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ACRONYMS

BMI	Body Mass Index
BRFS	Behaviour Risk Factor Survey
CAREC	Caribbean Epidemiology Centre
CARICOM	Caribbean Community
CARPHA	Caribbean Public Health Agency
CCH3	Caribbean Cooperation in Health 3
CCHD	Caribbean Commission on Health and Development
CEHI	Caribbean Environmental Health Institution
CFNI	Caribbean Food and Nutrition Institute
CHOGM	Commonwealth Heads of Government Meeting
CMC	Caribbean Member Countries
CMO	Chief Medical Officer
COHSOD	Council on Health and Social Development
CRDTL	Caribbean Regional Drug Testing Laboratory
CROSQ	Caribbean Regional Organization for Standards and Quality
CSME	Caribbean Single Market and Economy
CWD	Caribbean Wellness Day
ECC	Eastern Caribbean Countries
ECT	Eastern Caribbean Territories
EPI	Expanded Programme on Immunization
FCTC	Framework Convention on Tobacco Control
HIV	Human Immuno-deficiency Virus
IDB	Inter-American Development Bank
IEC	Information, Education, and Communication
MDGs	Millennium Development Goals
NCD	Non Communicable Disease
NGO	Non-Governmental Organization
ODA	Official Development Assistance
PHC	Primary Health Care
PLHIV	Persons living with HIV
POS	Port of Spain
STEPS	STEPWISE Approach to Surveillance

STI	Sexually Transmitted Infections
TCC	Technical Cooperation Among Countries
UN	United Nations
UN HLM	United Nations High Level Meeting
UWI	The University of the West Indies

EXECUTIVE SUMMARY

This report on the proceedings of the Regional Consultation on Health Policies and Protocols for Non Communicable Diseases emanated from a two-day workshop attended by many of the Caribbean region's Chief Medical Officers of Health, Country NCD Focal Points and technical experts in the field of non communicable diseases. The meeting was hosted by the IDB-funded Regional Non-Communicable Diseases Surveillance System Project which is being executed by The University of the West Indies, St. Augustine Campus. The meeting was held on September 1 and 2, 2010 at the Institute of Critical Thinking, St. Augustine Campus, Trinidad.

The purpose of the consultation was to define and develop appropriate regional health policies and models of care for chronic diseases and primary health care. This initiative works towards achieving the commitments made during the CARICOM Heads of Government NCD Summit Declaration "Uniting to Stop the Epidemic of CNCDs" to improve the management of chronic diseases and risk factors and improve the quality of care based on regional guidelines. The IDB-funded project has as one of its objectives the development of health protocols for regional harmonization of public policy on the promotion, prevention, treatment and rehabilitation of NCDs. This consultation thus served to begin work on the development of health policies and protocols for the management of chronic diseases and primary health care.

The participants were provided with an update of the region's response to the commitments made in the 2007 Port of Spain Summit Declaration on Non Communicable Disease - "Uniting to Stop the Epidemic of Chronic NCDs" and discussed the region's preparation for the United Nations High Level Meeting on NCDs to be held in September 2011.

Professor Surujpal Teelucksingh, the UWI Project Lead of the IDB-funded Regional Non-Communicable Diseases Surveillance System Project welcomed the participants and focused the participants' attention on Item #5 of the Port of Spain Declaration on NCDs which states:

> *That our Ministries of Health, in collaboration with other sectors, 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 NCDs would receive quality care and have access to preventive education based on regional guidelines.*

He indicated that this consultation will initiate the process of developing a common solution to address this item.

Dr. Kumar Sundarneedi brought greetings from the Chief Medical Officer of Health of the Ministry of Health and the Government of Trinidad and Tobago and shared with the meeting the initiatives being undertaken to address CNCDs in Trinidad and Tobago. Mr Ian Ho-A-Shu, Social Sector Specialist of the Inter-American Development Bank (IDB) which is the funding agency for the Regional NCD Surveillance System Project, brought greetings from the IDB and acknowledged the region's previous successes in working collectively to address regional health problems and expressed confidence that it could continue to do so to address the challenges of NCDs.

Dr. Karen Sealey, PAHO Representative at the UN Headquarters in Washington explained the processes in the lead up to the United Nations High Level Meeting on NDCs and identified the important role the region's health leaders need to play by providing briefing information to the foreign service professionals who represent the region in the decision making fora. The United Nations High Level Meeting had been agreed to by the UN member states due to an initiative of the CARICOM region. She emphasised the success of advocacy at the Commonwealth Heads of Government Meeting and the need for building consensus and widespread momentum for what the Caribbean region wanted to achieve from this meeting. She stressed the need to involve all sectors including the media and international non-government organizations and raise the profile of NCDs as a developmental problem.

Dr. Alafia Samuels, the CARICOM NCD Consultant summarised the impact of CNCDs on premature mortality and morbidity in the Caribbean region, the impact of risk factors on morbidity, the lack of awareness of those with these risk factors and the marked improvement in outcomes with the utilisation of evidence-based guidelines. She provided an update on the region's response to the mandates in the Port of Spain Declaration including the status of its response to the establishment of NCD Commissions, the holding of multi-sectoral consultations and development of NCD plans, ratification of the Framework Convention on Tobacco Control, the status of labelling standards and taxation policies of tobacco products, reduction of salt intake in diets, support for increased physical activity, increased use of the media for sensitisation of the population and improvement in surveillance of NCDs and risk factors.

Dr. Samuels provided the consultation with an overview of the WHO chronic care model and its complementary approaches - population, high risk and secondary prevention to address chronic care. She emphasised the importance of monitoring and addressing risk factors, implementing evidence-based management to improve care, reported on the region's progress in development of guidelines for key chronic diseases and the need for extensive training in the use of these guidelines.

