A Tool for Strengthening Chronic Disease Prevention and Management

Through Dialogue, Planning and Assessment

How-to Guide

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The Tool and supporting resources will be available online at http://chronicdisease.cpha.ca effective July 2008.

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1.0 Introduction

An important function of the Tool is to initiate and guide a process of engagement to strengthen chronic disease prevention and management at the community/regional level.

The Tool aims to strengthen collective efforts to prevent and manage chronic disease by:

- Engaging a range of stakeholders in dialogue
- Promoting information exchange
- Assessing current policy, planning and practice
- Identifying actions, roles and shared responsibilities for strengthening prevention and management of chronic disease

The process of using the Tool takes time and a number of steps. It is neither a one-time event, nor an end it itself, but introduces a new approach to comprehensive chronic disease planning.

To assist in this process, a series of how-to modules have been developed. They are intended to be a flexible launching point to build on regional chronic disease planning, current activities, energy and capacities. They can be adapted to tailor the use of the Tool to the needs of your region.

These modules draw on the experience of four health regions who piloted the Tool. Concrete examples of agendas, worksheets, and other templates used in the pilot are included.

Overview of the Modules

The modules are not meant to be used or read-through linearly. Pick and choose what is useful in whatever order works for you.

There are two types of modules provided as illustrated in Figure 1. While there are clear stages you will move through in using the Tool, the approach and specific process will depend on your unique context. For this reason, the modules can be used in part, or in full, in whatever order makes sense for you.

Key Stages for Using the Tool

The first group of modules outlines the key stages involved in using the Tool. All pilot sites that used the Tool moved through these stages to effectively engage stakeholders in collaborative planning and assessment.

There are five of these modules:

Getting Ready

Good preparation is important for any process. Before launching into a first meeting to use the Tool, there are some preparatory steps that have proven to be helpful. This module looks at three aspects of getting ready: understanding your regional context for chronic disease planning; thinking through who needs to be involved and information gathering.

Orientation Session

At an early point in the process, it is important to give those involved an opportunity to learn about the Tool and begin to explore its use. This module provides ideas on how to structure a session to provide an orientation to the Tool. It also provides a sample agenda and a sample PowerPoint that could be used to describe the Tool to others.

Priority-Setting

This module provides some ideas about setting priorities for using the Tool and for broader chronic disease planning objectives. It may get used at more than one place in your overall process as illustrated in Figure 1.

Doing the Assessment

This module outlines steps for doing the assessment using the guiding questions for Critical Success Factors. It covers:

- Using the Worksheets and Rating Scales
- Interpreting the Results
- Who to Involve in the Assessment
- How the Assessment is Done with the Group

Action Planning

One of the possible uses of the Tool is to provide a starting point for further planning and action in the key areas identified through assessment. This module provides some thoughts about action planning in complex systems and provides examples of two approaches to action planning used in the pilots.

Process Supports

The other type of modules offer broad process supports. They provide ideas that can be dipped into at almost any stage of the process as the need arises. They also provide some foundational ideas for thinking through the whole process and are worth reading through as part your preparation. There are three of these modules:

General Process Tips

Through the course of the pilot work, a number of good practices in process design and development were used. This module pulls together those that are generic to the application of the Tool. It includes:

- a framework for working on complex systems level issues like chronic disease prevention and management
- resource considerations, e.g., facilitation, resources
- principles and practices of good dialogue
- the importance of evaluation and record-keeping as a support to learning and communication

Stakeholder Engagement

This Tool is intended to bring together the range of stakeholders with shared planning responsibility for preventing and managing chronic disease. This module provides some general tools for thinking about stakeholder engagement, and in particular outreach. It also provides an example from the pilot of early engagement of chronic disease stakeholders.

Working Together Effectively

The Tool is designed to help strengthen collective efforts to prevent chronic disease and related health problems. Thus its use is generally a collaborative venture. This module looks at:

- some basics of group development and group functioning with examples from pilot sites using the Tool
- developing a shared language and understanding of chronic disease prevention and management and the concept of integration
- developing common values and goals

FIGURE 1: HOW-TO MODULES – KEY STAGES AND PROCESS SUPPORTS

2.0 Getting Ready

Good preparation is important for any process. Before launching into a first meeting to use the Tool, there are some preparatory steps that have proven to be helpful.

Getting ready is about:

- Becoming familiar yourself with the basic concepts and purpose of the Tool
- Understanding the context for work in chronic disease prevention and management
- Determining who the group will be to lead the process. This could be an existing management team, a working group or it could be a steering committee set-up specifically for this initiative.
- Seeking senior management support/approval for dedicating time to this activity
- Identifying who to engage in using the tool and taking early steps to communicate with stakeholders (see module on Stakeholder Engagement)
- Developing a plan for bringing the tool forward, including considering who needs to support this process to make it work and how to get buy-in and commitment
- Gathering information - about rates of chronic disease and risk factors, about relevant activities, about existing strategies and plans, etc.

This module looks at three aspects of getting ready:

- Understanding your context;
- Thinking through who needs to be involved
- Information gathering

Understanding Your Context

One of the key findings from the pilot work is the importance of context, i.e. understanding the lay of the land. The use of the Tool needs to be tailored to the reality you work in. Taking the time to assess, discuss and understand the regional context for your chronic disease work and the use of the Tool is essential.

It is helpful to consider the benefits of focusing efforts in areas where strategic directions or initiatives are already moving forward to strengthen chronic disease prevention and management. It is also critical to know your role and ability to change practice or make improvements.

The pilot sites found that the readiness phase was crucial and laid the foundation for the subsequent hands-on use of the Tool. They also found that it takes time, anywhere from a few weeks to a couple of months. Getting ready is not about perfection – it's about getting "good-enough" information and doing "good-enough" planning to feel that you can get the initiative off to a good start knowing that it will evolve once launched.

The following questions will help you think through your context.

Reflective Questions:

1 Is there a model or framework being used in your region to guide chronic disease prevention and management work, e.g., Wagner Expanded Chronic Care Model? Are people aware of it? Is there a good understanding of the model/framework and how to put it into practice? If not, this may be an indication that initial work is needed to build awareness and understanding.

See Cumberland case study

2 Are stakeholders interested in working collectively to strengthen chronic disease prevention and management efforts? Is there energy for this? Is there some level of common understanding about the need to do this work?

See the module: Working Together Effectively

3 Is the timing good? Or are people focused on other big issues?

4 Are there some emerging opportunities that might help us move this work forward? E.g., an emerging priority or initiative in a key area such as self-management, workplace health, poverty reduction, obesity.

5 What strengths/assets can we build on? E.g., existing chronic disease networks or community coalitions.

6 Is there a supportive environment for this work? E.g., senior management commitment, engaged community, supportive provincial strategies.

In Five Hills, the Medical Officer of Health initiated the pilot. Approval was received from the senior management team of the Regional Health Authority to use an obesity lens to apply the tool. A Healthy Living Action Group focusing on obesity was established in the first months of the pilot project as one of six Healthy Living Action Groups for other chronic disease areas. This group, co-chaired by the Medical Officer of Health and the Director of Primary Care, became the forum for applying the tool. The Task Group was co-chaired by the Director of Primary Care and the Medical Officer of Health, with members primarily from within the Regional Health Authority, including the manager of public health, director of patient education, epidemiologist, dietician, falls prevention coordinator and health promotion consultant (public health nursing background).

Who Is Around the Table?

As the Tool is intended to be used collaboratively with a range of stakeholders, a helpful first step is to consider who should be around the table - in the early planning stage and in actively using the Tool. The range of stakeholders with responsibility for public health, primary care, and/or chronic disease management and community programs are among those who may participate. This could include planners, managers and policy-makers who have an interest in collaboratively assessing their chronic disease practice, opportunities and challenges.

Thinking through who is the best group to lead the process is also crucial. The Tool can be applied formally through an organized, established group or in a more ad hoc fashion. An established group may decide to involve others in the assessment or to bring in new members. Examples of groups using the Tool have included a chronic disease prevention and management steering committee in a health authority, a public health team, and a task group focused on a particular risk factor for chronic disease.

Each region will take a different approach to working with stakeholders.

See the module: Stakeholder Engagement

The following questions will help you consider who should be around the table, and at what stage. This is a starting point, and, as the work unfolds, will need to be reassessed at each stage, based on what is learned.

The reflective questions assume there are established groups in your region that are already working on some aspect of chronic disease, health promotion and/or integration of activities along the health service continuum.

Reflective Questions

1 Is there an established group ready to lead the process? If not, how could we establish a group for this initiative?

2 Do we know who else needs to be at the table? To do what?

3 Is there a plan in place to communicate with our established groups about the Tool project?

4 In this early planning stage, are there key contacts that could help shape our approach to using the Tool?

- Key members of our established groups?
- Those we want to build new working relationships with through this project?

Who is around the table?

The range of stakeholders may include organizational leaders, planners, managers and coordinators who work in:

- regional health authorities, local health integration networks (responsibility areas for chronic disease, primary care, population health and health promotion)
- public health services/programs (responsibility areas for screening, health promotion/education, community epidemiology, health planning and disease surveillance)
- community health centers, clinics (community and hospital-based)
- chronic disease prevention and/or management programs (community and hospital-based)
- communities of practice for health promotion, chronic disease prevention and/or management
- NGOs, coalitions and networks (disease-specific, risk factor-specific, age-specific)
- Community members/consumers
- Non-health sector partners (school, workplace, municipalities, recreation and community services, immigrant service organizations)

- Internal or external champions/advocates for chronic disease prevention? E.g., organizational leaders, front-line advocates, innovators

5a Will our established group(s) serve as the forum for applying the tool?

5b How well is our group(s) working together?

5c Is there anyone missing around the table? For example, are there other stakeholders outside our established group(s) that could be engaged/invited to participate in the collaborative process?

6 Outside of directly participating in using the tool, are there stakeholders that might be involved in other ways? E.g., sharing information for assessment, communicating about the project, disseminating results

7 Do we expect any barriers/resistance to moving forward with using the Tool? What strategies could be used to build buy-in?

Information Gathering – Where Are We Now?

Building a better understanding of what is going on in your region in terms of chronic disease can help:

- to identify potential partners/stakeholders
- to understand how the "chronic disease community" is structured, e.g., around disease groups, by sub-regions, by language, identify the range of visions are around chronic disease prevention and management
- to be up-to-date on population health and the realities of those at risk of or living with chronic disease in your region

Through an initial scan of reports and activities, information gathering can help:

- to place the Tool initiative within the broader regional activities in the area of chronic disease
- to identify stakeholders to be a first step in engaging stakeholders
- to provide a common starting point for all stakeholders who will collaborate in the pilot
- to highlight opportunities/strengths that can be built on through the pilot
- to focus/guide the evolving regional workplan for the pilot

Using the Information

Collecting the data can be a first step in the engagement of the stakeholders you hope to involve in the use of the Tool. Sharing with those involved can provide a common starting point for all stakeholders who will collaborate. A summary format may be useful for easily sharing the collected information with stakeholders. This will prime them for considering the eight Critical Success Factors outlined in the Tool.

See the module:
Working Together Effectively

Ways to achieve this are many and include:

- preparing a written summary for distribution
- presenting key points at the orientation session or at a stakeholder forum
- preparing posters to share activities and goals (see Text Box)
- providing an analysis for consideration in setting priorities

Types of Information

There are several types of information you may want to collect as part of an initial scan. These are provided below. A sample template for each area of data collection follows this section, and provides more detail. Templates are intended as a guide only. They will need to be adapted based on where you are currently in your own regional process.

