

# CHRONIC DISEASE MANAGED CARE

## PROGRAM CO-CHAIRS

**Michael Sharpe**  
*Director, Chronic Disease Control  
and Management Division  
Centre for Chronic Disease  
Prevention and Control  
Public Health Agency  
of Canada*

**Dr. Quentin Smith**  
*Medical Director, Primary Care  
and Chronic Disease Management  
Fraser Health Authority*

**June 13 – 14, 2006 • Four Seasons Hotel • Vancouver**

The burden of chronic diseases in Canada continues to increase and make demands on health services in terms of both financial and human resources. The goal of this conference is to provide practical strategies that have been or can be applied in:

- Cost effective chronic care delivery – staffing and funding strategies
- Moving to better chronic care – a cross country report on the key underpinnings for successful health and illness prevention
- Improving care for chronic illness without totally redesigning the system
- Effective implementation of self management programs for patients with chronic conditions
- A results-based logic model for chronic care management
- PRIISME – strategic and successful partnerships in chronic disease management
- Effective health programs for several chronic diseases – similar concerns: different requirements
- From education to practice: transforming chronic care management
- Building a team – interdisciplinary care that works for chronic illness management
- Meeting the special needs of seniors with chronic conditions
- Desire, intimacy and sexuality issues with chronic life-limiting disease

and much more...

## KEYNOTE ADDRESS

**Facing the Challenges that Chronic Diseases Represent for Health Care Systems**

**Honourable George Abbott** (invited)  
*Minister of Health, Government of British Columbia*

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## WHO SHOULD ATTEND

*Presidents, CEO's, Directors, VP's, Managers, Program Directors and Heads of Research; Wellness, Public Programs as well as Health Officers, Nurses, Physicians and Chiefs of Staff of:*

- Health Canada
- Ministries and Departments of Health
- Regional Health Authorities
- Federal and Provincial Government Agencies
- Professional Associations & Regulatory Bodies
- Patient and Health Advocacy Groups
- Public Health Agencies
- Hospitals – Family Practice Units, Cardio-Vascular Units
- Private Healthcare Facilities
- Health Services
- Geriatric Health Centres
- Convalescent Hospitals
- Long Term Care Facilities
- Mental Health Institutions and Facilities
- Community Healthcare Facilities
- Nursing Homes
- District Health Authorities / Boards
- Community Care Access Centres
- Health Care Services and Health Management
- Family Physician
- Consultants

### Also

- Dietitians
- Respiratory therapists
- Physiotherapists
- Physiologists

Dear Colleague,

It is no secret that there is a growing burden of chronic disease amidst an aging and growing population. This burden has and will continue to have an enormous impact on every level of healthcare in both acute and community sectors, as well as individual families so affected. This burden places such huge demands on human and financial resources that a new model for chronic disease prevention and management is growing. This model seeks to merge the world of public health with primary health-care and encourages the patient to be an integral part of the healthcare team by supporting the patient in self-management.

The goal of course it is to achieve better health outcomes for patients and their families by reducing and controlling the symptoms and impact of disease and thereby improving the quality of life of those so affected, while achieving better utilization of health and community resources. In order to achieve these improved outcomes, one must have informed, activated patients interacting with prepared, proactive practice teams: lofty goals but not impossible to achieve.

This **Insight Information** conference will bring you updates and case studies on the Canadian applications of the USA Chronic Care Model (McColl Institute for Healthcare Innovation) and report lessons learned to date as these and other chronic care initiatives are studied and evaluated.

We look forward to seeing you there.

Yours sincerely

Michael Sharpe  
Director, Chronic Disease Control  
and Management Division  
Centre for Chronic Disease  
Prevention and Control  
Public Health Agency of Canada

Dr. Quentin Smith  
Medical Director, Primary Care  
and Chronic Disease Management  
Fraser Health Authority

*Delegates will receive a set of original materials as well as online access to fully searchable conference papers through Insight's **in**CONFERENCE™ that will serve as an invaluable reference source.*

# TUESDAY

JUNE 13, 2006

**8:15 Registration and Continental Breakfast**

**9:00 Welcoming Remarks from Insight Information**

**9:05 Co-Chair's Opening Remarks**

**Dr. Quentin Smith**

*Medical Director, Primary Care  
and Chronic Disease Management  
Fraser Health Authority*

**9:15 Opening Keynote Address:  
Facing the Challenges that Chronic Diseases  
Represent for Health Care Systems**

**Honourable George Abbott** (invited)  
*Minister of Health  
Government of British Columbia*

**9:45 The Blended Funding Program in British Columbia –  
Supporting Group Practices in the Delivery of Team  
Based Chronic Care**

**Beverlee Sealey**

*Manager, Primary Care  
Ministry of Health Services  
Government of British Columbia*