Dr. James Hospedales, Senior Adviser, Prevention and Control of Chronic Diseases at PAHO/WHO, Washington shared the findings of the 3rd Global Survey of National NCD Response and Capacity which showed that while the region has developed policies and action plans with a focus on cardiovascular disease? and diabetes, surveillance continues to focus on mortality rather than on morbidity with few disease registries. He indicated that there continues to be a need to focus on prevention and health promotion in the region.

Dr. Joy St. John, Chief Medical Officer of Health of Barbados and Dr. Virginia Asin-Oostburg, Deputy Director of Health Services of Suriname shared the experiences within their countries with the implementation of integrated chronic care models. Dr. St. John shared Barbados' experience of firstly involving the health care community to address issues related to policy, health care organisation and community issues and in the second phase of including the expanded multi-sectoral involvement in the discussion. Dr. Asin-Oostburg described the transformation of the health organisations, networking, establishing partnerships and involvement of public officials to share the messages about healthy living and including the general public in discussions about maintaining health. She also reported on the work undertaken to implement the evidence-based primary care model.

Professor Surujpal Teelucksingh introduced a different approach to providing clinical services, describing a coordinated model where the many interactions needed for comprehensive care are provided in one setting, utilising appropriately trained persons, including opportunities for interactive learning and maximising the quality of the encounter.

The consultation then broke up into five working groups to develop a roadmap for the development and implementation of the integrated chronic care model for the region. The consultation used a working draft policy developed by Dr. Alafia Samuels and focused on revising the draft, identifying the training needs for implementation, formulating the methodology for quantification of the numbers of persons with chronic diseases in the region, identifying mechanisms and timelines for the development of evidence-based screening and treatment guidelines and mechanisms for implementing shared treatment services for tertiary care.

The group reporting on training needs noted that all levels of staff needed to be trained in change management as the health services became patient-centred with issues of customer service, leadership and management needing to be addressed. Other important training needs included: applied epidemiology skills for data collection and utilisation for decision making; curricula development specialists to address

the development of appropriate training materials; and grant proposal writing, project management and partnership development to address funding.

The difficulty of quantifying the chronic disease challenge was discussed and it was stated that screening, surveillance and prevalence studies were needed to provide the data to advise policy makers on the extent of the problem.

A step-by-step roadmap for testing and finalising of the CVD guidelines and the different levels of training that would need to be undertaken for sensitisation and operationalising was provided by the group which looked at screening and evidence-based training.

The group working on identifying the mechanisms for shared tertiary care services stated that the first principle that needed to be agreed upon was that geographic location and socio-economic issues should not be a barrier to access to any shared tertiary service. The group summarised that there needed to be ready access to detailed information on services available in each country and of skilled personnel, the establishment of standards of care and systems of mechanisms for payment for these services.

On the second day of the consultation, a presentation on the IDB-funded Regional Non-Communicable Diseases Surveillance System Project which has developed an interactive web-based surveillance system for the Caribbean region was delivered by Dr. Rohan Maharaj, Senior Lecturer in Public Health and Primary Care at The University of the West Indies and Mr. Ashish Bhatt, the project's software engineer.

They highlighted some of the key aspects of the project, that is the identification of the gaps in the data to evaluate and monitor NCDs and risk factors and the development of the software to facilitate the collection, analysis and sharing of this data. During the discussion, participants from the project countries also identified the additional benefits that the countries have already obtained from the project's activities. Some Chief Medical Officers have reported using the Gap analysis to identify and review the weaknesses of the surveillance system at country level. This has provided impetus for additional human and financial resources. In addition, Chief Medical Officers have been impressed by the development of the web-based surveillance system and its potential for user accessibility, secure user access, online data capture forms and spreadsheet upload and ad hoc, interactive and intuitive query tools. The project by its support for this consultation was also addressing its third component, that is, the harmonisation and development of regional policies and protocols.

The region's Chief Medical Officers of Health also worked on drafting a framework for the review of primary health care policies in the Caribbean. They identified the key elements of the primary health care policy and plan, the programme management and coordination issues that need to be addressed, including the types of services to be provided, the target population, the types of providers, the mode and setting of service delivery, measurement criteria and a health research agenda.

The consultation also hosted the Inaugural Meeting of the region's NCD focal points and provided the opportunity for this group to identify common concerns, country and regional priorities for the next two years. The needs identified including increased technical cooperation and collaboration on guidelines for the work of NCD Commissions, NCD policies and plans, assistance with integrated NCD surveillance, access to training including that for grant proposal writing and health information toolkits.

Dr. Samuels ended by thanking the participants and organisers for a productive meeting, and reminding them that the success of any meeting depends on what happens after the meeting and on the need to maintain the momentum as the Caribbean region works towards getting maximum benefits from the UN High Level Meeting in September 2011.

INTRODUCTION

The epidemic of Non Communicable Diseases (NCDs) in the Caribbean region is one of the worst in the Region of the Americas. Cardiovascular diseases (which includes hypertension), diabetes, cancer and asthma all contribute to premature death, impairment, disability, loss of productivity and spiralling health care costs. CNCDs costs consume approximately between 1.4%-8% of the GDP in Bahamas and Trinidad and Tobago respectively and importantly affect many at their most productive years. Chronic diseases are associated with physiological factors such as obesity, high blood sugar, and high cholesterol and exacerbated by unhealthy diet, physical inactivity, tobacco use and harmful use of alcohol.

The Caribbean Community has a long history of successful collaboration in health such as achieving the elimination of communicable diseases of poliomyelitis, measles and rubella under the 'Expanded Programme on Immunization'. A similar strategy is being applied to the regional approach to addressing non communicable diseases. This strategy has been strengthened considerably with the Port of Spain Summit Declaration on Non Communicable Disease (2007) where CARICOM Heads of Government committed to an overarching framework for an integrated, multi-sectoral and regional response to the NCD epidemic. Several initiatives have also been undertaken to reduce the burden and impact of Non-Communicable disease which involve collaboration with regional/international institutions and partnerships with the private and non-governmental sector. One of the initiatives is the IDB-funded Regional Non-Communicable Diseases Surveillance System Project which has as one of its objectives the development of health protocols for regional harmonization of public policy on the promotion, prevention, treatment and rehabilitation of NCDs.

