

# A Tool for Strengthening Chronic Disease Prevention and Management

Through Dialogue, Planning and Assessment

Case Studies



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The Canadian Public Health Association worked with four health regions to pilot and evaluate "A Tool for Strengthening Chronic Disease Prevention and Management through Dialogue, Planning and Assessment". This document includes a case study for each pilot outlining the context, use of the Tool and results.

The Tool and supporting resources are available on-line at <http://chronicdisease.cpha.ca>.

This work was made possible through financial contributions from the Public Health Agency of Canada.

# Cumberland District Health Authority, Nova Scotia

## Context

The Health Promotion Coordinator of the Cumberland District Health Authority initiated this pilot project. The Cumberland District, centred in Amherst, Nova Scotia, is one of nine District Health Authorities (DHAs) in the province. Its services range from acute to long-term care and include public health, addiction and mental health programs. Primarily rural in character, the Cumberland DHA serves residents in three counties with a total population of 33,000.

The Health Promotion Coordinator wanted to use the Tool to provide structure and support to her planning role, which focuses on strengthening chronic disease prevention efforts within the DHA. She thought the pilot project and Tool would

provide opportunities to take a number of first steps, including:

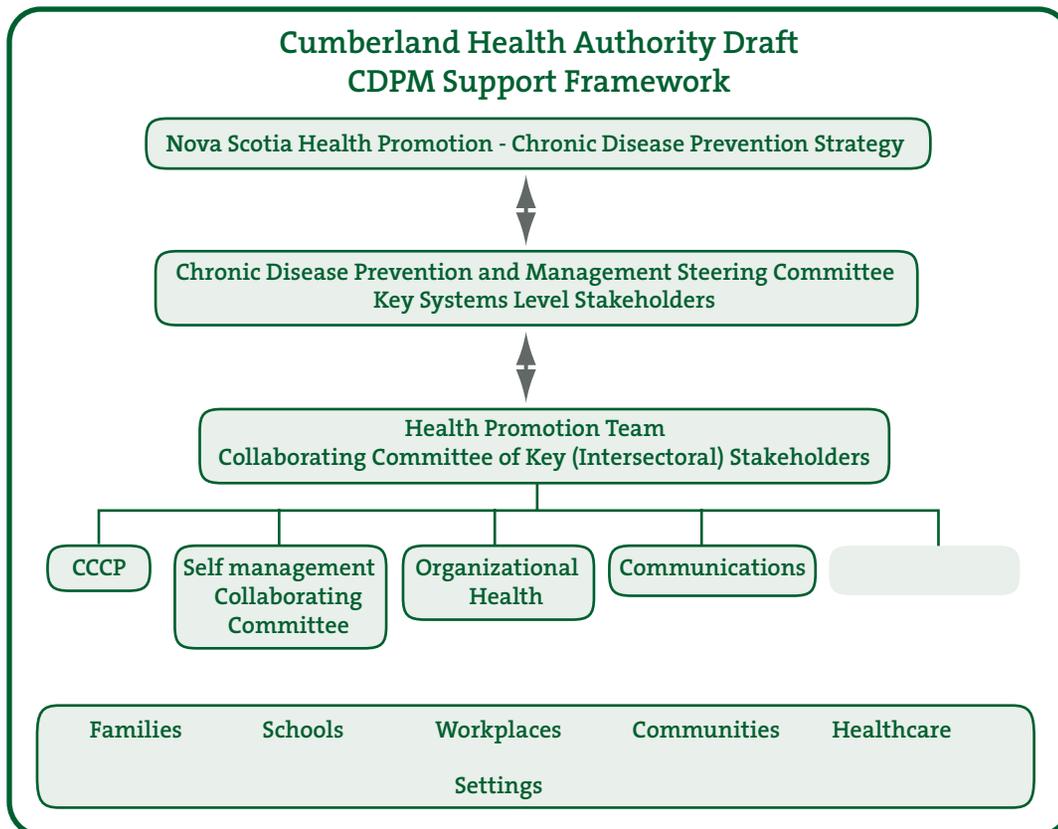
- Building collaboration among stakeholders along the continuum of service
- Introducing a determinants of health focus into the work of the health region
- Better linking population health and individual health approaches
- Building stronger links between DHA activities and intersectoral efforts in the community.

The newly-funded Health Promotion Coordinator's position was one of nine set up by the province in each DHA after a public health capacity review in 2006. The Health Promotion Coordinator had already established a small, internal DHA planning team for chronic disease. The team was planning

to host a stakeholder forum to learn about the Expanded Wagner Chronic Care model and how it could be implemented in their District. The timing of the pilot process and the Tool dove-tailed with their plan.

