

Chronic Disease Management Plan

Refresh Framework:
2009/10 – 2012/13



Final – August 31, 2009

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“Better together”

Purpose of this Framework

The inaugural VIHA Chronic Disease Management (CDM) Plan 2006/07-2008/09 laid the foundation for an innovative business approach embedded in relationships, partnerships and empowerment.

It is now time to refresh this Plan and reconfirm our vision, principles, and business model. We have consulted with and received input from our many partners to develop targeted strategies for work in the coming three years. Partners include:

- Chronic Disease Management Providers
- VIHA Programs
- VIHA Family Practice Council
- Non-Governmental Organizations
- Provincial Primary Health (PHC) Care Council

VIHA CDM Plan 2006/07 – 2008/09: What Has Been Accomplished

Significant progress has been made in the area of Chronic Disease Management in VIHA. The following table highlights our priority strategies from the inaugural plan and the accomplishments to date:

Area of Investment	Accomplishments to Date
Sustainability & Growth of Collaborative Program for Service Integration (CPSI)	<ul style="list-style-type: none"> • Transitioned into the PHC Regional Support Program overseeing the Integrated Health Networks (IHNs), Practice Support Program (PSP), and CDM Forums (CDMF) (with island-wide reach). • Exceeded targets for physician engagement across the island through PSP - 296 GPs participating in Regional Support Program (242 in PSP, 75 with IHNs, 29 with Seniors At Risk Integrated Network (SARIN), 123 CDMF).
Sustain and grow current VIHA program and services in Diabetes and Nutrition	<ul style="list-style-type: none"> • Island-wide management team with Central/North Island leader • Standardized referral and intake • Established Quality Improvement Committee • Diabetes and Nutrition Services Review • Integrated Care Clinics and specialty internal medicine clinics
CDM Service Frameworks for Integrated Care at the Provincial level	<ul style="list-style-type: none"> • Dementia Care framework • Arthritis • Chronic Obstructive Pulmonary Disease (COPD) • Congestive Heart Failure • Stroke Strategy
CDM Steering Committee	<ul style="list-style-type: none"> • Established in 2006 • Secretariat support- not available in 2007 • Disbanded in 2008 • Renewed mandate in 2009 with CDM Plan Refresh
Interdisciplinary Team CDM Education	<ul style="list-style-type: none"> • The CDM Forums are educational opportunities and will be provided through the PHC Regional Support Program across the island (bi-annual sessions in North and Central Island, quarterly sessions in the South Island communities) • PSP modules • IHN learning sessions • Interdisciplinary teams to Institute for Healthcare Improvement (IHI) Office Practice Summit
CDM Public & Provider website	<ul style="list-style-type: none"> • PHC/CDM website completed, linkages to related websites • Content for provider site - under review
Primary Mental Health Care Task Force	<ul style="list-style-type: none"> • Secured Specialist Service Committee (SSC) funding for building mental health capacity in GP practices in the South Island and Aboriginal communities (Ladysmith Community Health Centre obtained a psychiatrist/1x/week) • Canadian Mental Health Association (CMHA) Bounce Back program- pilot sites in Victoria, Sooke and Nanaimo • Central Island pilot sites of Nanaimo, Port Alberni, Oceanside and Campbell River for General Practice Services Committee (GPSC) funded Community Health and Resource Directory (CHARD) program

The Basics: Vision, Definition, Principles

Vision

At present, the Vancouver Island Health Authority has approximately 39% of its population living with at least one chronic disease. Our Ambulatory Care Sensitive Conditions (ACSC) rates show a significant opportunity to avoid more than 120 bed days of inpatient costs. The Chronic Disease Management Service (CDMS) model identifies overlapping levels of service, depending on the degree of acute exacerbation and the ability to stabilize and support primary care management in the community.

Our vision for the chronic disease management plan embraces our health authority vision of “Healthy People, Healthy Island Communities, Seamless Service”.

“An integrated, comprehensive chronic disease management approach that engages patients, families, care providers and community partners and provides them with education, tools and resources to inform and enable people to help them to prevent or better manage their chronic conditions”.

