The Way Forward

Chronic Disease Action Plan


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Introduction

The Chronic Disease Action Plan is part of a broader initiative to redesign the health sector in Newfoundland and Labrador that includes reforming primary health care, enhancing community-based supports, and addressing the growing burden of addiction and mental illness. This plan identifies concrete actions that the Government of Newfoundland and Labrador is committed to implementing in 2017 and 2018. A renewed focus on chronic disease is critical to the overall realignment of health care services as we seek to achieve better health, better care, and better value for all residents of the province.

The Chronic Disease Action Plan is in keeping with the goals and objectives set out in Healthy People, Healthy Families, Healthy Communities: A Primary Health Care Framework for Newfoundland, and Labrador and Improving Health Together: The Chronic Disease Policy Framework. Both of these frameworks aim to support and empower individuals, families, and communities to achieve optimal health and well-being within a sustainable system.

The action plan complements ongoing work led by the Department of Children, Seniors and Social Development, in particular in the vital areas of primary prevention, health promotion, and healthy active living. A collaborative effort, the action plan will help address the increasing burden of chronic disease in Newfoundland and Labrador by committing to implement effective prevention, early intervention, and chronic disease management actions. The actions described within this plan will assist those who may be already at-risk of developing, or who have already developed, a chronic disease.

Chronic disease prevention and management efforts may be individual or population-based and can occur in a variety of settings such as at home, in schools and workplaces, and within local communities. The Chronic Disease Action Plan outlines initiatives being undertaken within the health care setting to increase awareness and engage individuals in their own health. The Action Plan will help to enhance the effective prevention and management of disease delivering on key government priorities as outlined in The Way Forward: A Vision for Sustainability and Growth in Newfoundland and Labrador.

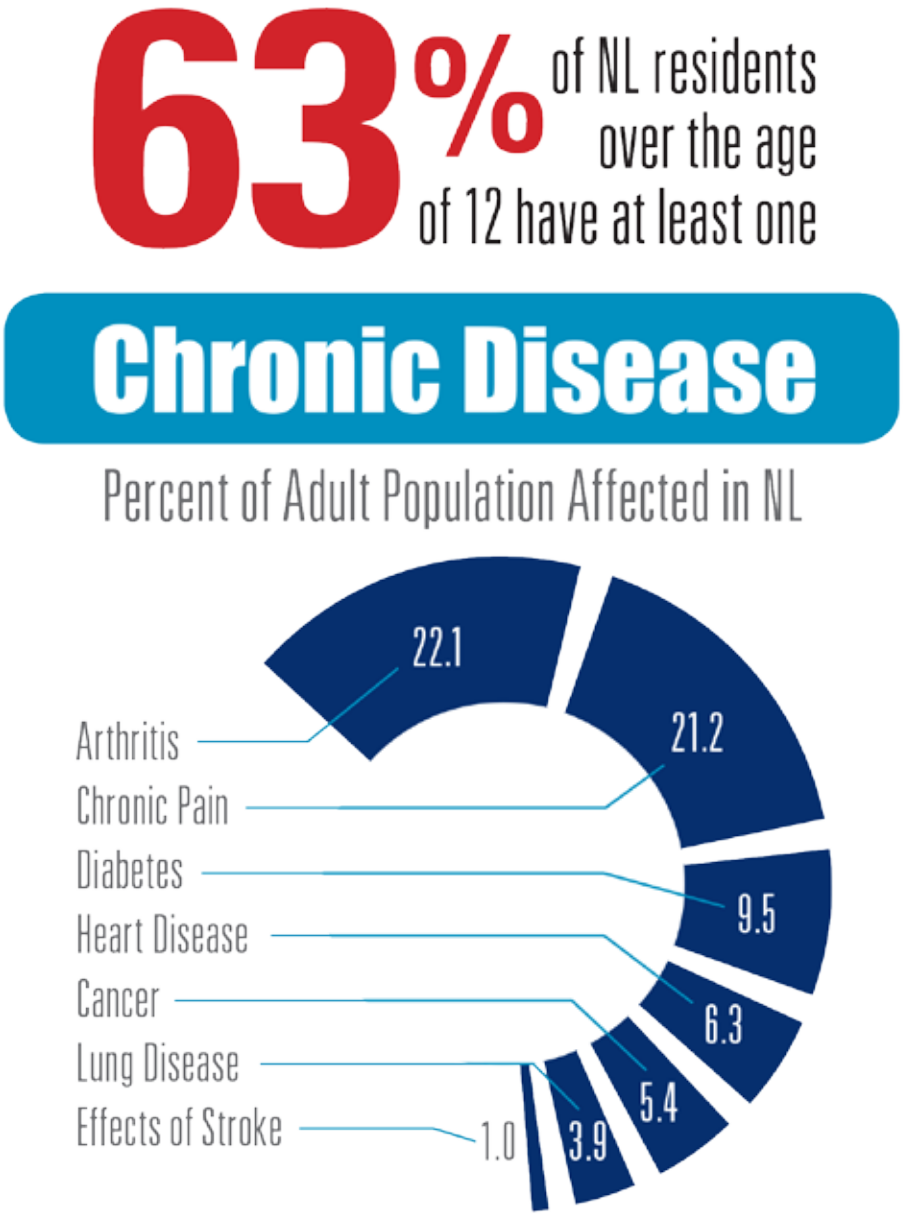
In 2017, the Department of Children, Seniors and Social Development will develop a Healthy Active Living Action Plan focusing on the healthy eating, smoking cessation, and physical activity targets outlined in the Way Forward: A Vision for Sustainability and Growth in Newfoundland and Labrador.

