



Alberta Health
Services

A Vision for Chronic Condition and Disease Prevention and Management



ALBERTA HEALTH SERVICES

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Introduction

A working group representing Alberta Health Services (AHS) Primary Care & Chronic Disease Management, Zone and Provincial teams came together in 2015 to draft a vision for Chronic Disease Management. This was spurred by the Office of the Auditor General Report on Chronic Disease Management in September 2014. The vision document was guided by the evidence and based on the Expanded Chronic Care Model and included the vision, mission, guiding principles and core elements. After approval from AHS PHC Steering in June 2015 a draft was circulated widely for input from a broad group of stakeholders in various health divisions, provincial and zone teams, facilities and disciplines within Alberta Health Services. This included the Strategic Clinical Networks, Continuing Care, Primary Care & Chronic Disease Management, Addictions and Mental Health, Nutrition Services, Communicable Disease, Allied Health, Palliative, Population and Public Health, rehabilitation services, and acute care to name a few. The team also sought input outside of AHS such as Primary Care Networks and the Project Management Office, Alberta Health, and various physicians. Alberta Health supported further stakeholder engagement who agreed on one unified vision statement and one definition of chronic condition and disease prevention and management and chronic condition and disease for Alberta.

From July 16 to September 24, 2015, feedback was received from 42 different teams/individuals. Overall, they expressed an overwhelming support for the vision. Partnership and collaboration really resonated. The input received assisted in revision and enhancing the Vision document and resulted in this Chronic Condition and Disease Prevention and Management (CCDPM) Vision. Resulting changes included:

- A focus on management and primary, secondary, tertiary prevention
- Reflect the whole continuum of care and the role of all teams in achieving the vision from prevention to palliation; including specialty, SCNs, Seniors, Addictions & Mental Health Shorter and more “visionary” “punchy” Vision statement
- Capturing continuity
- Strengthening the role of innovation
- Aligning with other strategies i.e. Patient First Strategy
- Clarifying overarching statements in the document
- Reducing duplication of concepts
- Detailing aspects in a “how to implement” appendix to the vision
- Defining certain terms

The vision document builds a foundation for whole system improvements and supports the AHS Vision, Healthy Albertans, Health Communities, Together. This document will evolve as we continue engagement and together, build on the great work in Alberta and strive towards high quality CCDPM and patient outcomes. Collaboration and integration with groups like Alberta Health, AHS Zones, Chronic Disease Prevention, Strategic Clinical Networks, Quality Improvement, patients and communities, Alberta Medical Association and Primary Care Networks will be critical to achieving the vision.

To discuss your work towards the vision, contact CCDPM Vision Implementation Committee co-chairs:

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Vision

In Alberta, individuals, families and communities are as healthy as they can be, through an integrated approach to chronic condition and disease prevention and management¹.

Mission

Individuals, families, communities and healthcare teams² work together to achieve a patient and family centered focus to improve population health, functional and clinical outcomes.

Guiding Principles

Stakeholders work together to achieve the vision and mission in alignment with the guiding principles and outcomes in Alberta's Primary Health Care Strategy, the AHS Provincial Chronic Disease Prevention Action Plan, the Health Quality Council of Alberta Quality Matrix, and AHS Core Values, taking responsibility to put patients first through flexible, local planning and delivery of collaborative chronic disease prevention and management; including the consideration of health equity and the social determinants of health, performing with integrity as trusted and valued partners. Partners are broad and may include individuals, families, communities and community supports and services, healthcare teams¹, patient advocacy groups, Alberta Health, Government of Alberta ministries and Alberta Health Service programs/services. The CD vision is grounded in the Expanded Chronic Care Model (ECCM) (Appendix 1) and the Population Health Promotion Model (Appendix 2). The following highlights the core elements for implementing the vision and mission. Appendix 3 highlights how the vision is being and could be achieved.

Core Elements

Communities (Primary Prevention)

1. **Build Healthy Public Policy**
 - 1.1. Build partnerships with community stakeholders to promote health and quality of life.
 - 1.2. Develop public policy that leads to equitable chronic disease prevention and management at community and provincial levels.
 - 1.3. Provide consistent health-based messaging across the continuum of care related to chronic disease prevention and management.
2. **Create Supportive Environments**
 - 2.1. Support safe and vital communities by building on current strengths to improve chronic disease prevention and management.
3. **Strengthen Community Action**
 - 3.1. Enable communities to build capacity to improve health and quality of life.

Health System (including Secondary and Tertiary Prevention)

4. **Delivery System Design**

¹ Vision statement was jointly developed with Alberta Health

² Healthcare Teams include varying providers from a number of programs/services (not all are listed): Specialty Teams, Strategic Clinical Networks, Primary Care Networks, Family Care Clinics, Chronic Disease Programs, Mental Health, Senior's Health, Palliative Care, Public and Population Health, Chronic Disease Prevention, Community Health Centers, Children's Services, Acute Care.

- 4.1. Support attachment of individuals to a specific health care provider and/or team in a health home.³
- 4.2. Coordinate care to ensure individuals are supported where they live, work, and play even where these may differ.
- 4.3. Provide access to quality chronic disease care to meet the needs of the individual.
- 4.4. Use population health and panel data to plan, define, modify and deliver chronic disease prevention and management programs/services based on the needs of the population.
- 4.5. Implement processes to identify and address social determinants that are barriers to health and access.
- 4.6. Champion an integrated, collaborative approach to whole-person chronic disease prevention and management

5. Self-Management Support

- 5.1. Individuals will have one coordinated plan of care developed in partnership with their health provider and/or team within the health home.
- 5.2. Provide patient and family centred care that supports the whole person and enables optimal self-management.
- 5.3. Providers will apply behavior change principles to support individuals and families to better manage their health.
- 5.4. Facilitate patient access to reliable evidence informed information (applying the principles of health literacy) and their personal health record.

