

## FREQUENTLY ASKED QUESTIONS

### 1. What is Partnerships for Health all about?

The *Partnerships for Health* initiative provides a unique opportunity to apply the Ontario Chronic Disease Prevention and Management (CDPM) framework. Supported by the Government of Ontario, *Partnerships for Health* helps practitioners integrate the component parts of the health care system by sharing information across the continuum of care. There is a specific focus on engaging external partners (CCACs, diabetes education centers, mental health and community pharmacies) with primary care to form partnerships ensuring continuity of care, delivery of evidence-based care across the community, improved linkages to tertiary care, and engaging the patient in self-care. In addition, *Partnerships for Health* prepares practitioners for the province's early adopter implementation plans for eHealth and diabetes.

### 2. Why is the focus on diabetes?

The patient population served by *Partnerships for Health* is adults with diabetes. Diabetes was specifically chosen for this project because of the rigour of the research findings regarding diabetes and the availability of nationally accepted practice guidelines. Data from across Canada and around the world demonstrates the positive impact of these guidelines on clinical outcomes.

A recently released report of the Health Council of Canada found that less than half of Canadians with diabetes get all the lab tests and procedures recommended for high quality diabetes care. These tests are important to monitor blood sugar, blood pressure, cholesterol, kidney health, vision and foot health. The report also found the following clinical outcomes:

- A one percent reduction in blood sugar has been linked to a 14 percent reduction in heart attacks and a 21 percent reduction in deaths related to diabetes complications; and
- Reducing blood sugar for people with diabetes can lower their risk of developing eye disease by 76 percent and their risk of developing kidney disease by more than 50 percent.

### 3. What is the role of home care in Partnerships for Health?

Central to this initiative is a partnership between the family physician and CCAC case manager whose role is to assist the individual with diabetes in navigating the health care system, accessing community resources and linking to specialist services and tertiary care when appropriate. The intent is for home care to be proactively involved in helping those at high risk and with chronic disease before an acute episode.

### 4. How does the Partnerships for Health initiative work?

The initial focus of the initiative is on developing partnerships between the primary care health teams and CCAC case managers. These teams create linkages to care providers across the continuum, from primary through tertiary care. Educational support is provided to these interdisciplinary teams in the form of learning collaboratives, lectures and web-based programs. All practices are assigned a practice coach. Teams use existing materials such as practice guidelines and care algorithms and modify them to reflect their care processes. Teams are given support in

order to apply their patient evidence in planning care and are provided with tools to extract relevant data from their patient files.

A key premise to this approach is providing the right services, in the right place, at the right time, by the right person, thereby leveraging the capability of each member of the health care team.

## 5. Who are the participants of the initiative?

Over 30 primary care practices are enrolled from across the South West LHIN, and additional participants are welcome. In addition, the *Partnerships for Health* partners include:

**South West LHIN.** The LHIN serves as the primary lead for the initiative with oversight responsibility for the project office and key deliverables.

**Primary care physicians/allied health professionals.** Existing primary care practices are the sites for implementing primary care partnerships with CCAC, implementation of clinical algorithms and creating linkages to electronic records and information systems.

**South West CCAC.** The key contribution of the CCAC role is in case management within the test sites, creating linkages to home care providers and aligning information systems within the integrated network. The CCAC also serves as the transfer payment agency, providing oversight of the project agreement and funding arrangement with the Ministry of Finance.

**Community hospitals** (community and referral centres affiliated with each primary care site). Within the South West LHIN, community hospitals provide a key role in diabetes education and support within the local area. As key providers within each community, the hospitals are included in the health care planning and systems integration.

**Physician specialists.** As key partners in the health care continuum, physician specialists participate in the ongoing development of a more robust system of care for patients with diabetes and pre-diabetes; contributing in the areas of treatment, education and research. As academic leaders, these clinicians are key advisors to the clinical planning and evaluation components of the project.

**Centre for Studies in Family Medicine (CSFM), the University of Western Ontario.** As one of eight health system linked research units in Ontario funded by the MOHLTC and the only unit focusing on primary care, CSFM is responsible for the evaluation of the impact of the clinical team integration. The evaluation methodology includes multiple approaches and measures, such as patient interviews, provider surveys and chart audits.

