

November 24–25, 2009 — Delta Toronto East

Taking Charge of Our Health

Partnership Development Initiative--Building the Self-Management Community



Achieving Self-Management *What Will It Take to Succeed?*

After two days of inspiring presentations, stimulating discussion, and sharing of challenges, participants at the 2009 Taking Charge of our Health Conference worked together to articulate the goals, barriers, and opportunities to achieving patient self-management integrated across the continuum of health promotion and chronic disease management, encompassing community services, primary care, specialty clinics and institutions. Above all, participants ...*cont'd p. 2*

Upcoming Opportunities

Ontario Patient Self-Management Network

Become a member!
Join the Advisory
Council. Contact
IOHO for info.

Regional Events Spring & Fall 2010

Help organize peer
and professional
workshops in your
region.

TCOOH 2010 Nov. 3 - 4, 2010

Suggest workshop or
presentation. Watch
for upcoming Call
for Proposals.

Take Charge!

We have had the vision, the tools, know-how and motivation! Now we also have a shared vision, mutual inspiration, and a commitment to moving forward together.

2 Days

135 participants:

*Physicians, nurses, dietitians,
physiotherapists, pharmacists,
social workers, researchers,
administrators, government,
industry, patients*

Int'l, Nat'l & Local Models:

*UK, Wisconsin, Oregon
Nova Scotia, Calgary
CE, SW & MH LHINs
Sherbourne, Guelph, Timmins,
Halton, Ottawa, Toronto*



Next Steps to Integrated Self-Management

Goals, Barriers, Opportunities

...emphasized the importance of collaboration and coordination.

Goals. To achieve successful integration of self-management within chronic disease management and healthcare, participants identified the importance of a “common language” across the various forms of “self-management” programs. We need to identify the critical elements that define self-management and differentiate it from patient education and patient support. Success also means self-management is widely available: for every patient, in every province, as a core component in primary care, across the care continuum, and in mental health and social healthcare. Successful integration would be facilitated (and evidenced) by self-management being taught as core curriculum in medical and professional education and endorsed by groups such as the Ontario Medical Association. It would also be a “hot topic” in the media, leading to the creation of a self-management culture and community engagement in SM support activities.

Barriers. Participants identified barriers to achieving the vision of self-management. Importantly, success does not depend entirely on funding. Nevertheless, the lack of dedicated funding is a barrier, especially as it affects available time and human resources to deliver and support self-management. Another key barrier is communication, in particular, not effectively communicating the “fuzzy” concept of self-management, which also has a common (generic) meaning and not specific to the

“patient self-management” programs. A third limiting factor has been the lack of (robust) evaluation demonstrating the value of self-management. Self-management programs suffer from a lack of volunteer peer leaders. Finally, there is a need to align self-management with other system priorities.

Next Steps. To deal with barriers and to move toward the goals of integrated self-management, participants identified the need to work collaboratively and to actively engage other stakeholders. Initial activities include formalizing collaboration, reactivating the Ontario Patient Self-Management Network, discussing funding, and developing key messages that speak to the positive value of self-management. We need to collaborate with others, starting perhaps with IBM and the Calgary health and wellness CRM model. We also need to broadly disseminate SM concepts and activities and to partner with community groups. Finally, we need to promote self-management as part of the university curriculum. To increase awareness, we need to create a “brand” for self-management” that connotes positive action, to seek political champions (those personally affected), to contact the media and to use personal impact stories. Collectively, we should seek ways of “redirecting” funding to self-management for activities such as staff education and to link with other initiatives, for example, Romanow’s work on the Canadian index of well being. Finally, it was suggested that we could encourage the use techniques, such as action plans, in our own work.

Plenary Sessions Day 1

Taking Charge of Opportunities

James Meloche, Central East LHIN

There are commitments at all levels of the health system for chronic disease management. The Central East Local Health Integration Network (CE LHIN) is taking charge of these opportunities through a series of action steps.