Possible sources of data are also provided. In many cases these are existing reports, templates, and data easy to access from your Ministry of Health or local public health unit/authority. However, you may find some gaps in information and decide to supplement this through surveys, key informant interviews, a stakeholder forum or other methods.

The templates are:

- Basic Epidemiology of Chronic Disease in Your Region
- Vision, Goals, Strategies and Priorities for Chronic Disease
- Current Partners, Activities, Strengths and Opportunities

Template 1: Basic Epidemiology of Chronic Disease in Your Region

This template was used in the Five Hills Pilot as one component of their environmental scan. It provided stakeholders with a common starting point for understanding rates of chronic disease, risk factors and underlying determinants in their region.

Reflective Questions:

1 What do you know about the rates of major chronic diseases, risk factors and underlying health determinants in your health region?

2 Are chronic disease/risk factor rates higher, lower or similar to provincial rates? If they are different than provincial rates, why? Is more information required to answer this question?

3 Are there specific population groups with rates higher than the average rate? e.g., adults, seniors, women, Aboriginal peoples, ethnocultural groups, low income? Why? Is more information required to answer this question?

4 Has the community identified current priorities for action in the area of chronic disease, risk factors and underlying health determinants? What sources did you use to identify these priorities?

Sources of data might include:

- local health reports, e.g., health status report, needs assessment, environmental scan
- Statistics Canada census data, e.g., income, education, country of origin, mother tongue
- Canadian Community Health Survey, e.g., disease/risk factor prevalence, health behaviors
- regional/provincial health surveillance data, e.g., mortality database, hospital admissions, emergency visits
- local sources for assessing determinants of health, e.g., local food bank statistics, municipal housing statistics

Chronic Disease Planning Forum

The Champlain Local Health Integration Network (LHIN) has a number of community of practice networks in place. Most of these networks are structured around different diseases or risk factors, e.g., diabetes, heart health, lung health. In working to move forward chronic disease planning, the LHIN wanted to establish a "network of networks" that could provide a cross-disease perspective.

They decided that a first step was to collect information on the different networks and bring them together in a Planning Forum to share that information and see if there was interest in collaboration. The survey presented in Template 3 was developed to collect information before the forum. Each group completed the survey and then posters were developed based on the information provided.

Time was built into the planning forum for participants to walk around the room to review the posters and ask questions. Presentations provided a statistical overview of chronic disease in the region and an overview of the chronic disease prevention management framework used in Ontario.

A more detailed environmental scan was later completed using a key informant survey, document review and information gathered from community meetings hosted by different networks, e.g., lung health network. One outcome was the readiness to take advantage of a new provincial funding opportunity in the area of self-management.

Template 2: Vision, Goals, Strategies and Priorities for Chronic Disease

Used in the Five Hills pilot, this template drew together information from the major provincial and regional strategies for chronic disease prevention and/or management. This type of grid helps to identify commonalities and differences across the various strategies and helps begin to identify the level of shared vision and/or goals that might exist.

Reflective Questions:

1 At the provincial level, what vision, goals, strategies or priorities are in place to reduce the major chronic diseases and their complications (In government and non-governmental organizations/networks/coalitions)?

2 In your health region, what vision, goals, strategies or priorities are in place to reduce the major chronic diseases and their complications (in government and non-governmental organizations/networks/coalitions)?

See the module:
Working Together Effectively

Sources of data might include reports, strategy documents or workplans developed by:

- Various networks/groups, disease-specific, risk-factor specific, age-specific areas
- Regional departments/divisions
- Provincial ministries/departments
- Community coalitions

You may want to consider visions, goals, strategies and priorities directed at:

Reducing Health Inequities

E.g. Targeted resources/strategies for population groups with poor health, high rates of chronic disease and/or complications.

Addressing Social and Economic Determinants of Health

E.g. Income and food security, social exclusion, adequate housing.

Healthy Living

E.g. Health eating/weights, physical activity and recreation, stress reduction/ management, blood pressure.

Building Environments that Support Health

E.g. Legislation, regulation, incentives and intersectoral collaboration (anti-tobacco, food labeling, fiscal policies/incentives, active transportation, sports/recreation, school/ workplace health promotion).

Preventive Screening for Chronic Disease

E.g. Assessment tools, preventive guidelines, financial incentives for providers to screen/ monitor glucose, blood pressure, risk factors.

Self-Management Support

E.g. Telephone information/ referral lines, web-based information, health messaging, investment in infrastructure for individual/group education, training, counseling.

Chronic Disease Management

E.g. Decision support for providers/use of clinical guidelines, information systems (e.g., client registries),case management/system navigation.

Primary Care/Public Health/Community Capacity

E.g. Investment/support for interprofessional models, alternate funding to provide incentive for prevention, community development/health promotion, training and human resource development.

Template 3: Current Partners, Activities, Strengths and Opportunities

This template was developed by the Champlain LHIN to collect information on the various practice networks and other organizations working together in their region. The Ontario Chronic Disease Prevention and Management Framework was used to categorize the various sets of activities.

Reflective Questions:

1 Who are the key partners/stakeholders you are currently working with in the area of chronic disease prevention and management?

2 In your health region, is there an inventory of current chronic disease programs/services/activities in the following areas?

- Tackling root causes of chronic disease and health inequity? E.g., poverty reduction, food security
- Health promotion/healthy living?
- Chronic disease prevention and screening?
- Chronic disease management?

3 Have service gaps or priorities been identified by health and social service organizations that relate to the prevention and management of chronic disease? If yes, what are these service priorities?

4 For those programs/services/activities you are aware of, what is working well? Are there opportunities to build on these? (Factors to consider could include: strong leadership, well-resourced, competent staff, strong community engagement, evidence-informed practice).

5 How do you see your initiative/project helping to move forward existing vision/goals priorities for chronic disease prevention and management i.e., what will be the "value added"?

6a What are the conditions currently in place that will contribute to the success of your initiative/projectat your initiative/project?

6b Are there significant barriers that will need to be overcome? What are these?

Sources of data might include the organizations involved in chronic disease prevention and/or management, activity or service inventories, annual reports and websites.

Additional/Related Information:

- Stakeholder Engagement
- Orientation Session
- Working Together Effectively

Template 1: Basic Epidemiology of Chronic Disease in Your Community/Region

Disease/Risk Factor	Regional Rate	Provincial Rate
Cardiovascular Disease % of Total Deaths % of Total Illness and Disability		
High Blood Pressure Prevalence Rate Number of new cases		
Type 2 Diabetes Prevalence Rate Adult Children and Youth		
Obesity Adult Children and Youth		
Daily Fruit & Vegetable Consumption Eating less than 5 servings per day		
Physical Activity % physically active		
Alcohol Consumption % consuming 12 or more drinks per week		
Smoking % daily smokers		
Secondary Education % with no high school diploma % with post-secondary education		
Income % of families below low-income cut-off		
Depression Number of new cases		
Food Insecurity # of visits to food bank		
Homelessness % of adults or families without shelter		

Note: Sample indicators only provided under each disease/risk factor. Regional data may not be available.

Download: Chronic Disease Snapshot.doc (Word Template)

Template 2: Vision/Goals/Strategies/Priorities for Chronic Disease

	The Action Plan for Provincial Health Care	A Population Health Promotion Strategy	Chronic Disease Management Charter	Regional Strategic Plan
Reducing Health Inequities				
Addressing Social and Economic Determinants of Health				
Healthy Living				
Building Environments that Support Health				
Preventive Screening for Chronic Disease				
Self-Management Support				
Chronic Disease Management				
Primary Care/ Public Health Capacity				

Note: Columns can be added as needed for the different strategies and visions that exist. The column titles provided are for purposes of example only.

Download: Goals.doc (Word Template)

Template 3: Current Partners, Activities, Strengths and Opportunities

1. Name of Community of Practice Network/Organization

2. Please indicate scope of membership on your Network .

3. What is the general mandate of your Community of Practice Network/Organization?

4. Within each component of the Ontario Chronic Disease Prevention and Management Framework, please describe the activity/ projects/ initiatives of your Community of Practice Network/Organization.

Components of the Ontario Chronic Disease Prevention & Management Framework	Comments
Self Management Empower individuals to build skills for healthy living and coping with disease	
Delivery System Design Focus on prevention and improve access, continuity of care and flow through the system	
Provider Decision Support Integrate evidence based guidelines into daily practice	
Information Systems Enablers to enhance information for providers to provide quality of care and for clients to support them in managing their disease, and for integrating services across the health system	
Community Action & Linkages Encourages communities to increase control over issues affecting them	
Supportive Environments Removes barriers to health living and promotes safe, enjoyable living and working conditions	
Healthy Public Policy Policies to improve individual and population health and address inequities	
(Note: In the original template, possible areas of activities were provided as examples)	

5. What are your top three barriers/challenges to advancing your work in CDPM?

   i.

   ii..

   iii..

6. From your perspective, what opportunities exist to build on regional strengths, assets and current energy related to CDPM in the Champlain region?

Download: Opportunities.doc (Word Template)

3.0 Orientation to the Tool

At an early point in the process, it is important to give potential participants an opportunity to learn about the Tool and begin to explore its use. This module provides ideas on how to structure a session to provide an orientation to the Tool. It also provides a sample agenda and a sample PowerPoint that could be used to describe the Tool to others.

Preparation:

Ideally the following steps would have been taken before launching an orientation session.

- The three steps outlined in the Getting Ready module have been completed or at least initiated:
  1. The regional context for the work on CDPM is understood
  2. A group has been established to lead the process (and/or interest has been solicited to be sure the right people are at the orientation session)
  3. At least an initial scan of regional CDPM activities has been conducted.
- A coordinator or resource person has been identified to move the process forward in the region.

See the module: General Process Tips

- A facilitator has been identified to help plan and facilitate the orientation session.

Key Components:

The orientation session generally includes:

- An overview of the context for CDPM in the region. This will likely build on some of the work that you have already done, e.g., early scan of CDPM activities and chronic disease statistics for the region.

See the module: Getting Ready

Some of this information can be shared in advance and some could be presented at the orientation. The key here is to link the possible use of the Tool to current work being done in the area of chronic disease.

- An overview of the Tool which covers the following points:
  - How and Why the Tool was Developed
  - What the Tool Looks Like
    - Basic Concepts
    - Critical Success Factors for Strengthening Chronic Disease Prevention & Management
  - How the Tool Might Be Used

!

Don't be over-ambitious with what might be accomplished in this session, especially if this is the first time the group has come together. People will have different perceptions and maybe even different vocabularies if they come from different professions. Developing a shared understanding of why the group has come together can take time, let alone having a sense of what strengthening chronic disease prevention and management means and how the Tool could be used to help achieve that.

See the module: Working Together Effectively

A sample PowerPoint document provides possible slides and speaking notes to cover this content. The PowerPoint includes examples of slides that could be used to provide some aspects of the regional context, e.g., the chronic disease prevention and management model being used in the region or province.

Download: Orientation.ppt (PowerPoint)

- A hands-on activity for participants to explore the Tool. This generally gives participants a chance to examine in more detail one or more Critical Success Factors; to try out the assessment questions and to begin to think about how they might apply the Tool in their work together.
- A discussion to share reflections on how the Tool might be used, e.g., through the lens of a particular risk factor like obesity or by focusing on a limited number of Critical Success Factors. At the orientation you may want to keep this to a preliminary discussion depending on whether some thought has gone into this by the organizers or leaders of the process before the session. A next step could be a meeting to determine priorities.
- A determination of the immediate next steps, e.g., a session to set priorities for the use of the Tool and information needed to help set those priorities.

