



## **Improving Health Together:**

A Policy Framework for Chronic Disease Prevention and Management in Newfoundland and Labrador





## Message from the Minister

### Chronic Disease Policy Framework

December 2011



I am pleased to present **Improving Health Together: A Policy Framework for Chronic Disease Prevention and Management in Newfoundland and Labrador**. This document provides a comprehensive and coordinated approach that considers the common issues and needs of all those living with or at risk for chronic disease. This framework will guide our government over the next several years as we work to manage and prevent chronic disease in Newfoundland and Labrador.

Over the course of the last several years, the Provincial Government has illustrated its commitment to not only enhancing health care services throughout the province, but has invested significantly to improve the overall health and well-being of Newfoundlanders and Labradorians.

This policy framework will build on that commitment. **Improving Health Together** is guided by six core policies that focus on self-management, prevention and awareness, health care delivery, practice guidelines, information systems and research, and community action.

The Provincial Government has undertaken several initiatives that work towards promoting health and wellness, including the Poverty Reduction Strategy, the Provincial Wellness Plan, the Provincial Healthy Aging Policy Framework, Working Together for Mental Health, the Recreation and Sports Strategy, as well as disease-specific initiatives like the Cancer Control Strategy and the Provincial Kidney Program.

Our policy framework for the prevention and management of chronic diseases in the province will complement our current initiatives and help inform individuals of the signs of chronic disease, provide programs and services to manage and prevent chronic disease, and provide avenues so that people can address chronic disease in their own home, in their community and throughout the province.

Sincerely,

A handwritten signature in black ink that reads "Susan Sullivan".

Honorable Susan Sullivan  
MHA, GrandFalls-Windsor-Buchans  
Minister of Health and Community Services



## Executive Summary



### Vision

Newfoundland and Labrador will be a place where individuals at risk for or living with a chronic disease, can achieve optimal health and well-being with the support of the community and the health care system.

### Mission

To create a supportive, evidence-based, and coordinated system that meets the needs of individuals at risk for or living with a chronic disease.

### Guiding Principles

The following principles will guide chronic disease prevention and management:

- Client-centered
- Accessible
- Evidence-based
- Integrated
- Accountable
- Long-term and sustainable

### Key Concepts

The Expanded Chronic Care Model (ECCM) (see Appendix) provides a common basis for coordinating programs and services for individuals with chronic disease. It can be used to develop effective changes in the health system that support improvements in the prevention and management of chronic disease. The model also supports the development of disease-specific programs and services. **Improving Health Together** is based on this model.

### Priority Areas of Focus

This policy framework will focus on a select number of chronic diseases that affect many individuals and have a high impact on quality of life.

- Arthritis
- Cancer
- Chronic pain
- Diabetes
- Heart disease
- Kidney disease
- Lung disease
- Stroke

### Policy Statements

The policy statements, based on the elements of the ECCM, provide the overall approach for improving chronic disease prevention and management. Future actions over the next several years will stem from these policy statements.

- **Self-Management:** Being the manager of your own health
- **Prevention and Awareness:** Promoting health and preventing disease
- **Health Care Delivery:** Organizing and coordinating services to meet the needs of individuals
- **Practice Guidelines:** Using current information and standards to provide quality care
- **Information Systems and Research:** Collecting and using data to guide and monitor programs and services
- **Community Action:** Working together for better health





## Introduction



In Newfoundland and Labrador, the rates of chronic disease are significant. Of residents 12 years of age and up, over half (approximately 61 per cent) report having at least one chronic disease<sup>1</sup>, and many have more than one. Chronic disease is the biggest threat to the health of the population and to the sustainability of the health care system. It also poses a significant challenge for communities and the labour force where good health is essential for the well-being of individuals and the continued prosperity of the province. The human and economic costs of chronic disease cannot be ignored.

The World Health Organization defines chronic diseases as, “diseases of long duration and generally slow progression.” Common themes found in other definitions state that chronic diseases:

- Have many causes but often share common risk factors
- Usually begin slowly and develop gradually over time
- Can occur at any age, although they become more common in later life
- Can impact quality of life and limit daily activities
- Require ongoing actions on a long-term basis to manage the disease, with involvement from individuals, health care providers, and the community

While chronic diseases can include both infectious diseases, such as HIV/AIDS, and non-infectious diseases, **Improving Health Together** will focus on a select number of non-infectious diseases and conditions<sup>2</sup> that affect a large portion of the population and have a significant impact on quality of life.

