Communities of Practice
List of Reference and Discussion Documents on Chronic Disease Prevention and Self-Management
Website links checked March 15, 2010

DOCUMENT TITLE	DESCRIPTION
System level approaches	
Wagner, E. (2004). A recipe for improving outcomes in chronic illness. Retrieved from http://www.improvingchroniccare.org/index.php?p=The_Model_Talk&s=27	Foundational ppt presentation.
Lee, J. (2006). Ontario Chronic Disease Prevention and Management Framework. Retrieved from http://www.toronto.ca/health/resources/tcpc/pdf/conference_lee.pdf (p.12)	Presentation with diagram of model on p12 • Community action; Supportive environments; Healthy public policy • Delivery system design, Personal skills & Self-management support • Provider decision support: evidence-based tools, training • Information systems
Ontario's Chronic Disease Prevention and Management Framework. Presented March 2 2007 by Meera Jain, MOHLTC at GTA Rehab Network Best Practices Day http://www.gtarehabnetwork.ca/downloads/bpd2007/bpd2007-pres-plenary.pdf	Appears to be an expanded version of the Lee pdf file.
Grey Bruce Integrated Health Coalition, Feb. 2008 Chronic disease prevention and management framework tool kit.	Useful introduction to the CDPM Framework
Johnston, S., Liddy, C., Ives, S. M., & Soto, E. (2008). *Literature review on chronic disease self-management*. Ottawa: Champlain LHIN.	Overview of main ideas, useful references; foundation document for Champlain LHIN, CDSM workshop fall 2008; part of LHIN planning

Champlain Local Health Integration Network (LHIN). (2006, October). Working document environmental scan. Retrieved from Champlain LHIN: http://www.champlainlhin.on.ca/WorkArea/showcontent.aspx?id=924	
British Columbia's expanded chronic care model. http://www.health.gov.bc.ca/cdm/cdminbc/chronic_care_model.html	
Boyd, B. (2007). Regional chronic disease prevention and management strategy. Voices for Change. Community engagement report. August 2007. Vancouver, Vancouver Coastal Health: 77. Available at: http://www.vch.ca/media/07_08_cdsm_exec%5B1%5D.pdf	This report is based on interviews with community members. Many useful suggestions for organizing self-management of chronic disease. * Interesting approach: Shows involvement of public in health care planning, consistent with principles of primary health care
Canadian Alliance of Community Health Centre Associations (CACHCA) & Association of Ontario Health Centres (AOHC). (2007). The second stage of medicare: CACHCA & AOHC. http://www.aohc.org/aohc/conference	Objectives to complete 2nd stage of medicare: • Planning designed to improve the health of our population as a whole • More effective care • More health promotion and illness prevention • Improved access to care • More patient-centred care • High quality programs and services for everyone • More meaningful engagement of communities in decision making • Strengthening and completing the First Stage of Medicare

Ontario Chronic Disease Prevention Alliance (OCDPA) Report: http://www.ocdpa.on.ca/rpt_MovingHEALForward.htm	Report is intended to promote dialogue between tobacco control & healthy eating & active living & presents priorities for action (comprehensive agenda for action within CD prevention & management framework; research & policy engagement agenda for Ontario; comprehensive knowledge exchange plan, and plan to build regional capacity to implement effective HEAL programs and policies.
Ontario Health Quality Council. (2008). 2008 Report on Ontario's health system. Toronto: Ontario Health Quality Council. http://www.ohqc.ca/pdfs/ohqc_2008_report_-_english.pdf http://www.ohqc.ca/pdfs/ohqc_2008_report_highlights.pdf	Identifies 9 attributes of a high-performing health system: accessible, effective, safe, patient-centred, equitable, efficient, appropriately resourced, integrated, focused on population health. Section 3 addresses management of chronic disease.
McWilliam, C., S. Coleman, et al. (2003). "Building empowering partnerships for interprofessional care." Journal of Interprofessional Care 17(4): 363-376.	Goals: Flexible, client driven partnerships with shared goal of optimizing client-centredness and empowerment of all involved in care. Key Concepts: • Client-centred and empowering care relationships v expert driven model • Multiple partnership (individual, interprofessional, intra & across organizations) v. fragmented responsibilities for assessment & care delivery and, top down v. bottom up approaches.