See the module: Priority-Setting

In the Five Hills pilot, an orientation session was conducted with senior managers to get their buy-in and approval for the use of the Tool. The session was three hours long. It gave people an opportunity to ask questions and develop a common understanding of what the Tool is and could help them do. An approach to using the Tool was approved which involved using the guiding questions in the Critical Success Factors to assess current practice in tackling obesity (i.e. placing an obesity lens on the Tool). It was agreed that an already established group (the Obesity Task Group) would lead the process. This group met the following day to review the Tool and determine some initial priorities.

Possible Processes:

There are several ways an orientation session could be done depending on the needs of your region. One important consideration is whether the group using the Tool is newly formed or already established. For a newly formed group, more time will be needed.

See the module: Working Together Effectively

Three examples are provided below:

1. For an established group using the Tool:

   A four to five hour meeting will allow the group to work through the orientation session. This approach was used in pilot regions with a Chronic Disease Prevention and Management Steering Committee already in place.

2. For a broader stakeholder group:

   A full-day meeting will allow broader discussion of opportunities and challenges for strengthening chronic disease prevention and management in the region. Orientation to the Tool may be built into the agenda for the day. This approach was used in pilot regions where using the Tool was part of a broader chronic disease planning process.

See the module: Stakeholder Engagement

3. For a newly formed group:

   a. A half-day meeting with the broader constituency, from which the group to lead the use of the Tool could be struck, if one does not already exist;

   b. A four to five hour meeting will allow the new group to discuss mandate/role and to work through some components of the orientation session.

Additional/Related Information:

- Getting Ready
- Orientation PowerPoint
- General Process Tips
- Priority-setting
- Working Together Effectively
- Stakeholder Engagement

Sample Orientation Agenda:

Here is a sample agenda for an orientation session. This would need to be adapted to your context.

Orientation Session Integrated Chronic Disease Prevention And Management

Agenda

Time: 1 pm – 5 pm

Purpose of Session:

1. To provide participants with an overview of the Tool within the context of strengthening chronic disease prevention and management (CDPM) in your region
2. To begin exploring how the Tool might be used
3. To identify next steps

Supplies:

- Copies of the Tool for participants
- PowerPoint equipment
- Flipchart, markers and masking tape

Time	Content & Process
1 pm	**Welcome and Introductions** ▮ Welcome and review of meeting objectives ▮ Participant introductions ▮ Review of agenda
1:10	**Setting the Context** ▮ A presentation on the current context for CDPM in the region. ▮ Discussion
2:00	**Overview of the Tool** ▮ A brief presentation on the Tool itself. (The Orientation Power-Point could be used.) ▮ Q & A
3:00	Break
3:15	**Exploring the Tool** ▮ Divide into pairs and have each pair review one of the critical success factors. Try to apply it the context of the region. ▮ Full group discussion: *What questions emerged as you explored the tool in more depth?*
3:50	**Using the Tool – Initial Reflections** ▮ First in triads and then in the full group, discuss: *Given what we know about the region and chronic disease prevention and management, how do you think we should use the tool? What do we want to achieve with it?* **Consider:** ▮ *Should we focus using the Tool on a specific area or do a broad assessment of regional chronic disease prevention and management efforts? (See Potential Uses of the Tool-Introduction Section)* ▮ *Is there additional information we need to make that determination?*
4:30	Next Steps ▮ Discussion re: next steps – Could consider questions like: ▮ *Do we want a next meeting? To do what?* ▮ *Who else should be there?* ▮ Completion of Evaluation Form
5:00	Closure

4.0 Priority-Setting

You've arrived at the point where there has been an orientation to the Tool and people have a basic understanding of its content areas and how it might be used. The next step is to set priorities for applying the Tool. Even if you are intending to use the whole Tool, chances are you'll still need to set some priorities in terms of what to start with first to keep the process and expectations manageable.

This module provides some ideas about setting priorities. Two examples are provided – one for selecting Critical Success Factors to focus use of the Tool and the other for broader chronic disease prevention and management planning objectives.

Approaching Priority-Setting

After information gathering and first discussions exploring the Tool, you will likely have found that assessing all eight Critical Success Factors is a daunting task and that the time devoted to dialogue and assessment needs to be balanced with the pressing day-to-day demands on those participating. Setting priorities can help keep the initiative manageable.

Pilot regions found it helpful to set priorities for using the Tool as an exercise at a Group meeting, e.g., steering committee, task group. In some cases, this involved setting priorities about:

- Which Critical Success Factors to explore, and/or in what order?
- Which questions within a Critical Success Factor to address?
- The lens through which the Tool will be used, e.g., will it be used to look at all aspects of chronic disease prevention and managemnt across the system, will it look at particular risk factors or a particular setting or will it look at a particular practice area, e.g., self-management?

In other cases, setting priorities required a more significant planning step that involved a broader stakeholder group in establishing priorities for chronic disease prevention and management. The use of the Tool was then focused on one or more of the priority areas that emerged from this broader planning process.

In either case, an important part of the priority-setting will be sharing and reviewing information already gathered through a summary of chronic disease epidemiology and current initiatives directed at preventing and managing chronic disease. The information will also help to place the activities of the Group within the big picture of the vision, strategies and goals of your region, and at the provincial level.

See the module: Getting Ready

Pilot sites found it important to link the use of the Tool to the provincial framework guiding chronic disease prevention and/or management. Similarly, if there are specific goals and objectives identified in a regional health plan, it will be helpful to include this information.

Priority-Setting Examples

Two examples of priority-setting are provided:

1. Prioritization of Critical Success Factors

The first example provides a process for selecting which Critical Success Factors to work on. It assumes a relatively small number of people and could be done just with the Group.

2. Prioritization of Chronic Disease Prevention and Management Objectives

The second is a more complex process that engages the broader community in establishing priorities for chronic disease prevention and management in the region, which the Tool could then be focused on. Adapt and add to these ideas to suit your own context.

The examples provided here give the impression that the process of priority-setting is linear. In reality, even in the most straight-forward example, the process may take place over two or more meetings for clear priorities to emerge.

One factor to consider is the need to take selected priorities to others to validate and verify between meetings. This may result in new information being brought into discussion, leading to further review, discussion and revision of priorities.

Designate a facilitator. Ideally this would be some-one from outside who has been brought in to fulfill this role. If that is not possible, have one member agree to "abstain" from being part of the prioritization process.

In the Five Hills pilot, the Task Group (their Group leading the Tool process) came together to determine which Critical Success Factors to prioritize. In this situation, a decision had already been taken in the Orientation Session to focus in on the risk factor of obesity.

The group members decided to initially focus on three Critical Success Factors: Common Values and Health Goals, Focus on Determinants of Health and Integration of Chronic Disease Prevention and Management.

Success Factors related to capacity and infrastructure were flagged for future work that needed to be coordinated with provincial reviews impacting the regional mandate and resources in public health and primary care. As next steps, they decided to work systematically through the three Critical Success Factors selected as priorities, using one meeting for each Critical Success Factors.

See the module: Doing the Assessment

Sample Agenda: Prioritization of Critical Success Factors

Objectives:

- To review relevant information about your region. At a minimum this probably includes the basic epidemiology of the region and the visions, goals and strategies being applied to chronic disease prevention and management in your region.

See the module: Getting Ready, for ideas on collecting this information

- To determine which Critical Success Factors to begin with.
- To determine next steps

Timing:

At least 3 hours - depending on how much information there is to review. (The sample uses 9 – 12 noon).

Participants:

Eight to 16 people. (If there are more people, you may require more time.)

Supplies:

1. Copies of the Tool and worksheets
2. PowerPoint or other way to provide the relevant information. Ideally this has been sent out beforehand.
3. Red dots (optional)
4. Two flipcharts and markers

Time	Content & Process
9 am	**Welcome and Introductions** - Welcome - Review of meeting objectives and agenda
9:10	**Regional Context** - Presentation on the information gathered re: epidemiology, plans and strategies - Discussion
9:20	**Setting Priorities** Key Question: Which Critical Success Factors (CSF) should we focus on? Why? - Divide the groups into pairs or triads, assigning one or two Critical Success Factors to each small group. (The number assigned will depend on the number of groups). Have each group review the Critical Success Factors and determine if they would recommend that the Factor be considered a priority and why or why not.
9:40	- Ask each group to report-back on their deliberations. Note on one flipchart the Critical Success Factors being recommended as possible priorities. (Flipchart 1) - Note on the second flipchart, the reasons given for making a Factor a priority. These will become the starting point for criteria. (Flipchart 2) - Encourage groups to ask questions of each other to be sure people understand why groups are recommending what they are.
10:10	- Review the list on Flipchart 2. Ask if these are the criteria that people feel are important in determining which Critical Success Factors to pursue? Add, modify, delete as agreed to by the group. - Ask people to consider which Critical Success Factors they would give priority to, given the criteria.– OR- OPTIONAL: Give each person 3 red dots (the number given depends on how many Critical Success Factors are being recommended. (Adjust the number of dots so that people do have to make some choices.) Ask them to consider the criteria on Flipchart 2 and place their dots on the three Critical Success Factors they think are the most important ones to begin with (or to work on – depending on the time frame of your initiative.)

Time	Content & Process
10:30	**Break** Ask people to take their break while they are putting their dots up (if that process option has been chosen), being ready to begin again at 10:50.
10:50	▮ Review the results of priority selection to see if there are any clear winners. If there are more than three or four, ask the group to clarify whether they feel they can or want to take on this many. Work to consensus if possible. ▮ OPTIONAL: A second round of dot voting can be done to narrow down further if need be ▮ Validate the final selection with the group.
11:10	**Next Steps** Key Question: Given the decision about which critical success factors to focus on, what are the next steps? Discuss: 1. Do we have the information we need to work-through the questions under each Critical Success Factors? 2. Do we have the right people at the table to do this work? 3. How do we want to work on these?, e.g., meet once a month and work-through a Critical Success Factors at each meeting? ▮ Help the group develop a work plan for the next four-six months (or whatever time frame makes sense). ▮ Identify in more detail the immediate next steps and who is responsible for what.
11:50	**Wrap-up** ▮ Completion of Evaluation Form (if there is one). Or do a verbal go-round together people's impressions of the meeting.
12 pm	**Closure**

In the Champlain LHIN pilot, the priority-setting work came after a meeting in which each member brought in three priorities from their own network/ organization. These were reviewed collectively and grouped into clusters of priorities. These served as a backdrop to the next meeting which worked through the prioritization process of Critical Success Factors as provided above.

Sample Process – Prioritization of Chronic Disease Prevention and Management Objectives

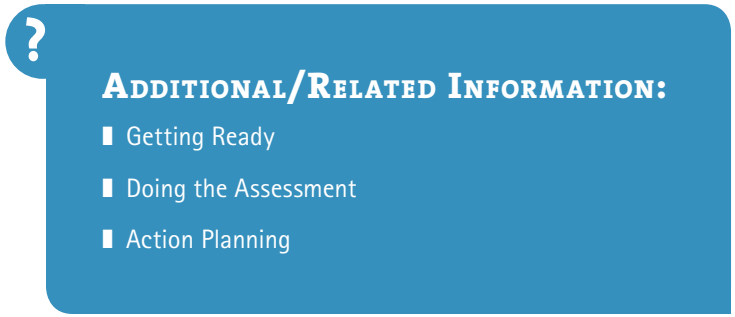
Step 1:

Identify Opportunities and Challenges for Strengthening Chronic Disease Prevention and Management

The Cumberland pilot group hosted a one day forum, "Accelerating CDPM Day" to bring stakeholders together to contribute to a district plan for chronic disease prevention and management. The objectives of the session included:

- raising awareness of the provincial models and strategies for chronic disease prevention and management
- identifying local successes related to these models underway in the Cumberland District
- identifying local opportunities and challenges related to each component of the Chronic Disease Prevention and Management model i.e., reorienting health services, information systems and decision support, self management and community.