Step 1 is to understand the burdens caused by chronic diseases led by arthritis, COPD, hypertension, diabetes on Emergency Department (ED) and General Practitioners/Family Physician visits. The modifiable risk factors for cardiovascular disease, for example, include high blood pressure, obesity, smoking, physical inactivity, and poor diets. In response, the CE LHIN has introduced the Self-Management workshop, “Living a Healthy Life,”

Step 2 is to identify collective aims. A collaborative strategic aim of CE LHIN is to save one million hours of patient time in the ED over four-year period, from 2009-13. In addition, we are committed to reducing patient hospitalization days due to vascular disease by 10%, which would save 10,000 in-patient days over four years. We are incorporating lessons from others, namely the Institute for

Healthcare Improvement (IHI) Framework’s for System Quality Improvement and Triple Aim (addresses enhancements in public health, patient experience, and value for money). We also need to ensure sustainability by focusing on common interests, practical coalitions, and a diversity of service providers.

Step 3 consists of moving forward with an execution strategy, which includes: designing the structure, developing initiatives, deploying resources, and providing oversight. The IHI Framework for Spread calls for iteration from ideas to partnering to spread changes into the social system. We use the patient experience (as expressed through stories) as the common tool for coalition building. By articulating a vision, establishing high-level coalitions, and identifying patient streams, we can move to refined strategic coalitions (including self-management), all of which lead to the goal of reduced ED visits.

Step 4 is to get started. This step has included documenting the patient/caregiver experiences, coalition team building, continued focus on improving health, rapid tests of learning, and alignment of strategic aims. Critical success factors are measure, learn and communicate.

Up Close & Personal

Conversation Hour with

Simon Knighton, Expert Patients Programme UK

Q: What are the secrets to successfully implementing the program in communities?

A: Partnerships with local primary care and community groups are essential to attracting local volunteer leaders and recruiting participants.

Q: What are important changes that you have made to EPP over the years?

A: Quality in group leadership is important. That means fidelity to the program but also training in group skills. We have also created supplementary programs: for carers, professionals, teens, addictions, and chronic pain.



Expert Patients Programme and Community Interest Company

Simon Knighton, Expert Patient Programme-Community Interest Company

The Expert Patient Programme Community Interest Company (EPP CIC) was established in April 2007 following a successful EPP pilot launched in 2002. To date, over 5,000 courses have been delivered to 70,000 participants. The EPP CIC Vision is to establish the principle of individual self-management as a recognized public health measure, delivered in a cost-effective, sustainable way. The public policy context is that the National Health Service of the future will be “patients engaged and taking control of their own health and healthcare.”

Self-management training (Stanford-based) is provided in small groups where participants learn goals, problem solving, action plans, communications, managing emotions and relationships, importance of exercise and healthy eating, managing fatigue, sleep, pain, anger, depression. The success of the program is based on understanding the factors that contribute to health: 10% access, 20% genetic, 20% environmental, and 50% behavioural. Similarly, the factors that affect mortality are comprised of 5% environmental exposure, 10% healthcare, 15% social circumstances, 30% genetic, and 40% behavioural.

The EPP CIC has a structure of 130 staff in five regions. The Primary Care Trusts participate as customers. Thus, EPP delivers 600 courses and assists in the delivery of 2000 courses. In addition, EPP provides assistance with tutor training, supervision and assessment. We work with “hard to reach” communities and offer courses in nine languages as well as professional development and new courses and materials.

Non-Stanford courses include carers courses, WISE UP (EPP for social care and health professionals), Forward Steps (falls prevention program), persistent pain, New Beginnings,

support for recovery from substance and alcohol, positive self management (for HIV/AIDS participants), young peoples workshops, and several disease-specific products.

The EPP is participating in research with Universities of York and Manchester. A randomized control trial, involving 700 participants, is examining processes, clinical outcomes, and cost-effectiveness. The outcome measures include: health status, disease process, healthcare use, mortality, and cost-effectiveness. The analysis to date shows a 94% probability of cost-effectiveness of EPP intervention based on a cost of £250/300 per QALY. Moreover, there is a likely protective effect on health-related quality of life (HRQoL) for patients with poor health or low confidence, due to the translating of patient confidence into behaviour change.

