

# REGIONAL STRATEGY AND PLAN OF ACTION ON AN INTEGRATED APPROACH TO THE PREVENTION AND CONTROL OF CHRONIC DISEASES, INCLUDING DIET, PHYSICAL ACTIVITY, AND HEALTH

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# Previous WHO and PAHO Resolutions on CNCDs

- The WHO Global Strategy for the Prevention and Control of Chronic Diseases (WHA53.17, 2000);
- Cardiovascular Disease, especially Hypertension (CD42.R9, 2000);
- Public Health Response to Chronic Diseases (CSP26/15, 2002)
- Framework Convention for Tobacco Control (WHA56.1, 2003);
- Global Strategy on Diet, Physical Activity, and Health (WHA57.17, 2004); and
- Cancer Prevention and Control (WHA58.22, 2005)

*Reducing chronic disease mortality by 2% annually would result in an estimated **36 million fewer deaths** between 2005 and 2015 worldwide, of which 28 million would be averted in low-income and middle-income countries*

*Kathleen Strong, Colin Mathers, Stephen Leeder, Robert Beaglehole. Preventing chronic diseases: how many lives can we save? Lancet S0140-6736 (05)67341-2*

*Ministries of Health in collaboration  
with other sectors in the Caribbean  
will establish by mid **2008**  
comprehensive plans for the  
**screening and management of  
chronic diseases and risk factors**  
so that by **2012, 80%** of people  
with chronic diseases would  
**receive quality care***

Port-of-Spain NCD Summit Declaration,  
2007



# Major Chronic Diseases and Their Risk Factors

- Cardiovascular diseases
- Cancers
- Diabetes
- Chronic respiratory diseases
- Injuries and violence
- Mental health disorders
- Risk factors of unhealthy diet, physical inactivity, tobacco, and alcohol abuse



# Countries' Capacity

- Lack of integrated action on chronic diseases;
- Countries still lacking tobacco-control or food and nutrition legislation as part of the prevention and control of chronic diseases;
- Few countries have assigned resources to NCD prevention and control.

Source: WHO survey on country NCD capacity, 2005

# PAHO's Response

***Regional Strategy and Plan of  
Action for the Integrated  
Prevention and Control of CNCDs,  
Including Diet and Physical Activity***

**Goal:**  
To prevent and reduce  
the burden of chronic  
diseases and related  
risk factors in the  
Americas.

A faint, light blue background map of the Americas is centered on the page. To the right, a portion of a globe is visible, showing latitude and longitude lines. A bright cyan horizontal bar is positioned across the middle of the page, containing the title text.

# Lines of Action

**Public Policy & Advocacy**

**Surveillance**

**Health Promotion & Prevention**

**Integrated Management of CNCDs**

# Health Promotion & Prevention

To foster, support, and promote social and economic conditions that address the determinants of chronic diseases and empower people to increase control over their health and to adopt healthy behaviors.



*Implement strategies and actions  
for health promotion in key  
settings*

# Public Policy

**To ensure and promote the development and implementation of effective, integrated, sustainable, and evidence-based public policies on chronic disease, their risk factors, and determinants.**



***Strengthen NCD public policy development***

# *Development and strengthening of chronic disease surveillance systems*

## Surveillance



**To encourage and support the development and strengthening of countries' capacity for better surveillance of chronic diseases, their consequences, their risk factors, and the impact of public health interventions.**

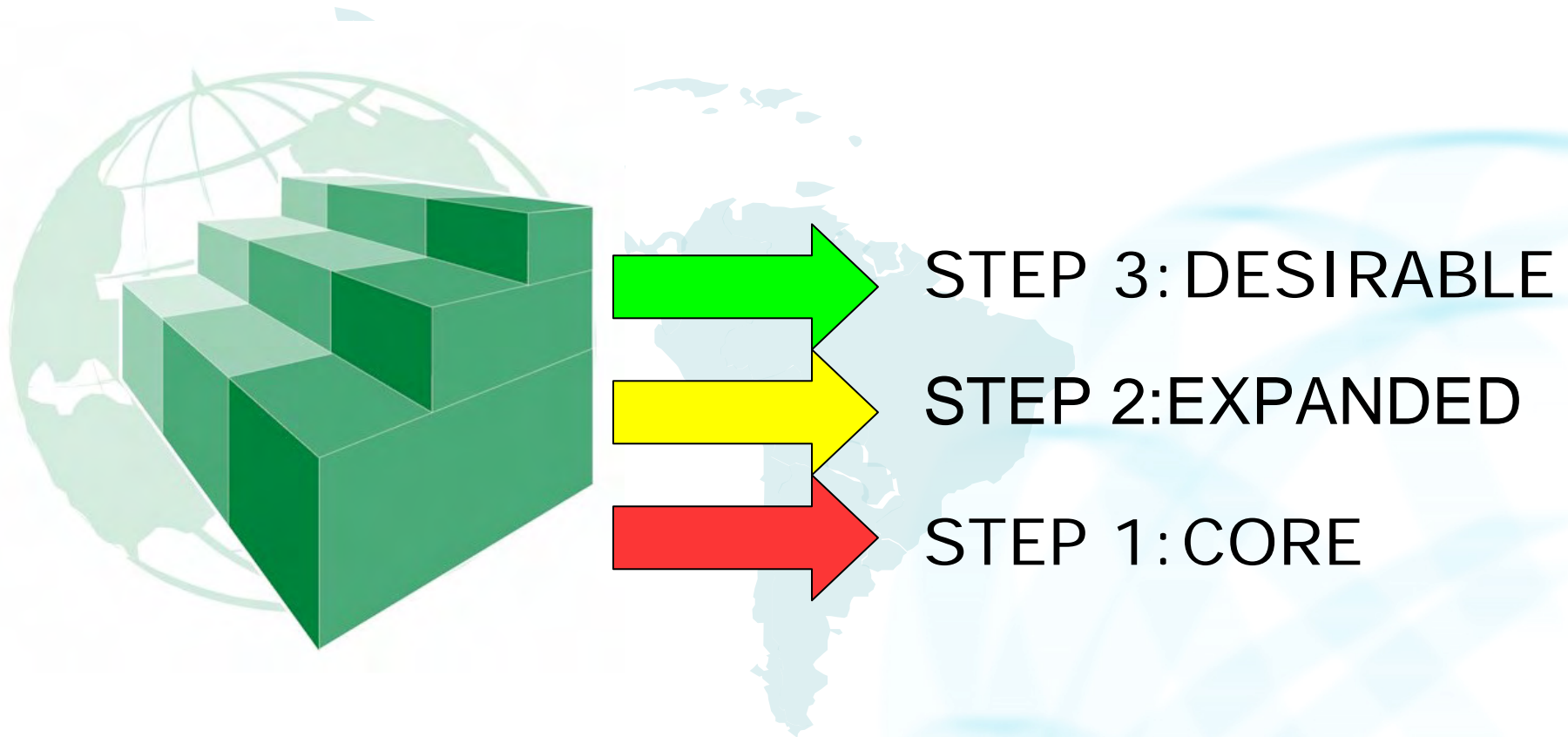
*Provide technical assistance to countries  
in the development, strengthening,  
implementation, and evaluation of their  
chronic disease programs*

