

**NE LHIN and the Health Professional Advisory Committee
Chronic Disease Prevention Management Forum**

Summary Report

November 16, 2011

**Prepared by:
Erika Espinoza**

TABLE OF CONTENTS

| | |
|---|-------------------------------------|
| Introduction..... | 3 |
| Strategic Considerations | 3 |
| Current Initiatives | Error! Bookmark not defined. |
| Pre-Meeting Questionnaire | 6 |
| Break-out Session | 8 |
| Theme 1: Communication / Sharing of Tools | 8 |
| Theme 2: Integration / Collaboration | 9 |
| Theme 3: Common Referral and Assessment Tool used region wide..... | 9 |
| Theme 4: How do we increase access to First Nation and Francophone Communities? | 9 |
| NE LHIN CDPM Forum Evaluation | 10 |
| Next Steps | 10 |

Introduction

On October 14, 2011 the NE LHIN held its first regionally focused Chronic Disease Prevention and Management (CDPM) workshop. The event provided an overview of CDPM related programs, identified both access and gaps to services, and developed and identified related priorities. The session targeted health planners, hospitals, family health teams, health service providers, community health centres, and chronic disease-related organizations in the NE LHIN.

Strategic Considerations

Northeastern Ontario's health profile shows a higher prevalence of chronic diseases in the NE LHIN, including:

- arthritis/rheumatism - 24.0% vs. 16.8%;
- asthma - 10.0% vs. 8.2%;
- high blood pressure - 23.% vs. 17.2%;
- diabetes - 7.2% vs. 6.4%; and
- hospitalized acute myocardial infarction event rate - 314 vs. 216 per 100,000 people.

There is a need to align NE LHIN regional efforts with the MOHLTC CDPM framework. Factors compounding the prevalence of chronic disease in the NE LHIN region:

- 17% of people in our region are age 65 and over. This number is expected to increase to 30% in 20 years.
- The Statistics Canada 2010 Health Profile (Statistics Canada, Canadian Community Health Survey, 2009) reports that there is a smaller proportion of NE LHIN residents who report their health as 'very good' or 'excellent' compared to Ontarians overall. Also, the profile shows a higher prevalence of self-reported activity limitation in the NE LHIN compared to Ontario - 34.8% vs. 27.8% - and a higher proportion of persons who report pain or discomfort preventing activities - 17.4% vs. 13.2%.
- In addition, the profile indicates a lower rate of contact with a medical doctor in the previous 12 months in the NE LHIN - 79.7% vs. 82.9%; and a smaller proportion of persons who report having a medical doctor - 86.0% vs. 91.5%. The proportion of the population with a family physician is significantly lower than the provincial average (Access to Primary Care in Ontario: 2009; Health Analytics Branch, Health System Information Management and Investment Division September 2010).
- According to a report released in October 2007, the prevalence of diabetes is significantly higher in the NE LHIN compared to the rest of the province. The report indicated that compared to provincial rates, the NE LHIN has significantly higher rates associated with diabetes for:
 - in-patient hospital discharge;
 - mortality; and
 - emergency department visits.

The NE LHIN will support the provincial Diabetes Strategy to help increase access to integrated diabetes care and education programs.

The NE LHIN has two goals for diabetes care: (1) identify and plan local diabetes initiatives in the NE LHIN; (2) support self-management for those people living with diabetes.

Comments from Louise Paquette, CEO of the North East LHIN:

The CEO provided the context for the forum and round table discussions, describing the strategic considerations in the North East and recognizing the work of the Health Professional Advisory Committee (HPAC) for their leadership and advice in helping to structure the forum. HPAC is a multidisciplinary committee of the NE LHIN's Board of Directors, representing a wide range of health care professionals.