The EPP has also focused on the engagement and understanding of clinicians and health professionals and has identified seven actions to change behaviour. These are: changing unhelpful beliefs; changing unhelpful coping actions; boosting motivation to make change enjoyable; boosting confidence; setting small goals; increasing feeling of control; improving self-management knowledge on using medication, lifestyle, anxiety and depression.

Currently, the EPP is redesigning courses to emphasize quality delivery and enhanced lay skills. Co-creating Health (with healthcare professionals) is a 3-year pilot across 8 sites, focusing on depression, COPD, musculoskeletal pain, and diabetes. Healthcare professionals are introduced to tools to support self-management, including supported agenda setting, goal setting, and follow-up on goals. Teams are trained, employing quality improvement principles.



Successful Statewide Collaborative Implementations Examples from USA

Wisconsin: Living Well with Chronic Conditions, *Anne Hvizdak, Wisconsin Department of Health Services*

The Wisconsin Living Well with Chronic Conditions is structured as prevention programs embedded in public health and aging networks. Key functions include pursuing public/private partnerships and providing technical assistance and statewide coordination.

Services include: training leaders for Living Well; promoting community workshops through area Agencies for Aging and local Public Health Departments; hosting Stanford CDSMP Master Leader Training; and providing a leaders tool kit, policy and procedure manual, and the Wisconsin Evidence Based Prevention website.

To date, the program has delivered 220 Living Well workshops to 1678 individuals, with availability in 52 of 72 counties. The WI Institute for Health Aging is conducting translational research. There are several sources of government funding, as well as partnership agreements with HMOs and medical providers and nonprofit agencies.

Building Sustainable Infrastructure for CDSM Oregon, *Cara Biddlecom, Oregon Department of Human Services*

Oregon's Living Well Network promotes sharing of strategies, resources, and best practices. It provides workshops, marketing and recruitment, quality assurance and fidelity, and reimbursement. Living Well has 400 trained leaders, 70+ Master Trainers, and 46 licensed organizations.

Partners include hospitals, clinics, parish nurses, VA, Department of Health Services, education institutions, mental health, senior centers, nonprofit organizations, housing, employee benefits, parks & recreation, and community foundations. Successes include state-level coordination, diverse partners, and new programs. Challenges include the diversity of organizations, sustainable funding, rural populations, healthcare system buy-in, and leader retention. Lessons learned include the need for diverse partnerships, need for combined and diverse funding streams and the importance of letting programs and participants speak for themselves.

Implementing Self-Management in Communities

ANCHOR: Interdisciplinary Community-Based Research. *Claudine Szpilfogel, Research Power Inc.*



ANCHOR (A Novel Approach to Cardiovascular Health by Optimizing Risk Management) is a 1-year intervention study with two case control groups. The 6 partners are Nova Scotia Dept. of Health, Capital District Health

Authority, Cape Breton District Health Department, Heart & Stroke Foundation, QEII Foundation, and Pfizer Canada. The ANCHOR Model consists of health risk assessment, review and goal setting, counseling or intervention, education, community programs, medication review, and specialty referral. The ANCHOR Intervention Schedule depends on participant's risk category. The preliminary data (n = 1509) shows that 38% of participants dropped one risk category and 8% reduced their risk score with intervention. A Minimal Intervention (follow-up) Study will evaluate efficacy of different levels of intervention and efficient means of sustaining improvements with "minimum" clinician contact.

Engaging Diverse Patient Populations.

James Read, Sherbourne Family Health Team

The Sherbourne Health Centre is a downtown Toronto primary care site serving three marginalized communities (lesbian, gay, bisexual, transgender, homeless, and newcomers). Services include a Family Health Team, mental health, and social services. Barriers include poverty, unstable housing, income and food insecurity, language/cultural barriers, gender identity, substance use, trauma, mental illness, co-morbidities, judgments, and mistrust.