At the conclusion of this session, a Steering Committee was struck to guide the development of the Cumberland chronic disease prevention and management strategy. This Steering Committee used the Tool to help initiate and move forward their work together.



In the Cumberland pilot, there was extensive engagement of the broader community working on chronic disease prevention and management. The overall focus was on the Expanded Wagner Chronic Care model and how it could be implemented in the District. The Tool was one vehicle to support this. The process of selecting priorities was first and foremost focused on selecting objectives for joint Chronic Disease Prevention and Management work in the region. The process was iterative and moved between the Steering Committee (the group leading the Tool process) and larger community/stakeholder forums. The steps and template provided in this sample come from this work.

Step 2:
Establish Criteria for Selection

At the first meeting of the Cumberland CDPM Steering Committee, the group reviewed the opportunities and challenges identified in the "Accelerating CDPM Day" forum report. To help with priority-setting, the group identified criteria together in a brainstorming exercise. These were further refined by the project coordinator and the facilitator. The resulting criteria in Cumberland were:

Criteria	Definition
Fit	Fit with strategic directions of CHA and CHBs
Readiness	There exists an appropriate level of awareness/ readiness among key stakeholders including: staff, community, patients, board, province, etc., to move quickly.
Builds on Capacity	It builds on existing resources and capacity within the district
Integration	It is a clear opportunity to practice/ promote CDPM integration
Inclusive	It is inclusive of the continuum of health care providers
Provincial Alignment	It aligns with provincial priorities and resources (timing!)
Impact	It will have a big impact on improving clinical, functional and population health outcomes

Step 3:
Prioritization of CDPM Objectives

Following the meeting, a goal statement and objectives were developed for each identified opportunity and the criteria were applied to each. The Steering Committee members individually rated each opportunity using a standard form followed by a group discussion. The results of this exercise were summarized in a report. A plan was made to validate the priorities through a second large stakeholder meeting,

See The Sample Template: Prioritization Table.

Step 4:
Validation of the Priorities

At the second stakeholder forum, the priorities were presented and participants provided feedback in small groups. This resulted in priorities for action to guide the work of the CDPM Steering Committee and broad stakeholder group.

See the Module: Action Planning for sample worksheets

Sample Template: Prioritization Table

Indicator	Please rate using the following scale: 0 = Don't know, 1 = strongly disagree, 2 = disagree, 3 = agree, 4 = strongly agree							Total Score
	Criteria							
	Fit	Readiness	Builds on Capacity	Integration	Inclusive	Provincial Alignment	Impact	
Model Component: Health System Design								
Goal: Increased awareness, understanding, skills and commitment to CDPM and integration across the continuum of health care service providers and community-based stakeholders including Community Health Boards (CHB).								
▮ Develop and implement learning and knowledge exchange opportunities related to CDPM and integration for key internal and external								
▮ Develop, support and strengthen interdisciplinary practice teams with internal and external partners in Cumberland County								
Model Component: Information Systems and Decision Support								
Goal: Creation of comprehensive information management systems and decision support tools to support CDPM. (NOTE: This is currently an IT/IM strategic planning process underway which will support the actioning of this goal and priority setting is probably not needed)								
▮ Identify and implement tools (such as flow sheets, population health reports or chronic disease passports) that can be used across the system to support CDPM.								
▮ Explore opportunities for linking existing information systems to facilitate the sharing of CDPM data and information across organizations in Cumberland County.								

Download: Setting Priorities.doc (Word Template)

Sample Template: Prioritization Table (cont.)

Indicator	Please rate using the following scale: 0 = Don't know, 1 = strongly disagree, 2 = disagree, 3 = agree, 4 = strongly agree							Total Score
	Criteria							
	Fit	Readiness	Builds on Capacity	Integration	Inclusive	Provincial Alignment	Impact	
Model Component: Self Management								
Goal: Increased patient and family self-efficacy (would this include knowledge and skills) to solve problems, access resources, make decisions, and take action to effectively manage their chronic disease.								
▮ Explore the implementation of the Stanford peer led self-management support program to help patients' effectively manage their chronic disease.								
▮ Explore the use of patient navigation models to support CDPM.								
Model Component: Community								
Goal: Increased access to supportive environments for health in Cumberland County.								
▮ Explore the development and implementation of a comprehensive workplace health initiative for Cumberland County.								
▮ Support the Cumberland Community Collaborative Partnership (CCCP) in developing a comprehensive, multi-sectoral approach to poverty reduction using the Vibrant Communities model for community-based poverty reduction work.								

Download: Setting Priorities.doc (Word Template)

5.0 Doing the Assessment

You have reached the point where you are ready to begin the assessment using the worksheets that accompany the Tool. Ideally this means that:

- A group has been identified/established to carry out the assessment (called the Group).
- Background information on chronic disease and risk factor rates and current initiatives has been collected.

See the module: Getting Ready

- The group has been oriented to the Tool and taken time to explore the Critical Success Factors.

See the module: Orientation Session

- The group has selected certain Critical Success Factors to focus the initial assessment.

See the module: Priority-Setting

While the basic steps of using the worksheets to help do the assessment is fairly straight-forward, determining how you want to do the assessment, including who needs to be around the table will vary with your overall intent for using the Tool.

This module will outline:

1. Using the Worksheets and Rating Scales
2. Interpreting the Results
3. Who to Involve in the Assessment
4. How the Assessment is Done with the Group

As noted, you will have already explored the Tool as a group through the orientation and selected priority areas to focus the assessment. It may be helpful to review the results of these earlier discussions to ensure doing the assessment builds on your earlier discussions.

The Tool can be used in a number of ways:

- To provide a common frame of reference for stakeholders to discuss their respective roles in preventing and managing chronic disease
- To assess current strategies and activities in the eight Critical Success Factor areas (a "snapshot" or baseline);
- To identify strengths and opportunities for improvement in one or more Critical Success Factor areas;
- To provide a starting point for further planning and action in the areas identified;
- To track progress over time from the initial "snapshot" or baseline assessment;
- To share successes and challenges and support problem-solving among communities/ regions

1. Using the Worksheets and Rating Scales

For each Critical Success Factor, there are a series of guiding questions presented in worksheet format. Each worksheet includes:

- The question
- A couple of sentences with additional information or an example
- A rating scale that outlines a possible range of practice (indicators) in response to the guiding question (0=nothing in place through to 4=better/promising practices in place).
- A space to note your own rating information or indicators
- A space for tracking comments, opportunities/ challenges or areas for follow-up identified through the assessment

The rating scale is intended to provide general cues about what better/promising practices might look like for each component. The indicators in the scale are based on research and practice examples from academic and grey literature, and from input from key informants in the field. The indicators do not represent a validated "gold standard", but are intended to serve as a general guide for discussion, assessment and action planning.

For example: the Rating Scale for Question 1 under the Critical Success Factor Integration of Chronic Disease Prevention and Management reads as follows:

1. How do stakeholders collaborate on the development of key health messages to support healthy living and self-management of chronic disease?

Development of common messages and collaboration between stakeholders on communication strategies can create a greater combined effect for the general public by providing messages through multiple channels. This could be especially effective when regional, provincial and national social marketing campaigns are also coordinated.

No collaboration on common messages.	Stakeholders share information on communications campaigns on an ad hoc basis.	Stakeholders designate representatives to be responsible for discussing communications plans.	Stakeholders agree on joint communications priorities and develop action plan.	Stakeholders implement plan and conduct joint evaluation. Stakeholders look for ways to combine resources to achieve larger impact
0	1	2	3	4
Other indicators from your region/experience?				

As noted, the indicators (for example: No collaboration on common messages) are intended as a guide only. You may identify other indicators from your own research or experience, or choose to otherwise adapt the scale to fit your own context. For example, there may be a different end-point you set as the "4" rating, or you may want to include/exclude other indicators along the scale. Adapt the scales as needed.

2. Interpreting the Results

The exact rating number you choose is less important than identifying and discussing where there are strengths and where there are opportunities for improvement.

You may want to consider follow-up action for areas where you are rating clearly on the low end of the scale.

Similarly, where you are rating on the high end of the scale, you may want to track these areas of strength and see how you can build on them further. The discussion points that arise can be recorded on the worksheets.

In doing the rating and discussing the assessment questions, the Group will identify areas for follow-up and possible short-term next steps:

1 An area where more information is needed to answer the questions

E.g. In assessing whether common messages are in place, the Group decides that a targeted scan is needed to identify current activities in this area and the stakeholders involved. The public health and primary care managers agree to collaborate to gather this additional information to inform the assessment.

2 A challenge or area for improvement

E.g. The Group gives a low rating to collaboration to develop common messages for healthy living and self-management of chronic disease. The chronic disease prevention coordinator agrees to connect with relevant stakeholders and to organize a task group to move forward work in this area.

3 An opportunity or strength to build on

E.g. The Group identifies a new provincial funding opportunity for training in self-management approaches. Two Group members agree to gather additional information and take the lead on developing a proposal.

4 An area that is outside the ability of the Group to assess

E.g. In assessing Community Capacity and Infrastructure, the Group finds there are major gaps in knowledge in this area. An action item to consult with community stakeholders is recorded.

!

Once you have determined your overall approach to the assessment and who should be at the table, you may still find that you want to invite specific people to help with certain parts of the assessment. For example, you may want to invite key community stakeholders to help assess the Critical Success Factor related to Community Capacity and Infrastructure.

3. Who to Involve in the Assessment

The Tool assumes that strengthening chronic disease prevention and management requires dialogue among the variety of groups who have a role to play. Therefore, who you may want to have around the table to help do the assessment will depend on:

- Your purpose for using the Tool
- How broad the process of dialogue is planned to be
- The stakeholders involved (See Stakeholder Engagement module.)

You will also want to consider the size and diversity of the Group. The assessment process can be straight-forward for a Group with a specific focus or clear mandate, e.g., Obesity Task Group; Public Health team. The shared, common purpose of the Group may facilitate dialogue and assessment.

If a more diverse stakeholder group is doing the assessment, e.g., a Chronic Disease Prevention and Management Steering Committee for a health authority, more time may be required to discuss and interpret results. This is to be expected, recognizing that Group members will have different backgrounds and understandings of key concepts.

There is no right or wrong approach. It is your determination of how you want to use the Tool and what is feasible. Whatever the approach, it is important to clearly identify:

- When and how to engage stakeholders in the assessment
- How the assessment will be brought into the regional planning process for chronic disease
- How results of the assessment will be shared with and validated by stakeholders not directly involved

In the Five Hills pilot, the assessment was done by the health region's Obesity Task Group. At the orientation session, the Group had identified three Critical Success Factors to focus on in their initial assessment: Common Values and Goals, Focus on Determinants of Health, and Integration of Chronic Disease Prevention and Management. A workplan was established with four 2-hour meetings set aside to do the assessment over a 3 month period. Additional stakeholders were invited to participate, including the regional intersectoral coordinator. For each Critical Success Factor reviewed, all component questions were used. The Group used information gathered on chronic disease rates, current strategies/initiatives and stakeholders to be useful when answering the assessment questions.