## Integrated Management of NCD



**To facilitate and support the strengthening of the capacity and competencies of the health system for the integrated management of chronic diseases and their risk factors.**

# STEPWISE IMPLEMENTATION



# Example of objectives and indicators for a national diabetes / hypertension implementation plan as part of the chronic disease strategy

Objective	Indicator
Opportunistic screening of blood glucose, blood pressure, body weight and physical activity pattern	Number of cases screened Number of new cases of DM Number of new cases of hypertension
Provide continuous quality diabetes and hypertension care	Number of people with diabetes or hypertension participating in educational activity
Increase coverage of A1c	Number of A1c tests among people with diabetes

# The Chronic Care Model: Overview



# Chronic Care Model

- ◆ The Chronic Care Model developed by the MacColl Institute for Healthcare Innovation (USA) provides a road map for redesigning the system to better manage chronic conditions
- ◆ This model can be applied to a variety of chronic illnesses, health care settings and target populations

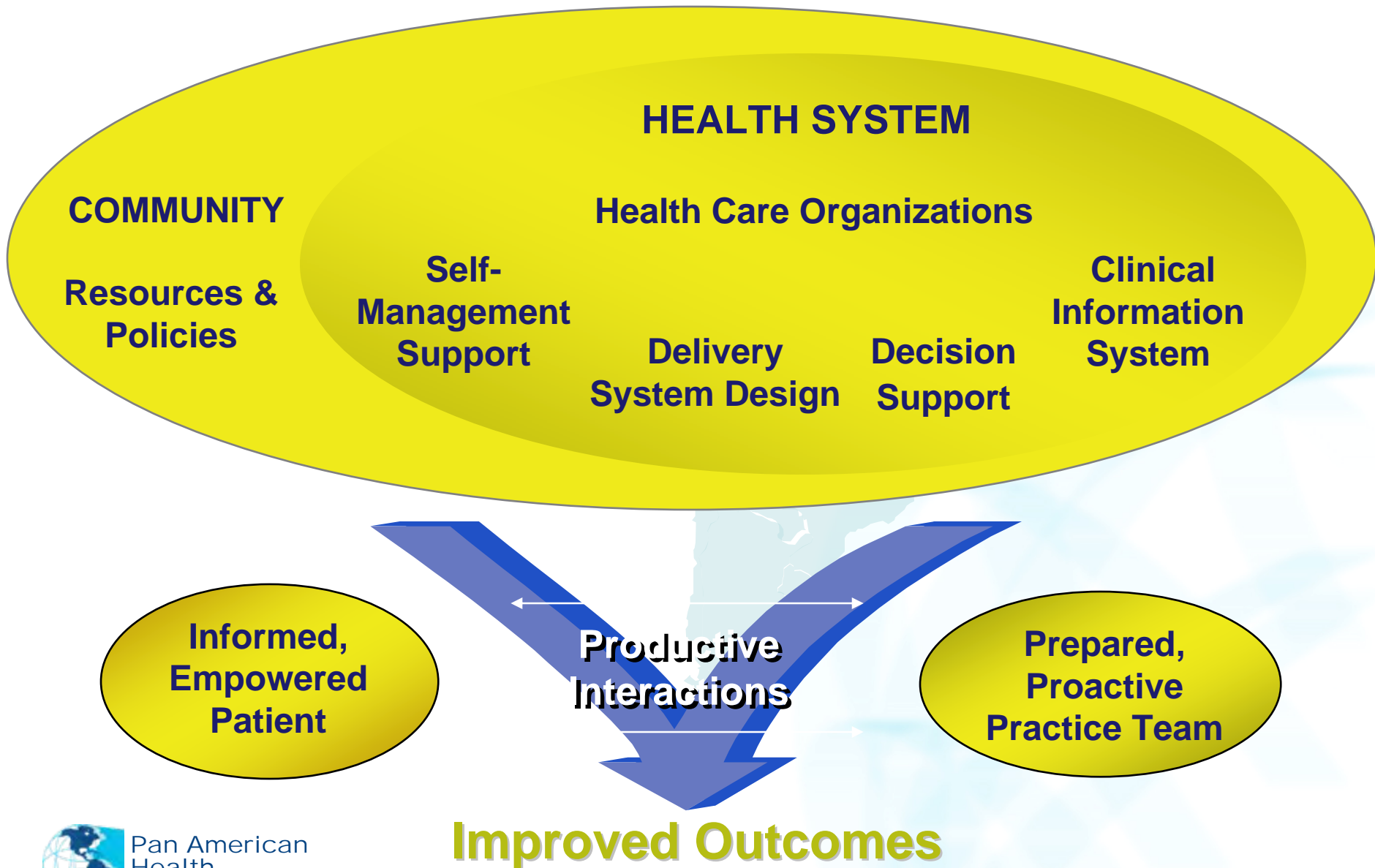
***[www.improvingchroniccare.org](http://www.improvingchroniccare.org)***

