CHARTING THE COURSE

An integrated wellness and chronic disease prevention and management strategy for Nova Scotia

nova scotia health

IWK Health

NOVA SCOTIA

Table of Contents

Version 12 | November 23, 2022

Author: Primary Health Care and Chronic Disease Management Network, Nova Scotia Health

Contact: primaryhealthcare@nshealth.ca

Acknowledgements

Charting the Course: an integrated wellness and chronic disease prevention and management strategy for Nova Scotia is the result of close collaborative work across many portfolios within Nova Scotia Health, the IWK Health Centre, the Nova Scotia Government's Department of Health and Wellness and our Patient and Family Advisors. The table for collaborative strategy development was the Wellness and Chronic Disease Advisory ("Advisory"), a forum of the Primary Health Care and Chronic Disease Management Network at Nova Scotia Health. The Advisory provided advice and feedback on all aspects of the process. Thank you to all Advisory members for your ongoing commitment and dedication to this work.

***Dr. Alison Wellwood**, Family Physician*

***Brenda MacDonald**, Senior Director, Food and Nutrition Services*

***Cheri Gunn**, Program Manager, Rehabilitation Services*

***Chris Rice**, Patient Family Advisor*

***Courteney Doane**, Registered Nurse, Diabetes Centre*

***Ed Wark**, Senior Communications Advisor, Primary Health Care & Chronic Disease Management*

***Erin Christian**, Director (previous), Primary Health Care & Chronic Disease Management Network*

***Graeme Kohler**, Director, Primary Health Care & Chronic Disease Management*

***Heather Beaton**, Operations Consultant, Primary Health Care & Chronic Disease Management Network*

***Holly Wilson**, Social Worker*

***Jacklynn Humphrey**, Wellness Facilitator (Behaviour Change)*

***Jill Robison**, Operations Consultant (Physical Activity)*

***Joanne Collins**, Senior Analyst, Mental Health and Addictions*

***Jo-Anne Wentzell**, Director, Primary Health Care, Primary Health Care & Chronic Disease Management*

***Judith Purcell**, Manager, Prevention and Health Promotion, Nova Scotia Cancer Care Program*

***Judy Porter**, Patient Family Advisor*

***Kady Myers**, Health Service Lead, Virtual Wellness & Chronic Disease Management*

***Kate Melvin**, Director, Clinical Networks, Episodic and Integrated Acute Care Network*

***Kathleen Steele**, Health Service Lead, Primary Health Care & Chronic Disease Management*

***Kelly MacInnis**, Pharmacist, One Door*

***Kelsey Kennedy**, Wellness Facilitator / Dietitian*

***Kim d'Entremont**, Patient Family Advisor*

***Kristin Currie**, Manager, Diabetes Care Program of NS and Chronic Disease*

***Laura Wentzell**, Manager, Primary Health Care & Chronic Disease Management Network*

***Lauren Pyke**, Clinical Lead, Outpatient Physiotherapy*

***Leanne Webb**, Health Service Lead, Primary Health Care & Chronic Disease Management*

***Lindsay MacKinnon**, Project Coordinator, Primary Health Care, IWK Health*

***Lindsay Sutherland**, Director, Primary Health Care & Chronic Disease Management*

***Mary Synette**, Admin Assistant, Primary Health Care & Chronic Disease Management Network*

***Melanie Newell**, Manager, Primary Health Care and Chronic Disease Management*

***Michelle DePodesta**, Director, Primary Health Care & Chronic Disease Management*

***Michelle Robinson**, Clinical Educator, Interprofessional Practice & Learning*

***Mila Anderson**, Family Practice Nurse*

***Pam Talbot**, Epidemiologist, Diabetes Care Program of Nova Scotia*

***Rachel Harvey**, Nurse Practitioner, Primary Health Care*

***Richelle Sparks**, Nurse Practitioner, Primary Health Care*

***Rita McAuley**, Senior Strategist, Primary Health Care & Chronic Disease Management, Department of Health and Wellness*

***Rob Dickson**, Occupational Therapist / Clinical Team Lead, Integrated Chronic Care Service (ICCS)*

***Robert Patey**, Patient Family Advisor*

***Roger Bolt**, Patient Family Advisor*

***Dr. Ryan Sommers**, Senior Regional Medical Officer of Health and Senior Medical Director Public Health*

***Samantha Aiton**, Project Executive, Primary Health Care & Chronic Disease Management, Department of Health and Wellness*

***Sarah MacDonald**, Manager, Primary Health Care, IWK Health*

***Sarah Manley**, Senior Policy Analyst, Primary Health Care & Chronic Disease Management Network*

***Sarah O'Brien**, Director, Primary Health Care & Chronic Disease Management*

***Sharon Houle**, Occupational Therapist / Clinical Team Lead, Integrated Chronic Care Service (ICCS)*

***Dr. Stephanie Connidis**, Medical Director INSPIRED COPD Outreach Program*

***Stephanie Noga**, Nurse Practitioner, Obesity Care*

***Sybil Flemming**, Patient Family Advisor*

***Dr. Tara Sampalli**, Senior Director of Implementation Science and Evaluation & Global Health Systems Planning*

***Trina Guthro**, Mental Health and Addictions*

***Verna McKinnon**, Wellness Navigator*

***Wanda Firth**, Program Lead, Hearts and Health in Motion, Heart Health*

Dr. Maria Alexiadis,
Senior Medical Director

Primary Health Care & Chronic Disease Management Network

Muhammad Azam,
Director Clinical Networks

Primary Health Care & Chronic Disease Management Network

Introduction

ACHIEVING ACTION FOR HEALTH

The Nova Scotia Government released **Action for Health: A Strategic Plan** in April 2022 that provides a path to shape a healthier Nova Scotia by addressing the key challenges facing our province. This multi-year health strategic plan lays out a plan to transform health care over the next four years. It specifically references wellness, chronic disease prevention and management through several of the solutions. Through collaborative partnerships and working together with the Department of Health and Wellness, IWK Health and Nova Scotia Health (NSH) to develop this strategy for wellness and chronic disease management, the aims and objectives aligned within are well positioned to describe a long-term vision with high impact actions for people living with and at risk for having a chronic condition to achieve the solutions set out in Action for Health.

This strategy, embedded as part of the broader Primary Health Care System (PHC) Strategy, is the culmination and synthesis of much work in wellness and chronic disease prevention and management. It acknowledges and builds on work already in place and underway in Nova Scotia. It also provides a framework for guiding innovation and emerging priorities to keep Nova Scotians well and prevent and optimize the management of chronic conditions. The strategy represents a convergence of visioning and action planning and will be a key enabler to transforming this aspect of the health system.

The strategy provides a coordinated roadmap to advance shared government and health system goals and builds on a strong foundation of past and present work, a comprehensive body of literature, and experience from other jurisdictions. It provides a framework to:

1. Guide the collective work of key partners, including citizens, community organizations, government, and the health system in wellness, chronic disease prevention and management, through a shared guiding vision, and principles.
2. Address the common, cross-cutting, system-level components required to keep Nova Scotians well, and reduce the impact of chronic conditions in the province.
3. Confirm the needs-based population health approach, prioritizing equity, diversity, inclusion, anti-racism, and reconciliation in the planning and implementation of strategy actions and objectives.
4. Strategically coordinate priorities, initiatives, actions, and innovations to support planning and execution to achieve the vision.

The strategy sets the vision, destination, aims, objectives and actions over a 5-year time horizon, aligned with key priorities such as the PHC Strategy, integrated service planning (Integrated Health Services Planning Framework, Health Service Plans) and **Action for Health** (Nova Scotia Government, 2022). The strategy's progress and impact will be measured over time. The framework will be reviewed and updated at regular intervals to ensure it remains relevant and responsive to our ever-changing context.

PRIMARY HEALTH CARE AS THE FOUNDATION OF THE HEALTH CARE SYSTEM

Primary Health Care is the foundation of the health care system, where the majority of people experience most of their health care and is the ongoing point of contact a person has with the overall health system. Improvement to the community based PHC system is a critical starting point for transforming health care systems, including improving the experiences for people with and at risk for chronic conditions (Primary Health Care, 2017).

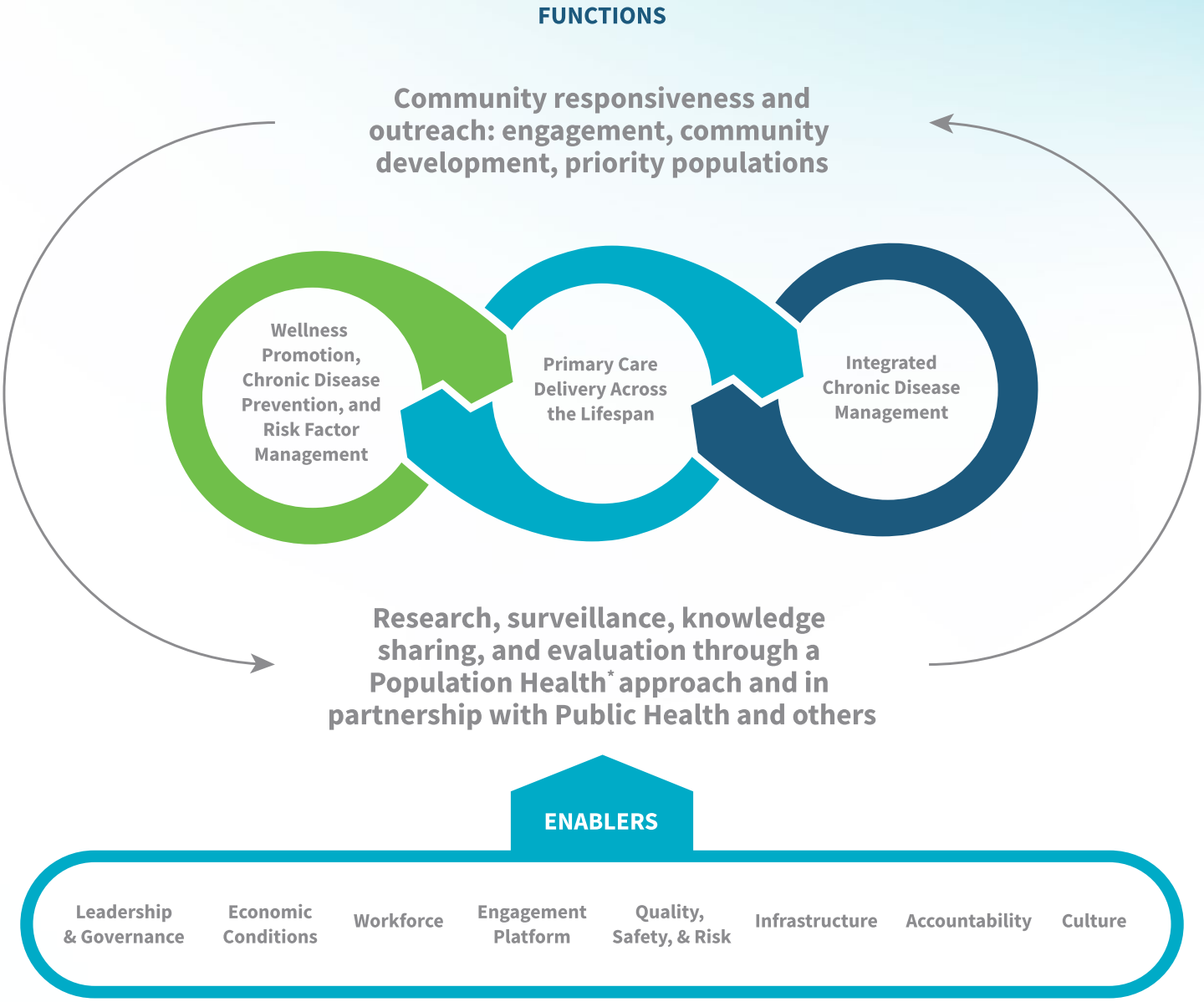
Within the literature, having a strong PHC system is recognized as the strongest enabling factor in providing high quality chronic care for those with single and multiple chronic conditions (Nasmith, 2010). In a study by Hansen et al. (2015), it was identified that living in a country with a strong PHC system (both related to structural elements and attributes, such as continuity and coordination) had positive impacts to the health status of individuals living with a chronic condition(s) and this effect was particularly pronounced with for those with multimorbidity. Primary health care interventions also have a population health impact, which has corresponding effects on determinants of health (Dahrouge, 2012).

