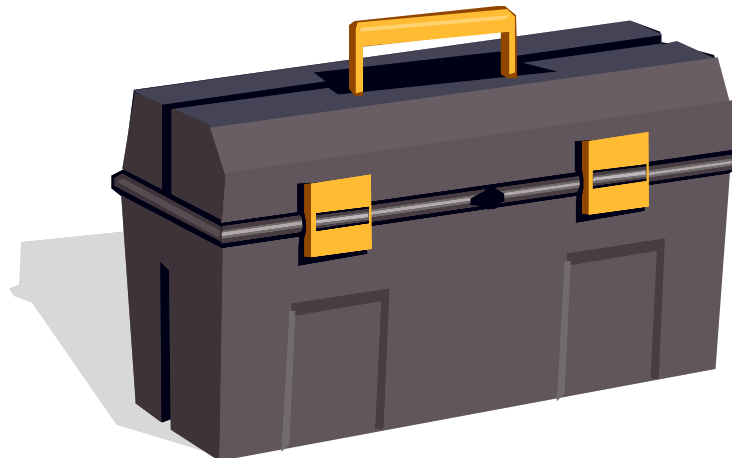
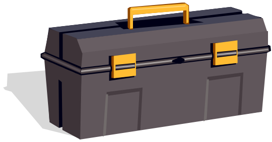
CHRONIC DISEASE PREVENTION AND MANAGEMENT FRAMEWORK TOOL KIT

Grey Bruce Integrated Health Coalition

February 2008





CHRONIC DISEASE PREVENTION AND MANAGEMENT FRAMEWORK TOOL KIT

Section I: Understanding the model

- Project overview and partners
- Introduction

Power point presentation

- Model history, context overview
- Key model elements
- Model applications
- Model development applications/initiatives
- Introduction to use of tool box
-

Model elements/ application

- Workflow for applying the model
- Chronic Disease Prevention and Management Framework
- Element definitions

Section II: Applying the model

- Introduction
- High level logic model of CDPM Framework components
- Mid-level systems logic model(stakeholder roles/responsibilities and components

Section III: Building your program

- Introduction
- Service/Program Feasibility Review
- Logic Model Development
- Checklist: Initiating a Health Care Program
- Application Q&A's

Section IV: Grey Bruce CDPM programs and initiatives inventory

Section V: Resources and References

Section VI: Evaluation

- Kit evaluation

Section 1

Understanding the model – Steps 1 & 2

Welcome
- Project overview and partners
- Introduction

Power point presentation

- Model history, context overview
- Key model elements
- Model applications
- Model development applications/initiatives
- Introduction to use of tool box

Model elements/ application

- Workflow for applying the model
- Chronic Disease Prevention and Management Framework
- Element definitions

Project Overview and Partners

The Grey Bruce Integrated Health Coalition (GBIHC) CDPM Framework Tool Kit project is the result of emerging local initiatives in the hospital sector, community, and in primary health care. As well, the changing dynamics of health care emerging from Ontario Ministry of Health's transformation agenda has influenced the ways in which partners work together to provide a continuum of care.
The CDPM framework is referred to as the context within which existing and developing services should function. The Southwest LHIN has established a Priority Action Team targeting chronic disease prevention and management as a strategic priority.
In order to take the framework from a conceptual level to a useful resource that drives and supports the design of services, activities and initiatives, the GBIHC mandated the development of a tool kit. The kit walks users through understanding the framework, to developing programs that maximizes use of existing resources, and reflects an integrated care approach for individuals living with chronic illness (es)

Why is using the kit useful to your organization or group?
It:

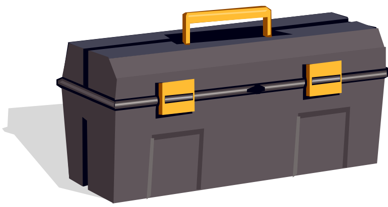
- Avoids possible parallel initiatives and maximizes the use of existing resources for care delivery.
- Ensures that key stakeholders are involved in planning/redesigning services and programs.
- Clarifies and makes best use of the complementary roles/services provided by stakeholders.
- Helps build service systems that are person and community centred and reflect the continuum of care from prevention and health promotion through to palliation.

The Tool Kit is intended to be used in its entirety, and may be used as such with acknowledgement that it is the work of the Grey Bruce Integrated health Coalition.

