PROJECT FUNDING REQUEST

SCC Information (to be completed by SCC Initiative Liaison)			
SCC Initiative Liaison Name: David Hebb	Phone #: 604-230-4275	Email: Dhebb@doctorsofbc.ca	Project ID:

The cardiometabolic collaborative clinic aims to offer comprehensive risk factor management for patients at risk of cardiovascular disease, and to optimize the management of patients with existing cardiovascular risk factors to prevent vascular events. The program is geared toward intensively managing metabolic risk factors through a collaborative multidisciplinary model that incorporates a group based patient education program to facilitate long term behavior change that is an essential component of chronic disease management. This group based program will focus on the healthy behavior change for patients with adiposity related diseases (diabetes, fatty liver disease, hypertension, dyslipidemia). Achieving the standard of care for the management of patients with adiposity related cardiometabolic risk factors is limited by access to structured programs with physicians and general practitioners addressing medical management alongside with allied health care professionals that serve to increase health literacy and encourage self-efficacy and self-monitoring required for sustainable healthy behavior change. This structure improves the individual patient's changes of success in achieving long term control of cardiovascular risk factors. This proposal outlines a program to address the current challenges in the management of this at risk population while meeting the recommended standards of care with reasonable effort by health care professionals.

EOI/Proposal Summary – Please complete prior to submission to SCC Initiative Liaison	
Title of Proposed Project	Collaborative Approach to Achieve Standards of Care for Cardiometabolic Health
Date of Submission	8/18/2023
Submission Type	Expression of Interest (EOI)
Funding Amount Requested (Rounded number)	$25,000
Fund Holder, Location	Division of Family Practice, Victoria South Island.
Project Lead Name	Dr. Priya Manjoo, Dr. Kevin Garside, Dr. Jenny Rajala
Shared Care Initiative	Coordinating Complex Care for Cardiometabolic patients
Length of Project	☐ 3- 6 month (EOI) ☐ 12 months ☐ 18 months ☒ 2 years
Project Summary (100 words maximum)	*Please refer to the SCC guidelines for further information.* This collaborative cardiometabolic clinic from the Victoria/South Island area aims to optimize the care of patients with chronic cardiometabolic disease, through a co-ordinated approach involving primary care practitioners, specialists and allied health care professionals geared toward increasing patient education and health literacy to support sustainable engagement in chronic disease management which has been shown to improve the control of medical risk factors. This approach has been shown to be very effective in the STENO 2 trial however the

	targets set out in this trial are currently not being adequately achieved in Canada. The access to consisted health care professionals and allied support are notable obstacles to achieving this goal. We have been utilizing group medical visits facilitated by primary care physician and allied health care professionals to optimize engagement in the behavioral aspects of chronic disease management that have been shown to improve the effectiveness of pharmacotherapies and specialist interventions. In so doing we have been addressing an important health care gap. Our pilot data provides support that the current collaborative approach to chronic disease management used in our clinic can improve patient outcomes efficiently while improving patient support and reducing unnecessary referrals to multiple specialists. Our data supports the sustainability of this project. If successfully developed this project can also serve a model for training physicians and allied health care professionals and can be applied and adapted to other environments, specific patient populations and potentially to the management of other chronic diseases. The use of GP run group visits have been shown to be a very powerful tool in chronic disease management and is central to the model of care.

EOI/Proposal Details – Please complete prior to submission to SCC Initiative Liaison

If submitting an EOI, please provide brief outlines to the questions below, and indicate where information is not yet available.
If submitting a Proposal, please provide more in-depth responses to the questions below.

Project Aim Statement

What is the gap/problem you are trying to address? Who was involved in identifying the gap?

Many patients with clinically significant excess adiposity have multiple co-morbidities that co-exist but are not addressed in a congruent fashion. For example patients with diabetes often have dyslipidemia, a higher cardiovascular risk, undiagnosed fatty liver disease, early renal insufficiency, undiagnosed atherosclerosis or obstructive sleep apnea. They may have a few visits with a GP or a visit with a specialist or a one hour visit with a dietitian or diabetes educator. This does not provide enough support to meet the standards of care that are supposed to improve patient engagement and support health behavior change.