**André Van Wyk, MBChB, MBA, CCFP**  
*Fort Family Practice, Langley  
Fraser Health Authority*

- The Blended Funding Model in British Columbia is available to interested group practices who are collaborating with health authorities in primary care renewal
- The model includes a combination of fee-for-service, capitation and incentives to support chronic disease
- The capitation component of the model is unique in Canada in that it uses a system of virtual rosters and acknowledges the impact of comorbid conditions on the need for medical services
- The Blended Funding Program encourages and rewards the efficient delivery team based care and is well suited to the delivery of chronic care services

**10:30 Coffee Break**

**10:45 Moving to Better Chronic Care – A Regional Report**

**Moderator:**

**Irene Clarence**

*Executive Director  
Mid-Main Community Health Centre (Vancouver)*

**Réal J. Cloutier**

*Chief Operating Officer  
Deer Lodge Centre  
Vice President, Long Term Care and Chief  
Allied Health Officer  
Winnipeg Regional Health Authority (MB)*

**Sandra Delon, PhD, MPsyCh**

*Director, Chronic Disease Management  
Calgary Health Region (AB)*

**Victoria Stewart**

*Coordinator, Chronic Disease Prevention  
and Management  
Northern Health (BC)*

- Interdisciplinary practices – team approach to care
- Use of Electronic Medical Records to identify points and monitor care
- Use of group patient visits
- Supporting and strengthening self-management skills in people who are dealing with chronic illness
- Need for Open Access or Advanced Access policies in care centres for all patients but especially those with chronic illnesses (strategies for ensuring patients get same day service when they call and need to see a doctor)
- Why the prevention of heart disease is such a challenge
- Building community capacity as a key underpinning to successful health and illness prevention
- Successful engagement between patients and the health system
- Supported self-management approaches

PANEL DISCUSSION

**12:00 Networking Luncheon**

**1:00 How to Improve Care for Chronic Illness Without  
Totally Redesigning the System**

**Sandra Delon, PhD, MPsyCh**

*Director, Chronic Disease Management  
Calgary Health Region*

**Peter Sargious, MD, MPH, FRCPC**

*Medical Director, Chronic Disease Management  
Calgary Health Region*

- Build on existing strengths
- Work within current operational systems
- Focus on infrastructure, rather than individual diseases

**1:45 The Winnipeg Regional Health Authority's Long Term  
Care Strategy and its Impact on Chronic Care Delivery**

**Réal J. Cloutier**

*Chief Operating Officer  
Deer Lodge Centre  
Vice President, Long Term Care  
and Chief Allied Health Officer  
Winnipeg Regional Health Authority (WRHA)*

*The WRHA has developed a long term care strategy  
that has the following features:*

- 5 year client need, business case approach
- Demonstrates how a regional health system can plan across the care continuum
- Demonstrates how a regional health system can work with government departments to support inter-sectoral policy to support community living and aging in place
- Net re-investment of \$15.5 million into broadening community care options as an alternative to institutional care
- Business case supports operating and capital investments in long term care

CASE STUDY

CASE STUDY

# WEDNESDAY

JUNE 14, 2006

- Addresses the needs of individuals with complex care needs and unique populations (aboriginal, brain injured, behavioural populations, etc)
- Provides a broader range of community care alternatives for individuals who do not fit well in traditional institutional models
- Aims to re-align the number of institutional care spaces in the system
- Will result in a significant reduction of multi-bedded institutional spaces and improved home care

## 2:30 Refreshment Break

## 2:45 Shifting the Organizational Culture in Northern Health Around Improved Chronic Disease Prevention and Management (CDPM) – A “5As” Approach

CASE STUDY

### Victoria Stewart

*Coordinator, Chronic Disease Prevention and Management  
Northern Health (BC)*

- The Community Collaborative approach in NH (Diabetes, CHF, Prevention, CKD, asthma)
- Applying a self management 5As approach to all aspects of the Expanded Chronic Care Model
- Building in Shared Care in NH (CKD, Diabetes)
- Tools of the trade: Group visits, planned visits, team work, website (treasure chest), orientation manual

## 3:30 Chronic Disease Management, Self-Management for Physicians

### Dr. Carole Williams

*Medical Director, Chronic Disease Self Management Project  
The British Columbia College of Family Physicians (BCCFP)*

- Self management – made in BC for BC
- Integration into your busy office
- Expansion of the program, teach the teachers

## 4:15 A Results-Based Logic Model for Chronic Care Management

### Dr. Anne-Marie Broemeling

*Centre for Health Services and Policy Research  
University of British Columbia  
Director, Research and Evaluation  
Strategic Information and Planning, Interior Health Authority*

- Building on the Treasury Board of Canada Results Based Management and Accountability framework, the Primary Health Care Logic Model developed by Watson et al., research literature and consultation
- The model covers population characteristics and contexts, through inputs, activities, outputs and outcomes, as well as efficiency and effectiveness measures
- Recognizing linkages between inputs, activities and outputs
- Utilizing a common evaluative framework for chronic care initiatives

## 5:00 Conference Adjourns for the Day

## 8:15 Continental Breakfast

## 9:00 Co-Chair's Opening Remarks

### Michael Sharpe

*Director, Chronic Disease Control and Management Division  
Centre for Chronic Disease Prevention and Control  
Public Health Agency of Canada*