She pointed to the wide range of providers in attendance – from physicians and nurses to administrators and planners—which demonstrates that health care is indeed a continuum and that chronic disease prevention and management has a significant impact on the entire system. The objectives of the forum were also outlined, including:

- To increase awareness of the services needed by those with chronic diseases within the NE LHIN region, which is central to the NE LHIN's mission of improved local access to care.
- To increase awareness of CDPM successes within our region, allow for knowledge exchange, lead to improvement in the health status of NE residents, reduced demand and cost of chronic disease on the NE LHIN health system by identifying integration opportunities or sharing of tools/resources, and the development of equity across the region with respect to resources and services.

Presentations

A series of short presentations provided the participants with background information on the various chronic disease initiatives in the NE LHIN.

Chronic Disease in the NE LHIN – A Physician Perspective
Dr. Ian Cowan, NE LHIN Board member

Doctor Cowan spoke to the challenges experienced by family practitioners, to the changing dynamics in providing health care to those with co-morbidities, and for the need for collaboration and use of best practices.

Working Together for Planned and Proactive Care
Elisha Laughren, Timmins Family Health Team

Elisha Laughren gave an overview of the CDPM programs available at the Timmins Family Health Team (TFHT). She discussed some of the initial challenges experienced by TFHT in providing CDPM services at 6 different sites, with 24 Physicians, 5 Nurse Practitioners serving 21,000 patients. She provided examples of program success and collaboration between the TFHT and the Diabetes Education Program, to program linkages with the Porcupine Health Unit.

Making Everything Count: Measuring Chronic Disease Success in Primary Care
Mary Ellen Szadkowski, Group Health Centre

Mary Ellen Szadkowski described the care maps use by the Group Health Centre. She detailed how evidence based research and best practices are documented at the Group Health Centre. She provided

examples on VIP Action Score and Respiratory Tracking System; the use of simple but effective automotive reports that could be easily adopted by others to track the care and follow-up of their clients.

Northeastern Ontario Stroke Network, Regional Strategic and Evaluation Plan

Sue Verrilli, Northeastern Ontario Stroke Network

Sue Verrilli presented on the Northeastern Ontario Network Strategic Plan. In particular, how the Ontario Stroke Network Report Card based on 20 indicators measuring stroke quality of care across the continuum is reported at a provincial, LHIN and sub-LHIN level. Her presentation provided the participants an opportunity to discuss how the NE LHIN performance is measured against provincial benchmarks, as well as highlight opportunities for collaboration and partnership with the network.

North East Rehab Network, Promoting Access

Andrea Lee, North East Rehab Network

Andrea Lee provided a brief summary on the referral process of the Rehab designated beds, and how the inconsistency of that past process combined with an informal structure led to the creation of the Rehab Network and the Common Inpatient Rehabilitation Referral Form. The Form was briefly discussed as well as recent progress and initiatives taken by the Network.

Early Detection of Chronic Kidney Disease & Prevention of Progression

Lise Corriveau, Ontario Renal Network for North East Region

Lise Corriveau presented the major milestones of the Ontario Renal Network, from the creation of the Regional Networks, the engagement of the stakeholders, to the creation of regional summary reports and capacity planning. In particular, she highlighted the primary care projects, the Aboriginal Community Program Pilots, and how promoting early detection fits into the shared care model.

Complex Diabetes Care

Teresa Taillefer, Sudbury Regional Hospital

Teresa Taillefer introduced the recently established Complex Diabetes Care (CDC) program. She showcased the program development of the CDC, the eligibility criteria and future initiatives the program will take to ensure it provides regional care.

Chronic Disease Self-Management in the NE LHIN

Tracie Parks, Sudbury Regional Hospital

Tracie Parks provided an overview of the Ontario Diabetes Strategy. She then explained the Self-Management program, how it provides both a patient centered workshop and health care provider training. In detail, she discussed the breakdown of the workshop, the session and topics, and its impact on patient care.

Chronic Obstructive Pulmonary Disease (COPD) Management Program

Jo-Ann Lennon Murphy, West Nipissing General Hospital

Jo-Ann Lennon Murphy provided a background on COPD, the creation of the French toolkit, the roll-out of the patient education program, and its partnership with other Francophone stakeholders in providing better care to elderly Francophone patients who have problems conversing in English.