The Cardiometabolic Collaborative Clinic Proposal will improve the management of complex patients with cardiometabolic issues (diabetes, hypertension, lipids and metabolic liver disease) in a collaborative manner that used group medical visits in parallel with specialist and GP visits in order to support the patients engagement in chronic disease management through increasing education and self-efficacy among patients.

We anticipate the use of this collaborative model of care will also reduce wait times to begin chronic disease management and reducing referrals to multiple specialists. Specialists and GPs work together, building on each others strengths while pooling resources and utilizing allied health care professionals to support engagement in chronic disease that is the recommended standard to care.

2. Please provide a **brief patient story** that illustrates the challenges faced or gaps that need to be addressed and why addressing these gaps is important.

A patient with diabetes or another adiposity related disease (OSA, dyslipidemia, CV disease) may visit with their GP and be started on a medication or have a single visit with the diabetes education center or a dietitian for about one or two sessions of one our each. If referred to a specialist they may be seen once or twice per year. In total their points of contact with health care professionals are 3-4 per year. This does not set the patient up for successful management of chronic diseases that progress over time. The specialist may note other adiposity related issues that need to be addressed such as BP or lipid management and send a note to the GP with recommendations but the GP may be quite busy dealing with their patient load or the patient may not fully understand the importance of these additional issues. This is exacerbated by the current family physician crisis.

Additionally patient engagement in chronic disease management requires time and support to effect healthy behavior change through the development of self monitoring and self efficacy. The patient may have a sense of what they need to do in terms of healthy behavior changes or medication titration but become frustrated with the challenges of environment stressors and social stressors.

A patient in our clinic would be seen for one adiposity related disease such as diabetes, but screened for hypertension, fatty liver disease and dyslipidemia etc. It is difficult to deal with all of these issues at one visit and the patient is often overwhelmed if too much is addressed. A well trained primary care physician or allied health care professional aligned with the goals and procedures in the cardiometabolic clinic would be able to address these issues separately with specialist input from within the collaborative group as needed. Additionally, the healthy behavior change that is being encouraged will address multiple comorbidities. This system will have enough redundancy built in to support the patient journey to better cardiometabolic health. This model of care has been envisioned as being a necessary step forward to improve population health while making effective use of the existing resources including pharmacotherapy.

Patients would participate in group visits over several weeks to improve their understanding and engagement of healthy behaviors that are meant to be life long and to support their success in these endeavors. These behavioral aspects of chronic disease management improves the effectiveness of medications and other interventions and in the STENO 2 study collaborative care aimed at improving metabolic parameters has resulted in a decrease in major adverse cardiovascular events and a decrease in mortality even if the patient is able to achieve adequate control over periods of 1-2 years. When patients hit a stumbling block they are able to connect with primary care physicians to address their concerns with the back-up of specialists.

3. Describe the activities and/or improvement strategy the project team plans to take to address the gap(s) in care.

This is achieved through intermittent visits with specialists, group medical visits run by family practice and allied health care professionals. The system will improve points of contact with the patient, develop self-reliance and self-efficacy and reduce the burden of care on individual specialists and primary care physicians. There are many aspects of cardiometabolic health that are not adequately addressed that are noted on our comprehensive assessments (outside of the scope of the referral) that can be effectively managed by primary care physicians working in parallel with specialists in the clinic and focused on cardiometabolic health. This will reduce specialist

referrals and wait times. The clinic will have well integrated algorithms to address and manage these issues by primary care physicians working collaboratively in the program.

