Northwest Territories

Chronic Disease Prevention and Management

Strategic Framework

Questions and Answers - Internal

What are chronic diseases?

Chronic diseases are diseases of long duration with a generally slow development.

While chronic diseases can develop and progress differently, they have some common characteristics (e.g. risk factors, burden on patient and family, impact on health).

What are the impacts of chronic disease?

Chronic diseases affect a person's quality of life, lead to hospitalization and sometimes premature death.

Chronic diseases represent a significant threat to the health of the population, to the sustainability of the health and social services system, and to the economic productivity of patients and families.

What is chronic disease prevention?

A healthy lifestyle, including participating in physical activity, eating a nutritious diet, limiting alcohol intake, living smoke free, managing stress and participating in protective factors (e.g. breastfeeding), can reduce the risk (prevention) of chronic disease.

What is chronic disease management?

Chronic disease management refers to coordinated interventions that help monitor and control chronic diseases to improve health outcomes for the patient.

- Medical management (e.g.: prescriptions, diagnostic and follow up tests)
- Self-management support (e.g.: holistic approach, family, community)
- Self-management skills (e.g.: problem solving, decision making, taking action)

What is the Chronic Disease Model?

The Expanded Chronic Disease Model (Barr et al., 2003) is the Gold Standard in integrating concepts and strategies for chronic disease prevention and management. This Expanded Chronic Disease Model includes personal, community and health system approaches.

The Department of Health and Social Services' (HSS) chronic disease framework is based on this model and targets the *health system* approach.

This systems approach includes four key areas*:

- Self-Management / Develop Personal Skills
- Delivery System Design / Re-Orient Health Services
- Information Systems
- Decision Support

What is the purpose of the CDPM Framework?

The *Chronic Disease Prevention and Management Strategic Framework* will:

- guide the HSS systems' approach and direction to chronic disease prevention and management;
- outline the HSS' patient, family and community-centered approach to the prevention and management of chronic disease; and
- identify key priorities for planning initiatives necessary to strengthen the health and social services system and support individuals and communities.

What is the approach? What are the HSS priorities? What does this mean? Are there examples?

It is expected that the strategic priority areas are applied by decision makers to ensure initiatives aimed at chronic disease prevention and management reflect these elements.

See table on next page.

Who should I contact?

If you have any questions about the Framework and how to apply it, please email nursing@gov.nt.ca.

*Four Key Areas – see next page

Systems approach area: **Self-Management / Develop Personal Skills**		
Strategic Priority for HSS	***Meaning***	***Example***
Evidenced based, patient & family centered care	This means that there will be: 〉increased patient and family involvement in chronic disease care and decision making 〉increased knowledge, skills, and awareness among patients and families to prevent and self-manage chronic diseases 〉targeted and meaningful professional development for care providers, as a result of identified gaps in knowledge or skill 〉regular updating and further development of documents and tools for chronic disease prevention and management.	Smoking cessation program – information for health care provider AND health promotion for tobacco user AND partnering with schools and community groups. Goal directed care-plans – education for professionals what this is AND central role of the patient to determine goals of care and to manage own care AND *programs and services available to achieve goals. *from Delivery System Design

Systems approach area: **Delivery System Design / Re-Orient Health Services**		
Strategic Priority for HSS	***Meaning***	***Example***
Equitable access via restructured and strengthened health care delivery systems	This means there will be: 〉increased patient satisfaction and decreased wait times for appointments and procedures 〉increased efficiency and decreased redundancy 〉decreased medical costs 〉improved communication between care providers, patients and families.	Goal directed care-plans –programs and services available to achieve goals. Facilitating connections with social, political and medical that to ensure health, not illness that underpin healthcare work (Bestbrains). Influence how health research is done and have healthcare professionals be proactive advocates for health and well-being.

Systems approach area: **Information Systems**		
Strategic Priority for HSS	***Meaning***	***Example***
Enhanced use and expanded availability of information systems	This means there will be: 〉 improved care delivery without additional travel costs 〉 greater access to usable resources for care providers, patients and families 〉 current and NWT-specific chronic disease data 〉 continuous, targeted improvements in chronic disease prevention and management.	Optimizing use of available technologies e.g. Telehealth. Standardized NWT Diabetes Screening Guidelines. Using available community based data for prioritizing prevention and management initiatives. Updating and upgrading end-user or employer publications (standards, policies, guidelines). Knowledge sharing portal of community based initiatives.

Systems approach area: **Decision Support**		
Strategic Priority for HSS	***Meaning***	***Example***
Strong partnerships and guidance for chronic disease management	This means there will be: 〉 increased community capacity 〉 improved communication between the health and social services system and communities 〉 improved programs and services for underserved populations 〉 community wellness.	Partnering with other departments to address determinants of health. Regional Wellness Councils. Proactive care for vulnerable groups (safe houses). HSS system analysis of existing community engagement activities and wellness plans to better understand community priorities and impacts of social determinants of health on achieving well-being.