

Ontario's Chronic Disease Prevention and Management Framework

More Prevention = More Cure

**Ontario's Chronic Disease
Prevention and Management
Framework**

- Dr. Jack Lee, MOHLTC
 - May 30, 2006

CDPM Framework - Purpose

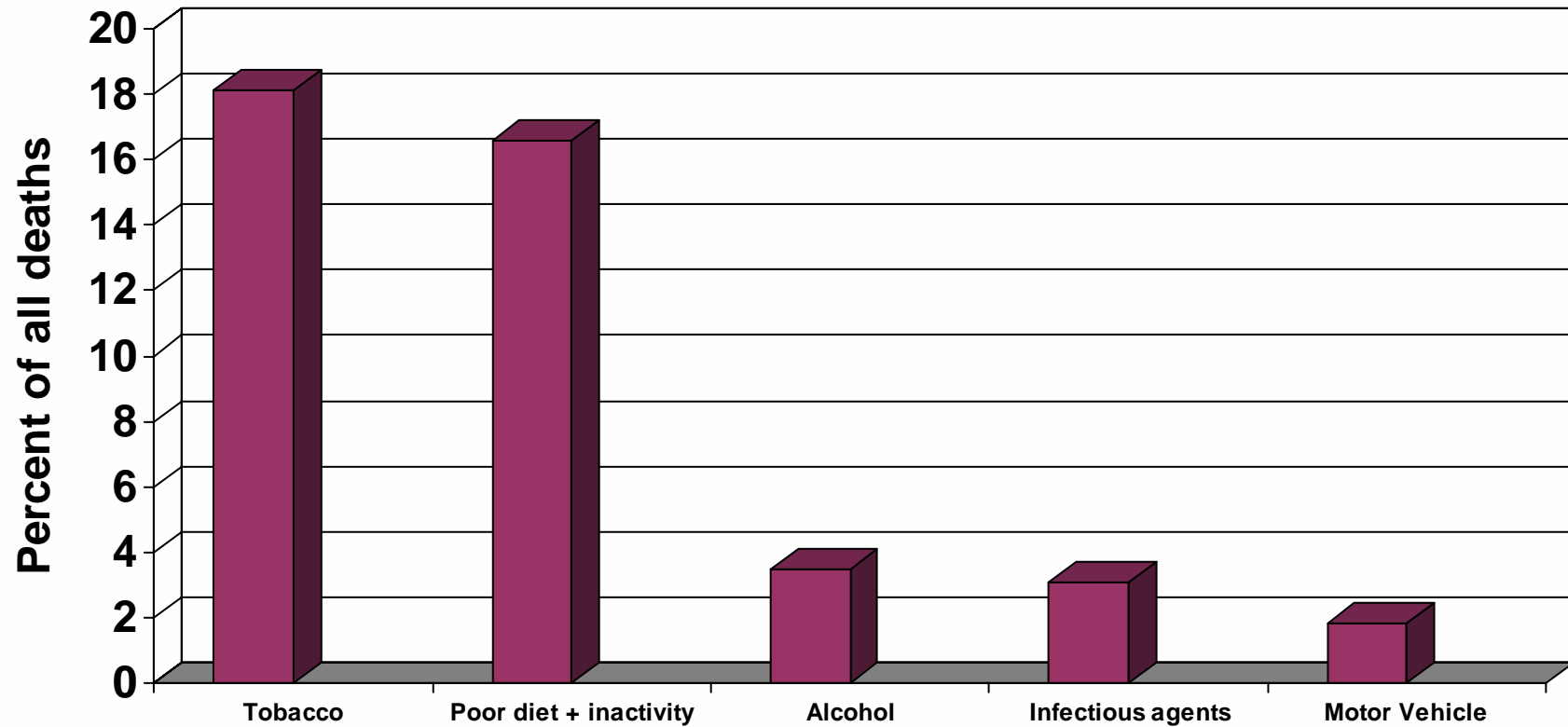
- To provide a common policy framework to guide efforts toward effective prevention and management of chronic diseases
- To guide Ministry transformation initiatives with a focus on CDPM, such as:
 - Primary Health Care Renewal, Family Health Teams
 - Public Health Renewal - health promotion and prevention initiatives
 - Local Health Integration Networks, e-Health strategy,
 - Specific chronic disease strategies
- To engage ministry stakeholders in a systematic approach to addressing chronic disease