During this EOI stage, over the next six months, family physicians and specialists participating in the clinic and those with an interest in cardiometabolic health will come together through a variety of formats (virtual and in person meetings) in order to listen and learn from each other's experiences and to develop upon the existing infrastructure of the clinic. For example all of our cardiometabolic clinic patients are offered the opportunity to attend a 12 week group based program that meets once per week for one hour via zoom to address different aspects of healthy behavior for change. Group based visits can be developed to address different aspects of cardiometabolic disease and healthy behavior change as this is a very heterogenous population that requires a more tailored approach in some cases. Healthy behavior change is an important aspect of improving control of hypertension, diabetes, fatty liver disease, dyslipidemia independently of weight loss. The group based visits provide patients with more information and support than simply attending a one hour session with a dietitian at the hospital which is the current standard in our health care system. Patients are not charged for the participation in the group visits. Currently we have been supporting these with other funds but the process is becoming more self sustaining.

During the EOI stage additional group sessions can be set up to address other aspects of care such as the behavioral pillars of weight management, diabetes management, physical activity etc . This would reduce the burden on our diabetes education centers and the hospital based dietitians while offering patients more points of contact .
The EIO stage can also be used to determine which algorithms for medical management of patients with adiposity related cardiometabolic issues would be of greatest benefit and to develop more informed referral pathways that can continue to improve the efficiencies of the system. This might include one on one education sessions with the patient by trained personnel in the clinic (who have completed the bariatric educator program though Obesity Canada). Improving patient engagement in the group visits is important for sustainability.

4. Using the boxes below, identify which outcomes will be addressed by the project (suggestion of 3-4). This information will assist in identifying the relevant Shared Measures for your project:

☒ SCC1 - Improved patient care and health outcomes ☒ SCC2 - Improved patient ability to self-manage care ☒ SCC3 - Improvements in physician and other health provider coordination, flow of care and communication ☒ SCC4 - Improved patient transitions between provider and care environments	☒ SCC5 - Improvements in GP access to specialist consultations ☒ SCC6 - Improve timeliness of patient access to physician care ☐ SCC7 - Improvements in appropriateness of GP referrals to specialist physicians ☒ SCC8 - Improved per capita cost of care or improved sustainability
	Identify the primary and secondary Dimensions of Quality that are being addressed.

What **patient populations** would the project target? Please check all that apply:

☐ General Population
☒ Adults
☐ Child & Youth
☐ End of life / Palliative
☐ Maternity
☐ Older Adults & Seniors
☐ Other (please list):

	Primary (select one)	Secondary (select one)
Accessibility	☐	☒
Appropriateness	☐	☒
Effectiveness	☒	☐
Efficiency	☒	☐
Equity	☐	☐
Respect	☐	☐
Safety	☐	☐

5. **Engagement strategy:** Which partners or stakeholders would you involve into the project to meet outcomes?

The cardiometabolic collaborative clinic has been in touch with the Divisions of Family practice to try to recruit family physicians who are interested in joining the clinic. We have been advertising for over one year and have interviewed some GPs. Ms. Welch can attest to this. Dr. Kevin Garside is a member of the divisions of family practice and a founding member or our collaborative clinic. Dr. Jennifer Rajala is a cardiologist in the South Island region, a founder of the cardiometabolic collaborative clinic and medical lead at the Pulse Cardiology clinic. Dr. Priya Manjoo is an endocrinologist boarded on Obesity Medicine and Hypertension Medicine. She serves on the Council of Health promotion of the Doctors of BC and the Subspecialist Services Committee (Medical Specialist) at the Doctors of BC. She is an author of the Canadian Cardiovascular Society 2021 Dyslipidemia guidelines and the Obesity Canada Clinical Practice Guidelines in 2020, Pharmacotherapy chapter update 2022. She has been involved in setting the standards for care for the management of patients with cardiometabolic disease and is aware of the challenges faced by physicians in achieving these standards of care in the current environment.