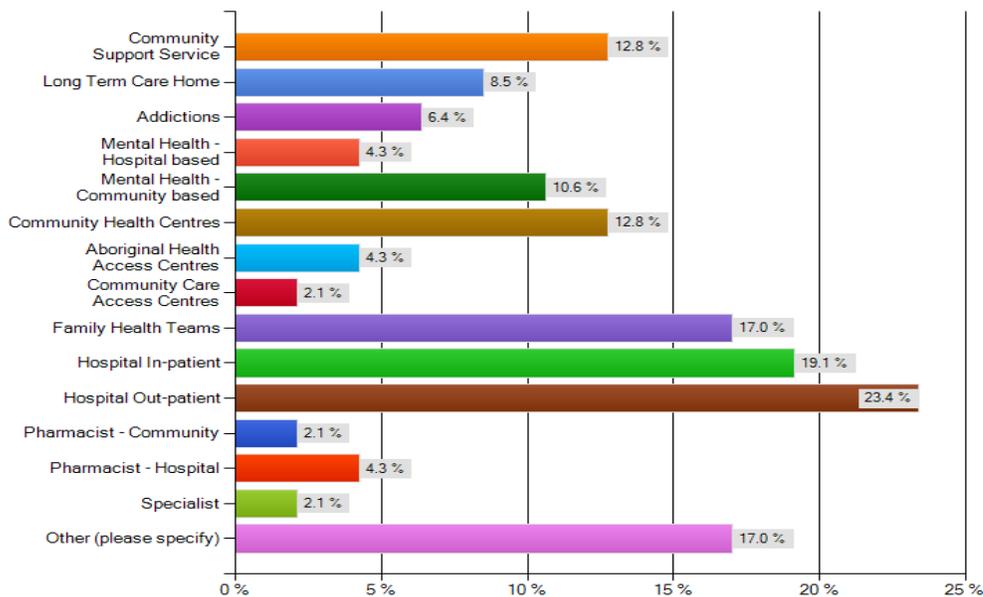
Note: The presentations are available to view or download via the NE LHIN website.

Pre-Meeting Questionnaire

To facilitate the workshop agenda, a link to a pre-meeting questionnaire available in English and French was emailed to our CDPM stakeholders. The questionnaire looked to identify:

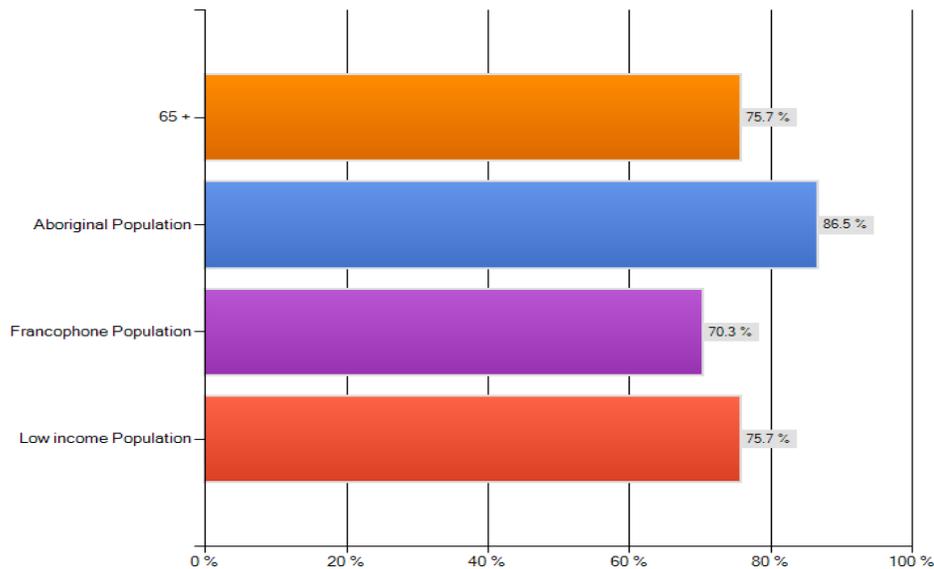
- CDPM programs and services;
- opportunities for collaboration; and
- identification of best practice used by those stakeholders.