Figure 1 articulates the functions and enablers of a strong PHC system, and was developed through a synthesis of the literature, consultation with PHC leadership, health care providers and partners across Nova Scotia. The model serves as a conceptual and foundational framework to inform planning of the primary health care system across the province. Wellness promotion, chronic disease prevention, and risk factor management along with integrated chronic disease management are two key functions of a high performing primary health care system and the focus of this strategy. For more information, **click here**.

The functions of primary health care system include:

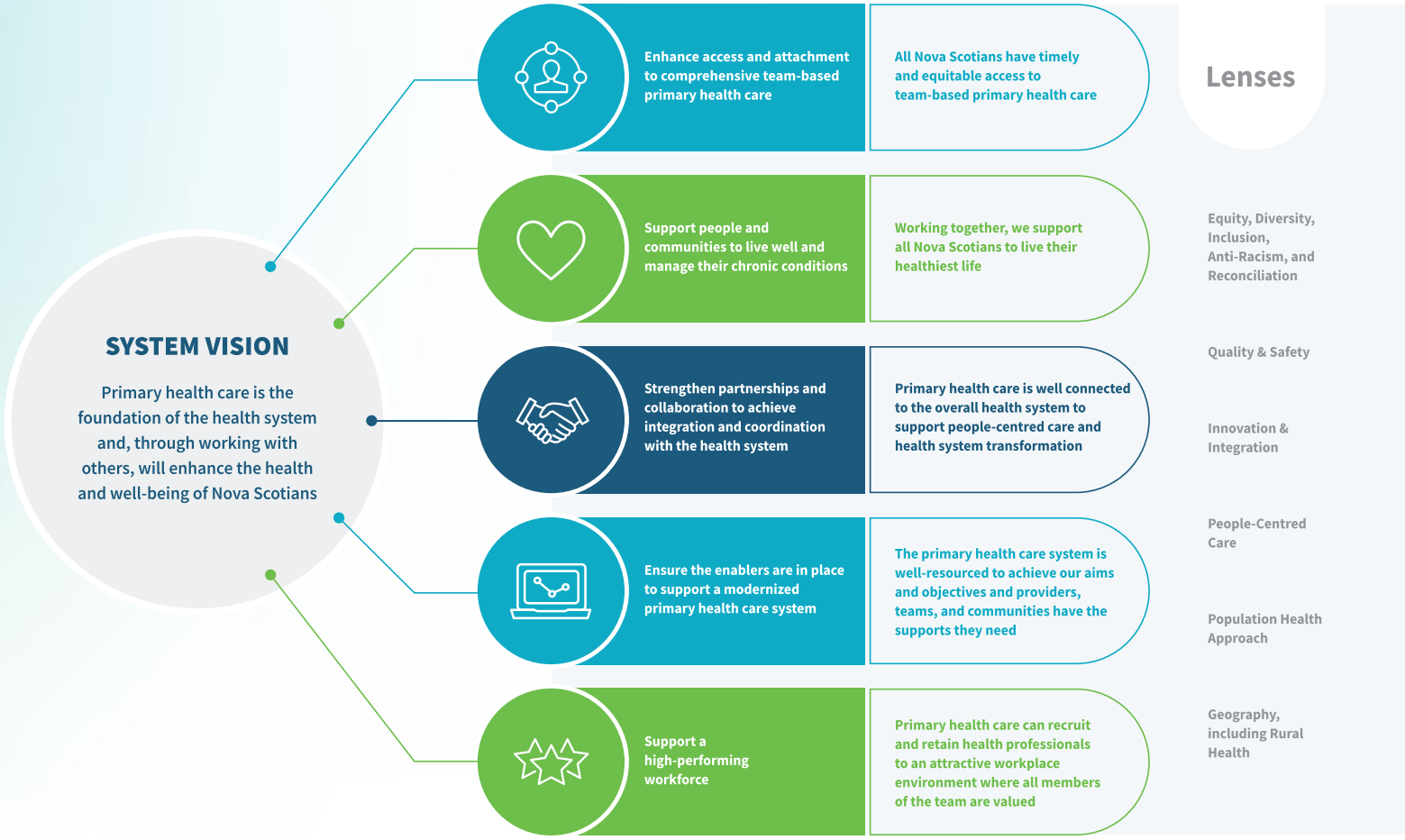
- Primary care delivery across the lifespan from birth to end of life care
- Wellness promotion, chronic disease prevention, and risk reduction for individuals, groups, and communities
- Integrated chronic disease management
- Research, surveillance, knowledge sharing, and evaluation through a Population Health approach and in partnership with public health and others; and
- Community responsiveness and outreach: engagement, community development, and priority populations

Figure 1: Functions and Enablers for the Nova Scotia Primary Health Care System, Nova Scotia Health (Edwards et al., 2107)



The Nova Scotia PHC System-Level Strategy (Figure 2) provides a framework for collective action to achieve the vision of primary health care being the foundation of the health system and, through working with others, enhancing the health and well-being of Nova Scotians. Key aims, objectives and actions outline the steps to achieving the vision. The Wellness and Chronic Disease Prevention and Management Strategy will drive the achievement of the second aim, supporting people and communities to live well and manage their chronic conditions.

Figure 2: Primary Health Care System-Level Strategy



THE RISING TIDE OF CHRONIC CONDITIONS

Chronic conditions are the major cause of death and disability worldwide, with 44% of adults in Canada living with at least one chronic condition (Canadian Community Health Survey, 2016). Compared to other Canadian provinces, Nova Scotia has a higher prevalence of many chronic health conditions such as diabetes, chronic obstructive pulmonary disease (COPD), cancer, heart disease, high blood pressure and obesity (Canadian Community Health Survey, 2016). 46.4% of the population is living with at least one chronic condition and 18% are living with at least two chronic conditions. The impacts become greater in rural areas where more than 50% of people have at least one chronic condition.

Chronic conditions are known to increase with age. In 2030 it is estimated that one in four people in Nova Scotia will be 65 years and older, (Statistics Canada, 2020; Nova Scotia Dept of Seniors, 2017). Given the exponential ageing of the population, frailty intersects with the prevalence of chronic conditions, with impacts on health, social services, and the economy. Older adults who live with frailty are at greater risk of death, falls, delirium, and prolonged stays in hospital (Hogervost et al., 2021). Amongst Nova Scotians aged 65 and older, approximately one third are frail, and by including the fraction with very mild frailty, the proportion approaches almost half of older adults (Hoover et al., 2013).

While population ageing is said to be only a moderate driver of increasing health care costs (estimated at 0.9% per year), health care spending per person increases with age: the cost of health care for the average senior is about $12,000 per year compared with $2,700 for the rest of the population. Over the next decade, population ageing will add $93 billion to health care costs (Conference Board of Canada, 2018).

Chronic conditions present a considerable challenge in Nova Scotia, both for residents who must manage their health, live with the impact on quality of life and experience the health outcomes of the disease; and the health care system that must bear the direct and indirect costs to deliver care and effectively manage chronic conditions. The evidence around chronic disease prevention and management has been clear for some time - we must shift from acute and reactive care, to proactive, planned, and population-based health care (Coleman, Austin, Brach, & Wagner, 2009).

We must chart a course for a healthier Nova Scotia. The destination is described through the vision statements in the strategy. Transformational change is going to require us to work differently, to think differently, to take risks and try new things. This culture shift is described through the principles, a commitment of a shared way of working to help move us toward the vision. The work required to achieve this strategy cannot succeed in isolation. The enablers describe the necessary foundational supports in the complex system.

DEVELOPMENT APPROACH

Recognizing that people with chronic conditions interact with all aspects of the health system and community, this strategy spans the health system, across the continuum and across multiple care settings – from public health, through to acute care, specialty care, home care and toward end-of-life.

The Primary Health Care and Chronic Disease Management Network (PHC-CDM) led the development of the system-level Strategy based on best evidence and through extensive collaboration and input from partners including, Nova Scotia Health networks, provincial programs, zone leaders, clinicians, corporate service teams, patient and family advisors, Department of Health and Wellness, and IWK Health Centre. Given that many stakeholders outside the formal health system also have a stake in wellness, chronic disease prevention and management, input will be garnered to ensure strategy alignment and facilitate opportunities to partner, collaborate and work together on shared priorities.

The Wellness and Chronic Disease Management Advisory is one forum for the Network to achieve targeted chronic disease management objectives through the established network functions, including strategy development. The Advisory membership has been designed to support the complexity and the breadth of developing a system-level strategy.

The approach to strategy development included 5 key phases between March-July 2022:

1. Scoping the planning activity
2. Understanding the population and service environment
3. Strategy development, identification of aims, objectives and actions
4. Evaluation and monitoring approach
5. Implementation

The evidence around chronic disease prevention and management has been clear for some time - we must shift from acute and reactive care, to proactive, planned, and population-based health care

(Coleman et al., 2009)

Figure 3: Strategy Development Roadmap

March / April 2022

Scope the Planning Activity

- Confirm planning horizon
- Governance and PM structure
- Guiding frameworks / models
- Updated Rapid Review

April / May 2022

Understanding the Population and Service Environment

- Population data / projections
- Patient experience/engagement
- Past planning work
- Policy/strategies scan
- Alignment of initiatives/PoCs

Lessons learned from proof of concepts and alignment of other strategic initiatives will occur in parallel.

