

# Integrated Health Service Plan

## ***Integration Priority & Action Plans:***

### ***Preventing and Managing Long-Lasting (Chronic) Conditions***

Mississauga Halton Local Health Integration Network

Section Appendix G.4

Appendix  
G.4

# Preventing and Managing Long-Lasting (Chronic) Conditions

## Description

Chronic disease prevention and management is a pro-active, population-based approach that addresses chronic diseases before they begin through health promotion or early detection to prevent or reduce the rate of disease progression and potential health complications. CDPM delays the need for medical interventions and is an important aspect of primary health care, health promotion and prevention activities.

Many chronic diseases are preventable with education and behavioural/lifestyle changes. CDPM focuses heavily on health promotion and disease prevention both for at-risk individuals and the general population and helps people maintain their independence.

Successful chronic disease prevention and management programs share the following characteristics<sup>1</sup>. They:

- are evidence-based;
- use multiple strategies and interventions ;
- are patient-centred and considers all aspects of the patient needs (holistic);
- empower individuals to increase control over and improve their health;
- promotes collaboration among providers, organizations, individuals, families and community groups; and
- include an evaluation component to ensure that programs are achieving their objectives.

A chronic disease is an illness, functional limitation or cognitive impairment that lasts (or is expected to last) at least one year, limits what a person can do and requires ongoing care.<sup>2</sup> There are many types of chronic diseases. Some examples include asthma, arthritis, diabetes, and congestive heart failure.

In Ontario, the economic burden of chronic disease is estimated at 55% of total direct and indirect health costs.<sup>3</sup> Almost 80% of Ontarians over the age of 45 have a chronic condition, and of those, about 70% suffer from

<sup>1</sup> "Guide to Chronic Disease Management", Ontario Ministry of Health and Long-Term Care. Draft for Distribution, September 27, 2005.

<sup>2</sup> Source: National Academy of Social Insurance, "Medicare in the 21st Century: Building a Better Chronic Care System," January 2003.

<sup>3</sup> EBIC 2002

two or more chronic conditions.<sup>4</sup> Left untreated, chronic diseases like diabetes and depression are causally related to other diseases. In general, the health care system has tended to focus more on curative approaches to illness and less on prevention and management of conditions that lead to the illness. With more effective prevention and management of chronic conditions such as, diabetes, asthma, congestive heart failure and depression, Ontario could avoid an estimated:

- 29,000 emergency department visits
- 67,300 hospitalizations, and
- \$200 - \$350 million annually, in hospital costs<sup>5</sup>

Chronic Disease Prevention and Management (CDPM) builds on the traditional definition of CDM by recognizing that many chronic diseases are preventable with education and behavioural/lifestyle changes. CDPM focuses heavily on health promotion and disease prevention both for at-risk individuals and the general population.

The classic definitions used in public health distinguish between primary prevention, secondary prevention, and tertiary prevention.<sup>6</sup> Primary prevention is the prevention of a disease before it occurs; secondary prevention is the prevention of recurrences or exacerbations of a disease that already has been diagnosed; and tertiary prevention is the reduction in the amount of disability caused by a disease to achieve the highest level of function.

### **The Framework**

The Ontario CDPM framework is built on evidence-based models and reflects this province's commitment to keep people healthy, takes an individual and family-centred approach, and encourages community involvement.

The CDPM Framework represents a systems approach that will lead to more productive interactions and relationships among individuals and their families, health care organizations, and the community that will, in turn lead to better individual health outcomes, better population health outcomes, and better use of health resources.

This approach includes both prevention and management of chronic disease, and incorporates health promotion for everyone including: people who are healthy, people at risk of developing a chronic disease, and people with one or more chronic conditions.

It emphasizes the importance of collaboration between health care organizations and the community, and with individuals and families to prevent and manage chronic disease. As the following case study illustrates, when the