Dr. Rohit Pai and Dr. Oscar Cruz Perreira are both hepatologists in the South Island who have been involved in sharing the care of complex patients with fatty liver disease who have high burdens of associated metabolic disease. They have developed a robust pathway of referral for hepatology patients within the south island and have been instrumental in adapting this pathway to changing access to resouces. They are collaborators within the cardiometabolic clinic and local experts in chronic liver disease. They are increasingly aware that metabolic liver disease is now becoming the leading cause of liver disease, liver cancer and referral for liver transplant nationwide. Dr. Rohit Pai is lead for the liver care clinic at the RJH which is another collaborative clinic for patients with decompensation liver disease.

We will also seek input from other primary care physicians and specialist practicing within the field of cardiometabolic health to ensure that their patients' needs are represented and to allow other interested parties particularly family physicians to participate. The VIHA leads in the department of Medicine will also be involved in the planning and needs assessment.

6. **Engagement strategy**: How will you engage the patient family caregiver voice, inclusive of diverse populations, and capture the patient experience?*)* All patients attending our lifestyle clinic are invited to complete questionnaire assessing different aspects of their health behaviors and challenges and these can be tracked to ensure that their needs are being met.
7. **Which Indigenous communities** will/have be engaged throughout this project and in what capacity? If these communities will/have not being engaged meaningfully, please explain why. Practitioners representing diverse patient populations would be invited to participate in the planning of the clinic. We recognize indigenous communities as being particularly at risk for metabolic disease and would like to learn more about how to access this population and adapt our group visits to ensure that they are culturally appropriate.
8. Does this project **align with other quality improvement activities related to this work** (if so, please list)? Not sure how to answer this.

9. Are there **particular barriers** that could prevent your communities moving forward with the needs assessment, engagement, and planning? What is your plan for addressing these barriers? (i.e. COVID-19 restrictions)

Funding and time to inform community based physicians of this effort are potential barriers. The program would do better with greater primary care involvement however, there are fewer GPs available. Hopefully some of the funding can be used to engaged community based physicians and encourage them to become involved.

Having funding for a nurse or project manager will assist in developing strategies for patient engagement.

10. If successful, **how will these improvements be sustained**? Include how it will be operationalized and supported post project (See Appendix C for optional sustainability assessment)

We have done some cost analyses and once the group visits are up and running with adequate attendance the cost of the group visits can be covered.

11. Do you have a **governance structure or Steering Committee** in place that will oversee this work in your community? If yes, what is that structure?

12. Do you have any additional comments to add?

Family Physician Name	Email	Community	Lead
Dr. Kevin Garside	kevingarside@hotmail.com	South Island Family Practise	☒
Specialist Name	**Email**	**Specialty**	**Lead**
Dr. Priya Manjoo	psmanjoo@gmail.com	Endocrinology	☒
Dr. Jenny Rajala	**Jennyrajala123@gamil.com**	**Hepatology**	

Dr. Rohit Pai	Pai.rohitpai@gmail.com	Hepatology	
Dr. Cruz Perreira	Ocruz.pereira@gmail.com	Hepatology	
Family Physician with Focused Practice	Email	Focus Area	Lead
			☐
Health Authority Representative	Email	Community	
Indigenous and Patient Partner	Email	Community	
Allied Health Professionals	Email	Focus Area	
Heather Dueck		Dietitian	
Carla Beer-Carpenter		Dietitian	
Fairuz Siraj		Diabetes Educator and Pharmacist	
Bernadette Bebb		Bariatric Counsellor	
Project Manager and/or Others	Email	Focus Area	
Chanhee Kim	laonixi@gmail.com	Health information Science	
Kerry Buffalo	Kerry.buffalo@gmail.com	Student, Island Medical Program, U Vic	

13. Please identify which Family Physicians/Specialists/Family Physicians with Focused Practice, other health care providers, and project manager will be involved and identify which are project leads:

See above.