See the module: Getting Ready

Sample Record of Assessment: Cumberland Health Region

Critical Success Factor: Common Values and Health Goals

Component of the Tool	Question 1: How are stakeholders engaged in working together to strengthen Chronic disease Prevention and Management	
General Feedback	**Many partnership networks** ▮ Cumberland Collaborative Community Partnership ▮ Healthy Beginnings Network (Early Childhood Support in the district) – linking on initiatives and strategies, information sharing. ▮ Youth Health Centres ▮ Health Promotion Team ▮ Community Heath Boards	Groups within themselves are committed to collective goals, membership crossover exists Need to connect with other chronic disease groups(and NGO service agencies) and inventory into our information directories and communication mechanisms Challenge: Need more communication between bigger networks listed above
Additional Comments	As a Public Health Services team, there is opportunity for growth - more collaboration and developing and articulating shared values that drive our collective work internally and with partners. Cumberland Health Authority facilities are accessible within our communities – good sharing of resources in this way Helping Tree Resource (Inventory of Services) is an asset	Vibrant communities Initiative – common value and health goal – poverty reduction Cumberland Community Collaborative Partnership and Community Health An example of how we are beginning to broaden our partnership connections is the engagement of a diverse subcommittee to support the CD Self Management priorities – involving kidney foundation, Cancer NS, Acute care rep, Cardiovascular Health, Chronic Pain, Continuing Care
Group Response	**Rating:** We are in the middle on this one – Some stakeholders meet regularly and have started to plan together. Need to be certain to align our Values and Vision with the general Cumberland Health Authority Mission Vision and values and as well provincial strategies. We work from a strengths based approach with clients. The need to support the strengthening of other care providers' ability to provide care differently –i.e.: strengths based – i.e.: physicians, front line care providers.	Communication of our collective work to the broader HC community through website, media is needed. This is a way to build capacity and share our values. i.e.: Around the determinants / Vibrant communities

Download: Assessment.doc
(Word Template)

4. How the Assessment is Done as a Group

Choosing the appropriate process depends on your context, who is involved in the assessment and how quickly the Group feels they need to move to action. Two pilot site examples are presented in the boxes.

The steps to move through when assessing any one Critical Success Factor will likely include:

- Review of the detailed description, background information, examples and references provided in the Tool for the Critical Success Factor being discussed
- Determine if there are any terms or definitions that people needs to clarify
- Specify the level of assessment. For example, the term "stakeholder" in a question could be defined narrowly to just the Group or more broadly to include the full range of stakeholders
- Clarify if there are any priority questions for the Critical Success Factors, or whether all the questions for that factor will be included in the assessment
- Divide into pairs/triads and do the rating, using information gathered previously as needed. Depending on time, the Group may decide to assign different questions to different pairs or triads

See the module: Getting Ready

- Discuss the ratings
- Capture discussion and provide Group rating on worksheets
- Summarize any follow-up actions
- Evaluate the exercise with the Group

Additional/Related Information:

- Getting Ready
- Orientation Session
- Priority-setting
- Stakeholder Engagement

In the Cumberland pilot, the members of the Public Health Services team of the district health authority met to assess three Critical Success Factors: Common Values and Goals, Public Health Capacity and Infrastructure and Integration of Chronic Disease Prevention and Management. Not all questions were assessed – certain questions were selected as a first step in the group process.

The Group spent a full day doing the assessment. Small groups were assigned questions, recorded their discussion and initial rating. Report-backs from small groups generated further discussion and a group rating.

The details of the assessment, additional comments, group rating and follow-up actions were summarized by the health promotion coordinator using the table format below. The region's Chronic Disease Prevention and Management Steering Committee reviewed the meeting results and built action items into its workplan and next steps. Some illustrative content is provided in the Table.

6.0 Action Planning

One of the possible uses of the Tool is to provide a starting point for further planning and action in the key areas. Moving to action planning assumes:

- That an assessment of the identified Critical Success Factors has been conducted and areas of strength as well as opportunities for improvement identified
- That there is a common understanding, shared vision and goals for moving forward efforts to prevent and manage chronic disease
- That there is buy-in from the stakeholders, both in the health and broader community sectors, who will need to be part of the action plan

This module provides some thoughts about action planning in complex systems and provides examples of two approaches to action planning used in the pilots.

Action Planning and Systems Thinking

There are many approaches to action planning. A number of useful resources are available that take into account complex systems, such as those we are working within in the area of chronic disease.

See the module: General Process Tips

There are a couple of important principles:

- Have the right people in the room – that is a cross-section of the whole system and those who will need to be involved in taking the actions resulting from the plan. In the case of chronic disease, this would include those involved in preventing disease and mitigating risk factors and underlying determinants through to those supporting people living with chronic disease in the care system.
- Enable people to take responsibility for their own action plan. This recognizes that any one group, e.g., steering committee, can only control about 15% of what goes on around them. For things to move forward, those involved have to ultimately take on ownership for moving many of the actions forward and /or playing a significant role.

Throughout this guide, tips and tools have been provided to help you engage stakeholders - in getting ready to use the Tool, in orientation, setting priorities and doing the assessment. Areas of common ground need to be found in key areas, but not everybody has to be involved in everything or be in agreement with everything. By being conscious of stakeholder engagement at every step leading up to action planning, you will be more likely to have the kind of buy-in that leads to moving forward with concrete, relevant actions.

See the module: Stakeholder Engagement

Approaches to Action Planning

In the piloting of the Tool, action planning was done at two levels:

- To identify short-term action steps
- To link the results of the assessment to a broader chronic disease planning process with a larger stakeholder group.

1. Short-term Action Steps

When the assessment of a particular Critical Success Factor is complete, it is often possible to determine some immediate action steps that can begin to improve practice. This immediacy helps to build momentum and keep involved those members of the group who feel a need to spend "less time talking and more time doing". The Tool then provides the "touchstone" for checking on progress and determining next steps.

In the Champlain LIHN pilot, balancing the assessment with collaborative action as opportunities arose was a source of creative tension. In an early meeting of the group using the Tool (the Group), possible priorities for collaboration were identified and provided a framework for thinking about new opportunities while the process of assessment was underway.

For example, self-management was an identified priority area for collaboration. The Group was ready and able to respond when a funding opportunity around self-management arose.

In another situation it was the assessment process itself that led to an immediate action. When assessing the first Critical Success Factor, the Group rated themselves low on having Common Values and Health Goals. They decided to use the next meeting to develop a set of shared values and goals to guide their work together.

2. Broader Chronic Disease Planning

In the Cumberland pilot, two stakeholder fora were held. At the first "Accelerating CDPM" forum, stakeholders identified opportunities and challenges for moving forward with chronic disease prevention and management. Soon after the first forum, the Chronic Disease Prevention and Management Steering Committee organized the information collected into a set of priority goal statements with objectives.

The process used to develop the goal statements and objectives is included in the Priority Setting module of this guide. At the second stakeholder forum, participants reviewed priorities in small groups and took first steps towards developing an action plan.

A table summarizing the goal statements and objectives is included below along with the worksheet used for action planning.

Additional/Related Information:

- General Process Tips section on Working in Complexity
- Stakeholder Engagement
- Priority-setting
- Working Together Effectively

Sample: Cumberland County Chronic Disease Prevention and Management (CDPM) Goals and Objectives

Component	Goals	Objective
Reorienting Health Services	▮ Increased awareness, understanding, skills and commitment to CDPM and integration across the continuum of health care service providers and community-based stakeholders including Community Health Boards (CHB).	▮ Develop and implement learning and knowledge exchange opportunities related to CDPM and integration for key internal and external stakeholders ▮ Develop, support and strengthen interdisciplinary practice teams with internal and external partners in Cumberland County and ensure effective linkages across teams and organizations.
Information Systems & Decision Support	▮ Creation of comprehensive information management systems and decision support tools to support CDPM. (NOTE: There is currently an IT/IM strategic planning process underway which will support the actioning of this goal).	▮ Identify and implement tools (such as flow sheets, population health reports or chronic disease passports) that can be used across the system to support CDPM. ▮ Explore opportunities for linking existing information systems to facilitate the sharing of CDPM data and information across organizations in Cumberland County.
Self Management	▮ Increased patient and family self-efficacy to solve problems, access resources, make decisions, and take action to effectively manage their chronic disease in collaboration with providers.	▮ Explore and support the planning and implementation of the Stanford peer led self-management support program and other resources to help patients effectively manage their chronic disease.
Community	▮ Increased access to supportive environments for health in Cumberland County.	▮ Explore the role of the DHA in supporting comprehensive workplace health initiatives for Cumberland County. ▮ Identify and support comprehensive multi-sectoral approaches to improving the determinants of health in the County.

Sample: Action Planning Worksheet

Cumberland County CDPM Workshop Action Planning Worksheet

Objective:

What actions are required within Cumberland County to ensure the successful implementation of this objective?

Write these actions clearly in brief statements below (your facilitator will be recording the discussion on behalf of the group).
Begin each statement with a verb. Include a suggestion for accountability (i.e. who is responsible), resources required to complete, a timeline for completion, and how you will know whether you have been successful.

Action (what will be done?):

_____

_____

Accountability (who will do it?):

_____

_____

Resources Required (e.g., funding, time, people, infrastructure, etc.):

_____

_____

Timeline (Done by when?):

_____

_____

Indicators of Success (How will you know that you are making progress?):

_____

_____

Download: Action Planning Worksheet.doc (Word Template)

7.0 General Process Tips

Beginning a collaborative process to strengthen chronic disease prevention and management can be a daunting task. The Tool provides a framework to assist with this through assessment and planning.

Through the course of the pilot work, a number of good practices in process design and development were used. This module pulls these together, including:

- a framework for working on complex system-level issues like chronic disease prevention and management
- resource considerations for using the Tool, e.g., facilitation, resource person to coordinate, time
- principles and practices of good dialogue
- evaluation and record-keeping to support learning and communication

Working in Complexity

There is no doubt that strengthening chronic disease prevention and management is a complex undertaking. With a whole range of approaches, health disciplines and organizations, it requires looking at the how each piece connects as a system.

When looking at systems, a single action can have many different impacts. New developments are constantly changing how the system works as a whole. It is impossible to control the full range of effects. Instead, the goal is to create the conditions for the system to change and adapt in positive ways. In this case, in ways that can strengthen collective efforts to prevent and manage chronic disease.

Although it is important to have a "big picture" view of the whole system, change arises from many small interactions, rather than just large-scale attempts to control the system. Bringing people together to reflect on their approaches to chronic disease prevention and management, to explore collaboration and to assess current practice are all activities that can stimulate change. This is where the Tool can be helpful, whether it is used in whole, in part, by a small group or a larger collective such as a regional steering committee for chronic disease prevention and management.

Working in complexity is about releasing control. One picture to illustrate this is the idea that "Farmers don't grow crops. They create the conditions in which crops grow". Similarly, how can we create environments in which more integrated prevention and management efforts can flourish?

The Capital Health pilot group used this thinking to make sense of their own approach to integration. They decided to move forward with a specific initiative, community-based health teams, to demonstrate better integration of prevention and management. They strategized that the learning from this initiative would "enrich the soil" for broader system change by showing where connections are needed, how the links are made between public health and primary care and what strategies are needed to nurture integration.