May / June 2022

Strategy Development, Identification of Goals and Objectives

- High level aims and corresponding system-level objectives
- Prioritized actions

June / July 2022

Evaluation and Monitoring Approach

- Evaluation / monitoring framework
- KPIs
- QI spread/scale lens

July 2022 onward

Implementation

- Communication plan
- Establish future planning cycle
- Action plans based on priorities
- Ongoing monitoring

JURISDICTIONAL SCAN

A jurisdictional scan of local, national, and international chronic disease management and wellness strategies, frameworks, key documents, and policies was conducted to inform development of the strategy. Advisory members were surveyed to ensure all relevant documents were collected, including consideration of any key initiatives underway or planned that would impact strategy development. See Appendix C for the products identified through the jurisdictional scan process.

LITERATURE REVIEW

A rapid review was completed in March 2022 (Sampalli, 2022) focused on the critical elements of chronic disease management (CDM) strategies and frameworks, including priorities, directions, objectives, goals, and desired outcomes. Results included 25 sources that describe such strategies in Canada, the United States, Australia, New Zealand, the United Kingdom, Ireland, and Spain, as well as two academic articles that provide a description and comparison of CDM strategies and frameworks. The review identified common drivers of chronic disease strategies and frameworks, including:

- Chronic diseases as the leading cause of death and disability globally and growing,
- Chronic diseases leading to lower quality of life, lower income, and premature death,
- Chronic diseases impacting the health care system by accounting for 2/3 of hospital inpatient stays, 1/3 of physician visits, and over 1/4 of emergency visits; and
- The preventable nature of chronic diseases by addressing lifestyle factors such as diet, physical activity, and smoking.
- Common strategic priorities identified within the Canadian jurisdictional review included:
- Surveillance transformation combined with a monitoring, evaluation & learning strategy
- Healthy living/healthy weights: Focus on common risks for chronic diseases
- Targeted action on major chronic diseases
- Knowledge mobilization for sustained action
- Alignment with government priorities and appropriateness of roles and responsibilities
- Common values and health goals
- Focus on the determinants of health
- Integration of chronic disease prevention & management
- Evidence-based, patient and family-centred care
- Equitable access through restructured and strengthened health care delivery systems
- Strong partnerships and guidance for chronic disease management
- Enhanced use and expanded availability of information systems

Please see the **complete rapid review** for the in-depth summaries of the identified system-level strategies.

The Strategy

The goal of the strategy is to provide a cohesive vision for Nova Scotia to coordinate and align the planning and development of shared priorities, to provide care and opportunities for Nova Scotians to live well, prevent, and manage chronic conditions.

VISION

Working together, we support all Nova Scotians to live their healthiest life.

VISION STATEMENTS

The vision is articulated in a variety of experienced based statements, to further define how the future state will look and feel from the perspective of individuals, families and caregivers, health care providers and the health care system when we have achieved the aims and objectives of the action plan.

Individuals, Families and Caregivers

What will this preferred future state look and feel like for individuals, families, and caregivers?

I am a valued member of my health care team; working in partnership to manage my health and make decisions about my health care.

My information will be shared with the members of my health care team so that everyone involved in my care is aware of my needs, preferences, goals, and care plan.

I can access the programs, services, and supports that help me to live my healthiest life.

I know my care will be coordinated among the health care providers and services I need.

When accessing care, I feel treated with dignity and respect in a non-judgmental environment; it is understood that my background, experiences, and culture shape who I am and how that impacts my health. It is recognized that I am the expert of my own life.

I have the knowledge and confidence to be the driver of my own health and well-being, taking into consideration the broad range of factors that impact my ability to live a healthy life.

Health Care Providers

What will the preferred future state look and feel like for health care providers?

We know where and how to access information on resources, programs, services and supports within and beyond the health system to support individuals and their families.

We are supported to participate in professional development and education opportunities that enable me to provide high quality care.

We have the knowledge, skills and confidence to work collaboratively with individuals and families to ensure their needs, preferences, and goals are considered in the development of their care plans.

The social determinants of health guide how each of us on the team practice. We use a non-judgmental approach and treat individuals, families and caregivers with dignity and respect recognizing that people are the experts of their own life and are valued members of the health care team.

We understand and value the roles of the health care team; we support one another to provide high quality people-centered care.

We participate in organizing and coordinating care within the team and across the continuum in support of a person's care plan, leveraging the knowledge, resources, processes and technology to ensure communication is coordinated and efficient.

Health Care System

What will the preferred future state look and feel like at the system level

System performance data is reported and monitored to inform decision making and understand impact and outcomes.

Health care providers and leaders recognize, acknowledge, and articulate the importance of wellness and chronic disease management in the system, and can describe the work underway.

The system design, culture, and orientation is focused on wellness and prevention, to support people to live their healthiest life.

Relationships and partnerships within and across sectors enable coordinated action to maximize impact.

Integrated electronic health information systems, innovative technology and clear processes are in place to facilitate efficient communication and coordination of care across the health system.

Approaches to wellness and chronic disease management are coordinated, cost effective, equitable, innovative and informed by the evidence, population health needs and the social determinants of health.

PRINCIPLES

The following principles are foundational elements to the system-level strategy and weave throughout the vision, aims, objectives, and actions. Principles have been identified to enable the success of the work, and will be clear in the planning, design and implementation of policies, strategies, and actions stemming from the strategy (National Strategic Framework for Chronic Conditions, Australian Health Ministers' Advisory Council, 2017; PHC-CDM Health Service Planning Playbook, 2019).

Population Health Approach

We are responsive to and directed by the needs and priorities of Nova Scotians to improve the health and wellness of the population, including geographical considerations, community assets, population health, and other factors related to health service planning.

Prevention Oriented

Upstream prevention is critical to helping people live their heathiest life and addressing chronic disease in Nova Scotia.

Self-Management Focused

Self-management is a core element of high-quality, evidence-based care for people with chronic conditions.

Equitable

Nova Scotians have access to safe, appropriate, high-quality care in a timely manner. A needs-based approach, prioritizing equity, diversity, inclusion, anti-racism, and reconciliation will be adopted in the planning and implementation of strategy actions and objectives.

Collaborative

Work collaboratively to achieve shared goals and maximize impact and value.

Evidence Informed

Evidence, information, quality, safety, and experience informs the planning and the delivery of services.

Inclusive

Be respectful, value diversity, and promote equality of opportunity. Be inclusive of the life span and of the continuum of care.

Holistic

Reflect the social determinants of health in how we partner, engage, plan, and deliver programs, services, and supports.

Innovative

Be creative, innovative, and brave. Optimize the use of technology to support our work and achieve the vision.

Sustainable

Coordinated planning reduces duplication and supports responsible use of public resources to maximize impact and value in the system.

Collectively Responsible

All partners commit to working together, guided by the strategy, to support all Nova Scotians to live their healthiest life.

ENABLERS

Enablers are foundational supports that are required to achieve the strategic vision for wellness, chronic disease prevention and management described. The enablers have been adapted from the Enablers for a Primary Health Care System (Edwards et al, 2015).

Accountability

Culture

Economic Conditions

Engagement Platform

Funding

Infrastructure

Leadership and Governance

Quality, Safety and Risk

Standards, Policy, and Legislation

Workforce

STRATEGY VISUAL

Key elements of the action plan are illustrated in the below visual, including principles, enablers, and aims. A description of each aim, as well as the objectives and actions to achieve the aim are described in subsequent pages.

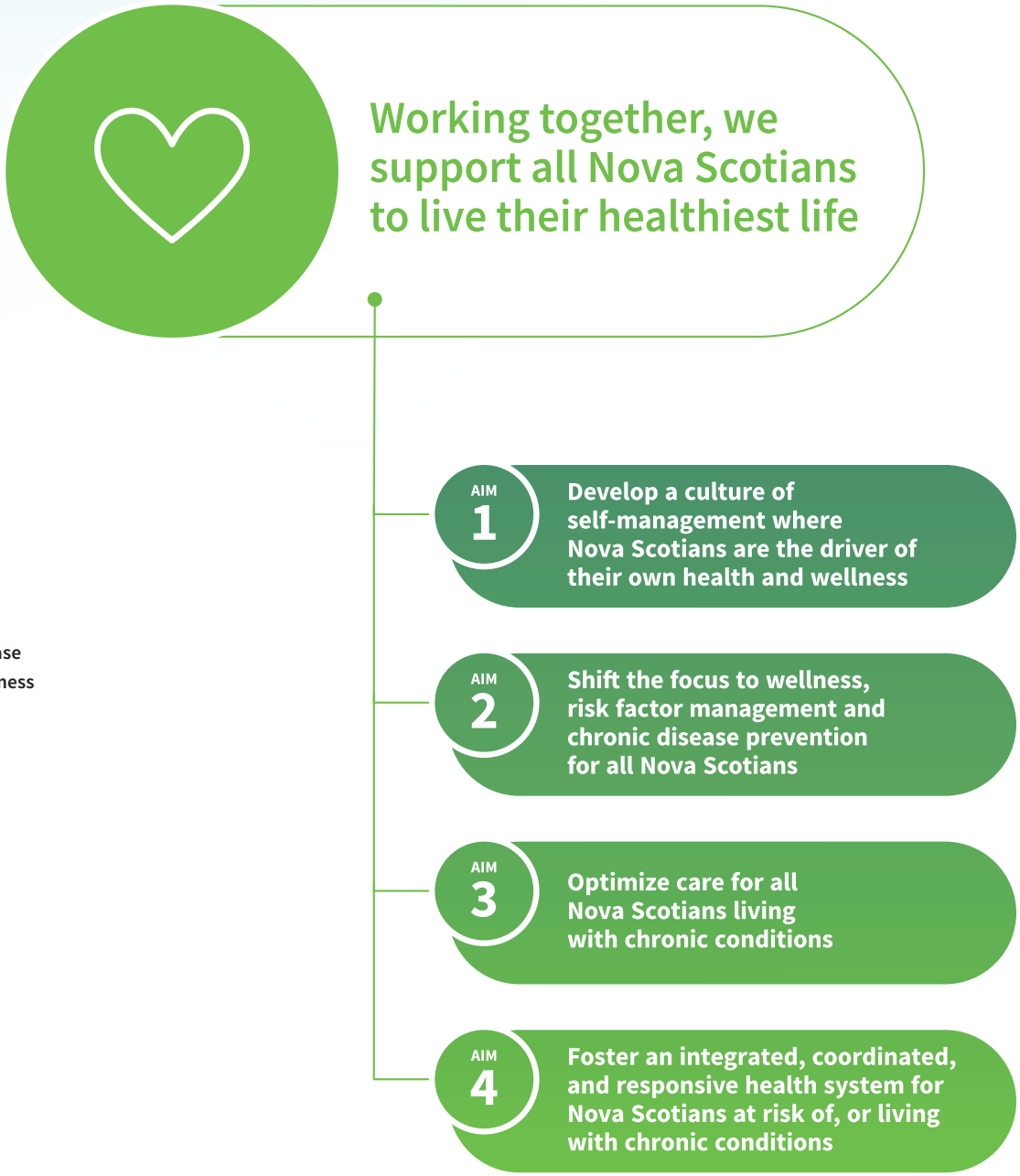


Figure 4: Chronic Disease Management and Wellness Strategy Visual

AIMS AND OBJECTIVES

AIM 1

Develop a culture of self-management where on Nova Scotians are the driver of their own health and wellness

It is well documented in the literature that people benefit from being actively engaged in their health and wellness. Those with chronic conditions often need education, coaching and other interventions to help them gain the confidence, knowledge, skills, and motivation to manage the impacts of their disease (Health Council of Canada, 2012). Many high quality randomized controlled trials and systematic reviews suggest that supporting self-management improves individual's attitudes and behaviours, quality of life, clinical symptoms, and use of healthcare resources (Health Council of Canada, 2012; Brady et al., 2013; deSilva, 2011). Both self-management and self-management support are core elements of high quality, evidence-based care for people with chronic conditions (Taylor et al, 2014).