14. Budget & Work Plan		
Attachments Included	**Yes**	**No**
Appendix A: Budget (click HERE for required budget template)	☐	☐
Appendix B: Detailed Work Plan for **Proposals only** (click HERE for a Work Plan Guide)	☐	☐
Appendix C: Evaluation plan template – this is to be completed for **Proposals only** and submitted either at the time of proposal submission, or with the first quarterly report following distribution of funds.	☐	☐
Appendix D: Sustainability Assessment for **Proposals only** (optional)	☐	☐

Questions?

shared_care@doctorsofbc.ca
Shared Care Team Contacts

Submission Instructions

For **EOI submissions**, please include the following documents:

Project funding request form – please submit in .doc format

Appendix 1. Infographic for proposed model of care

Appendix 2. Preliminary data from CMCC pilot project

Appendix 3. Group based visit financial feasibility.

For **proposal submissions**, please include the following documents:

Project funding request form – please submit in .doc format

Appendix A: Budget

Appendix B: Detailed work plan

Appendix C: Evaluation plan (or at time of submission or first quarterly report)

Appendix D: Sustainability assessment (optional)

APPENDIX A – Budget

(Screen snip from Budget Template)

APPENDIX B – Workplan

Add Fields as appropriate to your Project. Projects may use any workplan format.

Activities/Milestone	Key Stakeholders	Outcomes/Alignment with Goals	Target Date/Date Range
Project Planning: 1. Appoint Steering Committee 2. Book Steering Committee Meetings 3. Book Project Meetings/Workshops 4. Develop detailed Project Plan			
Evaluation – Current State/Needs Assessment: 5. Conduct Patient Surveys 6. Conduct Provider Surveys 7. Evaluate Results 8. Update Project Goals			
Project Execution: 9. Conduct Project Meetings/Workshops 10. Identify Opportunities & Best practices 11. Develop Future State Vision 12. Design/Strategy Development 13. Implementation			
Evaluation – Future State: 14. Data Collection (document review, surveys, interviews, etc.) 15. Data analysis 16. Make recommendations 17. Create Final Evaluation Report			

Project Close: 18. Follow Shared Care Project Close Guidelines 19. Create Project Close Report			

APPENDIX C: Evaluation plan

For examples of how to fill out this form, please see the Shared Care Learning Centre

Shared Care Evaluation Plan Template

Project Title	
Estimated Timeline (start to end)	

OVERVIEW / BACKGROUND

State what problem you are addressing and why it is important. Include relevant data, literature, best practices, or sources to support the project. Describe who will benefit from the project (consider both the individual and organization) and how it will impact patients.

Click or tap here to enter text.

AIM STATEMENT

What is the problem or opportunity, who will the project benefit, where, by when and by how much? Provides initial orientation toward activities of improvement initiatives.

Click or tap here to enter text.

OBJECTIVES

Objectives are specific and measurable steps. Objectives are narrow, precise and concrete. Make your objectives SMART – Specific, Measurable, Achievable, Realistic, and Time bound. In the section titled Evaluation Framework, be sure to identify the measures and data collection tool that will capture the necessary data to indicate if the objective has been achieved.

Click or tap here to enter text.

TARGET POPULATION

Identify who will your participants be, how will you select them and why? How will you approach people to participate in your project? What are your inclusion and exclusion criteria and why? Consider including a brief Participant Communication Plan (optional). This component of the plan will likely need to be updated / altered as the project progresses and the problem / issue is better understood.

Click or tap here to enter text.

PROJECT DELIVERABLES

Provide a list of the deliverables that you will produce at the conclusion of your projects. In addition to having a clear aim statement and objectives, clearly identifying the deliverables may assist you in focusing your evaluation plan. This list can be added / adjusted throughout the life of a project as new ideas emerge over time.

Click or tap here to enter text.

EVALUATION FRAMEWORK

Define measures (quantitative and/or qualitative) used to monitor the impact of this improvement effort. Customize the table and include additional columns according to your approach. For examples illustrating of a completed matrix, please see the Evaluation Planning Toolkit on the Shared Care Learning Centre.

IHI Modified Triple Aim	Expected Outcome	Data Source	Measure

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Appendix D: Optional Sustainability Assessment

Please refer to the sustainability toolkit and evaluation on the Shared Care Learning Centre.