

CHAP + AP

Cardiovascular Health Awareness Program + Action Plan
Programme de sensibilisation à la santé cardiovasculaire + plan d'action



CHAP Meeting in Mississauga

October 15, 2008

Welcome to key provincial stakeholders

Brenda Fraser	(Quality Improvement and Innovative Partnership(QIIP))
Nick Kates	(QIIP)
Chris O'Callahan	(Ontario Stroke System (OSS))
Sharon Mytka	(Health Promotion Committee –OSS)
Wendy Graham	(Association of Family Health Teams of Ontario)
David Reeder	(Ministry of Health Promotion)
Margaret Moy	(High Blood Pressure Strategy,
Lum Kwong	Heart and Stroke Foundation of Ontario)

CHAP Meeting in Mississauga

October 15, 2008

Objectives

- Review evidence on elements of community programs
- Learn about CHAP+AP and MHP support
- Exchange experiences with family health teams
- Generate action items
- Networking (e-mail addresses)

Community Organizations at CHAP October 15, 2008 Meeting

Local CHAP Lead Organizations

Group 1 Strathroy, Orangeville, Kenora,
Wallaceburg, Leamington

Group 2 Cornwall, Prembroke, Port Hope,
Lindsay, Bracebridge, Gravenhurst,
Thorald, Stratford, Elliott Lake,
Tilsonburg, Woodstock, Paris,
Collingwood

Group 3 Orillia, Aurora

Community Organizations at CHAP

October 15, 2008 Meeting (cont.)

Family Health Teams

- Kenora (Sunset Country FHT)
- Paris (Prima Care FHT)
- Stratford (Stratford FHT)
- Stratford (STAR FHT)
- Collingwood (Georgian Bay FHT)
- Fenelon Falls (Fenelon FHT)
- Fergus (Upper Grand FHT)

Agenda for October 15

Welcome, Introductions, Overview of Day, Essential Elements of CHAP, SHRTN

Orientation Sessions (Group 1 and Group 2)

Sharing Experiences & Innovations with CHAP

Community meetings with CHAP Central

Cardiovascular Health Awareness in Diabetes

The Quality Improvement and Innovation Partnership and Improving Health Promotion and Chronic Disease Management in FHTs

Foundations for Delivery and Integration of Community Cardiovascular Disease Management Programs across the Primary Health Care System

Heart and Stroke Foundation HPI Program

Key Actions

Closing

CHAP Meeting in Mississauga October 15, 2008

Meeting venue and other info

Ontario's Chronic Disease Prevention and Management Framework

- unites the health system and the local community to promote productive interactions between empowered citizens and proactive health care teams, to achieve improved outcomes
- explicitly adds 'activated communities' and community partners to the interactions and relationships leading to improved clinical, functional and population health outcomes

http://www.toronto.ca/health/resources/tcpc/pdf/conference_lee.pdf. Accessed August 20, 2008. 2008

Ontario's Chronic Disease Prevention and Management Framework (continued)

Envisioned as a way of conceptualizing and re-organizing care to:

- increase detection rates,
- offer comprehensive treatment,
- provide ongoing monitoring, and
- enhance self-management support to involve individuals in their care.
- based on best-available evidence,
- supported by organizations and information systems, and
- linked with community partners to help build healthier communities

Essential CHAP Components

Scope of the program

- CHAP+AP must be a community-wide program and offered free of charge to community residents

Location/setting

- At least one regular CHAP+AP session a month in a local pharmacy
- Additional sessions in pharmacies or other settings that are deemed appropriate (where a health care professional will be present – Examples: public health units, local health agencies such as VON or CCAC, medical clinics, and seniors centres)

Essential CHAP Components (continued)

Collaboration with appropriate primary health care providers

- Local family physicians involved in referring or inviting patients to participate in CHAP. Other health professionals such as nurse practitioners, pharmacists, dietitians etc. encouraged to invite or refer patients and/or become involved in CHAP+AP in other ways
- With participant consent, participant data collected from CHAP+AP sessions (including blood pressure measurements) transferred regularly, wherever possible, to participants' family physicians, using the CHAP Summarized Patients' Results Report Form.
- Pharmacists and other health professionals encouraged to receive and use the CHAP Summarized Patients' Results Report Form for their patients, especially if patient does not have a family physician

Essential CHAP Components (continued)

Blood pressure measurement

- At each CHAP+AP session visit, participants' blood pressure measured, using a validated, automated and accurate blood pressure measuring device such as the BpTRU™, and have it recorded on the CVD and Stroke Risk Profile Form or similar document

Referral for follow-up

- Blood pressure and CVD and Stroke Risk Profile results for each participant at each session visit evaluated based on the CHAP Blood Pressure Protocol to ensure that CHAP+AP session participants receive the appropriate follow-up from their health care providers

Essential CHAP Components (continued)

Education component

- In addition to capturing participant risk factor data for feedback to family physicians and potentially other health care professionals, this information used to provide relevant education resources and materials to help participants reduce their risk for CVD and stroke
- Education materials available for distribution at sessions, address a wide variety of topics, and updated regularly.
- Linkages to other local and provincial/national sources of information/programs provided and updated regularly

Essential CHAP Components (continued)

Evaluation

- At a minimum, the Local Lead Organization or Local CHAP Coordinator, with the help of a Data Management Company (if contracted), track, at regular time intervals, the:
 - Number of sessions held;
 - Total number of assessments conducted;
 - Total number of unique participants;
 - Average number of visits per participant;
 - Total number of participating family physicians and other health care professionals, and;
 - Total number of trained peer health educators
- This information used on an ongoing basis to evaluate and improve the quality of the program since communities are diverse and will not necessarily experience the same challenges

Key areas of work

1. Increased stroke prevention activities and capacity in Ontario communities through the implementation of a sustainable stroke health promotion and primary prevention model

- Core components
- Targeting high risk patients
- Personal action plans for patients
 - Heart and Stroke Foundation of Ontario
- MedsCheck
- Peer mentorship
- Engage FHTs

- 2. Developing and disseminating an evidence-based health promotion web tool-kit for primary care**
- 3. Analysis, translation and consensus on best practices in health service integration for health promotion and primary prevention**
- 4. Contribute to the advancement of performance indicators to help measure local systems, services and outcomes for health promotion and primary stroke prevention programs within Ontario's Chronic Disease Prevention and Management Framework**

Stroke prevention activities in Ontario communities

- Initial sustainability activities started in early spring 2008.
- New funding approved summer 2008.
- Request for proposals from communities Sept / Oct 2008.

Funds available for community support (Objective 1)

• Direct transfers to communities	400,000
• Data management	70,000
• Central coordination / support	233,000
• Meeting support	<u>20,000</u>
	723,000

Other funds are used for web tool kit, case study, and indicator development, and other expenses that will indirectly support sustainability of CHAP and integrate CHAP into OSS and other relevant initiatives.

Community Meetings Breaks and Lunch

Front Door Janusz Kaczorowski

Podium Tracy Gierman and Andrea
Moore

Back Door Lisa Dolovich and Christine
Rodriguez

Food Larry Chambers