Central East Priority Project Summary

Project Name: Strengthening Diabetes Care in CE LHIN: Leveraging the 2008 Diabetes Clinical Practice Guidelines

Purpose of Board Review	☐ For Information Only ☐ For Approval ☒ For Endorsement to Proceed with Further Planning/Refinement/Review		
Project Charter Sponsor(s)	Central East Diabetes Network		
Project Type	☐ Service Enhancement ☐ New Service / Program ☒ Integration Activity ☐ Demonstration Project	☒ Single Phase Project ☐ Multi-Phase Project	
Funding Required	$72,000 $25,000 (2007-08) $52,000 (2008-09)		
Funding Source	LHIN Priority Funding	Funding Year (s) 2007-08 and 2008-09	Funding Type One Time
Anticipated Project Owner (Accountability)	☐ CE LHIN ☐ CE LHIN Health Service Provider	☒ Assigned CE LHIN Project Team	
Project Deliverables / Goals	▪ Design and implementation of a CE LHIN Strategy to improve awareness of diabetes and uptake of 2008 Clinical Practice Guidelines		
Project Timelines	Start: December 2007	Completion: March 2009	
Project Reviewed By:	**Networks:** CDPM Steering Committee received update on project goals; Members participate on project sponsor group **Collaboratives:** No **Task Groups:** Primary Care Working Group will receive an update Oct 2007 **CE LHIN Staff:** Involved in Charter Development		

Strategic Directions

- ☒ The LHIN Board will lead the transformation of the health care system into a culture of interdependence.
- ☐ Healthcare will be person-centred in safe environments of quality care.
- ☐ Create an integrated system of care that is easily accessed, sustainable and achieves good outcomes.
- ☒ Resource investments in the Central East LHIN will be fiscally responsible and prudent.

Priorities for Change

- ☐ Seamless Care for Seniors
- ☐ Mental Health and Addictions
- ☒ CDPM
- ☐ Wait Times and Critical Care

Enablers

- ☒ Primary Care
- ☐ E-health
- ☐ Health Services Planning
- ☐ Health Human Resources
- ☐ Diversity
- ☐ Back Office Transformation
- ☐ Moving People Through The System

System Outcomes

☐ Accessible	☐ Safe	☐ Appropriately Resourced
☒ Effective	☐ People Centred	☐ Equitable
☐ Efficient	☒ Integrated	☐ Focused on Population Health

Project Name: **Strengthening Diabetes Care in CE LHIN: Leveraging the 2008 Diabetes Clinical Practice Guidelines**		Project Acronym or No.: **Diabetes CPG 2008**	
Project Sponsor: Central East Diabetes Network	Project Coordinator: TBD	Target Project Completion Date: 2009/03/31	
Project Lead/Project Manager: TBD		Version No.: 0.2	Version Date: 2007/10/02

Project Background

The Central East Local Health Integration Network (CE LHIN) Integration Health Service Plan (IHSP) identifies the prevention and management of chronic disease as a LHIN priority; diabetes is identified as an initial condition on which to focus activities. Further the IHSP recommends that partnerships be encouraged between diabetes care and education providers to develop strategies related to delivering effective, coordinated, consistent care and standardized tools and education across the CE LHIN. This project will advance these objectives.

This is the inaugural project undertaken by the CE LHIN Diabetes Network (CEDN), which was formed in August 2007. The CE LHIN Diabetes Network is the expert condition-specific advisory group of the broader CE LHIN CDPM Network. The CEDN is the first sustained effort to coordinate, on a CE LHIN basis, stakeholders in diabetes education and care.[1] This project would provide a solid foundation on which a robust, performance oriented LHIN wide Diabetes Network will develop. Although newly established, the CEDN members/organizations have a solid track record of developing and delivering professional and client based programs. Examples include, but are not limited to the work of the Durham Region Diabetes Network including education sessions to introduce the Chronic Care Model and Stanford Self Management Support to health professionals; the development of a regional physician's referral form; development of Certified Diabetes Educator (CDE) community of practice, initiation of a pilot self management support group program, standardized community based diabetes education without physician referral, an Active standardization working group, development of a Physical Activity (Fitness) work group and related communication strategy targeting the hard to reach chronic care clients. This project will build knowledge and relations across the CE LHIN amongst diabetes stakeholders.

The Clinical & Scientific Section of the Canadian Diabetes Association is preparing to release the 2008 Clinical Practice Guidelines (CPG) in the Spring 2008 (specific date not available). The CDA Dissemination & Implementation Committee is developing a nation-wide rollout strategy. Advice from the CDA DPG Committee has been provided regarding this project. This project is intended improve the readiness of health service providers and the public in CE LHIN to receive and implement the 2008 CPGs. A pre-launch preview of the CPGs highlights is scheduled for October 27, 2007. This project will leverage the opportunity created by the CPG 2008 by creating local momentum for uptake; it is not intended to pre-empt the official release and will utilize the rollout tools and adopt guidelines for rollout from the CDA as they become available.

