Section IV:

Grey Bruce CDPM Programs and Initiatives Inventory

(If printing please note that logic models are legal size)

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Application of the CDPM Logic - Lessons Learned

Here are some comments from organizations who have applied the CDPM Framework Logic Model their initiative:

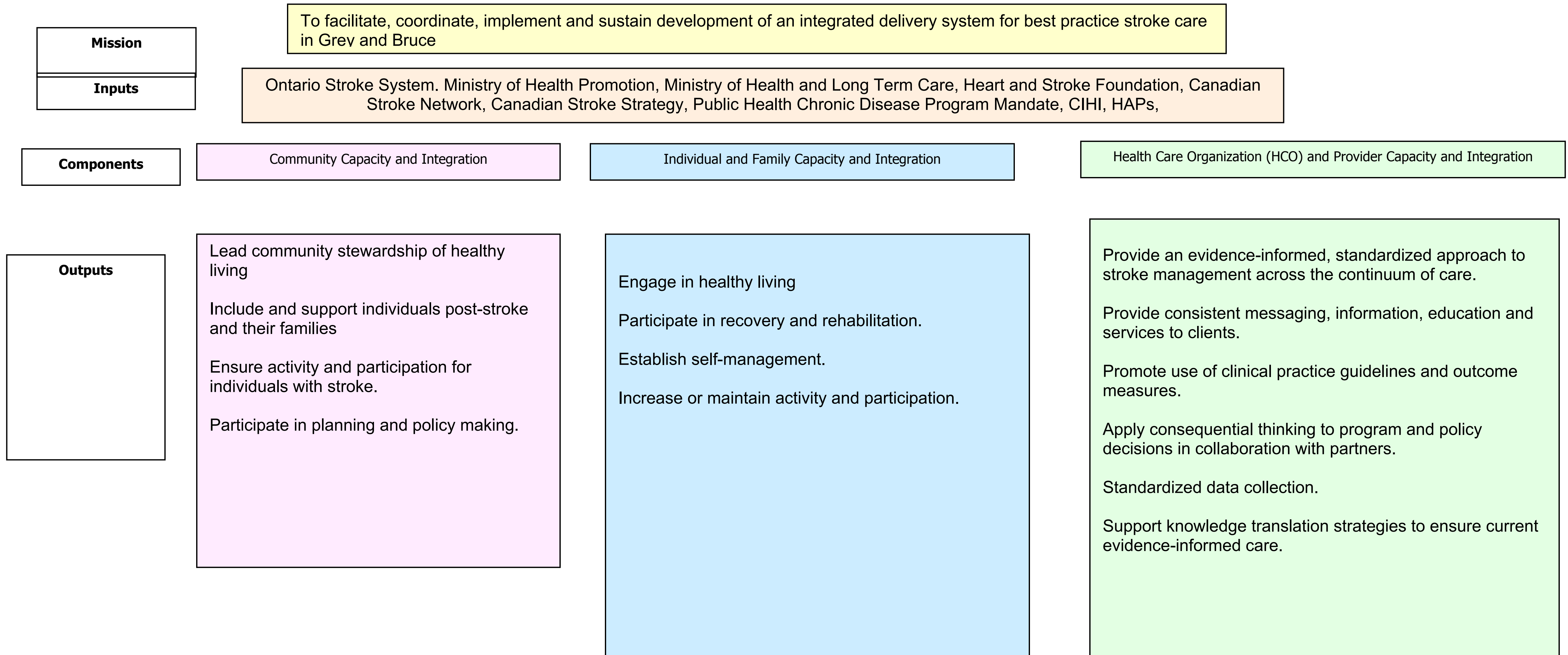
District Stroke Centre and Priism Project (Diabetes)

- A good exercise. Explicitly explains our relations, roles and responsibilities.
- Health Care organization and the individual component of the model are easy to complete
- Identifying outputs succinctly is challenging
- Community component is challenging due to the need to be inclusive
- Identify time frames of outcomes – used 1 – 5 years with stroke
- Outcomes will depend on disease process or the goal of the initiative
- For stroke dividing Health Care Organizations into Education, Evidence Base Practice etc was helpful
- Need to identify partners and relationships
- Need a glossary of terms e.g. International Classification of Function – can add this to the Definitions in the Model
- Outcomes section forces you to indicate how you would measure the outcome.
- Model helps to identify where we needed to strengthen relationships
- Self Management – messages or skills sets are the same with different groups

Inventory

An inventory of CDPM programs in Grey Bruce is underway and will be added to this section.