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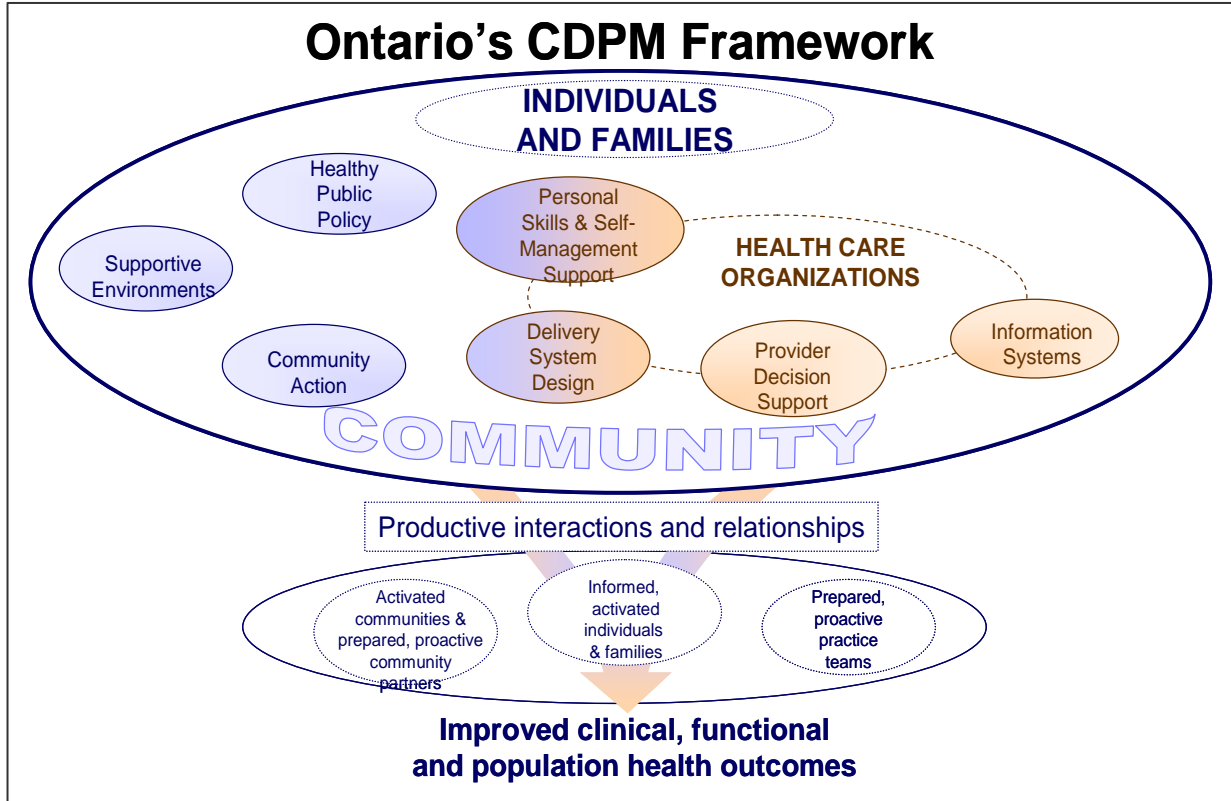
<sup>4</sup> CCHS 2003

<sup>5</sup> Ontario's Chronic Disease Prevention and Management Framework, Marjorie Keast, MOHLTC, April 10, 2006

<sup>6</sup> Commission on Chronic Illness, 1957

CDPM framework is used to guide care, it changes the individual's relationship with health care practitioners as well as his or her experience with the health care system.

Ontario's CDPM Framework, developed by the MOHLTC is shown below:



**The Partnership among Individuals and Families, Health Care Organizations, and their Community<sup>7</sup>**

In Ontario's CDPM framework, individuals, families and health care organizations work together with their communities to improve the health of individuals and the population, and to provide individual and family-centred care.

**Individuals and families** are at the centre of CDPM. To achieve the best possible outcomes, they must be directly and actively involved in keeping themselves healthy and/or managing their chronic condition(s). They work with providers to make decisions about their care. They understand the risk factors and disease process, and how it may affect them. They are supported and empowered to manage their day-to-day health, to direct their care, and to make informed choices. Care is person-centred, rather than provider or disease-centred.

<sup>7</sup> Ministry of Health and Long Term Care "A Systems Approach To Chronic Disease Prevention And Management In Ontario: A Framework," Draft – For Discussion Only, Dec. 2, 2005

**Health care organizations** include all those who deliver services as well as those who plan, fund and coordinate services (e.g., public health units, family health teams, community health centres, hospitals, community agencies, other health practitioners, the Ministry of Health and Long-Term Care, the Local Health Integrated Networks (LHINs), provincial associations, and provincial and regional service networks). Their role is to champion the changes required to shift from reactive episodic acute care to proactive chronic disease prevention and management. Health care organizations work with individuals and families, with other health care organizations, and with their community to develop the full range of high quality health services required to prevent and manage chronic disease. To make this kind of fundamental change in service delivery, health care organizations:

- provide strong leadership that visibly supports CDPM;
- align resources and incentives to support a systems approach to chronic disease prevention and management;
- are accountable for services and outcomes; they set goals, evaluate the effectiveness of their services and strategies, and use performance results to continually improve quality of care and support organizational changes.