6. Decision Support

- 6.1. Enhance and spread prepared proactive healthcare teams¹ through capacity and capability building in evidence based chronic disease prevention and management including:
 - 6.1.1. Demonstrated commitment for improved chronic disease prevention and management in primary, secondary and tertiary care.
 - 6.1.2. Collaboration between primary and secondary care to develop local level clinical decision supports and connections; subsequently impacting provincial primary level clinical decision supports and connections that are team and multi-morbidity based. e.g. referral pathways; clinical guidelines
 - 6.1.3. Skill development and quality improvement through education, training, decision supports, collaboration and facilitation.
- 6.2. Identify and set appropriate standards for chronic disease prevention and management.
- 6.3. Provide clinical expertise, services and supports for specific chronic conditions.

7. Information System

- 7.1. Integrate information systems that support:
 - 7.1.1. Measurement and evaluation of chronic disease prevention and management (including population health, functional and clinical outcomes) across the continuum.
 - 7.1.2. Collection and reporting of relevant population health and panel data.
 - 7.1.3. Registry building, tracking and reporting of chronic disease management indicators and outcomes.
 - 7.1.4. Current information on the supports and services available to providers, individuals and families related to chronic disease prevention and management.

³ Health Home as defined in the Primary Health Care Strategy

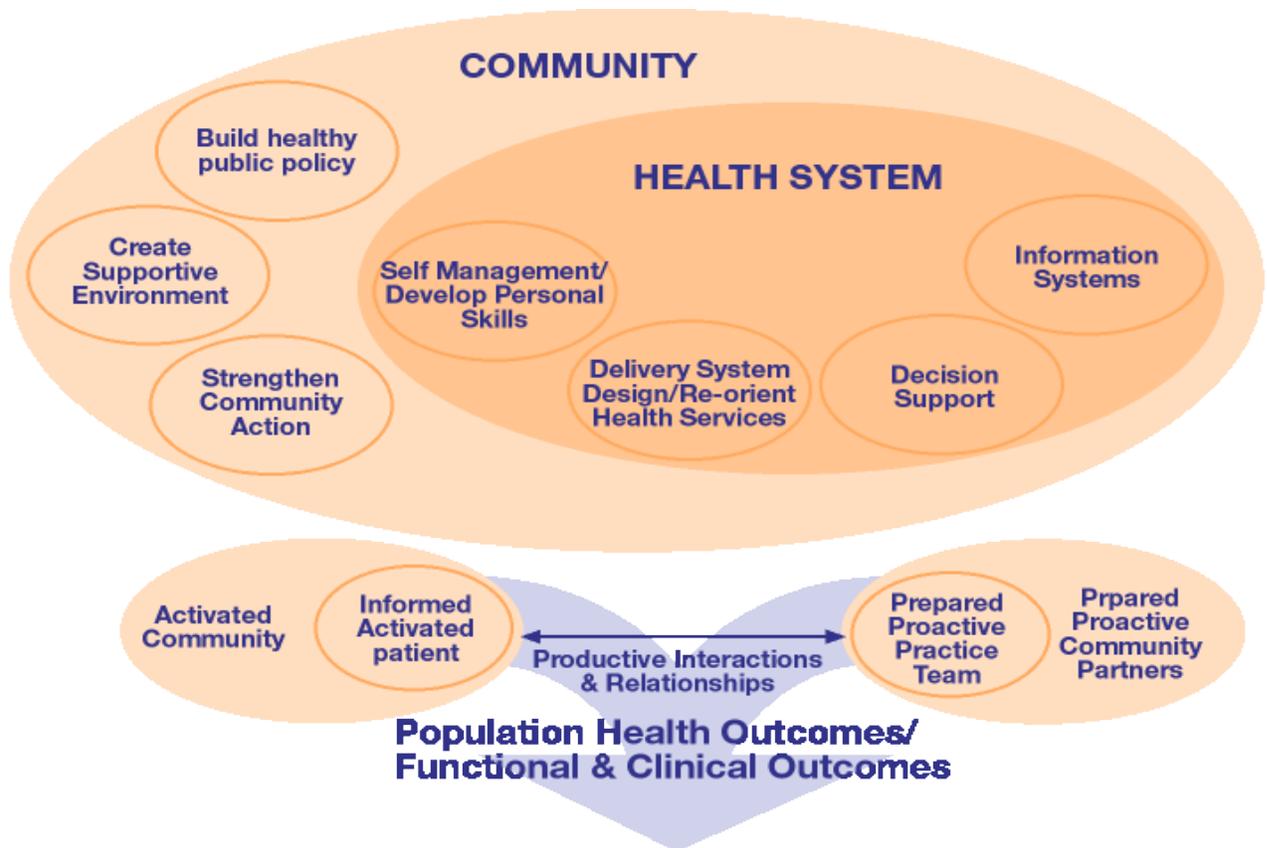
APPENDIX 1: Expanded Chronic Care Model

APPENDIX 2: Population Health Promotion Model

APPENDIX 3: How to Implement the Vision

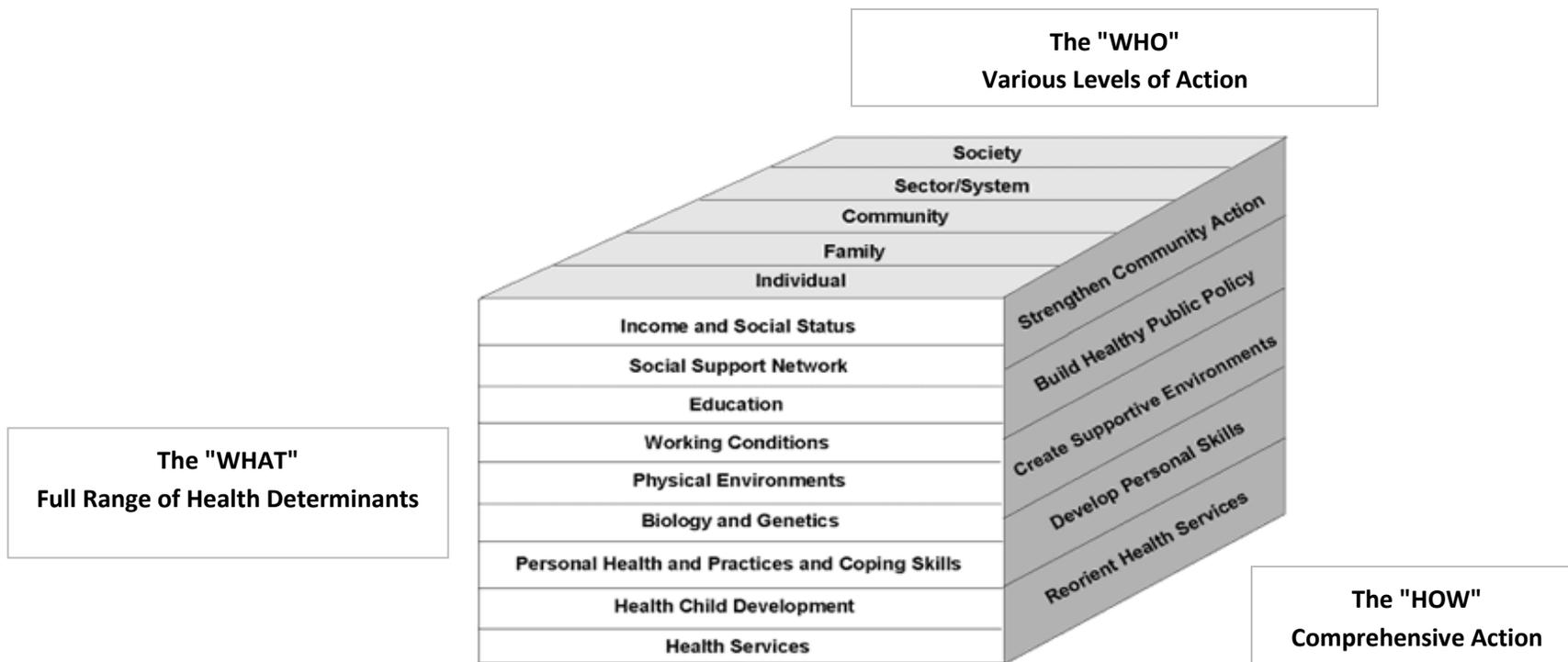
APPENDIX 4: Concept Definitions

Appendix 1 - Expanded Chronic Care Model



Created by: Victoria Barr, Sylvia Robisson, Brenda Marin-Link, Lisa Underill, Anita Dotis & Darlene Revanadale (2002)
Adapted from Glasgow, R., Orleans, C., Wagner, E., Curry, S., Solbery, L. (2001) Does the Chronic Care Model also serve as a template for improving prevention? *The Milbank Quarterly*, 79(4), and World Health Organization, Health and Welfare Canada and Canadian Public Health Association (1986) Ottawa Charter of Health Promotion.

Appendix 2 – Population Health Promotion Model



Population Health Approach (<http://www.phac-aspc.gc.ca/ph-sp/php-psp/index-eng.php#toc>)