Grey Bruce Integrated Health Coalition Chronic Disease Prevention and Management Logic Model - Stroke



Short-term outcomes

1-3 years

- Increased public awareness of healthy lifestyle, stroke risk factors, prevention
- Increased public awareness of stroke signs & symptoms
- Improved risk factor profiles in Grey Bruce
- Lower incidence of stroke in Grey Bruce
- Increase number of community partners engaged in health stewardship and re-engagement.
- Increased opportunities for community participation.
- Increased opportunities for physical activity for stroke survivors with deficits
- Increased community opportunities for

▪ Increased skills and knowledge for healthy behaviours.
▪ Increased self-efficacy and self-management of life style management, recovery, rehabilitation and re-engagement.
▪ Increased awareness and use of community programs and resources.
▪ Increase awareness of the warning signs of stroke
▪ Increased awareness to call 911
▪ Increased participation in stroke prevention.
▪ Increased participation in rehabilitation.
▪ Increased participation in family and community
▪ Increased number of pre-stroke meaningful activities resumed
▪ Increased number of new meaningful activities post-stroke
▪ Increased level of fitness of the stroke survivor
▪ Effective adaptation to roles and responsibilities
▪ Decreased caregiver burden

- Increased use of evidence-based practice
- Increased responsiveness of the continuum to the needs of individuals with stroke or at risk of stroke.
- Increased number of interdisciplinary teams, with links to specialists working collaboratively and providing coordinated, patient-centred care.
- Increased use of electronic information systems and sharing information among team members, their clients, other health providers and settings.
- Established quality improvement approaches for prevention, assessment and management.
- Coordinated, effective evaluation system
- To improve capacity for the stroke service delivery across the continuum.
- Decrease readmissions for stroke related debility
- Stroke survivors in the right place, right time, right treatment

Intermediate outcomes

5 years

- Improved healthy public policies and supportive environments.
- Increased collaboration between community and HCO
- Increase number of stroke survivors actively contributing to their community
- Improved risk profile for Grey Bruce
- Lower incidence of stroke

- Increase in healthy behaviours
- Increased benefits through involvement in self-management
- Increased participation in community programs and resources
- Increased overall satisfaction of individuals and families with the responsiveness of the health care system to meet their needs
- Increased quality of life for stroke survivor and caregiver
- Increased ability to effectively navigate the stroke system
- Increased quality of life

- Health promotion and prevention integrated across continuum of care.
- Health care coordinated across the continuum of care, providers and settings – acute, rehabilitation, Community and LTC
- The appropriate type and number of health care providers working in collaboration to meet the needs of the individual and family.
- Care is evidence based and meets the diverse needs of consumers.
- Care is proactive, and provides for complex and continuing care, with follow-up and ease of navigation.
- Integrated information systems with consumer, decision support and community information.

Long Term Outcomes

10 years

Activated communities and prepared, proactive partners

Informed, engaged individuals and families

Prepared, proactive practice teams across the continuum
Responsive system
Evidence-based management of stroke

Vision

An integrated, coordinated system for the prevention and management of stroke that is proactive, individual and family-centred, and that provides access to quality care by the right provider at the right time in the right place, resulting in improved clinical, functional and population health outcomes