Chronic Disease - the Issue

- Ontario - economic burden of chronic disease estimated at 55% of total direct and indirect health costs (EBIC 2002)
- Almost 80% of Ontarians over the age of 45 have a chronic condition, and of those, about 70% suffer from two or more chronic conditions (CCHS 2003)
- Left untreated, chronic diseases like diabetes and depression are causally related to other diseases
- Yet...the current system is designed to treat and cure acute illness, not prevent nor manage chronic illness

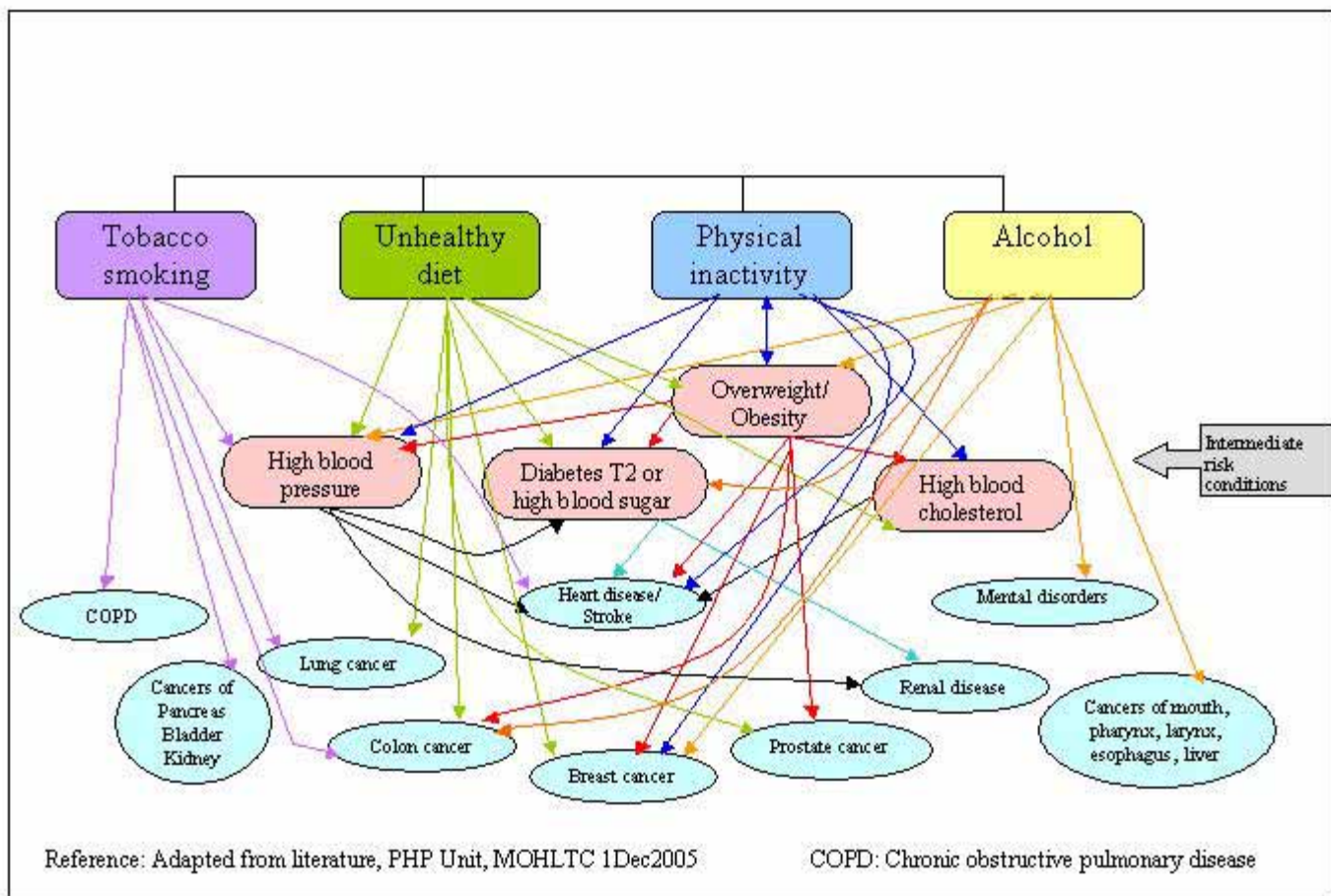
Real Causes of Death

(JAMA 2004;291:1238)