**The community** collaborates with health care organizations to: identify priority health issues for the community; link and coordinate services for individuals and families; and minimize threats to health. For example, if there are high rates of obesity in the population, the community can mobilize to encourage healthier eating and promote physical activity. The community can help promote health and prevent or manage chronic disease by reducing threats to health (e.g., smoke-free public spaces, initiatives to reduce smog), creating supportive environments (e.g., restaurants that serve heart healthy meals, street lights that allow enough time for older people with mobility problems to cross the road), and providing opportunities for people to participate in healthy activities (e.g., bike paths, recreation programs). The community also plays a key role in addressing the social determinants of health by, for example, supporting social housing and employment programs.

An integrated chronic disease prevention and management systems approach, such as the one outlined above, requires productive interactions and relationships among individuals and their families, communities, health care organizations and providers.

#### **Personal Skills and Self-Management Support<sup>8</sup>**

*“When it comes to managing chronic diseases, the practitioners can do about 20% of what an individual needs, but the other 80% comes from the person him or herself.” - Merrickville CHC*

<sup>8</sup> Ibid.



When individuals and families have access to the right information, support and resources, they develop the knowledge and skills they need to play a more active role in managing their health and coping with disease. Certain types of self-management support are effective in helping people set goals, overcome barriers and challenges, and manage their health day by day.

**Shared decision-making**

As members of a care team, practitioners, individuals and families work together to establish goals and develop care plans. Individuals and families are full partners and key decision-makers in planning their care. Practitioners are resources or guides. Individuals and families are given the information they need to become more knowledgeable about their health and the chronic conditions they have, so they are able to make more informed choices. As a result, they have a greater sense of control, and more confidence in their ability to manage their day to day health.

**Education and skills development**

Individuals and families participate in organized education programs that help them:

- understand the factors that increase their risk and the steps they can take to improve their health and/or manage symptoms;
- develop the skills they need to enhance their health, such as how to recognize changes in their health, when to contact a health care provider, how to exercise, or how to administer medications;
- make more informed choices;
- develop problem solving skills; and
- access other services they may need.

**Behaviour change programs**

Individuals who need support to adopt healthier behaviours benefit from behaviour modification programs, such as personal fitness programs or courses to help them stop smoking. Through these programs, they learn skills and strategies they can use to make healthier choices.

**Counselling and support services**

Being at risk of or living with a chronic disease is stressful. Counselling and support services, such as telephone advice lines, help people and families cope with chronic conditions. Some people find it particularly helpful to attend mutual help/support groups, where they are able to talk to others facing the same risk or illness, and share their experience. This helps them feel less isolated and build their own personal support network.

**Links to community resources**

Many of the supports that individuals and families need, such as fitness programs, cooking classes, employment support programs, counselling

services for depression, subsidized housing and income programs, smoking cessation programs and culturally specific services, are already available in their communities. The care team links individuals and families to these community resources.

**Follow-up**

As part of CDPM, practitioners contact individuals and families regularly to see how their care plan is working and ask if they need any other support. Individuals also receive regular reminders about the things they need to do to manage their health (e.g., self monitoring of blood pressure or blood glucose levels) as well as any tests or check ups that are part of their ongoing care. Regular follow-ups also remind and reassure people that the rest of the team is there to answer questions and provide assistance as needed.

**Additional Requirements Identified by the Framework****Case Management:**

Individuals with complex needs or who have multiple chronic conditions receive case management services that take into account all their health needs and develop a person-centred care plan that will help them optimize their health.

Practitioners consistently use clinical management tools, such as practice guidelines, case management programs, and disease assessment and management flow sheets to help them provide evidence-based care in their daily practice. They also use alerts and prompts that remind them when individuals should be seen for regular monitoring or testing.