These include:

- Arthritis
- Cancer
- Chronic pain
- Diabetes
- Heart disease
- Kidney disease
- Lung disease
- Stroke

Contributing to the prevalence of chronic disease are the high rates of modifiable risk factors, such as smoking, physical inactivity, unhealthy diets, and excess alcohol use. As well, chronic diseases become more common as people get older. Newfoundland and Labrador has an aging population, with 16 per cent of its residents now 65 years of age or older. Other factors, including low incomes, poor social supports, and unhealthy physical environments, also influence the development of chronic disease. All of these factors combined can contribute to a decreased quality of life for individuals, and increased costs to the health care system. **Improving Health Together** will build on and collaborate with other Provincial Government initiatives to improve health and wellness, such as the Provincial Wellness Plan, the Recreation and Sport Strategy, and the Poverty Reduction Strategy.

<sup>1</sup> “Chronic disease” in this case includes: asthma, chronic bronchitis, high blood pressure, migraine headaches, diabetes, back problems excluding fibromyalgia and arthritis, heart disease, cancer, intestinal or stomach ulcers, effects of stroke, urinary incontinence, Alzheimer’s disease or other dementia, mood disorders (such as depression, bipolar disorder, mania or dysthymia), anxiety disorders (such as phobia, obsessive-compulsive disorder or panic disorder), arthritis excluding fibromyalgia, bowel disorders (such as Crohn’s Disease, ulcerative colitis, irritable bowel syndrome or bowel incontinence), and chronic obstructive pulmonary disease/emphysema

<sup>2</sup> “Diseases and conditions” will be described as “diseases” throughout this document.



## Introduction (continued)

Although chronic diseases are the most common causes of death and the most costly to the health care system, they can often be prevented and better managed to prevent complications and progression of disease. This requires a comprehensive, coordinated approach with:

- All parties working together, including individuals, the community, and health care providers
- Individuals being supported to become more engaged and active in managing their own health
- Use of the most current evidence and guidelines to provide quality care in a coordinated, team-based approach with many disciplines working together
- An increased focus on promoting health and preventing disease and the progression of disease

**Improving Health Together** is a policy framework which outlines a long-term approach for addressing chronic disease prevention and management in Newfoundland and Labrador. The framework document lays the foundation for actions to be developed and implemented over several years. Some outcomes can be achieved in the short term (one to two years) while others will require a much longer term (five to ten years).



# Chronic Disease in Newfoundland and Labrador



## The changing face of disease

The face of disease has changed since the mid-1800s and early 1900s. The major causes of death in colonial Newfoundland were infectious illnesses such as tuberculosis, whooping cough, and influenza. Outbreaks of cholera, diphtheria, and typhoid fever were also a constant threat. The first health services in Newfoundland and Labrador were set up to deal with those types of infectious illnesses.

In general, improvements to nutrition, water and sewer services, vaccines, and medical treatments have brought many infectious illnesses under control, reduced infant mortality, and allowed people to live longer. A baby born in Newfoundland and Labrador during the early 1970s had a life expectancy of about 72 years. Today, life expectancy at birth is roughly 78 years. Longer lifespans, sedentary lifestyles and other societal changes have contributed to the increase of chronic disease.

## Rates of chronic disease in Newfoundland and Labrador

The leading causes of death in Newfoundland and Labrador are now diseases of the circulatory system, such as heart disease and stroke; cancer; and respiratory diseases. These diseases accounted for 71 per cent of all deaths in 2006.

Table 1 gives examples of the percentage of the population living with select chronic diseases in 2009-10.

About 61 per cent of Newfoundlanders and Labradorians, aged 12 and older, live with one or more chronic diseases. Nearly one third of that group has three or more chronic diseases.

Chronic disease and risk factor rates tend to be even higher among Aboriginal people. In Canada, Aboriginal people are three to four times more likely to experience type 2 diabetes than non-Aboriginal people.

**Table 1: Rates of Select Chronic Diseases in Newfoundland and Labrador**

Chronic Disease	% of population affected
Arthritis	23%
Chronic Pain	17%
Diabetes (Type 1 or 2)	8%
Heart Disease	6%
Cancer	5%
Lung Disease	5%
Effects of Stroke	1%



## Chronic Disease in Newfoundland and Labrador (continued)

### Modifiable risk factors of chronic disease

Contributing to the high rates of chronic disease are high rates of common risk factors such as poor nutrition, physical inactivity, smoking, and excess alcohol use. These risk factors give rise to other intermediate risk conditions, such as high blood pressure, high blood sugar, excess body fat, and high blood cholesterol. In addition, mental and emotional stress can be factors in the development or progression of chronic disease. These conditions put many individuals in Newfoundland and Labrador at a higher risk for developing a chronic disease. The World Health Organization states that “up to 80% of cases of coronary heart disease, 90% of type 2 diabetes cases, and one-third of cancers can be avoided by changing to a healthier diet, increasing physical activity and stopping smoking.”