Clinical Practice Guidelines[2]

The 1998 Clinical Practice Guidelines for the Management of Diabetes in Canada were the first comprehensive, evidence-based, clinical practice guidelines for diabetes care that allowed readers to independently judge the value of the diagnostic, prognostic and therapeutic recommendations. A volunteer expert committee comprised of key stakeholders across Canada drafted the Canadian Diabetes Association 2003 Clinical Practice Guidelines for the

[1] Current membership is expanding but presently includes all Diabetes education centres (hospital and Community Health Centre), representatives from the Durham Region Diabetes Network and pharmacy. The group has identified the need to expand to include physicians, social work, Chiropody, Optometry, renal care and primary prevention/Public Health Units.

[2] 2003 CDA Clinical Practice Guidelines, Introduction

Project Background

Prevention and Management of Diabetes in Canada. The process included a broad-based review to ensure that the diabetes community at large had input into the document. It is expected that the process for development of the 2008 guidelines will build on the learnings from the 2003 roll-out process.

2003 CDA Dissemination and Translation of Guidelines[3]

Health care providers have been inundated with clinical practice guidelines during the last decade. While the effect of guidelines in primary care practice has been under-researched, studies on this topic have shown that guidelines have often fallen short of their intended objective to improve patient care and health outcomes. Therefore, the publication of guidelines should be seen as the starting point, rather than the end
point, of their dissemination.

The challenges of effective dissemination and implementation of guidelines is recognized by CDA. The dissemination strategy is being developed concurrently with the development of the 2008 guidelines. The 2003 guidelines included appendices and clinical and patient tools, a searchable web-based version and identified additional resources to help clinicians adopt and implement evidence-based recommendations. Further, the CPGs provide evidence about prevention and management of diabetes which will also be translated into messages targeted to the general public and people with diabetes. It is expected that these tools for implementation will be further strengthened in the 2008 CPGs.

Background on Diabetes in Ontario

Diabetes is a chronic illness that affects more than 800,000 people, or 8.73 per cent of Ontario's population. About one in 20 Canadians will develop diabetes. More than 60,000 new cases are diagnosed annually, including 20,000 in Ontario. (Insert CE LHIN #s)

The exact causes of diabetes are unknown. In most cases, both hereditary and lifestyle factors are involved. There are two main types of diabetes: Type 1 and Type 2. A third type, gestational diabetes, is a temporary condition that occurs during pregnancy.

Type 1 diabetes occurs when the pancreas is unable to produce insulin. It is usually diagnosed in children and adolescents. Approximately 10 per cent of people with diabetes have type1 diabetes. Type 2 diabetes occurs when the pancreas does not produce enough insulin or when the body does not effectively use the insulin that is produced. It usually develops in adulthood, though children can develop type 2 diabetes as well. Type 2 diabetes accounts for most of the remaining 90 per cent of people with the illness.

If left untreated or improperly managed, diabetes can result in a variety of complications, including:
- Heart disease
- Kidney disease
- Eye disease
- Problems with erection (impotence)
- Nerve damage

Diabetes is a serious chronic disease that is costly to both the affected individual and to society and requires the daily commitment of the individual with diabetes to self-manage through a balance of lifestyle and medication. Because of the complex nature of the disease, diabetes management requires regular access to health care services to prevent long-term complications.

[3] 2003 CDA Clinical Practice Guidelines, Introduction

Project Background

Ontario Diabetes Strategy:

The $35 million Ontario Diabetes Strategy is focused on diabetes education, early intervention and effective prevention of complications. Ontario's diabetes strategy includes the following initiatives:

- The Pediatric Diabetes Initiative (PDI) for children with type 1 diabetes was established to make appropriate education, treatment and follow-up resources available to children with diabetes and their parents by 34 programs across Ontario
- The Diabetes Complications Prevention Strategy (DCPS) was created to provide basic-level diabetes education programs in southern Ontario.
- The Southern Ontario Aboriginal Diabetes Initiative (SOADI) was developed and continues to be directed by representatives of all major Aboriginal organizations in southern Ontario.
- The Northern Diabetes Health Network (NDHN) was established to address the high rate of the disease and lack of services for it in Northern Ontario. The network funds 34 diabetes education programs in large and small northern communities.