Partners in Tool Kit development:

Lynda Bumstead	Grey Bruce Health Unit
Nancy Dool-Kontio	Southwest Community Care Access Centre
Cathy Goetz-Perry	Grey Bruce Victorian Order of Nurses
Carolyn Grace	Owen Sound Family Health Team
Jessica Meleskie	Grey Bruce Health Network
Lisa Miller	Grey Bruce Diabetes Program
Susan Pouget	Closing The Gap Health Care Group Grey Bruce
Mary Solomon	Grey Bruce District Stroke Centre
Michelle Walter	Brockton and Area Family Health Team

Copyright January, 2008



Introduction: How to use the tool kit?

Many health care and health promotion organizations as well as communities and individuals play a role in chronic disease prevention and management (CDPM) therefore planning a CDPM initiative needs to be explicit and inclusive. In planning a CDPM initiative:

- How do you proceed?
- What is the purpose and scope of the initiative?
- Who are the recipients of the initiatives?
- Who are the partners and stakeholders?
- How does the initiative fit in the current, local system of CDPM?
- Are the objectives and deliverables identified?
- How will outcomes be measured?

The Grey Bruce Integrated Health Coalition CPDM Framework tool kit is a step- by-step approach to planning CDPM initiative, strategy or program.

Power point presentation

The Power Point presentation consists of background information on the Ontario CDPM framework as well as the development of the framework for Grey and Bruce. Many slides are based on presentations by Majorie Keast, Ontario Ministry of Health and Long Term Care.

See Appendix A for slides and notes. Power Point is on the tool kit disc.

CDPM Framework Workflow

Understanding the Framework

Step 1 **Review the Ontario Chronic Disease Prevention and Management Framework diagram**

Step 2 **Review the Element Definitions in CDPM**

Step 3 **Review the Logic Models**

Applying the Framework

Step 4 **Complete Program Feasibility Checklist**

Step 5 **Complete the Logic Model for Program Planning**

Step 6 **Complete the "Initiating a Health Program Checklist"**

Step 7 **Revise Program (Logic Model) Plan as required**

To Begin:

Understanding the CDPM Framework

Step 1 Review the Ontario Chronic Disease Prevention and Management Framework diagram.

The Grey Bruce Integrated Health Coalition Chronic Disease Prevention and Management framework is based on the Ontario Chronic Disease Prevention and Management Framework (Figure 1). The Ontario Chronic Disease Prevention and Management Framework is a picture of the components, relationships and interactions needed to improve clinical, functional and population health outcomes.

Ontario's Chronic Disease Prevention and Management Framework

INDIVIDUALS AND FAMILIES

Healthy Public Policy

Supportive Environment

Community Action

Personal Skills & Self-Management Support

Delivery System Design

HEALTH CARE ORGANIZATIONS

Information Systems

Provider Decision Support

COMMUNITY

Productive interactions and relationships

Activated communities & prepared, proactive community partners

Informed, activated individuals & families

Prepared, proactive practice teams

Improved clinical, functional and population health outcomes

Step 2 Review the Element Definitions in CDPM

CDPM is a complex. Common language and definitions help to increase the understanding of CDPM. The following definitions are common to the Ontario and Grey Bruce Frameworks.

Individuals and families

Individual and families are at the centre of Chronic Disease Prevention Management (CDPM).To achieve the best possible outcomes, they must be directly and actively involved in keeping themselves healthy and/or managing their chronic conditions(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.

Health Care Organization

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 the kind of fundamental change in service delivery, health care organizations:

- Provide strong leadership that visible support CDPM
- Align resources and incentives to support a system 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 organizations changes.

1. **Personal Skills and Self-Management Support**:
   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
- Education and skills development
- Behaviour modification programs
- Counselling and supportive services
- Links to community services
- Links to community resources
- Follow-up

2. **Delivery System Design**:

Delivery systems for CDPM must be designed to focus on prevention (i.e.: primary prevention for people who are healthy, and secondary and tertiary prevention to keep people who have an illness from developing further complications), to improve access to and continuity of care, and to help people move easily between services and health care providers.