Chronic Disease Management—Systems Approach—Kaiser Permanente N. California, 'Yes we Can" http://www.cdc.gov/asthma/interventions/yes_we_can.htm	Similar systems approach to chronic disease management: 1. Adopt a chronic disease model rather than an acute illness model 2. Risk Stratification: Specialist team conducts assessment, assigns level of risk and level of treatment, i.e. primary health care or more specialized health providers 3. Case management model of care 4. Social care coordination by community health worker 5. Championing, Coaching, Training
Chronic Care: Self-Management Guideline Team, Cincinnati Children's Hospital Medical Center (CCHMC) (2007). Evidence-based care guideline for Chronic Care Self-management (long & short). http://www.cincinnatichildrens.org/svc/alpha/h/health-policy/ev-based/chronic-care.htm	Website with numerous guidelines and resources, including background information on self-management, 5-A's cycle (widely used process to reinforce self-management approach)
'Flinders model' of chronic condition self-management http://som.flinders.edu.au/FUSA/CCTU/self_management.htm	Useful summary of key model elements, including difference with Stanford model. On Flinders Human Behaviour & Health Research Unit website
Battersby, M. (2006). The Flinders model of self-management support (Vol. 2008). Melbourne, Australia.	Powerpoint presentation, contains self-management tools
Royal Australian College of General Practitioners (RACGP). (2002). Sharing health care: Chronic condition self-management guidelines. Desktop guide for nurses and allied health professionals [Electronic Version]. Retrieved October 8, 2008 from http://www.racgp.org.au/Content/NavigationMenu/ClinicalResources/RACGPGuidelines/SharingHealthCare/20020703laminategp.pdf.	One pager (algorithm), incorporating stages of change intervention, plus sample care plan
Improving chronic illness care (icic). (October 8, 2008). Improving your practice manual. Retrieved October 8, 2008, from http://improvingchroniccare.org/index.php?p=Learning_Materials&s=209 (Website has many resources http://improvingchroniccare.org)	Manual with step by step approach to improving a primary care practice. Developed from Wagner model – CCM, from which the Ontario CDPM Framework was derived. Contains tools

Health Council of Canada. (2009). *Getting it right: Case studies of effective management of chronic disease using primary health care teams*. Toronto: Health Council. http://www.healthcouncilcanada.ca/	Five examples of a primary care, team-based approach to management of patients with a chronic disease. Differences in scope and structure. but all pursued three common purposes: • Provide the best possible environment and increased access to services through PH care teams for patients with a chronic disease. • Ensure that team members have the tools and resources necessary to provide high-quality care for patients with a chronic disease. • Provide patients with the tools and support required to manage chronic illness effectively. The recipe for success includes, but is not limited to: Effective communication; Patient-centred programs; Clinician engagement; Community involvement and empowerment; Community outreach; Strong support from senior leadership.
Individual self-care strategies	
Podlonsky, W. H. (2006). Coaching patients for successful self-management.[Electronic version] from http://www.chcf.org/topics/chronicdisease/index.cfm?itemID=124673 To view the entire video online or order free DVD copies, you must agree to licensing terms, provide your information and click the "I AGREE" button	South East Ottawa CHC showed video at the Ottawa COP workshop in January 2009 Highlights: • Engage the patient and understand why behavior change might or might not be perceived as worthwhile from the patient's perspective; • Explore and enhance the importance of making healthy behavior changes; and • Engage in collaborative action planning to support the patient's efforts in making a concrete, personally meaningful and achievable plan for change