The chronic disease management model defines an "informed, activated individual" as one with motivation, information, skills, and confidence, that is, a self-manager. The role of the HCP is to provide client-centred support, empowerment, shared decision-making, shared guidelines, and follow up. An example is the East Toronto Hepatitis C Program, a partnership of three health centres. A peer HCV worker facilitates weekly groups with content driven by members. The informal outcomes show weekly attendance is high; substance use and mental health are more stable; and more individuals are engaged in managing their health.

Another example of a peer program is "Gender Journeys." Two "trans" individuals facilitate an eight-week group for transgender clients, focusing on education, peer support, community building, and empowering clients. The results have been 97% positive response to the information and support.



Self-Management Teamwork

Living a Healthy Life *Margery Konan, Central East LHIN*

The Central East LHIN has partnered to implement the Stanford CDSP across the region with a goal of 3000 participants in 3 years. Success steps include building relationships with existing Peer Leaders and Master Trainers, identifying a Project Leadership Team, and implementing diabetes and chronic pain self-management programs with transition to permanent programs. Accomplishments include a website for registration, participants in 92 SM workshops in all nine LHIN zones, four T-Trainers, and 18 Master Trainers.



Using Teamwork in Halton Diabetes Program

Cathy Benbow Plewes, Halton Diabetes Program

A very important component of the Halton Diabetes Program has been the development of Physician Ambassadors, who teach other physicians on patient-focused diabetes education. Halton has developed an Information Kit as well as patient-focused assessments and support materials, including those for joint goal setting and problem solving. There are mechanisms for on-going education, support, and communications as well as annual CMEs for FP, newsletters to HCPs; and referral forms and treatment (monitoring) guidelines.



Peer Leader Perspectives

The key to success in CDSM programs is having peer leaders, who are often patients and caregivers with personal experience in managing chronic conditions. Participants from the 2nd TCOOH Conference heard from three extraordinary leaders, Ann Lyddiat, Tara Jeji, and Jim Dove, on how they have integrated self-management in their daily lives, on-going challenges, and what it means to be a peer leader.



Plenary Sessions Day 2

Building Self-Management Support into Practice. *Mike Hindmarsh, Hindsight Healthcare Strategies*

Healthcare Strategies

According to the Wagner Chronic Disease Model, which serves as the framework for provincial disease management, good health outcomes are based on productive interactions between the “informed, activated patient” and “prepared, proactive practice team.” This requires self-management support, delivery system design, decision support, and clinical information systems.

Patient education and self-management support are both necessary but not the same. Information is necessary but skills must also be taught for behaviour change to occur. Finally, collaborative care must recognize that patients are experts in their own lives; the physician can add medical knowledge.

The “5 A’s” of SMS (Assess, Advise, Agree, Assist and Arrange) form another useful framework. It is important to provide SMS throughout the patient experience, for example, waiting room assessment, feedback on achievements, peer support, and follow up.

An effective training program requires buy-in from the physicians. Staff can be trained to

deliver goal setting and action planning, with the use of IT to track goals and action plans and dedicated staff time for follow-up. Examples of SMS initiatives are Open Airways for children with asthma and the SM Toolkit developed by the South West LHIN with tools, techniques, and a website.

CDSMP in Canada. *Barbara Paterson, University of New Brunswick*

An environmental scan of programs across Canada identified best practice and evidence-based models. Method included interviews with 91 service providers and 36 persons with chronic disease, literature review, and consultations with government, disease groups and SM experts. Models included: Stanford and other group-based CMDSP, individual education and support, and technology-based SM.

Identified issues in SM delivery included: attraction and retention of participants, leadership, coordination and integration, sustainability, credible evidence, inequities in access, and issues not covered by the programs.

The discussion summarized issues regarding leaders, access, coordination, evaluation, and the future.

Thoughts from Round Tables

16 Round Tables of 5 to 12 delegates participated in a “mini-SWOT” to develop a consensual Vision for Integrated Patient Self-Management in Canada, the enablers and the barriers.

Commonalities in Vision were: integration across the continuum of care from wellness to end of life care, buy-in by governments and HC/education institutions, and adequate funding investment. Enablers were CD strategies, successful models in Canada and elsewhere, and tie-in to priorities related to increasing burden of CD and primary care reform.



