Eastern Health

The Development of a Comprehensive Chronic Disease Prevention and Management Strategy

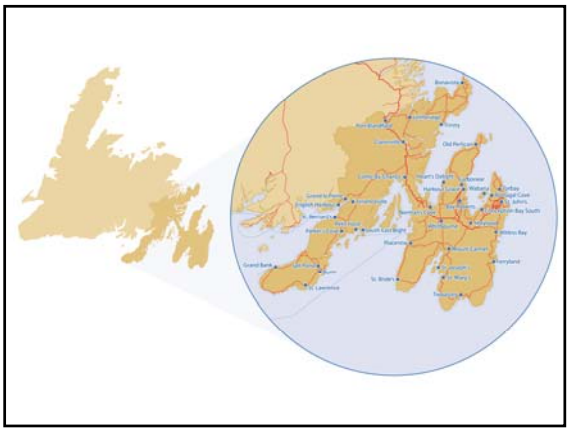
CHNC National Conference
May 2012

Agenda

- The RHA
- The Picture
- The Impact
- The Background
- The Plan
- Update

Eastern Health

- Largest integrated health organization in Newfoundland and Labrador.
- Provide the full continuum of health services to a population of 290,000 and a geographic territory of approximately 21,000 km2
- Responsible for a number of unique provincial programs.
- Over 13,000 health care and support services professionals



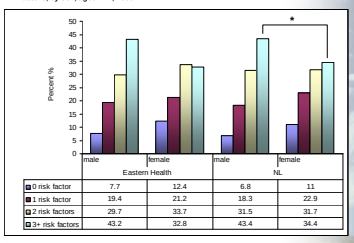
Newfoundland and Labrador Tourism / Ned Pratt

Defining Chronic Disease

- *Diseases of long duration and generally slow progression;*
- *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; and,*
- *Require ongoing actions on a long term basis to manage the disease, with involvement from individuals, health care providers, and the community*

Chronic Disease: The Picture

Percentage of Eastern Health residents reporting having 0, 1, 2, 3+ risk factors, by sex, aged 12+, 2009

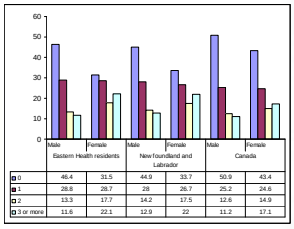


	Eastern Health male	Eastern Health female	NL male	NL female
0 risk factor	7.7	12.4	6.8	11
1 risk factor	19.4	21.2	18.3	22.9
2 risk factors	29.7	33.7	31.5	31.7
3+ risk factors	43.2	32.8	43.4	34.4

Source: Statistics Canada, Canadian Community Health Survey, Share File, 2009 * = Significant difference; P<0.05

Chronic Disease: The Picture

Estimated percentage of the population aged 12 years and older who report having 0, 1, 2, or 3 or more chronic conditions1 by sex, Residents of Eastern Health, Newfoundland and Labrador, and Canada, 2009/10



	Eastern Health residents Male	Eastern Health residents Female	Newfoundland and Labrador Male	Newfoundland and Labrador Female	Canada Male	Canada Female
0	46.4	31.5	44.9	33.7	50.9	43.4
1	28.8	28.7	28	26.7	25.2	24.6
2	13.3	17.7	14.2	17.5	12.6	14.9
3 or more	11.6	22.1	12.9	22	11.2	17.1

Source: Statistics Canada, Canadian Community Health Survey, Share File, 2009 * = Significant difference; P<0.05

Chronic Disease: The Impact

- **Increase in Chronic Disease**
  - 72% of seniors aged 65 and older had one or more chronic diseases
  - Individuals are living longer with chronic disease, but developing complications earlier in life.