Appendix 3 – Examples of how to Implement the Vision

Communities:

1. Build Healthy Public Policy

- 1.1. Build partnerships with community stakeholders to promote health and quality of life.
- 1.2. Develop public policy that leads to equitable chronic disease prevention and management at community and provincial levels.
- 1.3. Provide consistent health-based messaging across the continuum of care related to chronic disease prevention and management.
 - 1.3.1. *Recognize and strengthen community and zone staff capacity to advocate, partner and engage in the development of community level prevention, chronic disease, and primary health care policy.*
 - 1.3.2. *Support the actions identified in the AHS Chronic Disease Prevention Action Plan e.g. develop “policy toolkit” for chronic disease prevention;*
 - 1.3.3. *Partner with Population, Public and Aboriginal Health and others to support development of provincial level healthy public policies.*

2. Create Supportive Environments

- 2.1. Support safe and vital communities by building on current strengths to improve chronic disease prevention and management.
 - 2.1.1. *Partner with the Provincial AHS Chronic Disease Prevention and Oral Health Healthy Living team and other stakeholders to:*
 - *integrate the chronic disease management and prevention action plans and strategies for implementation.*
 - *support communities through evaluation, consultation, and advocacy at the provincial level.*

3. Strengthen Community Action

- 3.1. Enable communities to build capacity to improve health and quality of life.
 - 3.1.1. *Mobilize and build on community resources and assets using a community development approach.*

Health System:

4. Delivery System Design

- 4.1. Support attachment of individuals to a specific health care provider and/or team in a health home.⁴

⁴ Health Home as defined in the Primary Health Care Strategy

- 4.1.1. *Work with Primary Care Networks (PCNs), Family Care Clinics (FCCs), community health centres and other primary care clinics and services to prioritize achieving the goal of accurate patient panel.*
- 4.1.2. *Verify with individuals as they visit AHS programs and services who their primary care provider is. If they do not identify a primary care provider work with them to attach them to a primary care provider.*
- 4.1.3. *Promote attachment to a primary care provider.*
- 4.1.4. *Develop processes/policy to identify and connect/link unattached individuals and populations in Alberta.*