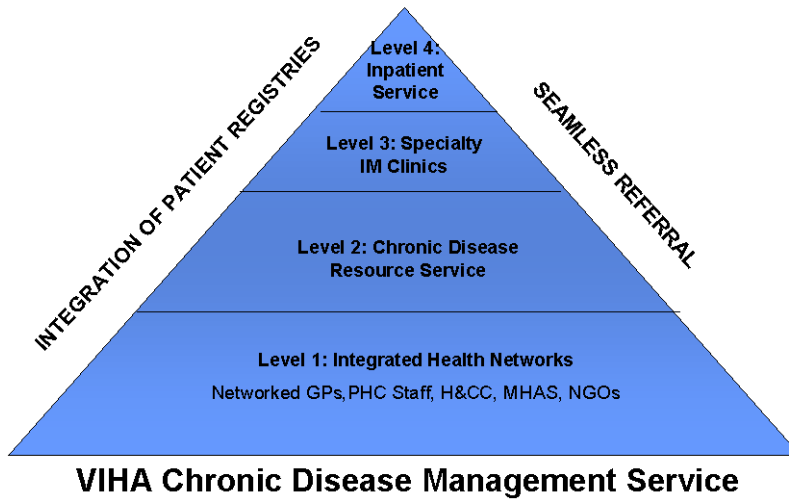
Across our country and around the world, governments and non-governmental organizations are seeing the need to redefine how the health care system manages chronic disease. Chronic disease is becoming an increasing burden on the health care system, impacting the health of individuals, the economy, and creating a burden of care for providers around the world. There needs to be a shift from the traditional approach of “find it and fix it” to a model of “prevent it, find it and manage it”. The World Health Organization has acknowledged that chronic conditions (illnesses or diseases) can no longer be considered illnesses in isolation. Many chronic diseases share common, usually related risk factors and by developing systems to integrate the care of these varied conditions, we may find improved health outcomes for many complex conditions.

The goal of this Framework is to develop a comprehensive Chronic Disease Management Service at the primary, secondary and tertiary levels of care for VIHA that provides:

1. Planned proactive care for chronic disease populations,
2. Timely intervention at time of disease exacerbations; and
3. Enable patients and their families to function as vital partners within their care teams.

Described on the following page is the model for the VIHA Chronic Disease Management Service. Key principles of the VIHA CDMS model include: integration, supportive and responsive service, and a focus on secondary and tertiary prevention based on collaborative partnerships directed to those people whose need is greatest and accountable for outcomes. The intention of the VIHA CDMS model is to coordinate a seamless referral for access to the various service functions and to facilitate “shared care” planning. Coordination of planned, proactive care through the development and integration of patient registries will enable care providers to create a new way of providing service to distinct, identified patient populations. The CDMS model offers a clear and concise service delivery model to engage all levels of care in an integrated and coordinated way. This CDMS model will describe the continuum of services for our community partners.

VIHA Chronic Disease Management Service



VIHA Chronic Disease Management Service (CDMS) Model functions

The proposed VIHA CDMS model has four integrated levels of care:

Level 1: Integrated Health Networks - Planned, proactive longitudinal care and self-management. Provide the overall coordination of longitudinal care through already established teams focused on patients living with chronic disease. If higher levels of care were required, a seamless referral mechanism would “pre-package” all workup information for the next level of service. Once patients are ready to be transferred back to Level 1, necessary information would be provided from Levels 2, 3 or 4 to the Level 1 team.

Level 2: Chronic Disease Resource Service (Integrated Care Clinics) – A secondary (specialist) ambulatory service focused on newly diagnosed patients, group education, and exacerbation management within community.

Level 3: Specialty Internal Medicine Clinics - Acute exacerbation stabilization, early discharge planning in ambulatory environment.

Level 4: Inpatient Chronic Disease Management Services - Acute exacerbation stabilization, early discharge planning in inpatient environment.

Working Definitions

A **chronic condition** is defined as any condition that requires ongoing adjustments by the affected person and ongoing interactions with the health care system.

(www.improvingchroniccare.org/index.php?p=The_Chronic_Care_Model&s=2).