#### Of Newfoundland and Labrador residents (12 years and older, except where noted)

- **73%** do not eat enough fruits and vegetables
- **53%** are not physically active
- **20%** are current smokers (15 years and older)
- **33%** drink five or more alcoholic drinks at least once per month
- **23%** have high blood pressure

#### In addition

- **65%** of adults and **30%** of children are overweight or obese

### Chronic disease and the aging population

Declining birthrates, migration trends, and longer lifespans have meant that over the past 30 years, the average age in Newfoundland and Labrador has risen faster than that of any other province in Canada. Today, 16 per cent of the population is over 65 years of age. By 2020, it is expected that 22 per cent of the population will be over 65, and 46 per cent will be over 50 years of age.

Thirteen of the 20 most common chronic diseases in Canada are linked to age. In 2009-10, 88 per cent of Newfoundland and Labrador seniors aged 65 or older had one or more chronic diseases. In that year, 48 per cent of seniors aged 65 or older had arthritis, 21 per cent had diabetes, and 22 per cent had heart disease. As the general population continues to age, and as people live longer with their health conditions, the rates of chronic disease are expected to rise. Programs and services related to chronic disease prevention and management will need to adapt to the changing needs of an aging population.

**Perfect health is not required for healthy aging. Making the most of health is key to positive aging. All people can have good health and well-being. They can even do so as they cope with impairments and health issues. One can learn to live well in spite of limits. This is a true mark of health and strength.**

**Provincial Healthy Aging Policy Framework**



## Chronic Disease in Newfoundland and Labrador (continued)



### Other factors that influence health

There are many other factors that affect health including income level, education level and where an individual lives. It is clear that social, economic and environmental conditions influence a person's ability to maintain good health, prevent chronic disease and manage the complications of disease.

Individuals living with low income may face difficult choices based on their financial circumstances. Their ability to afford adequate housing, healthy food, transportation and other basic needs is often challenging, and may be especially so, due to the added costs associated with living with a chronic disease. These costs can include medications, devices, and travel to appointments. As well, having a chronic disease may create barriers to working or lead to the loss of employment. There is a relationship between chronic disease and income level. For example, diabetes rates in low income populations are double those found amongst high income groups. This results in individuals living with low income using about twice as many health care services as those with high incomes. The social and economic impacts of living with a chronic disease are significant.

**Poverty is the most significant barrier to well-being for all who experience it. Poor families experience a greater incidence of...obesity and specific diseases, such as diabetes, cardiovascular disease and other chronic conditions, particularly those caused by environmental factors.**

### **Reducing Poverty: An Action Plan for Newfoundland and Labrador**

In order to achieve optimal health, all of the determinants of health must be considered. An effective response to chronic disease prevention and management includes government, community groups, employers, the health system, and individuals working together to address these bigger issues.

### **The Determinants of Health**

- Income and Social Status
- Social Support Networks
- Education and Literacy
- Employment/Working Conditions
- Social Environments
- Physical Environments
- Personal Health Practices and Coping Skills
- Healthy Child Development
- Biology and Genetic Endowment
- Health Services
- Gender
- Culture



## **Improving Health Together:**

A Policy Framework for Chronic Disease Prevention and Management in Newfoundland and Labrador

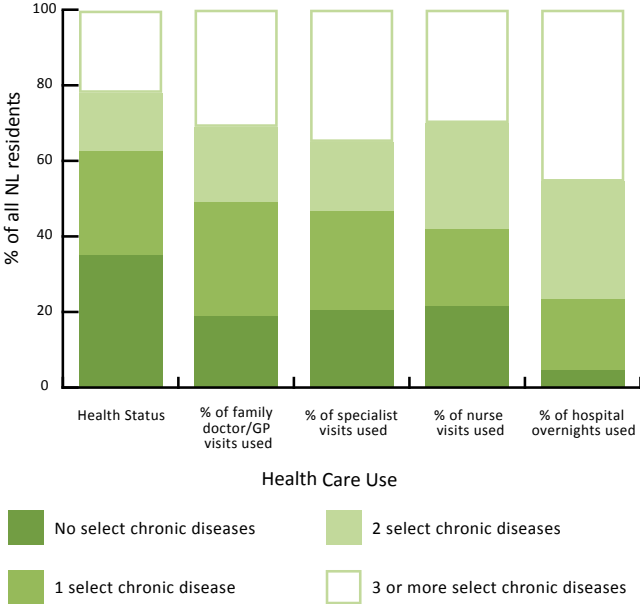
Chronic Disease in  
Newfoundland and  
Labrador  
(continued)

The impacts of chronic disease

Chronic disease impacts more than an individual’s physical health, as it can also limit day-to-day activities. About one third of the population of Newfoundland and Labrador feels unable to fully participate in activities at home, school, work, or in other settings, because of health issues.

As well, chronic disease can impact an individual’s interactions with the health care system. For example, when compared to people with just one chronic disease, those with three or more chronic diseases use more health care resources (Figure 1). This trend remains true regardless of the age of the individual.

