

Chronic Disease Prevention and Management Planning Day Summary Notes

Friday, May 9, 2008
10:30 p.m. to 3:30 p.m.

Present:

Mieke Busman	Janine Black	Sandra Jordan
Lori Marshall	Tanis Fretter	Mike Hindmarsh: Facilitator, Hindsight Consulting
Peggy Lewis	Katherine Campbell	
Susan Fairservice (videoconference)	Lori Wilson	
Dr. Terry O'Driscoll	Marlis Bruyere	
	Barb Adams	

Regrets:

Dr. Robert Elgie	Janet Gordon	
Diane Hiscox		

LHIN Staff:

Gwen DuBois-Wing	Heather Gray	Laura Kokocinski
Kristin Shields	Shirley Salt	Cory Russell
Karen Ingebrigtsen		

Summary of Discussion	
	<p>Introductions & Setting the Stage</p> <p>Participants introduced themselves and stated their expectations for the planning day. The intention of the meeting was described as an opportunity to examine possible tangible ways in which chronic disease prevention and management might be improved in the North West LHIN with the creation of a list of possibilities as the end product. A CDPM work plan will then be drafted based upon the discussion.</p>
	<p>The Chronic Care Framework and System Change</p> <p>Consultant, Mike Hindmarsh provided an overview of the Chronic Care Framework. He focused on 5 key areas in the framework where achieving change might be possible including: Self Management Support; Delivery System Design; Provider Decision Support; Community Action and</p>

	<p>Information Systems. A conversation then ensued related to each of the five attributes and potential initiatives were considered for each area. As the discussion related to each of these areas was lengthy, responses have been summarized in clusters related to specific topics.</p>
	<p>Self Management Support</p>
	<p>The importance of building capacity in the area of self management was identified. As a follow up to the Stanford Master Training session, the need to have a follow up session was identified. This session is planned for June 17.</p> <p>Building capacity in the area of self management was identified as an important goal. The need for increased awareness and capacity amongst clients and providers was suggested several times and it was agreed that a common definition and broad marketing of the concept would help to increase capacity. It was suggested that a common language for both providers and patients would support this further. The need for basic self management training for all providers was also discussed.</p> <p>Three broad barriers to engaging in self management planning with clients were identified - clinician time pressures, lack of experience, and client expectations that clinicians have the answers. The need to spread the concept of taking responsibility for one's own health and self managing chronic illness was discussed.</p> <p>Potential for public health to be involved in an awareness campaign aimed at responsibility for health across various age groups was suggested. The need to connect the dots for people as many do not associate their behaviours with specific health outcomes was put forth. With the high rate of unhealthy behaviours in the North West this was considered to be particularly relevant.</p> <p>The importance of giving people the tools they need to self manage was agreed upon. Enablers such as increased health literacy, access to healthy food and linking people with quality resources available in their communities were suggested.</p> <p>"Meeting the people where they are at" – whether that is in the baseball diamond, the shopping mall, the school or the seniors' centre was identified as an alternative to the current trend to have people coming to the health system. This might include skills training for people in food preparation or building strong, healthy communities in other ways. Working with lay people was considered important in helping communities help themselves.</p> <p>Receiving care from appropriate care provider was suggested as a way of improving self management. Lack of time was cited as a common reason that physicians in particular, do not participate in self management activities with clients. Having other health professionals connect with clients at the right time was identified as a strategy that would increase the likelihood of this taking place.</p>

The importance of culturally appropriate interventions was suggested – in particular for Aboriginal people.

The creation of widely available “Reach Boxes” for Self Management Support training was also suggested. The content of information should be disease neutral, clear and brief. The provision of patient education materials such as fact sheets was suggested as an appropriate starting point.

The need for self management training to be integrated into the curriculum for students in health professional programs was identified. Meeting with faculty from various health professional programs was suggested as a way of facilitating this.

The need to set goals with clients as an important component of self management was reiterated. The client must identify what he/she is prepared to do. The power of internal motivation was highlighted.

An inventory of quality community resources was identified as a key prerequisite to making linkages for clients with quality services. Lay persons can often be very helpful with follow up.

The importance of leveraging videoconferencing as much as possible to serve people in rural/remote areas was also suggested.

