Partnerships for Health
A Chronic Disease Prevention and Management Initiative

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Backgrounder: Partnerships for Health Initiative

- Partnerships for Health was funded by the Province of Ontario and sponsored by the South West Local Health Integration Network and the South West Community Care Access Centre.
- Launched in early 2008, the goal of the initiative was to integrate the component parts of the health care system by:
  - > Sharing information across the continuum of care
  - > Advancing primary and community care partnerships and linkages to tertiary care
  - > Engaging patients in self-care
  - > Enabling improved information management
- Diabetes was chosen as a focus because of the high prevalence rate and potential for improvement.
  - > More than 7% of people in South West Ontario aged 20 or older have diabetes mellitus
  - > Only 58% of diabetes patients in Ontario are tested for blood sugar levels, and less than half of those tested have optimal sugar levels
  - > 97% of patients taking insulin have retinopathy, yet almost half of all people with diabetes in Ontario have gone more than one year without an eye exam
- The first wave of Partnerships for Health consisted of three integrated teams from Brockton, Clinton and Strathroy.
- In January 2009, an additional nine teams joined the initiative.
- In total, 73 primary care practices across the South West LHIN were involved.
- The teams included doctors, nurses, diabetes educators, CCAC case managers, mental health practitioners, pharmacists, and other community providers.
- The teams developed care improvements based on Ontario's Chronic Disease Prevention and Management Framework. They tested them using the using a model developed by the internationally renowned Institute for Healthcare Improvement, and then implemented successful changes in their practices.
- The teams received technical support to help improve their use of electronic medical records.
- Practice coaches worked with each team as facilitators, convenors, skill builders, knowledge brokers and change agents.
- CCAC case managers met with the family practice teams to ensure people with diabetes were connected with resources in the community to manage diabetes and avoid hospital.
- A formal independent evaluation of the initiative is being conducted by the Thames Valley Family Practice Research Unit.
- Partnerships for Health teams reported that:
  - > Patients received more regular screening tests and more comprehensive, proactive care
  - > Clinical outcomes improved
  - > Patients felt more satisfied and supported, and more confident about managing their own condition
  - > Communication and collaboration among health professionals providing primary and community care to people with diabetes improved
  - > People were connected with more resources in the community and avoided hospital
- Partnerships for Health will change the way chronic disease is managed across the South West.
- The lessons of Partnerships for Health will be sustained and shared in the months and years ahead.

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Backgrounder: South West Local Health Integration Network

- The South West Local Health Integration Network (LHIN) is a crown agency responsible for the planning, integration and funding of nearly 200 health service providers including hospitals, long-term care homes, mental health and addictions agencies, community support services, community health centres, and the South West Community Care Access Centre.
- 14 Local Health Integration Networks (LHINs) were created across Ontario in 2006.
- The South West covers an area from Lake Erie to the Bruce Peninsula and is home to almost one million people.
- In 2009/10, the South West LHIN allocated over $1.9 billion to the following health service providers:
  > 20 hospital corporations (33 sites)
  > 1 community care access centre (South West CCAC)
  > 76 long-term care homes
  > 60 community support services
  > 4 community health centres (1 additional in development.)
  > 38 mental health and addiction agencies
- The LHIN works closely with but is not directly responsible for the funding of physicians, public health, ambulance services, laboratories, and provincial drug programs.
- The South West LHIN Board of Directors developed the Health System Blueprint in 2009. The Blueprint is a framework for how the system should be structured and contains the vision of an integrated system of health care across the South West.

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Backgrounder: South West Community Care Access Centre

- The South West CCAC is one of 14 CCACs across Ontario
- The CCAC is a local point of access to community-based health care
- It is funded by the Ministry of Health and Long-Term Care through the South West LHIN
- The CCAC connects people with the care they need to:
  > Recover at home from illness, injury or treatment in hospital
  > Live independently in the community
  > Die with dignity at home
  > Care for children with chronic illnesses or disabilities
  > Apply for admission to a long-term care home
  > Manage chronic disease
  > Find a family physician
  > Link with other services and supports in the community
- The CCAC has 600 full-time equivalent employees at seven local offices and in all hospitals across the South West
- More than 60,000 clients are served every year
- *Vision:* Outstanding care – every person, every day
- *Mission:* To deliver a seamless experience through the health system for people in our diverse communities, providing equitable access, individualized care coordination, and quality health care
- The CCAC is guided by a Community Board of Directors
- The annual budget for 2010-2011 was $171 million
- 93% of South West CCAC clients rate their satisfaction with their care as good or excellent