**Information technology systems that connect team members, sites and data:**

Information systems connect team members working in any location, so they can share up-to-date information anytime, anywhere. This means that, when a practitioner sees an individual, he or she has the information and decision support tools required to communicate with other members of the team and to deliver evidence-based care and support. Ideally, the system should provide access to population and environmental data in the community, so team members can use this information to help understand the prevalence of various diseases and risk factors, set priorities for prevention programs, and influence community action.

Interactive tools and technologies, such as web-based guidelines, hand-held devices, videoconferencing, multimedia tools, case management software, drug interaction software and telemedicine make it faster and easier for team members – including individuals and families -- to find the information they need. These help health care providers be proactive, monitor an individual's care, react at the first sign of a problem, and provide more effective follow-up services. These tools improve communication among care providers, and between care providers and individuals. They also provide information and prompts that help individuals and families with self-management.

## **Rationale**

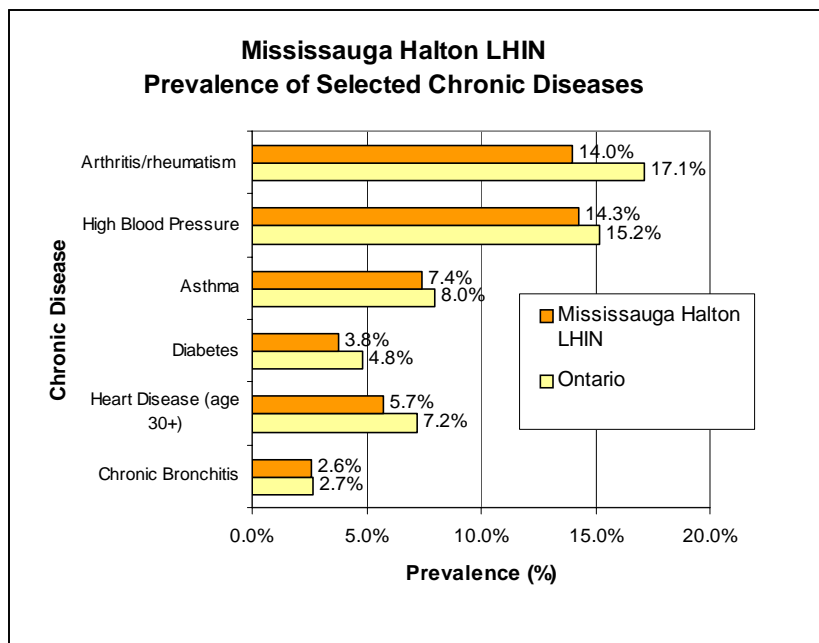
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### **Environmental Scan:**

Mississauga Halton Local Health Integration Network is home to approximately 215,000 adults over the age of 55. It is also the fastest growing LHIN region in the province. In the next decade the number of older adults will increase 48% to over 317,000. This poses a significant challenge for the local health system. Chronic disease including strokes, heart disease and osteoporosis are exacerbated by age.

The next table highlights the prevalence rate for selected chronic diseases in Mississauga Halton and Ontario. Mississauga Halton has a higher prevalence of asthma than the province as a whole.

## Prevalence of Selected Chronic Conditions (age 12+), Mississauga Halton LHIN and Ontario



Source: Canadian Community Health Survey, Mississauga Halton LHIN Population Profile

There are a number of chronic disease prevention and management initiatives already underway in Mississauga Halton upon which to build. For example, chronic disease management is a major focus of the National Home Care and Primary Care Partnership Project which serves individuals with diabetes. The project, which has been in place for over two years, involves the CCAC of Halton, CCAC of Peel and groups of family physicians in Oakville and Mississauga. (Calgary is another site for this initiative.) A comprehensive evaluation was completed on the project including patient surveys conducted at two points in time. The evaluation provides evidence of the value of chronic disease prevention and management programs.

### Community Engagement:

#### Phase 1 Engagement:

In forums held with providers there was support for chronic disease prevention and management as a priority area. Although members of the public did not use the term “chronic disease prevention and management” they articulated strong support for the elements inherent in chronic disease prevention and management including health promotion, disease prevention, early intervention, patient education and other supports to encourage self-care, a holistic focus on client needs and the need to address the determinants of health. Both providers and the public recognized the important link between lifestyle (e.g. diet, exercise) and chronic disease.