# Chronic Care Model

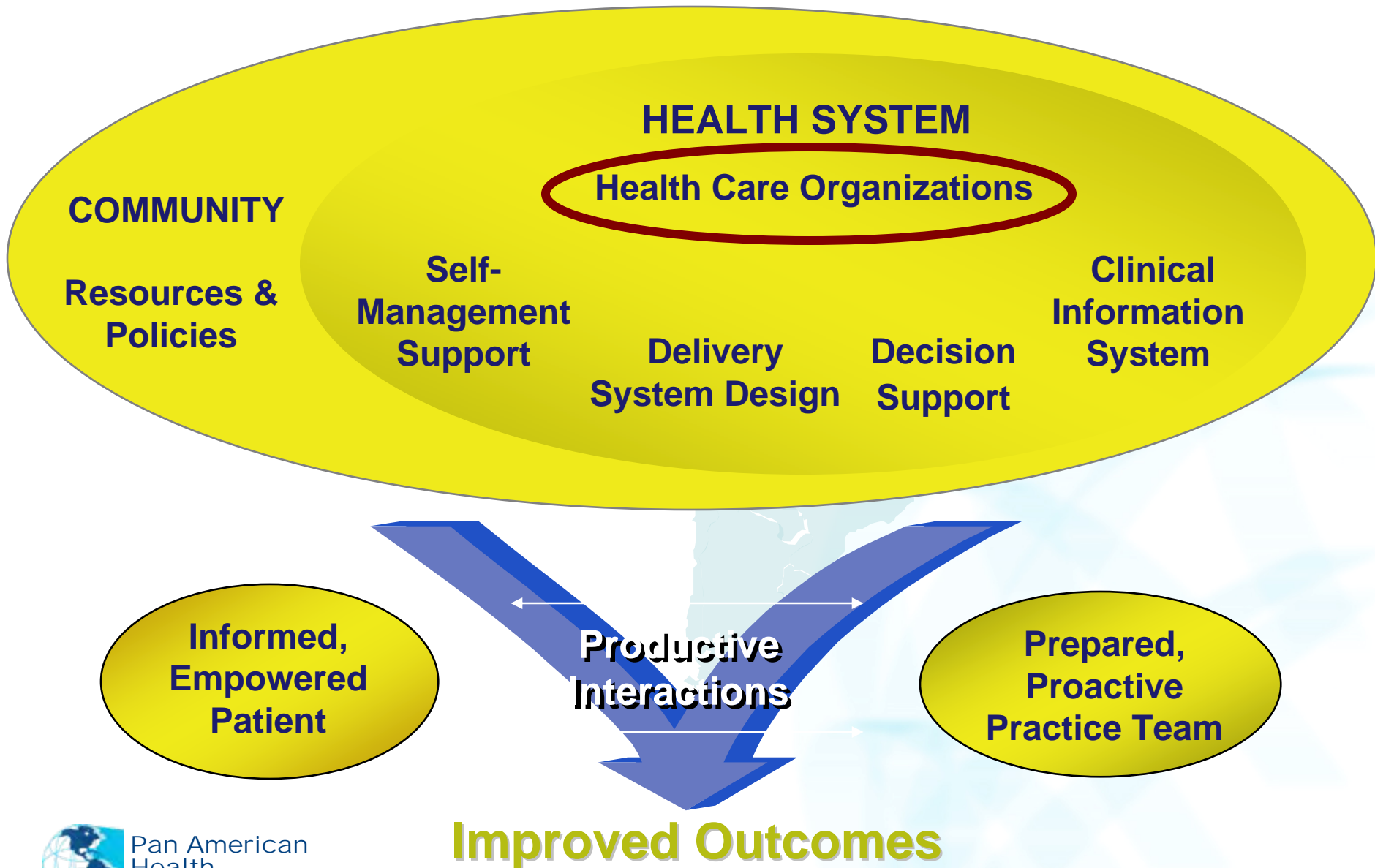
- ◆ The model has been adopted by the PAHO as the basis for action plan for managing chronic conditions
- ◆ Is used in many countries and health care organizations around the world
- ◆ Has been shown to be useful in organizing strategies to improve patient outcomes and reduce costs for many chronic conditions