- 4.2. *Coordinate care to ensure individuals are supported where they live, work, and play even where these may differ.*
 - 4.2.1. *Improve transition planning and communication between all areas of health services. Identify and spread innovations that are effective. e.g. AIM, Path to Care, COACT, Triple AIM, service agreement examples, referral services, central access, etc. Investigate the potential for Quadruple AIM in Alberta.*
 - 4.2.2. *Establish policies, priorities, tools, and processes to provide care management support from a whole person perspective to individuals who require it.*
 - 4.2.3. *Establish or adopt criteria regarding what populations require care management and who should provide; supporting the concept of the medical/health home and attachment.*
 - 4.2.4. *Define roles and distribute tasks among team members to provide care management.*

- 4.3. *Provide access to quality chronic disease care to meet the needs of the individual.*
 - 4.3.1. *Support the implementation of advanced access (AIM) in all AHS CDM programs, clinics, and services; reducing waiting times for and at an appointment.*
 - 4.3.2. *Expand and use AIM redesign, implementation, and evaluation with primary care.*
 - 4.3.3. *Work with PCN's, FCC's, community health centres and other primary care clinics to promote and support 24/7 access and availability of care and services.*
 - 4.3.4. *Support and promote the use of technology to improve 24/7 access to primary care and chronic disease management services i.e. telephone, email, telehealth, videoconferencing*
 - 4.3.5. *Engage Healthlink in discussions and plans around 24/7 access to primary care.*
 - 4.3.6. *Align AIM principles with AHS and other Quality Improvement (QI) initiatives to enable measurement and monitoring of access, supply, demand, and delay the same across services and settings.*
 - 4.3.7. *Identify opportunities for QI and implement activities/initiatives from a system and community perspective.*
 - 4.3.8. *Work with acute care, AHS programs and primary health care partners to reduce ER and hospital utilization through community, primary care, primary health care, and other improved collaborative chronic disease prevention and management efforts.*
 - 4.3.9. *Develop processes to use individual and community input in service delivery approaches and priorities.*

- 4.3.10. *Integrate with other strategies and plans of care as appropriate e.g. Chronic Disease Prevention Action Plan, Mental Health, Senior's Health, etc.*
- 4.3.11. *Develop 3-5 year implementation plan and evaluate the 3-5 year outcomes, building towards a 10 year sustainability plan.*
- 4.4. Use population health and panel data to plan, define, modify and deliver chronic disease prevention and management programs/services based on the needs of the population.
- 4.4.1. *Support the process to clearly define and identify individual "communities" across Alberta.*
- 4.4.2. *Work with partners to gather, evaluate, utilize and share data for the community population on an ongoing basis to inform service planning between AHS, primary care, and the community including:*
- *Panel data*
 - *Population health data*
 - *Data on health needs, especially prevalence/incidence/related to chronic conditions for the community.*
 - *Health service utilization data for the community population (including utilization of health services outside the community).*
- 4.4.3. *CDM services in the community are planned in partnership with AHS, primary care, and community; identify duplication, gaps and opportunities to improve care based on population need.*
- 4.4.4. *Include the community population in validating community need and service planning.*
- 4.4.5. *Utilize data to measure the success of the services offered.*
- 4.5. Implement processes to identify and address social determinants that are barriers to health and access.
- 4.5.1. *Build and sustain relationships among local health services, community partners, industry, and workplaces; assess capacity, mobilize/utilize community assets and resources to support individuals to prevent or manage their chronic disease.*
- 4.5.2. *Review current AH/AHS initiatives working to address social determinants that are barriers to health and access; particularly for vulnerable populations Egg. Triple Aim, IMPACT, other.*
- 4.6. Champion an integrated, collaborative approach to whole-person chronic disease prevention and management
- 4.6.1. *Engage partners as to how to achieve the vision and their role and responsibilities.*
- 4.6.2. *Develop a plan for the implementation and evaluation of the vision.*
- 4.6.3. *Advocate for and assist in the development and implementation of compensation models that better support whole person, team based care including other models, modes of care and new creative approaches to compensation for community based health providers e.g. Peer navigators, community health workers, health brokers, interdisciplinary professionals, physician and team compensation.*
- 4.6.4. *Advocate for and support inter-professional collaborative practice across settings, services, and ministries that support integrated whole person care.*
- 4.6.5. *Develop opportunities and processes for connecting providers and teams at the community level to encourage teamwork across settings and services.*

- 4.6.6. *Develop resources, supports, and processes to promote and implement a team based approach across the continuum of care for the improvement of individual centred care.*
- 4.6.7. *Identify and incorporate evidence, innovations, and best practices from Alberta and elsewhere in supporting chronic disease care and prevention.*
- 4.6.8. *Provide change management, evaluation, coaching, facilitation, consultation, and quality improvement supports that can address needs from a system and community versus a specific service and clinic perspective. Provide necessary training and skill support to accomplish this; supporting evolution and sustainability over the long term.*

