# Central East Priority Project Summary

**Project Name: Self Management Training for Consumers and Caregivers in Central East LHIN**

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|---|---|
| **Purpose of Board Review** | ☐ For Information Only<br>☐ For Approval<br>☒ For Endorsement to Proceed with Further Planning/Refinement/Review |
| **Project Charter Sponsor(s)** | Durham North Central Collaborative |
| **Project Type** | ☐ Service Enhancement<br>☒ New Service / Program<br>☐ Integration Activity<br>☒ Demonstration Project<br>☐ Single Phase Project<br>☒ Multi-Phase Project |
| **Funding Required** | $ 487,200 [**2007-08**: $123,400] [**2008-09**: $363,800] |
| **Funding Source** | LHIN Priority Funding<br>Funding Year (s)<br>2007-08, 2008-09 beyond based on Evaluation<br>Funding Type<br>2 Yr. Demonstration |
| **Anticipated Project Owner (Accountability)** | ☐ CE LHIN<br>☒ CE LHIN Health Service Provider<br>☐ Assigned CE LHIN Project Team |
| **Project Deliverables / Goals** | • Introduction of a consistent Chronic Disease Self-Management Model [CDSM] across the Central East LHIN.<br>• Establishment of a core group of Master Trainers and teams of Peer Leaders. (target: 36 by end of Yr 2)<br>• Self-Management Training Sessions for people with chronic conditions and their caregivers (target participants: 900 by end of Yr 2) |
| **Project Timelines** | Start: December 2007<br>Completion: New Program – Evaluation at end of Yr 2 (2008-09) |
| **Project Reviewed By:** | **Networks:** CDPM Steering Committee received update on project goals; Members participate on project sponsor group<br>**Collaboratives:** Durham North Central Collaborative lead Charter Development<br>**Task Groups:** No<br>**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
- ☒ Effective
- ☐ Efficient
- ☐ Safe
- ☒ People Centred
- ☐ Integrated
- ☐ Appropriately Resourced
- ☐ Equitable
- ☒ Focused on Population Health

| Project Name: **Self Management Training for Consumers and Caregivers in Central East LHIN** | | Project Acronym or No.: **CDSM** | |
|---|---|---|---|
| Workstream Lead/Project Sponsor: CDPM Steering Committee | Project Coordinator: Jeanne Thomas | Target Project Completion Date: A new program for CE LHIN | |
| Project Lead/Project Manager: **Project Charter Development**: Durham North Central Collaborative & Other Planning Partner Representatives **Project Implementation:** Lead Project Sponsor Agency (LPSA)* | | Version No.: 0.6 | Version Date: 2007/10/01 |

* The LHIN will identify the LPSA during project Start-up; the LPSA will lead implementation of the new program as outlined below.

## Project Background

The Central East Local Health Integration Network's (CE LHIN) Integrated Health Service Plan (IHSP) 2007-2010, identifies prevention and management of chronic disease as a LHIN-wide priority. The IHSP identifies the provincial Chronic Disease Prevention and Management (CDPM) Framework and the CDPM Model as the guidelines for improvements to the system of care for people with chronic conditions within the CE LHIN. Self-Management is a core component of the CDPM Model.

Further, the IHSP identified the need to adopt and implement a consistent self-management model across the CE LHIN. This project will achieve that objective; it is proposed as LHIN wide program. This project would be an effective provincial demonstration project for potential application in other LHINs.

Self-management is defined as a patient-centred, collaborative approach to care that promotes patient activation, education and empowerment. [i] Self management is identified as key to achieving the CDPM Model's three stated outcomes; *productive interactions* amongst *informed and activated patients* working with a *prepared and proactive practice team*.

Improving an individual's ability to self-manage their chronic condition is recognized as a contributor to consumer health and well-being and increasingly, the sustainability of the healthcare system. Self management emphasizes the importance of taking responsibility for one's own health. Research has shown that self-management programs can improve health status in people and can reduce healthcare service utilization among those with chronic conditions. Research yields a ratio of approximately $1 invested: $10 saved. [Source: Stanford Patient Education and Research Centre - http://patienteducation.stanford.edu/programs/cdsmp.html]

People with chronic disease and their caregivers play a central role in managing their disease on a day-to-day basis. Self management recognizes that people with chronic conditions, must work with their caregivers and healthcare support team to manage their medical needs, everyday roles and responsibilities and emotional issues. For example, a person with diabetes has medical management needs including blood glucose self-monitoring, medication taking, nutrition management, physical activity, managing high/low blood sugar, foot care, eye care and keeping medical appointments. In addition to managing medical needs, people with chronic conditions must also manage their everyday need to go to work, school, compete in athletics or cook as well as deal with the emotional stress (e.g. depression, denial, anxiety, fear) associated with having a long-term, potentially disabling, condition.