[www.who.int/chp](http://www.who.int/chp)

# Chronic Care Model



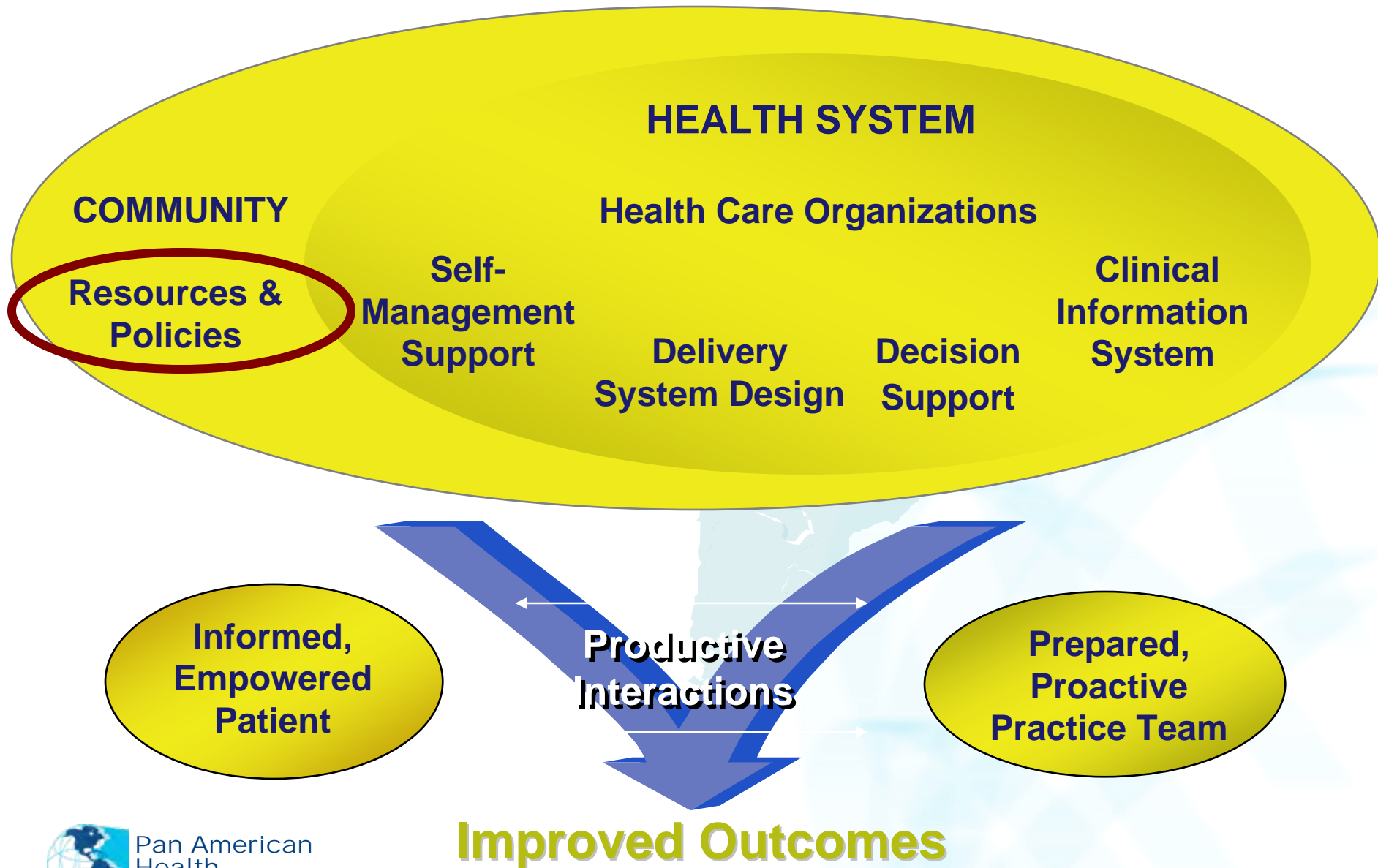
# Chronic Care Model



# Six Focal Areas

- ◆ Health Care Organizations
  - ◆ Visibly support improvement in chronic illness care at all levels of the organization
  - ◆ Provide incentives to encourage better chronic illness care
  - ◆ Facilitate care coordination throughout the organization

