

**Figure 2: Ontario's Chronic Disease Prevention and Management Framework**



Mission	Care of diabetes in Grey and Bruce counties is delivered through an integrated, Regional Diabetes Program that is centred around the individual with or at risk for diabetes, their family, and community resources, that focuses on self-management and best informed practice treatments to improve health outcomes.		
Inputs	Canadian Diabetes Association Clinical Practice Guidelines and Resources, Standards for Diabetes Education in Canada, Diabetes Educators, Public Health Chronic Disease Program Mandate and Ontario Action Plan, CIHI/LHIN/MOHLTC Data and Guidelines, PRIISME and GBHN Regional Program Funding, Integrated Health Coalition, Community Stakeholders		
Components	Community Capacity and Integration	Individual and Family Capacity and Integration	Health Care Organization (HCO) and Provider Capacity and Integration
Outputs	<ul style="list-style-type: none"> <li>Provide and expand on healthy lifestyle programs based on community needs</li> <li>Actively participate in policy development promoting healthy lifestyles.</li> <li>Engage consumers in diabetes management planning and strategy development</li> </ul>	<ul style="list-style-type: none"> <li>Participate in educational opportunities and utilize resources for self manage their diabetes</li> <li>Engage in healthy lifestyle behaviours</li> </ul>	<ul style="list-style-type: none"> <li>Providing a standardized approach to information and care that is based on best informed practice guidelines</li> <li>Promote consistency of information for clients by producing a standardized teaching package to be distributed to healthcare providers in our region</li> <li>Refine and standardize data collection</li> <li>Promote the use of clinical practice guidelines and standardized diabetes education</li> <li>Provide education opportunities, and form partnerships with physicians and other healthcare providers in the area.</li> <li>Promote diabetes education services and advocate on behalf of our clients.</li> <li>Supporting existing community programs by providing information about healthy lifestyles</li> </ul>
Short-term outcomes (1 year)	<ul style="list-style-type: none"> <li>Increase in supportive environments for healthy living (i.e. workplaces, schools)</li> <li>Increased availability of healthy lifestyle programs, services and resources</li> </ul>	<ul style="list-style-type: none"> <li>Increase awareness of risk factors for diabetes and other chronic diseases</li> <li>Increase awareness of appropriate actions to reduce risk factors</li> <li>Increased knowledge/resrouces/accessibility of diabetes management</li> <li>Use of technology to improve self management</li> <li>Increased overall satisfaction with responsiveness of healthcare system to meet their needs</li> </ul>	<ul style="list-style-type: none"> <li>Linkages between community stakeholders throughout the healthcare continuum (i.e. FHT, Nurse Practitioners, Social Workers, consumers)</li> <li>Ongoing evaluation of program, modifying as needed</li> <li>Education and capacity building of health care workers</li> <li>Care is based on a proactive approach, incorporating mechanisms to support progressive and continuing care needs of client</li> </ul>
Intermediate outcomes	<ul style="list-style-type: none"> <li>Improved healthy public policies and supportive environments.</li> <li>More community information and programs integrated with health care services.</li> </ul>	<ul style="list-style-type: none"> <li>Individuals and families engaging in healthy behaviours</li> <li>Individuals and families at the centre of the care team, actively engaged in decision-making, and daily managers of their wellness.</li> <li>More individuals and families gaining benefits through involvement in self-management</li> <li>Increased access to health care services and resources</li> <li>Increased participation in community programs and resources</li> <li>Individuals and families express satisfaction with the responsiveness of the health care system to meet their needs</li> </ul>	<ul style="list-style-type: none"> <li>Health promotion and prevention integrated across continuum of care.</li> <li>Health care coordinated across the continuum of care, providers and settings.</li> <li>The appropriate type and number of health care providers working in collaboration to meet the needs of the individual and family.</li> <li>Care is evidence based and meets the diverse needs of consumers.</li> <li>Care is proactive, and provides for complex and continuing care, with follow-up and ease of navigation.</li> <li>Use of technology to improve linkages and information transfer, ensuring seamless care</li> <li>Integrated information systems with consumer, decision support and community information</li> </ul>
Long-term outcomes	<ul style="list-style-type: none"> <li>Change toward healthy living culture</li> <li>Policy development to support healthy living</li> </ul>	<ul style="list-style-type: none"> <li>Reduced incidence of diabetes and long term complications associated with diabetes <ul style="list-style-type: none"> <li>Earlier diagnosis and treatment</li> <li>Clients accessing care/tools/resources, achieving a self management model in a supportive environment.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Reduced hospitalizations, ER usage related to diabetes</li> <li>Increased efficiency in system, quality care in appropriate setting by appropriate provider, at right time</li> <li>Sustainability of regional diabetes program</li> </ul>
Vision	The Grey Bruce Regional Diabetes Program will provide residents with diabetes in Grey and Bruce with consistent evidence informed practice information and care, to be provided by expert health care providers throughout the community. Care will be equally accessible, integrated and efficient with a focus on creating an environment which empowers the individual to take control of their health and supports the concept of self-management. The Grey Bruce Regional Diabetes Program will endeavor to form community partnerships to help improve health outcomes and prevent complications.		