The health care system plays an important role in enabling people to become effective self-managers, especially those with multiple chronic conditions. However, the work of self-management is not limited to individuals and the health system. A wider-system approach to self-management is required to fully realize an integrated and coordinated approach to self-management, including linkages and partnerships between individuals, health systems, community, academic, and government organizations (HSE, 2019).

The following objectives are necessary to achieve the first aim, using a whole-system approach to self-management supports, including actions aimed at supporting individuals, their families and caregivers, health care providers, the health system, and the wider system (e.g., community organizations, not-for-profits, private sector). Actions under each objective can be found in Appendix D. For further details, see the PHC Self-Management Support Framework, which informs the objectives and actions for this aim.

OBJECTIVES:

Objective 1.1: Enable and support individuals, families, and caregivers to be the driver of their own health and wellness

Objective 1.2: Create an engaged and supported workforce that enables self-management

Objective 1.3: Enhance and prioritize organizational support for self-management

Objective 1.4: Build wider system support for self-management through collaboration and partnerships

AIM 2

Shift the focus to wellness, risk factor management and chronic disease prevention for all Nova Scotians

Nova Scotia has some of the highest rates of chronic disease in the country, and in 2030 it is estimated that one in four people will be 65 years and older (Statistics Canada, 2020; Nova Scotia Dept of Seniors, 2017). While the causes of chronic conditions are complex, most chronic conditions are directly attributable to common modifiable risk factors and health behaviours such as inactivity, poor eating habits, smoking, alcohol use, overweight/obesity, and stress (WHO, 2020). It has been shown that an 80% risk reduction for development of chronic conditions can be conferred by practicing health promoting behaviours, such as healthy eating, regular physical activity, and avoiding smoking (U.N., n.d., Ford et al., 2009; Tamakoshi et al., 2009). Despite the well-known benefits, only a small proportion of adults engage in healthy behaviours (UN, n.d.). While knowledge and skills are important, people need to be supported to achieve their best health despite the many factors and barriers that impact health, including socioeconomic status, geography, and racism. A social determinant of health and health equity lens is a critical aspect of health services planning and delivery.

Nova Scotia Health has taken important steps to prioritize wellness, prevention, and risk factor management through the delivery of wellness programs, chronic disease screening and detection programs, navigation services, and a focus on community engagement and partnerships. However, gaps remain in access for certain areas of the province, and we have yet to fully realize a comprehensive wellness and prevention model that serves the unique needs of the population. A concerted and coordinated effort and focus is required to stem the rising tide of chronic disease, and support Nova Scotians to live their healthiest lives.

The below objectives outline how we will achieve Aim 2. Actions for each objective can be found in Appendix D.

OBJECTIVES:

Objective 2.1: Create a culture of wellness and prevention in Nova Scotia

Objective 2.2: Identify, partner, and support local and provincial opportunities to advance population health

Objective 2.3: Ensure comprehensive health system approaches are available and accessible for wellness, screening, prevention, and risk factor management

AIM 3

Optimize care for all Nova Scotians living with chronic conditions

As evidenced above, chronic diseases represent a in Nova Scotia. Half of Nova Scotians are living with at least one chronic condition, and almost 1/5 of the population has more than one chronic condition – the highest rates in the country (Canadian Community Health Survey, 2016). The impact of chronic conditions goes beyond individual level impacts, including societal, economic, and health system impacts. The Canadian health care system was designed to support acute care needs through episodic interactions, with medically necessary care provided in hospitals and by family physicians (Government of Canada, 2019). Chronic disease management requires a focus on health promotion and prevention, self-management, and collaboration with multiple members of the health care team, often outside the formal walls of the health care system over the course of the disease(s) and lifespan (Moody et al., 2022). Unfortunately, many Nova Scotians have challenges accessing timely, coordinated, and person-centered care they deserve.

Optimizing care for chronic conditions includes effective and efficient care best highlighted by the Triple Aim: simultaneously aiming to improve the health of the population, enhancing the experience and outcomes for the patient, and reducing the per capita cost of care for reinvestment and sustainability (Berwick, Nolan & Whittington, 2008).

There are many different chronic disease models outlined in the literature, with different elements, contextual factors, and target populations to consider (Grover & Joshi, 2014). The literature demonstrates that chronic disease prevention and management (CDPM) planning should incorporate interventions from four key domains, including person and family centered care, the work force, organizational structure and systems, and finance and governance. Person and family centered interventions are most cited, with self-management and care coordination/case management having the most consistently positive results on individual and systems outcomes (Kontak et al., 2019). Given the incidence of multimorbidity (the presence of two or more chronic conditions), interventions that support service integration and coordination, that are focused on the patient/family priorities and goals of care is critical to ensuring Nova Scotians receive the best care possible and are supported to live their healthiest life (Fortin, 2021).

The below objectives outline how we will achieve Aim 3. Actions for each objective can be found in Appendix D.

OBJECTIVES:

Objective 3.1: Nova Scotians can access timely people-centered, comprehensive chronic disease care, coordinated through their health home, to meet a range of needs

Objective 3.2: Programs, services, supports must align with chronic disease management best practices, and are designed to meet the needs of the populations they serve

Objective 3.3: Support decision making and enhance communication, coordination, and continuity across the continuum of care, including with patients, families and caregivers through technology, tools, and practice supports

AIM 4

Foster an integrated, coordinated, and responsive health system for Nova Scotians at risk of, or living with chronic conditions

People-centred care ensures "we are working to place the dignity and respect of patients, families and communities at the heart of every decision". As an organization, "NSH seeks to build trust-based relationships to achieve more genuine partnerships with those we serve" (NSH, p. 3, n.d.). This includes providing care that is respectful, compassionate, culturally safe, and competent while responding to individual needs, values, backgrounds, preferences, and beliefs (NSH & IWK, 2017).

Patient and family engagement is one component of how NSH supports and strives for people-centred care. "Engagement is a process that involves a broad range of interests to identify and set priorities or direction, contribute to or make decisions, influence change, assess and evaluation programs, policies and service" (NSH, p. 3, n.d.). Engagement involves two-way communication, transparency, common understanding and leads to trusting and sustainable relationships (NSH, n.d.).

The development of strong partnerships and ongoing intentional engagement with diverse communities and partners is essential to the provision of high-quality culturally competent health care. This is especially critical, because health outcomes between population groups are not distributed equitably in Nova Scotia. This can be attributed to the social, economic, and cultural factors that have and continue to impact health, including enslavement, systemic racism, poverty, low literacy, and housing affordability. Rates of chronic diseases and health behaviours such as smoking, physical inactivity, and alcohol use are significantly higher for those in the lowest income quintile compared to those in the highest income quintile, as well as those with lower levels of education, compared to higher levels of education (Nova Scotia, 2015). Using a population health approach, including a health equity lens to planning and service delivery ensures resources are allocated effectively, to those who need it most. Leveraging the knowledge, skills and capacity of community partners and organizations can improve the care experience through improvements in access and continuity of care (NSH & IWK, 2017).

OBJECTIVES:

Objective 4.1: Engage Nova Scotians in the planning, delivery and evaluation of chronic disease management and wellness programs and services

Objective 4.2: Engage Nova Scotians through the lens of anti-racism, equity, diversity, and inclusion so that everyone has access to welcoming, trusted, and culturally safe chronic disease management and wellness health services and supports

Objective 4.3: Develop and foster relationships and partnerships within and across sectors to improve integration and connection with community

AIM 4

Foster an integrated, coordinated, and responsive health system for Nova Scotians at risk of, or living with chronic conditions

Measuring, monitoring, and reporting on key health system performance indicators ensures the actions within this plan are improving the health of Nova Scotians. This includes having efficient and accessible data collection infrastructure and technology to ensure data is collected and used effectively to inform decision making. Understanding who uses our services and how they use them can positively impact the allocation of resources and ensure diverse communities are engaged and reflected in this data collection. Population Health Management (PHM) is the organization and management of the health care system that makes it more clinically effective, more proactive, more cost effective, and safer. The core premise of PHC includes segmenting the population based on identified characteristics (socioeconomic, geography, health system usage, chronic disease incidence) to identify local "at risk" cohorts. In turn, programs, services, and interventions can be designed and implemented to prevent ill-health and improve care and support for people with chronic conditions (Health Catalyst, n.d.). Over time, it is recommended that Nova Scotia work towards a PHM approach, which will require investment in digital infrastructure and expanding on existing data collection and reporting to include the socio-cultural identifiers and characteristics such as race, ethnicity, language preference, and sexual orientation to allow for comparability between population groups, identify those not being served, and support the development of targeted interventions (Hasnain-Wynia & Rittner, 2008).

The below objectives outline how we will achieve Aim 4. Actions for each objective can be found in Appendix D.

Objective 4.4: Measure, monitor and report data that supports decision making at all levels, continuous system improvement and understanding of impact and outcomes

Objective 4.5: Reorient the health system to use a population health approach to plan, deliver, coordinate, and monitor progress of people living with, or at risk for, chronic conditions

Sustainability of the Strategy

This Strategy is meant to be a living document. It will be reviewed annually and updated as needed to reflect changes in context and evidence and by the organizations' progress against the objectives and priority action areas. The Wellness and Chronic Disease Management Advisory, a structure of the PHC-CDM Network, will be the forum for regular review of progress against the aims and objectives, coordinated action planning and identification of new opportunities.