The Vice President of Community Services agreed to champion the CPHA pilot project and chair a new Chronic Disease Prevention and Management (CDPM) Steering Committee. Creating the Steering Committee was a key action item at the initial stakeholder forum, "Accelerating CDPM Day". Over the course of the pilot project, the Cumberland CDPM Support Framework evolved to its present structure (see Figure 1). The Health Promotion Coordinator supported the Committee's work and during the early stages of the pilot project, an external facilitator provided assistance.

**Figure 1. Cumberland CDPM Support Framework**



## Use of the Tool

*Accelerating CDPM Day* was a full-day, DHA-hosted broad stakeholder meeting in the Fall of 2007. The meeting was organized as a first step in getting ready to use the Tool and had three main objectives:

- To launch region-wide chronic disease prevention and management work
- To provide information for a situational analysis of current opportunities and challenges for the CPHA pilot project
- To engage regional stakeholders in the early stages of chronic disease planning

Participants gave positive evaluations of the meeting. The meeting's program included:

- An overview of the evolving provincial CDPM framework (adapted from the expanded Wagner model)
- A recap of the provincial chronic disease prevention strategy
- Presentations of promising practices in Cumberland
- Small group discussions

At the end of the meeting, interested participants volunteered to form the new CDPM Steering Committee, leading regional planning and the use of the Tool. Members included the Vice President of Community Services and managers/coordinators of:

- Public health
- Primary care
- Dietary services
- Organizational wellness
- Regional addiction and mental health services
- Cardiovascular health
- Quality improvement
- Decision support

The orientation session to the CPHA Tool took place during the first meeting of the newly-established CDPM Steering Committee. They met to review the results of the planning day, identify priority areas for action and develop a plan for applying the Tool.

In the early stages, the Committee used the Critical Success Factors as launch points for discussion of current activities and their state of readiness for promoting more integrated chronic disease prevention and management planning. To continue to build buy-in among stakeholders, the Committee held a second stakeholder forum. Their aim was to set priorities, using clear criteria and a group process to establish short-term priorities for CDPM action (see Table 1).

**Table 1. Cumberland DHA: Priority-Setting Criteria for CDPM Goals and Objectives**

Criteria	Definition
Local Alignment	Fits with the strategic directions of Cumberland Health Authority and Community Health Boards
Readiness	An appropriate level of awareness/readiness already exists among key stakeholders including: staff, community, patients, board, province, to move quickly
Builds on Capacity	Builds on existing resources and capacity within the district
Integration	Is a clear opportunity to practice/promote CDPM integration
Inclusive	Includes the continuum of health care providers
Provincial Alignment	Aligns with provincial priorities and resources (timing!)
Impact	Will have an impact on improving clinical, functional and population health outcomes

The Committee wanted to balance three areas of activity:

- Taking action in priority areas
- Building capacity for integrated CDPM within the District
- Carrying out ongoing assessment and evaluation.

The Tool and Critical Success Factors became touchstones for their CDPM work.

As a starting point for more in-depth application of the Tool, the DHA's 15-member Public Health Services team worked through pertinent questions for three of the Critical Success Factors:

- Common Values and Goals
- Public Health Capacity and Infrastructure
- Integration of Chronic Disease Prevention and Management

The discussion highlights were recorded and participants evaluated the process. The results were shared with the CDPM Steering Committee as an example of how the Tool can help with opening up dialogue and assessing opportunities and challenges

**See [Doing the Assessment in the How-to Guide](#)** [↗](#)

### Results to Date

During the early stages of the pilot project, the Committee identified priority areas which would guide more integrated chronic disease prevention and management. Stakeholders validated the priorities at a second priority-setting forum. (see Table 2)

**Table 2. Cumberland DHA: Priority Areas for Action to Strengthen CDPM**

Priority Areas	Strategies and Linkages
Reorienting Health Services	Increasing awareness of collaborative, systems approach to CDPM and opportunities in Cumberland Health District Facilitating knowledge translation to strengthen current practice
Chronic Disease Self-Management	Linking to training opportunities through the Chronic Disease Self-Management Provincial Initiative (Stanford Self-Management model)
Community Action	Focusing on implementing Comprehensive Workplace Health, building on provincial strategy Focusing on Determinants of Health through multi-sectoral approaches to reducing poverty

The Steering Committee developed a good understanding of the context needed to move forward with a collaborative, systems approach to strengthening CDPM, as well as the actions and resources required to continue their regional work.

They identified next steps in an action plan, taking into account some of the barriers and challenges. These next steps include:

- Developing a communications plan about CDPM
- Organizing a planning committee to focus on using the Tool to raise awareness, to help stakeholders “digest” and better understand CDPM, and to build capacity for action
- Establishing a collaboration committee for the region’s self-management initiative, involving stakeholders from within the DHA as well as community stakeholders, such as representatives from disease-specific NGOs
- Conducting an inventory of CDPM and integration points to map out the “lay of the land” for regional work in CDPM
- Exploring the opportunity for Public Health to be a leader/role model regarding determinants of health and accessibility issues with Primary Health Care, through knowledge and best practice exchange.