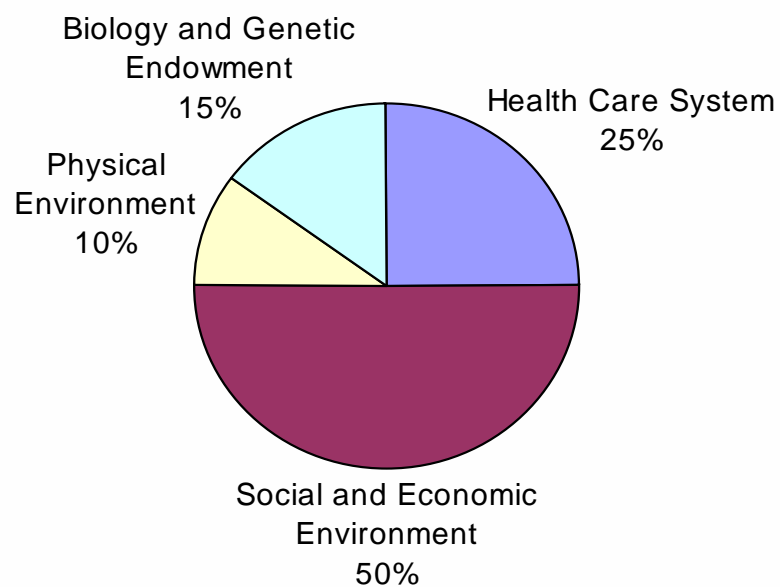
Poor diet to Inactivity ratio: Approximately 1.5 : 1

Chronic Disease Risk Factors are Common to Many Conditions



What Makes People Healthy / Unhealthy?

Estimated Impact of Determinants of Health on the Health Status of the Population



Preventing Chronic Diseases Improves Outcomes

- 90% of type 2 diabetes and 80% of coronary heart disease avoided with good nutrition, regular exercise, elimination of smoking and stress management (WHO, 2002)
- Daily diets high in vegetables and fruit reduce cancer incidence by an estimated 20%
- If 70% of women between ages 50 and 69 had mammography screening, approximately one-third of breast cancer deaths in Ontario could be prevented over a 10-year period
- Colorectal screening by fecal occult blood testing could reduce mortality by 15%-33% in the 50-75 year age group, and 90% of cervical cancer is preventable with regular screening

Keeping people well and preventing disease is the most cost-effective, affordable and sustainable strategy for coping with chronic disease

MANAGING CHRONIC DISEASES IMPROVES OUTCOMES AND DECREASES COSTS

- Multi-disciplinary, community-based Latino diabetes self-care clinic delivered with Latino health professionals licensed outside Ontario yielded 14% absolute reduction in blood glucose levels within one year (London InterCommunity Health Centre)
- Community based breast health program reduced time to diagnosis by more than 50% through coordination of imaging services (Group Health Centre, Sault Ste Marie)
- Congestive heart failure discharge program reduced number of readmissions by 68% in first 9 months by coordinating care & educating clients, families (Group Health Centre, Sault Ste. Marie)