Diabetes Education:

Educating patients is essential in the treatment of diabetes, and people with diabetes are encouraged to take an active role in the day-to-day management of their own health care. Self-care, however, requires that patients have certain skills. Ontario's 50 Diabetes Education Centres (DEC) assist people to develop the skills they need to manage their diabetes and prevent complications. Based on the Best Practice recommendation of the CPG each DEC consists of an interdisciplinary team of a nurse, a dietitian and a physician advisor. The team may also include a nurse practitioner, social worker, clinical psychologist, chiropodist, pharmacist and/or physiotherapist. In addition to the supports provided as part of the Ontario Diabetes Strategy, the province provides funding for diabetes equipment and supplies for individuals requiring insulin under the Assistive Devices Program (ADP).

Project Scope

Project Purpose

	The launch of the 2008 Diabetes Clinical Practice Guidelines is an opportune time to increase awareness of diabetes in the CE LHIN. This project will develop a CE LHIN specific strategy to increase the profile of diabetes, diabetes services and implementation of the 2008 CPG. The Central East Diabetes Network (CEDN) will utilize the tools and guidelines developed by the Canadian Diabetes Association in the design and implementation of the local roll-out plan. The CE LHIN dissemination strategy will not be finalized and fully implemented until after the release of the Clinical Practice Guidelines however, to be effective and ready for the release, work needs to begin immediately in preparation for this roll-out. This project will be the cornerstone for enhanced coordination amongst diabetes stakeholders and consistency of practice across the CE LHIN; it is an ideal inaugural project for the new CEDN. The project will: • increase the health service provider and public knowledge and understanding on diabetes; • provide health service providers including physicians' with knowledge of the new 2008 guidelines; • provide public and health service providers with information on what resources are available to them and their patients in their community for diabetes; • provide a foundation of LHIN wide diabetes information and establish the

Project Purpose	
	relationships necessary to improve coordination between diabetes care/care providers themselves and coordination with those who deliver supports for other chronic conditions such as cardiovascular, chronic kidney and respiratory disease.

Strategic Alignment	
	1. Advances actions in the CE LHIN Integrated Health Service Plan related to diabetes coordination. 2. Leverages national roll-out of CPG within CE LHIN.

Project Benefits	
	1. Increased public awareness of diabetes and diabetes care and supports. 2. Improved likelihood of implementation of CPGs by HSPs.

Goals, Objectives & Performance Measures

GOAL:

To develop a Strategy to improve awareness of diabetes and uptake of 2008 CPG within CE LHIN

Objectives	Deliverables	Performance Measures
Objectives are clear statements of specific activities/tasks that must be performed to achieve the goals. Identify both project product/service and people/organization change objectives.	*Deliverables are tangible, verifiable outcomes that signify completion of objectives.*	*Performance measures are used to determine if objectives have been completed. They check if the expected results have been successfully achieved. For each objective/deliverable, list the measures that will be used to evaluate success of results achieved.*
1. Increase health service provider and public knowledge and understanding on diabetes;	A. Develop a profile of diabetes and diabetes care in CE LHIN. B. Develop strategies for dissemination of profile to public, various HSPs including physicians C. Identify CE LHIN target populations/providers	• Profile completed • Strategies identified and implemented • CE LHIN diabetes stakeholder database developed
2. Improve awareness of public and health service providers regarding CE LHIN diabetes resources.	A. In partnership with CCAC and other community information providers, develop strategies to increase awareness of local resources.	• More than 50 % of physicians are aware of the new CPG • Clients report being aware of the CPG

3. Increase knowledge of the new guidelines and implementation amongst health service providers including physicians.	Building on CDA dissemination tools/guidelines, A. Develop CE LHIN specific roll-out and uptake strategies including but not limited to, exploration of CE LHIN Continuing Medical Education (CME) education sessions for physicians and other health service providers[4]	• CDA tools disseminated to CE LHIN 100% of physicians • Pre-post questionnaire at CME indicate increased knowledge of differences in 2003 and 2008 CPG
4. Develop a Community of Practice amongst CE LHIN diabetes stakeholders. Extend links from the Diabetes Community of Practice to those who provide care and supports for other chronic conditions such as cardiovascular, chronic kidney disease and respiratory disease are formed.	A. Diabetes stakeholders are working collaboratively amongst themselves and with other providers of chronic disease care to implement best practices and develop shared knowledge. B. Resources and tools for implementation of CPGs are disseminated to various chronic disease providers.	• Non-diabetes specific stakeholders are participating in education and/or report utilizing CPG tools. • 100% of cardiovascular, nephrology and respiratory services report receiving information on CPG

Project "IN" & "OUT" of Scope Items

"IN" Scope	"OUT" of Scope
• Dissemination of CDA developed tools • Utilization of existing directories/databases to identify diabetes stakeholders (health service providers, community agencies) in CE LHIN • Develop local media advocacy strategies to build on CDA national dissemination plan • Exploration of Continuing Medical Education (CME approved) education sessions for physicians and other health service providers	• Creation of new tools for public or health service provider use (CDA tools will be utilized and adapted)