The Health Promotion Coordinator stressed the importance of communications and awareness-building to ongoing CDPM work. Those involved need a bilateral information-sharing and communication plan to share knowledge and direction of planning with external stakeholders. Critical information about current activities, barriers and challenges needs to be brought back to the planning table.

The Tool will contribute to the ongoing work of building awareness and capacity for CDPM, helping to create “Ah ha!” moments for people – opportunities to strengthen their collaborative work.

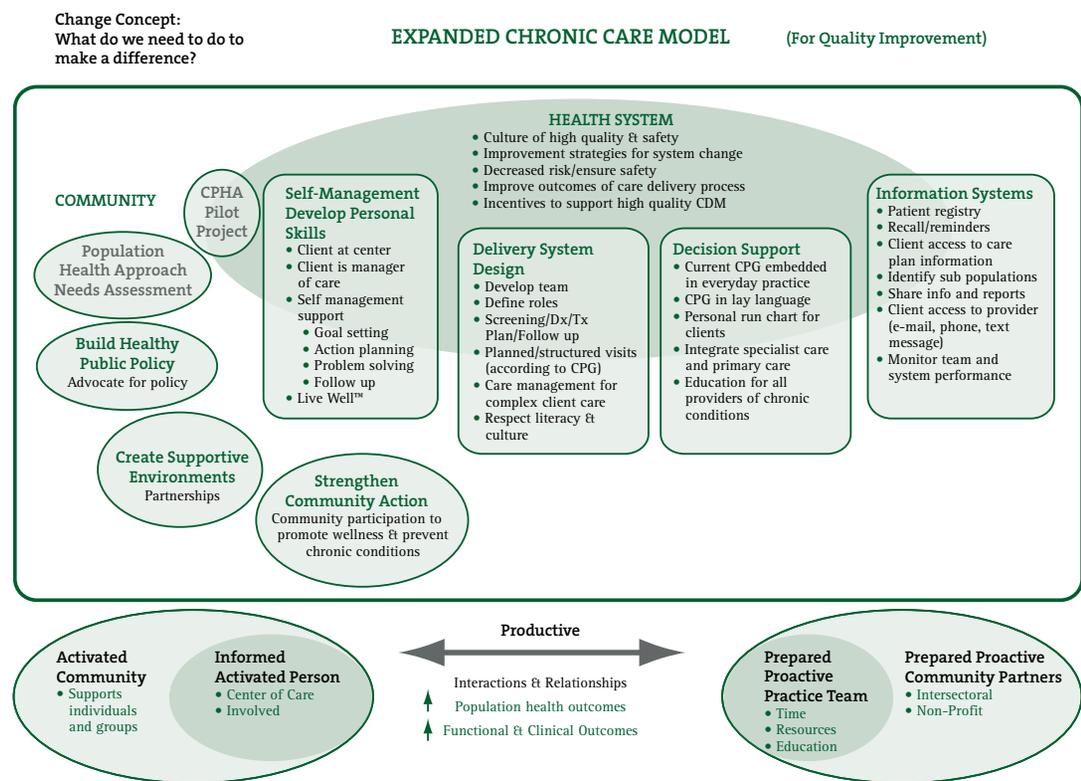
# Five Hills Health Region, Saskatchewan

## Context

This pilot project was initiated by the Medical Officer of Health (MOH) for the Five Hills Health Region (FHHR). The FHHR is one of 13 Regional Health Authorities (RHAs) in Saskatchewan, with responsibility for acute care, long term care, home care, ambulance services, public health, mental health and addiction services. The Health Authority is located in south-central Saskatchewan and serves a population of 55,246 people.

The MOH wanted to use the tool to boost the prevention component of the Authority's Healthy Living Project Charter. This Charter had been spearheaded by the RHA's Director of Primary Care and adapted from the Wagner Expanded Chronic Care Model (ECCM), which is widely used across the country (see Figure 2).