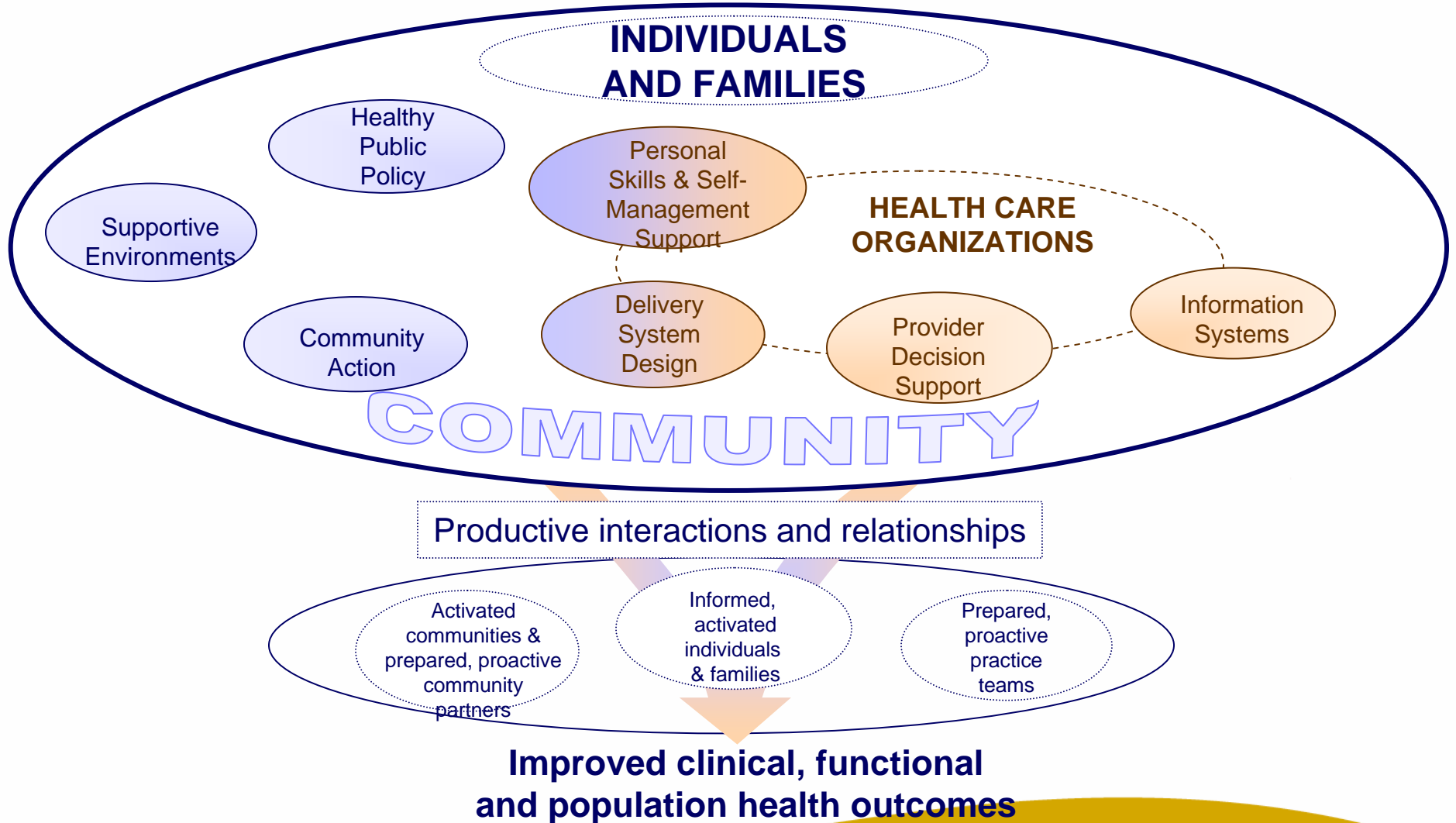
Managing Chronic Diseases Improves Outcomes and Decreases Costs (continued)

- Veterans Health Administration by focusing on primary and ambulatory care reduced hospitalizations, leading to a reduction in acute operating beds from 52,000 to 19,000 over a 7-year period and a drop of about 60% in average daily inpatient population. (Department of Veterans Affairs, Program Statistics April 2003)
- Kaiser Permanente achieved the following results over a 10 year period by using: a multidisciplinary steering group, physician champion for each guideline; registries, reminders, outreach programs, and empowering local clinicians:
 - 30% lower heart disease mortality than other plans
 - 15% decrease in death rates from CHF between 1996-2001
 - smoking rate among N. California KP members was 12% compared to 18% for state as a whole (Kaiser Permanente)

A CDPM Systems Approach Has the Potential to Achieve

- Fewer people with chronic diseases
- Better clinical outcomes, longer more functional life
- Increased efficiency in the system, quality care in the appropriate setting by the appropriate provider at the right time
- Reduced hospitalizations, reduced use of emergency departments and reduced duplication of services
- Increased healthy behaviours

Ontario's CDPM Framework



Framework Components

Health Care Organizations - make systematic efforts to improve prevention and management of chronic disease:

- **strong leadership** (e.g., CDPM champions)
- **alignment of resources, incentives** (e.g., OMA agreement, Admin support, IT support for providers, etc.)
- **accountability for results** (e.g., set goals, measure effectiveness in improving outcomes for clients, population and system)

Delivery System Design - focus on prevention and, improve access, continuity of care and flow through the system:

- interdisciplinary teams (e.g., FHTs with defined roles & responsibilities)
- integrated health promotion and disease prevention (e.g., nutrition and physical activity counselling)
- planned interactions, active follow-up (e.g., care paths, case management)
- adjustments, innovations in practice (e.g., group office visits, central appointment booking service)
- information systems (e.g., EHR; population health data)
- outreach and population needs-based care (e.g., Latin American Diabetes)

Provider Decision Support - integrate evidence-based guidelines into daily practice:

- provider education (e.g, guidelines, working in interdisciplinary teams)
- tools (e.g., disease assessment and management flow sheets)
- clinical information systems (e.g., drug interaction software)
- provider alerts and reminders (e.g., reminders for tests, examinations)
- access to specialist expertise (e.g, team social worker; cardiologist at tertiary care centre)
- measurement, routine reporting/feedback, evaluation (e.g., continuous quality improvement loop for target blood glucose levels in client population with diabetes)

Information Systems – are essential for enhancing information **for providers** to provide quality care; **for clients** to support them in managing their disease on a day to day basis; and for integrating services across health system:

- electronic health records (e.g. test results, treatment, interactions, health status)
- case management software (e.g., tracking systems, automated reminders)
- client registries integrated with EHR to identify patient subpopulations for proactive care (e.g., clients suffering from multiple chronic conditions)
- web support (e.g., interactive clinical practice guidelines)
- information for clients (e.g., health care advice, access to records)
- links (e.g., between team members, care centres)

Personal Skills & Self-Management Support - empower individuals to build skills for healthy living and coping with disease:

- emphasizing the individual's and families' central role in their health, and as a member of the care team
- engaging them in shared decision-making, goal-setting and care planning
- providing access to education programs & health information (e.g., asthma education programs, consumer information)
- behaviour modification programs (e.g., smoking cessation)
- counselling and support services (e.g., self-management support groups)
- integration of community resources (e.g., referral to community physical activity programs)
- follow-up (e.g., reminders, self-monitoring assistance)

Healthy Public Policy - develop and implement policies to improve individual and population health and address inequities:

- **legislation, regulations** (e.g., smoking by-laws)
- **fiscal, taxation measures** (e.g., lowering duty on imported fruit)
- **guidelines** (e.g., Health Canada food guidelines, screening)
- **organizational change** (e.g., flex hours, day care in the workplace)

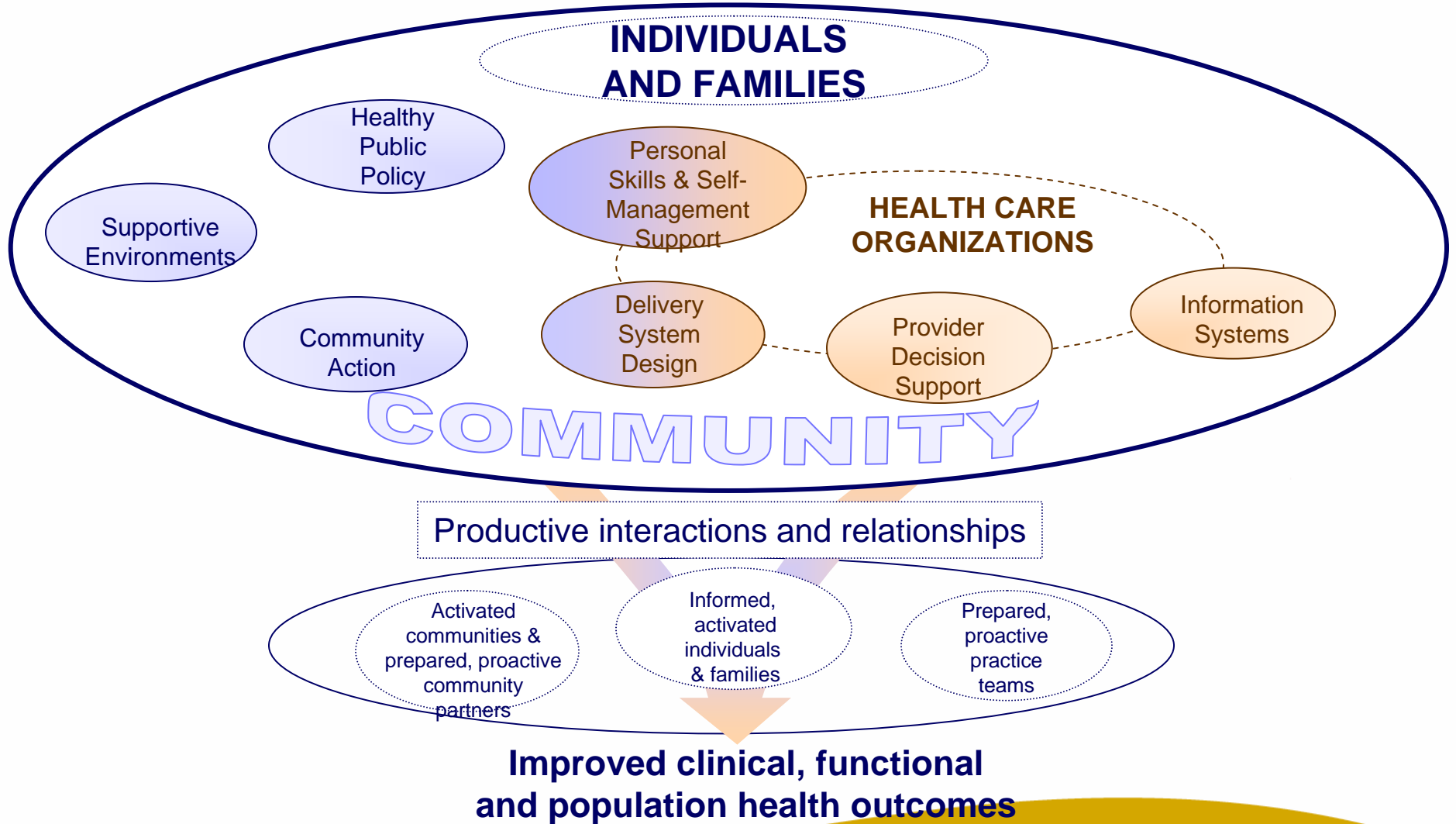
COMMUNITY ACTION - encourage communities to increase control over issues affecting health:

- collaboration between the health care sector and community organizations (e.g. Latin American diabetes program, London, Ont)
- effective public participation and intersectoral collaboration (e.g. community members, private sector and schools providing breakfast nutrition/physical activity programs)

Supportive Environments - remove barriers to healthy living and promote safe, enjoyable living and working conditions:

- **physical environments** (e.g., safe air, clean water, accessible transportation, affordable housing, walking trails, bicycle lanes)
- **social and community environments** (e.g., daily physical activity in schools, seniors programs in community centres, on-site health promotion programs in the workplace)

Ontario's CDPM Framework



What Characterizes a “Prepared, Proactive Practice Team”?

**Prepared,
Proactive
Practice
Team**

At the time of the visit, they have the consumer information, decision support, people, equipment, and time required to deliver evidence-based clinical management, health promotion/prevention, and self-management support

What Characterizes “informed activated individuals & families”?

**Informed,
Activated
Individuals &
Families**

Individuals understand the disease process, are part of the care team, and realize his/her role as the daily self manager. Family and caregivers are engaged in the individual's self-management. The provider is viewed as a guide on the side, not the sage on the stage

What Characterizes “Activated Communities & prepared, proactive community partners”?

**Activated
communities &
prepared, proactive
community partners**

Communities are collaborating across sectors and with health care organizations to identify and meet the needs of their population. Individuals and families are linked to community resources

Thank You

For more information about CDPM, please refer to the websites on the attached pages

To request an electronic version of the framework, please contact:

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Chronic Disease Prevention and Management Web Links

Canadian CDPM Web Resources:

Chronic Disease Mgmt in B.C.

<http://www.healthservices.gov.bc.ca/cdm/cdminbc/>

Chronic Disease Prevention in Alberta

http://www.health-in-action.org/library/pdf/AHLN/framework/COMOSH_framework_Dec_2003.pdf

Chronic Disease Prevention Alliance of Canada

www.cdpac.ca

Integrated Chronic Disease Prevention: A brief synthesis of Canadian Initiatives

<http://www.cdpac.ca/content/pdf/CDPAC-%20Synthesis%20of%20Canadian%20Initiatives%20May%204%202004.pdf>

Chronic Disease Prevention and Management Web Links

Canadian CDPM Web Resources: (continued)

The Change Foundation

Seeking Program Sustainability in Chronic Disease Management: The Ontario Experience – May 2004

[http://www.changefoundation.com/tcf/TCFBul.nsf/\(\\$DocID\)20040514084846VWOO-5YYH2H?Open Document](http://www.changefoundation.com/tcf/TCFBul.nsf/($DocID)20040514084846VWOO-5YYH2H?Open Document)

Ontario Chronic Disease Prevention Alliance (OCDPA)

<http://www.opha.on.ca/projects/ocdpa.html>

OCDPA mission is to improve the health of Ontarians through leadership that supports collaborative action to promote healthy living and to address the determinants of health necessary for chronic disease prevention.