5. Self-Management Support

- 5.1. Individuals will have one coordinated plan of care developed in partnership with their health provider and/or team within the health home.
 - 5.1.1. *Work with the individual and the providers to develop, monitor and provide follow up around one plan of care.*
 - 5.1.2. *Integrate the plan of care from specialty and other AHS services and programs with primary care and the individual's medical home and primary care attachment relationship; close the loop on all individuals referred whether seen or not.*
 - 5.1.3. *Advocate and develop processes for improvements in whole person care planning including communication with primary care about acute care admissions and discharges and plan of care; incorporating involvement of other community health care services i.e. AHLP, Home Care, Public Health, Addictions & Mental Health, Allied Health, Seniors Health; linking to panels and the "attachment" relationship.*
 - 5.1.4. *Work with other AHS services and partners to develop opportunities for collaborative care planning including the health portal, email, sharing of desktops (Lync style), texting, apps, videoconferencing, IT solutions and other technologies.*
 - 5.1.5. *Support attachment and understanding of panel population by providers for the purpose of improving continuity of care and better relationship/knowledge of individuals, allowing for increased comfort in addressing individual needs through other avenues of care besides face to face visits.*
 - 5.1.6. *Reach out to individuals through other avenues than face to face visit where relationship is established; being proactive rather than waiting for the individual to reach out to us as providers.*
- 5.2. Provide patient and family centred care that supports the whole person and enables optimal self-management.
 - 5.2.1. *Emphasize the individual's central role in managing their health.*
 - 5.2.2. *Empower and prepare individuals to manage their health and health care.*
 - 5.2.3. *Use evidence informed and effective self-management support strategies that include assessment, goal-setting, action planning, problem-solving and follow-up.*
 - 5.2.4. *Identify internal and community resources available to provide ongoing self-management support to individuals.*

- 5.2.5. *Support all providers to engage individuals and families and their supports (as defined by them) in their own care and decision making by providing the training and tools required to do this well.*
 - 5.2.6. *Identify needs and develop tools and processes that support the identification of issues, concerns and solutions around the social determinants of health in the provision of whole person care at the primary health care level; starting with those with chronic care concerns.*
 - 5.2.7. *Identify needs and develop tools to support whole person plans of care at the primary health care level; integrating specific disease approaches and plans of care focusing on the individual's priority needs and abilities.*
 - 5.2.8. *Develop processes to support clearer linkages to specialty and community chronic disease care services for primary care in caring for their panel population.*
 - 5.2.9. *In collaboration with AHS/AH IT and primary care work to establish EMR and informational continuity; access to individual plans of care and patient information between primary care and specialty/community chronic disease care services.*
 - 5.2.10. *Identify and incorporate evidence, innovations, and best practices in supporting whole person care from Alberta and elsewhere.*
 - 5.3. Providers will apply behavior change principles to support individuals and families to better manage their health.
 - 5.3.1. *Establish clear competencies for all health care providers in supporting behaviour change including but not limited to health coaching; establish a training, accountability, and implementation plan to integrate these competencies into provider practice.*
 - 5.4. Facilitate patient access to reliable evidence informed information (applying the principles of health literacy) and their personal health record.
 - 5.4.1. *Establish a 'source of truth' for health information for individuals.*
 - 5.4.2. *Develop processes, resources, and a commitment across AHS services in support of keeping this "source of truth" up to date e.g. MyHealth.Alberta.ca*
 - 5.4.3. *Provide clear processes for all health care providers to establish input, use, and trust in the information available and provided.*
 - 5.4.4. *Establish processes for individual input to the source of truth; is it meeting their needs, what is required, what is missing, etc.*
 - 5.4.5. *Continue to work with AH and AHS IT on the development of Alberta's personal health portal and the individual's ability to access their own personal health records.*
 - 5.4.6. *Continue to work with AH and other AHS Programs and the public to identify barriers, establish processes, communications and approaches addressing privacy issues and access to personal health records.*
- 6. Decision Support**
- 6.1. Enhance and spread prepared proactive healthcare teams¹ through capacity and capability building in evidence based chronic disease prevention and management
 - 6.1.1. Demonstrated commitment for improved chronic disease prevention and management in primary, secondary and tertiary care.

6.1.2. Collaboration between primary and secondary care to develop local level clinical decision supports and connections; subsequently impacting provincial primary level clinical decision supports and connections that are team and multi-morbidity based. e.g. referral pathways; clinical guidelines

6.1.3. Skill development and quality improvement through education, training, decision supports, collaboration and facilitation.

- *Develop, improve or adopt existing education initiatives and tools; implement education initiatives within AHS and with appropriate partners using proven provider education methods e.g. primary care.*
- *Provide consistency in education and training to support common competencies required across CDM programs, services, and roles/responsibilities.*
- *Develop capacity in our CDM and primary care services related to measurement and evaluation e.g. EQ-5D, self management, patient experience and PROMs*
- *Provide QI specific training and support: AIM, Lean, Yellow belt (AHS QI support system) and determine approaches to provide this for our primary care and community partners in an integrated approach.*
- *Align the work of the PHC Portal and CDM resource center expansion with the CDM vision creating a source of truth and an interactive portal for providers.*
- *Work with AHS PCN governance members to understand the priorities and needs around primary care, primary health care and CDM from an AHS perspective and the importance of their role as joint venture partners at these governance tables.*
- *Provide team building tools and supports at the community level; building local capacity through teamwork across settings and services.*
- *Develop clinical pathways in partnership with specialty and primary care providers that are feasible and appropriate for primary care practice; improving and supporting consistent evidence based practice related to chronic disease care across the continuum and supporting whole person care. Ensure these support an equitable approach to care through an ability to adapt based on geography, culture, social determinants and social inequities.*
- *Integrate specialist expertise and primary care.*
- *Develop processes, tools, and evaluation mechanisms to ensure knowledge translation and implementation of standard evidence based practices in chronic disease care at the local and provincial levels across the continuum.*
- *Share evidence-based guidelines and information with patients to encourage their participation.*
- *Work with academia to support and identify research around what best supports management of multi-morbidity in chronic disease care and prevention.*
- *Develop Communities of Practice as a possible option, where appropriate, for support and translation.*
- *Consider the “High performing health care system CDM attributes” outlined in the CDM OAG report –Appendix A in developing the detailed implementation plan for this CDM vision.*

