An environmental scan of policies in support of chronic disease self-management in Canada

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Abstract

Introduction: The evidence supporting chronic disease self-management warrants further attention. Our aim was to identify existing policies, strategies and frameworks that support self-management initiatives.

Methods: This descriptive study was conducted as an environmental scan, consisting of an Internet search of government and other publicly available websites, and interviews with jurisdictional representatives identified through the Health Council of Canada and academic networking.

Results: We interviewed 16 representatives from all provinces and territories in Canada and found 30 publicly available and relevant provincial and national documents. Most provinces and territories have policies that incorporate aspects of chronic disease self-management. Alberta and British Columbia have the most detailed policies. Both feature primary care prominently and are not disease specific. Both also have provincial level implementation of chronic disease self-management programming. Canada’s northern territories all lacked specific policies supporting chronic disease self-management despite a significant burden of disease.

Conclusion: Engaging patients in self-management of their chronic diseases is important and effective. Although most provinces and territories have policies that incorporate aspects of chronic disease self-management, they were often embedded within other initiatives and/or policy documents framed around specific diseases or populations. This approach could limit the potential reach and effect of self-management.

Keywords: chronic disease self-management, self-management support, health policy, primary care, environmental scan

Introduction

Chronic disease is Canada’s most prominent health care problem, costing more than $80 billion each year1,2 and causing increased use of emergency departments, extended hospital stays, reduced quality of life and increased mortality rates.3-10 Improving the quality of care for people with chronic diseases is complex,11 requiring timely diagnosis and treatment, access to primary and specialist care and a focus on self-management tasks and decisions.12,13 Supporting people in self-management has been shown to be effective at improving outcomes and has been promoted across the widest array of conditions and populations.14-20 Self-management support (SMS) focuses on the individuals and their families by using collaborative goal setting and a variety of self-efficacy strategies.16 These strategies enable patients, together with their health care providers, to medically manage their illnesses more effectively, carry out normal roles and activities and manage the emotional impact of their illnesses.15 Adams et al.21 further this definition by highlighting what health care providers can do through “the systematic provision of education and supportive interventions by health care staff”21,p57 to increase patients’ skills and confidence in managing their health problems, including regular assessment of progress and problems, goal setting and support in problem-solving.

There is much interest in implementing SMS programs in Canada. However, many programs are being implemented in isolation, often by disease-specific organizations or local public health or community-based organizations.22 But while the patients and their communities, health providers and the health care delivery system are certainly linchpins in the success of chronic disease support and care, federal, provincial and territorial governments have major roles to play because they set and implement public policy for health and health care across Canada.

While there is some mention of the importance of self-care and self-management in national strategies, such as healthy aging23 and the Canadian Diabetes strategy,24 little is known about provincial and territorial government policy directions associated with SMS, despite that these governments are responsible for health and health care within their jurisdictions.

As part of a broader project on chronic disease care and self-management conducted with the Health Council of Canada (HCC),25 we performed an environmental scan to identify provincial and territorial...
government strategic policy documents that support patient self-management.26 The HCC is an independent, not-for-profit organization established by the country’s first ministers in 2003 to monitor the health care system within the context of the Health Accords. The HCC has focused some of its attention on the prevention and management of chronic conditions to encourage discussion of the changes to public policy, health care management and health services delivery required to improve health outcomes for all Canadians.27

The intent of this report is to increase awareness of provincial activities and policy directions to allow jurisdictions to build on emerging trends across the country.

**Methods**

We conducted the environmental scan of SMS and chronic disease care in three phases: (1) an online scan using the Google search engine to identify publicly available policies that support or influence SMS initiatives; (2) interviews with jurisdictional representatives of the HCC to gain an inside perspective on existing policies and strategies and future plans related to SMS; (3) a second online scan based on interview findings.

The aim of the first online scan was to identify publicly available policy documents at the provincial and territorial level. We defined policy as any course of action or broad direction endorsed by a body of authority in government and included frameworks, strategies, action plans and official priority documents.28

Three people from our research team scanned online literature and websites from each of the provinces and territories in September 2011 to identify policies, legislation, strategies and frameworks that discussed or focused on SMS and programs or their implementation. Keywords used in the search were “self-management,” “self-care,” “self-management support,” “chronic conditions,” “policy,” “action plan,” “framework,” “strategy” and “initiative.” Relevant findings were organized in a database using Microsoft Excel version 12 (Redmond, WA, US), tracking the year and details of each initiative.

Next, for a more in-depth and accurate view of existing policies, we interviewed individuals involved in policy in the ministries of health. Jurisdictional representatives from all provinces and territories, with the exception of Quebec, were identified and invited by email to participate in a 30-minute telephone interview through the network of the HCC. At the time, Quebec was not in a formal partnership with the HCC so we identified our Quebec participant through academic networking. All the jurisdictional representatives invited agreed to participate and granted informed consent. The interview process was approved by the Ottawa Hospital Research Ethics Board.