Stakeholders who provided their input via the pre-meeting questionnaire represented the following organizations:



NE LHIN Pre-meeting questionnaire September 2011

They served the following populations:



NE LHIN Pre-meeting questionnaire September 2011

As the aim of the pre-meeting questionnaire was to facilitate the creation of the break-out session, the participants were asked a series of questions. The NE LHIN then tallied the answers which are included in Appendix A of this report. Below is a summary of the pre-meeting questionnaire, under three themes: gaps and challenges; discussion topics; and recommendation to the LHIN.

Gaps and challenges

What are the perceived gaps in CDPM related areas?

- Collaboration / public awareness of programs/ formal partnership
- More integrated approach and continuity of care e.g. hospital, home, physician
- Linking of services by HUB
- Need for Self-Management
- Need to link Mental Health and Chronic Disease
- French programs

What are the challenges?

- Communication / information sharing
- Proximity of programs
- Resource – education/ buy-in / limited staff
- Access to programs by First Nation and Francophone community

Identified forum themes

If you could identify one thing that you believe should be discussed at the CDPM workshop, what is it?

- Joint ventures / sharing of program models / best practice
- Information on programs available in the NE LHIN e.g. which programs are available in French
- Screening / asking participants what they need to be better equipped to handle / provide care to CDPM patients

What are the main three priorities the NE LHIN should discuss at the one-day CDPM workshop?

- Identifying resources / education opportunities
- Analyzing community gaps
- Self-Management / health promotion

Recommendations and Next Steps

What recommendations can the participants of this survey make to the NE LHIN regarding strategies and initiatives to move forward?

- Improved information sharing / collaboration
- Easier referrals
- Break down of services by HUB
- Better linkages with CCAC
- Identifying leads in agencies / hospitals who can assist peers who deliver service to chronic disease patients who also have mental illness
- Active promotion of French language program e.g. point of access
- Enable partnership/integration through additional funding

Break-out Session

Participants at the break-out session represented the following organizations:

- 8 FHTs
- 4 CHCs
- 9 Hospitals
- 2 District Health Units
- 4 Aboriginal Health Access Centres
- 2 LTC
- Networks: Stroke, Rehab, ABI, Diabetes, Renal and MS
- Addictions and Mental Health services
- Pharmacist
- NE CCAC

The participants were separated into four colour coded groups (e.g. red, blue, green, and yellow). Each group had regional representation and the discussion were facilitated by NE LHIN staff.

Four themes emerged from the pre-meeting questionnaire that was used to create the break-out session. A summary of each theme from the break-out session is listed below, as well as the input provided from those who completed the evaluation form.

Theme 1: Communication / Sharing of Tools

- Further engagement e.g. forum or other means
- Creation of directory / repository
- Share CDPM information with other stakeholders
- Repository / inventory of CDPM services e.g. list via the portal
- Examine how to better market this community/stakeholder
- Sharing of information / database
- Communicating amongst the different organization
- Website / Community of Practice (CoP) development on CDPM services

- Leveraging social networking tools
- Formalized structure for future communication
- Two audiences – a) professionals and b) public
- Culturally and language sensitive communication plan
- Common CDPM mailing list
- Use of OTN
- EMR linkages

Theme 2: Integration / Collaboration

- Link CDPM stakeholders
- Identify partners and future linkages
- Share models
- Engage physicians / LTC, sharing information & tools
- Use of OTN to provide training / education
- Working collaborative, reducing the silos
- 24/7 info availability
- Team of care / Blanket of care
- Id / inventory of specialist / experts
- Id navigator
- Sharing of tools / resources / develop joint policies
- Development of shared policies
- Sharing of care models
- Access to existing EMR system
- Identify resources