Evaluation of the Strategy

This Strategy is in support of a strong and coordinated wellness and chronic disease management approach to support Nova Scotians to live their heathiest life. The strategy impacts will be monitored through the Primary Health Care System Performance framework and approach. The framework and indicators can be found in Appendix E. Actions in support of the strategy implementation will be monitored using a project management approach through the Wellness and Chronic Disease Management Advisory forum.

References

Adams, K., Greiner, A.C., Corrigan, J.M. (2004). *The 1st Annual Crossing the Quality Chasm Summit: A Focus on Communities, National Academies Press (US), Washington (DC).* **https://doi.org/10.17226/11085**

Australian Health Ministers' Advisory Council. (2017). *National strategic framework for chronic conditions.* Australian Government. Canberra. **https://www.health.gov.au/sites/default/files/documents/2019/09/national-strategic-framework-for-chronic-conditions.pdf**

Barr, V.J., Robinson S., Marin-Link, B., Underhill, L, Dotts, A, Ravensdale, S.S. (2003). The expanded chronic care model: An integration of concepts and strategies from population health promotionand the chronic care model. *Hosp Q*, 7(1): 73-82. **https://doi.org/10.12927/hcq.2003.16763**

Berwick, D. M., Nolan, T.W., & Whittington, J. (2008). The triple aim: care, health, and cost. *Health Affairs.* May-Jun;27(3):759-69. **https://www.healthaffairs.org/doi/10.1377/hlthaff.27.3.759**

Boyd, C.M., Fortin, M. (2010). Future of multimorbidity research: How should understanding of multimorbidity inform health system design? *Public Health Rev* 32, 451–474. **https://doi.org/10.1007/BF03391611**

Brady, T.J., Murphy, L., O'Colmain, B. J., Beauchesne, D., Daniels, B.,Greenberg, M., House, M. & Chrvin, D. (2013). A meta-analysis of health status health behaviors, and healthcare utilization outcomes of the chronic disease self-management program. *Preventing Chronic Disease,* 10. **https://doi.org/10.5888/pcd10.120112**

Canadian Disease Prevention Alliance of Canada (CDPAC). (2017). *2018 pre-budget submission to the House of Commons Standing Committee on Finance.* **https://www.ourcommons.ca/Content/Committee/421/FINA/Brief/BR9073636/br-external/ChronicDiseasePreventionAllianceOfCanada-e.pdf**

Conference Board of Canada. (2018 July). *Meeting the care needs of Canada's aging population.* **http://www.cma.ca/sites/default/faile/2018-11/Conference Board of Canada/Meeting the Care Needs of Canada's Aging Population**

Contandriapoulos, A.P., Denis, J.L., Touati, N.& Rodriguez, C. (2003). *Groupe de recherche interdisciplinaire en santé. Working Paper N04–01 In: Montréal: Université de Montréal. The integration of health care: dimensions and implementation.* **http://nelhin.on.ca/assets/0/16/2100/3734/3736/6cab135d-87c1–45bd-88cd-2c1d5404ec9b.pdf**

Dahlgren, G., & Whitehead, M. (1991). *Policies and strategies to promote social equity in health.* Stockholm, Sweden: Institute for Future Studies. **https://eurohealthnet. eu/sites/eurohealthnet.eu/files/publications/DETERMINE-Final-Publication-Story.pdf**

de Silva, D. (2011). *Evidence: Helping people help themselves. A review of the evidence considering whether it is worthwhile to support self-management.* **https://www.health.org.uk/publications/evidence-helping-people-help-themselves**

Edwards, et al. (2017). *Functions and enablers of the primary health care system.* Nova Scotia Health.

Ford E.S., Bermann, M.M., Kroger, J. (2009). Healthy living in the best revenge: Findings from the European Prospective Investigation into Cancer and Nutrition-Potsdam study. *Archives of Internal Medicine*, 1355-1362. **https://doi.org/10.1001/archinternmed.2009.237**

Fortin, M. (2021). Implementing patient-centred integrated care for multiple chronic conditions. *Can Fam Physician,* 67(4), 235-238. **https://doi.org/10.46747%2Fcfp.6704235**

Global Wellness Institute. (n.d.). *What is wellness?* **https://globalwellnessinstitute.org/what-is-wellness/**

Government of Canada (2019). Canada's health care system. **https://www.canada.ca/en/health-canada/services/health-care-system/reports-publications/health-care-system/canada.html**

Government of Canada. (n.d.) *Key elements and actions that define a population health approach.* **https://www.canada.ca/content/dam/phac-aspc/documents/services/health-promotion/population-health/population-health-approach/summary_table-en.pdf**

Government of Canada. (2022). *Social determinants of health and health inequalities.* **https://www.canada.ca/en/public-health/services/health-promotion/population-health/what-determines-health.html**

Grover A, Joshi A. (2014). *An overview of chronic disease models: a systematic literature review. Glob J Health* Sci. Oct 29;7(2):210-27. doi: 10.5539/gjhs.v7n2p210.

Harrison, C., Fortin, M., van den Akker, M., Mair, F., Calderon-Larranaga, A., Boland, F., Wallace, E., Jani, B., Smith, S. (2021). Comorbidity versus multimorbidity: Why it matters. *Journal of Multimorbidity and Comorbidity,* 11. **https://doi.org/10.1177%2F2633556521993993**

Hasnain – Wynia, R., and Rittner S. S. (2008). Improving quality and equity in health care by reducing disparities. **www.hret.org/ltc_safety/resources/Articles/EnhancingresidentsafetyOverview%20Paper.pdf**

Health Catalyst. (n.d.). *Population health management leverages analytics for care and financial transformation.* **https://www.healthcatalyst.com/learn/ebooks/population-health-management**

Health Council of Canada. (2012). *Self-Management support for Canadians with chronic conditions: A focus for primary health care.* **http:/www.healthcouncilcanada.ca/tree/HCC_SelfManagementReport_FA.pdf**

Hogervorst V.M. et al. (2021). Emergency department management of older people living with frailty: a guide for emergency practitioners. *Emerg Med J.* 2021 doi: 10.1136/emermed-2020-210014. Epub ahead of print.

Hoover M., et al. (2014). Validation of an index to estimate the prevalence of frailty among community-dwelling seniors. *Health Rep,* 24, 10-7. **https://www150.statcan.gc.ca/n1/pub/82-003-x/2013009/article/11864-eng.htm**

HSE Working Group. (2017). *Living well with a chronic condition: Framework for self- management support. National framework and implementation plan for self-management support for chronic conditions: COPD, asthma, diabetes and cardiovascular disease.* **https://www.lenus.ie/bitstream/handle/10147/622639/HSE-Self- management-Support-Final-document1.pdf?sequence=1&isAllowed=y**

Kontak, J., Rowe L., Grant, A., Jeffers, E. Boulos, L., Wentzell, L., Ryan-Cason, S., Manley S., and Sampalli, T. (2019). Chronic disease management models and interventions. Halifax, Nova Scotia: Maritime SPOR SUPPORT Unit and Nova Scotia Health Authority. **https://mssu.ca/wp-content/uploads/2020/09/KS_CDM-Models.pdf**

Kodner DL, Spreeuwenberg C. (2002). Integrated care: meaning, logic, applications, and implications–a discussion paper. *International Journal of Integrated Care.* DOI: **https://doi.org/10.5334/ijic.67**

Mills, S., Brady T., Jayanthan, J., Ziabakhsh, Sargious P.M. (2017). Toward consensus on self- management support: The international chronic condition self-management support framework. *Health Promotion International,* 32: 942-952. **https://doi.org/10.1093/heapro/daw030**

Nova Scotia. (2015). *Nova Scotia health profile - 2015.* **https://novascotia.ca/dhw/publichealth/documents/Population-Health-Profile-Nova-Scotia.pdf**

Nova Scotia Department of Seniors. (2017). *Shift: Nova Scotia's action plan for an aging population.* Halifax: Province of Nova Scotia. **https://novascotia.ca/shift/shift-action-plan.pdf**

Nova Scotia Health (October 2022). Integrated Health Services Planning Framework: Primary Health Care and Chronic Disease Management Standards. **Standards Excerpt - Primary Health Care and CDM.docx (sharepoint.com)**

Nova Scotia Health. (n.d.). People-centred care: Nova Scotia health toolkit. **https://library.nshealth.ca/ld.php?content_id=36262198**

Nova Scotia Health & IWK. (2017). *Provincial diversity and inclusion framework.* **https://library.nshealth.ca/ld.php?content_id=34785349**

OHTAC OCDM Collaborative. Optimizing chronic disease management in the community (outpatient) setting (OCDM): an evidentiary framework. Ont Health Technol Assess Ser [Internet]. 2013 September;13(3):1–78. Available from: **http://www.hqontario.ca/en/documents/eds/2013/full-report-OCDM-evidentiary-framework.pdf**

Moody, E. et al. (2022). Patient perspectives on primary care for multimorbidity: An integrative review. Health Expectations, 1-14, **https://doi.org/10.1111/hex.13568**

Poitras M.E., Maltais M.E., Bestard-Denommé L.,Stewart M., Fortin M. (2018). What are the effective elements in individual-centered and multimorbidity care? A scoping review. *BMC Health Services Research,* 18(1): 446.