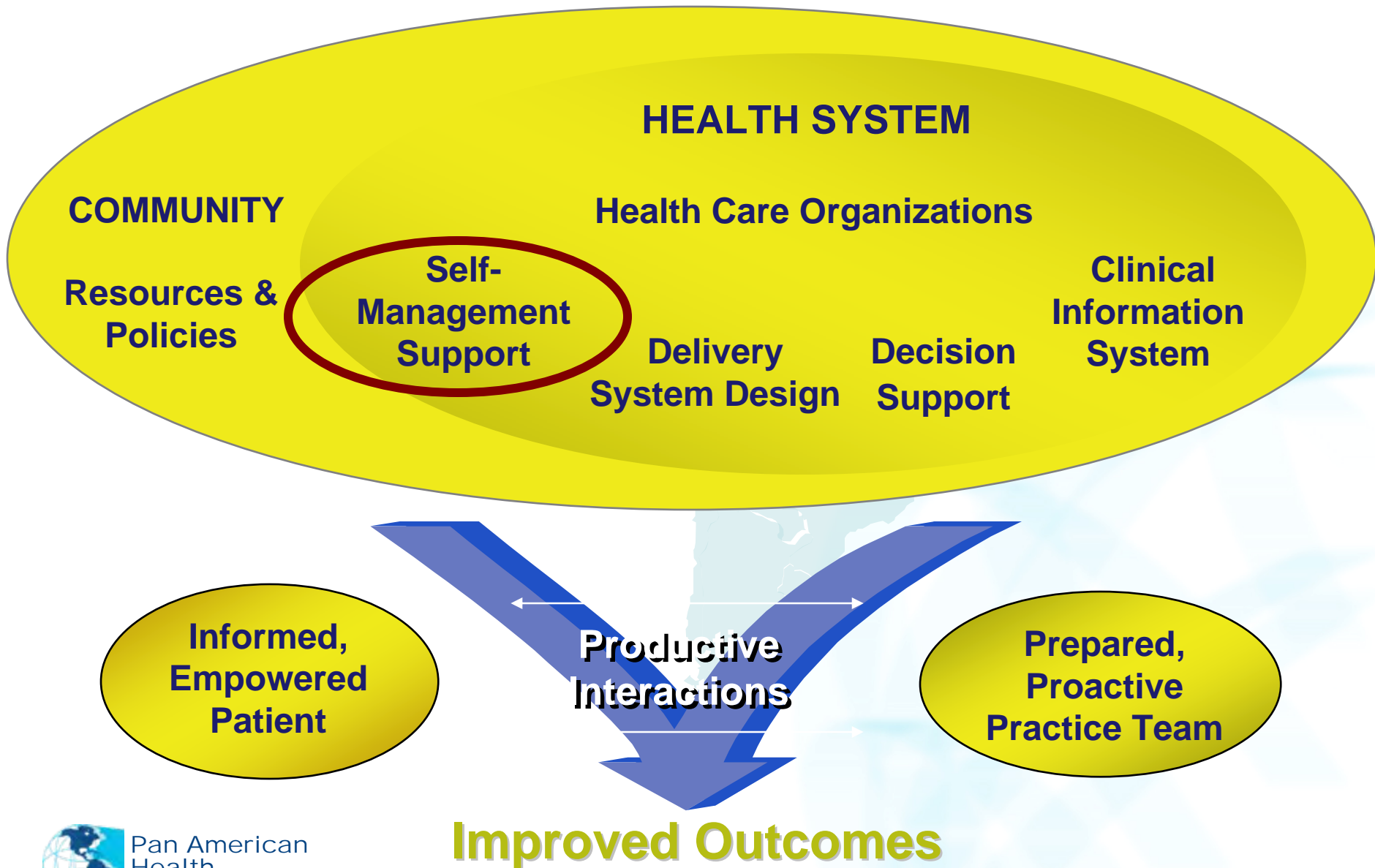
# Chronic Care Model



# Six Focal Areas

- ◆ Community Resources & Policies
  - ◆ Form partnerships with community organizations to support and develop interventions that fill gaps in needed services
  - ◆ Encourage patients to participate in effective community programs
  - ◆ Advocate for policies to promote health, prevent disease and improve patient care