Figure 1: Relative use of health care services in Newfoundland and Labrador (2009-10)



Chronic disease places a heavy burden on the health care system in terms of demand for services and cost for treatment. The total economic cost of chronic disease can include direct costs such as hospital costs, physician visits and the cost of drugs. In 2009-10, the Government of Newfoundland and Labrador spent over \$1.88 billion in health and related services through the Regional Health Authorities, \$400 million towards publicly funded (MCP) physician services, and \$141 million for medical and drug subsidy programs.

As noted previously, chronic diseases also have an impact on the workplace. Chronic diseases are associated with indirect costs such as productivity losses. Absentee rates can be high and there are increased benefit costs for medications and treatments. There are also costs associated with modifications to workspaces, schedules and equipment for individuals living and working with a chronic disease.

The Canadian Diabetes Association estimated the economic cost of diabetes in Newfoundland and Labrador to be approximately \$254 million in 2010 (including \$214 million in indirect costs). These costs are expected to increase to \$322 million (\$260 million in indirect costs) by 2020. Much of this increase is determined by the number of new people expected to be diagnosed with diabetes in the future.

Chronic diseases have a great impact on individuals, their families, the economy, and the health care system. There is potential to improve health outcomes and the quality of life for individuals at risk for or living with a chronic disease. As well, there is great potential for health care system savings by detecting and managing disease early to avoid costly complications of chronic diseases.



## Working Together and Building on Success



**Improving Health Together** is one of the Provincial Government's many strategies to promote healthy living. It builds on other Provincial Government initiatives that seek to improve health and well-being such as the Provincial Wellness Plan which focuses on promoting and supporting healthy eating, physical activity and being smoke free.

**Improving Health Together** also provides an opportunity to improve health outcomes by focusing on areas such as self-management, standards of care, team-based care and stronger partnerships between the health care system and community agencies.

**Improving Health Together** continues to strengthen and advance existing collaboration with many Provincial Government initiatives, including:

- The Poverty Reduction Strategy
- The Provincial Wellness Plan
- The Provincial Healthy Aging Policy Framework
- Working Together for Mental Health
- The Recreation and Sport Strategy

**Improving Health Together** also focuses on disease specific interventions. The Provincial Government has partnered with health-based community organizations to develop the Provincial Cancer Control Strategy and the Provincial Integrated Stroke Strategy. The Provincial Government will continue to collaborate with these and many more organizations as it identifies and implements actions which support the policy framework.

While much work has already been done to support the prevention and management of individual chronic diseases, a comprehensive and coordinated approach is required that considers the common issues and needs of those with chronic diseases.

**Improving Health Together** brings together the many elements of health and wellness with disease-specific strategies. Actions will be organized based on a model that involves individuals, the health care system, and the community. Where needed, the actions will also target special areas and populations such as women, rural areas, Aboriginal people, and low income people and families to achieve effective health outcomes.

**Improving Health Together** uses the Expanded Chronic Care Model<sup>3</sup> as a basis for policies and programs related to chronic disease prevention and management (see Appendix). This model, used by other Provincial Governments and regional health authorities, incorporates a number of elements that have been linked with improved health and health system outcomes and satisfaction for individuals living with a chronic disease.

<sup>3</sup> Barr, V.J., Robinson, S., Marin-Link, B., et al. "The expanded chronic care model: an integration of concepts and strategies from population health promotion and the chronic care model." *Hospital Quarterly*. 2003;7:73–82.



## Setting Direction



### Vision

Newfoundland and Labrador will be a place where individuals at risk for or living with a chronic disease can achieve optimal health and well-being with the support of the community and the health care system.

### Mission

To create a supportive, evidence-based, and coordinated system that meets the needs of individuals at risk for or living with a chronic disease.

### Guiding Principles

The following principles will guide the work of chronic disease prevention and management in Newfoundland and Labrador:

#### *Client-centered*

Individuals are treated with dignity and respect, and are valued in the decision-making processes regarding their health. All aspects of an individual's life are considered in relation to their health including his or her social, economic, environmental, and physical needs. The stories, opinions, and concerns of individuals and key stakeholders are considered in the actions for the prevention and management of chronic disease.

#### *Accessible*

Programs and services are coordinated regionally and provincially to ensure they are consistent and available in the various regions of the province. Barriers to

program participation such as low literacy, disabilities, transportation costs, distances to services, and access to plain language health information are accommodated as much as possible. Modern technology allows for greater access to information and for provision of health services throughout the province.

#### *Evidence-based*

Current research, surveillance, and best practice information informs the development and implementation of programs, services, and practices to address chronic diseases.

#### *Integrated*

Health care services that individuals receive are planned and coordinated across services, settings, and sectors over time. This level of coordination requires a commitment by all parties to a team-based and client-centered approach that includes prevention, self-management, and response to the multiple and changing needs of clients. Approaches to prevent and manage chronic diseases are integrated into all aspects of the daily practice of health care providers to help the individual move easily from one service to another.