The Regional Consultation on Health Policies and Protocols was therefore convened to review various working documents that have been developed as part of the process to address the prevention and control of non communicable diseases in the Caribbean region. The participants were expected to produce draft documents and identify the mechanisms for the implementation of the recommended strategies. This consultation would lay the foundation for the participation of Caribbean countries in the United Nations High Level Meeting (UN HLM) on NCDs in September 2011, a meeting which was promoted by CARICOM countries. Caribbean leaders are expected to examine and influence this process, both before and after the UN HLM, to maximize the benefits to Caribbean region.

The Objectives of the Workshop were to:

- produce the first draft of a Chronic Care Model of care for the region
- produce the first draft of an updated CARICOM Primary Health Care (PHC) policy
- identify mechanisms for implementation of POS Declaration Item #5 (improving quality of care for persons already living with NCDs)
- enhance awareness of the IDB NCD Regional Surveillance System project
- review NCDs in relation to CARPHA, CCH3, UN HLM
- convene the Inaugural Annual Meeting of CARICOM NCD Focal Points.

WELCOME/OPENING REMARKS

Professor Paul Teelucksingh

Chair, Opening Session

After welcoming the participants, Professor Teelucksingh stated that the Port of Spain Declaration was the de facto *magna carta* of Caribbean public health, and that was essentially the basis of this meeting. He hoped to have the broadest possible basis for the consultation, and to draw people who were the movers and shakers in the Caribbean dynasty together to develop a common solution to the common enemy of non communicable diseases, the number one killer in the region.

Professor Teelucksingh observed that the IDB had been a major catalyst to this project, this meeting and one or two other events that had preceded it. He drew the attention of participants to item #5 of the Port of Spain Declaration which was the main theme of the deliberations over the next two days. He noted that while much work had already been started with respect to achieving the tenets of the Port of Spain Declaration, much remained to be done. He hoped that over the next two days, a fertile environment would be created for deliberations and discussions, and for those present to initiate the process of developing a common solution to the common cause that was faced by the entire region.

Dr. Kumar Sundarneedi

(Opening Remarks on behalf of Dr. Anton Cumberbatch), Ministry of Health

Dr. Sundarneedi brought greetings on behalf of the CMO, Trinidad and Tobago, and the Ministry of Health. He outlined some of the health programmes that were currently being implemented to reduce the prevalence of NCDs in Trinidad and Tobago.

Dr. Sundarneedi stated that in the Caribbean, deaths from CNCDs are expected to double by 2020 and the rapid increase is estimated to affect disproportionately among the poor and the disadvantaged members of the population. In relation to these chronic non communicable diseases, there were several initiatives, starting with the Declaration of Port of Spain, and followed by other initiatives involving collaboration with Johns Hopkins University, also the IDB and The University of the West Indies. He noted that the IDB-funded Regional Non-communicable Diseases Surveillance System

Project has as one of its objectives, the development of health protocols for the regional harmonization of the public policy, and the promotion, prevention, treatment and rehabilitation of Non Communicable Diseases.

The Ministry of Health of Trinidad and Tobago wished to empower citizens to live longer and healthier, happier, productive lives, and has positioned itself as an institution to promote positive lifestyle changes and to improve health across the population. This has been done through healthy public policies, prevention and health education initiatives which include the development of physical activities initiatives, nutrition education and counselling, strengthening of school health initiatives, scaling up of a population-based disease prevention mobile programme, and diabetic education and prevention programmes.

Dr. Sundarneedi acknowledged the contribution of the UWI, headed by Professor Paul Teelucksingh, in terms of sensitization and education with the RHAs, especially the South-West Regional Health Authority.

Mr. Ian Ho-A-Shu

Representative of Inter-American Development Bank

Mr. Ho-A-Shu stated that in 2004, the IDB and the Board of Executive Directors created the initiative for the regional public goods to promote cooperation and initiatives within the region.
In May 2008, the Caribbean Regional NCD Surveillance System Project Agreement was signed by the IDB and the UWI. The project is being funded to the sum of US$650,000.00 from the regional public goods initiative of the Bank. In 2009, six countries signed letter agreements, thereby demonstrating their commitment for a sustained cooperation with this project.

The project is aligned with Latin America and Caribbean Regional Health agenda that is being articulated by WHO. It aims to respond to the need for reliable comprehensive data on NCDs and the risk factors and to promote harmonized regional public policy in Latin America and the Caribbean. The project is fast-tracking a number of innovative approaches to national prevention and control of NCDs which is consistent with the social development strategy of the Bank. It focuses on six countries by achieving better balance of prevention and control by focusing on and by addressing costly unhealthy behaviours.

This project takes into consideration the fact that many of the components needed for the monitoring of NCDs are already in place, and that NCD surveillance can be improved by building on a harmonized and complementary system. The project also recognizes that when the experiences and initiatives of Caribbean countries are brought together and the countries work closely together and work collectively, a regional solution can be achieved for a regional problem.

In particular, the project seeks to achieve improvements in the capacity of the countries to deliver cost-effective health services associated with NCDs and the project supports the region in developing its own regional data collection system. This is a solid example of successful South-South cooperation - when six countries work closely together to produce a surveillance system that will eventually be rolled out.

Presentations & Reports

UN Conference on NCDs/NCD Challenges and Timelines

Dr. Karen Sealey

Special Adviser, PAHO/WHO

In her presentation, Dr. Sealey highlighted the issues that the health sector in the region needs to address in the twelve months leading up to the United Nations High Level Meeting on NCDs in September 2011. She explained the need for the representatives of the health sector to be the key movers and strong advocates with all stakeholders and with the country representatives in the foreign service to provide them with the necessary information to guide the decision making process for the planning of the meeting.