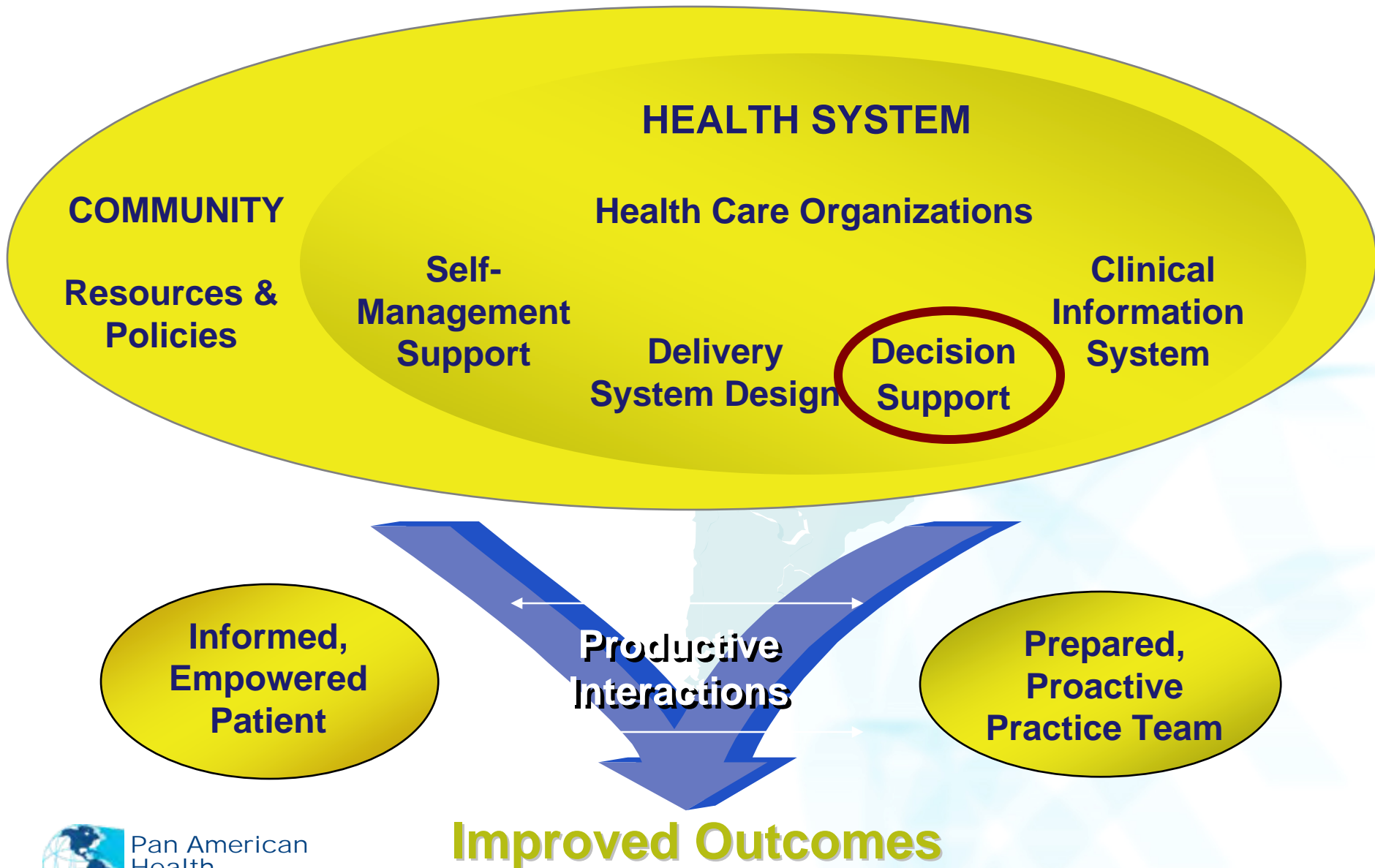
# Chronic Care Model



# Six Focal Areas

- ◆ Self-Management Support
  - ◆ Emphasize the patient's central role in managing his/her health
  - ◆ Use effective self-management support strategies that include goal setting, action planning and problem-solving
  - ◆ Organize internal and community resources to provide ongoing self-management support to patients