Self management programs require a commitment from the person with the chronic disease and their health care providers. Consumers and their families/caregivers benefit from education and training to empower them to be confident, active participants in positively managing chronic conditions. Self-management advances the principle of self-efficacy; individuals are their own agents for health and need the confidence, empowerment and skills to be able to be effective.

The Chronic Disease Self Management Program (CDSM) [commonly referred to as the Stanford University model or Kate Lorig model] has been adopted within Canada and internationally as best practice. CDSM is a six week, 15 hour

## Project Background

interactive program for people with chronic conditions and/or their caregivers. Subjects covered include:

- techniques to deal with problems such as frustration, fatigue, pain and isolation;
- appropriate exercise for maintaining and improving strength, flexibility, and endurance;
- appropriate use of medications;
- communicating effectively with family, friends, and health professionals
- nutrition, and;
- how to evaluate new treatments.

In the CDSM Program, Master Trainers train Peer Leaders. Two Peer Leaders deliver the Program to groups of approximately 10-15 people with a chronic condition. Each peer leader must have a chronic condition and one member may be a health service provider. The program is applicable for all chronic conditions and can be adapted for different age groups. The CDSM model augments, and does not replace disease specific medical education/teaching, which remains necessary. CDSM should be offered in readily accessible locations within the community (i.e. where people live or go regularly such as schools, supportive housing, food banks, churches, recreation centres, libraries, community health centers etc.). Increasingly, it is recommended that self management programs should be offered in concert with exercise/physical activity programs for a complete approach to “living well’ with a chronic condition and include a follow-up component. These two additional elements are included in the CDSM approach proposed for CE LHIN.

Awareness of the importance and benefits of chronic disease Self-Management and the Stanford CDSM program is growing amongst Health Service Providers in the CE LHIN. This project will leverage this growing interest and provide the foundation for development of a robust, consistent and sustainable CDSM program in the CE LHIN.

## Project Scope

### Project Purpose

PLEASE SEE GOALS AND OBJECTIVES FOR SPECIFIC SUGGESTIONS ON MOVING FORWARD.

The purpose of this project is to consistently implement the Chronic Disease Self-Management Model [CDSM] across the Central East LHIN. The LHIN will adopt the CDSM as the preferred Self Management education program for the LHIN and will pursue consistent implementation by incorporating CDSM into Service Accountability Agreements with Health Service Provider Agencies.

The project will produce a core group of Master Trainers and teams of Peer Leaders to deliver the CDSM program in the CE LHIN. The number of Master Trainers and Peer Leaders will grow each year.

During the 15 hour – 6 week, licensed program, Peer Leaders work *with* consumers and caregivers to set reasonable goals for health and lifestyle modifications and build their capacity and confidence to achieve these goals.

The CDSM project for CE LHIN will also include a formal follow-up/follow-through component and a required link to exercise and lifestyle adjustment programming. These additional components build on the core CDSM program and are recommended enhancements to further increase the positive outcomes.

An evaluation of the CE LHIN program will be conducted. The CDSM model has been extensively evaluated.

There will be two phases:

**Phase 1:** Includes project start-up/initiation, development and implementation components.

## Project Purpose

**Phase 2:** Builds on Phase 1 of the CDSM program. The Project Team will initiate action to implement an additional IHSP priority: Self-Management in Home Using Health Monitoring Equipment. In Phase 2, the Project Team will work with the Ontario Telemedicine Network's Tele-Homecare project, the CE LHIN Ehealth Steering Committee and other interested partners to develop a Project Charter to demonstrate and then implement more broadly, Self-Management in-home devices to monitor medical conditions and video conferencing.

## Strategic Alignment

This project is aligned to national, provincial and CE LHIN priorities and strategies. Self Management Training goes beyond promoting an individual's responsibility for maintaining their own health through appropriate utilization of healthcare services and adoption of healthy life-styles (e.g. diet, exercise) to encompass maintenance of their own well-being.