#### Phase 2 Engagement:

This phase has included dialogue with physicians, numerous forums with the public, expert panels made up of providers and partners from the LHIN and the provider conference. From these conversations it has been suggested that:

- Getting the right, accurate information is job one.
- Multiple conditions per patient is the norm.
- Establish a team approach to deal with the complexities of the conditions – critical mass.
- Teams going to the client rather than the client always coming to the team.
- For CDPM, we need to work across ministries.
- Lack of inclusion of marginalized populations.
- Lack of understanding of services and how to access them by the public.
- Assistive Devices Program only funds the initial purchase and provides no support for maintenance.
- Inequity in service provision - CCAC homemaking for Multiple Sclerosis.
- Some family physicians do not regularly perform preventive check-ups.

“Chronic conditions will not go away; they are the health care challenge of this century. Alteration of their course will require determined effort among decision-makers and leaders in health care in every country in the world. Fortunately, there are known, effective strategies to curtail their growth and reduce their negative impact. The solution is to embrace a new way of thinking about and managing chronic conditions. Through innovation, health care systems can maximize their returns from scarce and seemingly non-existent resources by shifting from an acute to a chronic care model. Many countries are making the shift and starting with the development of innovative chronic conditions programmes. Small steps are as important as system overhaul. Those who embrace change, large or small, are experiencing benefits today and creating the foundation for success in the future.”  
*“Innovative care for chronic conditions: building blocks for action: global report”, World Health Organization.*

**Other Relevant Evidence:**

The move towards chronic disease prevention and management is a global trend stemming from a growing body of evidence to support this approach.

The Latin American Diabetes Program of the London Inter-Community Health Centre has been identified by the MOHLTC as an excellent example of an integrated systems approach to chronic disease prevention and management (CDPM) in practice.

The McColl Chronic Care Model developed in Seattle has been adapted for use in both British Columbia and Alberta.

The World Health Organization has shown leadership in promoting CDPM internationally through a number of reports, models and frameworks to

facilitate the implementation of CDPM approaches in health care organizations.

### **Overview of Action Plans**

The overall implementation plan will require two action plans:

- 1) Development of a comprehensive chronic disease prevention and management approach to service delivery across the continuum of care. This includes:
  - Identifying a generic CDPM model that can be applied to a range of different chronic diseases
  - Ensuring the delivery of services in the most appropriate setting with a view to shifting certain ambulatory services from the hospital sector to the community
  - Building on existing evidence-based initiatives in Mississauga Halton and in other jurisdictions
- 2) Development and dissemination of integrated, comprehensive care pathways for specific chronic disease issues.

**Please note** that Action Plan 2 will be a sub-project of Action Plan 1 and thus will require dialogue and coordination.

### **Challenges that Could Impact Success**

This phase has included dialogue with physicians, numerous forums with the public, expert panels made up of providers and partners from the LHIN and the provider conference. From these conversations it has been suggested that:

- Definitions for terms will be important in detailed design (i.e. prevention).
- Orphan patients are a huge problem for follow-up and thus will need to be considered and addressed.
- Large organizations get the biggest piece of the funding envelope and may not be the most appropriate ones to deliver what is needed within this priority.

### **Networks and Current Best Practices Identified to Support Success**

The following networks responded to the call for input on the integration priorities:

- GTA Rehab Network
- Halton Peel Adult Rehabilitation Network
- Mississauga Halton - Mental Health and Addiction Leaders
- Halton Peel Regional Diabetes Network
- Halton Peel Palliative Care Network
- PRISME (Chronic Disease Management Project)
- West GTA Stroke Network

The following initiatives or opportunities were identified through the Phase 2 Community Engagement with the providers as strengths that the Detailed Planning and Action Teams could use as a basis for further development:

- Leverage existing networks and partnerships
- Leverage data that is available on current services
- Existing clinical best practices and care plans (e.g. Diabetes)
- Wait time strategy in relation to chronic disease issues
- E-health initiatives
- New Convalescent Care Program
- Use community rehabilitation specialists
- Palliative Care Network
- Success of Alzheimer's Society in bringing groups together

## **Action Plan #1**

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### **Development of a comprehensive chronic disease prevention and management approach to service delivery across the continuum of care**

#### **Description**

Research has shown that effective chronic disease prevention and management (CDPM) programs use multiple strategies and interventions and promote collaboration among providers, organizations, individuals, families and community groups. Individuals with chronic diseases often require a range of services and with the aging of the population the number of individuals with multiple chronic diseases will increase. Therefore, CDPM must involve the full continuum of care. Rehabilitation to maximize functional levels is an important component of the continuum of care required for effective chronic disease prevention and management. This provides an opportunity to: review the roles of providers in terms of chronic disease, review the various settings in which patients receive treatment and support for chronic disease and build on several evidence-based models and resources from other jurisdictions.