- *Support competencies and capacity in the following areas:*
 - *Patient and family centred care*
 - *Self-management support*
 - *Behaviour change support / Health Coaching*
 - *Evidence-informed practice*
 - *Cultural Diversity/Social Determinants of Health*
 - *Inter-professional collaborative practice*
 - *Population health and community approaches*
 - *Creating a culture of quality improvement*
 - *Communication and information*
 - *Chronic Disease Prevention*
- 6.2. Identify and set appropriate standards for chronic disease prevention and management.
- 6.2.1. *Develop clinical standards in partnership with specialty and primary care providers improving and supporting consistent evidence based practice related to chronic disease care across the continuum and supporting whole person care.*
- 6.2.2. *Ensure chronic disease care and prevention meet accreditation standards related to chronic disease, primary care and other services e.g. Mental health, Continuing Care.*
- 6.3. Provide clinical expertise, services and supports for specific chronic conditions.
- 6.3.1. *Create and support a virtual team of coordinated expertise on specialty conditions as support delivery teams across the province*
- 6.3.2. *Implement clinical standards for specific chronic conditions across the province; align with standards of care for primary care and chronic disease to support the provision of specialized services as required.*
- 6.3.3. *Establish processes to support best evidence practice within primary health care services related to specific chronic conditions; this may include consultation, use of technology, email, just in time education supports, specific training around common chronic conditions seen in that specific primary care panel population, care pathways, or other best practice possibilities.*
- 6.3.4. *Establish consistent, transparent referral processes and criteria to all AHS CDM and specialty chronic care services; supporting local processes where appropriate, taking into account the need for rural access to urban specialty services where those services don't exist in communities.*
- 6.3.5. *Support establishment of consultation services by specialty CDM providers to enable primary care to support individuals outside of formal referral processes.*
- 6.3.6. *Establish processes and systems as appropriate where specialty attends primary care clinic where large populations exist with specific chronic conditions.*
- 6.3.7. *Develop and implement a common template for chronic disease pathway development to ensure ability to align and integrate across multiple comorbidities.*
- 6.3.8. *Integrate pathway development and implementation work as appropriate e.g. C Change.*
- 6.3.9. *Support a broad spectrum of conditions within this vision as per the definition provided in the glossary*
- 6.3.10. *Advocate for strong medical leadership to support and champion the integration of specialty with primary care.*

7. Information System

- 7.1. Integrate measurement and evaluation of chronic disease prevention and management (including population health, functional and clinical outcomes) across the continuum.
- 7.2. Collection and reporting of relevant population health and panel data.
- 7.3. Registry building, tracking and reporting of chronic disease management indicators and outcomes.
- 7.4. Current information on the supports and services available to providers, individuals and families related to chronic disease prevention and management.
 - 7.4.1. *Advocate for and support information system work that aligns clinical information between providers enabling joint care planning across settings and services*
 - 7.4.2. *Influence, develop, implement and sustain a provincial electronic infrastructure that supports access to an accurate and sustainable inventory of health and community services available by community that is up to date, user friendly, evidence based and integrated around primary health and whole person care.*
 - 7.4.3. *Provide timely reminders for providers and individuals.*
 - 7.4.4. *Access data to identify relevant subpopulations for proactive care.*
 - 7.4.5. *Share information with individuals and providers to coordinate care.*
 - 7.4.6. *Monitor performance of practice team and care system.*
 - 7.4.7. *Support AH to build disease registry information and data from the ground up; maintained and updated at the medical/health home and rolled up to inform provincial registry data on specific chronic conditions.*
 - 7.4.8. *Create and support web based portals and link individual and population health data between primary care and AHS at the community level.*
 - 7.4.9. *Identify population health, functional and clinical outcomes for chronic disease care and prevention to be utilized across the continuum.*
 - 7.4.10. *Advocate for alignment of individual records and plans of care to 24/7 access to primary care; maintaining provider and team attachment relationship in the process.*
 - 7.4.11. *Support alignment and validation of panel work with the individual, the provider, the team, the clinic, and the PCN, FCC, community health centre or other primary care service through the ability to electronically manage, report and coordinate this information.*

Appendix 3 - Concept Definitions

Access: the opportunity or ease with which consumers or communities are able to use appropriate services in proportion to their needs.

(Access to primary health care: three challenges to equity. Mark Fort Harris, Elizabeth Harris and Martin Roland. *Australian Journal of Primary Health* 10(3) 21 – 29, 2004)

Activated: Those who are activated believe patients have important roles to play in self-managing care, collaborating with providers, and maintaining their health. They know how to manage their condition and maintain functioning and prevent health declines; and they have the skills and behavioral repertoire to manage their condition, collaborate with their health providers maintain their health functioning, and access appropriate and high-quality care.

(Development of the Patient Activation Measure (PAM): Conceptualizing and Measuring Activation in Patients and Consumers Judith H. Hibbard, Jean Stockard, Eldon R. Mahoney, and Martin Tusler *Health Services Research* 39:4, Part I (August 2004))

Activity: A retrospective measure of the hours (resources measured in minutes and hours) actually used in a day.

(Access- Improve- Measure (AM)) (with revisions)

Advanced Access is a set of beliefs, principles and practices that, when implemented, enables a Primary care provider to “do today’s work today.” “The core principle of Advanced Access is that patients calling to schedule a physician (provider) visit are offered an appointment the same day.”

(M. Murray and D. Berwick. Advanced Access Reducing Waiting and Delays in Primary Care. *JAMA* 2003;289:1035-1036)

Attachment: Attachment is the expression of a continuous and longitudinal relationship between individuals and their providers.

(Coordinated Approach to Continuity, Attachment and Panel in Primary Care *A Common Vision for Alberta’s Quality Improvement Organizations*, March 2014. Published by TOP)

Care Management: A set of activities designed to assist individuals and their support systems in managing medical conditions and related psychosocial problems more effectively, with the aim of improving health status and reducing the need for medical services. It is a broad set of longer-term services focusing on individuals with multiple chronic conditions, and includes medical management and assistance in navigating the system, with both quality enhancement and cost reduction as goals.