**Figure 2. Five Hills Health Region**

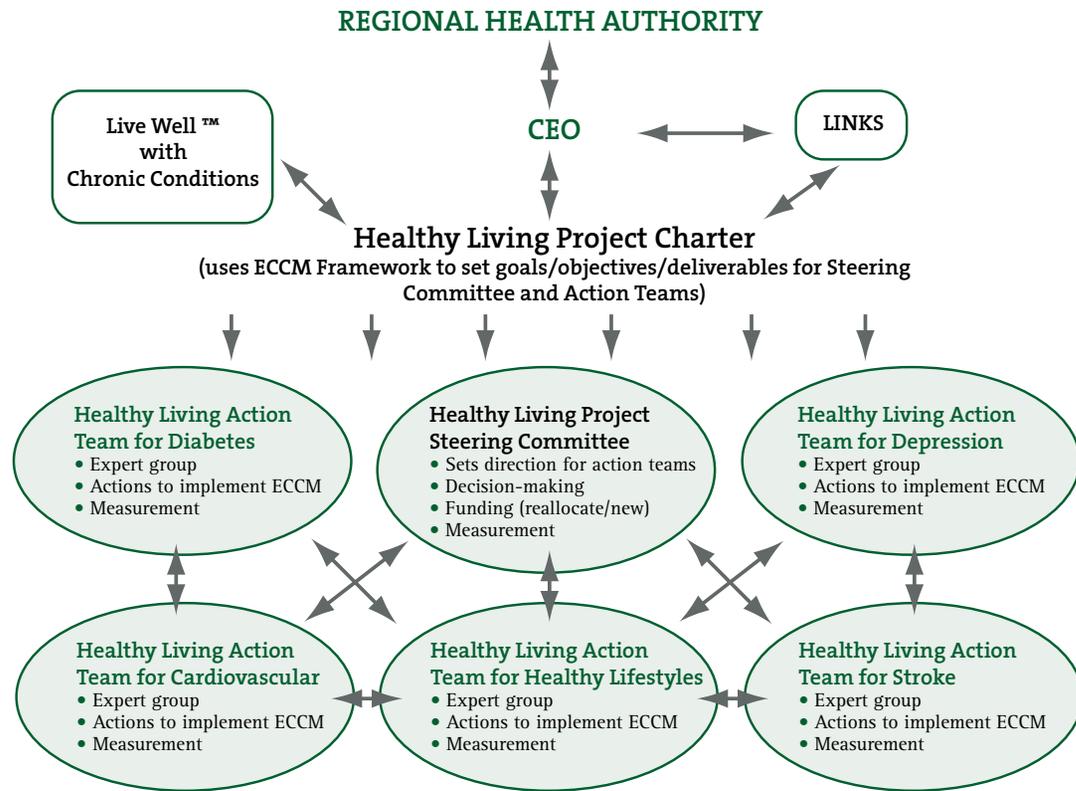


In the first months of the pilot project, the RHA established a Healthy Living Action Group, focusing on obesity. It was one of six Healthy Living Action Groups dedicated to chronic disease areas (see Figure 3). The Obesity Task Group became the forum for applying the Tool.

The RHA's senior management team, the LINKS group, gave their approval for the Obesity Task Group to apply the Tool. They also set up a plan to review the results of the pilot project and to share more broadly within the RHA, any valuable knowledge gained. The goal was to create a more integrated approach to chronic disease prevention and management.

The RHA contracted a part-time public health nurse to support the work of the Obesity Task Group in applying the Tool. She was to work closely with the MOH and Manager of Public Health.

**Figure 3. Organizational Chart – FHHR Healthy Living Project Charter**



## Use of the Tool

The new Obesity Task Group became the forum for using the Tool. The Director of Primary Care and the MOH co-chaired the Obesity Task Group, with members drawn primarily from within the Regional Health Authority. Members included:

- the manager of public health
- the director of patient education
- an epidemiologist
- a dietician
- a falls prevention coordinator
- a health promotion consultant (public health nursing background).

In preparation for the orientation session, the newly-contracted staff resource person prepared three background documents for the Task Group, adapted from the readiness templates in the How-to Guide:

- (1) A table that summarized the current vision, strategies and activities in chronic disease prevention and management, both regionally and provincially
- (2) A table that summarized obesity prevention and management activities, identifying regional stakeholders
- (3) Key population health indicators for obesity, such as risk factors and underlying determinants.

The Obesity Task Group orientation session took place right after the second International Conference on Chronic Disease Management, held in Calgary in early November 2007. Three group members had attended the conference and shared the key themes, which reinforced some of the Critical Success Factors identified in the Tool. The themes focused on:

- Improving communication and coordination both within and outside the health sector
- Re-orienting efforts to focus on prevention and health promotion
- Addressing the social determinants of health to see a longer term health gain
- Sharing ownership and control of health with community partners.

With these themes top of mind, Task Group members decided to target three Critical Success Factors:

- Common Values and Health Goals
- Focus on the Determinants of Health
- Integration of Chronic Disease Prevention and Management.

The Success Factors dealing with capacity and infrastructure were flagged for future work. They need to be coordinated with provincial reviews that have an impact on regional mandates and on resources in public health and primary care.

Task Group members devised a short-term plan to apply the Tool over a four month period. It would be part of the regular business of Task Group meetings, where the need for assessment and dialogue would be balanced with the need to move forward with the development and implementation of an obesity strategy.

At each meeting, members used the assessment questions and background material from the Tool as launch points for discussion. In talking about current practice, challenges and opportunities, the group referred to the qualitative rating scales, but did not assign a specific rating for each question.