#### *Accountable*

Programs and services are monitored to ensure they are providing the best results. Action plans guide the work and regular reports keep the public and stakeholders informed of the progress. When required, client feedback is a critical component in shaping and re-directing programs and services.





## Setting Direction (continued)

### *Long-term and sustainable*

New programs and services are developed which reflect the capacity and resources at the time, ensuring they are cost effective and sustainable. Short-term actions are implemented over time to support long-term priorities, which may take several years to achieve. All actions are developed in collaboration with the Provincial Government's other related strategies and initiatives.

## Policy Statements for Chronic Disease Prevention and Management

Six policy statements set the direction for **Improving Health Together** and identify the kinds of initiatives that will be explored and advanced under this policy framework over time. It is a long-term comprehensive approach which requires all partners – individuals, community groups, employers, health care providers, and governments – working together to improve health. The framework highlights:

- A greater emphasis on individuals being informed and more active in their own health with the support of health care providers and the community
- A planned and integrated approach with many health care providers working together and with the community
- The use of current information and guidelines to provide quality care to better meet the needs of individuals with chronic disease
- A shift towards prevention - preventing disease and preventing complications and the progression of

disease. This will include increasing the awareness and assessment of the risk factors and signs of disease, and integrating health promotion and prevention messages into all aspects of care

### Six Policy Statements

1. **Self-Management:** being the manager of your own health
2. **Prevention and Awareness:** promoting health and preventing disease
3. **Health Care Delivery:** organizing and coordinating services to meet the needs of individuals
4. **Practice Guidelines:** using current information and standards to provide quality care
5. **Information Systems and Research:** collecting and using data to guide and monitor programs and services
6. **Community Action:** working together for better health

### Policy Statement 1

**Self-Management: being the manager of your own health**

Individuals who take an active role in the daily management of their conditions generally experience better health and a better quality of life. Self-management of health slows the progression of disease, often prevents



### Improving Health Together:

A Policy Framework for Chronic Disease Prevention and Management in Newfoundland and Labrador

## Setting Direction (continued)



complications and/or disabilities, and may also reduce the number of hospital visits.

Appropriate learning opportunities, with support from the community and health care providers, can encourage individuals with any type of chronic disease to be more active in their health. New information, skills, and self-confidence increase an individual's ability to manage his or her symptoms and lead a healthier life. Most importantly, it is the individual who decides, with the support of a health care provider, if and when they want to be more involved and are able to develop skills and confidence to manage their health.

Self-management support can be delivered through a variety of formats including government and community-based group programs, self-help resources, web-based modules, video conferencing, and telehealth. Through these methods, individuals learn to problem solve, set personal health goals, choose information to make appropriate decisions about their health, communicate with their health care providers and make changes to improve their health.

Peer-led group programs in the community combined with ongoing counselling and support from health care providers have been the most effective ways to produce long-term benefits. Health care providers who are trained to offer self-management support see the benefits and integrate it as a regular part of ongoing care for individuals with chronic disease.

**Examples of initiatives that could support individuals to manage their health include:**

- Community-based chronic disease self-management programs
- Initiatives that reduce barriers to participation in self-management programs
- Telehealth services to support self-management
- Models of practice for health care providers to support self-management
- Self-management models in other formats (such as web-based or video conferencing)
- Self-management approaches that support unique populations
- Self-management electronic portals for individuals and health care providers

## Policy Statement 2

**Prevention and Awareness: promoting health and preventing disease**

Disease prevention begins with broad-based health promotion efforts. This involves individuals, communities, and the health care system working together to promote health and wellness. Partners can develop healthy public policies, create healthy environments, and strengthen community actions which contribute to healthy people and healthy communities. Efforts which focus on the common risk factors for chronic diseases aim to increase physical activity, improve healthy eating, and reduce



## Setting Direction (continued)



smoking. **Improving Health Together** will build on Provincial Government initiatives such as the Provincial Wellness Plan and the Recreation and Sport Strategy by integrating information and resources developed through these initiatives into chronic disease prevention and management activities.

The next level of prevention will build on these efforts by supporting disease prevention among individuals with such things as high blood pressure, excess body fat, or high blood cholesterol or blood sugar. Regular check ups, which may include tests for these risk factors, and screening for signs of early disease, can help to prevent or identify chronic diseases at a point when treatment may be more successful. Targeted prevention efforts may also be implemented for at-risk populations including women, Aboriginal people, and individuals living with low income.

Individuals must receive clear, consistent, and accurate information about their health and health care services to support them in leading healthier lives. In addition, individuals must have the skills to use the information to make informed decisions and take action for better health.

