

# Partnerships for Health

A Chronic Disease Prevention and Management Initiative

## Leading the Way

*Partnerships for Health (PFH)* is at the forefront of province-wide initiatives to tackle chronic disease management and introduce electronic health records



**You could say it's a case of being in the right place at the right time. Thanks to recent announcements from the Ontario government, PFH will now have more impact.**

The government confirmed the South West Local Health Integration Network (LHIN) as an early adopter of the provincial e-Health strategy and as a site for advancing team-based family health care as a component of the diabetes strategy. With these announcements came a commitment to make new resources available. Says Kelly Gillis, Senior Director, Planning, Integration and Community Engagement with the South West LHIN, "This means we can refocus existing PFH funding to support a broader reach to more primary health care settings."

Information technology has always been a key component in PFH. The original plans called for the creation of a system to support patient self-care and connect providers across disciplines and organizational boundaries. Now the Ontario government has committed significant funding for a diabetes registry, starting in "early adopter" LHINs like the South West. Once fully implemented, the registry will provide instant access to electronic information and educational tools to help patients manage their care. Doctors will be able to use it to check patient records, access diagnostic information and send patient alerts. It is expected to be operational by Spring 2009.

Diane Beattie, Integrated Vice President and Chief Information Officer, London Health Sciences Centre and St. Joseph's Health Care, London and Strategic Alliances e-Health Lead for the South West LHIN, explains that the registry is in turn part of a larger vision to have long-promised Electronic Health Records (EHRs)

for all Ontarians by 2015. "Chronic disease management will be used as the starting point for the EHR," says Beattie, "and implementation will begin in 'early adopter' LHINs." That means that people in the South West will enjoy the benefits of EHRs – sooner.

In the short term, the PFH initiative will not change dramatically. The first wave will proceed as planned, with FHTs in Brockton, Clinton and Strathroy following through on their improvement efforts. The second wave, however, will involve more primary care practices than originally planned and the third wave will reach some 100 practices. "We've evolved from being a demonstration project to being a cornerstone of the South West LHIN e-Health strategy," says Barb Willis, a member of the PFH leadership team. "Instead of developing our own solutions, we will now be focused on helping family practices prepare for the electronic solutions being developed at the provincial level."

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Expansion of the PFH initiative is good news for everyone, says Gillis. "There are a lot of resources in our LHIN to support diabetes management but it's not always easy to understand how all the pieces fit together," she says. "PFH allows providers to better understand what resources exist and how best to use them. Knowing that there is continuity of care and that information is being shared across the circle of care is good for patients too."

## Definitely Not a Spa Day

The first PFH Learning Collaborative session is held



**B**enmiller Inn is a tranquil resort where many go to be pampered and primped. Not so for the group of 40 participants from the PFH site teams who met there in late September for a busy and challenging two-day learning session.

“We don’t make it easy,” says Marg McAlister, a member of the PFH leadership team. “We lay out the concepts and let the site teams figure out how to operationalize them in their own contexts. That’s the most sustainable approach.”

Among the outstanding speakers at the session was Dr. Stewart Harris, a family physician with a special interest in diabetes care. He set the stage by pointing out that in 1985 there were an estimated 30 million people in the world living with diabetes: by 2030, that number is expected to be 370 million. Regardless of treatment, diabetes is progressive, he told the group, and lifestyle changes alone are not enough to manage the disease.

But the news is not all bad. “If we don’t discover anything else about diabetes in the next 30 years,” Dr. Harris said, “we have enough knowledge now to effectively manage the disease and prevent complications.” He went on to share the recently-released 2008 guidelines for diabetes care, discussing glycemic management, management of high blood lipids and high blood pressure, and prevention of nephropathy and neuropathy. For many participants, it was an opportunity to better understand the overall clinical management and reflect upon their contribution toward achieving the best outcomes.

Sandra Coleman, Executive Director of the South West Community Care Access Centre (CCAC), also addressed the group, encouraging them to take a fresh look at community care. “We’re a new organization with a revitalized mandate,” she said, “We are committed to supporting primary care better than ever before.”

Eileen Patterson of the Ontario Health Quality Council talked about the challenges and benefits of integration, using a pilot project in Taber, Alberta as a case study. Among the positive outcomes of that project: patient travel was significantly reduced, health providers had better access to one another, and physicians were more satisfied with the level of care they were able to deliver. “Don’t just think about what happens when you’re talking to the patient,” she urged the group. “Think about what happens in the gap between that conversation and their next conversation with a provider.”

Other sessions addressed improvement models, self-management support, planned visits, measurement and reporting, and the use of information technology to improve management of patient information.

McAlister says feedback on the session was positive, and participants left feeling energized. Over the next three to four months, each site team will look at their patient profile, select some strategies to improve care, implement them, and measure the results. They will be supported by coaches from the PFH leadership team. In January they will gather again to share their experiences and results. “Then we’ll challenge them to take it further and do more,” says McAlister. “This is all about breaking out of our current paradigms and working in new and different ways.”

For more information about Partnerships for Health:

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