Theme 3: Common Referral and Assessment Tool used region wide

- Look at other models – how they implemented Common Referral across board
- Id point of entry – how is it being accessed?
- Support for region wide referral – examples provided
- Need to ensure referral can be easily accessed / infrastructure in place
- Didn't think the different providers would share one form / who would be the keeper of the form/ could not be left to one organization, couldn't see how it could work
- Needs to be communicated more effectively
- Need a feedback from, so when you do a referral you also know what is happening, getting something back from it
- Referrals applied on services that have similar structure / shared commonalities
- Standardized(process, approach, forms) vs common (tools, screening)
- Referrals need a buy-in, feedback form, navigation tool

Theme 4: How do we increase access to First Nation and Francophone Communities?

- Bilingual documentation, culturally appropriate
- Look at collaboration with those who provide service / involved in projects with FN / Francophone communities

- Id project / services / stakeholders that provide care to FN
- Connect with FN / Francophone – id specific opportunities
- Adapt tool to suit community needs
- Need to know available / what is needed and right language
- Instead of having people and patient going to the site, the site (care van) goes to them / this would expose the providers to what these people deal on a daily basis / service hours increased not just mon – fri 9 – 5 as these people need to work, hours need to be extended
- They like OTN but still need to face-to-face
- Id programs / services ensure culturally appropriate
- Connect stakeholders and id training / sharing of opportunities
- Leverage technologies to increase access to services
- ID experts and tools/resources for training / to share
- Include FN / collaboration
- Promote integration and expanded hours

The results of the break-out session are compiled and included in Appendix B of this report.

NE LHIN CDPM Forum Evaluation

Over 50% of the participants completed the evaluation form. Their feedback indicated the following:

- 98% of the respondents found the forum useful
- 98% found the forum provided them with a better understanding of chronic disease in Northeastern Ontario
- 89% found the presentation by the speakers valuable
- 62.5% would like a follow-up forum with a more clinical focus
- 75% want the NE LHIN to develop an action plan with recommendations

A summary of the responses appear in Appendix C of this report.

The Health Professional Advisory Committee (HPAC) will be meeting on November 16, 2011 for a debriefing on the outcomes of the forum. The Summary of the forum, evaluation and presentations will be provided to the HPAC for consideration as they advise the NE LHIN to the next steps.

Next Steps

The Health Professional Advisory Committee recommends the NE LHIN take the following steps:

| Recommendation | Details | Person Responsible | Timeline |
|----------------|---|---|-------------------------------|
| Action Plan | Create a CDPM Action Plan | Erika Espinoza, Chronic Disease Officer in consultation with HPAC | Fall of 2011 |
| Inventory | Create a NE LHIN CDPM webpage | Erika Espinoza, Chronic Disease Officer and Lance Belanger, Web Service Administrator | Fall of 2011 |
| Inventory | Create a CDPM inventory that identifies services, best practices, referrals tools, training | Erika Espinoza, Chronic Disease Officer | Fall of 2011 – Spring of 2012 |

| | | | |
|---------------------------|---|---|-----------------------|
| | opportunities and if the service is offered in French | | |
| CDPM follow-up Forum | Hold a follow-up CDPM Forum in partnership with the Health Units | Erika Espinoza, Chronic Disease Officer and HPAC members | Spring / Fall of 2012 |
| CDPM follow-up discussion | Discuss CDPM at the Community Engagement mini-submits | Erika Espinoza, Chronic Disease Officer and Cynthia Stables, Senior Corporate Advisor | Spring of 2012 |
| First Nation CDPM Forum | Hold a First Nation CDPM forum in partnership with LAHC / transfer this to LAHC | Erika Espinoza, Chronic Disease Officer and Natalie Atkinson, Aboriginal Officer | Spring of 2012 |