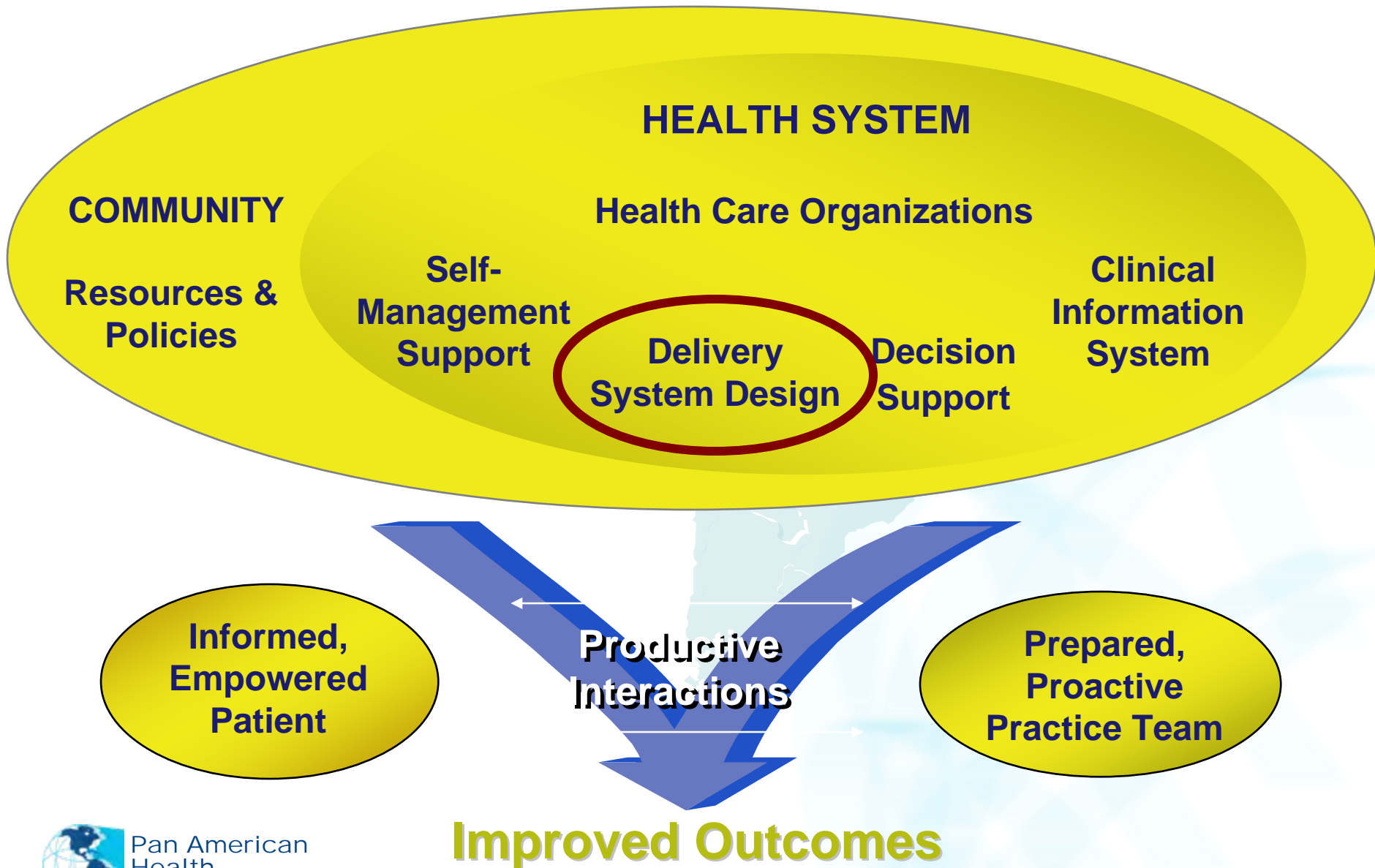
# Chronic Care Model



# Six Focal Areas

- ◆ Decision Support
  - ◆ Embed evidence-based guidelines into daily clinical practice
  - ◆ Share evidence-based guidelines and information with patients to encourage their participation
  - ◆ Integrate specialist expertise and primary care

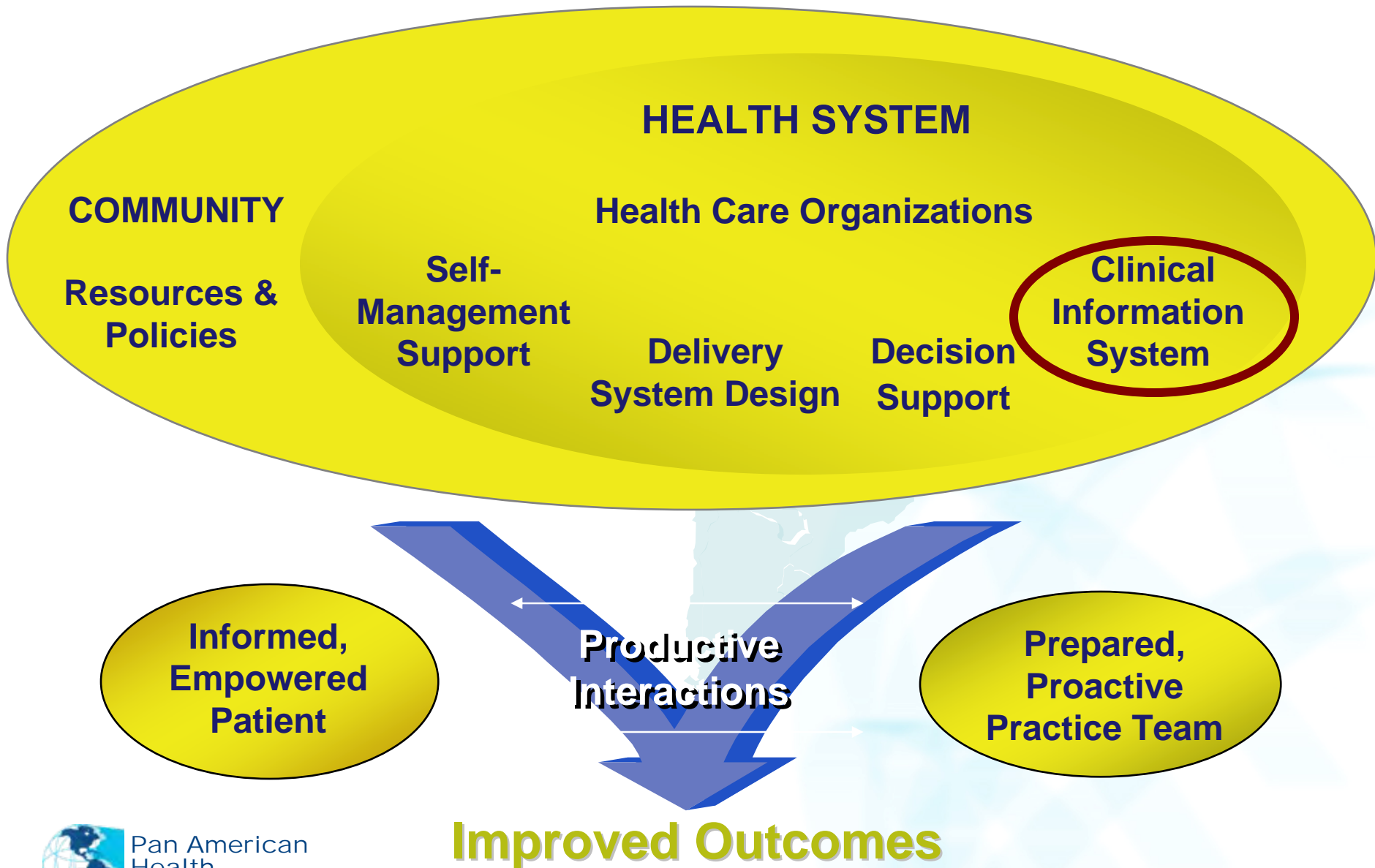
# Chronic Care Model



# Six Focal Areas

- ◆ Delivery System Design
  - ◆ Define roles and distribute tasks among team members
  - ◆ Use planned interactions to support evidence-based care
  - ◆ Ensure regular follow-up by the care team
  - ◆ Give care that patients understand and that fits with their cultural background