BACKGROUND

Newfoundland and Labrador continues to have some of the highest rates of chronic disease in Canada and as the population continues to age the prevalence of chronic disease is expected to grow.

Sixty-three per cent of residents have at least one chronic disease and Newfoundland and Labrador has the highest rates of diabetes, high blood pressure and obesity across Canadian provinces. Newfoundlanders and Labradorians continue to report low rates of fruit and vegetable consumption and high rates of smoking and inactivity. Evidence clearly shows that these challenges have a negative impact on health outcomes, result in poorer quality of life, increase the cost of delivering health care services, and negatively affect economic growth.

While diabetes, heart disease, chronic obstructive pulmonary disease (COPD), and other chronic diseases continue to be high priorities, they cannot be addressed without considering a person's overall health. The Chronic Disease Action Plan outlines health system initiatives in the areas of prevention, self-management, and treatment and care. Each initiative includes specific actions to support health care providers in delivering high quality person-focused care and to empower individuals in achieving their personal health goals.



Obesity

	Newfoundland and Labrador	Canada
Normal	30%	47%
Overweight	42%	34%
Obese	28%	19%

100,000

people in NL live with a mental illness

70% of mental illnesses develop during childhood and most go undiagnosed

NL Residents 12 Years+

76%	Don't eat enough fruit and vegetables
50%	are not physically active
20%	are current smokers
27%	Consume 5+ units of alcohol at least once per month

PREVENTION

The Provincial Government is focused on increasing awareness and engaging individuals to encourage healthy living. Reducing the incidence of chronic disease begins with keeping people healthy. This can be achieved through actions like ensuring access to affordable and nutritious food, providing opportunities for physical activity, developing personal coping skills, and creating health-supportive environments. The Department of Children, Seniors and Social Development provides leadership on healthy active living initiatives, involving a wide variety of stakeholders.

While some chronic disease risk factors cannot be changed, such as age, gender and family history, research shows that efforts focused on risk factors such as smoking, unhealthy eating, alcohol use, and physical inactivity, contribute to the prevention of chronic disease. The health care system plays an important role in ensuring individuals are empowered to take action for healthy living and the following initiatives highlight actions to enhance prevention within the health system over the next two years.

Prevention Initiatives

Dial a Dietitian

Dietitians can make it easier for individuals and families to make healthy food choices. In 2017, the Provincial Government will trial an expansion of the Newfoundland and Labrador HealthLine to include the services of Registered Dietitians. Through this service, the public will be able to call a dietitian to ask questions, receive information on healthy eating, and be referred to additional services in their region. The service will increase access by making it easier to contact a Registered Dietitian.

811 HEALTHLINE

Registered dietitians are health care professionals who are trained to provide advice and counselling about diet, food and nutrition. They use the best available evidence coupled with good judgment about the client's or communities' unique values and circumstances to determine guidance and recommendations.

ACTIONS:

- In 2017, ensure new dietitians are hired and trained to work as Healthline providers.
- In 2017, launch and promote the dial-a-dietitian service to individuals, families and health care providers across Newfoundland and Labrador.
- In 2018, evaluate the dial-a-dietitian service to ensure it is meeting its goals.

