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# Family Health Teams

*Advancing Primary Health Care*

## Guide to Chronic Disease Management and Prevention

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## Introduction

Ontario faces increasing challenges in meeting the needs of people with chronic diseases. The aging population means that illnesses such as cardiovascular disease, diabetes, and arthritis are becoming more prevalent and demands for care are rising. To address these needs, Ontario is collaborating on a number of chronic disease management initiatives in areas such as diabetes, heart disease, stroke, cancer, osteoporosis, asthma, Alzheimer's dementia, mental health and arthritis that are aimed at enhancing patients' health and quality of life while reducing costs to the health care system.

Expansion of Ontario's Diabetes Strategy will increase access to screening for high-risk individuals and reduce the number of diabetes-related complications through early intervention following diagnosis of both diabetic and pre-diabetic conditions. Enhanced evidence-based guidelines for providers and self-management supports for patients will be introduced in 2006. The Memorandum of Agreement between the Ontario Medical Association and the Ministry of Health and Long-Term Care (the ministry) provides for two new initiatives:

1. Incentive bonuses for physicians following recommended protocols for diabetes will be implemented in 2006.<sup>1</sup>
2. Guidelines and patient information for the management of congestive heart failure will follow in 2008 with similar incentive structures for physicians following recommended protocols.<sup>1</sup>

The ministry is developing Ontario's Chronic Disease Prevention and Management (CDPM) Framework to recognize and promote collaboration between providers, health care organizations and communities to keep people healthy and ensure quality evidence-based care. A web-based resource will soon be available as part of this framework.

## Purpose

This guide has been developed to assist groups that are forming Family Health Teams to plan chronic disease management and prevention programs for their patients. The guide is intended as a companion to the Guide to Strategic and Program Planning, which provides an overview of the strategic and program planning process.

The information in this document is intended only as a guide. Additional resources are provided at the end of this document which interested groups may wish to review.

Chronic disease management and prevention and health promotion are related approaches to the provision of comprehensive care to patients and their families. Both approaches stress prevention at different points along the health continuum. Chronic disease management and prevention focuses on preventing diseases from progressing following diagnosis. Health promotion focuses on maintaining health and preventing diseases from occurring. A partner Guide to Health Promotion and Disease Prevention has also been developed as a resource for interested groups.

Gathering information to plan and implement programs does not happen overnight. Each team will develop its own strategies at its own pace, based on the needs of its patients and the skills and expertise of its interdisciplinary providers.

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<sup>1</sup> Appendix E: Memorandum of Agreement between the Ministry of Health and Long-Term Care and the Ontario Medical Association.

## What is Chronic Disease Management and Prevention?

Chronic disease management is a pro-active, population-based approach that addresses chronic diseases early in the disease cycle to prevent disease progression and reduce potential health complications. Multiple strategies are used to improve the health of all patients diagnosed with specific conditions, not only those who visit the provider's office. This approach reduces the subsequent need for acute interventions in the future and allows people to maintain their independence and remain healthy for as long as possible.

Successful chronic disease management programs share the following characteristics. They:

- are evidence-based
- use multiple strategies and interventions
- are patient-centred
- empower individuals to increase control over and improve their health
- promote collaboration among providers, organizations, individuals, families and community groups
- include an evaluation component to ensure that programs are achieving their objectives

## Developing Chronic Disease Management and Prevention Programs

During the strategic planning process (see the Guide to Strategic and Program Planning), Family Health Teams will develop a set of strategic objectives that address the health needs of their communities. Objectives might include maintaining the health of their patients or reducing the need for acute interventions. Chronic disease management programs are a means of supporting these objectives. For example, your team may propose a program for patients with diabetes if this condition is prevalent in your patient population. Program objectives might include short-term goals, such as increasing the proportion of diabetic patients receiving treatment according to recommended protocols. Other objectives may include maintenance of specific glycemic, blood pressure and lipid targets and/or a reduction in the number of diabetic complications and acute care interventions.

The following steps will help teams plan successful chronic disease management programs and empower their patients to be good self-managers.

### a. Identifying patients

Effective chronic disease management programs depend on the ability to reach all enrolled patients who have been diagnosed with a chronic condition, even those that may only see a provider on an infrequent basis. Family Health Teams may also consider including individuals from groups with increased risk of developing certain chronic conditions. For example, individuals from particular ethnic/cultural groups may have an increased risk of developing diabetes. Patients from these groups may be disease-free, or in the early stages of disease and may not show any clinical signs. Chronic disease management programs may also benefit these patients.

A patient registry can help to identify patients, monitor care, and flag patients for follow-up. Electronic medical records may assist in developing a patient / client registry. The process that each team develops to identify and track patients with chronic conditions will be very important to the success of the program. These processes will allow teams to link their patients to the appropriate providers and monitor their health status on an on-going basis.

