
WORKSHOP ABSTRACT

Hyperlocal impact in the community| An Emerging model of Integrated Chronic Disease Prevention and Management

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Background: North York, Toronto faces unique healthcare challenges, with 70% of its population identifying a primary language other than English. This language barrier, combined with an aging demographic and high prevalence of chronic conditions, limits access to healthcare and complicates system navigation. These challenges particularly affect the prevention and management of Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), and diabetes. Underlying mental health concerns have emerged due to difficulties in navigating the healthcare system, exacerbated by inconsistent access to primary care services. The overall rate of unattachment to primary care for North York Toronto Health Partners (NYTHP) is around 13%, with "uncertain attachment" in some neighbourhoods ranging from 15% to 23%. In response, NYTHP, an Ontario Health Team (OHT), developed an Integrated Chronic Disease Prevention and Management (ICDPM) Hub in November 2024 to address these systemic issues through low-barrier, community-centered care.

Methods: NYTHP launched the ICDPM Hub, based on best practices from the Diabetes Prevention Program, Diabetes Education Program, and Community Health Information Fairs (CHIFs). The initiative engaged all 22 OHT core partners, including primary care organizations, hospitals, service providers, community agencies, and equity-deserving communities with lived experiences. The ICDPM Steering Committee guided the transition from planning to implementation. The model

embedded social determinants of health (SDOH) supports throughout client journeys and gathered health equity data to inform services. It relied on Community Health Ambassadors (CHAs), trusted local change agents trained in peer education, to provide multilingual engagement, education, and navigation support. Interprofessional care teams included CHAs, community health workers, care navigators, nurse practitioners, pharmacists, and physicians. Mobile care models enhanced access for underserved populations. The system integrated data sharing and consent frameworks, enabling coordinated care and holistic supports backed by evidence-based decision tools.

Results: By spring 2025, the ICDPM model aims to enroll at least 100 patients and clients to receive integrated prevention and management services. It will establish care pathways with 10 key partners and include co-creation and ongoing evaluation with five providers and community health ambassadors. Four pilot ICDPM Hub Clinics featuring CHIF events focused on CHF, COPD, and diabetes will be implemented. The team expects to identify 30 individuals for access to the ICDPM Hub through referrals, with 15 participants enrolled in prevention and management education programs and 10 receiving direct point-of-care services. A survey of 200 community members projects a 10% increase in system knowledge and service usage. Digital engagement is anticipated to reach 1,000 website visits through 10 partner organizations. The ICDPM model will use a learning health system framework to iterate improvements, with outcome data available by spring 2025.

Conclusions: This community-co-designed Integrated Chronic Disease Prevention and Management (ICDPM) model addresses the urgent needs of equity-deserving populations by providing culturally relevant, language-specific care tailored to diverse urban communities. Integrating Community Health Ambassadors (CHAs) within clinical pathways shifts away from disease-specific approaches, offering holistic support for equity-deserving groups. Key insights emphasize the value of co-design, collective impact, and integrated care across the continuum to improve health outcomes for those facing systemic barriers.