The Ontario Chronic Disease Prevention Alliance first met in February 2003 in recognition of the fact that there was a momentum developing nationally for chronic disease prevention as well as in individual provinces.

Chronic Disease Prevention and Management Web Links

Canadian CDPM Web Resources: (continued)

Nova Scotia Chronic Disease Prevention Strategy

http://www.gov.ns.ca/ohp/repPub/CDP_Strategy_Report_Final_October30.pdf

Group Health Centre, Sault Ste. Marie, Ontario

<http://www.ghc.on.ca/home.html>

PRIISME CDM projects in Ontario

http://www.gsk.ca/en/media_room/news/priisme_en.pdf

National Home Care and Primary Health Care Partnership Project

http://www.cdnhomecare.ca/primary/public_display/index.php

Chronic Disease Prevention and Management Web Links

Canadian CDDPM Web Resources: (continued)

International CDDPM Web Resources:

WHO Preventing Chronic Diseases

http://www.who.int/chp/chronic_disease_report/en/index.html

This WHO global report, “Preventing chronic diseases: a vital investment”, makes the case for urgent action to halt and turn back the growing threat of chronic diseases. It presents a state-of-the-art guide to effective and feasible interventions, and provides practical suggestions for how countries can implement these interventions to respond successfully to the growing epidemics.

Chronic Disease Prevention and Management Web Links

Canadian CDPM Web Resources: (Continued)

Improving Chronic Illness Care (U.S. Robert Wood Johnson Foundation)

<http://www.improvingchroniccare.org/>

Promoting effective change in provider groups to support evidence-based clinical and quality improvement across a wide variety of health care settings.

CDPM in Australia

<http://www.nphp.gov.au/publications/strategies/chrondis-bgpaper.pdf>

The Background Paper presents a national framework for system-wide strategic action that draws on the evidence about underlying determinants of poor health, knowledge of risk factors that are common to a number of diseases, and a lifecourse perspective on predisposing factors.

Chronic Disease Prevention and Management Web Links

Canadian CDPM Web Resources: (Continued)

The framework is based on public health principles and practice, with a strong emphasis on health promotion, and describes how this practice can be incorporated across the continuum of care. The Paper was endorsed by the Australian Health Ministers' Advisory Council as the basis for further national collaborative action. This is being pursued by the NPHP under its agendas specific to nutrition, physical activity and injury prevention, and through its links with the National Health Priority Action Council and the Australian Chronic Disease Prevention Alliance.

Centre for Health Improvement (U.S. California)

Health Policy Guide provides evidence-based, peer-reviewed policy guidance and resources to support advocacy and decision-making at the state and local levels. Search or browse over 150 policy topics below.

<http://www.healthpolicyguide.org/>

Chronic Disease Prevention and Management Web Links

Canadian CDPM Web Resources: (Continued)

Department of Health - Improving Chronic Disease Management (U.K.)

<http://www.dh.gov.uk/assetRoot/04/07/52/13/04075213.pdf>

Improving Care for Long Term Conditions -King's Fund Reading List with links
(U.K.)

http://www.kingsfund.org.uk/resources/information_and_library_service/reading_lists/

<http://www.kingsfund.org.uk/document.rm?id=198>

RAND Corporation - Improving Chronic Illness Care Evaluation (U.S.)

<http://www.rand.org/health/projects/icice/findings.html>

Chronic Disease Prevention and Management Web Links

Canadian CDPM Web Resources: *(continued)*

Kaiser Permanente's Care Management Institute

<http://www.kpcmi.org/>

Kaiser Permanente's Care Management Institute (CMI) is a unique, pioneering institution with a mandate to drive, fund, and catalyze care management activities throughout our non-profit HMO. CMI strives "to make the right thing easier to do."

Related Conferences:

Chronic Disease Management: The Calgary Conference

<http://www.cdmcalgary.ca/Default.aspx?tabid=50>