Bodenheimer, T., MacGregor, K., & Sharifi, C. (2005). Helping patients manage their chronic conditions [Electronic Version] from http://www.chcf.org/topics/chronicdisease/index.cfm?itemID=111768.	Describes 5 interlocking strategies: Collaborative decision making: establishing agenda Information giving: ask, tell, ask; Information giving: closing the loop; Collaborative decision making: assessing readiness to change; and Collaborative decision making: goal setting
3 minute empowerment: Improve efficiency – support behaviour change. (Workshop HO provided by MJ Herlihy) http://www.healthcarecomm.org/index.php?sec=courses&sub=workshops&course=1	Based on stages of change theory: Identify stage; determine conviction to change behaviour and confidence in making change; intervention strategies to increase confidence & conviction.
RNAO BPG on Self-Management Support – not yet released (March 15, 2010) http://www.rnao.org/Page.asp?PageID=122&ContentID=1634&SiteNodeID=344&BL_ExpandID	Document out to external reviewers Nov 09
Coulter, A., & Ellins, J. (2006). Patient-focused interventions: A review of the evidence. London: The Health Foundation & Picker Institute Europe. http://www.health.org.uk/publications/research_reports/patientfocused.html	Review of evidence-based, patient-focused interventions: improving health literacy; improving clinical decision-making; improving self-care; improving patient safety; improving access; improving the care-experience, and improving service development. Discussion of UK Expert Patient Programme (EPP), based on Kate Lorig's Stanford model.
McGowan, Patrick Patient Self Management (March 2004) http://www.phsa.ca/NR/rdonlyres/CA1D2FFA-2DDA-4D45-8DD7-A093529EEE5F/8330/PatientSelfManagementPatrickMcGowanBC1.pdf	Patrick McGowan, undated ppt presentation – (appears to combine previous presentations) McGowan presented at LHIN workshop Sept 17 08

McGowan, P. Self-management: A background paper. New Perspectives: International Conference on Patient Self-Management. Victoria, British Columbia, University of Victoria, Centre on Aging. http://www.coag.uvic.ca/cdsmp/documents/What_is_Self-Management.pdf	Definition: Self-management relates to the tasks that an individual must undertake to live well with one or more chronic conditions. These tasks include gaining confidence to deal with medical management, role management, and emotional management. (Adams et al., 2004).
Henson, F. (2008, May 2008). Kootenays Prevention Services Self-Management Support Pilot Blog: Handbooks for Provider strategies and Client guides. Retrieved September 11, 2009, from http://self-managementsupport.blogspot.com/ _http://henf56.googlepages.com/handbooks	Fran Henson's Blog contains information on the pilot project and links to many resources Patrick McGowan was the project consultant.
Stanford Self-Management Programs http://patienteducation.stanford.edu/programs/	For information on training and fees click on the sidebar: Licensing/Trainer Policies
Huffman, Melinda, (2007). Health coaching: A new and exciting technique to enhance patient self-management and Improve outcomes. Home Healthcare Nurse 25(4), 271-274. http://www.wholehealtheducation.com/news/pdfs/health-coaching-for-health-care-providers.pdf	Paper with useful references.
Rudy, S., Tabbutt-Henry, J., Schaefer, L., McQuide, P., & Health, T. J. H. B. S. o. P. (2003). Improving client-provider interaction. *Population Reports, 31*(4), 1-24.	Although the examples provided are primarily focused on Family Planning within the context of International Health, the model could be adapted to a wide range of issues and diverse contexts. It could nicely complement some of the approaches discussed at the workshop (see for instance p. 6). The evaluation model provided in this issue of Pop Reports is mostly quantitative, but there are examples of (very informative) qualitative evaluations.

Ottawa Public Health (2006) Chronic disease prevention: Putting the pieces together.	Handbook of resource sheets on chronic disease prevention for health professionals. An excellent 'quick tips' resource. No longer available – March 15, 2010
California Health Care Foundation (CHCF) (2008) Coaching patients for effective self-management http://www.chcf.org/topics/chronicdisease/index.cfm?itemID=133717	Video of coaching techniques for providers to educate & motivate patients to take charge of their health (using an action planning process & ensuring patients take medications appropriately).
National Institute for Health and Clinical Excellence (NICE). (2007). *NICE public health guidance 6: Behaviour change at population, community and individual levels*. London, UK: NICE. Available at: http://www.nice.org.uk/PH006	Generic principles that can be used as the basis for planning, delivering and evaluating public health activities aimed at changing health-related behaviours. Full document & quick reference guide
Diabetes-related self-management	
BC Ministry of Health and BC Medical Association. (2005, September, 2005). Diabetes care: Guidelines and protocols. Retrieved 28 August, 2008, from http://www.healthservices.gov.bc.ca/gpac/pdf/diabetes_cguideline.pdf http://www.healthservices.gov.bc.ca/gpac/pdf/cognitive_summary.pdf http://www.healthservices.gov.bc.ca/gpac/pdf/diabetes_care_flow.pdf	Full guideline 1 page summary of guideline Diabetes care Flowsheet
Canadian Diabetes Association 2008 Clinical Practice Guidelines http://www.diabetes.ca/for-professionals/resources/2008-cpg/	Latest guidelines
Best and promising practices in diabetes education http://www.diabetes.ca/files/Best-or-Promising-Practices-Catalogue.pdf	CDA project – Catalogue of Best/Promising practices
Diabetes_Patient_Q'aire.doc	Example simple diabetes lifestyle assessment tool used in family practice