Part of working from a complex systems perspective is to know your context - who are the key players, how are they linked, what they are doing, what are their visions and goal. The modules on Getting Ready and Stakeholder Engagement provide some tools for collecting this information.

Resource Considerations

Using the Tool takes a commitment of time and energy. The amount required varies with how you decide to use the Tool. For example, the most resource-intensive approach would be to engage a broad group of stakeholders in a full assessment of all the Critical Success Factors. Fewer resources would be required for a more focused assessment, done with a smaller group such as a public health team or task group.

Regardless of the scale of the process, the pilot experiences did highlight the following considerations:

1. Coordinator or Resource Person

As with most projects, it is important to identify someone who will be responsible for keeping the project rolling and on-track. In the pilot experiences, this was not a full-time role. Rather, a staff person within the health authority included coordination in his/her workplan (or a part-time coordinator was engaged for a short period of time). This person was essential in ensuring that the decisions of the Group using the Tool were acted upon, e.g., required outreach and information-gathering done; process documented, action items implemented.

See Case Studies for more detail

The Butterfly Effect – the idea that a butterfly flapping its wings can influence the weather on the other side of the world, is a popular expression for the notion that a small nonlinear change in one part of the system can have an unpredictable and major impact.

Following the release of the Nova Scotia's Chronic Disease Prevention Strategy, infrastructure was enhanced including nine chronic disease prevention (CDP) coordinator positions, one for each District. In the Cumberland Health Authority, the person in the District CDP position built using the Tool into her work plan. The workplan already included objectives for strengthening chronic disease prevention and management in the Cumberland District. She became the coordinator for their pilot process, using the Tool as part of this larger initiative.

Funds (under $20,000) were allocated to support the use of the Tool.

The funds supported a range of activities, including research and information-gathering, facilitation support, logistical support and expenses, administration and coordination.

2. Funds

Some funds may need to be allocated to support using the Tool. The amount may vary with how you use the Tool and the degree of "in-house" support available. For the pilots, resources were used for such things as research and information-gathering, for facilitation and process design support and for meeting expenses.

3. Time

Using the Tool takes time, both to prepare for its use and to do the assessment. A lesson learned in the pilot process was that the time required to get ready to use the Tool is easy to under-estimate. In their experience, 2-3 months is needed to gather the appropriate information and do outreach to engage the desired stakeholders.

Some preliminary work, e.g., awareness-building on the regional approaches to chronic disease prevention and management may also be needed, such as review and discussion of integrated models)

See the module: Getting Ready

4. Facilitation

This Tool is intended to stimulate a process of engagement with the range of stakeholders that have shared planning responsibility for preventing and managing chronic disease. This means that group process is important.

See the module: Stakeholder Engagement

The pilot sites found it useful to have a facilitator who is focused on the process. This allows others around the table to participate in the discussions, focusing on content. This was particularly true for larger meetings, e.g., stakeholder forums.

The facilitators generally worked with the coordinator to design the meeting and in some cases the longer-term process of engagement, e.g., over several meetings. Engaging a facilitator skilled in fostering good dialogue was also important.

Sample Ground Rules for Dialogue

- Be open and listen to others even when (especially when) you disagree, and suspend judgment.
- Identify and test assumptions (especially your own).
- Listen carefully and respectfully to the views of others: acknowledge you have heard the other especially when you disagree.
- Seek to understand rather than persuade.
- Look for common ground.
- Express disagreement with ideas, not with personalities or motives.

Good Dialogue

Preventing and managing chronic disease is a collaborative venture and requires the development of a shared understanding of chronic disease prevention and management. Health professionals from a variety of disciplines and settings have varied perspectives and may find it challenging to look outside their own area of expertise.

Dialogue is essential to help achieve this. While we all use the term dialogue, it is important to distinguish it from debate and decision-making. Dialogue is an exploration of ideas – it promotes understanding and learning together to arrive at common ground from which decisions and action can be taken. Thus dialogue precedes decision-making by enabling people to determine and take action in ways that are informed and effective.

Dialogue is very different from debate (which is the form of engagement we are probably most familiar with). You can't win a dialogue, whereas a debate is usually about winning and about convincing others of your point of view. See Table below.

For many of us, getting used to dialogue takes a change in our habitual way of interacting. To help engage in good dialogue, it is it is often useful to work with a facilitator skilled in dialogue – at least at the start to help establish good practice. This person can also help to design processes that encourage good dialogue. It is also helpful to set and follow a set of ground rules. Examples are provided in the text box.

Dialogue	Debate
The objective is to find common ground	The objective is to win
Participants listen to increase understanding and find meaning	Participants listen to find flaws
Participants are open to being wrong, accept that others' thinking can improve their won and are open to change	Participants are determined to be right and defend their views against others
Participant's points or views are enlarged and possibly changed	Participant's point of view is affirmed
The atmosphere is one of safety; facilitators propose, get agreement on, and enforce clear ground rules to enhance safety and promote respectful exchange	The atmosphere is threatening; attacks and interruptions are expected by participants and are usually permitted by moderators.
Assumptions are revealed for reevaluation	Assumptions are defended as truth
It allows for an exploration of the problem and considers the possibility that people sometimes have different solutions because they see the problem differently.	One's own position is defended as the best solution; other solutions are excluded and new solutions are not considered
Holds that many people have pieces of the answer and that together they can potentially build a better solution than any existing solution	Holds that there is a right answer and that someone has it

Evaluation and Documentation

The Tool is designed to help stakeholders increase their collective capacity for effective chronic disease prevention and management. While there are several dimensions to capacity-building, one key aspect is the ability to learn from experience.

Evaluation is an effective and disciplined way for helping us to reflect on our experiences and what we are learning from them. Thinking about evaluation early in a process and developing an evaluation framework up-front can be helpful. This can help build a common understanding of what success means and what data needs to be collected to assess progress.

Evaluation was a key component of the pilot process. For each group using the Tool, data was collected through participant evaluation forms and project activity logs.

A sample evaluation form used by the Public Health Team in Cumberland district is provided below. It provided immediate feedback on participants experience assessing three Critical Success Factors: Common Values and Health Goals, Public Health Capacity and Infrastructure and Integration of Chronic Disease Prevention and Management.

Additional/Related Information:

- Getting Ready
- Stakeholder Engagement
- Case Studies

Bringing together a diverse group of stakeholders to work collaboratively on chronic disease prevention and management is a continuous process. New people enter and others may leave discussion.

Good documentation is very helpful so that new participants can more quickly get" up-to-speed" with the thinking that has already occurred and any consensus that has been arrived at.

Evaluation is one component of this documentation and helps to improve process over the life of the initiative.

Chronic Disease Prevention Tool Pilot Session, February 25: Evaluation and Reflection

Thank-you for participating in the pilot test of the questions for the Critical Success factors for Chronic Disease. Your input into the process will help with tool redesign and promotion strategies.

Using the 5-point scale, please rate the following statements

It is important to me to connect with my team on Health Promotion work.	1	2	3	4	5
The presentation yesterday increased my understanding of: local Chronic Disease work	1	2	3	4	5
The pilot tool questions stimulated good discussion in our group	1	2	3	4	5
I was able to understand the purpose of the tool	1	2	3	4	5
The meaning of the questions on the tool were clear to me	1	2	3	4	5
The language level used in the questions was clear for me	1	2	3	4	5
I enjoyed talking about the questions with my team	1	2	3	4	5
Our group can be a leader in modeling this process to other groups	1	2	3	4	5
I got some new information and ideas on how to improve my practice or enhance my work	1	2	3	4	5
It is important that we contribute to the development of a chronic disease strategy for the DHA	1	2	3	4	5
The Tool Questions were / can be, useful in helping us move forward with our work	1	2	3	4	5
I would like to get together in this way again to talk about our work together	1	2	3	4	5

Note: CDPM (means Chronic Disease Prevention and Management)

Download: Session Evaluation.doc (Word Template)

Chronic Disease Prevention Tool Pilot Session, February 25: Comments

Reflections on the process.

Any suggestions for changing the format of the tool.

How would you see this tool enhancing:

1. Your work in public health and health promotion:

2. Systems level work in Chronic Disease prevention:

Additional Comments:

Download: Session Evaluation.doc (Word Template)

8.0 Stakeholder Engagement

This Tool is intended to bring together the range of stakeholders with shared planning responsibility for preventing and managing chronic disease. Typically in any community, this would be led by managers/coordinators of public health, primary care and other parts of the care system that help people living with chronic disease.

Planning would include engaging a broad range of other stakeholders, including community and non-health sectors such as education, recreation and municipal planning.

This module provides some general tools for thinking about stakeholder engagement, and in particular outreach. It also provides an example from the pilot of an early engagement of the stakeholder community.

Stakeholders

Anyone with an interest in the outcome or who can potentially have impact.

Types of Engagement

As noted in the module Getting Ready, considering who should be around the table to move forward on strengthening chronic disease prevention and management strategies and activities needs to happen early in the process. But it is also an ongoing process that cycles through engaging stakeholders, assessing strategies and activities, taking action, evaluating outcomes and learning. Through this iterative process, not everyone needs to be involved in all the stages. For example:

- The Group leading the use of the Tool will probably be fairly small, but represent a cross-section of stakeholders involved in chronic disease planning, both within government organizations such as health authorities and those working in the community.
- There may be a larger reference group, who are involved and informed. They may be brought in to provide input to various stages of the process, e.g., identifying opportunities/challenges, priority-setting, assessment, or action-planning. They may also validate the findings of the Group using the Tool. This would likely be individuals or groups whose buy-in to the assessment and any resulting action plan(s) would be crucial to their success.
- There may be an even larger engagement that includes activities to exchange information, build networks and develop joint initiatives or

In Cumberland region, the Chronic Disease Prevention and Management (CDPM) Steering Committee served as the Group applying the Tool. Establishing the Steering Committee was a key action item arising out of a full-day, DHA-hosted broad stakeholder meeting in Fall 2007, "Accelerating CDPM Day". The Steering Committee was chaired by the VP of Community Services for the District Health Authority, and included managers of public health, primary care, dietary services, organizational wellness, regional addiction and mental health services, cardiovascular health, quality improvement and decision support.

partnerships. It may also include a broad-based regional planning process to develop a shared understanding, vision, goals and/or priorities for strengthening chronic disease prevention and management efforts.

Systems Approach to Engagement

Strengthening collective efforts to prevent chronic disease and related complications is a complex undertaking with many organizations and individuals working together as a system. A system can be thought of as a set of interconnected, complex and interactive relationships.

See the Module: General Process Tips – Working in Complexity

The parts work together as a whole or with a single purpose to create environments that support health, reduce risk, and provide support to those living with chronic disease. Such systems are complex, with a great number of connections between a wide variety of people, processes and networks.

Networks are purposeful and communication-based. They share an identity based on having common language, knowledge, goals, etc. It may be helpful to think of the work of strengthening chronic disease prevention and management (and the associated use of the Tool) as creating a new network with a common interest.

Example of a Stakeholder Forum

In two of the pilot sites (Champlain and Cumberland), there was early engagement of a broad range of stakeholders through a forum for information-exchange and regional chronic disease planning.

The forum helped build understanding of the model being used in the province to guide chronic disease prevention and management work, the profile of chronic disease in the region, and elicited stakeholder perspectives about opportunities and challenges.