Chronic Disease: The Impact

- **Aging Population** (≥ 65)
  - 11.6% in 2001
  - 13.1% in 2006
  - 14.2% in 2010
  - 22.3% by 2025

Chronic Disease: The Background

- **Work on Strategy Started July 2010**
- **Literature Review completed**
- **Data review completed**
- **Consultations completed**
  - **Eastern Health Program Directors**
  - **Communities -17**
  - **Staff 12**
  - **Physicians 7**
  - **NGOs 13**

Staff Consultation

- Clinical site leads
- Coordinators
- Managers
- Community Health Nurses
- NP Student
- Physiotherapists
- Behaviour Management Specialists
- Occupational Therapists
- Social workers
- Diabetes Nurse Educator
- Speech Language Pathologist
- Dietician /Nutritionist
- Nurse Practitioner
- Psychologist
- Executive
- Pharmacist
- Staff nurses
- LPN
- Doctor

Consultations

- Total Consultations
  36 +
- Total Participants
  277+

Community Consultation
Theme: Access

- Allied Health
- Information
- Services (decreased wait times)
- Women's wellness
- Diabetes Management
- Multidisciplinary Teams
- Drop in Clinics
- 'One Stop Shopping'
- Nurse Practitioners
- Timely Follow-up
- Health Line
- Alternate Care Options
- Peer support
- Home Support
- Care giver Support groups (buddy system)

Community Consultation
Theme: Prevention

- Information
- Lifestyle clinics
- Screening clinics
- Use of pools/gyms/ seasonal sports
- Use of schools after hours

Community Consultation
Theme: Communications & Navigation

- Information/ assistance on how to access services
- A Toll Free Number for chronic disease information
- How to find out about peer support groups
- Calendar of Events

Community Consultation
Theme: Determinants of Health

- Impact of Poverty
- Disconnect between good work that is being achieved

The Plan

BC Expanded Chronic Care Model

Chronic Disease Prevention and Management Continuum

Well Population Primary Prevention	At Risk Population Secondary prevention	Established Disease	Controlled Chronic Disease
• Surveillance of disease & risk factors • Promotion of healthy behaviours • Creation of supportive environments • Universal & targeted approaches	• Screening • Case finding • Periodic health examinations • Early intervention • Medication to control • Universal & targeted approaches	• Treatment and acute care • Complications Management • Self-management	• Continuing Care • Maintenance • Rehabilitation • Self-Management
Health Promotion	Health Promotion	Health Promotion	Health Promotion

Prevent Movement To at-risk group

Prevent Progression to established disease

Prevent progression to complications and/or hospitalizations

Chronic Disease: Provincial Policy Framework

Goal

- To implement a coordinated, systematic approach to effective chronic disease prevention and management that will positively impact the health status of individuals and communities served by Eastern Health

Chronic Disease: The Plan

- The seven components of the plan coincide with the components of the model
- Each component has one main objective and identified activities to meet the objective
- Each component will require a work plan that includes actions, target dates, performance measures and assigned responsibility.

Chronic Disease: The Plan

Creating Supportive Environments

Objective 1:

Expand population-based initiatives that will allow individuals to engage in healthy living activities and choices that support their health throughout the lifespan

Chronic Disease: The Plan

Strengthening Community Action

Objective 2:

Support communities in setting and achieving health priorities by addressing known barriers that prevent healthy living

Chronic Disease: The Plan

Self-Management Support

Objective 3:

Support active self-management to increase the individual's capacity in preventing and managing chronic disease

Chronic Disease: The Plan

Building Healthy Public Policy

Objective 4:

Contribute to improved programs and service delivery through advocacy and development of healthy public policy

Chronic Disease: The Plan

Decision Support

Objective 5:

Implement the use of clinical practice guidelines and evidence informed practice protocols

Chronic Disease: The Plan

Delivery System Design

Objective 6:

Support integrated management and clinical care for people with chronic disease

Chronic Disease: The Plan

Clinical Information Systems

Objective 7:

Utilize clinical information systems to provide all health care providers timely information, feedback and status reports on their clients/patients at risk of or managing diabetes

Chronic Disease: Next Steps

- **Identify leads for each component of the plan**
- **Work with the leaders to develop and implement work plans**
- **Work with research to develop and implement evaluation plan**
- **Work with communications on a communications plan**

Chronic Disease: An Update

- **Self Management workshops around the region**
- **Lay leaders trained**
- **Strategy release date: June 14, 2012**
- **Media interviews and promotion**
- **Prioritized work plans are being developed**
- **Working with research to develop and implement evaluation plan**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Questions


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