For the purposes of the framework VIHA has adopted the National Health Service working definition of **chronic disease management**: “an organized, proactive, multi-component, patient-centered approach to healthcare delivery that involves all members of a defined population who have a specific disease entity (or a subpopulation with specific risk factors). Care is focused on, and integrated across the entire spectrum of the disease and its complications, the prevention of co-morbid conditions, and relevant aspects of the delivery system. Essential components include identification of the population, implementation of clinical practice guidelines or other decision-making tools, implementation of additional patient-, provider-, or healthcare system-focused interventions, the use of clinical information systems, and the measurement and management of outcomes.”

Principles

We will achieve our vision by building a system based on the following principles:

Integrated

Supportive and Responsive

Based on Partnerships and Collaboration

Evidence Based

Population Health Needs Based

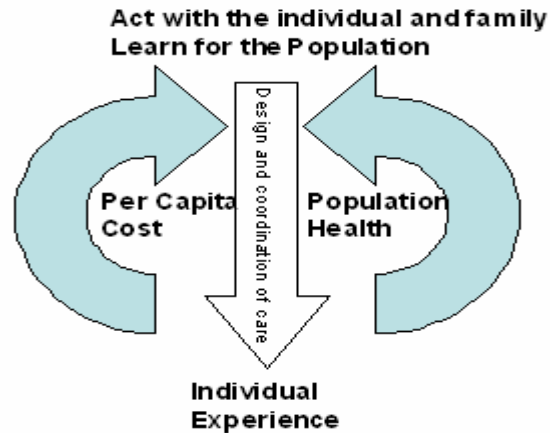
Patients as Partners

Accountable

Our Business Model: The Triple Aim Approach

Transformation of our Chronic Disease Management Service requires integration of services provided in our facilities and communities focused on population health needs, delivered in a way that is meaningful to our patients and sustainable within our health care system. Our CDM business model must support transformational change. And we see this opportunity by implementing the “Triple Aim” approach, as developed by the Institute for Healthcare Improvement.

Triple Aim Model



The goal of the Triple Aim is to optimize the health care system taking into account three key dimensions:

1. The experiences of the individual (both patient and provider),
2. The health of a population, and
3. Per capita cost for the population.

Our ongoing chronic disease management service business model will utilize these three aims to gather individual patient experiences, to identify population health needs, to identify opportunities for integration and partnerships and to create services that reduce the overall per capita cost per patient whenever possible. We will do this by:

1. Working with our VIHA programs and community partners across Vancouver Island Health Authority to identify community chronic disease management needs within a population health approach (priorities will be directed to those at risk populations and high needs communities with limited resources/services);
2. Assessing the current structure and resources available in those communities and explore local innovative collaborative solutions with providers and their communities in a way that simplifies each patient's journey through the health system in a coordinated way;
3. Where chronic disease management service disparities exist, we will collaborate with community and regional partners to create partnership agreements, funding agreement (scalable) and other creative solutions; and
4. We will consider new investments through redesign, restructure and community collaboration that reduces the per capita cost to the health system in order to achieve a sustainable, predictable, stable health care system.

A Positive CDM Environment

A brief environmental scan exemplifies the positive environment for action in the area of chronic disease management both provincially and regionally. This is by no means an exhaustive listing, but is meant to give a flavour of the number and types of initiatives underway.

Provincial Initiatives

Primary Health Care Charter - Best Care for BC

The Primary Health Care Charter (the Charter) sets the direction, targets and outcomes for the primary health care system in BC. Areas of focus include access, maternity services, disease prevention, disease management, comorbidities, frail elderly and end-of-life.

Provincial Primary Health Care Council

The Provincial Primary Health Care Council has oversight for a coordinated and integrated approach to primary health care transformation as identified in the Provincial PHC Charter. The PHC Council is comprised of Ministry of Health Services representatives and Health Authority representatives working collaboratively towards a goal of a strong primary health care system across the province.

General Practice Services Committee (GPSC)

The GPSC was formed under the 2004 Agreement between the British Columbia Medical Association (BCMA) and the provincial government. The GPSC is comprised of representatives from the BCMA and the Ministry of Health as voting members and Health Authorities as guests. Its role is to develop and implement strategies that allow for optimum use of the cumulative total of \$422 million designated budget to support improvements in primary care. Current initiatives include new incentive-based fees, Practice Support Program, Divisions of Family Practice and the creation of the Community Health and Resource Directory (CHARD).