Information about chronic disease is available from a variety of sources. Public awareness campaigns promote messages about health care programs and services. Health care providers and community agencies deliver information to individuals and families about health and health care services. Information can also be provided in a variety of settings including such things as community

health fairs, cultural events and community feasts and dinners. Regardless of the way the information is delivered, the message needs to be presented in plain language at a level that can be understood by everyone.

Strategies to increase knowledge of preventing disease, reducing the risk factors and preventing further complications of chronic disease are more effective when combined with other strategies such as screening programs and behaviour changes. Building health promotion and disease prevention strategies into all aspects of care will see improvements in health outcomes.

### **Examples of initiatives that could increase prevention and awareness efforts include:**

- Awareness campaigns and initiatives to promote health and prevent disease
- Guides to programs and services
- Screening and assessment tools and initiatives
- Community-based prevention clinics
- Health literacy initiatives



### **Improving Health Together:**

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## Setting Direction (continued)



### Policy Statement 3

#### **Health Care Delivery: Organizing and coordinating services to meet the needs of individuals**

Chronic diseases are complex and varied. Providing the best care for individuals at risk for or living with any type of chronic disease requires changes in the way that health care is organized and delivered. It involves clarifying the roles and responsibilities of health care providers and enhancing the scope of practice where necessary. It requires re-organizing the way care is delivered and implementing new models of practice to best meet the needs of individuals. It also involves health care providers playing a coordination role linking individuals with the services they need in an organized and timely manner.

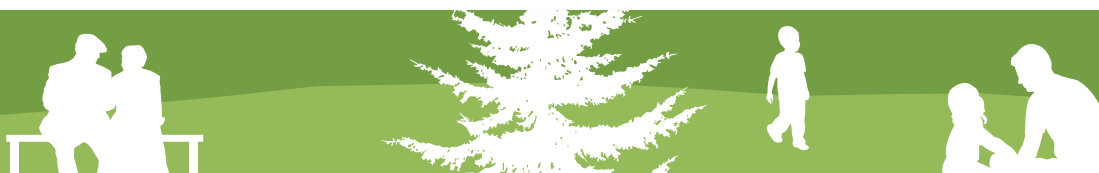
The effective prevention and management of chronic disease requires a long-term commitment and a planned approach to care. Improvement in the quality of care can be accomplished through a team-based approach. Teams can comprise providers such as nurses, dietitians, pharmacists, social workers, home care workers, physiotherapists, physicians and others. The mix of health care providers can be varied and is organized to reflect the needs of the individual. The health care team works with the individual and the family towards identified health goals. In this model, health promotion and disease prevention become a regular part of practice. While recruitment and retention of some health care providers is challenging in some parts of the province, the Department of Health and Community Services is developing a strategic health workforce plan for the province.

New approaches to care increase access to services and provide opportunities for individuals to become more active in their care. Group appointments and clinics for individuals having the same disease may be beneficial for some; for others, internet-based modules for self-management may be more effective. Some individuals may prefer to communicate or schedule appointments with their health care provider by email or through other electronic formats. As well, telehealth solutions such as video conferencing are becoming more widely used. Programs and services can be provided in a variety of ways, in addition to the traditional methods, to best meet the needs of the individual.

Health services will need to be further integrated and streamlined, with strengthened collaboration among primary, secondary, and tertiary care. In doing so, health care providers will be better able to meet the needs of individuals at risk for or living with chronic diseases, with regard to prevention, early detection, and ongoing management. Working together with health care providers and health agencies and associations will achieve these changes over time.

#### **Examples of initiatives that could improve health care delivery include:**

- Primary health care team models of practice
- Team-based care in acute and specialized settings
- Regional networks for programs and services
- Referral processes to improve access to services
- Case management, care planning and coordination



## Setting Direction (continued)



- Provincial coordination of programs and services
- Professional development opportunities that promote team-based care and the client-centered approach
- Strategies to support innovative practice

### Policy Statement 4

#### **Practice Guidelines: Using current information and standards to provide quality care**

The effective prevention and management of chronic disease requires the use of a recommended set of guidelines. Practice guidelines provide health care professionals with the latest recommendations for prevention, diagnosis, management, and treatment of specific diseases. The guidelines are based on current research and use best practices in client care. The development and use of practice guidelines is important for ensuring that decision making and care is consistent in all parts of the province.

To ensure a consistent approach to practice, provincial guidelines will be developed or adopted to best meet the needs of individuals and the health care system in Newfoundland and Labrador. Provincial guidelines will be based on current evidence, and will consider both clinical and cost effectiveness. Health care providers, health based organizations and health research bodies will help inform the development and adoption of provincial practice guidelines.

To be effective, these guidelines must be implemented into daily practice. Health care providers must have access to, and be knowledgeable about, the guidelines. This will require education and the development of tools such as protocols and flow sheets to support the integration of the guidelines.