A delivery system designed to prevent and manage chronic diseases has the following features:

- An interdisciplinary team
- Focus on health promotion and wellness
- Planned interaction, active follow-up and easier navigation thought the system
- The capacity to tailor services to meet individual needs
- Capacity to provide culturally competent care
- Innovative practices
- Surveillance system

3. **Provider Decision Support**:

To provide consistent, proactive care, the team uses tools and resources that will help them develop evidence-based care plans and make informed decisions. Decision support includes:

- Education and training
- Clinical management tools
- Access to expertise
- Performance measurement systems

4. Information Systems

Information systems support all aspects of chronic disease prevention and management by connecting members of the team, providing effective ways to monitor individuals' needs and care, and maintaining timely accurate information to help guide care. They give team members easy access to the decision support

tools and other information they need to plan care, make clinical decisions, and coordinate services across the health system. Information systems also help individuals and families with their own self-management and care.
They include:

- Information technology systems that connect team members, sites and data
- Electronic health records
- Registries
- Interactive tools and software
- Health information for individuals and families
- Health care organizations

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. The community plays a key role in addressing the social determinants of health. Examples of community: schools, churches, municipalities, recreation centres, chambers of commerce, service clubs, YMCA, Parks Canada, First Nations, agricultural organizations, safety associations.

1. **Healthy Public Policy**:
   Improving the overall health of the population – including preventing and managing chronic disease – is a shared responsibility. To influence the many determinants of health, a variety of sectors – health, education, justice, labour, social services, housing, transportation, technology, recreation – must work together to improve individual and population health and reduce inequality. All must be actively engaged in developing and supporting healthy public policies that will ultimately lead to the prevention and reduction of chronic disease.

   Healthy public policies help people who are well stay healthy and people with chronic disease take care of their health. In a systems approach to CDPM, healthy public policy involves health care organization working with community partners to advocate for changes such as:
   - Legislation and regulations
   - Fiscal policies
   - Guidelines
   - Organizational policies

2. **Supportive Environments**:
   People are more likely to be empowered to prevent and manage their chronic diseases if they live in supportive environments where it is “easier” to make healthy choices. Supportive environments remove barriers to healthy living, and

promote living and working conditions that are safe, stable, secure and enjoyable. They give people more opportunities to be healthy and they enhance self-reliance.

- Supportive physical environments
- Supportive social environments

3. **Community Action**:
   Effective chronic disease prevention and management depends on communities being able to take action on issues that affect their overall health. Community action engages people and organizations, and uses the wisdom of the community to find solutions to often complex problems.

   As part of CDPM, the health care sector collaborates with other sectors and parts of the community to share their knowledge, expertise, strengths, and resources to create a healthier community. They identify key issues, build trust and relationships, and work together to find shared solutions. Community action is an important element of CDPM because many of the major determinants of chronic disease are outside the health care sector.

   - Community engagement/mobilization
   - Community partnerships/coalitions

Adapted from Ontario Ministry of Health and Long Term Care (2005) *A Systems Approach to Chronic Disease Prevention and Management in Ontario: A framework.*

Productive interactions and relationships – Interactions (e.g. education, coaching, treatment) and relationships (e.g. hospitals, public health, family health teams) resulting in a coordinated, integrated approach that focuses on the person and not the disease. The goal is to reduce and control symptoms and to help the individual lead a healthier life (Adapted Hindmarsh, 2006).

Activated communities and prepared, proactive community partners - Information, programs, services and policies in communities that support individuals in healthy living and to manage their condition. Partners are knowledgeable in chronic disease prevention and management, prepared to support healthy living as routine and anticipate the support needed to maintain a healthy life style. Communities are collaborating across sectors and with health care organizations to identify and meet the needs of their population. Individuals and families are linked to community resources (Keast, 2006)

Informed, activated individuals and families – Directly and actively involved in keeping themselves healthy and managing their chronic condition. Work with providers to make decisions about their management. They understand the disease process, are part

of the care team and realize his/her role as the daily self manager. Family and caregivers are engaged in the individual's self- management. (McColl Inst. For Health Care Innovation, Group Health Cooperative of Puget Sound)

> ***"The provider is viewed as a guide on the side, not the sage on the stage"***
>
> ***Keast, 2006***

Prepared, proactive practice teams – Practice teams bring together individuals and families, different health care practitioners, community providers and volunteers. The team members have a common goal, understand each member's skills, roles and expertise. The team has consumer information, decision support, people, equipment and time required to deliver evidence-based clinical management, health promotion/prevention and self-management support (Keast, 2006, adapted from McColl Inst. For Health Care Innovation, Group Health Cooperative of Puget Sound)

A copy of the MOHLTC Preventing and Managing Chronic Disease: Ontario's Framework is on the Tool Kit disc.