Mission	To facilitate, coordinate, implement and sustain development of an integrated delivery system for best practice stroke care in Grey and Bruce		
	Roles and Responsibilities		
Components	**Community Capacity and Integration**	**Individual and Family Capacity**	**Health Care Organizations**
Health Promotion All individuals **And** **Primary Prevention** All individuals at risk for Stroke	Promote and organize community activities for the reduction of stroke e.g. Active 2010; Good Food Box; Pedometer Program; FOCUS Low Drinking Guidelines Identify and work with non-traditional community partners to establish the community stewardship of health e.g. churches Present healthy lifestyle information sessions. Participate in policy development on healthy lifestyles. Identify and participate in local and regional awareness campaigns Promote and support the use of libraries for health information and motivational tools for active, healthy living. Promote community fitness project for individuals with a disability. Participate in awareness events such as the Big Bike. Support media presentations on stroke and living with stroke. Promote and advertise community resources to assist in maintaining a healthy lifestyle. Assist in adapting lifestyle information and resources to the community e.g. First Nations	• Participate in risk reduction and self-management initiatives • Use the libraries for guided health information on stroke through Health Information Prescription Project • • Know the warning signs of stroke • Participate in educational opportunities on risk factor reduction and healthy living. • Be familiar with resources available locally to assist in establishing a healthy lifestyle. • Seek help when risk factors are not controlled. • Participate in research	**Education** • Identify and support the provision of education to health care professionals to enhance best practice stroke care in the community and LTC. **Evidence-based Practice** • Identify best informed practice in healthy lifestyle promotion • Participate in the Towards Evidence Informed Practice Project • Act as knowledge broker for stroke prevention information e.g. creation or use of tools to assist in community development, individual lifestyle change or health provider knowledge and intervention **Delivery System Design** • Participate on the Network Chronic Disease Management Framework • Participate on the Southwestern Stroke Strategy Prevention Committee • Input to the LHIN CDM team **Information System/Communication** • Identify opportunities to use individuals stories s to increase stroke awareness • Participate in media campaigns and opportunities e.g. FOCUS • Participate in evaluation projects • Keep current on data concerning lifestyle promotion, risk reduction e.g. Heart and Stroke Blood Pressure Campaign • Keep current on local stats on chronic disease • Audit practices and implement improvements **Partnerships** • Identify potential partners especially in primary health care, community • Develop and support partnerships with other healthcare organizations and coalitions (Healthy Living Partnership, Partners in Health, Regional Stroke Prevention Committee) • Partner with provincial agencies for health promotion (Heart Health Coalition, Ontario Prevention Clearinghouse)

Secondary Prevention	Promote the use of the secondary prevention clinic. Promote appropriate referrals to stroke prevention clinic. Promote the use of community resources to initiate or maintain healthy living. Assist community agencies in engaging their residents in healthy living – evidence-based practices; inclusion of those with impairments Engage communities in planning for prevention activities and strategies	Know where to seek help and resources. Participate in lifestyle modification and risk reduction programs. Be knowledgeable and compliant with medication and lifestyle changes. Engage in self management. Attend the stroke prevention clinic. .As appropriate trial BP monitors at home. Give feedback on services and resources. Know the warning signs of stroke and seek help. Participate in research.	**Education:** • Identify and support the provision of education to health care professionals including physicians to enhance best practice stroke care in the community and LTC. • Develop tool kit for health professionals on the main messages for lifestyle change for use on acute care, rehab and community • Develop a PSW tool which would trigger specific actions to help PSWs support their clients in stroke prevention • Standardize patient education and approaches including Understanding of TIA book. **Evidence-based** • Identify and implement best informed practices e.g Behaviour Modification Framework • Act as a knowledge broker for EBP • Develop tools to assist in knowledge transfer e.g. TIA Algorithm; use of the ABCD score • Participate in the regional pilot for the standardized questionnaire for stroke prevention clinic **Delivery System Design** • Establish a behaviour modification framework • Implement and support a TIA ER protocol • Develop a case management system to improve navigation of the system for individuals with TIA. • Identify and pursue opportunities for integrated disease management. **Information System**: • Use ALERTS to communicate best evidence to stakeholders • Participate in Stroke Performance Indicators for Reporting, Improvement and Translation (SPIRIT) database • Use other available data bases • Patient feedback process to be developed. **Partnerships:** • Participate on the regional stroke prevention nurse network • Identify and work with CDM partners • Establish linkages with appropriate pharmaceutical companies for prevention initiatives • Participate in the provincial stroke prevention roundtables.

Stroke Management – Acute and Rehabilitation

- Support the provision of evidence-based stroke care
- Support family and friend of the stroke survivor e.g. library information prescription project; spiritual support through churches; social support

- Participate in assessment, treatment and discharge planning including goal setting.
- Be part of the recovery and rehabilitation team.
- Be knowledgeable about your condition. Ask questions. Use the patient pathway.
- Seek information. Give feedback.
- Become a self-manager.
- Participate in educational opportunities.
- Awareness of caregiver burden and the need for training as a caregiver.