Central East LHIN

- Project will advance the stated objectives of the LHIN Vision: Engaged Communities – Healthy Communities namely "People are supported and proactively engaged in managing their own health and wellness"

- Applicable to all priority populations and complimentary to numerous LHIN priority projects including:
  - Caregiver Support project;
  - Disordered Eating project;
  - Enhanced Case-management project of the Primary Care Working Group;
  - Mental Health and Addictions projects;
  - Pain Management;
  - E-Health Working Group.

Provincial

- Self Management is a key component of the CDPM Model and the Ontario Chronic Disease Prevention and Management Framework;

National

- Project advances the objectives and expectations of the Ottawa Charter of Health Promotion namely enabling people to increase control over, and to improve their health. The Charter identifies that to reach a state of complete physical, mental and social well-being the individual or group must be able to identify and realize aspirations; to satisfy their needs, and to develop strategies to change or cope with their environment. [1]

## Project Benefits

Consumers & Family/Friend Caregivers:

- Supports individuals with multiple chronic conditions.
- CDSM Evaluation demonstrates success with adult populations but with modifications CDSM can be offered for youth.
- CDSM offers generic self-management training which augments disease or condition-specific education.
- Supports an individual's or caregiver's desire to be involved in own care and informed about what is available in

[1] Ottawa 21 November 1986 WHOHPR/HEP/95.1

## Project Benefits

their community.

- Individuals who took the CDSM (Stanford) Self Management Program, when compared to those who did not, demonstrated significant improvements in[2]:

    - exercise,
    - cognitive symptom management,
    - communication with physicians,
    - self-reported general health,
    - health distress,
    - fatigue,
    - disability, and
    - social/role activities limitations

    They also spent fewer days in the hospital, and there was also a trend toward fewer outpatients' visits and hospitalizations.

    Sustained results for as long as three years. Note: this is without a formal follow-up component for the program as planned for CE LHIN program.

- Trainers, Leaders and Programs will be identified from various communities in the LHIN and programs offered in locations in which groups of people with chronic conditions congregate/live; leveraging local health service provider readiness/capacity and reducing requirement for consumer/caregiver to travel to obtain support.

Health Service Providers & Agencies:

- Promotes awareness and potentially, use of disease/condition specific programs presently offered within the LHIN.
- Assists clients with day-to-day coping and problem-solving thus reducing un-necessary healthcare visits (e.g. physician/primary care provider, Emergency Department).
- Provides a similar platform for client support between various agencies. This build the relationships needed for improved communication between agencies about services delivered and needs of common clients.
- A common registry of Master Trainers, Peer Leaders and consumers/caregivers who have taken the program.
- Provides a mechanism for training and follow-up with their clients who have multiple chronic conditions
- Promotes awareness of HSPs and consumers/caregivers of the services that are available in the community.
- Builds expertise within HSPs in various communities.
- Builds on current Self Management initiatives underway in the CE LHIN (e.g. Durham Region Diabetes Network Self Management Support initiative, St. Elizabeth Healthcare, Carefirst for Seniors, Ross Memorial CDPM Clinic).

Health Care System:

- Consistent and coordinated application of the CDSM model across all HSPs and communities in the CE LHIN.
- Promotes partnerships between agencies/institutions (i.e. physical space, provision of trainers, common clients enrolled in a common program)
- Stanford evaluation of CDSM yields a cost to savings ratio of approximately $1 invested: $10 saved [3] Accordingly, the program has the potential to reduce costs to health system in CE LHIN and slows the acceleration of

[2] Stanford University – Patient Education and Research Centre.
[3] Stanford University - Patient Education and Research Centre.

## Project Benefits

healthcare costs through cost avoidance – although it is acknowledged that this is difficult to track through a large scale implementation of the program.

