

Planning and assessment tool for chronic disease prevention and management

A summary of

Canadian Public Health Association (2008). A Tool for Strengthening Chronic Disease Prevention and Management Through Dialogue, Planning and Assessment. Ottawa, ON: Canadian Public Health Association. Retrieved from: <https://www.cpha.ca/tool-strengthening-chronic-disease-prevention-and-management-tool>



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Categories:

Tool, Implement, Evaluate, Organizational capacity and management, Partnership development and maintenance, Program planning, Leadership

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Tool

Relevance For Public Health

The Chronic Disease Tool has been piloted in four health regions across Canada. This tool could be used to develop a coalition among stakeholders to address diabetes prevention or management, with subsequent actions at the individual, practitioner, public health unit and community levels.

Description

The Canadian Public Health Association developed the Chronic Disease Tool as a comprehensive and integrated approach to address chronic disease prevention and management. This tool helps delineate public health, primary care and community stakeholder roles and responsibilities. It also helps determine how public health can have a collaborative role in chronic disease initiatives. The Chronic Disease Tool aims to make connections among those working in public health to integrate prevention and management efforts. It serves to: engage stakeholders in dialogue; promote information exchange; assess current policy, planning and practice; and identify actions, roles and shared responsibilities for preventing and managing chronic illness. The Chronic Disease Tool is based on these key concepts:

Building prevention into the chronic disease management system: there is limited capacity for prevention in both public health and primary health care system infrastructure. Using the Expanded Chronic Care Model (an integrated model for chronic disease prevention and management): see below.

Collaboration: includes both formal and informal ways of collaborating with community partners, community members and other stakeholders.

Capacity-building: involves developing infrastructure, program maintenance and sustainability and problem-solving among key players. Capacity-building can occur through a number of strategies, including workforce development, resource allocation, leadership, partnership development, etc.

The Expanded Chronic Care Model (Barr et al., 2003) integrates the prevention and management of chronic disease. It recognizes that coordinated efforts within public health, primary care and the community are critical in a comprehensive approach. The Expanded Chronic Care Model builds on the Chronic Care Model (Wagner et al., 2001) by broadening the clinical management of chronic disease to address prevention using a population health promotion approach. Population health promotion integrates the evidence of social determinants of health (as articulated in the Population Health Approach) with the actions of health promotion. It proposes that strategies based on efforts to address the root causes of illness and taking actions to prevent illness are most effective in improving health. For more information on the population health approach, see summary statement Accessing effective chronic disease prevention and health promotion initiatives. The Expanded Chronic Care Model consists of three elements.

1) Health System efforts to improve chronic disease prevention and management, including the following:

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Personal Skills and Self-Management Support: involves practitioners (within public health, primary care and the community) supporting individuals with self-management in coping with chronic illness, and developing personal skills for health and wellness for prevention.

Delivery System Design/Re-orient Health Services: includes a focus on prevention and improving access, continuity of care and flow through the system.

Decision Support: involves professionals and lay people making choices that support health and well-being and that prevent and minimize the impact of chronic illness.

Information Systems: includes increasing access to information for public health and clinical setting providers, community stakeholders and members for community mobilization and individuals. Community stakeholders include municipalities, local advocacy groups, recreation centres, schools, etc. Relevant information includes population health data in addition to clinical information.

2) Community efforts to support the health system in managing chronic illness and addressing the social determinants of health for prevention. This element includes the following:

Build Healthy Public Policy: involves developing organizational and governmental policies to ensure safer and healthier goods, services and environments. These policies enable individuals, businesses, organizations and governments to make health-enabling choices.

Create Supportive Environments: includes fostering living and work conditions that are safe, stimulating, satisfying and enjoyable. This goes beyond the physical environment to include fostering social and community environments supportive of health and wellness. Strengthen

Community Action: involves working with community groups to address chronic illness issues and increase community control over issues affecting their communities. This includes working with partners for community mobilization and advocacy.

3) Developing Key Relationships among these partners in chronic disease prevention and management, including the following:

A prepared, proactive practice team with the capacity to deliver evidence-based clinical management, health promotion/disease prevention and self-management support to individuals with chronic illness.

Informed, activated individuals and families with the capacity to understand chronic illness that can self-manage their condition (or support the self-management process).

Activated communities and prepared, proactive community partners who collaborate across sectors and with the health system to identify and address community needs. Individuals and families have effective links to community resources.

Implementing the Tool

Who is Involved?