## Results to Date

The Task Group achieved some good results. These included:

- Identifying and engaging stakeholders
- Establishing a "to do" list to guide Task Group work
- Team-building
- Creating a state of readiness for continued collaborative work.

After reviewing the assessment questions, the Task Group decided to broaden their membership to include the regional intersectoral coordinator. This gave them a strong link to an already well-established committee infrastructure, which supports intersectoral work across health, education, social services, recreation, housing, police and other areas.

Other areas they identified for action included:

- Planning to more broadly engage community stakeholders
- Reviewing how information about community health could be better communicated with stakeholders outside the RHA
- Sharing the environmental scan with other RHA expert groups working on related issues, such as diabetes and heart health.

The Task Group felt that the CPHA Tool helped them build on other assessment work they had recently completed, such as the Assessment of Chronic Illness Care (ACIC) Tool used with the Wagner chronic care model. Participants also reported that applying the CPHA Tool was a valuable team-building exercise. It brought primary care, public health and other stakeholders around the table to a better understanding of current activities, respective roles and opportunities for collaborative planning.

Integration of prevention and management work is in its early stages in the FHHR. Coordination across diseases and across the continuum of interventions needs more work, involving stakeholders within and outside the RHA. However, the CPHA pilot process and use of the Tool were catalysts for bringing primary prevention into the RHA's chronic disease management framework. The initial work of the Obesity Task Group has created a state of readiness for future work.

## Champlain Local Health Integration Network, Ontario

### Context

The senior planner responsible for chronic disease initiated the pilot project in the Champlain Local Health Integration Network (LHIN). The Champlain LHIN is one of 14 newly-created organizations across Ontario, responsible for integrated health system planning, funding and performance. It serves a total population of approximately 930,000, most of whom live in the Ottawa area. But it also includes rural areas and smaller municipalities, such as Cornwall, Clarence-Rockland and Pembroke/Petawawa.

The Champlain LHIN was established at the same time the CPHA pilot project was being initiated, introducing the Tool into an environment that was fast-moving and transitional.

The senior planner became interested in the Tool after participating in a focus group during the pilot project's research and design phase. The Champlain LHIN had identified chronic

disease prevention and management (CDPM) as one of six priority areas in its first Integrated Health Services Plan (IHSP). The Tool offered a structured method of engaging stakeholders in dialogue about how to put the IHSP into action within the new provincial CDPM framework, which had been adapted from the expanded Wagner Chronic Care Model.

The IHSP had identified action steps, which included:

- Organizing a network to coordinate the LHIN's CDPM work
- Developing integrated strategies
- Identifying priority areas for specific plans
- Signaling gaps in data and evidence
- Developing collaborative links with external experts, networks and associations working in CDPM.

As first steps in this priority area, a half-day stakeholder forum was held, which established a CDPM Collaborative Network. The majority of invited participants to the forum were representatives of 25 Community of Practice (COP) Networks. The Networks represented disease and age-related areas of expertise, such as cardiovascular disease, diabetes, geriatric care and lung health. What is noteworthy is that the CDPM Collaborative Network also provided an opportunity to build links with public health and primary care networks, which are outside the LHIN's areas of responsibility.

The senior planner won the support of the chief executive officer (CEO) of the Champlain LHIN as an early champion. The CEO introduced the half-day forum and presented the LHIN's goals for CDPM. The senior planner provided the primary support for the ongoing work of the CDPM Collaborative Network, with the assistance of a contracted external facilitator.

## Use of the Tool

The newly-established CDPM Collaborative Network served as the forum for applying the Tool. In addition to the representatives from the Community of Practice (COP) Networks, there were also representatives from:

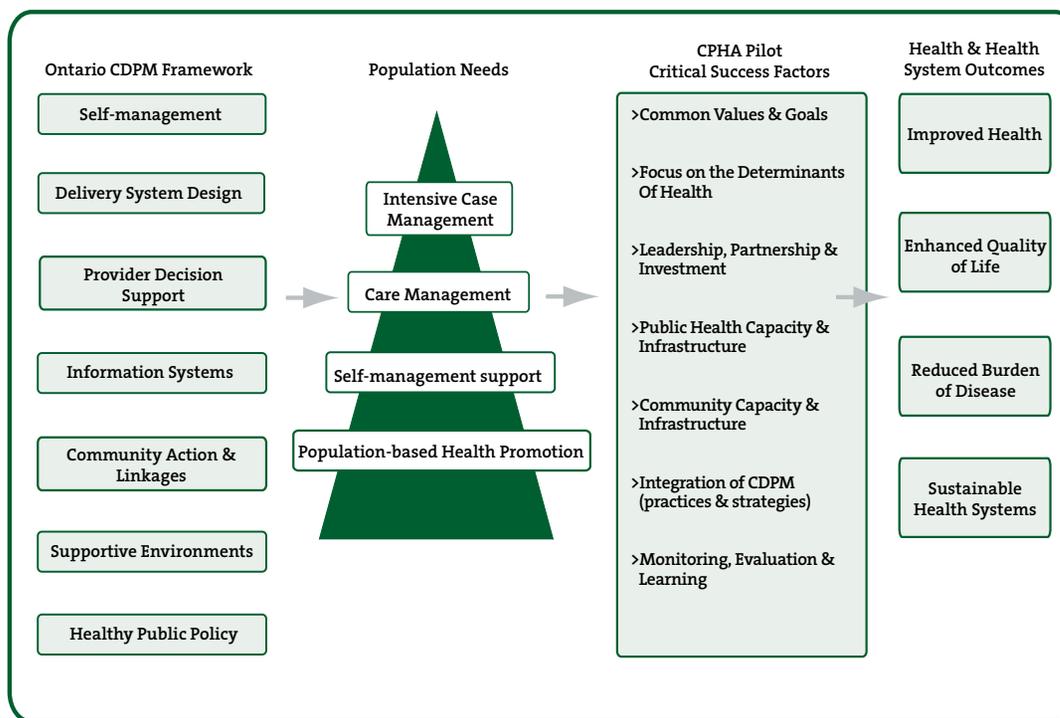
- Public health units
- Primary care networks
- The community health center (CHC) network
- Disease-specific or population-specific non-governmental organizations.

The Critical Success Factors of the Tool were built into the overall approach to regional planning. They were seen as enabling factors that support implementing the Ontario CDPM framework within a multi-level population health approach (see Figure 4). This population health approach aims to:

- Prevent chronic disease, risk factors and underlying determinants in the population
- Support self-management
- Provide effective care for those living with chronic disease, to prevent unnecessary complications.

**Figure 4.**

### CHRONIC DISEASE PREVENTION & MANAGEMENT IN CHAMPLAIN



In the early stages of the pilot project, the senior planner identified the need to map current CDPM activities in the LHIN, organizing the mapping around the Ontario CDPM framework. Prior to the half-day CDPM forum, a short initial survey was sent out to representatives of COP networks, to gather data on:

- Vision
- Mandate
- Partners
- Key initiatives/projects
- Future CDPM plans.

The survey results were shared in a poster session at the forum, providing an opportunity for participants to network and exchange information. As well, participants received a more detailed document analysis and key informant survey, which produced a snapshot of current activities, opportunities and challenges.

Out of the half-day CDPM forum, opportunities were identified for collaboration between and across networks to strengthen CDPM efforts. Over a four month period after the forum, the CDPM Collaborative Network held a series of meetings. These included two half-day orientation sessions to the Tool and three meetings where

part of the agenda was dedicated to applying the Tool. The CDPM Collaborative Network identified three Critical Success Factors to focus on initially in their work:

- Common Values and Goals
- Primary Care Capacity and Infrastructure (linking to the work of another LHIN Committee)
- Integration of Chronic Disease Prevention and Management.

### Results to Date

The early discussion and exploration of the Critical Success Factors resulted in priority areas the group needed to work on together. These included the needs to:

- Address systems issues about clarity of roles, gaps and continuity of care
- Strengthen prevention along the continuum of care, focusing on common risk factors and underlying determinants of health
- Develop strategies for underserved and/or vulnerable populations such as the francophone community, ethnocultural communities and groups with low socioeconomic status.

After discussing the integration of CDPM, Collaborative members committed to working together, rather than dividing efforts along separate prevention and management strategies and goals.

When the assessment of Common Values and Goals resulted in low ratings (0 or 1 on the scale for the assessment questions), the Collaborative decided to devote a full meeting to establishing common values and goals. As well, they set up a structure that would move their work forward.

A summary of the actions and outcomes generated are presented in Table 3. Throughout the pilot process, the senior planner aimed to balance concrete action with the need for collaborative planning and assessment, using the Tool. Specific action areas that emerged included:

- Conducting a literature review on self-management
- Doing an environmental scan of related activities in the LHIN
- Establishing a new e-health initiative.

**Table 3. Actions and Outcomes: Champlain Local Health Integration Network**

CDPM Collaborative		Actions	Outcomes
Oct	CDPM planning forum	CPHA tool introduced information sharing	CDPM Collaborative initiated
Nov	CDPM collaborative meeting	Early identification of areas of commonality Introduction to CPHA tool	4 month work plan
Dec	CDPM collaborative meeting	CPHA tool reviewed self-management project introduced Student mapping project introduced	3 areas of focus identified from CPHA tool
Jan		MPH student hired Mapping project underway Self-management project underway	Self-management Work Group forming
Feb	CDPM collaborative meeting	eHealth initiative introduced	eHealth Work Group forming
March			
April	CDPM collaborative meeting	Common Values & Goals discussion	Self-mgt literature review and scan completed Mapping project completed Common Values & Goals identified