In each case, the forum served as a way to collect information about the various stakeholders, groups, networks and activities underway. The forum acted as a springboard for further collaboration and the use of the Tool. The process used in the Champlain region is provided below as an example.

See the Module: Getting Ready

! In working with representatives of networks, it is useful to set-up shared expectations in terms of communication, e.g., each representative ensures consistent information flow to and from the other members of their network.

In the Champlain region, there are a number of Community of Practice networks– mainly disease or age-specific. The Champlain Local Health Integration Network wanted to establish a Collaborative that could provide a broad perspective to inform regional chronic disease planning. Its first activity was a planning forum where an open invitation was sent to all the networks and other stakeholders not linked into a particular network already. About 50 stakeholders participated.

Sample Agenda: CDPM Planning Forum

Objectives of Session:

To offer an opportunity for stakeholders in the Champlain region to:

- Exchange information about what is currently being done in chronic disease prevention and management (CDPM) among networks and other stakeholders
- Identify opportunities for collaboration, including between and across networks.
- Develop a CDPM Collaborative for ongoing collaboration

Preparation:

Each network/other stakeholder was asked to provide the following information for posters, which were prepared according to a common template:

- Mandate
- Membership
- Key initiatives
- Plans for the future

Posters were developed based on the information provided. These were posted up in the session room.

Possible Terms of Reference for the Collaborative were prepared in advance for discussion at the forum.

Time	Content & Process
1 pm	**Opening Remarks** - Welcome and review of meeting objectives – - Participant introductions - Review of agenda
1:30	**Setting the Context: Presentations** - Ontario Framework for Chronic Disease Prevention & Management, Opportunity for Collaboration; Introduction to the CPHA Pilot - Statistical Overview of Chronic Disease in Champlain
2:15	**Poster Session - Where Are We Now?** - Participants will have the opportunity to examine what others are doing in chronic disease prevention and management in the Champlain Region. - Two/three rounds of poster-viewing will be done to allow participants to view all the posters, ask questions and network. - One person from each network is present at their poster to answer questions while participants circulate.
3:00	**Opportunities for Collaboration** Small group discussion on the following: - Share observations/reflections from the poster round - Where are there opportunities for collaboration, including between and across our networks? - What 2 ideas for collaboration would your group like to share with the other tables?
3:30	**Report-back Plenary** Each table has 4 minutes to share 2 ideas for collaboration, followed by plenary discussion as time permits.
4:10	**Moving Forward** - Proposed structure for ongoing collaboration - Discussion: What changes would you suggest to the proposed Terms of Reference of the CDPM Collaborative (functions, composition & structure)? Who is missing?
4:45	Wrap-Up - Next Steps - Sign up sheets – CDPM Collaborative - Completion of Evaluation Form - Closing Comments

Process Overview:

The half day session began with presentations to provide a statistical overview of chronic disease in the region and an overview of the CDPM framework used in Ontario. Participants were then invited to review the posters in two rounds. For each round, different posters were displayed. One person from each network/group was present at their poster to answer questions while other participants circulated.

After a break, people returned to their small tables and discussed opportunities for collaboration. These were shared and discussed in plenary. The Champlain LIHN then presented the idea of an ongoing collaborative on CDPM and shared draft Terms of Reference. Participants provided feedback and there was consensus to move forward with the idea of a collaborative. An evaluation form was completed.

The planning forum was professionally facilitated. A report of the forum was prepared and sent to all participants to help inform network members who had not been able to participate directly and to provide a record of the discussion and next steps.

Outreach

Identifying and involving the range of desired stakeholders will likely require outreach. There are three steps to consider doing for effective outreach:

1. Situational Analysis

- Be clear about the issue for engagement and what the goals for engagement are, e.g., opportunity for shared learning, feedback on priorities; determine membership in a steering committee or reference group.
- Identify internal stakeholders
- Identify external stakeholders and analyze their influence, credibility, etc. It may help to develop a stakeholder network map that diagrammatically illustrates stakeholder groups and their connections. It can help to identify:
  - Who has to be engaged?
  - Linkages between stakeholder groups
  - Quality of existing relationships
  - Key leverage points, e.g., stakeholders of influence
  - Emerging stakeholders

Identifying Stakeholders

!

- Do not identify stakeholders in a vacuum. Ask others who they think will be interested in the issue.
- Partner or contract with others who know how to reach out to the groups/people you want to involve.
- Identify organized groups and characteristics of individuals that will most likely be interested in the potential impacts and controversy that have been identified.
- Identify any groups that may have special needs and ensure that they receive direct attention in the identification process.
- Identify groups and individuals that may not fall within traditional stakeholder categories, e.g., citizens.

2. Consultation:

- Meet with potential stakeholder partners individually to clarify perspectives, expectations, etc.
- Determine whether key stakeholders are willing to be involved, and under what conditions.
- What type of engagement are they interested in, e.g., member of steering committee or reference group?

3. Engagement Plan: Consider

- What kind of meetings will be needed? How often? When? Where?
- What resources will be needed?
- What are the roles and responsibilities?
- How will we communicate?
- What principles will guide our engagement?

Expanding Engagement

While it is important to take some time to think through who needs to be engaged and how the engagement will work, one doesn't want to become "paralyzed" by feeling that everyone has to be involved right from the start. Stakeholder engagement can grow and indeed, if momentum starts to build in your region for strengthening chronic disease prevention and management, you may find groups/stakeholders proactively asking to be part of the process. And the nature of the involvement will likely vary – some may be happy just to be kept informed, whereas others may become a key driver. Flexibility is important as is demonstrating inclusivity at appropriate points in your overall process.

Additional/Related Information:

- Working Together Effectively
- Getting Ready
- General Process Tips
  (Working in Complexity - Good Dialogue)

9.0 Working Together Effectively

The Tool is designed to help strengthen collective efforts to prevent and manage chronic disease. This requires collaboration and brings a range of factors into play to support stakeholders working together effectively.

Working together effectively requires time as a group develops to the point where it functions well and shares a common language, purpose and direction. When the group is diverse, across professional designations, settings and communities, additional time may be required for discussion and developing a shared understanding of vision, values and goal for strengthening chronic disease prevention and management.

This module looks at aspects of:

- Group development that may impact use of the Tool, including an example from one of the pilot sites
- Good group functioning, including Terms of Reference for committees who used the Tool in their chronic disease work
- Shared language and understanding of chronic disease prevention and management and the concept of integration
- Common values and health goals as a foundation for working together effectively

Group Development

Excellent resources are available describing stages of group development. Groups go through stages – from early formation through to more mature "performing" groups functioning effectively. Being aware of these stages and recognizing which stage your group is in can help guide the kind of process you choose for using the Tool.

Practically-speaking, you will want to take a different approach with a newly forming group than an established group. If the group is new, you will want to pay close attention to clarifying mandate, developing a shared understanding of expectations and understanding the context within which the work is taking place.

An example of a group's development in one of the pilot sites is provided in the text box.

!

Good group functioning is enhanced by good meeting preparation and completion, including:

- Adequate notice of meetings
- Agendas with objectives and a time frame
- Minutes of meetings so the record of discussion and decision-making is clear and can be shared with others
- Evaluation of the meetings, including group functioning so there can be continual improvement.

Group Development

Formation of a New Group – the Champlain Chronic Disease Prevention and Management Collaborative

Group formation is an interactive process that takes time. In the Champlain health region, there were a number of Community of Practice networks –most of whom were structured around different diseases, e.g., diabetes, heart health, lung health. The Champlain Local Health Integration Network wanted to establish a "network of networks" or Collaborative that could inform regional chronic disease planning. The process to develop the Collaborative took several steps, spanning a six-month period:

- The first step was to collect information on the different networks and bring them together in a Planning Forum to share that information, to see if there was interest in collaboration and if so, around what. Those who were interested let the organizers know of their interest and they were invited to a second meeting.
- The second meeting explored the purpose of the collaboration – Why do we want to work together? An initial orientation to the Tool was provided. There was discussion about how the group wanted to function, e.g., frequency of meeting times, and a work plan for the next four months was developed.
- At the third meeting there was a more thorough orientation to the Tool and the group looked at how it wanted to use the Tool. Priority Critical Success Factors were selected.
- The fourth meeting included an update on some additional ventures being undertaken by the group or key members. The group completed an initial assessment of the Critical Success Factor on Common Values and Health Goals. Draft Terms of Reference were presented.
- At the fifth meeting, the group developed its common values and goals. The activity helped clarify their role, leading to revisions to the draft Terms of Reference of the Collaborative.

And the work is ongoing....

Group Functioning

There are a variety of tools that groups use to clarify their work together and keep themselves on track. Workplans, clear agendas, minutes, a vision statement and Terms of Reference are some of these tools.

With the many people and processes involved in preventing and managing chronic disease, it is particularly important for groups working in this area to clarify their mandate and how this work fits within broader planning processes and regional initiatives.

Examples of Trust-Building Behaviours

- Sharing information pro-actively
- Open and honest communication
- Congruence between words and action
- Transparency, e.g., no hidden agendas
- Keeping promises and meeting obligations – reliability
- Sensitivity to the interests/needs of others
- Shared norms and reciprocity

Sample Terms of Reference

Terms of reference provide a written statement of a group's agreed-to purpose, mandate, membership and how it will function. This is useful for the group itself to ensure a common understanding of why it exists and its responsibilities and obligations. It also is a useful tool to help others understand what the group is about. Two examples, from pilots, are provided below.

Particularly with new groups bringing diverse stakeholders together, there are some trust-building behaviours that can strengthen group functioning and help avoid pitfalls of group work.

Cumberland Health Authority

Chronic Disease Prevention and Management Steering Committee

Draft Terms of Reference

Membership:

10-15 Cumberland Health Authority employees with expertise in public health practice, primary health care practice, acute care, quality improvement and decision support.

Consulting members from the community and other sectors may also be invited to participate.

Current Members:

VP Community Health
Manager Public Health Services
Nurse Practitioner (Primary Care)
Health Promotion Coordinator
Health Analyst (Decision Support)
Manager Dietary Services
Public Health Nutritionist
Manager Organizational Wellness
Manager Addictions Services (with alternate–Alcohol Strategy)
Mental Health Services (with alternate)

Purpose:

To provide leadership and direction to the Cumberland Health Authority's internal Chronic Disease Prevention and Management Strategy development process by:

- Overseeing the development and implementation of a participatory planning process
- Identifying opportunities and actions required to strengthen chronic disease prevention and management work in the Cumberland Health Authority and community
- Identifying challenges in carrying out this work and the resources, policies and programs needed to overcome these challenges

Operating Principles:

To be determined

Meeting schedule:

Regular meetings to be determined 1/month. Meetings will be scheduled at least 3 months in advance.

Meetings will run approximately 1.5 hours. Location and times will be confirmed in advance by e-mail.

Meeting Records:

Members will rotate a note-taking role for each meeting using a standard template. After each meeting, the note-taker will prepare a brief summary of decisions and actions arising from the meeting. These will be distributed no less than one week before the next meeting by the note-taker. The Health Promotion Coordinator will serve as meeting facilitator.

