To Health Care Providers:
Welcome to the first issue of the Chronic Disease Prevention and Management (CDPM) Information Bulletin. This bulletin provides information about programs and services offered through the Primary Care Networks that can assist you in supporting your patients with chronic disease. The bulletin will be distributed quarterly to health-care professionals across Health PEI by the CDPM unit. Please contact us for more information about these programs and services.

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Health PEI Community Hospitals and Primary Health Care

1 in 3 Islanders have a chronic condition
Canadian rate: 28%
Provincial rate: 30%

1 in 5 Islanders have hypertension

1 in 11 Islanders have diabetes

1 in 13 Islanders have COPD

(DHW,2012; CDSS, 2008)
Chronic Obstructive Pulmonary Disease (COPD)
COPD is a long-term lung disease that includes chronic bronchitis and emphysema. The rate of COPD has been rising over the past decade and many patients are frequently admitted to hospital with exacerbations and complications from the disease.

In 2011-2012, the Community Hospitals and Primary Care division implemented a COPD pilot project. The purpose of the pilot was to empower COPD patients to take control of their illness, enhance quality of life and improve health outcomes. Patients were very satisfied with the program and it was successful at reducing visits to the emergency room and reducing length of stay in hospital for these patients. Since that time, a temporary coordinator, Kendra Biggar was hired to expand the program across all of the primary care networks and it in now available to assist COPD patients across the Island. The goal of the program is to provide an integrated, collaborative approach to COPD management, improving health outcomes of patients living with COPD and reducing reliance on bed-based care. Primary care nurses across the island have been formally trained using the COPD Trec course preparing them as COPD educators. The course teaches the latest information and training in COPD care and is based on Canadian COPD management guidelines.

To refer patients to the program or for more information about the COPD program contact your local health centre at the following numbers: Alberton, 853-0403; O’Leary, 859-3929; Evangeline, 854-7259; Summerside (Harbourside), 432-2600; Hunter River (Central Queens), 621-3050; Charlottetown West (Four Neighborhoods), 569-7772; Charlottetown East (Polyclinic Bldg), 620-3260; Montague (838-0830); Souris (687-7033).

Provincial Diabetes Program
Diabetes is a serious and potentially life-threatening condition that requires ongoing disease management to avoid serious complications. About 9% of Islanders (ages 20+) are living with diabetes and many have other co-morbidities. Diabetes educators (nurses, dietitians and a social worker) in the Provincial Diabetes Program provide self-management support to patients to increase their knowledge, skills and confidence in managing their illness. Patients can be referred by their physician or other health professional or they can self-refer to the program. In June, 2012 a database, known as “D-CID” was launched across PEI that enables the program to track client visits, and clinical indicators such as HbA1C, lipids, foot exams, and etc. The system will support preventive care for patients by providing appointment test reminders and flag specific patients at high risk for proactive care. Over time, the Provincial Diabetes Program will have the ability to create reports at an individual client level, by clinic site, or by physician (by request).

This database will provide information to clinicians in an organized format and answer questions regarding the population served. For example: What is the average age at diagnosis of type 2 diabetes? How many clients are within target HbA1C of <7%? To refer a patient or for more information about the Provincial Diabetes Program, please call any of the health centres (numbers as listed above) or Martha St. Pierre, Health PEI’s Provincial Diabetes Program clinical leader, at 368-4243.
**Hypertension Pilot Project**

About 21% of Islanders have been diagnosed with hypertension. Hypertension is associated with the development of cardiovascular disease morbidity and mortality, significantly increasing the risk of stroke, ischemic heart disease and heart failure (PHAC, 2010).

Hypertension Pilot Projects are underway in the Central Queens Health Centre and in the Souris Health Centre. The Pilots are evidence-based and are for Islanders with high blood pressure or hypertension with the goal to improve disease management and achieve optimal blood pressure control.

The program is delivered by a team of health care providers and is based on the Canadian Health Education Program (CHEP) guidelines.

For more information about the program, contact Therese Harper at Four Neighbourhoods Health Centre at 569-7566.

![Nurse Arlene MacIsaac takes the blood pressure of patient David Jenkins at the Eastern Kings Health Centre in Souris](image)

**Implementation of an integrated organized stroke care model for PEI has been ongoing since 2009. Organized Stroke Care promotes a coordinated approach to early detection and assessment of warning signs of stroke, and timely access to appropriate treatments and specialized health care providers.**

To date many components of Organized Stroke Care (OSC) founded on the Canadian Best Practice Recommendations for Stroke Care have been implemented in PEI. Key system changes include: emergency stroke protocols, EMS by-pass agreements, implementation of t-PA, Provincial Acute Stroke Unit, enhanced Provincial Stroke Rehabilitation Services (in-patient Rehab, Provincial Ambulatory Clinic and two District Teams) and a Secondary Stroke Prevention Clinic. We are now moving our attention to community re-integration and provincial expansion of stroke prevention services.

For more information on the Organized Stroke Care Model or inquires around services available to you please contact Carolyn MacPhail, Provincial Stroke Coordinator at (902) 368-6527 or clmacphail@gov.pe.ca.
Colorectal Cancer Screening

Colon cancer is the second leading cause of cancer death in PEI. In May 2011, Health PEI launched a colorectal cancer screening program, and since that time over 6,000 Islanders have participated in the program. Islanders aged 50-74 years, who do not have a family history of colon cancer are considered of average risk and according to the Canadian Association of Gastroenterology, should be screened by fecal occult test every 2 years. As a health care provider you can play an important role in promoting colorectal screening to your patients.

Here's how:

1. Encourage your patients in the target age range to pick up a screening kit at their doctor’s office or by calling the Colorectal Cancer Screening Program at 1-888-561-2233,
2. Be a role model and get screened yourself, and
3. Invite the Colorectal Screening Coordinator, Marla Delaney at 368-5901 to your worksite or community for an information session!

Ambulatory Care Sensitive Conditions

Ambulatory care sensitive conditions as defined by CIHI, include: asthma, angina, heart failure and pulmonary edema, hypertension, grand mal status and other epileptic convulsions, diabetes, and COPD. These seven ACSC’s are responsible for considerable morbidity and mortality and account for a significant number of admissions to hospital each year in PEI.

Prince Edward Island has not fared well on the ACSC rate over the past five years when compared to the rest of the country. An ACSC project is underway to identify factors associated with admissions related to these conditions and to implement processes to reduce potentially preventable admissions and readmissions for these conditions.

For more information contact, Heather Diamond (620-3855), Marilyn Barrett (569-7640) or Pat Charlton (368-6721).

Contact us for more information:
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