# Capital District Health Authority, Nova Scotia

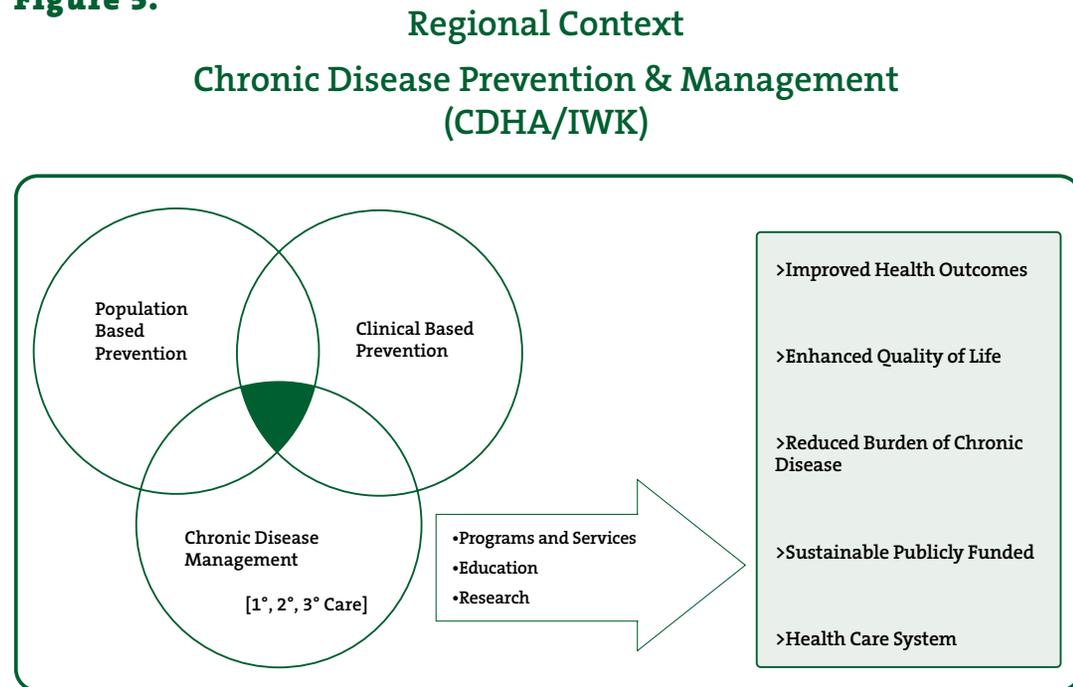
## Context

The Medical Officer of Health (MOH) of the Capital District Health Authority initiated the pilot project. The Capital Health District, centred in Halifax, Nova Scotia, is one of nine District Health Authorities (DHAs) in the province. The Capital Health District consists of the Halifax Regional Municipality and the western portion of Hants County in Nova Scotia. Capital Health provides core health services to 395,000 residents, or 40% of the population of Nova Scotia. It also provides tertiary acute care services to other residents of Atlantic Canada.

The pilot project offered the DHA an opportunity to build on, and help focus, the work of Capital Health's Chronic Disease Prevention and Management Core Committee. The Core Committee had been meeting for 18 months. Their purpose was to strengthen prevention of obesity and related medical conditions by planning, coordinating and integrating initiatives in population-based prevention, clinical-based prevention and disease management.

The Core Committee had already done much research and had many discussions. They had created a guiding framework, initially focusing on better understanding the integration of prevention and management. This integration is illustrated by the intersection point of the three circles in Figure 5.

**Figure 5.**



They considered carrying out a detailed environmental scan but thought this approach might be complex. Instead, the group decided to work on a specific initiative that would better integrate prevention and management of chronic disease.

This involved a plan to create a multidisciplinary Community Health Team (CHT). The CHT would engage largely in clinical preventive measures, such as nutrition, counseling and Body Mass Index monitoring. They would also identify and

manage early risk factors for disease and where needed, connect people to chronic disease management services.

However, group members found themselves wrestling with the scope of their work and the whole concept of integration. The opportunity to pilot the CPHA Tool arrived, offering them a new approach to explore. The MOH brought on board the managers of primary care and health promotion to support the Core Committee's work in piloting the Tool.

## Application Process

The Core Committee was the forum for applying the Tool. The Committee included:

- the DHA's medical officer of health
- the vice-president of medicine
- the director of community health
- the chief of the department of family practice
- managers of health promotion, primary care, public health services, geriatric medicine, spiritual care and palliative care.

To prepare for using the Tool, the managers of health promotion and primary care completed a preliminary environmental scan, adapted from the

pilot project readiness templates. This provided them with an early picture of the current vision, strategies and activities in chronic disease prevention and management (CDPM) in Capital Health.