Individuals living with chronic diseases, such as diabetes, cancer or heart disease, will benefit from dietary advice as evidence shows that healthy eating can improve disease management. This service will also benefit those caring for seniors or those with special needs who may struggle with not knowing how to modify diets for certain conditions, such as poor appetite, celiac disease, inflammatory bowel disease, and/or following a stroke.

Better Prevention and Screening

Prevention and screening of cancer, diabetes, cardiovascular disease, and other chronic diseases has been shown to reduce negative health outcomes and lower the burden of chronic disease. The Provincial Government will implement the BETTER program to improve chronic disease prevention and screening in primary health care settings. BETTER is an evidence-based program designed by a team of Canadian experts and tested in Newfoundland and Labrador. The approach enhances the skills of licensed practical nurses, registered nurses, diabetic educators, and other allied health staff to provide one-on-one lifestyle coaching as qualified Prevention Practitioners.

Under the BETTER program individuals are supported to address lifestyle behaviors associated with cancer and chronic disease including diet, exercise, smoking, and alcohol use. Program participants will benefit from improved health outcomes and the ability to more proactively manage their health and the health of their family.

ACTIONS:

- In fall 2017, recruit licensed practical nurses to work as Prevention Practitioners in select primary health care sites in each regional health authority including Happy Valley-Goose Bay, Corner Brook, North East Avalon, the Burin Peninsula, and Bonavista.
- In 2018, identify existing registered nurses, diabetes educators, and other providers to be trained as Prevention Practitioners in communities across the province including St. Mary's, Placentia, St. John's, and Springdale.
- In 2018, work with Memorial University researchers to evaluate and expand the BETTER program.
- In 2018, work with stakeholders to provide Prevention Practitioners with knowledge of local community recreation resources that BETTER program participant can access.

Cancer Screening Program Integration

Newfoundland and Labrador currently has provincial cancer screening programs for breast, cervical and colon cancer and all three programs are managed by Eastern Health. In 2017, Eastern Health, in consultation with the other regional health authorities, will examine ways to further integrate the cancer screening programs for breast, cervical and colon cancer. An integrated approach can maximize opportunities for promoting screening, recruiting participants, collecting and managing data, and providing appropriate follow-up to screening.

Cancer screening programs target individuals who are at increased risk of developing cancer due to age and gender. The goal of these programs is to detect the signs of pre-cancer or early stage cancer, in order to slow or stop its progress, or even to prevent cancer from starting.

ACTIONS:

- In 2017, form a Cancer Screening Program Integration Working Group, led by Eastern Health in partnership with the Department of Health and Community Services and the other regional health authorities.
- In 2017, begin proactive recruitment for cancer screening using the newly designated Cancer Care Registry.
- In 2018, begin integration of cancer screening databases and software.
- In 2018, begin further integration of the three provincial cancer screening programs.

SELF-MANAGEMENT

Individuals living with chronic diseases can live a healthy life through the active management of their conditions. Self-management refers to an individual's confidence and ability to manage their chronic conditions. This includes the tasks needed to deal with the medical, social, and emotional challenges of living with a chronic disease. Individuals can learn the skills to manage their own health and well-being through self-management education and support, using a recovery-focused approach. Good self-management practices have been shown to slow disease progression, often prevent complications and/or disabilities, and may reduce hospital visits.

SELF-MANAGEMENT SUPPORT METHODS

LEARNING OPPORTUNITIES ENABLE INDIVIDUALS TO

The following initiatives will be implemented over the next two years to enhance self-management efforts throughout the province.

Improving Health: *My Way*

Chronic Disease Self-Management Program for Newfoundland and Labrador

Improving Health: My Way is a provincially sponsored, free program designed to help people positively manage the daily challenges of living with a chronic condition. Workshops are co-led by trained Leaders who themselves have a chronic condition or have cared for someone living with a chronic condition. Workshops consist of six sessions that are offered for 2.5 hours once a week, over a six week period. For more information call the NL HealthLine at 811

Self-Management Initiatives

Remote Patient Monitoring

The province's Remote Patient Monitoring project is being used to support patients with diabetes, COPD, and chronic heart failure. The Provincial Government will build on the experience of remote patient monitoring projects currently being tested by Eastern Health and Labrador-Grenfell Health. To date, 584 individuals have enrolled and benefited from this project. The Department of Health and Community Services will expand remote monitoring across the province and further integrate remote patient monitoring with existing technology. Efforts will also be made to connect remote patient monitoring with primary health care providers to ensure continuity of care.