## 9:15 PRIISME – Strategic and Successful Partnerships in Chronic Disease Management

### Bob Rauscher

*PRIISME – Strategic & Successful Partnerships in Chronic Disease Management  
GlaxoSmithKline*

- Key challenges
- Shaping the partnership
- Designing and implementing the PRIISME framework
- Shifting the point of care from Institution to Community – focus on Family/General Practitioners
- Education – patient self-management, adoption of clinical practice guidelines, disease knowledge and management
- Building a team of health professionals: a multi-disciplinary approach to CDM
- Short and long-term program outcomes
- Site specific outcomes
- Assessment of successful partnerships

## 10:00 Coffee Break

## 10:15 Effective Health Programs for Several Chronic Diseases

### Moderator:

#### Lori Halls

*Executive Director, BC HealthGuide Program  
British Columbia Ministry of Health Services*

#### Gail Attara

*Executive Director  
Canadian Society of Intestinal Research*

#### Valerie Atyeo

*Executive Director  
Osteoporosis Canada  
British Columbia Division*

#### Jean Blake

*Executive Director  
Canadian Diabetes Association – Pacific Area*

#### Bev Gutray

*Executive Director  
Canadian Mental Health Association,  
British Columbia Division*

PANEL DISCUSSION

**Paddy O' Reilly**  
*Chief Executive Officer*  
**Healthy Heart Society**

- Why the prevention of heart disease is such a challenge
- Building community capacity as a key underpinning to successful health and illness prevention
- Successful engagement between patients and health system
- Supported self-management approaches
- Managing patients is not just a science, it's an art
- Medications differ on a patient by patient basis
- Patients with a particular disease cannot be lumped into one group – each is a person with a disease and needs to be treated as an individual
- Evidence supports that patients with the same disease respond differently to accepted treatments and our healthcare plans need to adapt to these intrinsic differences
- Similar concerns and different requirements:
  - shared care arrangements
  - quality improvement collaborative
  - increase emphasis on health promotion
  - disease and injury prevention
  - management of chronic diseases
  - multi issue patients

**11:45 From Education to Practice: Transforming Chronic Care Management**

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**Joyce Bruce**  
*Program Head, Primary Care Nurse Practitioner Program*  
**Saskatchewan Institute of Applied Science & Technology (SIASST)**

**Netha Dyck**  
*Dean of Nursing*  
**Saskatchewan Institute of Applied Science & Technology (SIASST)**

- Innovative educational approaches used to prepare practitioners to practice within the primary health care context
- Leading edge interactive technologies will be featured
- The role of the nurse practitioner in achieving client centered chronic care management

**12:30 Networking Luncheon**

**1:30 Implementing Chronic Care in the Primary Care Setting**

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**Laurie Gould**  
*Executive Director*  
*Primary Care & Chronic Disease Management*  
**Fraser Health**

- Shared Care – what it is and how it works
- Role of multidisciplinary teams in the primary care environment
- Implementing the expanded chronic care model
- Use of IT in chronic care
- Measuring results
- Key challenges ahead

CASE STUDY

**2:15 Building A Team – Interdisciplinary Care That Works**

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**Dr. Sue Turgeon**

*Lead physician*  
**Mid-Main Community Health Centre (Vancouver)**

- How our non-profit community health centre got started on this team approach
- The way each new discipline was added to the team of clinicians
- The impact of each new skill set on the individual practice of each physician and the clinic approach to care as a whole
- The impact on our patients – improved outcomes on every measurement scale

**3:00 Refreshment Break**

**3:15 Implementing the “Chronic Disease Self-Management Program” in British Columbia**

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**Patrick McGowan, PhD**

*Associate Professor*  
**University of Victoria – Centre on Aging**  
*Director of Ladner Office, Delta, BC*

- History of implementation in BC and Canada
- Program theory
- *Chronic Care Model*
- Program targets
- Recruiting and training lay leaders
- Monitoring and providing support
- Quality monitoring and evaluation activities and findings
- Implementation models
- Program integration and sustainability
- Dissemination of program strategies
- Future projects and possibilities

**4:00 Desire, Intimacy and Sexuality Issues With Chronic Life-Limiting Disease**

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**Lynn Cummings, MN, CHPCN (C)**

*Nurse Manager*  
**Victoria Hospice Society**

**Anne Syme, BScN, MScN**  
*Provincial Leader, Pain and Symptom Management/Palliative Care*  
**BC Cancer Agency**

- Nature of desire, intimacy and sexuality and the impact of a debilitating disease on a person's sexual health
- Why this aspect of care is poorly addressed by care providers
- What care providers need to know to better attend to a person's intimacy needs and sexual expression
- A model for assessment and intervention
- Case discussions for learning application

**4:45 Co-Chair's Closing Remarks and Conference Concludes**

# CHRONIC DISEASE MANAGED CARE

June 13 – 14, 2006 • Four Seasons Hotel • Vancouver

Conference Code: HCC06989

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