Child Health BC (CHBC)

Child Health BC, an initiative of the BC Children's Hospital, links regional health authorities, the Provincial Health Services Authority, health professional and care facilities on projects related to excellence in the care of infants, children and youth. One of the recent initiatives is improving the health of children living with chronic conditions.

Provincial Stroke Strategy

In 2005, the Heart and Stroke Foundation of BC and Yukon developed the BC Stroke Strategy to improve the recognition of, treatment for and rehabilitation from stroke. This strategy identifies gaps in the care and the standards of practice for stroke in BC, and makes recommendations to close them.

ImpactBC

ImpactBC is a not-for-profit organization specifically established to work across BC's health system in support of system improvement and transformation. ImpactBC represents a strategic alliance between BC's Ministry of Health Services, the BCMA and the provincial health authorities that support health system quality improvement. Current initiatives include Practice Support Program, Innovation Community for Integrated Health Networks, Patients as Partners, and the Health Literacy Collaborative.

Patients as Partners

A provincial initiative to ensure “voice, choice and representation” in regards to health care system design is attained. Current initiatives include the Health Literacy Collaborative.

Physician Information Technology Office (PITO)

Funded through the Ministry of Health in collaboration with the BCMA, PITO is the not-for-profit program that assists GP offices with implementing an EMR (Electronic Medical Record). Physicians may apply as individual physicians, a practice, groups of practices, or as a Community of Practice. It is anticipated that with the implementation of EMRs, physicians and their practice staff will have improved access to patient information related to chronic disease.

CDM Toolkit

The Provincial CDM Toolkit is a web-based software program that provides decision support for health care providers based on clinical practice guidelines. The CDM Toolkit helps to ensure that physicians and their staff provide optimal care to high-risk patients with chronic conditions, such as: diabetes, congestive heart failure (CHF), depression, kidney disease, hypertension and chronic obstructive pulmonary disease (COPD). The CDM Toolkit is available to all physicians and their staff.

Self-Management Programs / Supports

There are a variety of resources available to assist people in helping them to manage their own chronic conditions. Many of the not-for-profit national disease-specific organizations have information available on their websites or in their regional offices to assist people who are newly diagnosed with a chronic condition. These resources can help patients, care providers and partner agencies to assist people with chronic conditions in working towards their own health goals through collaborative care planning. Examples include: the Arthritis Society's *Arthritis Self-Management Program*, BC Lung Association's *Living Well with COPD*, the Canadian Diabetes Association's *Cooking For Your Health*, University of Victoria Centre on Aging's *Chronic Disease Self-Management Program* (to include a newly developed Chronic Pain program).

Canadian Mental Health Association - “Bounce Back” and “Beyond the Blues”

Bounce Back: Reclaim Your Health is a new program designed to help people experiencing symptoms of depression and anxiety. The project is led by the Canadian Mental Health Association BC Division and funded by the BC Ministry of Health Services. *Bounce Back* offers a DVD video providing practical tips on managing mood and healthy living as well as a guided self-help program with telephone support. *“Beyond the Blues”* is an annual Depression Anxiety Education and Screening Day (DAESD). The event highlights successes with recovery and the availability of various treatment options as well as community resources and supports.

Shared Care Funding

The Provincial Specialist Services Committee (SSC) is comprised of representatives from the Ministry of Health Services (MoHS) and the BC Medical Association (BCMA). In 2008 and 2009, the SSC issued three Requests for Proposals to promote collaborative care opportunities between family physicians and medical specialists. To date, VIHA has been successful in soliciting funding for 23 initiatives, to include improved mental health services, aboriginal health services, pediatric services, geriatric services and internal medicine services.

VIHA Initiatives

VIHA Five-Year Strategic Plan

VIHA's Five Year Strategic Plan identifies both the development of a sustainable network of services and working with at-risk populations as priorities for 2009/10. This Framework is aligned and supports these goals.

VIHA PHC Strategy Refresh

Our vision for Primary Health Care in our health region is linked to our health authority's vision of: "Healthy People, Healthy Island Communities, Seamless Service".

"Comprehensive, seamless and locally accessible primary health care services delivered by a network of provider teams, integrated into a regional health care system that supports our population to stay healthy, get better, manage illness and disease, and cope with end of life".