## Goals, Objectives/Deliverables & Performance Measures

### GOAL

*This project has the following, single Goal:*

**Chronic Disease Self Management (CDSM) is a core strategy for the prevention and management of chronic diseases in each of the CE LHIN's Planning and Engagement Zones.**

| 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. Program start-up/initiation | A. LHIN will identify one Lead Program Sponsor Agency (LPSA) to lead program start-up/initiation, development and implementation. The LPSA will be accountable to the LHIN for development and implementation of the program.<br><br>The LPSA will:<br><br>B. Hire a Project Developer/ Coordinator for development and implementation of the program.<br><br>C. Identify and engage in planning, existing agencies that are providing CDSM in CE LHIN. (i.e. Carefirst for Seniors, St. Elizabeth Healthcare, the Arthritis Society, Ross Memorial Hospital)<br><br>D. In collaboration with the LHIN, implement a communication campaign to market the CDSM program to health care stakeholders and the general community and communicate the specifics and benefits of the SM program<br><br>E. Implement Education Session(s) to | • Lead Program Sponsor Agency selected and Service/Program Accountability Agreement signed with LHIN.<br>• Project Developer job description developed and hired.<br>• Engaged existing agencies that offer CDSM program within CE LHIN<br>• At least 10 Agencies contacted about participation in the CDSM program (e.g. client's stories shared/ disseminated and agency interest determined)<br>• Education/Launch session(s) held<br>• Lead Agencies selected and service agreements developed.<br>• Lead Agency has developed a coordinated plan for their catchment area (provider, communities) |

## Goals, Objectives/Deliverables & Performance Measures

### GOAL

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| OBJECTIVES | DELIVERABLES | PERFORMANCE MEASURES |
|---|---|---|
| | launch the Project with health service providers and the community (e.g. involve potential Lead Agencies).<br><br>F. Identify Lead Agencies for geographic communities or populations. Lead Agencies will provide trainers and organize programs in their area. Lead Agencies will be accountable to the LPSA and to the LHIN for the delivery of the CDSM program. | |
| 2. Mechanisms and resources required to coordinate, expand and evaluate the program are in place. | A. Project Coordinator hired.<br>B. Develop a registry to track Master Trainers, Peer Leaders and consumers who have received training and/or participated in education sessions.<br>C. Create a Website or develop a CE LHIN Home Page to support development of a "community of best practice" amongst Master Trainers and Peer Leaders.<br><br>D. Design and implement the qualitative and quantitative evaluative processes needed for continuous quality improvement and program sustainability. | • Project Coordinator job description developed and hired.<br>• Registry created, used and made available.<br>• Website/page developed with current information and "community of practice" established.<br>• Evaluation tool developed, completed and results available.<br>• Statistical reports that meet LHIN reporting requirements are produced |
| 3. A core team of Master Trainers and trained Peer Leaders in CE LHIN is created.<br><br>(Note: St. Elizabeth Healthcare Master Trainers have been offered to assist in project start-up by delivering education sessions and if needed, Peer Leader training sessions). | A. Master Trainer program is offered.<br>B. Peer Leader training program offered. | • 18 Master Trainers trained per year.<br>• Minimum of one PL Training session offered by each Master Trainer each year. |

## Goals, Objectives/Deliverables & Performance Measures

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| OBJECTIVES | DELIVERABLES | PERFORMANCE MEASURES |
|---|---|---|
| 4. CDSM program is implemented consistently in each Planning Zone across the LHIN. | A. Develop consistent program delivery and resource materials.<br>B. Establish consistent costs for participants in the program.<br>C. Acquire cost effective Stanford Licensing for all programming in the LHIN.<br>D. CD Self Management program is coordinated across agencies and communities within the various communities across the LHIN. | • Resource package/template developed<br>• Consistent costs established<br>• Licensing acquired<br>• Fair and equitable delivery of SM programs to consumer and caregivers regardless of location. |
| 5. Identification of SM leaders from various geographic communities across the LHIN (i.e. individuals and/or Health Service Providers) | A. LHIN board implements a fair, transparent and equitable process to identify one Lead Program Sponsor Agency for the LHIN<br><br>B. The LPSA implements a fair, transparent and equitable process to identify Lead Agencies within geographic communities across the LHIN.<br><br>C. Creation of a SM Council to advise on implementation of the CDSM program. Participants will include the LPSA, SM Leaders/ Lead Agencies, physician champion(s),allied healthcare provider and CE LHIN Planning Partnerships (i.e. CDPM Steering Committee). | • Each Collaborative has discussed/provided input to design of CDSM model/Lead Agency proposal in their area<br><br>• Lead Agencies for SM identified to cover all areas of LHIN<br><br>• SM Council is established and sets evaluation criteria for CE LHIN SM system including but not limited to:<br>a. Improved coordination amongst SM providers to identify and reduce redundancy;<br>b. Consistent program implementation;<br>c. Promote awareness of SM program;<br>d. Quality monitoring and improvement. |
| 6. CDSM offered in conjunction with disease or condition specific medical education and exercise/physical activity is incorporated/linked into all CDSM programs | A. Consumers/caregivers are participants in disease/condition specific education sessions and CDSM programs.<br>B. CDSM programs incorporate and/or link participants to physical activities/exercise. | • Increased number of consumers/caregiver who complete CDSM and disease/condition specific education.<br>• Increased participation in exercise programs (e.g. pre and post exercise participation survey) |