Delivery System Design

The need to improve communication amongst health service providers was identified as an important theme. More broadly, the need for all components of the system to communicate was suggested such as public health and primary, acute, chronic and long term care, community agencies, employers and schools. The benefits of internal multidisciplinary meetings inside were identified. Ways of building this into busy schedules was discussed.

Innovative solutions to access to service challenges such as the use of mobile units to travel to patients were suggested. The potential to expand this reach through expanded use of mobile units and videoconferencing was identified.

Leveraging existing resources such as 211 was suggested to expand access to information and support easier navigation of the complex health system. Resources such as this might be better advertised.

A good inventory of existing services would support improved referrals to quality community programs.

Improved linkages between specialty practice and family practice was suggested.

The need to leverage the skills, knowledge and judgement of expert clinicians approaching retirement was discussed. Innovative ways of using the skills of these people should be

	<p>considered.</p> <p>The concept of a Chronic Disease Network for the Northwest was suggested. There was limited discussion around this concept.</p> <p>The potential for First Nations communities to be included in the Reach Box initiative was discussed. Materials would have to be culturally appropriate in this case.</p> <p>Innovative ways of increasing access to primary care were discussed. Alternative approaches such as NP led clinics were suggested. The importance of timely access to primary care was highlighted as a strategy in improving chronic disease management and preventing acute exacerbations.</p> <p>The possibility of leveraging the new CCHSA standards to assess developments in the North West LHIN related to CDPM was discussed.</p>
	Decision Support
	<p>The need to increase use of the existing best practice guidelines was identified. This might be achieved by increasing access through the provision of guidelines in a Reach Box, the creation of easy access on-line and/or the development of a DVD.</p> <p>The dissemination of quality improvement strategies on-line was suggested. There is potential to link some groups such as FHTs to try out ideas. Academic partnerships might facilitate this.</p> <p>Site visits by preceptors to offer training in the area of decision making related to chronic disease prevention and management was suggested. This mentoring is effective in changing practice.</p> <p>Simple tools to prompt implementation of best practices created for posting on the walls of clinician offices was identified as a possible quick win.</p> <p>Health units might be involved in decision support around prevention.</p> <p>The need to move forward with ICT which includes decision support software was identified.</p> <p>I</p>
	Information Systems
	<p>The need for quality assurance in data entry was suggested. If the required data is not entered consistently, limitations in the usefulness of the data will occur.</p> <p>Provincial coordination of the software being purchased for clinical application in chronic disease management was suggested as a way of improving integration of care. The magnitude of choice that currently exists has resulted in a patchwork of different software being used throughout the</p>

	<p>region.</p> <p>Registry functionality has emerged as an issue when purchasing software. Having information available on the various software choices was identified as a possible strategy to support clinicians when purchases are made.</p>
	<p>Community Resources</p>
	<p>Lack of information re available community resources to support people with chronic illness was identified as an issue. The creation of “one pagers” which help providers to get patients to the appropriate resources was suggested. This could be parcelled with the Reach Box concept.</p> <p>Expanded 211 awareness was put forth as a way of expanding awareness of services without duplicating an existing service.</p> <p>It was suggested that LHIN wide inventories of community resources would be helpful</p> <p>Meeting people where they are – at community centres, schools, etc., was identified as a way of broadening the reach of primary care in educating people re prevention and management of chronic disease.</p> <p>The importance of teaching children with chronic diseases self management support was suggested.</p> <p>Enhanced linkages between health providers and educators, physical education teachers, and the developers of school curriculum was identified as a possible way to increase awareness of the need for responsibility for one’s own health. Health literacy of children might also be increased through conversations with school board officials</p> <p>On a broader level, coalition building across the community was suggested as a way of improving population health status. Employers, schools, family health teams, community health centres and primary caregivers were suggested as possible participants. Coalition building was described as an ambitious undertaking that would take years to establish.</p> <p>Organizing care for the developmentally delayed was suggested</p> <p>Programs to deal with stress management and change management in the community were suggested.</p>

	Closing Comments/Next Steps:
	The importance of ongoing, multifaceted planning in the area of Chronic Disease Prevention and Management was emphasized. Summary meeting notes will be sent to participants followed by a draft work plan for consideration by members of the Advisory Team. The next meeting to discuss the work plan is scheduled for June 27 from 10 am until 12 pm. Videoconferencing will be arranged for out of town participants.
	Adjournment
	The meeting was adjourned at 3:30 p.m.