She explained the communication strategy of referring to the up-coming meeting as a "Summit" rather than a UN High Level Meeting which is what has been agreed to by the member states. A 'Summit' mandates that the Heads of States attend while a High Level Meeting does not.

Dr. Sealey reported that her posting at the WHO Office in the UN at the time when the CARICOM Ambassadors were seeking to put the NCD issues on the agenda allowed her to share information with the foreign service officers. She informed them on the history of the effort to put NCD on the agenda that the Caribbean has been leading for several years. The work began in 1984 with the genesis of CCH-1, and it has taken a long time to get one person dedicated to this conversation. However the Caribbean had insisted that it should happen. She illustrated the role of advocacy with the example of the statement on NCDs from the Commonwealth Head of Government Meeting (CHOGM) in that this had come about through the promotion and advocacy of Dr. Denzil Douglas, Prime Minister of St. Kitts and Nevis who is responsible for Health at CARICOM, and the then Government of Trinidad and Tobago and other friendly governments. Dr. Sealey felt that the region's leading health professionals need to understand that this statement would not have happened had CARICOM not insisted.

Dr. Sealey explained the organisational operations of the United Nations. The World Health Organization is a specialized agency in the UN system. The General Assembly of the United Nations is where the resolutions are passed. One of the organs of the UN is the Economic and Social Council and its Commissions where health issues would generally be dealt with, although not all issues have to go through the commissions. Dr. Sealey referenced UN General Assembly Special Session on HIV/AIDS

(UNGASS) which was a special plenary session. She explained the success of UNGASS in increasing awareness and funding for HIV/AIDS. She further explained that UN Summits and UN High-level Meetings have round tables and side events and therefore these have more potential for sharing of information and for decision-making.

Dr. Sealey used the Millenium Development Goals (MDG) Summit to highlight what makes a meeting effective. She stated that success is directly related to ALL that has gone on before the meeting, where the countries have been able to state their challenges, why they are not achieving their targets and why the country needs additional funding. She identified this as the most important message that she wanted to share with the meeting. She explained that the health community needed to seize opportunities within the agenda of events/ meetings that are taking place, to be involved in side events around each meeting to profile NCD issues by launching reports, profiling challenges, for example on special issues experienced by small island states, less developed countries, etc. She cited an example of profiling NCDs at a Commission meeting by launching a report on Health in women of Latin America and the Caribbean.

Dr. Sealey explained that it is important that the Ministers of Foreign Affairs and the diplomatic missions understand, as the health community does, that NCDs is a global health issue of international importance. She encouraged the participants to become more familiar with the foreign policies of their countries, what they are and what they should be and to provide information to the foreign service officers at home and those posted overseas.

Dr. Sealey suggested that the region should try to achieve the following at the UN High Level Meeting:

i) Increased awareness of the development implications of NCDs;
ii) Strongly advocate for a political declaration of commitment. A precedent has been set by HIV, where UNGASS led to a declaration in 2001 on HIV/AIDS issues, and awareness and funding for HIV/AIDS immediately increased markedly. She noted that the health community was now more comfortable comparing NCDs with HIV.
iii) International solidarity in support of national plans including universal access and medicines. She noted that universal access is not always supported by all the countries.
iv) Increased commitment by international partners for overseas development aid and technical cooperation.
v) NCDs established as ongoing agenda item which would require the UN Secretary General to report on issues every two years.

Dr. Sealey outlined the process leading up to the UN High Level Meeting:

i) The selection of two member states to lead the process and to act as co-facilitators. She recommended that it was very important for one of the co-facilitators to be from the Caribbean. That designation will take place in September.

ii) Before the end of 2010, the scope and modalities of the meeting are to be finalized and the health community needs to guide the region's foreign service officers on these two issues. She recommended that the health sector convey the region's preference for a two day affair with side events. She alerted the health community of its responsibilities to provide the foreign officers with the information to support this recommendation.

iii) She also warned that the Caribbean region has to decide fairly quickly what it wants as a region out of this meeting and the need to seek the involvement of all sectors and in particular the NGO sector. She noted that the NGO sector is not a sector with which the UN generally involves and the Caribbean would need to advocate for their involvement.

iv) The Secretary General's report to the next General Assembly has to be prepared in April/May 2011 and again the health community needs to assist in preparing that report so as to ensure that the report reflects the challenges that it sees on the ground.

Dr. Sealey suggested that the following needed to take place in the next 12 months:

i) Evangelise about NCDs at every opportunity and not take it for granted that friendly countries will always be supportive and that the issues are interpreted similarly in each country.

ii) Seize the opportunity to meet with Foreign Affairs officials here in the region so that when there is any discussion, the health community is part of the discussion. Be insistent and expect them to be supportive.

iii) Develop relationships with the Ministry of Foreign Affairs and get to know the Officer in charge at the various desks - UN, Commonwealth Secretariat, etc. Find out who that person is and nurture a relationship with that person. That person will be able to assist by sharing information on when the meetings are taking place, share the agenda and discuss the opportunities for NCDs within the scope and modalities of meetings, etc.

iv) Influence the inclusion of NCD issues in the statement of the Head of Government and make sure that the Caribbean Heads of Government make a statement or incorporate into their statement issues on NCDs.

v) Be the major architect of the statement with the Ministry of Foreign Affairs at the time of the Summit.

vi) During May to August 2011, the documentation for the Summit will be prepared at the UN. The countries need to give feedback on the document and send a message to the contact in Foreign Affairs. That is the kind of relationship that the health community needs to have with the Ministry of Foreign Affairs and the Mission as well.

vii) Encourage the national NGOs to be in contact with their international counterparts, especially those with local chapters. They are very influential and powerful. Some of these include International Diabetes Foundation, and the World Heart Federation.

viii) Engage all disciplines, engage all sectors, and particularly engage the media over the next 12 months. It is an issue to keep high on the agenda for the media with monthly conferences, regular updates.

viii) Participate in key international and Caribbean meetings

ix) Build momentum at grassroots level.

x) Use Caribbean celebrities as advocates.

xi) Build momentum in all sectors in and out of the region.