Integrated Health Networks (IHNs)

BC currently has 26 Integrated Health Networks. These prototypes were initiated in 2007 in a joint partnership of the Ministry of Health Services and Health Authorities. The intent of the program is to formalize relationships between physicians, patients, health authorities and community agencies with an initial specific focus on people living with two or more chronic diseases. In VIHA, seven Integrated Health Networks have been established in thirteen communities across the island with a focus of employing primary health care staff to work with local networked physicians to assist them in utilizing quality improvement tools to best manage patient populations with complex chronic conditions.

VIHA Diabetes Education Centre Review

The purpose of the Diabetes Education Centre (DEC) Review (2006) was to conduct an inventory and a gap analysis of diabetes education services throughout the health authority (HA), comparing current services, recommending actions to move toward a desired state of services. The results of this DEC Review have led to the development of an island-wide Diabetes Education Centre core program, where all services operate with a shared understanding of the principles for the program, mandate, vision, and core services for populations to be served. The goal of this island-wide program is to provide equitable diabetes services throughout VIHA in order to enhance client care and ultimately to enhance diabetes management outcomes and quality of life.

VIHA Nutrition Services Review

The purpose of the Nutrition Services Review (2006) was to conduct an inventory and a gap analysis of nutrition services in acute care, ambulatory care, long term care, and Home and Community Care (HCC) throughout the health authority (HA), comparing current services, and recommending actions to move toward a desired state of services. The review findings led to the development island-wide Nutrition Services program, centrally managed, with regional operations support, and an infrastructure support. This approach is to optimize and to ensure equitable access to Nutrition Services throughout VIHA to ensure patient safety, and quality of life resulting in cost savings to the health care system through reduced hospital admissions and lengths of stay.

Integrated Care Clinic Development for Diabetes Education, Kidney Care and Cardiac Services

The goal of the Integrated Care Clinic prototyping initiative will be to develop a model of care that supports patients and their families in better managing their chronic conditions. Patient care services at these clinics will focus on adults living with one or more of the following diseases: diabetes, cardiac, or chronic kidney disease. The service model will be ambulatory, outpatient specialty care in a clinic setting. The initial site for model development will be Central Island, with an interest to expand the services in other regions across the health authority. To date, the “Heart Matters” curriculum is already integrated within the Diabetes Education Centres in Parksville, Campbell River and Port Alberni.

Proposal for the development of Internal Medicine Specialty Clinics/Teams

Structured, disease-management alternatives to acute care are being developed in various hospitals within VIHA. A key focus of the clinics or teams will be to provide urgent outpatient assessment, stabilization and follow-up of non-critical but deteriorating, at-risk patients who would otherwise be held in ER or in an inpatient bed waiting for internal medicine consults or follow-up. The goal of the service is to provide early implementation of tertiary preventive measures, reduce the incidence of complications in at-risk populations, and promote a successful transition from treatment to ongoing management, inpatient to outpatient management and, when appropriate, subspecialist to generalist care.

Nurse Practitioner Demonstration Project

In 2007, VIHA initiated a two-year demonstration project to integrate salaried Nurse Practitioners into three Fee for Service (FFS) physician practices. Early evaluation results show increased access, improved quality of care, improved patient satisfaction, improved provider satisfaction and increased fee-for-service billings.

Primary Mental Health Care Task Force

The Task Force is comprised of Program Leaders from both VIHA Primary Health Care and Chronic Disease Management Programs and VIHA Mental Health and Addictions Services, as well as representatives from family practice and medical specialists and the Canadian Mental Health Association. Current initiatives include the piloting of the Community Health Resource Directory (CHARD), Bounce Back, Practice Support Program Modules and the creation of a First Aid in Mental Health resource tools for primary care providers.

Home and Community Care (HCC) Partnerships

Home and Community Care has piloted projects in general practitioners’ office where a HCC case manager is attached to the practice and meets with the GP on a scheduled basis to review complex care needs of the physicians’ patients living in the community. The Seniors Integrated Health Network (SARIN) is an example of this model of care delivery.