Primary Health Care, NSHA (2017). *Strengthening the Primary Health Care System in Nova Scotia. Evidence synthesis and guiding document for primary care delivery: Collaborative family practice teams and health homes.* Nova Scotia: Primary Health Care, Nova Scotia Health Authority. **https://www.nshealth.ca/sites/nshealth.ca/files/phc_evidence_synthesis_april_2017_final_updated.pdf**

Primary Health Care, Nova Scotia Health. (2019). *Primary health care and chronic disease management health service planning playbook.*

Sampalli, Tara et al (2022). Integrated Chronic Disease Prevention and Management Strategies: Rapid Review. Nova Scotia Health. **https://s3.amazonaws.com/SmartsheetB1/e1cbada25dfa4f19bea832bbd342a431?response-content-disposition=inline%3Bfilename%3D"CDM+Rapid+Review_April+8+2022.FINAL.pdf"%3Bfilename*%3DUTF-8%27%27CDM%2520Rapid%2520Review_April%25208%25202022.FINAL.pdf&Signature=tR04DlpyNWa32%2FhKhV4WNfEAfNU%3D&Expires=1660923032&AWSAccessKeyId=11950YFEZZJFSSKKB3G2**

Statistics Canada. (2020). *Number and percentage of adults (aged 18 years and older) in the household population with underlying health conditions, by age and sex (two-year period).* **https://www150.statcan.gc.ca/t1/tbl1/en/cv!recreate.action?pid=1310077701&selectedNodeIds=1D4,1D20,1D21,1D22,1D23,4D1,4D2,4D3,4D4,4D5,4D6,4D9,4D10,4D12,5D2&checkedLevels=0D1,1D1,1D2,2D1,2D3&refPeriods=20170101,20170101&dimensionLayouts=layout2,layout3,layout3,layout3,layout2,layout2&vectorDisplay=false**

Tamakoshi A., Tamakoshi K., Lin Y., Yagyu K., Kikuchi, S. (2009). Healthy lifestyle and preventable death: Findings from the Japan Collaborative Cohort (JACC) Study. *Prev Medicine,* 48: 486-492. **https://doi.org/10.1016/j.ypmed.2009.02.017**

Taylor S.J.C., Pinnock, H., Epiphaniou, E., Pearce, G, Parke, H.L., Schwappach, A. (2014). A rapid synthesis of the evidence on interventions supporting self-management for people with long-term conditions: PRISMS – Practical systematic Review of Self-Management Support for long term conditions. *Health Services and Delivery Research,* 2(53). **https://doi.org/10.3310/hsdr02530**

United Nations. (n.d.). *Lifestyle diseases.: An economic burden on the health services.* **https://www.un.org/en/chronicle/article/lifestyle-diseases-economic-burden-health-services**

World Health Organization (2016). I*ntegrated care models: An overview.* Copenhagen: WHO regional Office for Europe. **https://www.euro.who.int/__data/assets/pdf_file/0005/322475/Integrated-care-models-overview.pdf**

University of California San Fransisco (UCSF). (2022). Understanding your risk for heart disease. **https://www.ucsfhealth.org/education/understanding-your-risk-for-heart-disease#:~:text=Risk%20factors%20are%20conditions%20that,means%20they%20cannot%20be%20changed.**

Appendix A:
Supporting Models and Frameworks

Several key frameworks serve as a foundation for the development of this action plan. A brief description of each is listed below.

Primary Health Care Self-Management Support Model

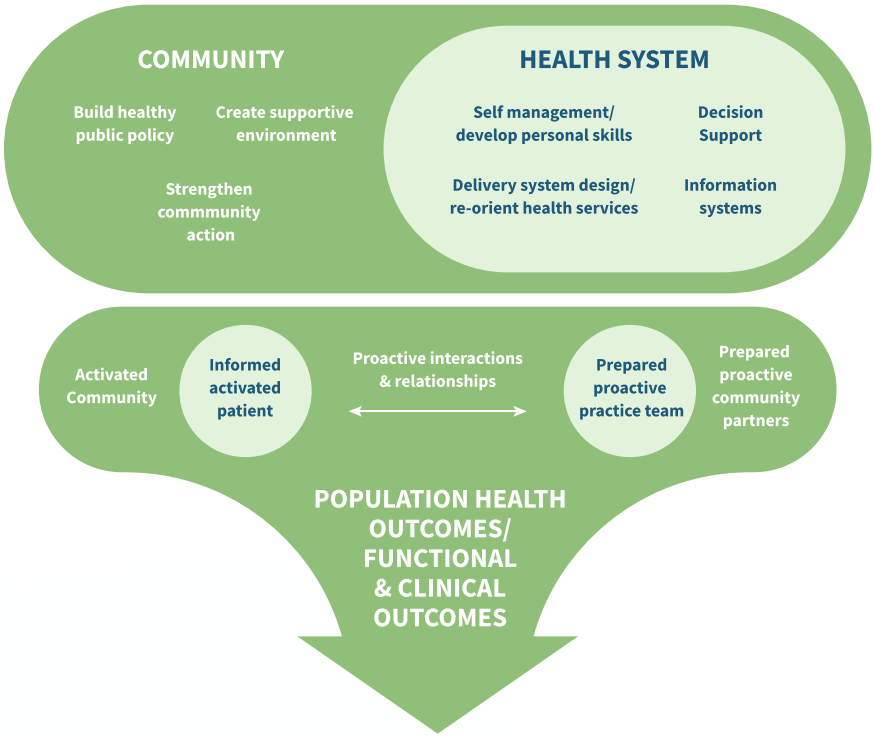
The Primary Heath Care, Nova Scotia Health, Self-Management Support Conceptual Model is adapted from the National Self- Management Support Framework for Chronic Conditions: COPD, Asthma, Diabetes and Cardiovascular Disease, Ireland, UK (2017). It describes a whole-system approach to self-management support and includes four key areas to support Nova Scotians to become effective self-managers, including appropriate supports and interventions that enable engaged and informed individuals, families and caregivers, supporting the development of informed and skilled health care professionals, organizational supports for self-management within PHC and NSH and wider system supports for self-management, including creating and strengthening partnerships internal and external to NSH. This model and the Primary Health Care Self-Management Support Framework (link) inform the actions and objectives for Aim 1 of the Strategy.

Figure 2: Primary Health Care Self-Management Support Model, Nova Scotia Health

Expanded Chronic Care Model

The Expanded Chronic Care Model (Barr et al., 2003) is an internationally recognized model for chronic disease management and population health. It recognizes that population health promotion and prevention, the social determinants of health, and enhanced community participation, in partnership with health systems achieve the best outcomes for population health. From an impact perspective, delivery system design has the largest evidence-base, followed by self-management.

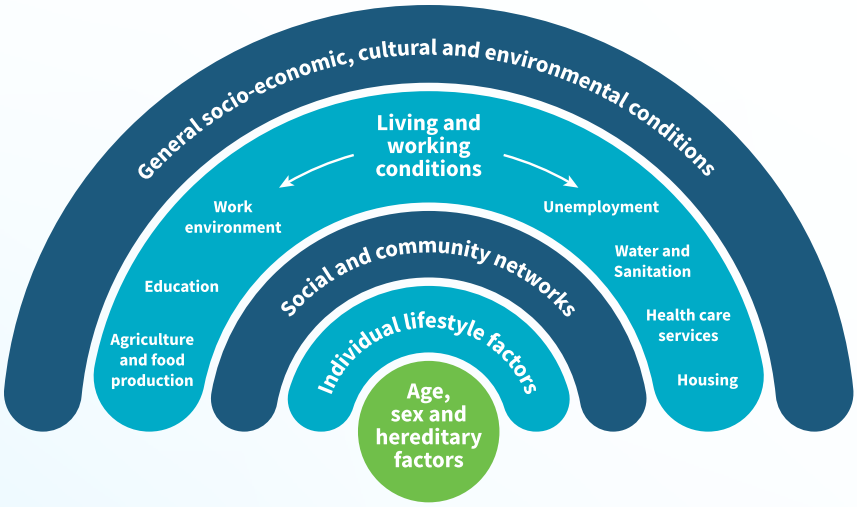
Figure 4: Expanded Chronic Care Model (Barr et al., 2003)



Social Ecological Model

The Wider Determinants of Health Model (Dahlgren & Whitehead, 1991), a social ecological model, is one of the most widely known and used models to describe the influence of various factors on individual health and well-being, including socio-economic, cultural, environmental, social and individual lifestyle factors. It illustrates that health is not merely the absence of disease, nor based solely on individual factors, and recognizes the importance of multi-sector collaboration to achieve health equity and improved population health outcomes.

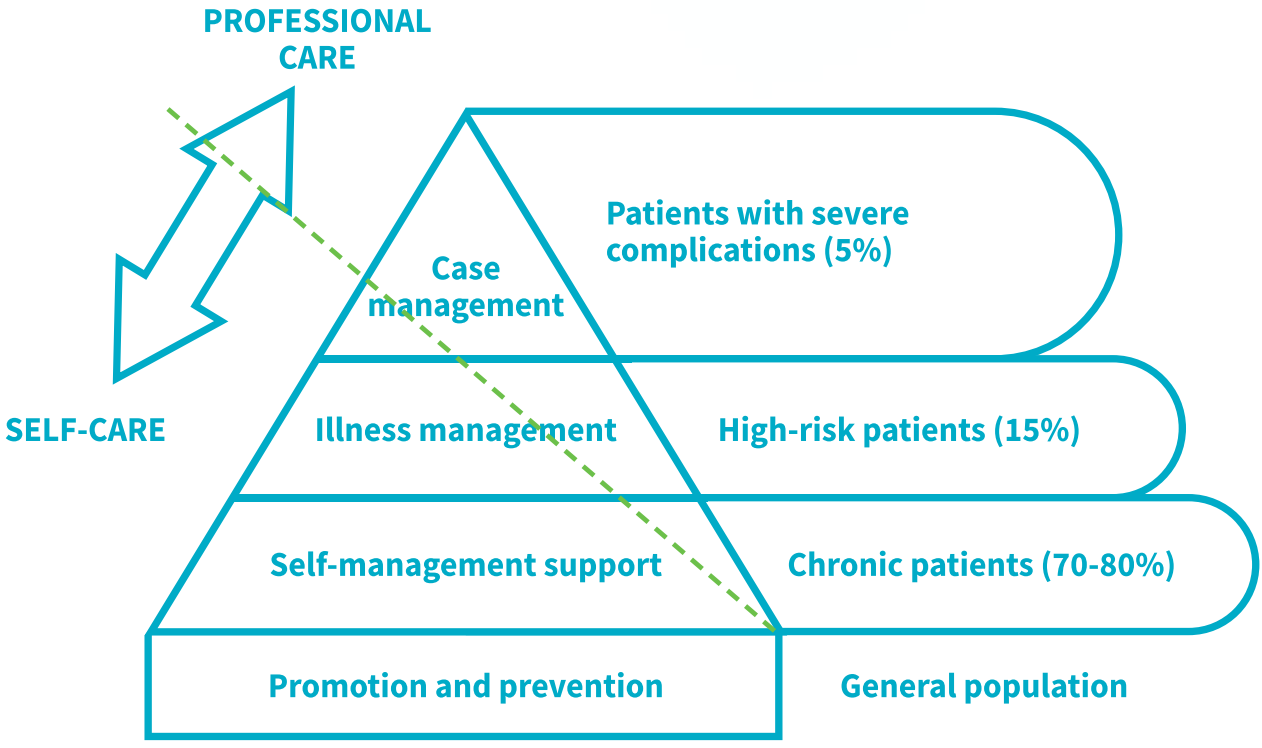
Figure 5: The Wider Determinants of Health Model (Dahlgren & Whitehead, 1991)



Kaiser Permanente Model

The Kaiser Permanente Model of Integrated Care stratifies the population and health services based on needs. At the bottom of the pyramid, the general population receives prevention supports to reduce development of risk factors. Self-management supports are integral for everyone with a chronic condition(s), while more intensive supports, including case management, are provided to patients with more complex needs. All members of the health care team are mutually accountable for a patient's outcomes and health care experience within this model, and provider incentives are linked with quality of care and patient satisfaction (WHO, 2016).