Project Timelines

High-Level Milestones	Target Completion Dates
Hire Initiative Consultant	♦ December 2007
Develop a profile of diabetes and diabetes care in CE LHIN.	♦ January - February 2008
Identify CE LHIN target populations/providers	♦ January - February 2008
Develop proposed strategies for dissemination of profile to public, various HSPs including physicians In partnership with CCAC and other community information providers, develop	♦ Feb – April 2008

[4] Partnerships with pharmaceutical industry will be explored

High-Level Milestones	Target Completion Dates
strategies to increase awareness of local resources.	
Explore and as appropriate, develop a plan to deliver CE LHIN Continuing Medical Education (CME) education sessions for physicians and other health service providers	♦ December 2007 – July 2008
Resources and tools, where necessary, are developed and are disseminated to various CE LHIN chronic disease providers.	♦ Spring 2008
Evaluation of CE LHIN CPG strategy is designed and conducted	♦ December 2007 , July 2008

Project Costs

Category	2007-08	2008-09	TOTAL
Initiative Consultant	20,000	16,000	36,000
Consultant Travel (500/mth)	2,000	4,000	6000
*CME Session (200ppt *$50)*		10000	10,000
Resource Dissemination:			
*printing ($2.50*1600items)*	500	3,500	4000
*Postage(2.50*1600items)*	500	3,500	4000
communications/advertising	2,000	10,000	12000
Evaluation tool design – included in consulting fees	-	-	-
TOTALS	**25,000**	**47,000**	**72,000**

Funding Source

CE LHIN Priority Funding for core Strategy Development and Communications/Local Tool roll-out

Pharmaceutical Industry for support to CME Education will be sought

Canadian Diabetes Association for resource tools

Project Team

Team Member, Organization	Role on the Project	Required Involvement	
		Estimated Duration	Level of Effort
• Members (or designates) of the Central East LHIN Diabetes Network • Member of the Durham Region Diabetes Network • Family Physician • Specialist/Endocrinologist • Member of the CE LHIN CDPM Network Steering Committee • CE CCAC • Consumer/Caregiver • LHIN Communications Team • MoHLTC Diabetes Program	• Provide advice on development of the Strategy • Media advocacy by CE LHIN DN upon release of CDA CPG		

Project Partners

Partners	Common Interests & Priorities	Roles & Responsibilities
• Canadian Diabetes Association • Ministry of Health (Diabetes Program) • Pharmaceutical Industry • Pharmacies in CE LHIN		

Project Stakeholders

Stakeholders	Interests & Needs	Management Strategies
• Health Service Providers including physicians • Consumers/caregivers • General public	• Information and tools that are easy to understand and implement	• Utilize CDA tools/guidelines and augment with local resource information

Other Related Projects & Initiatives

Project/Initiative	Interdependency & Impact
• CDA CPG Dissemination Strategy	• CE LHIN strategy will have to be reviewed and adjusted as necessary upon release of the CPG 2008

People & Organization Change Impacts

Description of Impact	Impact Management Strategies
Diabetes Education Centres	• very positive impact if project funded: likely will result in greater compliance by health care provider of CPG (best practice) because broad reach and increased intensity of local campaign

Project Communications

Audience	Information Needs	Format & Timing	Responsible
• Communication will be a core element of the Strategy			

Project Risks

Risk	Likelihood	Impact	Risk Response
• CDA strategy is all encompassing and over-rides a need for CE LHIN level rollout strategy	• Low	• High	• Baseline information on CE LHIN diabetes (profile, resources) will continue to be relevant

Critical Success Factors

- Alignment with CDA roll-out
- Physician participation
- Diabetes Education Centre participation

Assumptions & Constraints

Assumptions	Constraints
• CDA CPG rollout will benefit from development of a local CE LHIN action plan	• CE LHIN work must be completed to coincide with CPG release

Sign-Off

Workstream Lead/Project Sponsor		
Name & Organization	Signature	Date
CDPM Steering Committee		

Project Lead/Project Manager		
Name & Organization	Signature	Date
CE Diabetes Network, Chair/Representative		

Project Partners		
Name(s) & Organization(s)	Signature(s)	Date(s)
CDA		

Project Team Members		
Name(s) & Organization(s)	Signature(s)	Date(s)

Charter Revision History

Version Numbering:
- 0.x - internal draft - under development *(Working copy for Project Coordinators)*
- 1.x - document under review / internal draft *(Begin 1.0 numbering when sent to Workstream Lead for comment)*
- 2.x - document submitted for approval *(Begin 2.0 numbering when sent to Oversight for approval)*
- 3.x - document approved *(Renumber to 3.0 after Oversight Approval)*

Revision No.	Description	Modified By	Date
0.1	Development of first draft	Jeanne Thomas	Oct 1, 2007
0.2	Input to draft	Tracy Howson, DRDN Coordinator	Oct 3, 2007