Central West
LOCAL HEALTH INTEGRATION NETWORK

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LEADERS COME TOGETHER **TO ADDRESS CHRONIC DISEASE**

With challenge comes opportunity, and that's exactly what the Central West LHIN's Leadership Forum on March 30th was all about – opportunity. Bringing together 90 diverse participants including health and social care leaders, as well as clients, the full-day session opened the doors to innovative and collaborative thinking on the topic of chronic disease prevention and management.

Statistics clearly show that chronic disease in Ontario is a growing health care issue. According to Statistics Canada (2003), 80 percent of people over the age of 45, or 3.7 million Ontarians, are living with a chronic disease. What's more concerning is that 70 percent of those individuals are living with two or more chronic conditions such as arthritis, high blood pressure, diabetes, osteoporosis, asthma, depression, cancer and the effects of stroke.

If you translate those numbers into dollars, the resources necessary to support these conditions across the province represent 55 percent of provincial health care costs.

Representatives from various organizations collaborating and providing feedback during group sessions.

Chronic disease impacts almost every aspect of our health system from family physicians and specialists to community agencies, hospitals and long-term care homes. It was this common thread that brought together a distinguished panel of expert speakers who shared their experiences and insights into best practice approaches for chronic disease prevention and management.

To place the day's presentations in perspective, the forum began and concluded with comments from clients, emphasizing the importance of patients' point of views and the increased opportunities for successful prevention and management when patients take an active role in their care. Patients are, after all, what the LHIN's work is all about.

"The reality is that 80 percent of ischemic heart disease, lung cancer, chronic lung disease and diabetes cases could be prevented with what we know today," says Dr. Michael Rachlis, a consultant in health policy analysis, noting that this could free up 2,900 acute care hospital beds in Ontario and reduce costs. *"However, for this to happen, system change is necessary because our current system is designed to manage acute illnesses, not prevent and manage chronic illnesses."*

Echoing that sentiment was Sophia Papadakis, Project Leader with the Champlain Cardiovascular Disease Prevention Network. (CCPN). The CCPN is

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a group of health and community partners dedicated to reducing the burden of heart disease and stroke in the Champlain region. *"We recognized the opportunity to link resources from health care, public health and academia, to share a common strategic focus and goals, and to mobilize our resources to maximize our capacity for prevention, management and research,"* says Papadakis, emphasizing that these actions will ultimately improve individual and population health outcomes. *"By working together across jurisdictions, across health care sectors and across chronic diseases, greater impacts can be achieved."*

Members of the Panel keenly engaged in the presentation by the Key Note speaker.

(left) **Mark Cassleman**
Project Manager, Shared Information Management Systems
University Health Network

(right) **Dr. Frank Martino**
Chief of Family Medicine
William Osler Health Centre

CCPN has embraced the province's Chronic Care Model as a framework for change, and is poised to provide cardiovascular disease interventions in seven key areas: primary care, specialty care, hospitals, work sites, schools & families, communities, public policy, and surveillance & performance evaluation.

"The idea is to move away from a state of 'project' mentality where individually funded programs have little or no sustainability, to a more transformational concept where integrated, system-level interventions can have a significant impact on population health."

Mike Hindmarsh, President of Hindsight Healthcare Strategies, acknowledged that the Chronic Care Model (CCM) developed by the MacColl Institute for Healthcare Innovation, upon which Ontario's model is based, is being successfully applied in multiple countries and settings with diabetes, depression, asthma, chronic heart failure, cardiovascular disease, arthritis and geriatrics.

"The CCM provides an ideal approach for spreading health system change," says Hindmarsh. *"Two of its defining features are informed patients, actively involved in the self-management of their chronic diseases, and prepared, proactive practice teams that are able to provide care that patients understand and that fits their culture and health needs."*

Key Note speaker, **Mike Hindmarsh** *addresses a group of 90 attendees on CDP&M.*

Chronic disease prevention and management is one of eight health care priorities identified by the Central West LHIN in our Integrated Health Service Plan (IHSP), which will guide health care planning over the next three years.

The Leadership Forum follows on the heels of two successful chronic disease prevention and management best practice seminars held recently for physicians.

"This is clearly an opportunity for us to start thinking collaboratively as a health system," notes Mimi Lowi-Young, CEO, Central West LHIN. *"We all want to contribute to improved outcomes for residents living with chronic diseases in our communities, and coming together like this was an important first step to starting the dialogue that will bring about positive change."*