Remote access to real time health information can help in managing chronic disease and reduce the burden of travel for patients in rural areas. Remote patient monitoring allows individuals with chronic diseases to check and record their personal health measures, such as their blood pressure, oxygen or blood sugar levels, and send this information directly to a health care provider. This allows early identification of issues so providers can coach and support their patients and clients before a condition worsens and results in an emergency department visit or negative health outcome.

ACTIONS:

- In August 2017, review the evaluation outcomes of the current proof of concept remote patient monitoring project.
- In 2017, begin to expand remote monitoring to Western and Central Health Regions making the program accessible to more clients and patients.
- In 2018, begin integration of the Remote Patient Monitoring Program with the province's Electronic Health Record and Electronic Medical Record systems to allow for the seamless sharing of information with health care providers.
- In 2018, use remote patient monitoring to support clients receiving home care with the goal of supporting individuals to remain living independently as they age.
- In 2018, begin to utilize remote patient monitoring to support clients receiving home-based dialysis and palliative care.
- In 2018, seek to expand remote patient monitoring to include additional chronic diseases.

Home-Based Dialysis

Home-based therapy options for kidney dialysis provides patients with a better quality of life and eliminate the need to travel and spend time away from family. The Provincial Government will support home-based therapy initiatives assisting individuals to take an active role in the daily management of their health and well-being.

The Provincial Kidney Program aims to increase the rate of home-based therapy among patients for whom this treatment option is appropriate, from 9 per cent to 15 per cent by 2018. Currently, 57 kidney disease patients use home-based dialysis therapy. To support achieving this goal, a phased-in approach will be used to shift from facility-based care and gradually increase home-based care. Health care providers will be supported to teach and educate patients, their caregivers, and families on the benefits and positive outcomes of home-based dialysis therapy.

ACTIONS:

- In 2017, expand testing of self-care model to evaluate patient transition from health centre dialysis to home-based therapy.
- In 2017, increase patient use of new home-based therapy equipment to support patient self-care in their own homes.
- In 2017, encourage the uptake of home-based therapy by working with health care providers, patients, and their families to provide support and education on the benefits and positive health outcomes of home-based therapy.
- In 2018, increase the rate of home-based therapy from 9 per cent to 15 per cent.

Chronic Disease Case Management

Individuals living with chronic diseases, such as heart failure, COPD, cancer and diabetes, can benefit from a case management approach where they are fully supported with wrap around services. Beginning in 2017, the Department of Health and Community Services will work with Central Health and other regional health authorities to expand the use of case management for patients living with chronic disease.

Case management takes into consideration all of an individual's needs and includes tailored treatment plans, long-term support, system navigation, and improved coordination of care. Central Health has successfully tested a Heart Failure Outreach Program that includes these components of case management. This approach can be transferred to a broad range of other complex conditions, and can be integrated into primary health care settings, as well as information systems such as the provincial Electronic Health Record, the Electronic Medical Record and the hospital-based Meditech health record.

ACTIONS:

- In 2017, continue to build the case management program into Central Health's Meditech system.
- In 2017, share key components (assessment tools, training modules, and protocols) with other regional health authorities.
- In 2018, with leadership from Central Health, begin the integration of a chronic disease case management program in all regional health authorities.

Self-Management Support

Supporting individuals to manage their own health is crucial to improving their well-being and quality of life. In partnership with regional health authorities, the Provincial Government will work to ensure staff and local providers such as pharmacists and family physicians are trained to support self-management. This will help to achieve the goal of ensuring clients, particularly seniors and people living with chronic diseases, are empowered to take an active role in managing their physical and mental health.

Individuals living with or at risk for developing chronic disease can also benefit from health coaching to reduce their risk and improve their personal health management. For example, Central Health is developing a Self-Management Health Coach Program based on a grassroots champion and mentorship model.

Professional development opportunities on Self-Management Support and Recovery Approaches to Care will be offered to staff in the regional health authorities. Training will also be open to community-based pharmacists, fee-for-service family physicians, and other community-based providers.

ACTIONS:

- In fall 2017, review existing self-management and recovery oriented professional development tools currently being used across the province.
- In 2018, adopt or develop new Recovery Approach and Self-Management Support professional development modules for use across the province.
- In 2018, ensure professional development tools are available electronically so that regional health authority staff and health care providers are able to access them no matter where they live and work.
- In 2018, begin the integration of a Self-Management Health Coach Program in all regional health authorities.
- In 2018, open access to professional development modules to all providers and interested members of the public.