(Alberta Health Services (AHS) System Wide Case Management Definitions Glossary, December 21, 2011)

Chronic Conditions and Diseases: A health condition or disease that is persistent or otherwise long lasting. They can occur at any age, and span non-communicable and communicable disease, and are inclusive of neurological conditions and mental health.

(AH and AHS collaborative work, January 2016)

Chronic Condition and Disease Prevention and Management: Preventing and managing chronic conditions and diseases, involves an integrated and coordinated system of supports, including families and communities, that empowers individuals to maintain and improve their health, their quality of life, and prevent and manage conditions/diseases independently or in partnership with health and social care.

(AH and AHS collaborative work, January 2016)

Chronic Disease Management: provides care that helps people with chronic disease improve their quality of life and live as long as possible. Chronic disease management emphasises several approaches in managing chronic diseases effectively.

- Self-care and self-management: supporting people to take an active role in managing their own care to be as healthy as possible and to prevent complications from occurring.
- Disease management: interdisciplinary teams providing high quality, evidence-based care, including the use of pathways and protocols or clinical practice guidelines.
- Case management: the active management of high-risk individuals with complex needs within an integrated care system.
- *Proactive strategies:* the ability to identify at-risk individuals and groups within the population, carry out needs assessment, understand resource and activity levels and identify trends.

(Alberta Health (AH), March 2015) (with revisions)

Chronic Disease Prevention: “In Canada, chronic diseases are some of the leading causes of death and reduced quality of life. Several risk factors that lead to chronic diseases are becoming more common. These risk factors (i.e. unhealthy diet, physical inactivity, tobacco use and harmful use of alcohol) can be mitigated and chronic disease prevented or its onset delayed.”

(Public Health Agency of Canada publication called “Multisectoral Partnerships to Promote Healthy Living and Prevent Chronic Disease (June 4 2015))

Primary prevention seeks to prevent the onset of specific diseases via risk reduction: by altering behaviours or exposures that can lead to disease, or by enhancing resistance to the effects of exposure to a disease agent. Examples include smoking cessation and vaccination.

Secondary prevention refers to preventing the establishment or progression of a disease once a person has been exposed to it. Examples include early detection via screening procedures that detect disease at an early stage when intervention may be more cost-effective.

Tertiary prevention takes place once a disease has developed and has been treated in its acute clinical phase; it seeks to soften the impact caused by the disease on the patient’s function, longevity, and quality of life. Tertiary prevention can include modifying risk factors, such as assisting a cardiac patient to lose weight, or making environmental modifications to reduce an asthmatic patient’s exposure to allergens.

(AH, March 2015)

Collaborative Approach: 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.

(Improving Health Together: A Policy Framework for Chronic Disease Prevention & Management in Newfoundland & Labrador, p.9 , December 2011)

Collaborative Practice: A partnership between a team of healthcare providers and an individual/family in a participatory, collaborative and coordinated approach to shared decision making around health and social issues.

(Canadian Interprofessional Health Collaborative. (2010). *A national interprofessional competency framework*.
http://www.cihc.ca/files/CIHC_IPCompetencies_Feb1210.pdf)

Continuity of Care: Continuity of care is how one patient experiences care over time as coherent and linked as a result of *effective* information flow, *strong* interpersonal skills, and *ongoing* coordination of care. There are three types of continuity of care:

- **Informational Continuity** - Health information on prior events is used to give care that is appropriate to the patient's situation
- **Relational Continuity** - Recognizes ongoing relationship between patients and providers that connects care over time and bridges discontinuous events
- **Management Continuity** - Ensures that care received from different providers is connected in a coherent way; usually focused on specific, often chronic, health issues

(Reid et al, (2003). *Defusing the confusion: concepts and measures of continuity of healthcare*. Canadian Foundation for Health Services Research
http://www.cfhi-fcass.ca/Migrated/PDF/ResearchReports/CommissionedResearch/cr_contcare_e.pdf)

Coordinated Plan of Care: is a structured, comprehensive, accessible/available plan of care that is jointly created, maintained, and updated by the individual or his or her family, healthcare providers, and where appropriate, community and social services. It may include a summary of personal health information, a person's health goals, and the treatment and follow up care they receive. The purpose is to facilitate optimal understanding and management of chronic and/or complex health conditions by individuals, their families, and their healthcare providers working in collaboration and supported by clear communication and system navigation.

(Northeast Toronto Health Link Coordinated Care Plan Toolkit March 2014)

(Ref: <http://healthitboard.health.govt.nz/our-programmes/integrated-care-initiatives/shared-care-plans-long-term-conditions>. Retrieved June 2012)

Demand (for health services): (i) the health care expectations expressed by individuals or communities; (ii) the willingness and/or ability to seek, use and, in some settings, pay for services. Demand may be subdivided into expressed demand (equated with use) and potential demand. It may also be subdivided into rational demand (demand that corresponds to need) and irrational demand (demand that does not correspond to need).

(A glossary of terms for community health care and services for older persons http://whqlibdoc.who.int/wkc/2004/WHO_WKC_Tech.Ser._04.2.pdf. From the WHO glossary of terms.)

Evidence-informed practice: Evidence informed practice means ensuring that health practice is guided by the best research and information available. "It acknowledges that there are many factors other than evidence – for example, available resources or social and cultural norms – that influence decision-making."

(Canadian Nurses Association (CNA), 2010, p. 3)

Health Coaching: is a term for health behaviour change assistance, it is typically conducted as part of usual professional practice for health professionals. Health providers motivate patients toward readiness to change, working with them to change unhelpful thinking patterns, promote behaviour change and empower patients to achieve better health outcomes.