The organizational change taking place in the health authority was an important factor in applying the Tool and in the overall work of the Core Committee. Prior to the pilot process, Capital Health had begun a major shift in its organizational culture - the Strategic Quest. The Quest aims to move the health authority away from a "health repair shop", providing patient care to treat illness and injury, towards a people-centred network that creates the conditions for health, healing and learning. Health providers are asked to "show up differently" and use new processes to work more effectively with each other and with the community.

During the orientation session to the Tool, participants felt the influences of the Quest, acknowledging them and discussing them. In discussing the Committee's vision for integration, the concepts of "Big I" and "little i" integration came up. The organization's Strategic Quest represented what the group called "Big I" integration.

"Big I" integration means comprehensive, system-level change to improve health and health services, supported by healthy public policies and infrastructure. "Big I" integration involves moving away from working in silos/buildings that provide services, to networks for learning. The group saw "little i" integration happening on a smaller scale. It is the strategies or initiatives that integrate clinical and prevention services, such as the Community Health Team (CHT) approach.

The group agreed that both "Big I" and "little i" integration were needed to support health and learning. To serve the intent of the Quest, the group made an initial plan to host an open-forum community café centred on selected questions from the Critical Success Factors. Emphasis would be on two areas:

- Focus on Determinants of Health
- Integration of Chronic Disease Prevention and Management.

They identified next steps which included:

- Selecting the most relevant questions
- Adapting the questions to the language and approach of the Quest
- Identifying who to engage and how to engage them in the dialogue.

The group also discussed applying the Tool to help assess the Community Health Team (CHT) approach. They saw the CHT as a natural experiment for integration, which could also provide learning for broader system change.

Following the orientation, the Core Committee held two meetings. They applied the assessment questions in the Critical Success Factor "Integration of Chronic Disease Prevention and Management", focusing on the CHT approach. Group members discussed planning for the community café, but decided to postpone this event until they had a clearer idea of its intent.

### Results to Date

The Tool was applied primarily to clarify the concept of integration of prevention and management, and to identify the barriers and opportunities for integration in the Capital Health environment.

Key themes emerged from the dialogue, including the needs for:

- Stakeholder engagement
- Stronger links to the community
- Shifting dialogue from a focus on treating "body parts" to a people-centred approach that creates conditions for health
- Greater capacity of both providers and community for more integrated approaches.

**Table 4. Inconvenient Truths: Capital Health DHA**

<p>Does not follow a holistic approach to health</p> <ul style="list-style-type: none"> <li>■ We treat illnesses and care for sick people within the silos of the health care system.</li> <li>■ We are not successfully promoting health and wellness or disease prevention.</li> <li>■ We are inattentive to the social determinants of health.</li> </ul>
<p>Is not people-centred</p> <ul style="list-style-type: none"> <li>■ We are bureaucratic.</li> <li>■ We are rigid, inflexible and systemic in our thinking and approach to the care of patients and communities.</li> </ul>
<p>Is overly focused on the "politics" of health care</p> <ul style="list-style-type: none"> <li>■ We apply short-term thinking to problems that have long-term horizons.</li> <li>■ We do not challenge status quo thinking about the provision of health services.</li> <li>■ We do not challenge the entrenched interests within the system that resist change.</li> </ul>
<p>Does not empower people and communities</p> <ul style="list-style-type: none"> <li>■ We are not prepared to engage partners and citizens in dialogue.</li> <li>■ We do not share the difficult choices confronting us about setting new priorities with dwindling health care resources.</li> <li>■ We do not give them influence over the resources, funding and priorities.</li> </ul>

<sup>1</sup>From the Capital Health (Halifax) Story of Understanding Integration, Shannon Ryan

The group noted a significant gap in the current engagement of community organizations and citizens. With the exception of those working in health promotion and public health, service providers within the large DHA internal structure felt a clear sense of disconnection from the community. This raised the interesting opportunity of

using public health strategies and approaches to strengthen community engagement and to help shift the DHA towards the goals of the Quest.

As the work of the Core Committee, the pilot project and the Strategic Quest moved forward in tandem, the gap between the future vision and

current realities of the DHA environment became apparent. Those involved described these realities as “inconvenient truths”. They represent the real challenges for system change that impact the DHA’s efforts to strengthen chronic disease prevention and management. (see Table 4).

Despite the challenges and complexities of the current environment, the Core Committee members found the use of the Tool provided several “ah ha” moments for those around the table. They have identified action steps to further the Committee’s work towards integration of CDPM. These include:

- Harvesting the perspectives of integration from the dialogue to date
- Developing a plan for sharing learnings from the CPHA pilot with chronic disease prevention and management stakeholders
- Engaging the community in further refinement of the Community Health Team approach
- Exploring dialogue with the Citizenship Promise Council, to learn from their experience to date in:
  - (1) Connecting with community
  - (2) Using broad-based thinking and settings-based approaches to child, family, individual and youth health.