Strongest Families

Strongest Families is an evidence-based intervention for responding to mild to moderate mental health and behavioural difficulties. Increasing the reach of the Strongest Families program will help to build resilient children, families, and communities in Newfoundland and Labrador.

The Strongest Families Institute Program helps families by teaching skills through a distance coaching approach over the phone and online. The award-winning program supports children and youth with behavioural difficulties, anxiety, attention deficit hyperactivity disorder, bullying behaviours, and other disruptive behaviours that can cause stress at school and at home. Strongest Families Institute offers support and coaching to both children and their guardians.

In January 2017, the Government of Newfoundland and Labrador joined an Atlantic partnership with the Governments of New Brunswick, Nova Scotia, and Prince Edward Island, Strongest Families Institute, and Bell Aliant in an effort to increase access to youth mental health services.

ACTIONS:

- In 2018, leverage the Atlantic partnership to promote the use of the Strongest Families program with primary health care physicians, teachers, and child care providers in order to increase the number of youth and families availing of this program.

Anyone interested in accessing the Strongest Families program can be referred by teachers, guidance counselors, physicians, public health nurses, or staff working in mental health and addiction, and child youth and family services.

TREATMENT AND CARE

Treatment and care works best when individuals receive the right supports, in the right place, at the right time. An enhanced focus on chronic disease is a component of Government's plan to expand the number of primary health care teams and supports for individuals to help them achieve optimal health and well-being.

Enhanced monitoring, provider training, and the use of clinical and electronic tools such as care pathways and checklists based on research guidelines are methods to support primary health care teams and community-based providers in delivering effective chronic disease treatment and care. The following list of priority initiatives demonstrate government's commitment to improving the treatment and care for individuals at-risk of or living with chronic disease over the next two years.

Treatment And Care Initiatives

Telehealth System Enhancements

Access to health care near or in your home is convenient and affordable for patients and their families. Telehealth allows for health care to be provided remotely, limiting unnecessary travel. In 2016-17, there were 18,849 appointments held using Telehealth. The Provincial Government, in partnership with the Newfoundland and Labrador Centre for Health Information and regional health authorities, will enhance the use of Telehealth through the introduction of new mobile technology and changes to the current criteria that often times can restrict the use of Telehealth.

A proof-of-concept initiative is being tested with 40 clinicians across the province using new Telehealth technology. These new technologies will allow providers and patients more flexibility to offer or attend Telehealth consultation sessions on standard desktop devices or by visiting a Telehealth site in their community.

ACTIONS:

- In August 2017, complete and evaluate the proof-of-concept trial of new Telehealth solutions designed to work on personal computers.
- In fall 2017, develop health care provider guidelines for the use of community-based Telehealth software solutions.
- In fall 2017, ensure that community-based providers can access Telehealth from their offices and clinics.
- In 2018, spread the use of desktop Telehealth software solutions in new and existing primary health care teams.
- In 2018, test the use of Telehealth technology on personal computers and mobile devices to allow patients to access Telehealth services from home.
- In 2018, expand capacity for multiple individuals to case conference at the same time through the introduction of new multiparty technology.
- In 2018, explore opportunities to utilize Telehealth within long-term care facilities across the province thereby limiting unnecessary trips for appointments.

Services that can be provided by clinicians via Telehealth include mental health services, speech language pathology, wound care follow-up appointments, oncology, ophthalmology, rheumatology and services for long term care residents among many other potential options.

Chronic Disease and Cancer Registries

Disease registries allow health care providers, researchers, and administers to better understand the health care needs of the population by creating an accurate record of individuals living with specific health care challenges. The Provincial Government designated the Provincial Cancer Care Registry under the Personal Health Information Act in May 2017, pulling together the existing cancer care databases. A new Chronic Disease Registry, with an initial focus on diabetes, will also be created in summer 2017.

The creation of new registries will ensure more complete collection of data from a variety of sources, allowing detailed analysis to provide a clear picture of chronic disease in our communities. The creation of these registries will allow the health system to proactively invite individuals to participate in programs and services, such as cancer screening and self-management supports. Registries will also help to ensure appropriate follow-up and care from providers who will be able to access information through the provincial Electronic Health Record.