Chronic Disease Prevention and Management Core Team
Capital Health and the IWK Health Centre
Draft Terms of Reference

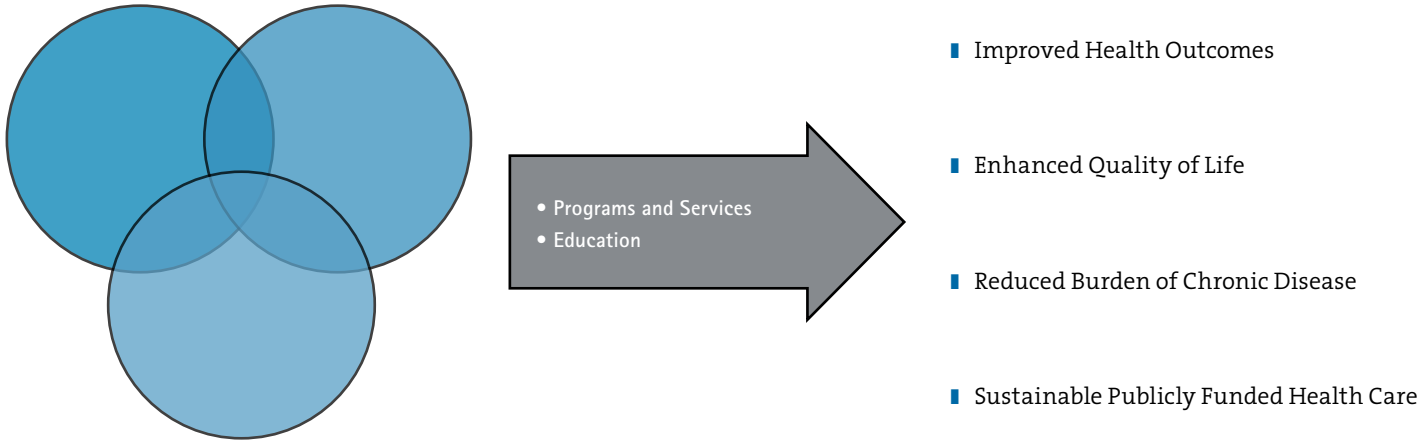
Background

Chronic disease prevention and management is provided along the continuum of health "care" planning, program and service delivery including:

- Community and public health with an emphasis on population based prevention targeted at communities and populations using health promotion approaches such as policy development and advocacy, community development, education and skill building, and developing supportive social and physical environments.
- Primary care with an emphasis on clinical based prevention and chronic disease management targeted at individuals and families with multiple risk factors and co-morbidities using one-on-one counselling, and group education and social support.
- Secondary and tertiary care and rehabilitation with an emphasis on chronic disease management (usually a specific disease) targeted at individuals using one-on-one counselling, and group education and social support.

Although the three pillars of health "care" described have unique focuses, there is overlap in functions with the various "pillars" sharing similar health goals including: health promotion, chronic disease prevention, and detection and management of risk factors and chronic disease. One of the main objectives of Primary Health Care Renewal is to facilitate coordination and integration between various levels/pillars of the health care system.

The following figure depicts the connection and overlap between the three components of health care:



Chronic Disease Prevention and Management Core Team
Capital Health and the IWK Health Centre
Draft Terms of Reference

Purpose

The purpose of the Chronic Disease Prevention and Management Core Team is to enhance communication, collaboration and integration across the continuum of health care programs (from community and population based initiatives to tertiary care programs and services) through enhanced research, services and education to improve chronic disease prevention and management. The Core Team, in collaboration and consultation with the Chronic Disease Prevention and Management Steering Committee, will lead the planning, implementation and evaluation of the chronic disease prevention and management model within the Capital district.

Mandate

- To provide a forum for communication and sharing between the various pillars of health "care" within Capital Health/IWK district to facilitate increased understanding about how the role of each pillar contributes to improving health.
- To facilitate the development of partnerships across the continuum of the health "care" system.
- In collaboration with the Steering Committee, establish priorities, goals and action plans that support implementation of the chronic disease prevention and management model including:
  - Identification and support of opportunities for integration across the continuum of the health care system to support more effective program and service delivery.
  - The identification of needs and opportunities for the development and implementation of shared tools and structures to ensure more effective health care delivery.
  - Gathering and analyzing epidemiological and other data to support planning efforts and increased integration across the continuum of the health "care" system.
- To provide leadership for the model and support implementation of actions and initiatives at the care team and program level.
- To build capacity to conduct and support research across the continuum of the health care system that will support effective integration and coordination of programs and services.
- To build knowledge and skills in primary health care and a population health approach among health care providers and students across the continuum of health care.
- To support, and provide direction to, the coordinators of population-based prevention, clinical-based prevention and chronic disease management

Membership

- Medical Officer of Health, Capital Health
- Director of Primary Care, Capital Health
- Director of Primary Health Care, IWK
- Family Physician representative from Capital District
- Specialist Physicians, one each from Capital Health and IWK
- Coordinators of population-based prevention, clinical-based prevention and chronic disease management

Chronic Disease Prevention and Management Core Team
Capital Health and the IWK Health Centre
Draft Terms of Reference

Chair

Co-chaired by the Medical Officer of Health and Director of Primary Care, Capital Health

Meetings

To be determined

Decision making

Decision making will occur by consensus whenever possible. When consensus cannot be reached, the Chair will request members to vote. Where a vote results in a tie the final decision rests with the Chair.

Quorum

Quorum for a meeting of the Steering Committee will require attendance of 50% + 1 of the membership.

Outcomes

Planning, programs and services across the continuum of the health "care" system will enable and support residents within the Capital district, and employees, physicians and volunteers at Capital Health and the IWK in their efforts to improve health outcomes, enhance quality of life, decrease the burden of chronic diseases, and ensure a sustainable publicly funded health care system.

Assumptions

- A population health approach will provide a framework for the work of the Steering Committee.
- The work of the Committee will be based on the best available evidence.
- Internal and external partners will be active participants in the planning, implementation and evaluation.
- Support for collaboration and integration across the continuum of health care and sectors will require financial and human resources on behalf of Capital Health, the IWK, and external partners in order to achieve meaningful impacts on chronic diseases across the District.
- The approach is based on participatory principles, and patient and family centred care.

Shared Language and Understanding

Different professions develop their own language for their domain of work. In our age of increasing specialization there is also increasing complexity of knowledge domains in professional areas. This is one good reason to collaborate – to share knowledge across these domains.

But when various professions are brought together there is invariably some miscommunication that occurs because of different terminology and the assumptions we make of each other. It is always important to check our assumptions about what we think some-one is saying.

See the Module: General Process Tips – Good Dialogue

In our work in chronic disease prevention and management, there are a number of terms and concepts that are understood differently both within and across professional groups. Examples which emerged during the piloting included: population health approach, integration, public health, primary (health) care and community.

The group may find it helpful to take the time to discuss terms and concepts. This might include an organized learning opportunity.

For example, in the Cumberland district, the Accelerating CDPM Day included two informative presentations and discussions about the provincial Integrated Chronic Disease Prevention and Management framework (adapted from the Wagner Expanded Chronic Care model) and the provincial chronic disease prevention strategy. This provided all forum participants with common information and frame of reference for future planning.

Once a common language is established at one level, e.g., a steering committee, care needs to be taken to not assume that there is now a common language when a larger group of stakeholders is engaged or when documents from one group are sent out to a broader audience, even one's own members.

The Cumberland pilot identified developing a communications plan as a key action step following use of the Tool.

Developing a Shared Understanding and Vision for Integration

The term integration is used in many different ways. People working in the area of chronic disease are in the early stages of trying to better understand and integrate population health and prevention approaches into chronic disease planning. Traditionally, planning has focused primarily on individual approaches to patient care.

The whole concept of integration of chronic disease prevention and management is challenging to understand and communicate. Before using the Tool, members of Capital Health's Chronic Disease Prevention and Management Core Committee decided to take time to discuss the concept of integration. They wanted to work towards a shared vision for integration of chronic disease prevention and management to guide their work. This example follows.

What is Integration of Chronic Disease Prevention and Management?

Integration of chronic disease prevention and management is one of the Critical Success Factors in the Tool. When talking about integration in the Tool, we mean:

- Better aligning strategies, visions and goals
- Linking individual and population-level approaches
- Building prevention into chronic disease management initiatives
- Shared planning to coordinate efforts and/or resources
- Mechanisms to support information-sharing, communication and coordination
- Service-level integration to improve comprehensiveness, continuity of care
- Based on who is participating in using the Tool and the goals of the group, a discussion of the group's vision for integration may be helpful. This was the case for Capital Health's Chronic Disease Prevention and Management Core Committee.

Defining Integration in Capital Health

As part of a day-long orientation to the Tool, participants decided that they first needed to clarify the group's vision of integration. The group had already developed a model for integration. However they felt that reviewing the model together was an important step to build understanding. It was also helpful to think about how their integration approach fit within an organizational change process that was underway.

After reviewing their model for integration, the facilitator asked people to explore three questions:

In this model, what does integration of chronic disease prevention and management mean for you? What would it concretely look like?

- Does this represent your vision of integration of chronic disease prevention and management for the district? Why or why not?
- What changes if any would you suggest?

One of the "ah-hahs" for the group was the realization that there were two levels of integration for consideration. For the Capital Health Core Committee:

- "Big I" integration was about comprehensive, system-level change to strengthen chronic disease prevention and management. This included broad strategies to move away from working in silos/buildings towards providing service through learning networks with strong community links and a focus on building health-promoting environments.
- "Little I" integration was about more focused strategies or initiatives to move forward integration, such as community-based health teams the region was establishing.

There was consensus that the Group intended to move forward on both fronts. They set out to learn from implementing focused strategies such as the community-based health team to strengthen integration. At the same time, they made a commitment to keep system-level change on the radar in their chronic disease planning.

Common Values and Goals

One of the 8 Critical Success Factors outlined in the Tool is Common Values and Goals. As your group begins its work, it may decide that it needs to have greater clarity about what it is trying to achieve together in strengthening chronic disease prevention and management efforts. The worksheets provide background material about common values and goals.

This Critical Success Factor was usually identified as a priority by pilot regions. Participants saw it as a fundamental building block to working together - even for using the Tool itself.

The development of common values and goals can happen at various levels. For example, the group using the Tool, e.g., steering committee, task group, work team may find it helpful to spend time assessing the degree to which values and goals are currently shared.

If there are limited shared values and goals, the group may find it helpful to devote time to developing these. It may also make sense to involve the broader stakeholder group. In this way, the development of shared values and goals may take place through a series of steps. It may begin at a committee/group level and then move outward to more broadly engage stakeholders.

An example of a process to develop Common Values and Goals is described in the text box. This group exercise took place at a meeting of the Chronic Disease Prevention and Management Collaborative of the Champlain health region.

This section describes a process for a session to determine common values and goals at a Steering Committee level. It assumes that this critical success factor has already been identified as a priority and that one of the areas of follow-up identified on the relevant worksheets is for the establishment of common values and goals.

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Additional/Related Information:

- General Process Tips (Good Dialogue)
- Stakeholder Engagement
- Doing the Assessment

The Champlain Chronic Disease Prevention and Management Collaborative selected Common Values and Health Goals as one of the Critical Success Factors to include in their initial assessment.

Using the questions on the worksheets for Common Values and Health Goals, the group rated themselves low ("0" or "1") in all areas. For this reason, they decided to dedicate a 3-hour meeting to focus on the following key questions:

- What values should be guiding our work together? (Shared Values)
- What do we want to achieve in our work together? (Common Goals)

As a starting point for discussion, the provincial Chronic Disease Prevention and Management framework and the strategic goals of the regional health plan were reviewed.

A dialogue was facilitated on each of these questions. At the end of the session, the output from the meeting was used to craft a formal Values and Goals Statement that could guide the work of the Collaborative and be shared with others.