The interview guide used for these semi-structured interviews is available from the authors on request. The principal investigator (CL) or the research assistant (KM) conducted the interviews between September and October 2011, with the Quebec interview conducted in May 2012. Interviews were recorded and transcribed by the research assistant. Copies of the interview transcripts were sent to each interviewee for approval to increase the trustworthiness of the results.

The third step of the study, which took place in July 2012, consisted of a focused online scan to identify newly released or updated policy documents that had been identified by the interviewees as forthcoming. The iterative analysis used examples of other policy scans for guidance.29,31 Based on the work by Dixon-Woods et al.,32 we used a descriptive narrative approach with thematic analysis. This approach has been identified as appropriate for reviews that focus on policy.32 Two members of the research team reviewed the policy documents and the interview transcripts to identify themes. Several team meetings were held during the analysis phase to discuss findings and come to an agreement upon key themes.32
<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Document Title</th>
<th>Document Type</th>
<th>Link</th>
</tr>
</thead>
</table>

**Table 1:** Examples of policy documents relevant to self-management of chronic diseases
### TABLE 2
Examples of Chronic Disease Self-Management Programs across Canada

<table>
<thead>
<tr>
<th>Province/territory</th>
<th>Program</th>
<th>Link/source</th>
<th>Additional information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alberta</td>
<td>Stanford Chronic Disease Self-Management Program (CDSMP) &quot;Better Choices, Better Health&quot;</td>
<td><a href="http://www.albertahealthservices.ca/services.asp?pid=service&amp;rId=1054851">http://www.albertahealthservices.ca/services.asp?pid=service&amp;rId=1054851</a></td>
<td>This Stanford program runs province-wide and is a component of the integrated community-based programming. Patients can be referred to it by their physicians or staff from one of the other integrated programs.</td>
</tr>
<tr>
<td>Manitoba</td>
<td>CDSMP &quot;Get Better Together: Building Capacity for Chronic Disease Self-Management&quot;</td>
<td><a href="http://www.gov.mb.ca/health/chronicdisease/cden/docs/2007/thursday/keyzer.pdf">http://www.gov.mb.ca/health/chronicdisease/cden/docs/2007/thursday/keyzer.pdf</a></td>
<td>A modified Stanford model that is co-ordinated provincially by the Wellness Institute within the Winnipeg Regional Health Authority. It offers self-management programs across the province and is open to all patients with chronic diseases. These programs are led by both professional and peer leaders.</td>
</tr>
<tr>
<td>New Brunswick</td>
<td>CDSMP &quot;My Choices – My Health&quot;</td>
<td><a href="http://www.gov.ca/0053/phc/workshop-e.asp">http://www.gov.ca/0053/phc/workshop-e.asp</a></td>
<td>This permanent program is based on the Stanford CDSMP and is offered in both official languages.</td>
</tr>
<tr>
<td>Newfoundland and Labrador</td>
<td>Stanford CDSMP</td>
<td><a href="http://patienteducation.stanford.edu/programs/cdsmp.html">http://patienteducation.stanford.edu/programs/cdsmp.html</a></td>
<td>This Stanford program is not offered province-wide yet. Only three out of four regional health authorities have run sessions, but all health authorities have master trainers available to lead the program.</td>
</tr>
<tr>
<td>Ontario</td>
<td>Many different titles, e.g. Stanford CDSMP &quot;Living a Healthy Life with Chronic Conditions&quot;</td>
<td><a href="https://www.healthylifeworkshop.ca/">https://www.healthylifeworkshop.ca/</a> and <a href="http://www.livinghealthychamplain.ca">http://www.livinghealthychamplain.ca</a></td>
<td>Many different programs, which are often in collaboration with academic health centres, offer self-management programs to patients with different chronic diseases. These programs are mainly based on the Stanford model with many specifically targeting people with diabetes.</td>
</tr>
<tr>
<td>Saskatchewan</td>
<td>CDSMP &quot;LiveWell Chronic Disease Management&quot;</td>
<td><a href="http://www.saskatoonhealthregion.ca/your_health/ps_cdm_about_livewell.htm">http://www.saskatoonhealthregion.ca/your_health/ps_cdm_about_livewell.htm</a></td>
<td>Saskatchewan has a central hub for several programs and services across the province called the LiveWell Chronic Disease Management Programs and Services. These programs and services target both patients with chronic conditions and their caregivers.</td>
</tr>
<tr>
<td>Yukon</td>
<td>&quot;Chronic Conditions Support Program&quot;</td>
<td><a href="http://www.hss.gov.yk.ca/ccsp.php">http://www.hss.gov.yk.ca/ccsp.php</a></td>
<td>The Yukon Department of Health and Social Services no longer offers a Stanford CDSMP, in large part due to the difficulties in finding a sufficient number of interested participants. The currently available Chronic Conditions Support Program is offered to both patients with chronic conditions and health professionals engaged in their care. The program is not primarily a self-management program, but does contain a few components that are related to self-management. It is offered in both French and English.</td>
</tr>
</tbody>
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**Abbreviations:** CDSMP, chronic disease self-management program; CPSMP, chronic pain self-management program.
programming include supervised exercise programs and nutrition information through either a dietician or a group workshop. Primary Care Networks in Alberta also strongly encourages self-management. The networks play a large role in the integrated community-based programming because of their ability to enhance care co-ordination and collaboration through shared care among the appropriate providers.