ACTIONS:

- Immediately begin utilizing the new Cancer Care Registry.
- In summer 2017, designate the Chronic Disease Registry under the Personal Health Information Act to allow for improved information utilization.
- In 2018, explore options to use registry data to improve recruitment to age-appropriate disease screening and supports.
- In 2018, begin integrating Registries with the provincial Electronic Health Record and Electronic Medical Record to ensure appropriate information is available to health care providers.

Diabetes Flow Sheet

Diabetes management is best achieved when individuals and health care providers follow a standard of care based on current evidence. In summer 2017, the Provincial Government, in partnership with the regional health authorities, Diabetes Canada, and the Family Practice Renewal Program, will establish a provincial diabetes flow sheet, based on national diabetes management guidelines. This checklist will assist health care providers in applying the most up to date standard of care as they support individuals living with diabetes, and will lead to improved monitoring of patients' diabetes management.

The diabetes flow sheet will be integrated into the provincial Electronic Medical Record, as one of many new forms and tools designed to help patients and providers better manage chronic disease and ensure the use of up-to-date guidelines proven to improve care and health outcomes.

ACTIONS:

- In summer 2017, finalize the provincial diabetes flow sheet to help ensure an evidence-based approach to diabetes management in primary health care.
- In 2017, promote the use of the provincial diabetes flow sheet to better manage diabetes in primary health care.
- In 2017, incorporate the diabetes flow sheet into the provincial Electronic Medical Record.
- In 2018, in collaboration with providers and stakeholders, develop additional guidelines-based chronic disease tools for inclusion in the Electronic Medical Record and Electronic Health Record, beginning with a COPD management flow sheet.

Insulin Dose Adjustment Certification

Individuals who manage their diabetes through appropriate insulin dose adjustments are better able to balance between high and low blood sugar levels. Insulin dose adjustment is a skill requiring adequate training. Increasingly, nurses and dietitians are being trained to appropriately adjust insulin doses. The Department of Health and Community Services will work with the regional health authorities to develop a provincial approach to insulin dose adjustment that will build on nurses' and dietitians' current abilities through a certification process based on a model used in other Atlantic provinces.

ACTIONS:

- In 2017, develop a provincial process and policy for insulin dose adjustment certification, to ensure consistent training and application of insulin dose adjustment principles.
- In 2017, share training manuals and references with all regional health authorities, as the basis of learning for insulin dose adjustment.
- In 2018, identify and train regional health authority nurses and dietitians who wish to avail of specialized training in insulin dose adjustment.

Janeway Lifestyle Program – Inter-Professional Network "Be The Wave"

The Janeway Lifestyle Program works with families of children who are at-risk of developing a chronic disease. As a part of its expansion of services, Traveling Consultation Clinics have been offered in all health care regions of the province. To further support these clinics, the Provincial Janeway Lifestyle Program created a new interdisciplinary health care network, "Be the Wave." This community of practice network shares practical information and case-based learning to promote best practices for chronic disease prevention and management among children. The program team has set a target to enroll 100 health care providers in the network by March 2018. Once established, the program team will explore options to offer online learning to network members via multiparty Telehealth technology.

ACTIONS:

- In 2017, promote participation in the community of practice network to connect urban and rural primary care providers across the province.
- In 2017, share best practices, practical information, and case-based learning on pediatric chronic disease prevention and management.
- In 2018, explore options to offer online learning to network members.

Families with children who are at-risk of developing a chronic disease will benefit from health care providers who are better informed of the latest research and best practices, and who are part of a network that supports each other through online case-based learning. Providers working in new or existing primary health care teams will be encouraged to join this network.

Supporting Family Physicians

Supporting family physicians to appropriately assist patients in the management of chronic disease is essential to improving health. The Provincial Government, in partnership with the Family Practice Renewal Program, will establish new supports for physicians that manage complex and chronic conditions. This will include helping to facilitate physicians working more closely with other health care providers and supports the goal of implementing client focused interventions for individuals with complex needs.