Education
- Develop and implement strategies for healthcare providers to develop stroke expertise.
- Assist with clinical pathway training .e.g. stroke scale training
- Support dysphagia screening training
- Support patient and caregiver education and training

Evidence-based
- Use the Heart and Stroke Foundation Best Practice Guidelines for Stroke in development of program, treatment and education
- Develop and disseminate the Evidence-Informed Practice Workbook for OT and PT
- Alerts issued on EB practice e.g. Older Client
- Clinical Nutrition Resource
- Knowledge broker for evidence based stroke information
- Implement Evidence to Practice Research Project
- Participate on Ontario Consensus Panel on Stroke Rehabilitation
- Implement Caregiver Burden Research Project

Delivery System Design
- Support of re-direct protocols and transportation/ EMS prompt card
- Development and implementation of clinical pathways
- Participation on the LHIN Rehabilitation Priority Action Team
- Participation on the Regional Stroke Rehabilitation Committee
- Participation on the GBHS Clinical Service Team Rehab.
- Develop and implement a caregiver strategy
- Develop an effective model of triage and transition from each section of the continuum e.g. TIP tool, Alpha FIM

Information/Communication
- SEAC data base for District Stroke Centre
- HAPS readmission and LOS indicators
- Ontario Stroke Audit
- Audit best practice and disseminate findings

Partnerships
- GBHS, SBGHC, Hanover, Evidence-based Care Prog.

Community Re-engagement

Participate, support and promote re-engagement activities e.g. stroke or CDM support groups, exercise programs, supported conversation groups

Facilitate inclusion and accessibility.

Environmental support for activities for individuals with stroke e.g. community space

Encourage stroke survivors to be community volunteers.

Participate in forums or information gathering on issues related to stroke care in the community.

Ensure recreational and leisure opportunities for stroke survivors.

Discuss and resolve transportation issues in the community.

Encourage social support for individuals living in LTC.

Support vocational opportunities for individuals with

Participate in the Living with Stroke Program.

Participate in appropriate fitness and exercise programs.

Participate in language, perception and cognitive programs and activities.

Seek out participation opportunities in the community.

Participate if appropriate in vocational or volunteer programs/education.

Attend driver retraining if appropriate.

Be aware of the signs of depression and seek help.

Be aware of community resources.

Be aware of how to re-enter the system if needed.

Thrive.

Participate in research

Education

- Develop and implement strategies for healthcare providers to develop stroke expertise e.g. Tips and Tools
- Develop and implement strategies for communities and community workers to increase knowledge and skills for stroke management in community
- Use Living with Stroke Program
- Standardizes education package for individual with stroke returning to community
- Participate on the Geriatric Education Cooperative

Evidence-based

- Implement the use of the Best Practice Guidelines for community
- Develop and Implement a community pathway/guidelines – outpatients, day away programs, community recreation, LTC
- Issue ALERTS
- Assist in forming a LTC physiotherapy network
- Act as a knowledge broker – Make It So group
- Participate in the Telephone follow-up Project
- Pilot the fitness centre for individuals with disabilities.

Delivery System Design

- Develop and implement community pathway/guidelines/ navigation system
- Map out community journey. Identify gaps and solutions.
- Participate in community planning. And development of services e.g. driving school; recreation opportunities
- Implement Community Engagement Framework

Information/Communication

- Access data on community re-engagement e.g. CCAC, LTC, community program
- Develop methods for feedback on the re-engagement experience and relate status to acute and rehab statistics
- Audit best practices and share

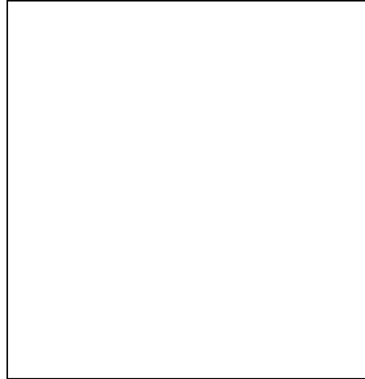
Partnerships

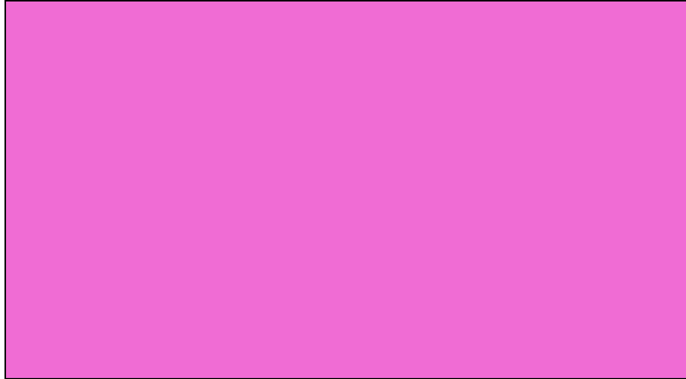
- CCAC, LTC, Home and Community Support Services, VON, Care Partners, Paramed, Red