# Chronic Care Model



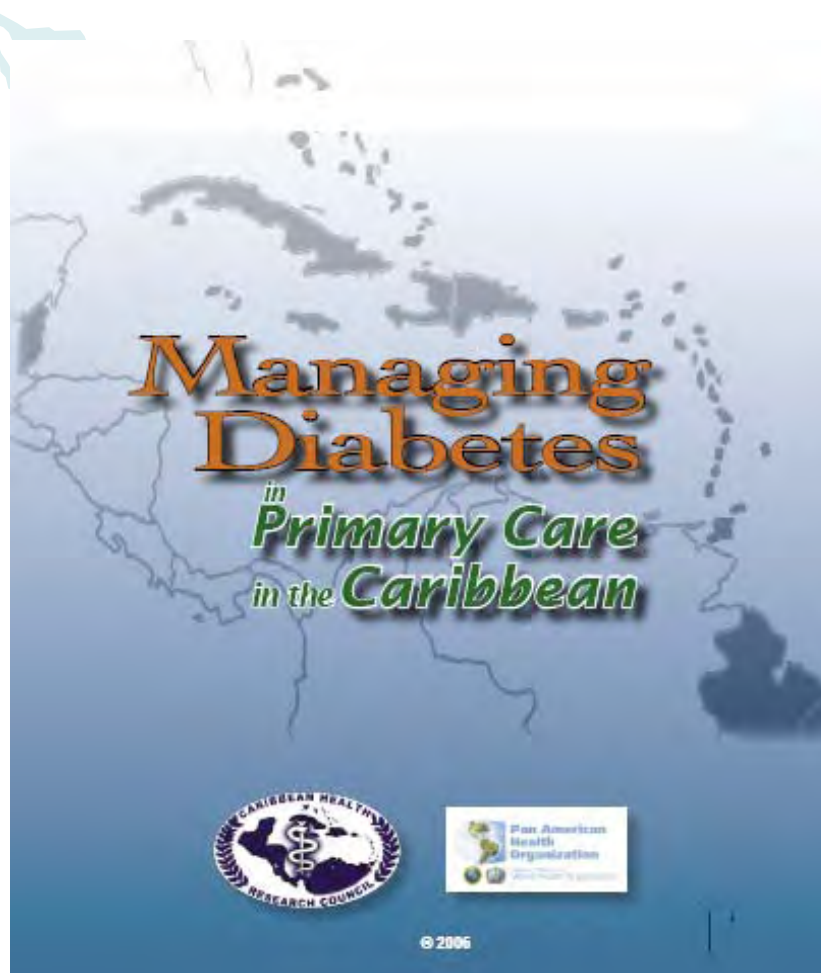
# Six Focal Areas

- ◆ Clinical Information Systems
  - ◆ Provide timely reminders for providers and patients
  - ◆ Identify subpopulations for proactive care
  - ◆ Facilitate individual care planning
  - ◆ Share information with patients and providers to coordinate care
  - ◆ Monitor performance of practice team and care system



# Guiding and supporting national quality improvement initiatives for diabetes a proof-of-concept project in the Caribbean

Build up on existing strategies such as the CHRC guidelines, the Caribbean Protocol for Nutritional Management of Diabetes and Hypertension, CCH3



## Goal

- To improve the quality of life of people with diabetes.

## Objective

- To achieve real and sustained improvements in the quality of diabetes care and outcomes in 10 Caribbean countries.

# Each country will identify the intervention areas

- Antigua and Barbuda,
- Anguilla,
- Barbados,
- Belize,
- Dominica,
- Grenada,
- Guyana,
- Jamaica,
- St Lucia,
- St Kitts and Nevis,
- St Vincent and the Grenadines,
- Trinidad and Tobago, and
- Suriname.

# Three Teams

- The National Teams
- The Local Teams
- The Faculty

# The National Teams

The national technical committee will be responsible at the country level. The team will consist of people with sufficient authority to implement changes in diabetes care.

# The Local Teams

The local teams will conduct the intervention in each participating center; members of the local teams will be the Director/Coordinator of the health center and health care providers.

# The Faculty

The role of the faculty of experts will be to provide detailed guidance and support to each country in the design, implementation and evaluation of initiatives to improve diabetes care.

# Activities

- **Baseline assessment**
- **Initial International Training workshop**
  - Chronic care model
  - Breakthrough series methodology
  - Assessment of Chronic Illness Care (ACIC) tool
- **Intervention**

# Expected Results

- To increase the knowledge about the chronic care model and its components: Clinical information system, decision support, delivery system design, and self management.
- To describe the specific changes in the clinical information system, decision support, delivery system design, and self management that have already been tried in other experiences.

# Expected Results

- Discuss the Improvement model, including the change and the need for the PDSA cycles.
- Support the teams in the application of the model and the PDSA cycles, especially the first step (Plan-Do) for each one of the changes that are planned.
- Achieve real improvement in the management of diabetes.

# Conclusions

- The NCD strategy and plan of action provides a framework to organize chronic disease prevention and control across the region
- The use of the chronic care provides a framework to evaluate and organize NCD management
- The Caribbean diabetes project focuses on improving chronic care and it is an entry point to initiate quality improvement strategies in the Caribbean