Other VIHA Program Strategies

Many VIHA Integrated Health Services (IHS) and Corporate Services strategies also link with and impact primary health care. These include the Population Health and Wellness Strategy, Seniors Health Strategy, VIHA Rural Health Framework, Aboriginal Health Plan, Care Continuum Strategy (IM/IT), Emergency Services Strategy, End of Life Strategy, Continuing Professional Development & Knowledge Translation Plan (CME), People Plan (HR) and the Capital Plan.

Our Priority Strategies for Investment

The Chronic Disease Management Plan priority strategies for investment will embrace our business model, the Triple Aim Approach. To that end, we will seek out opportunities to work within our scope of services, employing the three Triple Aim elements: (1) patient / provider experience; (2) population health management; and (3) cost per capita. We will also invest in two Triple Aim enabling strategies: (1) facilitating the redesign of primary health care; and (2) system integration.

Patient & Provider Experience

1. **Self-management supports and programs:** VIHA will continue to support partnerships with community agencies to provide patient self-management programs and supports to help patients set and work toward their own health goals.
2. **Patients as partners:** VIHA will continue to work within its programs to provide opportunity for meaningful patient and family input to its programs.
3. **Integrated care plans:** VIHA will continue to support the development of an Integrated Care Plan to support collaboration between patients and care providers. A common paper plan has already been implemented across VIHA's Integrated Health Networks.
4. **Standardized exacerbation protocols:** VIHA will work on the creation of standardized, evidence-based exacerbation plans to be used by primary care and other providers for their patients living with chronic disease. These protocols can be part of the patient's integrated care plan.

Population Health Management

1. **Populations of focus:** VIHA will target investments towards populations with the largest gaps in care and health disparities. These include aboriginal populations, those living with mental health and addictions issues, those living with multiple comorbidities, rural populations, homeless populations and the frail elderly.
2. **Integrated Health Networks and other teams:** An Integrated Health Network is a partnership between a patient, his/her family doctor, selected health care practitioners and community partners. Much of the work of the IHN team focuses on the management of chronic conditions for a co-morbid population. The CDM plan will continue to seek out opportunities to provide support to those compromised patient populations within the defined underserved communities of the island.
3. **Internal medicine specialty clinics VIHA** will continue to seek opportunities to implement specialty teams to keep patients from being admitted to hospital when they can safely be maintained in the community given good proactive care planning and exacerbation protocols.
4. **Chronic disease management forums:** VIHA will continue to work with family physicians and clinical experts to hold Chronic Disease Management Forums several times each year in the South, Central and North Island.

Cost Control

1. ***Ambulatory care sensitive condition case and days:*** Through the implementation of these strategies, it is VIHA's goal to reduce the number of Ambulatory Care Sensitive Condition cases and days by 10% by March 31, 2013.
2. ***Avoidable emergency department utilization through care coordination and exacerbation protocols:*** Through the implementation of these strategies, it is VIHA's goal to reduce the number of avoidable emergency room visits by 10% by March 31, 2013.
3. ***Optimizing resources through integrated care clinics:*** VIHA will look at ways to optimize use of clinical skills and other resources through the prototyping of Integrated Care Clinics.
4. ***Attachment to practice:*** Through these initiatives, VIHA is aiming to see a 5% increase in attachment to primary health care practice for those living with multiple comorbidities. Attachment to practice is now recognized as being inversely proportional to overall costs per capita across all cost domains of the health system (acute, home and community care, lab, diagnostics, drug costs, specialist costs).

Redesigning of Primary Health Care

1. ***Development of VIHA Chronic Disease Management Service:*** VIHA will continue to support the creation of a health authority-wide Chronic Disease Management Service through the implementation of these priorities for investment.
2. ***Practice Support Program - office efficiency improvement modules:*** VIHA will continue to provide quality improvement supports for family physicians wanting to improve access and care to their patients through supported implementation of office efficiencies. These modules include advanced access (allowing for consistent availability of same-day appointments), group visits and planned proactive recall through creation of patient registries.
3. ***Practice Support Program – disease management support modules:*** VIHA will continue to provide quality improvement supports for family physicians wanting to learn new skill sets to provide better care for patients living with chronic disease. These modules include self-management, mental health (focus on depression), child/youth mental health and COPD.
4. ***Clinical order sets:*** VIHA will continue to create a common clinical order set for all types of chronic disease patients so that acute care is provided consistently throughout the island.