Discussion

It was suggested that the coordination of regional advocacy through the regional CARICOM office would be more effective and strategic than individual country collaboration.

It was noted that there are a number of other ministries involved, including Agriculture, Trade and Education through COHSOD, and it was critical that all of these sectors be briefed about chronic disease.

It was also suggested that there is a need for a road map to obtain more information and to engage the representatives of meetings. For example, PAHO is engaging with the Central American presidents to brief them on NCD issues and will hold a preparatory meeting on November 17-18, 2010 in Trinidad.

It was recommended that the region sets the framework for the NCD Summit by looking at what is happening with the MDGs with respect to maternal mortality, infant and child mortality and poverty and link with the NCD indicators.

It was also noted that there is a need to ensure that NCDs is on the agenda of the Commonwealth Summit.

In targeting the NGO community, it was recommended that the international association of medical students would also be an effective advocate.

It was also noted that the EU representatives led the move to have the meeting be a High Level meeting rather than a Summit and therefore this community needs to be targeted for extra effort to ensure that some European Heads attend.

Also to raise the profile of this meeting and NCDs in the diaspora, there are also efforts to get key groups to celebrate Caribbean Wellness Day in New York and other capital cities.

POWERPOINT PRESENTATION

Towards the UN High-Level Meeting on Noncommunicable Diseases

Dr. Karen Sealey
PAHO/WHO Special Adviser
UN Matters
1 September 2010

Caribbean's leadership on NCD

- NCD emerging as a priority
  - CCH I ⟹ Nassau Declaration ⟹ CCHD
- Port of Spain Declaration 2007
- CARICOM HOG follow up – 2009
  - Mandate to elevate issue to UN & CHOGM
- CHOGM – Statement on NCD's
- CARICOM PRs lead UN Res.64/265

UN vs. WHO

UN	WHO
Highest level governance of system	UN Specialized agency
HOG/MOFA/Per. Rep.	Ministers of Health
International peace & security; relations among nations; social development and human rights	Health matters – normative/standard setting role; TC
Diplomats	Medical/health professionals

United Nations

- 192 member states
- Organs:
  - the **General Assembly**
  - the **Security Council**
  - the **Economic and Social Council and its Commissions**
  - other bodies and committees of GA
- **What is the difference between UNGASS, UNHLM, and Summit**

What might be expected from 2011 UN NCD HLM (1)

- Increased awareness of development implications of NCDs; changed perception that there are no cost effective interventions.
- Political Declaration of Commitment for coordinated, multi-sectoral, national & regional programs for the prevention and control of NCDs
- International solidarity for policies in support of national plans including for universal access to services and medicines req'd

What might be expected from 2011 UN NCD HLM (2)

- Increased engagement by international partners and commitment to significant increase in ODA and technical cooperation to assist countries to develop and implement national plans
- Establishment on UN agenda through request for status reports from SG every 2 years and reviews of situation by high level review meetings every 5 years

NCD High Level Meeting Next steps at UN

- President of the General Assembly selects 2 co-facilitators (member states)- September*
- Scope and modalities finalized – December*
- Secretary General's Report to next (65th)GA – May*

WHAT IS CRITICAL IS WHAT GOES ON BEFORE THE SUMMIT!

UN Advocacy opportunities

- **MDG summit**
- **2011 ECOSOC Annual Ministerial Review**: assess progress in achieving IADG with regards to education
- **Commissions relevant to NCDs:**
  - Social Development(CSD) – Feb.
  - Status of Women(CSW) - March
  - Population and Development(CPD) – Apr.
- **Regional Commissions: CEPAL/ECLAC**
- **WHA**

Action needed at national level

- **Develop relationship with MOFA**
  - Influence statement of PM/President
- **Influence outcome document**
  - Regional consultations on key issues to be included in outcome document
  - Inform NY Permanent Missions to G77 position
  - Encourage national NGOs to link to and maximize support from international NCD Alliance (NGOs)

What can you do? (3)

- Engage media on related global political issues
- Participate in key international preparatory meetings
  - International Ministerial Meeting on Lifestyles: Russian Fed - April/June
- Support civil society participation locally and internationally
- Caribbean "celebrity" as advocate??

UN 2011 NCD HLM….

ONLY 12 MONTHS LEFT

… LET'S BUILD THE MOMENTUM, IN ALL SECTORS, IN AND OUTSIDE THE REGION!

THE CARICOM NCD SUMMIT DECLARATION – THE CHRONIC CARE MODEL

DR. ALAFIA SAMUELS

CARICOM NCD Consultant

Dr. Samuels began by providing a brief recap of the NCD situation in the region. She observed that the patterns in Americas are similar to the patterns in Europe but with 30% more premature deaths (that is below the age of 70) from NCDs, and that total deaths from NCDs are about 60%. In females, NCDs are the leading five causes of deaths in the Caribbean and some countries have particularly heavy burdens. Suriname has an extremely high burden of stroke. Mortality from diabetes in Trinidad and Tobago is about 700% higher than the mortality from diabetes in Canada. The data from the Jamaica healthy lifestyle survey shows the prevalence of the various chronic diseases over the lifespan. It is important to note that while the STEP surveys show an overall prevalence of hypertension of 25%-30%, that hypertension prevalence almost goes with age, that is at age 50 - 50% of people have hypertension, age 70 - 70%, etc and it is greatest risk factor for death.