Sharing basic practice guidelines with individuals at risk for or living with a chronic disease helps them to better manage their health. When individuals understand the reason for the approach to care and the outcomes that are expected, they are more likely to comply with medication regimes, have recommended tests and improve healthy behaviours to best manage their health.

#### **Examples of initiatives that could increase the use of practice guidelines include:**

- Provincial practice guidelines
- Electronic protocols and flow sheets
- Professional development education and training opportunities
- Chronic disease management toolkits (electronic inventories of guidelines, standards, and protocols)

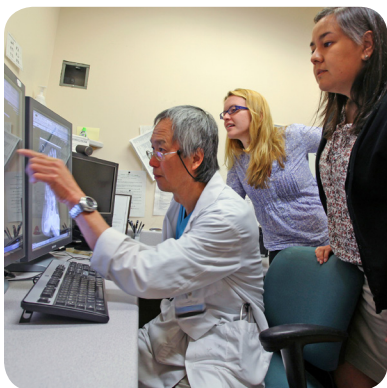


### **Improving Health Together:**

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## Setting Direction (continued)



### Policy Statement 5

#### Information Systems and Research: Collecting and using data to guide and monitor programs and services

Good information is important for providing quality service. To be most useful, data must be collected in a consistent and standard manner. There are a number of ways to collect information to inform good practice. Health care providers need access to timely and relevant clinical information about individuals and groups, as well as information about the entire population in a community or region. Information systems and research initiatives provide opportunities to collect quality information.

Electronic health records and disease registries are information systems that collect individual data in a coordinated and consistent manner. Chronic disease registries are most useful when data is collected and used by the health care provider at the time of the visit with the individual. The registry provides up-to-date information on an individual including test results, assessments, clinical measurements, and services provided by other health care providers. Some registries and electronic records allow health care providers to schedule regular appointments such as routine screening, testing, and follow-up appointments. A registry helps to organize, coordinate, and plan care appropriately for the individual. A registry not only collects individual data, but can be used to assess a group of individuals with similar needs to plan broad-based programs and services in a community or a region. **Improving Health Together** provides an opportunity to build on current work to

develop and implement an electronic health record in the province.

Chronic disease surveillance systems collect data on an ongoing basis from various sources. These systems provide information on such things as the number of new cases of a chronic disease, the number of current cases of a disease, the rates of risk factors for chronic disease, and trends over time at the regional, community, or neighbourhood levels. Surveillance systems can also provide opportunities to assess the information based on demographic factors such as age, income, gender, and culture.

Information about the prevention and management of chronic disease can be collected through research, audits of individual charts, reviews of programs and services, and interviews with individuals, families and caregivers. Such information helps to better understand chronic diseases and assists policy makers and health care providers to take appropriate actions and develop relevant programs and services to provide better care for individuals.

#### Examples of initiatives that could improve the collection and use of quality information include:

- Chronic disease registries
- Chronic disease surveillance systems
- Chronic disease databases
- Electronic health records
- Audits and program reviews
- Research initiatives



## Setting Direction (continued)



### Policy Statement 6

#### **Community Action: Working together for better health**

An individual's ability to effectively manage their health is partly based on the level of support provided by the community in which they live. The community includes local and Provincial Governments, community groups, local workplaces, health care centres, schools, churches, and all residents. Communities can work together to support individuals and families to live healthy through policies, programs, and services. Some examples include: providing safe spaces for being physically active, creating smoke-free spaces, supporting local food production, providing opportunities to learn skills and share information, and setting an example for healthy living in workplaces, at public events and in public places.

There are also many community groups and agencies that have made great contributions in supporting chronic disease prevention and management such as the Canadian Cancer Society, the Arthritis Society, the Newfoundland and Labrador Lung Association, the Heart and Stroke Foundation, the Long Term Pain Association, the Kidney Foundation, the Canadian Diabetes Association, and others. In addition, the Federal Government and Aboriginal groups and governments deliver health programs throughout the province. Agencies offer valuable information and support services to individuals with chronic disease, and provide the latest research evidence to health care providers and decision makers.

Individuals living with chronic disease, and the families and friends who support them, benefit from strong partnerships among the government, the health system, and the community. Referrals to community programs by health care providers greatly increase the likelihood of clients to participate, and ultimately to learn new skills and new information that will help them to better manage their health. Likewise, community programs benefit from the practical support and expertise provided by health care system partners. Partnerships among governments, employers, and community-based agencies and groups allow for the development and implementation of innovative solutions. This might include the development of aligned health messages, and wellness programs and risk factor screening services in workplaces and communities. Continued efforts to support community agency leadership and action will be important for addressing chronic diseases and **Improving Health Together**.