## Goals, Objectives/Deliverables & Performance Measures

### GOAL

*This project has the following, single Goal:*

**Chronic Disease Self Management (CDSM) is a core strategy for the prevention and management of chronic diseases in each of the CE LHIN's Planning and Engagement Zones.**

| OBJECTIVES | DELIVERABLES | PERFORMANCE MEASURES |
|---|---|---|
| Follow-up:<br>7. Lead agency establishes most appropriate mechanism to measure application of core SM skills by graduates.<br>(e.g. problem-solving, decision-making, resource utilization, forming a patient/healthcare provider partnership, taking action on own health) | A. Lead Agency carries out follow-up which may include<br>1. Telephone follow-up;<br>2. Peer to peer links/buddy system or support groups<br>3. Three month follow-up session;<br>4. Consumer/caregiver survey | • 100% of graduates have incorporated SM Skills into their daily lives. |
| 8. Explore opportunities to extend CDSM programs to include in-home medical monitoring and consultations. | A. Develop a Project Charter to guide Phase 2 – the demonstration and implementation of in-home devices to support Self Management. | • Project Charter developed<br>• Project Team for Phase 2 in place |

## Project "IN" & "OUT" of Scope Items

| "IN" Scope | "OUT" of Scope |
|---|---|
| Start-up, development and implementation of the Central East CDSM program as outlined above, including use of current telemedicine capacity across the LHIN. | Phase II: In home tele-monitoring equipment and/or in-home tele-video consults. |

## Project Timelines

| High-Level Milestones | Target Completion Dates |
|---|---|
| Lead Program Sponsor Agency identified (One for the LHIN) | November/Dec 2007 |
| Hire/second Project Developer/Coordinator and Administrative Support | December 07/Jan 08 |
| Launch: Education Session on CDSM | January/February 08 |
| Initial CDSM Leaders Council (Project Team) formed | January/Feb 08 |
| Inaugural CDSM Sessions held – utilizing existing Master Trainers from St. Elizabeth Healthcare | Jan – March 08 |

## Project Timelines

| High-Level Milestones | Target Completion Dates |
|---|---|
| Lead Agencies identified | June 08 |
| Registries developed | Could start when LPSA identified (2 mos) |
| New Master Trainers trained | April/May 08 |
| Peer Leaders Trained | Starting June 08 |
| On-going Education Sessions planned & offered | Starting Dec 08 |
| Evaluation Consultant retained; tools designed and implemented | January 08(retained) |

## Project Costs:

| Targets & Assumptions: | | | 2007-08 | 2008-09 | 2009-10 | Total |
|---|---|---|---|---|---|---|
| # of Master Trainer's Trained | | | | 18 | 18 | 36 |
| # of inaugural SM sessions to be seed bed for future PL | | St. Eliz Agency to provide 18 MT to provide 18 SM sessions to 10 clients/session. Out of these 90 people potential PL to be trained in Year 1 will be identified. | 180 SM graduates | | | |
| # of Peer Leaders Training Sessions (delivered by MTs) | | One session delivered by a pair of MTs per yr | 0 | 9 | 18 | 27 |
| # of Peer Leaders Trained | 20 | per session | 0 | 180 | 360 | 540 |
| # of SM sessions delivered by a pair of PL | 1 | Each session needs two Peer Leaders Each pair could deliver 2 sessions then their role is discontinued. These numbers assume that 1 pair deliver 1 session only hence allowing for volunteer availability. | 0 | 90 | 180 | 270 |
| SM Program Participants | 10 | clients per session | 180 | 900 | 1800 | 2900 |