(Health Change Associates)

Health Home: individuals have access to a set of comprehensive primary health care services delivered by a primary health care team, are connected with other services, and have their health care journey coordinated and managed.

(Alberta PHC Strategy 2014)

Health Screening: is defined as the use of a test or a series of tests to detect unrecognized health risks or preclinical *condition* in apparently healthy populations to permit prevention and timely intervention.

(Trade-off between benefit and harm is crucial in health screening recommendations. Part I: General principles Leonila F. Dans*, Maria Asuncion A. Silvestre, Antonio L. Dans. Journal of Clinical Epidemiology 64 (2011) 231-239.)

High Need/High Risk/High Cost Individuals: those with multiple or complex conditions, often combined with behavioral health problems or socioeconomic challenges.

(Hong, Siegel, & Ferris, 2014)

Integrated Chronic Care: is about integrating approaches to chronic care prevention and management; recognizing and addressing common risk factors in consistent ways and recognizing multi-morbidity in individuals. Common risk factor integration includes exercise; diet; stress; common education; self-management approaches. These are also important approaches to chronic disease management. Multi-morbidity includes patients with more than one chronic condition or multiple risk factors for same.

(Taken from the AHS Integrated Community Based Chronic Disease program – A Proposed Model for Alberta document (2013)

Interdisciplinary team (inter-professional team): Implies an integration of the knowledge and expertise of several disciplines to develop solutions to complex problems in a flexible and open-minded way. This type of team is characterized by ownership of common goals and a shared decision-making process. Members of interdisciplinary teams must open territorial boundaries to provide more flexibility in professional responsibilities in order to meet clients' needs.

(AH, March 2015)

Medical Home: Is a family practice defined by its patients as the place they feel most comfortable to present and discuss their personal and family health and medical concerns. It is the central hub for the timely provision and coordination of a comprehensive menu of health and medical services patients need.

(College of Family Physicians of Canada. A Vision for Canada: Family Practice- The Patient's Medical Home, September 2011. Available at: http://www.cfpc.ca/uploadedFiles/Resources/Resource_Items/PMH_A_Vision_for_Canada.pdf)

Patient and family centred care: "Care that is truly patient-centred, considers patients' cultural traditions, their personal preferences and values, their family situations, and their lifestyles. It makes patients and their loved ones an integral part of the care team who collaborate with health care professionals in making clinical decisions."

(AHS Patient First Strategy page 8-9.)

Population Needs-Based Approach: A population needs-based approach includes *assessing* the determinants of health, risk factors and population needs; and improving the health of the whole population and reducing inequities in health. This approach emphasizes: (a) the significant role that patients and families have in making decisions about their healthcare and (b) the distinct but complementary contribution of all members of the healthcare team in enabling individuals, families and communities to achieve optimum health and wellbeing.

(A Primer on the Population Needs-Based Approach, Health Systems and Workforce Research Unit, Alberta Health Services, 2009)
(Taken from the AHS Integrated Community Based Chronic Disease program – A Proposed Model for Alberta document (2013))

Primary care: is first-contact, accessible, continued, comprehensive and coordinated care. First-contact care is accessible at the time of need; ongoing care focuses on the long-term health of a person rather than the short duration of the disease; comprehensive care is a range of services appropriate to the common problems in the respective population and coordination is the role by which primary care acts to coordinate other care that the patient may need. Primary Care is a subset of Primary Health Care.

(WHO, 2008)(with revisions)

Primary Health Care: Is a broader concept than primary care that emphasizes prevention and wellness, and recognizes that success in improving people’s health is largely determined by factors in their daily lives, such as lifestyles, housing, relationships, spiritual beliefs, income, and workplaces.

(Alberta PHC Strategy 2014)

Self –management: What people with a chronic disease do (their action and behaviour) to cope with how their disease affects them. This includes working with health care providers and others so that they become more confident and skilled in managing their chronic disease. People skilled at managing their condition and treatments understand their condition and are actively involved in their total care. People help create their own care plan and follow it. They protect and promote their health; they monitor and manage their condition. They also manage the affect their condition has on them physically, emotionally, and socially.

(AHS System Wide Case Management Definitions Glossary, December 21, 2011) (with revisions)

Self –management Support: What others do to help someone successfully manage their chronic disease. These may include family, friends, healthcare providers or others. They may do this through the physical, social, and emotional support of the person with the chronic disease. Supports that help people manage their chronic condition can include programs, tools and policies, offered by their healthcare system, non-profit or non-government groups, and their communities.

(AHS System Wide Case Management Definitions Glossary, December 21, 2011) (with revisions)

Supply: A measure of provider or program capacity or availability, i.e., the number of hours that members of the healthcare team are available each day to see individuals.

(Access- Improve- Measure (AM)) (with revisions)

Vulnerable: Persons of all ages who despite high burden of chronic disease, experience barriers to accessing healthcare services and have a high relative risk for morbidity and mortality. This includes Aboriginal people, high risk ethno-cultural populations, immigrants, refugees, certain populations living in

remote and rural settings, colonies, persons experiencing homelessness, persons living with poverty, persons with disabilities, people with low literacy skills and other hard-to-reach populations.

(Context and Definition adopted and used by former Diverse Populations Strategy focuses on the vulnerable segments of the diverse populations)

Whole Person Care: Is *holistic* care that *assesses* the physical, mental, spiritual and social care needs of individuals *including* their environment and family context and *provides access to care as appropriate*. *Engages* the individual in the planning and provision of care. Requires integration, coordination and collaboration of care.

(Towards Whole Person Care, Report, Sarah Bickerstaffe, Institute for Public Policy Research, UK 2013) (with revisions)