Figure 6: Kaiser Permanente Pyramid (WHO, 2016)



Appendix B:
Key Definitions and Terminology

Care Coordination refers to the coordination of care and services between the individual and their care team. Care coordinators follow the delivery of care, facilitate communication between the individual, family and care providers, and provide supportive services (Poitras et al. 2018).

Chronic Conditions: This document will use the term 'chronic conditions' to describe the broad range of long-term health conditions that Nova Scotians are living with, including diseases, mental health, trauma, disability and genetic disorders. This broad definition and the use of the term 'condition' is intended to move the focus away from a disease-specific approach.

Co-Morbidity: The presence of one or more additional conditions, often co-occurring with a primary condition. Co-morbidity means that one "index" condition is the focus, and others are viewed in relation to this (Harrison et al., 2021).

Determinants of Health: The conditions in which people are born, grow, live, work and age that shape health, including income and social status, gender, race, culture, employment and working conditions, education, childhood experiences, physical environments, social supports and coping skills (Government of Canada, 2022).

Health Equity: Ensures that individuals have fair opportunities to achieve their full health potential and are not disadvantaged by the social, economic, environmental, and structural conditions in which people live (NCCDH, 2022).

Integrated: "Integrated health services are managed and delivered so that people receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease-management, rehabilitation and palliative care services, coordinated across the different levels and sites of care within and beyond the health sector, and according to their needs throughout the life course" (Contandriapoulos et al., 2003).

Multimorbidity: The co-existence of two or more chronic conditions, where one is not necessarily more central than the others". People with multimorbidity often have more complex needs affecting their quality of life, and use of health care resources (Boyd & Fortin, 2010).

Population Health: "The goals of a population health approach are to maintain and improve the health of the entire population and to reduce inequities in health status between population groups" (Government of Canada, n.d.)

Risk Factor: Conditions that increase a person's risk of developing a disease. Risk factors are either modifiable, meaning there are measures that can be taken to change them, or non-modifiable, which means they cannot be changed. Modifiable risk factors include high blood pressure, physical inactivity, smoking, and abnormal cholesterol. Non-modifiable risk factors include age, gender, culture, and family history (UCSF, 2022).

Self-management is defined as "the tasks that individuals must undertake to live well with one or more chronic conditions. These tasks include having the confidence to deal with the medical management, role management and emotional management of their conditions" (Adams et al., 2004).

Self-management support (SMS) can increase people's capacity to live well with chronic conditions by addressing some of the broad social and individual factors that influence their behavior and is a shared responsibility between individuals and society. It includes the social, physical and emotional support given by health professionals, significant others and/or caregivers, community and other supports to assist a person in managing their chronic condition" (Mills et al., 2017).

Wellness: "The active pursuit of activities, choices and lifestyles that lead to a state of holistic health". Dimensions of wellness include physical, mental, emotional, spiritual, social and environmental. Wellness is proactive, preventive and driven by self-responsibility. A solid foundation for wellness helps to prevent and overcome disease now and into the future (Global Wellness Institute, n.d.).

Appendix C: Jurisdictional Scan

The purpose of the jurisdictional scan was to collect past and current literature and resources to inform development of the strategy. This is not a fulsome list of all wellness, chronic disease prevention and management resources in the literature, but rather a list of key documents pertinent to the local context for planning and development of chronic disease prevention and management policies, program, services and supports.

*Note: Some documents are publicly available while others are internal documents. For more information, contact primaryhealthcare@nshealth.ca.

Identified Strategies, Documents or Reports:

- Action for Health: A Strategic Plan, Government of Nova Scotia, 2022 – 2026
- A Chronic Disease Prevention and Management Corridor to Supporting System-Level Transformations to Chronic Conditions, 2015
- A Patient-Centered Redesign Framework to Support System-Level Process Changes for Multi-morbidities and Chronic Conditions, 2015
- Atlantic First Nations Chronic Disease Prevention and Management Strategic Action Plan, 2018 – 2023
- Canadian Strategy for Cancer Control, 2019-2029
- College of Family Physicians of Canada. A new vision for Canada: Family Practice—The Patient's Medical Home, 2019
- 2021 Report Card on Child and Family Poverty in Nova Scotia
- Current State Assessment of the Primary Health Care System in Nova Scotia – Technical Document, 2021
- Department of Health and Wellness Target Setting, 2016
- Diabetes 360°: A Framework for a Diabetes Strategy for Canada, 2018
- Digital Equity for Mental Health and Addictions in Nova Scotia: A Situational Assessment, 2021
- Diversity, Equity, Inclusion Framework for Nova Scotia Health and IWK Health, 2017
- Full Expression of Interest for Accelerating Lung Cancer Screening Program Development and Implementation Initiative, Nova Scotia Health, 2020
- Integrated Health Service Planning Framework, Nova Scotia Health, 2022
- Implementing Smoking Cessation in Cancer Care Across Canada: A Framework for Action
- Izaak Walton Killam (IWK) Health Centre Strategic Plan, 2016 – 2020
- Izaak Walton Killam (IWK) Health Centre Strategic Plan, 2021 - 2024
- Key Performance Indicator Framework-Diabetes Care Program of Nova Scotia 2022
- Let's Get Moving Nova Scotia: Action Plan for Increasing Physical Activity, 2018
- Mi'kmaq Cancer Care Strategy, 2021
- Ministerial Mandate Letter, Minister of Health and Wellness, Nova Scotia, 2021

- National Strategic Framework for Chronic Conditions, Government of Australia, 2017
- Nova Scotia Chronic Disease Prevention Strategy, 2003
- Nova Scotia Population Health Profile, 2015
- Nova Scotia Health Community Health Board Plans
- Nova Scotia Health Ethics Framework, 2022
- Nova Scotia Health Youth Engagement: A Resource Guide, 2018
- Nova Scotia Health Diversity Lens Toolkit, 2018
- Nova Scotia Health Healthier Together, Strategic Plan, 2019 - 2022
- Nova Scotia Health Mental Health and Addictions, Direction 2025
- Nova Scotia Health People-Centred Care Toolkit
- Nova Scotia Health Involving Patients and Citizens in Decision Making, 2019
- Nova Scotia Health Community Health Teams Wellness Framework
- Overview of the Nova Scotia Mi'kmaw Client Linkage Registry
- Primary Health Care Self-Management Support Framework, Nova Scotia Health, 2019
- Primary Health Care and Chronic Disease Management Vision, Destination Statements and 4 Areas of Action, Nova Scotia Health, 2019
- Primary Health Care and Chronic Disease Management Playbook: Zone Health Services Planning Document, Nova Scotia Health, 2019
- Primary Health Care and Chronic Disease Management Health Service Plans, Nova Scotia Health, 2019
- Primary Health Care Patient Experience Survey Results, Nova Scotia Health, 2020
- Primary Health Care and Chronic Disease Management Network Fact Sheet, Nova Scotia, 2021
- Primary Health Care System Performance Reports, 2019, 2020 & 2021
- Rapid Review: Primary Health Care Innovations, 2021
- Speak Up For Healthcare; What We Heard Report, Nova Scotia, 2022
- Stemming the Tide, Health PEI Chronic Disease Prevention and Management Framework, 2013-18
- Strengthening the Primary Health Care System in Nova Scotia: PHC Evidence Synthesis, 2017
- The Future of Family Medicine Nova Scotia Family Physicians' Vision and Priorities, 2021
- The Way Forward, Chronic Disease Action Plan, Health and Community Service, Government of Newfoundland and Labrador, 2017-2018
- Thrive! Plan for Healthier Nova Scotia, 2012
- Ontario Chronic Disease Prevention Strategy, 2020-23
- Rapid Review: Chronic Disease Management System Level Strategies, Nova Scotia Health, 2022
- Rapid Review: Current Definitions and Dimensions of Integration in Healthcare, Nova Scotia Health, 2022

Identified Policies:

Dept. of Health and Wellness Policies:

- **Equity and Anti-Racism Legislation for Nova Scotia**
- **Home Care Policy Manual, 2011**
- **Nova Scotia Accessibility Act, 2017**
- **Provision of Publicly Funded Virtual Health Services**
- **Primary Care in Publicly Funded Nursing Home Policy**

Nova Scotia Health Policies:

- Patient and Public Engagement
- Patient/Family Feedback
- Smoke and Tobacco Reduction
- Virtual Care

Appendix D: Actions

AIM 1

Develop a culture of self-management where on Nova Scotians are the driver of their own health and wellness

Objective 1.1

Enable and support individuals, families, and caregivers to be the driver of their own health and wellness

ACTIONS

1. Public communication and education are available to facilitate understanding and acceptance of self-management
2. All patient facing materials (e.g., educational resources, tools, forms) are developed with a self-management, health literacy and digital literacy lens with consideration given to diversity among Nova Scotians
3. Ensure self-management approaches, resources and tools are available and accessible to Nova Scotians, including peer supports and caregiver supports
4. Make available a comprehensive platform to support self-management, including access to health information, health education, remote monitoring, peer support, etc.
5. Nova Scotians are supported to identify goals of care to ensure care decisions align with what is most important to them

Objective 1.2

Create an engaged and supported workforce that enables self-management

ACTIONS

1. Make self-management support capacity building practice supports available widely, including education, training, resources, and tools that facilitate a self-management support approach
2. Scale, spread and adopt the Behaviour Change Counselling Development Program
3. Develop practice supports for adult education approaches, care and support planning and group facilitation skills
4. Health care providers participate in the available self-management capacity building opportunities

Objective 1.3

Enhance and prioritize organizational support for self-management

ACTIONS

1. Prioritize and invest in self-management
2. Build a culture of self-management within the organization
3. The necessary standards, polices and guidelines are available and monitored to support self-management
4. The development and delivery of self-management supports are coordinated through partnerships, to reduce duplication and increase consistency.