| Self-Management Training Project Budget | | Explanation | 2007-08 | 2008-09 | 2009-10 | Total |
|---|---|---|---|---|---|---|
| Project Developer/Coordinator | | salaries and wages | 31250 | 75000 | 75000 | 181250 |
| benefits 22% | | | 7188 | 17250 | 17250 | 41688 |
| ODOE 5% | | | 1563 | 3750 | 3750 | 9063 |
| Admin. Assistant- shared/PT | | | 8333 | 20000 | 20000 | 48333 |
| benefits 22% | | | 1917 | 4600 | 4600 | 11117 |
| ODOE 5% | | | 417 | 1000 | 1000 | 2417 |
| Event Hosting ( I time) | | Education/Launch 200 people @$50/person/day; includes speaker costs $1500. | 10000 | | | 10000 |
| Expert Consultation | | Michael Hindmarsh/Hindsight: $1500/day- | 3000 | 3000 | 3000 | 9000 |
| Ongoing Education<br><br>Creating a community of practice amongst Master Trainers and Peer Leaders | | $50/person (master trainers or peer leader) | | 5400 | 10800 | 16200 |
| Communications/ Marketing | | Access to experts: displays, Ads, web site | 2500 | 1500 | 1200 | 5200 |
| Client material costs @ $20/person | | FY: see Inaugural session;Yr.1: 900; Yr.2:1800; Yr.3:2700 | | 18000 | 36000 | 54000 |
| Training Master Trainers | | Stanford University Trainer will be brought to Ontario to deliver training to Master Trainers<br>FY:0 Yr. 1:18 Yr.2: 18.Yr.3:18<br>@$1500 registration fee /person + $6000 Stanford Instructor cost + Air Travel $600+$1000 Hotel fee.<br>MTs receiving training will not be compensated for time away from agency | 0 | 34600 | 34600 | 69200 |
| Inaugural SM session | | St. Eliz MT to conduct 9 SM sessions with 10 clients /session @ no charge for time although $20/participant for books | 3600 | | | 3600 |
| Training volunteer Peer Leaders | | Each training session (4day) for PLs based on 20 participants and 2 MT trainers= $4300<br>Comprised of $3000 = MT compensation; books/copy costs $500 + $800 lunch<br>Yr.1: 0 sessions x 4300<br>Yr. 1: 18 sessions x 4300<br>Yr. 2: 27 sessions x 4300 | 0 | 38700 | 77400 | 116100 |

| | | | | | | |
|---|---|---|---|---|---|---|
| Peer leaders compensation providing training | | Year 1:$100 compensation fee/6wk session x 90 sessions ( 15h ea.)x2 leaders . Year 2: $100 x 180 sessions. Year 3 : $100x 270 | 0 | 9000 | 18000 | 27000 |
| Licensing | | $500 fee for 10 or fewer workshops / year $800 for offering 20 or fewer workshops /year $1000 for offering 30 or fewer workshops/year Year 1: 27 sessions ( 9zones@3 sess./zone) Year 2: 36 sessions (9z.@4 sess./z. ) Year 3: 45 sessions (9z.@5 sess./z.) | 1000 | 1000 | 1800 | 3800 |
| Follow-up/Follow-Through | | Lead Agency carries out follow-up which may include $75/client i. Telephone follow-up; ii. Peer to peer links/buddy system or support groups iii. 6 week follow-up session; iv. Consumer/caregiver survey | 13500 | 67500 | 135000 | 216000 |
| External evaluation | | | 16000 | 8000 | 8000 | 32000 |
| **Sub-Total** | | **For calculation of Administration Fee for LPSA** | **100267** | **308300** | **447400** | **855967** |
| Administration Fee for Lead Project Sponsor Organization | | 18% of total budget - office space, computer, IT, Phone, Housekeeping, staff travel, Long distance charges, postage, office supplies, professional development | 23123 | 55494 | 80532 | 159149 |
| **Totals** | | | **123 389** | **363 794** | **527 932** | **1 015 115** |

## Funding Source

- LHIN Priority Funding
- MoHLTC new resources for CDPM implementation – as identified (Provincial Strategy)
- Redirection by Agencies of current funding used for SM and/or education
- Ministry of Health Promotion

## Project Team

| Team Member, Organization | Role on the Project | Required Involvement | |
|---|---|---|---|
| | | Estimated Duration | Level of Effort |
| The CE LHIN Self Management Program Council will be the Project Team to advise the LPSA during development and implementation.<br>Target Size = 9-12people including:<br>1. Consumer/Caregiver<br>2. Master Trainer<br>3. Peer Leader<br>4. Agency(s) currently offering CDSM Program (Community and Institutional)<br>5. Physician - Primary Care Working Group linkage<br>6. Ehealth Work Group Linkage<br>7. CDPM Steering Committee Representative<br>8. Public Health Unit<br>9. CCAC<br>10. CHC<br>11. Citizen - general public | • Advisory to the Project Sponsor and the LHIN for implementation<br>• Develop Project Charter to guide Phase 2 (IT in home using SM) | | |