### **Improving Health Together:**

A Policy Framework for Chronic Disease Prevention and Management in Newfoundland and Labrador

## Setting Direction (continued)



Examples of initiatives that could strengthen community action include:

- Chronic disease community grant programs
- Health promotion programs with employers and industry (e.g. healthy eating restaurant programs; reduced sodium products and initiatives; physical activity opportunities; workplace smoking cessation programs)
- Innovative solutions for workplace wellness through strategic partnerships
- Partnerships with federally-funded Aboriginal health promotion and disease prevention initiatives

**The most significant health benefits are achieved when inactive people introduce activity into their daily lives.**

**Active, Healthy Newfoundland and Labrador:  
A Recreation and Sport Strategy for  
Newfoundland and Labrador**





## Conclusion



**Improving Health Together** outlines a long-term approach for the prevention and management of chronic disease in Newfoundland and Labrador. It will guide government over the next several years and lays the foundation for actions to be developed, implemented and monitored over time. The policy framework builds on existing initiatives and investments in the province, and the success of combining the elements of a healthy community with the work of the health care system to produce the best results.

The framework outlines examples of various initiatives to achieve improved health outcomes for individuals at risk for or living with a chronic disease. It identifies supports to help individuals become more involved in their health. It places a focus on promoting health and preventing disease. It promotes organizing health care services, the use of current standards and the adoption of provincial guidelines to provide quality care. Finally, the framework supports working together with all partners in the broader community to improve overall health.

The broader community contributes in many ways to the prevention and management of chronic disease. The development of healthy public policies, the creation of healthy spaces, and the delivery of programs and services are some of the key activities that communities and workplaces can offer. Individuals living with chronic diseases will benefit from the strong linkages between the health care system and the community.

While the rates of chronic disease and their risk factors are high in Newfoundland and Labrador, much work has been done to prevent and manage disease. This policy framework builds on existing work and will collaborate with all partners - individuals, community groups, employers, health care providers, and governments - in doing even more towards **Improving Health Together**.





## Appendix

### The Expanded Chronic Care Model

The original Chronic Care Model was developed by Dr. E. Wagner in 1999 in the United States. This health care service model was developed to support the care of persons with chronic disease. Past efforts to

address chronic disease management focused on single interventions or initiatives. The development of the Chronic Care Model combined a number of strategies to improve the overall management of chronic disease. Approaches such as this model that incorporate a number of strategies have been found to be successful.

### The Expanded Chronic Care Model (Barr, 2003)



## Appendix (continued)

Further work by Dr. V. Barr of the University of Victoria, British Columbia, led to the development of the Expanded Chronic Care Model (ECCM) in 2003. This model provides a broader approach to the prevention and management of chronic diseases. It combines elements of health promotion and population health with the work of the health care system. The ECCM demonstrates a clear association between the health care system and the community.

It is an action driven model designed to broaden the focus of practice and work towards health outcomes for individuals, communities, and populations. This expanded version of the model has been widely adopted within the Canadian context, as it highlights the importance of healthy public policy, community action, and the broader environment in supporting health and wellness.

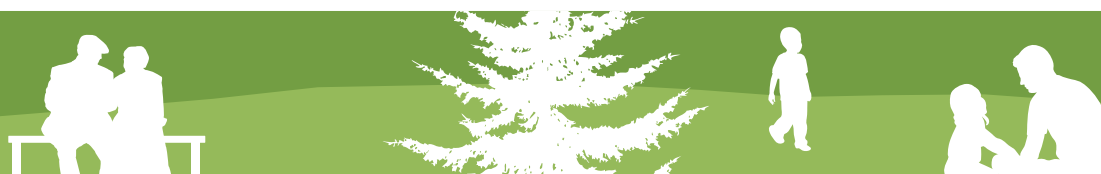
The Model combines elements in the health system, including

- **Self-Management** – Implementing various approaches to enhance skills and capacities for personal health and wellness. Individuals are offered support by their health care provider and in the community to develop skills to improve their health.
- **Decision Support** – Using guidelines and standards to guide health care services. Health care providers use specific information to help them make appropriate decisions about health care and disease management.

- **Delivery System Design** – Organizing and coordinating health care services in ways that meet the needs of individuals to better prevent and manage chronic disease.
- **Information Systems** – Developing systems to collect information about health. The information can be used to make the case for new policies and programs, evaluate established programs, and support new ways of working to improve quality of care.

With elements in the community, such as

- **Healthy Public Policy** – Developing and implementing policies that support health. Many partners can be involved in developing and promoting healthy policies including individuals, communities, companies, organizations, and governments.
- **Supportive Environments** – Creating living and employment conditions that are safe, stimulating, satisfying, and enjoyable. The aim is to create places that make the healthy choice the easy choice.
- **Community Action** – Collaborating with communities, employers, and community groups, to set priorities, take action, and deliver programs and services to enhance the health of the community.







# Improving Health Together:

A Policy Framework for Chronic Disease Prevention  
and Management in Newfoundland and Labrador

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