Diabetes Concerns Assessment Form and Guidelines for Using http://www.med.umich.edu/mdrtc/profs/documents/emh/ConcernsAssessment.pdf http://www.med.umich.edu/mdrtc/profs/documents/emh/webguidelinesforhcp.pdf	One of many diabetes self-management resources produced by Martha Funnell & Robert Anderson
Healthy-changes-plan.doc http://www.improvingchroniccare.org/index.php?p=Critical_Tools&s=162	One page self-management plan enables patients to document chosen healthy changes in terms of "what, when, how, where, and how often." (Robert Wood Johnson Foundation site—tools)
Jones, H., Edwards, L., Vallis, T. M., Ruggiero, L., Rossi, S. R., Rossi, J. S., et al. (2003). Changes in Diabetes Self-Care Behaviors Make a Difference in Glycemic Control. The Diabetes Stages of Change (DiSC) study. Diabetes Care, 26, 732-737. http://care.diabetesjournals.org/cgi/content/abstract/26/3/732?ck=nck	Research conducted by U of Toronto and Halifax with links to related articles
Social Determinants of Health	
Health Nexus and Ontario Chronic Disease Prevention Alliance (OCDPA). (2008). Primer to action: Social determinants of health. Toronto, ON: OCDPA. Available at: http://www.ocdpa.on.ca/docs/PrimertoAction2-EN.pdf	A resource for health and community workers, activists and local residents to understand how the social determinants of health impact chronic disease—and what to do about it.
Canadian Index of Wellbeing (CIW). http://www.ciw.ca/en/Home.aspx First report- June 10, 2009 http://www.ciw.ca/Libraries/Documents/FirstReportOfTheInstituteOfWellbeing.sflb.ashx	The CIW tracks changes in eight quality-of-life categories or "domains". Healthy Populations; Community Vitality; Time Use; Educated Populace; Ecosystem Health; Arts & Culture; Civic Engagement; Living Standards The domains will be blended into a composite index to give us a quick snapshot of whether our overall quality of life is changing for better or for worse.

Commission on Social Determinants of Health (CSDH). (2008). Closing the gap in a generation: Health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health. Geneva: World Health Organization.	Three principles of action 1 Improve the conditions of daily life – the circumstances in which people are born, grow, live, work, and age. 2 Tackle the inequitable distribution of power, money, and resources – the structural drivers of those conditions of daily life – globally, nationally, and locally. 3 Measure the problem, evaluate action, expand the knowledge base, develop a workforce that is trained in the social determinants of health, and raise public awareness about the social determinants of health.
Canadian Public Health Association (CPHA). (2008). Canadian Public Health Association response to the World Health Organization (WHO) Commission's Report Closing the gap in a generation: Health equity through action on the social determinants of health. Ottawa: CPHA. www.cpha.ca	Support for WHO report; quotes Monique Begin, that although Canada is a wealthy country, health inequities (poverty, social exclusion, discrimination, employment erosion, mental health and youth suicides0 present a serious public health problem; reaffirms the need to act on the social determinants. Action steps for CPHA identified.
Canadian Public Health Association (CPHA). (2008). A tool for strengthening chronic disease prevention and management through dialogue, planning and assessment. The tool, worksheet and resources. Ottawa: CPHA. Available from: http://www.cpha.ca/en/portals/CD.aspx#2	The CPHA Tool is intended to be a flexible resource for use by health regions across the country. The Tool helps to make connections among all those doing chronic disease work, taking steps to build understanding, break down silos and better integrate prevention and management efforts.
Community Health Nurses Association of Canada (CHNAC). (2003, Edited and translated March 2008). Canadian community health nursing standards of practice. Retrieve from http://www.chnc.ca/nursing-standards-of-practice.cfm	