### b. Understanding patient needs and available resources

The strategic planning process encourages teams to gather information about their patient population and the health care resources in their community. The population profile that emerges describes various attributes of the patient population including the prevalence of chronic conditions. This profile will help teams to develop chronic disease management programs that address service gaps and target the needs of their patient population.

An inventory of health care resources in the community might include chronic disease management programs offered by local Health Units, hospitals, Community Care Access Centres, social service agencies, or non-profit groups. Learning about existing programs and collaborating with community providers can help Family Health Teams to coordinate programs (see the Guide to Local Community Integration). A mechanism to ensure that collaborative partners provide feedback will keep team members up to date on management plans for their patients.

### **c. Developing Chronic Disease Management Programs**

Chronic disease management programs can address the full spectrum of interventions from screening and diagnosis, to treatment, patient education, and follow-up. They provide an organized, systematic approach to managing all patients with chronic disease, not only the ones that are seen in the office. Protocols for chronic disease management should be based on the best available evidence.

- **Accessing evidence-based guidelines**

Information on best practices is available from a number of reliable sources. The Guidelines Advisory Committee, the Cochrane Library and the Cancer Care Ontario Program in Evidence-based Care among others are excellent sources of information (see Resources, page 8). Each team will need to adapt guidelines to their unique practice environment.

Evidence-based protocols for the management of diabetes, to be developed by the Primary and Community Care Committee, a joint committee of the Ontario Medical Association and the Ontario Ministry of Health and Long-Term Care, will be implemented in 2006. Protocols for the management of congestive heart failure will be introduced in 2008.<sup>2</sup>

- **Translating guidelines into action**

Protocols to integrate evidence-based guidelines into everyday practice can capitalize on the skills and expertise of each interdisciplinary team member (see the Guide to Collaborative Team Practice, Guide to Interdisciplinary Team Roles and Responsibilities). Team members should have clear roles and responsibilities, so that each provider knows his or her role during each chronic disease visit. Family Health Teams may find it helpful to develop patient flow sheets to organize planned interactions with patients and to communicate roles and responsibilities to all members of the health care team. Ideally patient flow sheets should be computer-based.

### **d. Delivering Chronic Disease Management programs**

Clinical case management plays an important role in caring for patients with chronic disease, especially those that may have multiple conditions and a complex range of health and social service needs. Coordinating services across multiple providers and sites will require planning to ensure seamless delivery of care. Some Family Health Teams may find it helpful to assign a care navigator to oversee the care of patients who require more time, additional resources or closer follow-up.

Chronic disease management programs may be geared to individuals or groups with a specific condition, or families of affected individuals. Referring patients with the same chronic condition to a group program in the Family Health Team or in the community is an effective way of providing services. Group programs not only strengthen a patient's ability to deal with their condition but also provide an opportunity to establish a social support network. Family members or caregivers can also benefit from support programs. For example, families with young children can be referred to Healthy Babies, Healthy Children for assistance in mediating the impact of caregiver illness on their children.

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<sup>2</sup> Appendix E: Memorandum of Agreement between the Ministry of Health and Long-Term Care and the Ontario Medical Association.

- **Educating patients**

Evidence-based guidelines may include, or be supplemented by patient education and self-help tools. Empowering patients to be responsible for their health is an important part of the disease management process. Family Health Teams should consider how its mix of providers and community partners can best provide patients with the skills and motivation they need to become self-managers. A variety of tools and resources, including self-help guides, counselling and support services, or educational and skills development programs, can help patients to better manage their health. Self-help tools for patients with diabetes and congestive heart failure will be introduced in 2006 and 2008 respectively.<sup>3</sup>

- e. **Coordinating Chronic Disease Management programs**

Regular contact – either in person or by phone or email – with the appropriate provider will help to manage the chronic care needs of patients. Open and regular communication among providers is also an important factor in providing effective service coordination. Information technology systems and computerized records that allow providers to access clinical data as the patient is being seen can help to coordinate and monitor care between providers and sites (see the Guide to Information Technology).

- f. **Measuring success - evaluating chronic disease management programs**

Each program will have a set of objectives that describe what the program plans to achieve. Objectives for each program should be measurable, meaningful and centred on outcomes such as impact, quality, patient satisfaction, timeliness, and efficiency. A process to collect and review the information is also needed. For example, data collected at regular intervals can be displayed in a simple graph that is used to monitor progress towards a goal over time. On-going evaluation and feedback will allow providers to determine if the program objectives are being met and will let your team know if the program has led to improvements. Feedback also provides an opportunity to adjust programs and strategies if indicated.

## **Funding Assistance**

A developmental assistance grant is available to assist eligible groups, where appropriate, with program planning for chronic disease management (see the Guide for Development Grant Application and Family Health Team Development Grant Agreement).