Self-Management and Community-Based Primary Care

Self-Management in Primary Care Metabolic Syndrome and Diabetes. *Ross Kirkconnell, Guelph FHT*

The Guelph FHT comprises 70,000 patients, 50 physicians, 65 FHT staff, and 14 locations. The Diabetes Care Continuum is divided into three levels. Level 1 is Primary Care managed by PC physician, RN or NP, and pharmacist. Level 2 is Diabetes Care and provided by a multidisciplinary team, DM Team, and endocrinologist. Level 3 is Specialized Clinical Management provided by endocrinologist, pediatrician, and OBGYN.

Supports for lifestyle management include the Stanford-based CDSMP training and our websites (mydoctor.ca and guelfht.ca) as well as a blood sugar monitoring tool.

The benefit of this multidisciplinary approach has been demonstrated by the diabetes prevention trial (reported in NEJM), showing a 31% risk reduction by metformin intervention and 58% risk reduction by lifestyle intervention.

SM and Community-Based Care. *Elisha Laughren, Timmins FHT*

The Timmins Team is comprised of 18,982 Patients, 24 physicians, 21 physician staff, and 31 Timmins FHT sites. The initiative includes adopting SM, management support, resources, and training. Training has included the 3-Minute empowerment model (motivational interviewing) and Helping Patients Succeed (Institute for Optimizing Health Outcomes Self-Management Support workshop).

Self-management support includes: “1 on 1” clinical visits, education and supportive interventions, follow up, and collaborative goal setting and problem-solving support. The Healthy Lifestyle Sessions are available through self-referral or providers; they are led by HCPs and consist of educational sessions with skill development techniques. Another initiative is diabetic group medical appointments. It is primarily educational with a skills development component and follow-up visits.

Calgary HR— Bodacious Framework Integrating Health & Wellness

Dorothy Whittick, IBM GBS Health Care

IBM GBS Health Care facilitated the development of the Calgary Health Region Strategy Overview using a client engagement and relationship management (CERM) framework. The presenting challenge was articulated as siloed health and wellness services resulting in inconsistent messaging, redundant effort, and lack of continuity in services. The project purpose was defined as developing a CERM strategy to synergize services, engage citizens, inspire wellness and harmonize service delivery. The desired outcomes were articulated as a strategy for “citizen-centric” health and wellness with a vision, services, context, channels and roadmap to transition to future state of connected services.

In the context of the project, the CHR Wellness Portfolio goals were identified as: improve engagement of citizens to take responsibility for their own health and wellness; ... *cont'd p. 10*

Calgary HR—Framework Integration Health & Wellness *(cont'd from p. 9)*

... understand citizen needs; optimize information, communications, and channels to support; identify ways to engage and inspire; lever health system and partners to build relationships; and focus on citizen engagement and relationship.

The CHR identified current gaps as: provider-centric health service; lack of knowledge of citizen needs; difficulty in navigating health and wellness; siloed information development; inconsistencies and confusion; hand-offs between providers not coordinated; and lack of integration of health and wellness services.

CRM Principles were used to build the strategy. The CRM Functions to be adapted include: marketing, sales force automation, customer service, private sector roots to increase loyalty, recruitment, retention, (and profitability). The adaptation of private-sector models to the public sector used the following principles: know the citizen to provide the right service at the right time; migrate from reactive to proactive and self-service; use closed loop workflow or case management; use knowledge management; use content management; improve channel adoption (phone, email, mobile); optimize channels of choice.