Similarly, self-management is identified in the mission, vision and goals of the British Columbia Ministry of Health. The ministry initiative, Patients as Partners, part of the 2007 Primary Health Charter,34 specifically addresses self-management implementation and evaluation in asking primary health care providers and organizations to develop additional ways to support the central role of patients as partners in their own care. The province offers many SMS programs, including Chronic Disease Self-Management; Online Chronic Disease Self-Management; Arthritis/Fibromyalgia Self-Management; Chronic Pain Self-Management; Diabetes Self-Management; Active Choices; A Matter of Balance: Managing Concerns about Falls; Bounce Back: Reclaim Your Health; InterCultural Online Health Network; Patient Voices Network’s Peer Coaching; Dietician Services at HealthLink BC; and QuitNow Services.

Manitoba has also recently released a discussion paper specifically targeting self-management in primary care.

Frameworks

Many of the other provinces have chronic disease management and prevention frameworks that include self-management as a core component. For example, Ontario, New Brunswick and Quebec have aligned their Chronic Disease Management and Prevention (CDMP) Frameworks, based on the Expanded Chronic Care Model,34,35 to build future strategies and policies for the prevention and management of chronic diseases. The Expanded Chronic Care Model itself builds on the well-known Chronic Care Model (CCM),36 which has been shown to enhance the delivery and quality of care and control health care costs.14,19,37 The Expanded Chronic Care Model is more suited to the Canadian health care environment because it more effectively integrates health promotion and prevention in both the health system and communities.

Newfoundland and Labrador has also adopted a Chronic Disease Policy Framework that includes six policy statements, one which focuses on self-management.38 It has eight priority areas: arthritis, cancer, chronic pain, diabetes, heart disease, lung disease, kidney disease and stroke. It covers all four regional health authorities in the province.

Strategies

The Unit for Population Health and Chronic Disease Prevention at Dalhousie University, in collaboration with the Nova Scotia Department of Health, developed the Nova Scotia Chronic Disease Prevention Strategy in 2003; however, it does not explicitly emphasize self-management. The Strategy for Positive Aging in Nova Scotia, published in 2005, does speak of the importance of self-management for seniors.

Disease-specific policies with a focus on self-management

Many of the provinces have policies that focus on disease-specific conditions, such as diabetes, arthritis, stroke and chronic obstructive pulmonary disease. For example, The Ontario Diabetes Strategy, launched in 2008, emphasizes patients’ self-management as an important component. Under this strategy, funding was allocated to cover a four-year plan to execute a multidimensional approach to diabetes care that addresses the growing needs of the Ontario population. The Ontario Diabetes Strategy appears to be the leading strategy in Ontario in terms of incorporating self-management. However, the interviewed experts in the field expressed the belief that there is a need to go beyond a disease-specific strategy toward a general policy that addresses self-management of chronic diseases as a whole, especially in patients with multimorbidities.

Saskatchewan’s Provincial Diabetes Plan, released in February 2004, emphasizes the role of self-management. The Saskatchewan Ministry of Health and local health authorities have also set in place guidelines that mandate the delivery of SMS.

In Prince Edward Island, self-management of specific chronic diseases is also addressed in some programs, such as those for diabetes and arthritis. The province has also been piloting programs for chronic obstructive pulmonary disease, hypertension and weight management that include self-management components. Prince Edward Island does not have a specific policy document to support self-management of chronic diseases in general. Instead, it offers education and training for health care providers that incorporates self-management principles.

Lack of policies, frameworks, strategies in the North

Nunavut

Our policy scan, further supported by our interview with a local expert in Nunavut, revealed that the territory does not have policy documents or strategies that specifically address the issue of self-management for patients with chronic diseases. In addition, there are currently no active self-management programs to support either patients or health professionals in Nunavut.