## 6. Are the sites involved in this initiative because there are problems with the way care for patients with diabetes is provided?

No—this initiative is intended to help build upon the current approach to diabetes care.

Participants volunteer to be part of *Partnerships for Health* primarily because they are committed to continuous quality improvement and want to continue to evolve their approach to chronic disease prevention and management.

## 7. What is the goal of Partnerships for Health?

The **goal** of the *Partnerships for Health* initiative is to apply and evaluate key components of the CDPM framework in the South West LHIN by leveraging multi-agency partnerships across traditional health sector boundaries and experiences from other jurisdictions. Specifically, the initiative will advance chronic disease care by:

- Developing partnerships between family physicians/interdisciplinary primary care teams and CCAC case managers and the broader health care community in selected locations within the South West to:
  - Increase adoption/compliance by providers and patients of best practice guidelines for diabetes.
  - Adopt common workflow processes across all participating teams.
  - Enhance communication and enable exchange of health information.
  - Improve access to community resources—right place, right person, right time.
  - Improve linkages to regional diabetes centres.
  - Improve linkages to specialty care, community hospitals and tertiary care providers.
- Empowering patients and promoting self-management by:
  - Providing training and support to health teams to work within a patient empowerment model.
  - Improving access to information so the patient can assume responsibility for health and care outcomes (e.g. knows blood values, better regulates insulin).
  - Engaging the patient in monitoring health indicators.
- Demonstrating the impact of these interventions on improving clinical outcomes by:
  - Reducing the incidence of inappropriate referral to tertiary care.
  - Reducing the incidence of unplanned hospital encounters for unstable diabetes, co-morbidities.
  - Reducing the incidence of emergency care for diabetes management and related co-morbidities.
- Supporting information management, communication and integration between primary health care providers, CCAC and other members of the health team (hospitals, specialists, diabetes education centres) by:
  - Enhancing information sharing between project partners for the purpose of enhancing the delivery of best practice through the application of accepted guidelines.
  - Improving capacity of primary care practices to capture and report data through existing electronic medical records.
- Evaluating the effectiveness and impact of the initiative by:
  - Identifying improvement opportunities and applying learning to subsequent phases of implementation.
  - Assessing the effectiveness of deliverables.
  - Identifying opportunities to translate learning to other jurisdictions.
  - Identifying opportunities to translate learning to other chronic diseases.
  - Identifying future research questions.

### **8. How will information technology be applied to this initiative?**

To assist the clinical integration component of this initiative, information management support is provided to each team to enhance their use of current technology and facilitate the exchange of health information among providers. This support is provided through on-site, local, and web-based coaching and education tools and resources, making use of current technology and on-site processes to allow the efficient management of information relevant to patient care.

### **9. What is the timeline for Partnerships for Health?**

The initiative commenced January 28, 2008 and will conclude January 28, 2011. There have been three waves of practices participating in a range of learning and coaching techniques to facilitate team development, adoption of practice guidelines and process redesign. **Wave Three** is running currently until October 2010, and is accepting up to 100 primary care sites from the South West LHIN in one of four learning approaches:

- a. Spread Collaboratives
- b. Web-based Programs
- c. Knowledge Transfer Sessions
- d. Practice Coaching.

All three waves will participate in a final Outcomes Congress in October 2010 at which time experiences will be shared and discussion will focus on sustaining the gains beyond the life of the project and enabling further spread of practice changes within group practices and communities.

### **10. What will be the outcomes of Partnerships for Health?**

*Partnerships for Health* is anticipated to show improvement in four key outcome areas:

1. Partnership Development
2. Patient Empowerment
3. Clinical Measures
4. Communication and Information Sharing.

For each of these outcomes areas, a number of indicators will be developed, agreed upon by the partners and measured as part of the evaluation strategy.

### **11. How does Partnerships for Health fit with the work of the LHIN?**

*Partnerships for Health* will serve to demonstrate on a small population the impact of many of the recommendations arising from the LHIN Priority Action Teams. Many of the specific recommendations arising from the Chronic Disease and Diabetes Priority Action Teams will be applied through the initiative.

**For more information: [www.partnershipsforhealth.ca](http://www.partnershipsforhealth.ca)**