Dr. Samuels stated that the Caribbean is not doing well in terms of awareness of major risk factors faced. Surveys have shown that 25-33% of persons with diabetes are unaware that they have diabetes. For hypertension, 50% of persons do not know that they have it and this is the leading risk factor for death. 90% of the people with high blood cholesterol do not know that they have high cholesterol. The leading risk factors for death are high blood pressure, obesity, tobacco and alcohol.

Regional Policies

These facts prompted the regional governments to come together for the CARICOM Summit on NCD and resulted in the POS Declaration in 2007. Dr. Samuels then reviewed the region's status using the major headings of the POS Declaration. The headings were i) NCD Plan; ii) NCD Budget; iii) NCD Multi-sector Summits for each country hosted by the Head of Government, a multi-sector summit since NCD was a national issue rather than a issue for the Ministry of Health only; iv) Establishment of an Inter-sectoral Commission; and v) Communication Plan.

The highlights of this summary included:

i) Few countries have held the multi-sectoral summits.

ii) Three States have not ratified the WHO Framework Convention on Tobacco Control (FCTC). These countries were St. Kitts and Nevis, St. Vincent and the Grenadines, and Haiti. Dr. Samuels stated that the Caribbean Region as the sponsoring region could not go to the Summit at the United Nations on NCDs in 2011 and have countries that have not ratified the FCTC. An immediate response from St. Vincent and the Grenadines was that they had received positive communication from Cabinet with regard to ratification of the FCTC. Dr. Samuels continued her presentation with the recommendation that tobacco taxes needed to be increased by 50% of sales price as a deterrent since young people were very price sensitive. It was noted that Barbados will implement the 'no-smoking in public spaces' legislation on October 1, 2010. Dr. Samuels observed that there were still challenges with reaching consensus on the packaging of tobacco products given a setback with the labelling standards from CROSQ.

iii) Dr. Samuels noted that alcohol use does not appear as a risk factor on the Port of Spain Declaration although alcohol abuse is a major problem in the region.

iv) Dr. Samuels indicated that the region still has a lot of work to do on taxation, trade agreements and mandatory labelling to improve healthy eating. A suggestion had been made to increase taxes on all deep fat fried fast foods, as Canada has considered, and to use that tax to subsidise healthy foods.

v) Barbados is leading the way on salt labelling and others are moving forward.

vi) The other issues are physical activities in schools, increase ongoing mass physical activity, increased public spaces for physical activity, health education and promotion, and public and private institutions with physical activity programmes.

vii) To obtain more than 30 days of media broadcasts to talk about the risk factors and management of NCDs.

vii) To assess progress on surveillance, the region will report on the conduct of WHO STEPS surveys, the collection of the NCD Minimum dataset, the conduct of the Global Youth Tobacco Survey and the Global School Health Survey.

In terms of priorities discussed at the CMO Meeting in April 2010, the region agreed to complete the NCD plans. Dominica was congratulated on completion of its NCD plan. In terms of activities – World Health Day with the theme of "a thousand cities, a thousand lives" had been implemented. Dr. Samuels noted that CROSQ's involvement was critical as there were a number of items in the POS

Declaration related to regulations. Monitoring and evaluation need to be done, and the STEPS survey need to be conducted. Dr. Samuels indicated that for monitoring purposes, it was important to identify indicators that are measurable and to report on these.

Dr. Samuels emphasised that while fourteen (14) items on the POS Declaration are largely multi-sectoral, that Agenda item #5 is almost entirely the responsibility of the Ministries of Health. Dr. Samuels indicated that the outcome of this regional consultation must include a roadmap and the priorities identified to achieve some of the objectives of this mandate. Dr. Samuels stated that this item can in fact have the greatest potential impact on saving lives in the region. It is estimated that CNCD occurrence can be reduced by 75% by using evidence-based interventions, and thus potentially saving 38,000 lives over 10 years if evidence-based interventions are used for persons who are already assessing the system but whose care does not align with internationally evidence-based standards. All of this will cost less than 1% of the region's health budget, so that the returns are great. It is known that some interventions increase the life expectancy of persons by up to 15 years and reduce the risk of diabetes incidence. This is particularly important for Trinidad, Guyana and Barbados which have the highest risk burden of diabetes. WHO basically says that part of the road map is the development of prospective standards of care, global action on surveillance and establishment of networks and partnerships.

Dr. Samuels then went on to summarise the key points about the **chronic care model:** in terms of managing persons with chronic care. Three approaches are needed – i) population approach, ii) high-risk approach, and iii) the secondary prevention. All of these things have to be done at the same time – the approaches are complementary not competitive. She then referred to the diagram of the integrated care model. This model had been developed from the classic WAGNER chronic care model. She explained that WHO had taken the WAGNER model and made it more appropriate for kind of settings in the region. Basically, the model has the community health care team and patients and families working together for better outcomes. The elements are an informed and activated patient, prepared practice teams having productive interactions for better assessment of self management skills, the tailoring of clinical management using set protocols, collaborative goal setting process (that is, collaboration between the health care team and the patient) and problem solving in a shared care plan - patient-centred care and active, sustained follow-up.

However, the key factor is that most of the region's health facilities are not equipped to manage the chronic care model. They are still equipped for operating the acute care model. The evidence is clear

with the chronic care model and the integrated care for chronic conditions that the patients do better, and this information needs to be disseminated. The integrated care for chronic conditions focuses on the building blocks - the macro level which is the policy level, the middle level which is the organization and community, and then at the micro-level, that is, the patient. Again, all three levels have to be working at the same time. There needs to be an informed, motivated patient – this is the micro-level. At the middle level, the health care organizations have to be organized and equipped and this would also involve widespread training in the chronic care model. At the macro level, the policy level, there is need for legislation, advocacy, integrated policy, financing, human resource, legislation, and partnerships.