Northwest Territories

There are no policies in place in the Northwest Territories that specifically support the design and implementation of self-management programs for patients with chronic diseases, although a chronic disease management strategy is being developed by the Department of Health and Social Services, and a first draft of the document had been developed and was under review. SMS is recognized as an important component of the chronic disease management strategy and was included in the draft. The number of programs that fully integrate self-management is limited in the region; some diabetes education programs and a small number of other disease-specific pro-
grams, such as mental health programs, have incorporated elements of self-management. A chronic disease management strategy will provide opportunities to enhance the role of self-management in these programs and design new programs that better address the need for SMS in the Northwest Territories.

Yukon
The Department of Health and Social Services has applied for funding to begin developing a chronic disease prevention and management strategy. According to the experts we interviewed, the aim is to include self-management in this strategy. The Stanford Chronic Disease Self-Management Program is no longer being offered by the Department of Health and Social Services, largely due to difficulties in finding a sufficient number of interested patients. The Chronic Conditions Support Program is offered to both patients with chronic conditions and health professionals engaged in their care. The program is not primarily a self-management program, but does contain a few related components.

Discussion
Through our scan of environmental policies, we found that although most provinces and territories have policies that incorporate aspects of chronic disease self-management, these policies were often embedded within other initiatives and/or policy documents framed around specific populations or diseases. The lack of specific self-management policies in all of Canada’s North was surprising given that these regions have the highest burden of chronic diseases in the country. Residents also have many challenges in accessing care. Other competing health priorities, combined with the geographical spread of the population, may be reasons for self-management being under-developed here.

Great potential for improving health does exist in the North given that the most common and effective chronic disease self-management programs are based on the peer support model that does not rely on access to trained health care professionals. In addition, many of the programs have already been adapted and successfully implemented for many cultures and into different languages.

Canada has many disease-focused strategies that incorporate self-management as a theme. For example, SMS programs in Ontario are mainly funded as part of the Ontario Diabetes Strategy. This diminishes the ability to integrate care on a programmatic level as performance measures are then often linked to specific diseases and not to the population. Although diabetes care is often framed as a first step or template in tackling chronic diseases, the self-management approaches in diabetes remain tethered to disease-specific medical management, such as content knowledge on diabetes and learning medical tasks (i.e. managing insulin). In addition, the population that is targeted by these SMS programs are people with diabetes, which tends to exclude groups of people with other chronic diseases.

It is critical to maintain focus on a more generic approach (dealing with fatigue, action planning for a healthy lifestyle, etc.) that addresses all three dimensions of self-management: patients medically managing their illness; carrying out normal roles and activities; and managing the emotional impact. Focusing on common risk factors across all chronic diseases is a basic principle of the Chronic Care Model approach. The World Health Organization recommends that “sound and explicit governmental policy is the key to effective prevention and control of chronic diseases.” A generic strategy that takes a life course perspective and is co-ordinated among decision makers across sectors is recommended.

Alberta and British Columbia, the provinces that seem to have the most comprehensive self-management approaches, are also the ones with the most detailed policies/strategies that are not disease specific. Both feature primary health care and primary care prominently. The role of the primary care provider can be seen as foundational in supporting patient self-management. The nature of primary care and its position within the health care system makes it a perfect target for such interventions. Primary care not only has access to most patients with chronic conditions but can also address different medical conditions beyond one specific disease. Primary care providers are in an ideal position to play a central role in preventing and managing chronic conditions, as 95% of Canadians with a chronic disease report having a regular family physician. Primary care visits provide a unique opportunity to monitor patients’ health and to encourage self-management, as the majority of Canadians perceive their family physician to be a credible resource of health information and value their advice. As these provinces move forward with strategies grounded more in the primary health care community rather than disease areas, it will be important to evaluate the impact the different provincial policies have on program reach and overall effectiveness. To date, there is still very little published evidence that describes the overall reach of SMS programs in all provinces.

Future research examining the association of policy and program reach and effect in self-management of chronic diseases is needed.

Limitations
The findings of this study are limited by several factors including participation bias and issues related to timing. We relied mainly on the initial contact list of jurisdictional representatives provided by the HCC. Although we did speak to representatives from all the provinces and territories and we did follow up for verification and/or clarification as needed, individual depth of knowledge varied, probably as a result of how much time they had spent in that position and their overall knowledge of the governmental system. These aspects were not specifically assessed.

In addition, a common limitation of policy scans relates to much of the material being time sensitive and linked to political agendas and public statements; thus, material was not necessarily publicly available when we were conducting our research. We attempted to minimize this limitation through interviewing the experts in the field as well as by conduct-
Evidence suggests that engaging patients in self-management of their chronic diseases is important and effective. Although most provinces and territories have policies that incorporate aspects of chronic disease self-management, these policies are often embedded within other initiatives and/or policy documents framed around specific diseases or populations. This approach could limit the potential reach and effect of self-management. Creating policies that identify self-management as a key element in a total population approach could lead to improved care for Canadians living with chronic diseases.

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