PRIISM

Mission	A systems approach to provide integrated chronic disease prevention and management services		
	Roles and Responsibilities		
Components	**Community Capacity and Integration**	**Individual and Family Capacity**	**Health Care Organizations**
Health Promotion All individuals **And** **Primary Prevention** All individuals at risk for diabetes	• Organize and promote Community Physical Activity programs (i.e. Library Pedometer program, Walking clubs, workplace physical activity programs • Promote Health Unit's Healthy Eating Programs (i.e. Good Food Box, Eat Smart, work place healthy eating programs, supermarket tours, label reading, portion sizes programs) • Promote Health Unit's Poster campaigns (Fruit and vegetable) • Healthy lifestyles support groups (Diabetes support groups for those at risk) • Actively involved in policy development promoting healthy lifestyles • Participate in community needs assessments • Engage consumers in healthy lifestyle strategies • Promote use of evidence-based tools	• Participate in education opportunities and community resources/programs that support healthy living and increase awareness of risk factors • Engaged in healthy lifestyle behaviours • Remain socially connected within the community • Involved in wellness planning • Engage in behaviour modification programs for those at risk • Attend self management education opportunities • Participate in screening and risk identification opportunities • Participate in research studies	• Community needs assessment • Community Physical Activity programs (i.e. Library Pedometer program, Walking clubs, workplace physical activity programs) • Healthy Eating Programs (i.e. Good Food Box, Eat Smart, work place healthy eating programs, supermarket tours, label reading, portion sizes programs) • Poster campaigns (Fruit and vegetable) • Collaborates with the community to develop a system of promoting health and preventing illness, disease and injury • Support and participate in community health promotion awareness and education activities (i.e. public diabetes education opportunities) • Offer skill building opportunities for health care providers and individuals • Establish behaviour modification programs • Engage with the community and other health care partnerships to develop environmental supports for healthy lifestyles (i.e. smoking cessation, healthy eating and exercise) • Provide resources to aid creating healthy environmental supports – healthy homes, schools and workplaces, eating establishments and safe communities. Play an active role to establish healthy "health care organization" workplaces • Advocate for healthy public policy development • Participate in research, surveillance and evaluation • Promotes and provide screening for early detection of disease • Identify potential partners and roles and responsibilities

Diabetes Management: **Secondary Prevention/Care Management** Diagnosis of type 1, 2, or gestational diabetes **and** **Tertiary Management/Case Management** Diagnosis of diabetes with one or more complications	• Engage consumers in diabetes management planning and strategy development • Organize and promote opportunities for knowledge and skill development for residents with diabetes • Educate consumers in use of community secondary prevention strategies/programming • Educate consumers on expected impact of secondary prevention strategies on individual wellness and community health care system (e.g. fewer emergency visits and/or admissions related to diabetes) • Promote, engage in and support development of diabetes education and management strategies and programs • Organize and promote strategies supporting diabetes self-management – i.e. walking programs, restaurants offering heart healthy choices • Develop caregiver support strategies including education, communication, support • Diabetes support groups	• Increase access/awareness/knowledge of programs and services related to diabetes and other chronic diseases • Engaging in shared decision making, goal setting and care planning • Attend self-management education and behaviour modification opportunities • Seek out quality, evidence-informed disease management information • Client, family, caregiver participate in care planning to optimize well-being and reduce complications • Advocate for self/client in care planning with health providers • Utilize social support and health resources as planned/needed	Education: • Support professional development of diabetes educators to increase knowledge and skills • Establish CDE as standard for educators • Plan and coordinate educational activities and opportunities for healthcare practitioners in the region • Educate clients/patients in use of health system Delivery System Design: • Community needs assessment – ensure Consumers receive multidisciplinary care that is high quality and easily accessible • Establish organizational structure and budget, including a Diabetes Management Advisory Committee to ensure sustainability of program • Ongoing evaluation of programs objectives and outcomes • Identify location of services based on target populations and required staffing • Develop early intervention plan of care to help minimize the negative impacts and prevent disease progression • Provide active follow up, education and support • Promote and support strategies (when appropriate) to integrate the client/patient back into the community using linkages and defined roles and responsibilities • Standardize program structure, curriculum, resources, policy and procedures, documentation, and medical directives based on the CDA and best practices Information System: • Establish central referral and booking system • Establish and maintain a registry of patients with





prediabetes and diabetes
- Establish an integrated electronic health information system/electronic health record

Partnerships:
- Identify potential partners (i.e. primary health care, long term care facilities, community agencies, etc.)
- Develop and support partnerships with other healthcare organizations and community stakeholders
- Define roles and responsibilities of various partners
- Share resources