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<sup>3</sup> Appendix E: Memorandum of Agreement between the Ministry of Health and Long-Term Care and the Ontario Medical Association.

## Where to Get More Information

For more information on chronic disease management resources please refer to the list of Resources on page 8 or contact your professional college or association.

All potential Family Health Teams will be assigned a ministry Family Health Team co-ordinator. This ministry contact person will be your guide to assist you to work through the details and of establishing a Family Health Team.

If you have not yet been assigned a coordinator, please contact the ministry at:

E-mail: FHTinquiry@moh.gov.on.ca  
Address: Primary Health Care Team  
Ministry of Health and Long-Term Care  
1075 Bay Street, 9<sup>th</sup> Floor  
Toronto, ON M5S 2B1  
Telephone: 416-212-6155  
Toll Free Phone: 1-866-766-0266

For more information on Family Health Teams in general, please refer to the Family Health Team Fact Sheets or the Ministry of Health and Long-Term Care website at: [http://www.health.gov.on.ca/transformation/fht/fht\\_mn.html](http://www.health.gov.on.ca/transformation/fht/fht_mn.html)

## Resources

### Chronic Disease Prevention and Control

#### **Chronic Disease Prevention and Management (CDPM) Framework**

Web-based resource available December 2005

#### **Improving Chronic Illness Care (ICIC)**

Provides chronic illness resources for providers and patients

Improving your practice manual - Hindmarsh, M.

<http://www.improvingchroniccare.org/improvement/sequencing/Introduction.htm>

#### **Public Health Agency of Canada Centre for Chronic Disease Prevention and Control (CCDPC)**

Consists of links to CCDPC projects, initiatives, activities, information products, and contacts, organized by health and development topics.

<http://www.phac-aspc.gc.ca/ccdpc-cpcmc/topics/index.html>

### Evidence-Based Guidelines

#### **Canadian Centre for Health Technology Assessment (CCOHTA)**

Provides evidenced-based information on drugs, devices and best practices

[https://www.ccohta.ca/entry\\_e.html](https://www.ccohta.ca/entry_e.html)

#### **Canadian Medical Association (CMA) Infobase**

Provides guidelines produced or endorsed in Canada by national, provincial/territorial or regional medical or health organizations, professional societies, government agencies or expert panels.

<http://mdm.ca/cpgsnew/cpgs/index.asp>

#### **Cancer Care Ontario Program in Evidence-Based Care (PEBC)**

PEBC Web Resources includes PGI Practice Guidelines and Evidence Summaries.

[http://www.cancercare.on.ca/access\\_PEBC.htm](http://www.cancercare.on.ca/access_PEBC.htm)

#### **Cochrane Library**

Consists of regularly updated collection of evidence-based medicine databases, including The Cochrane Database of Systematic Reviews.

<http://www.cochrane.org/reviews/clibintro.htm>

#### **Guidelines Advisory Committee (GAC)**

Provides summaries of guidelines rated most highly by GAC and links to full text version of all available guidelines.

<http://gacguidelines.ca/>

#### **Registered Nurses Association of Ontario's Nursing Best Practice Guidelines (NBPG)**

Provides nurses guidelines for best practices in nursing client care

[http://www.rnao.org/bestpractices/about/bestPractice\\_overview.asp](http://www.rnao.org/bestpractices/about/bestPractice_overview.asp)

## Appendix

### Chronic Disease Management: A Checklist

- ❑ **Develop a process to identify and track patients with chronic illnesses in your patient population**
- ❑ **Understand patient needs and available resources in the community**
  - Review needs and resources information collected during the strategic planning process
  - Identify gaps in local services and opportunities to make the most of the skills of interdisciplinary providers
  - Collaborate with community partners and implement a mechanism for feedback
- ❑ **Develop CDM programs to meet patient needs and address gaps in services**
  - Access evidence-based guidelines and adapt them to your practice setting
  - Develop protocols to translate guidelines into action.
  - Use patient flow sheets to organize planned interactions
  - Communicate roles and responsibilities to interdisciplinary team members
- ❑ **Implement protocols and deliver CDM programs**
  - Coordinate services across providers and sites to ensure seamless delivery of care
  - Use self help tools and resources to educate patients about self management
- ❑ **Coordinate CDM programs and arrange systematic follow-up care**
  - Schedule regular contact with appropriate providers
  - Consider how clinical data can be accessed at the point of care, how care can be monitored and how information can be shared among providers
- ❑ **Monitor and evaluate success in achieving the CDM program objectives**
  - Select indicators that can be used to monitor progress towards CDM objectives
  - Develop mechanisms to collect and review data
  - Evaluate data
  - Adjust programs and strategies as required

## References

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