These are the elements for action for the 'integrated care for chronic conditions model'.

1. Support paradigm shift) Political support,
2. Manage political environment) POS NCD Summit
3. Integrated Health Care - Information systems
4. Align Sectoral Policies -Team approach - Partners, legislation, regulations
5. Use Health Care personnel more effectively - Team approach, Guidelines
6. Patient & Family centered care) Patient centered care
7. Support patients in their communities) Patient centered care
8. Emphasize prevention) Patient centered care

The Port of Spain Declaration (i.e. the macro-level) covers policy and advocacy. There is support for the paradigm shift from acute care to chronic care and the political environment in the Caribbean is favourable. Other elements for action are the integrated health system including health information systems, aligned sectoral policies and effective use of the health care team approach. Then following are some of the elements required to support "patient-centred care", that is patient and family centeredness, and support from the community with an emphasis on prevention.

Dr. Samuels stated that with respect to evidence-based guidelines, clinical guidelines and support systems, a high level meeting of CVD experts in Montego Bay in March 2008 concluded that the Caribbean region should implement a total risk approach using the WHO international guidelines for assessing and management and prevention of cardiovascular disease using the WHO risk assessment charts. That meeting also recommended that the region should align with evidence guidelines and target and treat especially those with the main risk factors of blood pressure and cholesterol, especially in diabetics. Lancet Dec 2007 shows that scaling up the evidence-based system and treating people

already in the system would reduce deaths from cardiovascular disease by 20% and more than half of those deaths would be persons less than 70 years old, even if there is only 40% to 60% compliance in patients with medication. Dr. Samuels reported that this demonstrates the potential for improved outcomes.

Dr. Samuels stated that there are both full and pocket guidelines for CVDs. The total risk assessment chart is the colour-coded chart for the regional response for standardised care for heart attacks and strokes prevention. This chart shows the steps to assess risk category and the actions to be taken for each level of risk. Low risk does not mean NO risk, as there may be risks to be managed such as smoking, diet and exercise. A very high risk would require more intense interventions and early referrals to ensure that these persons are targeted. The caveat is that all who need treatment are treated and that many socio-economic factors does impact on risk.

Dr. Samuels also shared the WHO suggestions for drugs that the region needs including the high quality generics. She indicated that volume discounts, collective purchasing and negotiating could reduce the costs as has been done with vaccine procurement in the Expanded Programme for Immunisation (EPI) Programme. She noted that while all aspects of the EPI Programme may not be relevant, the region could apply the relevant lessons from the EPI programme to the NCD programmes.

In terms of the team approach, Dr. Samuels noted that there is need to coordinate care with providers in multiple settings to provide primary care, that is in the public sector and the private sector which comprises 50 % of the services in some countries, and the NGO sector which also provides a significant amount of care in some countries. The region has to find methods to obtain all the health and health services information in each country. The region also has to review the range of skills for health workers including the community health workers, since a highly trained person should not be doing things that a lesser trained person could be doing. Dr. Samuels gave examples where lesser trained persons could perform simple tasks, for example taking photos of the back of the eye. She emphasised that this would require proper training and that standards would need to be established and monitored.

To provide patient-centred care, the health system would need to adapt to bring the team together in one place so as to facilitate the provision of care. She used the example of a diabetic clinic requiring the team to include the podiatrist, social worker, counsellor, eye specialist and dietician. In terms of

integration of care, the chronic care model recognises that persons can have both infectious and non-infectious chronic diseases, for example people with HIV may have diabetes.

Dr. Samuels noted that there is a need for information systems, disease registries and the sharing of information across organisations and the utilisation of technology, telephone, email and internet to communicate alerts and reminders to patients, including computerised support systems that can provide alerts and reminders. However, the gold standard would be electronic medical records which may be difficult to achieve.

In terms of patient-centred care, support and management, Dr. Samuels summarised the protocol with the five A's: Assess, Advise, Agree, Assist and Arrange, with specific action for patient-centred management and making the practice patient-centred. Assess – evaluate behaviour aspects. Advise – personally relevant recommendations. Agree – refers to the collaboration between provider and the patient, that includes sitting down and discussing what the objectives are, and what they think that they can do. Assist - by providing the assistance and Arrange - follow up contacts for services required.

Dr. Samuels summarised her presentation:

i) Evidence-based management of CVD will improve outcomes.

ii) Recommends innovative care for chronic conditions using the chronic care model, CVD guidelines using total risk approach and the evidence-based pharmaceutical interventions.

iii) Identifies the need to monitor the risk factors - diet, exercise, tobacco and alcohol as vital signs similar to the routine monitoring of blood pressure. She reiterated the need to recognize the fact that exercise is medicine and there is a need to include it on the prescription as this may change the perception of the relative importance of exercise to medication. Exercise could be more effective than medication in some cases.

Discussion

It was noted that obesity as a major risk factor had not been included in the presentation as a vital sign. Dr. Samuels agreed but noted that weight and blood pressure readings are currently normally measured.

The participant from Suriname noted that a resolution to reduce the harmful effects of alcohol use was passed for the first time at the most recent WHO Health Assembly Meeting in May 2010. She complimented Dr. Samuels for recommending the inclusion of such a resolution in the Suriname NCD plan. The participant noted that the health sector generally does not address alcohol use, since alcohol use is generally dealt with by the Justice and Police Ministry. The Ministry of Health of Suriname is collaborating with the Justice and Police Ministry so that the policies and plans of the two Ministries can work together. She advised that the region needs to follow up on the resolution passed.