The Chronic Disease Tool can be used for collaborative planning among diverse stakeholders to address chronic disease. These stakeholders include leaders, planners, managers and coordinators working in the following areas: regional health authorities and local health integration networks public health programs community health centres and clinics chronic disease prevention/management programs NGOs, coalitions and networks community groups non-health sector partners (school, workplace, municipalities, recreation and community services, immigrant service organizations)

Steps for Using Tool

The Chronic Disease Tool consists of these resources:

- Introduction to the Tool
- The Tool
- Worksheets and Resources
- A How-to Guide
- Case Studies from four pilot regions

The tool itself is based on eight critical success factors for strengthening chronic disease prevention and management. Each factor includes guiding questions to help use evidence-informed approaches in regional dialogue and planning. The critical success factors include the following.

Common Values and Goals: It is important to consider both health goals (such as the prevalence of chronic illness) and health system goals, which focus on specific areas of responsibility of the health system

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(e.g., screening, referrals, etc.). Reflective questions to guide discussion and planning for this critical factor include:

How are the stakeholders engaged in working together to strengthen chronic disease prevention and management?

How have stakeholders addressed the issue of developing common values to guide their work?

How have stakeholders addressed the issue of developing common goals for their work?

Focus on Determinants of Health: Two strategies are closely linked to support actions on the determinants of health: A) intersectoral policies to support basic needs and reduce health inequities, and B) creating environments that support health.

A) Reflective questions for intersectoral action include:

How are the Social Determinants of Health (SDOH) assessed and monitored in the community?

How are SDOH recognized in the core business, planning and evaluation functions of the stakeholders?

How do the stakeholders incorporate an intersectoral approach to addressing SDOH issues with respect to chronic disease prevention and management?

What resources or other assistance is available to support community action on SDOH?

B) Reflective questions for creating supportive environments include:

Are there currently any legislation or regulations in your region to build health-supporting environments?

What mechanisms have been developed to partner with schools to promote health and prevent chronic disease?

What mechanisms have been developed to partner with workplaces to promote health and prevent chronic disease?

Public Health Capacity and Infrastructure: Public health staff/organizations need specific capacities for chronic disease prevention and management, such as: an understanding of health equity and the barriers that can prevent people from taking care of their health; an ability to integrate a determinants of health approach into program planning (to address the root causes of chronic disease); an ability to develop and deliver programs that are accessible to all groups in the community, irrespective of language and culture; and an ability to work effectively with different types of health professionals, groups and organizations in the community. Reflective questions include:

How does the public health organization assess health needs/demands in the community?

How does the organization plan for the human resources required for chronic disease prevention and management?

How does the organization support its staff in developing competencies required for effective chronic disease prevention and management?

What resources has the public health organization allocated to implement the human resources plan and associated training?

What has been done to ensure that all services and programs have been developed or adapted to reach populations who face access barriers?

How are "root causes" considered in the development of programs to address chronic disease prevention?

Primary Care Capacity and Infrastructure: Working at the individual client and family level, primary care capacity refers to both the capacity of individual primary care providers in supporting self-management and prevention, and the organizational capacity of primary care organizations. The reflective questions for this factor include:

What role does primary care play in the regional plan for chronic disease prevention and management?

How are health needs/demands for primary care assessed?

How does the region plan for the human resources required in primary care for chronic disease prevention and management?

How are primary care providers supported in developing necessary competencies for chronic prevention and management?

What resources have been allocated to implement the human resources plan and associated training?

What has been done to ensure that primary care services are accessible to the entire population?

How does the region take an evidence-informed approach to the development of a primary care plan for chronic disease prevention and management?

How are primary care providers supported in implementing clinical prevention guidelines and self-management approaches?

What incentives are provided to primary care providers for developing competencies in chronic disease prevention and management?

What mechanisms are in place to support information and referrals between primary care providers, public health, home care and acute care?

Community Capacity and Infrastructure: Communities are diverse with respect to the capacity of specific groups and organizations working on community issues, and collective capacity garnered through coalitions and other mechanisms. Reflective questions for this factor include:

How do community groups/organizations participate in a comprehensive regional strategy for chronic disease prevention and management?

How do community groups/organizations assess the demand for their services?

How do community groups/organizations develop the capacity of their leadership to work effectively in chronic disease prevention and management?

How do community groups/organizations mobilize the resources required to do their work in this area?

How do community groups/organizations learn from their experiences and from the field of chronic disease?

Integration of Chronic Disease Prevention and Management: Integration involves linking individual and population-level approaches, building prevention into chronic disease management initiatives, integrating services and sharing planning to coordinate efforts and resources. Reflective questions include:

What kind of understanding of a collaborative systems approach to chronic disease prevention and management exists among key stakeholders?

How do stakeholders plan collaboratively to strengthen chronic disease prevention and management?

What mechanisms have been developed to support service integration across the continuum of chronic disease prevention and management services?

What systems are in place to facilitate data sharing for monitoring, surveillance and evaluation between stakeholders?