System Integration

1. ***Integrated care clinics and services:*** VIHA will continue to support the implementation of "Heart Matters" curriculum throughout its Diabetes Centres and will move forward on the prototyping of diabetes, cardiac and kidney care clinic.
2. ***Shared care:*** VIHA will support initiatives that provide patient-focused collaborative care between family physicians and consulting specialists. This includes our current Specialist Services Committee initiatives.
3. ***Primary mental health care:*** VIHA will support the work to improve primary mental health care in the community through collaborative partnerships between the Mental Health & Addiction Services Program and the Primary Health Care & Chronic Disease Management Program.

Triple Aim Elements: Initiatives			Enablers: Processes and Tools	
Patients & Provider Experience	Population Health Management	Cost Control	Realigning VIHA CDM Service	System Integration
1. Self management	1. Populations of focus	1. Reduction of ACSC	1. Development of CDMS model	1. CDM Steering Committee
2. Patients as Partners	2. Targeted conditions: co-morbid, mental health, chronic pain	2. Reduction in unnecessary ER utilization through care coordination and exacerbation protocols	2. Advanced access	2. Integrated care clinics development and integration
3. Integrated Care Plans	3. IHNs/PHCOs	3. Reduction in hospital admissions through integrated care clinics	3. Group visits	3. GP/SP compacts - SSC
4. Personal Health Records	4. Integrated Care Clinics for diabetes, cardiac and kidney care	4. Optimizing HR through integrated care clinics	4. Clinical order sets	4. Primary Mental Health Task Force
5. Standardized exacerbation protocols	5. Internal Medicine Specialty clinics	5. IHNs/PHCOs	5. Change Management supports	5. Operating plans for Shared Care models
6. Care coordination in the health care system		6. Partnerships (CMHA, pharmacies, NGOs, other)	6. CDM Service Frameworks	6. Telehealth Telemedicine
			7. Telehomecare	7. Standardized exacerbation plans
Cross-strategy themes				
← Measurement/Indicators →				
← Patient Safety/Quality Improvement →				
← IM/IT →				
← Healthy Public Policy →				
← ECCM →				

Appendix 1: Expanded Chronic Care Model



Created by Victoria Barr, Sylvia Robinson, Brenda Marin-Link, Lisa Underhill, Anita Dotts and Darlene Ravensdale (2002)
 Adapted from Glasgow, R., Orleans, C., Wagner, E., Curry, S., Solberg, L. (2001) "Does the Chronic Care Model also serve as a template for improving prevention?" *The Milbank Quarterly*, 79(4), and World Health Organization, Health and Welfare Canada and Canadian Public

Appendix 2: Glossary of Terms

ACSC- Acute Care Sensitive Cases

BCMA- British Columbia Medical Association

CHARD- Community Healthcare and Resource Directory (initial focus of this initiative will be for mental health and addictions)

CDM- Chronic Disease Management

CDMF- Chronic Disease Management Forums

CDMS- Chronic Disease Management Service

CRNBC- College of Registered Nurses of BC

FM- Family Medicine

FPs4BC- Family Physicians for BC

GP- general practitioner

HCC- Home and Community Care

IHC- Integrated Healthy Communities

IHH- Integrated Health Home

IHI- Institute for Healthcare Improvement

IHN- Integrated Health Network

IHT- Integrated Health Team

IM/IT- Information Management/Information Technology

ITHA- Inter-Tribal Health Authority

MoHS- Ministry of Health Services

NGOs- Non-Governmental Organizations

NP- nurse practitioner

P3- Private, Public Partnerships

PITO- Physician Information Technology Office

PHCO- Primary Health Care Organization

PHC- Primary Health Care

PRIISME- VIHA Outpatient lab services has developed a diabetes recall program. Patients' names are given to the lab and the lab brings patients in for regular HA1C checks. Results are sent to the GP. Currently operating at the Cowichan District Hospital and WCGH- Port Alberni. The next site for implementation will be Campbell River.

PSP- Practice Support Program

PPO- Professional Practice Office

RFP- Request for Proposal

RSP- Regional Support Program

SARIN- Seniors at Risk Integrated Health Network

SSC- Specialty Services Committee

Appendix #3: IHN schematic of network teams, proactive providers and collaborative community engagement