Objective 1.4

Build wider system support for self-management through collaboration and partnerships

ACTIONS

1. Build partnerships beyond the health system to strengthen self-management supports (e.g., professional bodies, academia, the research community, and community organizations)

AIM 2

Shift the focus to wellness, risk factor management and chronic disease prevention for all Nova Scotians

Objective 2.1

Create a culture of wellness and prevention in Nova Scotia

ACTIONS

1. Prioritize and invest in wellness and prevention resources and supports
2. Build awareness and understanding of the importance of healthy behaviors across Nova Scotia and the supports available
3. Encourage changes that will reorient the health system toward population health and the role of primordial prevention in keeping people and communities healthy through upstream approaches.
4. Measure, report on and prioritize wellness indicators, including social determinant of health

Objective 2.2

Identify, partner, and support local and provincial opportunities to advance population health

ACTIONS

1. Define and recognize the health system contributions and expertise in health promotion and healthy public policy by working together with government to influence shared priorities, including improved equity, ensuring safer and healthier living, and working environments to foster the conditions for optimal health and wellness in Nova Scotia
2. Identify and support multi-sector projects and approaches that address the social determinants of health
3. Actively partner with community organizations that address social determinants of health

Objective 2.3

Ensure comprehensive health system approaches are available and accessible for wellness, screening, prevention, and risk factor management

ACTIONS

1. Develop and implement processes and approaches to incorporate wellness into primary health care visits (e.g., wellness vitals)
2. Develop/strengthen, implement, and monitor comprehensive risk factor management programs for substance use disorders, tobacco use, raised blood pressure (or hypertension), physical inactivity, raised cholesterol, overweight/obesity, unhealthy eating and raised blood glucose.
3. Develop/strengthen, implement, and monitor comprehensive screening programs for chronic conditions based on standards

AIM 3

Optimize care for all Nova Scotians living with chronic conditions

Objective 3.1

Nova Scotians can access timely people-centered, comprehensive chronic disease care, coordinated through their health home, to meet a range of needs

ACTIONS

1. Support the implementation of the Primary Health Care system strategy, which recognizes primary health care as the foundation of the overall health system and a key enabler for ensuring improved population health and care of chronic conditions
2. Through Integrated Health Services Planning, each Zone will ensure that there is a plan to meet the needs of the population, which includes individuals at risk for and living with chronic conditions
3. Prioritize and invest to ensure a range of people centered approaches are available for accessing available programs, service and supports (e.g., in person, virtual (telephone, video, other), home visits, leveraging technology to support care such as remote monitoring)
4. Develop and implement processes for communication, information sharing and coordinating care across the health system, including the health home
5. Spread integrated models for managing risk factors and chronic conditions

Objective 3.2

Programs, services, supports must align with chronic disease management best practices, and are designed to meet the needs of the populations they serve

ACTIONS

1. Ensure the necessary standards, polices, and guidelines are available and monitored to support chronic disease management best practices and the design of models/ programs; including but not limited to:
    - People centered care; focused on functional health and goals of care to support multimorbidity, complex care and a palliative care approach
    - Care plans: co-developed by individuals, families, caregivers, and care team members, available to everyone involved in the care, and supported by regular review to manage chronic conditions
    - Transitions: goals of care are communicated, supportive approaches and processes are in place
    - Navigation, case management and care coordination
2. Spread and scale evidence-based best practice models designed to meet the population needs and geographical context
3. Partner with the academic institutions to build chronic disease best practices in health professional education programs
4. Support all providers to be working to top of defined scope of practice, based on needs of population.

Objective 3.3

Support decision making and enhance communication, coordination, and continuity across the continuum of care, including with patients, families and caregivers through technology, tools, and practice supports

ACTIONS

1. Ensure chronic disease best practices are implemented, and necessary practice supports are in place
2. Through One Person One Record, ensure chronic disease management best practices are included throughout the clinical information system, including clinical practice guidelines, standards, decision supports and integration

AIM 4

Foster an integrated, coordinated, and responsive health system for Nova Scotians at risk of, or living with chronic conditions

Objective 4.1

Engage Nova Scotians in the planning, delivery and evaluation of chronic disease management and wellness programs and services

ACTIONS

1. Raise awareness and build capacity in the patient engagement philosophy, policies and supports available
2. Identify and engage people and communities to ensure needs and priorities are at the forefront of all planning, projects, and initiatives

Objective 4.2

Engage Nova Scotians through the lens of anti-racism, equity, diversity, and inclusion so that everyone has access to welcoming, trusted, and culturally safe chronic disease management and wellness health services and supports

ACTIONS

1. Implement systems and processes for public engagement
2. Raise awareness and build capacity in equity, diversity, inclusion, and anti-racism across the organization and take concerted action to address inequities
3. Develop safe, non-judgmental, welcoming spaces to access health and wellness services and supports, including the physical space, and the attitudes, cultures, beliefs, and language of team members

Objective 4.3

Develop and foster relationships and partnerships within and across sectors to improve integration and connection with community

ACTIONS

1. Improve coordination and collaboration across the health system to address gaps and inefficiencies in services
2. Foster community partnerships for shared priorities that are conducive to health and wellness
3. Seek opportunities to engage with, learn from, and collaborate with groups/sectors/organizations locally and provincially to contribute to improved population health
4. Develop processes to partnering and collaborating with community (e.g., roles and responsibilities defined)

Objective 4.4

Measure, monitor and report data that supports decision making at all levels, continuous system improvement and understanding of impact and outcomes

ACTIONS

1. Define, measure and report data within a coordinated system performance framework for wellness and chronic disease
2. Use a continuous quality improvement approach in all planning and for making improvements at the practice/team level
3. Develop and implement an accountability framework approach and processes

Objective 4.5

Reorient the health system to use a population health approach to plan, deliver, coordinate, and monitor progress of people living with, or at risk for, chronic conditions

ACTIONS

1. Leverage data and information to implement a population health management approach in Nova Scotia
2. Use technology to improve access to health information for all members of the care team, including patients

Appendix E: Strategy Evaluation

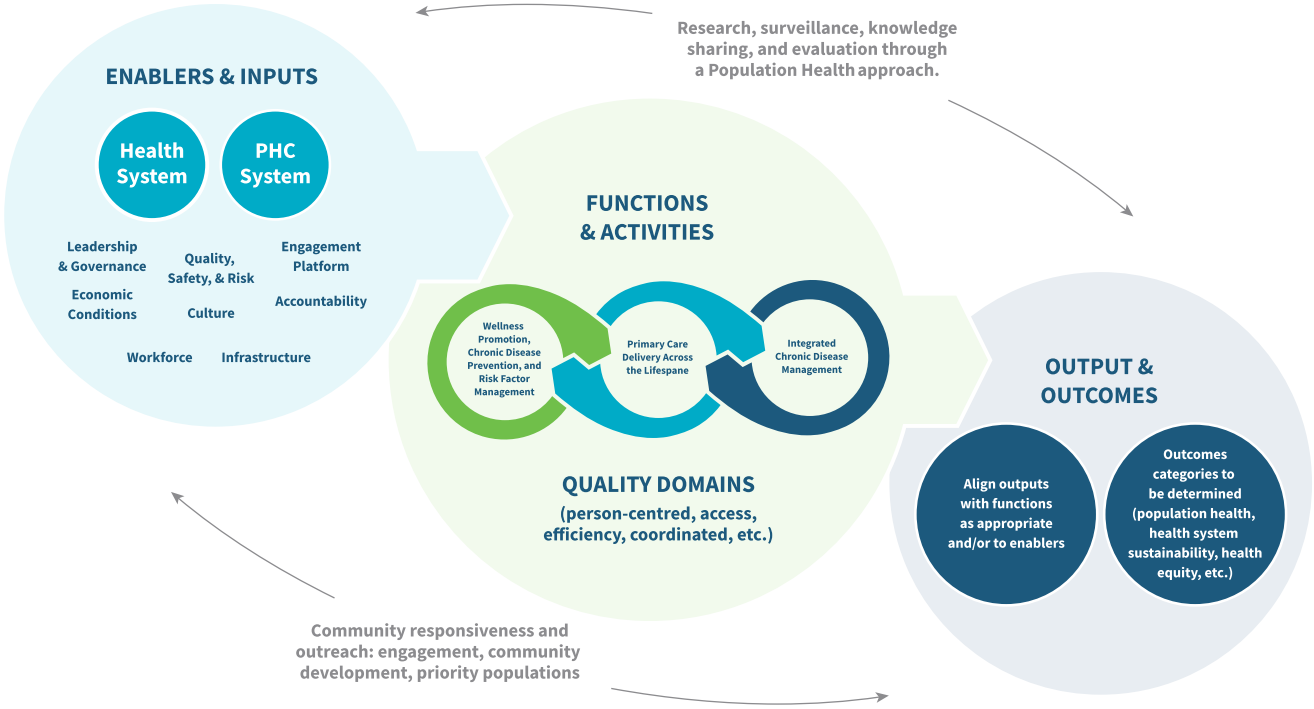
To guide indicator selection and alignment, a multidimensional evaluation framework was developed that reflects the complex nature of the PHC system, incorporates functions and enablers defined by Nova Scotia Health and considers the broader geographic, economic, and social context in Nova Scotia. The development of the Nova Scotia Health PHC System-level Evaluation Framework was guided and influenced by key documents, guiding frameworks, and stakeholder input.

Enablers and inputs are the resources and supports that are needed to carry out the activities of PHC delivery in Nova Scotia. Enablers are required from a PHC system orientation perspective as well as the broader health system.

Activities related to the key functions of the PHC system as defined by Nova Scotia Health are reflected in the center and around the diagram.

Outputs include the products and services delivered as part of the PHC system, as well as the outputs of the enablers.

Outcomes are what are achieved at an individual, population and system level as a result of the outputs of the enablers and the PHC system.



Contexts: Social, Economic, Legal/Regulatory, Cultural, Political, Physical, Technology, System Integration

Geographic Framework (community clusters, community health networks, zones, province

INDICATORS

Enablers and Inputs:

1. Family Physician Remuneration Method
2. Governance Model Distribution of Collaborative Family Practice Teams
3. Collaborative Family Practice Teams
4. Difference between Available and Required PHC Health Human Resources
5. Population with a Regular Healthcare Provider
6. Family Medicine Learners
7. Research Capacity (Participation, Training, Partnerships)

Functions and Activities:

1. Programs Dedicated Toward Priority Populations
2. PHC Providers' Sensitivity to Patients' Cultural Values
3. PHC support for self-management of chronic conditions
4. Scope of Primary Health Care Services
5. PHC Provider Time in Direct Patient Care

Outputs and Outcomes:

1. Per Capita PHC Expenditures
2. Patient Participation in Activities
3. PHC use of Electronic Medical Record (EMR)
4. Percentage of Population Served by a Collaborative Family Practice Team
5. Primary Care Providers Accepting New Patients
6. Provision of After-Hours Primary Care
7. Wait Times for Routine and Urgent Primary Care
8. Research Outputs
9. Influenza Immunization for Individuals 65 and Older
10. Family Physicians Working in Collaborative Family Practice Teams
11. Use of Emergency Department for Minor Complaints
12. Prevalence of Individuals with Self-Reported Five or More Chronic Conditions
13. Ambulatory Care Sensitive Conditions (ACSC) Hospitalization Rate
14. PHC Patient Access to Health Care
15. Patient Involvement in Decisions about their Care and Treatment
16. Patient Safety Culture


nova scotia
health
IWK Health
NOVA SCOTIA