How do stakeholders collaborate on the development of key health messages to support healthy living and self-management of chronic disease?

Monitoring, Evaluation and Learning: Monitoring of population health status through rates of chronic disease, risk factors, determinants of health and other key indicators of health, including health behaviours, is key to developing a strong evidence base for decision making. Evaluation data of regional initiatives and specific programs for chronic disease prevention and management is another element to inform decision making. The surveillance capacity for non-communicable diseases needs to be improved to assist in monitoring. Reflective questions for this factor include:

How is evidence used to guide planning and action in the regional chronic disease prevention and management system?

How do stakeholders develop their staff/volunteer capacity for monitoring, evaluation and learning with respect to chronic disease prevention and management?

What indicators and systems are used to monitor chronic disease prevention and management outcomes?

What is the regional capacity for regular analysis, interpretation and reporting of chronic disease prevention and management outcomes?

Are program allocations and expenses for chronic disease prevention and management accurately tracked?

Leadership, Partnership and Investment: Public health can have a stewardship role in chronic disease prevention and management by: providing effective direction, meaningful support, monitoring and evaluation and strategic intervention where appropriate; investing strategically based on the best available evidence; and facilitating best practice development and evaluation of legislation, policies, strategies, best practices and performance expectations. Reflective questions include:

How have stakeholders identified common priorities and actions for strengthening chronic disease prevention and management?

What resources have been committed to a comprehensive approach for chronic disease prevention and management?

Over what time period has this commitment been made?

Who coordinates the comprehensive regional strategy?

What do stakeholders do to model health promoting work environments?

What accountability mechanisms have been developed to monitor policy and program outcomes?

The tool provides a worksheet for each reflective question above that includes: the reflective question with a brief description or example; a rating scale with indicators outlining the possible range of practice (0 = nothing in place to 4 = better/promising practices in place); a space to note your own rating information or indicators; and a space for tracking comments, opportunities/challenges or areas for follow-up identified through the assessment.

Evaluation and Measurement Characteristics

Evaluation

Has not been evaluated

Validity

Not applicable

Reliability

Not applicable

Methodological Rating



Not applicable

Tool Development

Developers

Canadian Public Health Association

Website: www.cpha.ca

Method of Development

Based on a literature review, the Canadian Public Health Association developed a preliminary planning and assessment tool with funding from the Public Health Agency of Canada to address this question: "What are the critical success factors for integrating chronic disease prevention and management?" The literature review covered four areas: public health capacity and infrastructure governance and health service delivery models (focusing on the interface between public health and primary health care) evidence base and learning systems policy (focusing on population health approaches) The preliminary tool was tested in three regional focus groups in Calgary, Ottawa and St. John's. Using feedback from key information interviews, the Chronic Disease Tool was revised and piloted in four sites: Nova Scotia (2), Ontario and Saskatchewan.

Release Date

2008

Contact Person

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Resources

Title of Primary Resource	A Tool for Strengthening Chronic Disease Prevention and Management Through Dialogue, Planning and Assessment
File Attachment	None
Web-link	https://www.cpha.ca/tool-strengthening-chronic-disease-prevention-and-management-tool
Reference	Canadian Public Health Association (2008). A Tool for Strengthening Chronic Disease Prevention and Management Through Dialogue, Planning and Assessment. Ottawa, ON: Canadian Public Health Association. Retrieved from: https://www.cpha.ca/tool-strengthening-chronic-disease-prevention-and-management-tool
Type of Material	Online toolkit
Format	On-line Access
Cost to Access	None.
Language	English, French
Conditions for Use	Not specified

Title of Supplementary Resource	Improving chronic illness care: Translating evidence into action
File Attachment	None
Web-link	http://content.healthaffairs.org/content/20/6/64.short
Reference	Wagner, E.H., Austin, B.T., Davis, C., Hindmarsh, M., Schaefer, J. & Bonomi, A. (2001). Improving chronic illness care: Translating evidence into action. <i>Health Affairs</i> 20(6), 64-78.
Type of Material	Journal article
Format	Periodical
Cost to Access	
Language	English
Conditions for Use	Copyright © 2001 Project HOPE: The People-to-People Health Foundation Inc.

Title of Supplementary Resource	The expanded chronic care model: An integration of concepts and strategies from population health promotion and the chronic care model
File Attachment	None
Web-link	http://www.ncbi.nlm.nih.gov/pubmed/14674182
Reference	Barr, V.J., Robinson, S., Marin-Link, B., Underhill, L., Dotts, A., Ravensdale, D., & Salivaras, S. (2003). The expanded chronic care model: An integration of concepts and strategies from population health promotion and the chronic care model. <i>Hospital Quarterly</i> , 7(1), 73-82.
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