The elements of the CHR Health & Wellness Vision Framework were identified as: Wellness brand; Well Client Segmentation; Wellness services; Wellness service agencies, and Wellness channels. From these the Health & Wellness Eco-system-Citizen centric view was developed around all networks available to the client, namely:

- Personal network: family, friends, caregivers, social, lifestyle
- Work Network: employer, colleagues

- Personal Business Network: finance, communications, entertainment
- Health System Network: Wellness portfolio, Health region, providers, families, caregivers, and social
- Government Network: municipal, regional, provincial, national agencies

The ensuing vision was articulated as “Wellness innovates health.” This led to identification of enabling actions. The vision enablers include the “Be Well” Centre, which includes numerous products and services provided to citizens directly or through partners. Delivery is premised on a non-transactional way of looking at services, and marketing and service provision are aligned with channel adoption and segmentation, with a goal of the proactive engagement of citizens. Thus, healthy communities will be part of a one-stop be-well centre network. The Be Well Centre core requirements are proposed as:

The overall goal is to shift unengaged citizens to being active customers based on their current status: from “not a customer” to “passive customer” to “active customer.” To this effect, the proposed services are information and navigation; self-service and management; counseling and planning; scheduling; monitoring and surveillance.

In summary, it is important to view health and wellness services from the citizen perspective with segmentation that transcends silos and to identify ways and incentives to shift from passive to active customers. Use CRM framework to provide new insights.



Concurrent Workshops and Presentations

Power of a Team: VON Canada's SMART (Seniors Maintaining Active Roles Together)

Sheila Schuehlein, VON Canada

The VON SMART Program (Seniors Maintaining Active Roles Together) are volunteer-led functional fitness services provided through local VON sites to reach older adults who would not normally have access to exercise at an appropriate level and/or are unable to attend traditional community fitness programs due to barriers such as limited mobility, transportation, poor health and/or cost. Working with established partners at the community level, SMART supports community-dwelling older adults to begin, progress and maintain functional fitness regardless of their current level of ability or mobility.

Fifty percent of SMART Group participants reported that their health was improved; 41.9% indicated their health was about the same following completion of the program; and 82.4% indicated that the exercises were helpful for their physical problems. Overall, 93% of SMART In-Home participants reported achieving or surpassing their individual goal for participating in the program.

What Works? Evaluating Chronic Disease Self-Management Support in Canada.

Clare Liddy & Sharon Johnston, University of Ottawa Department of Family Medicine, Élisabeth Bruyère Research Institute; Susan Jaglal, Department of Physical Therapy, University of Toronto, Women's College Research Institute, Toronto Rehabilitation Institute

This presentation outlines our proposed national evaluation of the CDSMP. Measures go beyond the outcomes suggested by the Stanford evaluation toolkit and include those relevant to self-management stakeholders such as process indicators and clinical data abstracted from participant's health records.

By evaluating such CDSMP measures across Canada, we aim to determine if health care utilization decreases in the long term (past one year mark) compared to the year prior to enrolment in the program. As well, we will identify potential pathways by which the CDSMP can lead to improved health care utilization and other health outcomes indicating appropriateness of health care visits, changes in behaviour, health status, and the role of self-efficacy in facilitating improvements in health status and reductions in health care utilization.

Condition Specific Self- Management Programs: Facilitator Training for Health Care Professionals. *Anita D. Mendelson & Christina Wells-Rowell, Baycrest*

Baycrest offers three condition-specific SMPs (Program for Arthritis Control through Education and Exercise, Parkinson's Early Management Program, Moving On After Stroke) to address the daily challenges and changing needs of people living with these conditions. A Facilitator Training Program (FTP) for each SMP has been developed. The goals of the FTP are to train and support facilitators in the delivery of each SMP; to retain content integrity; to ensure the quality of program delivery; and to promote continuous evaluations and program improvements.

The expected outcomes are that through the FTP, health professionals develop the knowledge and skills to transform themselves from a care provider delivering service on a one-to-one basis to a group facilitator of self-management skills and health behaviour change for persons living with arthritis, stroke and Parkinson's. This partnership and community building will promote a wider dissemination of these programs, thereby improving accessibility for individuals living with these conditions, and support capacity building between organizations.