## Project Partners

| Partners | Common Interests & Priorities | Roles & Responsibilities |
|---|---|---|
| **Project Partners:**<br>Provincial:<br>Ministry of Health – branches TBD<br>Ministry of Health Promotion<br>Public Health Units<br><br>HSPs: core, but not limited to:<br>CE CCAC<br>Community Support Services<br>Community Health Centres<br>Diabetes Education Centres<br>Hospitals<br>Supportive Housing providers<br>Pharmacy<br><br>Child and Youth Service Providers for children with long-term conditions and disabilities (i.e. Children's Treatment Centres)<br><br>Family and Specialist Physicians (GP/FP, cardiology, nephrology, etc.)<br><br>LHIN Planning Partnerships:<br>Collaboratives (9)<br>CDPM Network<br>Seamless Care for Seniors Network<br>Primary Care Working Group<br>Other:<br>Stanford University - CDPM Self Management Program<br><br>Private and Not-for-profit visiting nursing and personal care agencies | | |

## Project Stakeholders

| Stakeholders | Interests & Needs | Management Strategies |
|---|---|---|
| • Health Service Providers<br>• People with chronic conditions<br>• Caregivers of people with chronic conditions | • Will provide support to the care provided by HSPs; will be involved in advisory/leaders Council<br>• Consumers and caregivers are direct recipients of education. | • Participation on advisory committees<br>• Involvement in program delivery as Peer Leaders<br>• Evaluation of program |

## Other Related Projects & Initiatives

| Project/Initiative | Interdependency & Impact |
|---|---|
| LHIN Projects:<br>Seamless Care for Seniors Network projects<br>CDPM Network projects<br>Caregiver Support Project<br>Disordered Eating Project<br>Community Projects/Initiatives:<br>St. Elizabeth Healthcare – various in LHIN<br>Carefirst for Chinese Seniors (Diabetes) – Scarborough<br>VON – Chronic Disease Program<br>Durham Region Diabetes Network Self Management Initiatives<br>Arthritis Society SM Program | |

## People & Organization Change Impacts

| Description of Impact | Impact Management Strategies |
|---|---|
| • Shift thinking of health service providers regarding benefit of self-management<br>• CDPM programs will need to re-align/allocate resources to backfill their staff who become SM Master Trainers<br>• CDPM programs will adjust programs to include attendance of participants in SM<br>• Education sessions for disease specific conditions will need to be aligned to coincide with SM support. Most programs have own education which will need to be aligned/connected (e.g. Diabetes Education | • Ensure communication to health providers so cognizant of project |

## People & Organization Change Impacts

| Description of Impact | Impact Management Strategies |
|---|---|
| Programs and physicians) | |

## Project Communications

| Audience | Information Needs | Format & Timing | Responsible |
|---|---|---|---|
| • Physicians (will work with the PCWG)<br>• HSPs<br>• Extended Family members<br>• Consumers<br>• Caregivers<br>• General Public<br>• Boards of Directors of HSP<br>• Community Leaders/Politicians<br>• Media | • 360 degree approach to Marketing - targets consumer awareness and targets those in their circle of influence (family, friends, providers, physicians)<br>• Link with community providers (churches, agencies, rec departments)<br>• Self Management needs to be seen as a move forward and not simply a cost reduction program. | • Many meetings, information sessions and presentations need to take place. | • LPSA/Project Manager and SM Council |

## Project Risks

| Risk | Likelihood | Impact | Risk Response |
|---|---|---|---|
| <u>Opportunity:</u><br>Demonstrates a significant shift in LHIN and MoHLTC thinking/action from illness to wellness/health promotion. | | | • A full communications & Education plan is required to ensure broad buy in. |
| <u>Threats:</u><br>HSP may not be willing to work collaboratively to support and promote generic CDSM training (e.g. share resources, re-align current programs) | Moderate | High | |
| Physician/HSP buy-in to shifting responsibilities to support client/caregiver self-management | Moderate/ high | M/H | |
| Client participation<br>Not all clients are able to self-manage | Low/ Moderate | M/H | |
| Viewed as a cost reduction measure | Moderate/High | M/H | |

