, shared care model between family docs and diabetes, cardiologist and stroke specialist, 2nd prevention clinics, agree with the above examples

Merge the funding envelopes so that service providers can serve each others' clients.



8. What support and/or leadership will your organization/network provide to the implementation of a joint diabetes, heart, and stroke strategy?

Could expand governance model of CCPN which currently includes Heart and Stroke to Diabetes including executive level leadership, shared resourcing of project management office, performance management agreements with partners leading initiatives.

Participation in conceptual and strategic planning, providing content expertise from multidisciplinary perspective, participating in education and evaluation

LHIN Lead on CDPM support, CIO lead on e-health, resources as available, linking and looking for integration opportunities, building on strengths, linking to MOHLTC

provide expertise and leadership in initiative development/implementation BUT only if there is funding - currently our network is not funded

Already have an organizational apparatus and a governance system; a track-record of developing integrated, cooperative, collaborative approaches to the delivery of prioritized programs; have human capacity to provide leadership to an integrated strategy; have experience in developing and managing a coalition; strategic planning and strategic thinking;

leadership role in stroke services and education, establishment of best practice guidelines, existing capacity in which to build new initiatives, share experience in building a regional system of care

Experience with CHAP that is community-wide, locally led and free; it operates monthly; the majority of community family physicians and other practitioners are involved; includes self-BP measurement with an automated device; provides follow-up of high-risk participants; participants receive targeted education resources and links to local programs; and, evaluation occurs for quality improvement.

TOH should have a leadership role at both the physician and expert level as well as through other specialized aspects of the strategy

better integration with needs of community via communication, education, clarification of roles and simplification of referral patterns

focus on multiple chronic conditions and promoting patient-centred services Primary care

link with OCFP LHIN Council for Primary care & Public Health

We have regional programs that address risk factors common to all 3 diseases- can broaden to include diabetics and stroke patients.