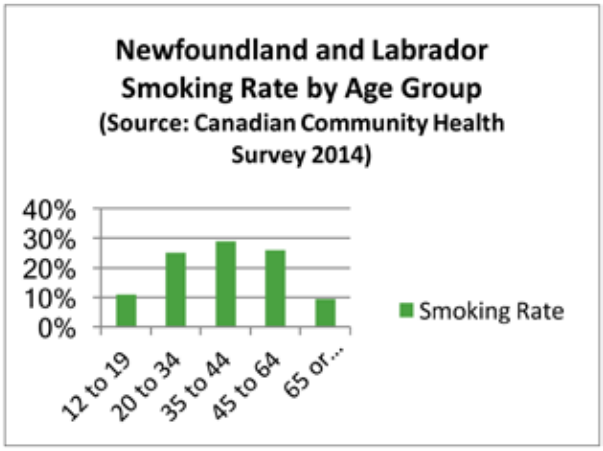
Providing opportunities to support continuing medical education and the use of evidence-based tools such as patient and self-management care plans will help physicians to provide better care for those living with chronic disease. Ensuring physicians can be compensated for the time they spend working with other health care providers will also help to encourage interdisciplinary teamwork and maximization of scope of practice.

ACTIONS:

- In 2017, the Provincial Government will work with the Family Practice Renewal Program to develop new patient-focused physician billing options for the management of complex and/or chronic conditions including methods to encourage interdisciplinary collaboration.
- In 2018, the Provincial Government will work with the Family Practice Renewal Program to identify appropriate standards of care, treatment pathways, and decision support tools for use in family medicine.
- In 2018, the Family Practice Renewal Program will support physicians in the management of complex and chronic conditions through professional development offered through the Practice Improvement Program.

Smoking Cessation and Cancer Care

Smoking cessation significantly improves the outcomes of cancer treatment, and is becoming a part of the standard of care for cancer patients who smoke. The Provincial Cancer Care Program, with funding from the Department of Children, Seniors and Social Development, will integrate smoking cessation and relapse prevention processes into clinical practice as part of a pilot project in the Cancer Care Ambulatory Oncology Program. New head, neck and lung cancer patients will benefit from increased support for smoking cessation, including counseling and medication that aims to improve cancer treatment outcomes and quality of life.



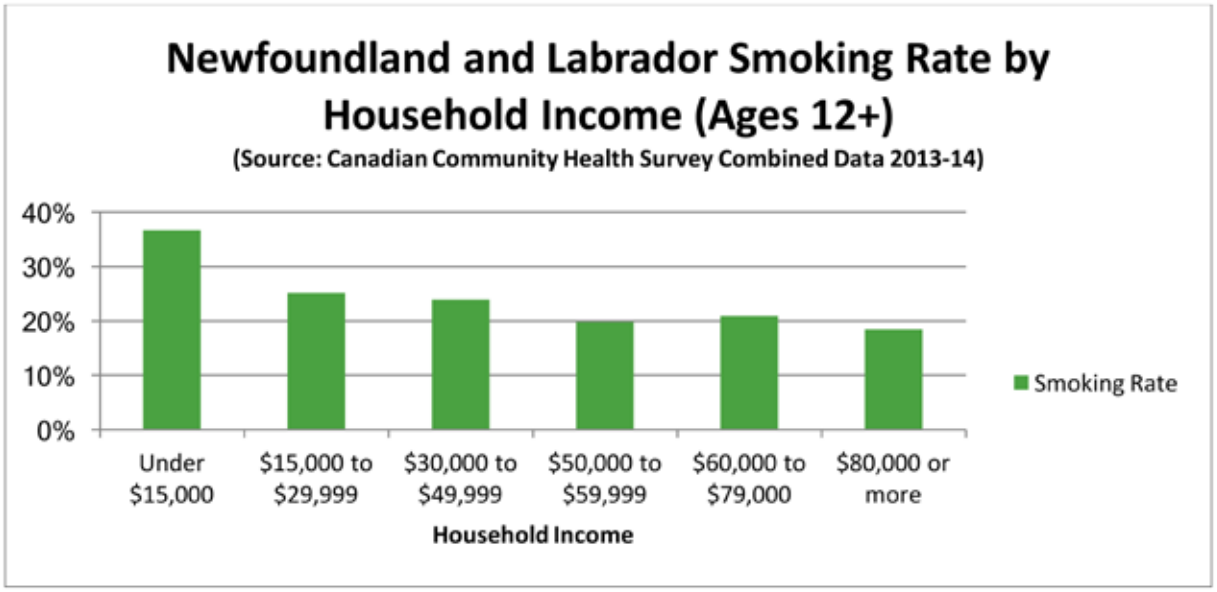
ACTIONS:

- In 2018, the Cancer Care Program will implement a pilot smoking cessation and relapse prevention clinic in the Ambulatory Oncology Program. The clinic will provide brief interventions to encourage smoking cessation, counselling, and medications to support quitting.
- In 2018, begin to evaluate the success of the pilot clinic and determine possible options for expansion of the program.

