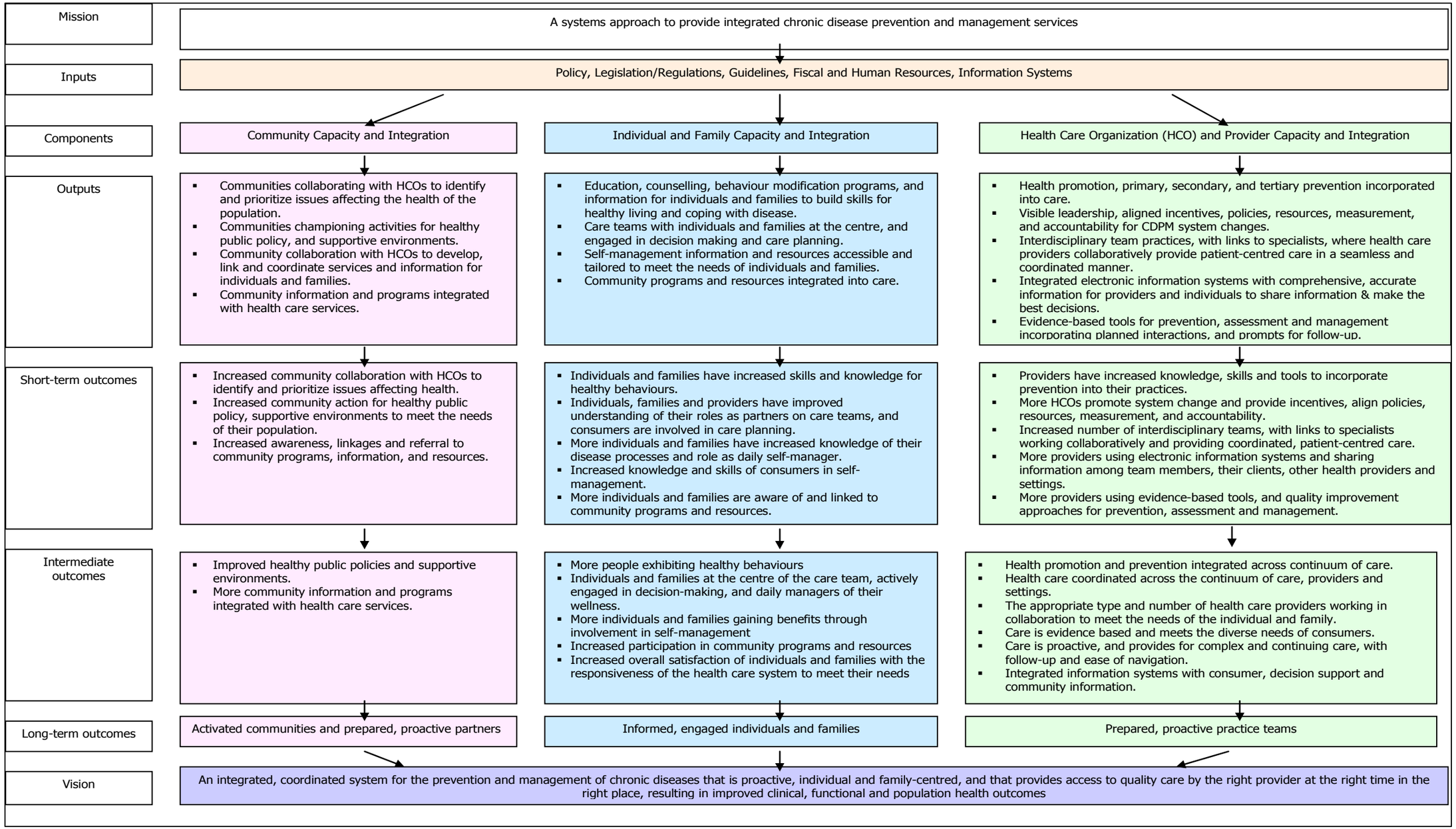
Figure 2: Ontario's Chronic Disease Prevention and Management Framework


Mission
A systems approach to provide integrated chronic disease prevention and management services
Inputs
Policy, Legislation/Regulations, Guidelines, Fiscal and Human Resources, Information Systems
Components
Community Capacity and Integration
Individual and Family Capacity and Integration
Health Care Organization (HCO) and Provider Capacity and Integration
Outputs
Communities collaborating with HCOs to identify and prioritize issues affecting the health of the population.
Communities championing activities for healthy public policy, and supportive environments.
Community collaboration with HCOs to develop, link and coordinate services and information for individuals and families.
Community information and programs integrated with health care services.
Education, counselling, behaviour modification programs, and information for individuals and families to build skills for healthy living and coping with disease.
Care teams with individuals and families at the centre, and engaged in decision making and care planning.
Self-management information and resources accessible and tailored to meet the needs of individuals and families.
Community programs and resources integrated into care.
Health promotion, primary, secondary, and tertiary prevention incorporated into care.
Visible leadership, aligned incentives, policies, resources, measurement, and accountability for CDPM system changes.
Interdisciplinary team practices, with links to specialists, where health care providers collaboratively provide patient-centred care in a seamless and coordinated manner.
Integrated electronic information systems with comprehensive, accurate information for providers and individuals to share information & make the best decisions.
Evidence-based tools for prevention, assessment and management incorporating planned interactions, and prompts for follow-up.
Short-term outcomes
Increased community collaboration with HCOs to identify and prioritize issues affecting health.
Increased community action for healthy public policy, supportive environments to meet the needs of their population.
Increased awareness, linkages and referral to community programs, information, and resources.
Individuals and families have increased skills and knowledge for healthy behaviours.
Individuals, families and providers have improved understanding of their roles as partners on care teams, and consumers are involved in care planning.
More individuals and families have increased knowledge of their disease processes and role as daily self-manager.
Increased knowledge and skills of consumers in self-management.
More individuals and families are aware of and linked to community programs and resources.
Providers have increased knowledge, skills and tools to incorporate prevention into their practices.
More HCOs promote system change and provide incentives, align policies, resources, measurement, and accountability.
Increased number of interdisciplinary teams, with links to specialists working collaboratively and providing coordinated, patient-centred care.
More providers using electronic information systems and sharing information among team members, their clients, other health providers and settings.
More providers using evidence-based tools, and quality improvement approaches for prevention, assessment and management.
Intermediate outcomes
Improved healthy public policies and supportive environments.
More community information and programs integrated with health care services.
More people exhibiting healthy behaviours
Individuals and families at the centre of the care team, actively engaged in decision-making, and daily managers of their wellness.
More individuals and families gaining benefits through involvement in self-management
Increased participation in community programs and resources
Increased overall satisfaction of individuals and families with the responsiveness of the health care system to meet their needs
Health promotion and prevention integrated across continuum of care.
Health care coordinated across the continuum of care, providers and settings.
The appropriate type and number of health care providers working in collaboration to meet the needs of the individual and family.
Care is evidence based and meets the diverse needs of consumers.
Care is proactive, and provides for complex and continuing care, with follow-up and ease of navigation.
Integrated information systems with consumer, decision support and community information.
Long-term outcomes
Activated communities and prepared, proactive partners
Informed, engaged individuals and families
Prepared, proactive practice teams
Vision
An integrated, coordinated system for the prevention and management of chronic diseases that is proactive, individual and family-centred, and that provides access to quality care by the right provider at the right time in the right place, resulting in improved clinical, functional and population health outcomes