Concurrent Sessions

From Research to Reality: The Champlain Community Connection Strategy. *Clare Liddy and Sharon Johnston, University of Ottawa Department of Family Medicine*

The CDSM team is a partnership between an academic research team and a Regional Health Authority in Ottawa, Ontario working to bring evidence into action. During the CDSM project, an iterative model called the Community Connection Strategy emerged and included the following steps: Identifying Stakeholders, Community Networking Meeting, Knowledge Exchange, and Program



Self-Management in MH LHIN. *Susan Swartzack, Mississauga Halton LHIN; Stacey Horodezny, Trillium Health Centre; Jan Baker, Halton Healthcare Services Corporation*



The Mississauga Halton LHIN has implemented a multi-faceted approach to providing access to self-management and self-management support. The initial focus was on building awareness of self-management for health care providers by offering workshops and then inviting HCPs to become trained CDSMP leaders. The multidisciplinary team of the Halton Renal Program was able to modify their entire program to reflect self management principles through self-assessment of the program, working together to identify opportunities where self-management would fit into existing programming, and creating new formats for assisting patients through their journey.

Initiating Change in Health Systems: Lessons Learned
Janis Leiterman & Cynthia Hitsman, VON Canada

Barriers to SMS include lack of system change elements such as delivery system design, decision support, clinical information systems, healthy public policy, and supportive environments. Collaboration is crucial within complex health care organizations and partnerships are required but inter-professional teams may resist change due to being at different places in the change process and lack of incentives. VON Canada shares lessons learned from implementation of their CD SMS Program with a CCAC & LHIN in Ontario and a Regional Health Authority in Nova Scotia.



Concurrent Workshops and Presentations (cont'd)

Program Framework based on Chronic Disease Self-Management: Integrating Evidence, Evaluation, Research and Partnerships

Catherine Goetz-Perry, & Janis Leiterman, VON Canada

Participatory action and consensus building methods were used with the VON CDM team and key external experts that resulted in the development of a framework for the program and individual projects that integrates evidence, evaluation, research and partnerships. The framework includes: (a) use of relevant evidence to support self-management and SM support interventions selected and provide decision support to health care providers; (b) use of logic model, outcomes, indicators, quantitative and qualitative methods and valid, reliable tools for evaluation; and (c) research partnerships supporting evaluation methods and identification of future improvement and self-management research opportunities from evaluation results.

Using Best Practice Health Information to Support Self-Management: Avoiding the Pitfalls of Gobbledygook.

Farrah Schwartz, Toronto Rehab; Jane Bowman, Urban Health Team, St. Joseph's Healthcare; Rita Kang, Toronto Western Hospital

A majority of Canadians (60%) lack health literacy skills. The gap between best practice and actual health information can create barriers for people to effectively manage their care. Those providing health information and self-management support need knowledge of health literacy challenges, strategies to address these challenges and best practice in health information design.

This workshop will engage participants to apply best practice in health information design and delivery to support self-management programming.

Topics include: Writing for consumers; Assessing material for consumer-friendliness and readability; Engaging consumers in the creation of health information; Using pictures and images to promote comprehension; Helping consumers find information online.

Increasing Access to Chronic Disease Self-Management Programs (CDSMP) in Rural and Remote Communities Using Telehealth.

Susan Jaglal, University of Toronto; Vinita Bansod, University of Toronto; Pia Kontos, Toronto Rehab; Gillian Hawker, Women's College Research Institute; Nancy Salbach, University of Toronto; Wendy Lou, University of Toronto; James Cameron, Saint Mary's University; Rhonda Cockerill, University of Toronto; Rob Williams, Timmins & District Hospital

Access to CDSM programs in rural and remote communities is limited due to a lack of trained leaders. We enrolled 213 participants from 13 northern Ontario communities in 19 six-week tele-CDSMP courses. Statistically significant improvements in self-efficacy to deal with chronic conditions were seen from baseline to four-month follow-up. Statistically significant improvements were also seen in exercise behaviours, cognitive symptom management and communication with physicians, self-rated health and mood.

Improvements in self-efficacy, health status and health behaviours were sustained four-months post participation in a tele-CDSMP. Access to self-management programs could be greatly increased by delivering self-management programs to rural and remote communities via telehealth.