#### **Deliverables – Years one to three**

##### **Year 1 Deliverables:**

##### **Establish a CDPM Detailed Planning and Action team**

- Ensure diverse representation that is multi-disciplinary and covers the continuum of care
- Include representation from organizations that have demonstrated leadership, interest, innovation and progress in moving forward with CDPM.
- Develop a detailed work plan and CDPM model.
- Identify resource requirements to support team in achieving its mandate.

##### **Conduct a Detailed CDPM Environmental Scan**

- Recognize that the data available is less than rigorous and plans should be considered for more accurate collection of data going forward.
- Analyze the prevalence of chronic diseases in Mississauga Halton (current and forecast).
- Identify issues related to population diversity and chronic disease.
- Identify key health service and support providers involved in meeting the needs of people with chronic diseases – an inventory of services is needed.
- Identify existing local collaborative CDPM initiatives.
- Conduct CDPM readiness assessment (consider use of existing tools such as the “ICCC Situation Assessment” that is based on the World

Health Organization Innovative Care for Chronic Conditions (ICCC Framework) rapid.

- Assess existing rehabilitation resources relative to population needs and identify gaps.
- Conduct a targeted scan of the literature on innovative approaches for rehabilitation in relation to chronic disease.
- Identify opportunities to improve the efficiency of the delivery of rehabilitation services including opportunities to shift rehabilitation services/resources to community settings.

#### **Develop Generic, System-wide CDPM Model/Approach**

- Based on the results of the CDPM environmental scan and review of models from other jurisdictions, develop/adapt a model that can be applied across the health system to a range of different chronic diseases.
- Identify case management model that is necessary to support the vision.
- Determine appropriate outcomes and indicators for both the process of achieving the successful implementation as well as those for the risk factors and the specific conditions identified.
- Identify the needed support services including but not limited to education, rehabilitation, and clinics.
- Ensure that this comprehensive model links appropriately and proactively with all health partners and cross ministries.

#### **Identify Implementation Leader**

- Members of the CDPM Detailed Planning and Action Team identify an organization to take the lead in implementing the system-wide CDPM model.

#### **Develop plan for roll-out of generic CDPM model to specific chronic diseases**

- Based on the results of the CDPM environmental scan, identify the timing/sequencing for detailed design and implementation of the CDPM model for specific chronic diseases and geographies.
- Identify mechanisms for integration/coordination/linkages across different chronic diseases to ensure a holistic approach and prevent the emergence of disease silos.
- Review service delivery settings and identify opportunities to shift ambulatory care services from the hospital setting to the community setting as appropriate.
- Develop strategies for incorporation of rehabilitation in the generic, system-wide CDPM model.
- Recognize that partnership across providers public and private will be necessary to meet the needs.

**Year 2 Deliverables:**

The second phase of the detailed design and implementation planning will include the following:

- Identify the scope of services for each chronic disease and within each geographic area.
- Implement the roll-out of the system-wide CDPM model.
- Establish linkages with other integration opportunities.
- Identify information requirements and flow to support the CDPM model – timing of this project needs to be aligned with the e-health strategy for the Mississauga Halton LHIN.
- Develop rehabilitation component for CDPM detailed design teams as required
- Develop rehabilitation component for integrated, comprehensive care pathways as required
- Develop performance measures specifically related to rehabilitation
- Develop performance measures and program evaluation framework.
- Develop and implement public relations strategy and community engagement communications strategy.

**Year 3 Deliverables:**

- Evaluate implementation of the CDPM model (overall and for specific chronic diseases) and refine as required.
- Develop plans and timelines for ongoing application of the CDPM model to other chronic diseases.