Enhanced Smoking Cessation for People with Low Income

Nicotine Replacement Therapies and medications are effective in helping individuals quit smoking. To help reduce smoking rates, the Department of Health and Community Services will expand the Provincial Smoking Cessation Program for People with Low Income to include Nicotine Replacement Therapies.

Individuals who are eligible for the Foundation, Access or 65Plus Plans under the Newfoundland and Labrador Prescription Drug Program will now be funded for Nicotine Replacement Therapies in addition to smoking cessation medications already funded. This program expansion will improve access to smoking cessation products. It is one component of the province's tobacco control efforts that aim to reach the target of reducing provincial smoking rates from 21.7 per cent to 18.1 per cent by 2025.



ACTIONS:

- In 2018, add Nicotine Replacement Therapies into the existing Smoking Cessation Program for People with Low Income.
- In 2018, in partnership with the Department of Children, Seniors and Social Development, develop communication tools to promote awareness of program changes and encourage client uptake.

Standardization of Wound Care

Individuals living with chronic diseases such as diabetes or peripheral vascular disease may receive ulcerative wound care from nursing staff in all sectors of the health care system. This care carries significant costs, representing an estimated three percent of total health care expenditures. The Department of Health and Community Services will work with the regional health authorities to continue to develop a standard evidence-based approach to delivering wound care. This will include streamlining the purchase of medical supplies, and providing additional training and support to frontline staff. Building on existing initiatives and the significant progress already made by regional health authority staff will allow us to move to a single provincial model for wound care.

Effective wound management is essential to avoiding potential harmful outcomes for individuals, including hospitalization, reduced quality of life, depression, infection, and increased risk of death.

It is anticipated that these measures will create savings for the health care system while ensuring patients receive high quality care. The potential benefits of this approach include informed and educated assessment of wounds, appropriate use of medical supplies, cost containment, workload efficiency, and improved quality of life for patients.

ACTIONS:

- Continue to support the integration of a provincial Wound Care Program to ensure consistent wound care across the province.
- In 2017, share key program components including pocket guide, order forms, and learning modules, with all regional health authorities, and look to integrate tools into existing e-health platforms.
- In 2018, provide in-service education sessions for frontline staff to help ensure consistent wound assessment, product selection and ordering, and patient care.
- In 2018, explore options to integrate wound care tools into provincial electronic health records and electronic medical records.

MOVING FORWARD

The 2017-18 Chronic Disease Action Plan includes commitments that will be implemented over the next two years. These commitments represent a concrete effort to address some of the health care challenges faced by the province, but they will not alone solve the serious issues faced by many individuals, families, and communities.

Addressing the challenges surrounding chronic disease will be a complex and difficult task. Changes in the health care system will not address the underlying social determinants of health that have the biggest impact on population health outcomes. To address these challenges the Department of Health and Community Services will continue to work with other government departments and stakeholders, find opportunities to collaborate on positive change, embrace a Health in All Policies approach, trial new innovations and technologies, and continue to monitor and evaluate the impact of implemented initiatives.

Individuals, communities, and the private sector all have an important role to play in helping to address the burden of chronic disease. The Department of Health and Community services will continue to work with community partners and support innovative approaches to improving health. This will include working with the private sector to adopt new and emerging technologies that can help us to manage population health issues.

As initiatives are implemented, the Provincial Government will work with stakeholders to, evaluate impact, determine next steps, and continue to identify opportunities to meet changing population needs. The success of individual projects and initiatives identified in this Action Plan will be assessed by identifying, monitoring and reporting on appropriate indicators. These findings will inform future directions and system changes.

The Provincial Government commits to evaluating and regularly updating this action plan, publicly reporting on progress, and engaging stakeholders in that process.

ACTIONS:

- Continue to work with partners across government and the social sector to address the root causes of chronic disease.
- Collaborate with partners across the four Atlantic Provinces to share best practices and seek out opportunities to work together on future initiatives.
- In 2017, identify key indicators and data sources for monitoring the success of action plan projects and initiatives.
- In 2018, develop partnerships with private sector stakeholders in an effort to harness the power of emerging technologies designed to help manage population health issues.
- Prepare annual updates on implementation progress and initiative outcomes.
- Work with stakeholders and identify opportunities to improve implementation existing initiatives or develop new approaches to chronic disease management.

Alternate formats available upon request.

Health and Community Service
Government of Newfoundland and Labrador

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