Concurrent Workshops and Presentations (cont'd)

Building Self-Management Climate among Immigrant Community. *Yan Gao & Pamela Mahatoo, Sherbourne Health Centre*

Sherbourne Health Center is an urban primary health care center. To engage the expertise and insights of the community, our team members have built partnerships with community agencies and established networks with community leaders. The health promotion program focuses on knowledge and skills transfer, prevention and self-management, including a health literacy program, self-help groups and group clinics. It is important to know how cultural backgrounds, values and education influence health behaviors.

Self-Management and Exercise for Arthritis, Parkinson's and Stroke: Demonstrated Success – Evaluation Findings. *Anita D. Mendelson & Christina Wells-Rowse, Baycrest*

Baycrest offers three SMPs: exercise practice for arthritis (PACE-Ex™), Parkinson's (PEMPTM) and stroke (MOST®). Over 8-10 weeks in twice weekly sessions, participants gain skills and practice in decision making, problem solving, healthy behaviours, and accessing resources for changing needs. They engage in one hour of facilitated group discussions, information sharing and goal setting. The second hour is warm water exercise, axial mobility exercise or land exercise circuit with warm water exercise. Participants show significant improvements in self-efficacy, coping, communications, exercise time, gait speed, balance and balance confidence.



Implementation and Evaluation of an Evidence-Based Chronic Disease Self-Management Program in Montreal. *Deborah Radcliffe-Branch & Lisa-Anne Elvidge, McGill University Health Centre.*

The “L’Atelier/My Toolbox” self-management program (Stanford’s CDSMP) provides a bilingual, comprehensive, chronic disease management program for patients and their families. There are more than 430 patients, 35 leaders and 5 master trainers. Most participants have complex disabilities that define chronic neurological conditions including muscular dystrophy, multiple sclerosis, and chronic pain. We showed statistically significant improvements in cognitive symptom management, communication with physicians, self-efficacy in managing symptoms and disease, general health, depressive symptoms, fatigue, health distress, pain, and illness intrusiveness. .

“It’s Hard to Paddle Upstream, When You’re Caught in the Current...”: Supporting Self-Management in Rural Older Adults with Heart Failure. *Catherine Goetz-Perry, McMaster University & VON Canada*

Interviews were conducted with rural older adults with heart failure and their caregivers and with primary care providers to compare the perceptions of the need for self-management and the provision of SM support. Goals expressed by clients and caregivers were “live for today”, and “control HF moderated by resilient acceptance” while the PHC providers identified goals as “stability” and “control HF to stay at home through compliance.”

This study shows that rural characteristics and context perpetuate the traditional “sick role” and acute care paradigm for clients and providers and also serve as barriers to the integration of SM support and chronic disease prevention and management into PHC.

Conference Evaluation

The 2nd Taking Charge of Our Health Conference met the needs of participants as a follow-up to the 2008 Conference on Integrating Patient Self-Management. The goal of the 2009 Conference on Developing the Self-Managing Community was to bring together local and international expertise to share strategies and build on experiences for implementing community-based self-management programs. The overall conference program was rated as 3.6 (out of a possible 4), with 59% reporting it as excellent. Participants responded positively to all plenary and workshop sessions, with very high ratings for the two keynote speakers, Simon Knighton from the UK Expert Patients Programme and Mike Hindmarsh, as well as Dorothy Whittick from IBM Healthcare Strategies speaking on overarching frameworks for Chronic Disease and Patient Self-Management.

All plenary sessions were evaluated as excellent good and excellent, with average ratings of 3.9 to 3.1 (out of possible 4). Similarly, the workshop sessions received mostly excellent and good reviews, with average ratings from 3.9 to 2.9. Finally, participants rated as highly valuable (average rating of 3.4) the plenary session, on Answering Challenges, Seizing Opportunities. The conference yielded recommendations for working collaboratively, increasing healthcare professional support for patients to assume self-management roles, and integrating the patient self-management in community programmes.

Conference Sponsors

On behalf of participating patients, families, and healthcare providers, we would like to recognize the following sponsors for their generous support of Taking Charge of Our Health Partnership Development Initiative, Building the Patient Self-Management Community.



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