**Outcomes**

- Quality:
  - Increased participation in health promotion/wellness programs
  - Improved management of specific chronic disease (based on clinical indicators e.g. HbA1C ranges for people with diabetes; body mass index etc)
  - Increased client empowerment and self-care
  - Increased client satisfaction
  - Reduced hospital admissions and ER visits related to complications of chronic disease
- Access:
  - Improved coordination of service delivery across the continuum
- Efficiency:
  - Realignment of service delivery settings to match client needs and improve efficiency
- System/Process:
  - Increased service provider partnerships

**Additional Outcomes Identified in Ontario's CDPM Logic Model**

**Short Term Outcomes**

- Increased community collaboration with health care organizations (HCO) to identify and prioritize issues affecting health.
- Increased community action for healthy public policy, supportive environments to meet the needs of their population.
- Increased awareness, linkages and referral to community programs, information, and resources
- Improved healthy public policies and supportive environments.
- More community information and programs integrated with health care services.
- Providers have increased knowledge, skills and tools to incorporate prevention into their practices.
- More HCOs promote system change and provide incentives, align policies, resources, measurement, and accountability.
- Increased number of interdisciplinary teams, with links to specialists working collaboratively and providing coordinated, patient-centred care.
- More providers using electronic information systems and sharing information among team members, their clients, other health providers and settings.
- More providers using evidence-based tools, and quality improvement approaches for prevention, assessment and management.

**Intermediate Outcomes:**

- More people exhibiting healthy behaviors
- Individuals and families at the centre of the care team, actively engaged in decision-making, and daily managers of their health.
- Individuals and families have increased skills and knowledge for healthy behaviours.
- More individuals and families gaining 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
- Individuals, families and providers have improved understanding of their roles as partners on care teams, and consumers are involved in care planning.
- More individuals and families have increased knowledge of their disease processes and role as daily self-manager.
- Increased knowledge and skills of consumers in self-management.
- More individuals and families are aware of and linked to community programs and resources.

- Health promotion and prevention integrated across continuum of care.
- Health care coordinated across the continuum of care, providers and settings.
- 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.

### **Performance Indicators**

- Self-management survey could determine how people with a chronic disease are managing on their own - McColl institute has a reliable tool
- Others as appropriate to be determined by Detailed Planning and Action Team

## **Action Plan #2**

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### **Development and dissemination of integrated, comprehensive care pathways for specific chronic disease issues**

#### **Description**

Integrated, comprehensive care pathways provide a standardized approach to the management of chronic diseases. Pathways can be developed to include multiple disciplines and service delivery settings. They are based on evidence-based clinical guidelines.

#### **Deliverables – Years one to three**

##### **Year 1 Deliverables:**

#### **Establish an Integrated Care Pathways Action Team (this could be a sub-Planning and Action Team that reports to the CDPM Detailed Planning and Action Team)**

- Ensure diverse representation that is inter-disciplinary and covers the continuum of care.
- Include representation from organizations that have demonstrated leadership, interest, innovation and progress in the development and use of care pathways for chronic disease.
- Develop specific clinical pathways.
- Identify resource requirements to support the Action Team in achieving its mandate.

#### **Assess the Current Situation**

- Identify existing care pathways for chronic diseases that are already in use locally.
- Conduct a targeted scan of the literature on care pathways in place in other jurisdictions that might be adapted for use in Mississauga Halton.
- Identify gaps – i.e. high impact chronic diseases for which no integrated care pathways exist.

#### **Prepare plans to develop or adopt integrated, comprehensive care pathways for specific chronic diseases**

- Develop plan for the timing/sequencing of specific care pathway development.
- Oversee the development of care pathways by expert teams.
- Clearly articulate roles and responsibilities across the process.

##### **Year 2 Deliverables:**

**Implement new clinical pathways as they are developed**

- Identify technology requirements to enable accessibility by all providers.

**Develop performance measures to assess the effectiveness of the new clinical pathways****Conduct ongoing monitoring and make course corrections as required****Initiate plans for system-wide implementation of care pathways (e.g. dissemination, education/training)****Year 3 Deliverables:****System-wide implementation of new care pathways****Conduct ongoing monitoring and make course corrections as required****Outcomes**

- Quality:
  - Increased number of patients for whom integrated care pathways are used
  - Increased client satisfaction
- Access:
  - Improved coordination and smooth transitions across the continuum
- Efficiency:
  - Improved average length of stay
  - Reduced number of ALC days
- System/Process:
  - Increased number of chronic diseases for which integrated care pathways exist
  - Increased number of service providers using integrated care pathways

**Performance Indicators**

For example:

- Determine what percentage of people with diabetes are at target A1C
- Flu shots
- Mammograms
- Pap smears
- Children's immunizations
- Stool for Occult blood
- Others as appropriate to be determined by Detailed Planning and Action Team