## Project Risks

| Risk | Likelihood | Impact | Risk Response |
|---|---|---|---|
| Opportunity or Threat:<br>Must be a component that is woven into service delivery models | Low/Moderate | High | |
| Widespread recognition that SM is an essential need and significant change in attitude for all (HCPs, consumers, me, you) | High | High | |
| SM is leading a change in behaviour at an individual level – this represents a significant shift in healthcare delivery philosophy/approach –consumer has shared responsibility and core contributor to the team; | Moderate | High | |
| Compensation for current programs who are moving ahead to implement Stanford SM in advance of CE LHIN program implementation will need to be compensated/ acknowledged. Current agencies offering programs will be encouraged to 'join' in the implementation of the CE LHIN SM program | High | Low/Moderate | |

## Critical Success Factors

- Successful negotiations with Stanford for licensing and roll-out
- Identify all potential partners, including the media, for roll out to the community in a coordinated media plan.
- Need to have CDPM Steering Committee/LHIN promote awareness of uptake of Self-Management – importance of education on SM. Promote importance of self management.
- Core Funding
- Buy-in from HSPs and participation of people living with chronic conditions

## Assumptions & Constraints

| Assumptions | Constraints |
|---|---|
| • That there will be moderate uptake by users<br>• CDSM can handle this size of rollout/level of generalization because of earlier successes; | • Requires licenses and relationship/agreements with Standford<br>• Do not believe it has been undertaken on this scale and in this manner. This might be a unique application. |

## Sign-Off

**Workstream Lead/Project Sponsor**

| Name & Organization | Signature | Date |
|---|---|---|
| Co-Chairs CDPM Steering Committee | | |

**Project Lead/Project Manager**

| Name & Organization | Signature | Date |
|---|---|---|
| Charter Development: Bill Eull, Durham North Central Collaborative Chair | | |

**Project Partners**

| Name(s) & Organization(s) | Signature(s) | Date(s) |
|---|---|---|
| | | |

**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 | Charter Team | July 30 2007 |
| 0.2 | Second Draft | Charter Team | Aug 24 2007 |
| 0.3 | Third Draft | Charter Team | Sept 17 2007 |
| 0.4 | Fourth Draft | Charter Team | Sept 24 2007 |
| 0.5 | Fifth Draft | Charter Team | Sept 25 2007 |
| 0.6 | Final Draft – for CDPM Steering Committee comment | CDPM + LHIN Senior Team | Oct 1, 2007 |
| | | | |

**Appendix A:**

**LPSA AND LEAD AGENCY ROLES AND RESPONSIBILITIES**

The following additional input is provided regarding the roles and responsibilities of the LPSA and the Lead Agencies. This information should be referenced, and augmented as required, by the LHIN when identifying a Lead Program Sponsor Agency and by the Project Team/Council.

- **Role of Lead Program Sponsor Agency (LPSA):**
    - The LPSA may also deliver services, as required.
    - Data collection – statistics (program level)
    - Standardization
    - Coordination amongst partners
    - Capacity building (program level)
    - Monitoring of quality assurance/consistency with use of model
    - Support the LHIN wide – SM Lead Council
    - Financial Responsibilities: Hold and disperse program resources
    - Marketing of program LHIN wide
    - Explore partnership with Educational Institutions (i.e. UOIT, Trent) for training of Master Trainers and Peer Leaders and Phase 2: Self Management using in-home monitoring devices.

- **Role of Lead Agencies for Self Management in Planning Zones/Communities**
    - Accountability – reporting to LPSA and LHIN
    - Data collection – statistics
    - Capacity building at community level
    - Participate in LHIN wide – SM Lead Steering Committee
    - Marketing of program within Zone, in coordination with Leads from other Zones
    - Zone level coordination – promote awareness of programs being offered; connection between providers in Zone
    - InterZone Coordination, especially regarding public communication and distribution of resources
    - Intake - Bookings of consumers to sessions
    - Data Reporting
    - Fund management
    - Demonstrated partnerships with other agencies
    - Innovative means to reach/educate youth, other populations in importance of SM and CD management.

[i] Wagner EH, Glasgow RE, Davis C et al. Jt Comnt Journal of Quality Improvement 2001; 27:63-80