The participant from Jamaica explained the difficulties experienced with obtaining agreement on the health warnings to be placed on tobacco products. Jamaica was given the task of amending the CARICOM Standard on Labelling of Tobacco products through its Bureau of Standards, to which the MOH provided technical support. A draft with 24 pictures was sent to CROSQ and this draft went through the various councils and committees and finally was sent to COTED (Council of Trade and Economic Development). The feedback received indicated that five member states did not support the resolution for various reasons. Trinidad and Tobago wanted a stronger standard that would have required more space for the warning and more pictures than what was required in the FCTC. Grenada did not support due to the possibility of job losses. St. Lucia wanted plain packing, that is, no brand name and no labelling at all on the package. While these are worthy goals, there was no consensus in the region for that. The participant advised that the region needs to reconsider the reasons that have prevented it from signing up and supporting the health warnings on the tobacco packages, which is an obligation under the FCTC treaty. She made an appeal that before the Summit in 2011, all member states re-consider their position. She stated that this issue is again on the COTED agenda in October 2010 and that the health officials need to speak to their Ministers of Foreign Affairs who represent the countries at these meetings and urge consensus. She informed that field testing of the 24 graphics will take place soon and if no consensus is reached then some countries will have to individually go ahead.

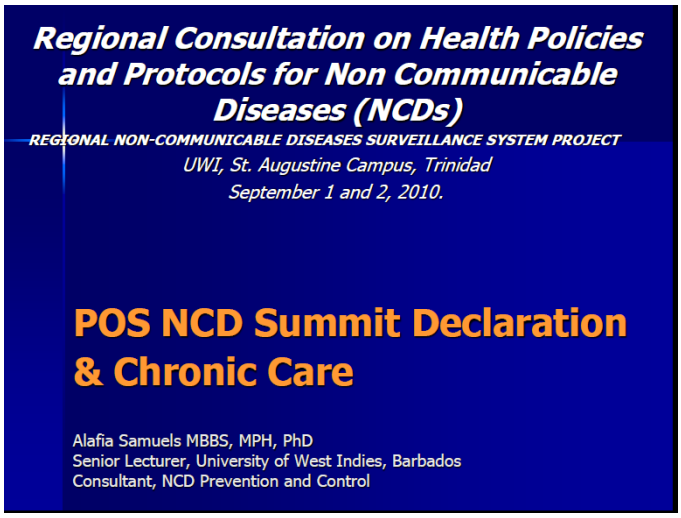
Another participant suggested that a study be conducted to compare the impact of ministers leading exercise versus physicians prescribing exercise. He also informed the meeting that the OECS has

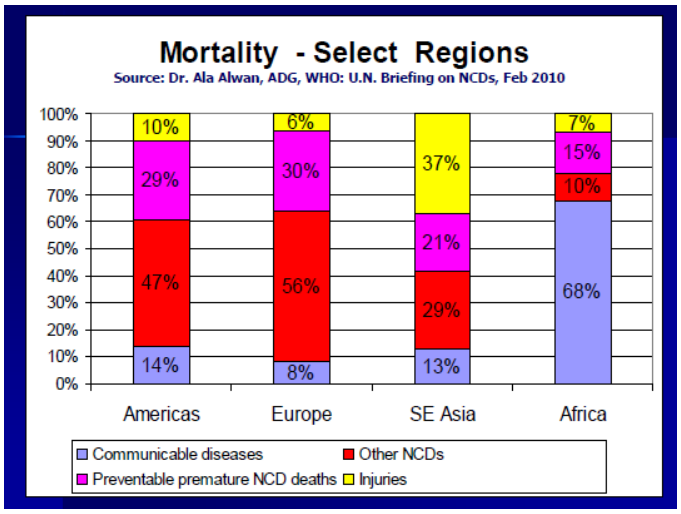
pooled efforts to purchase its pharmaceuticals and this has resulted in a 20-25% cost savings for 90% of essential medicines in St. Kitts and Nevis. However, he requested assistance to position chronic disease as a development issue for the Ministry of Finance using GDP and NCD data.

One participant sought clarification on what was meant by "patient-centred care" in this context. A classic example was used to demonstrate the model, for example instead of referencing that the health system requires 5 different specialists, the patient-centred care model would place the patient as the critical centre of focus with the health system organized around the patient so that there would be a single clinic with a podiatrist, nutritionist, counsellor and doctor. It was noted however that for number of years, the MOH of Trinidad and Tobago has stated that it offers patient centred care though the system does not meet the definition given. It was acknowledged that the criteria for patient-centred care needs to be established. It was also noted that in the "Now more than ever" document, it was the first time that that WHO has referred to patient centred level at the primary health care level.

Another participant commented that sufficient emphasis was not being placed on the impact of social determinants of health on the chronic diseases. While the health sector identified diet, exercise, and tobacco use, it has not emphasised the great role that stress plays in our setting and the region has not done enough work on this. The region has not done root cause analysis on this on mental health and the other risk factors.

POWERPOINT PRESENTATION

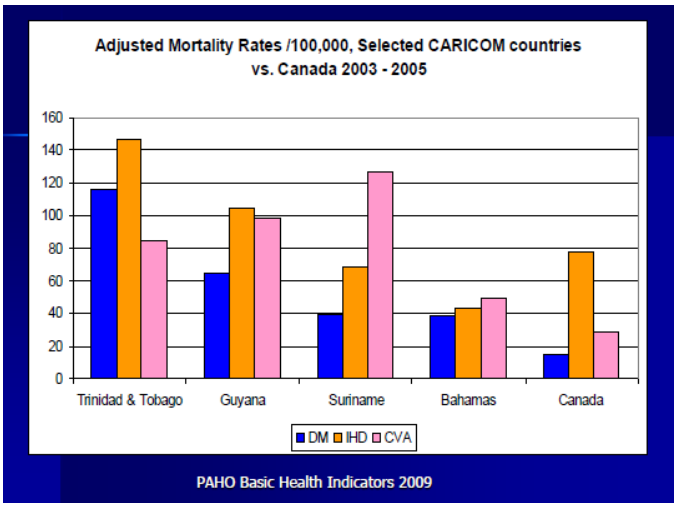


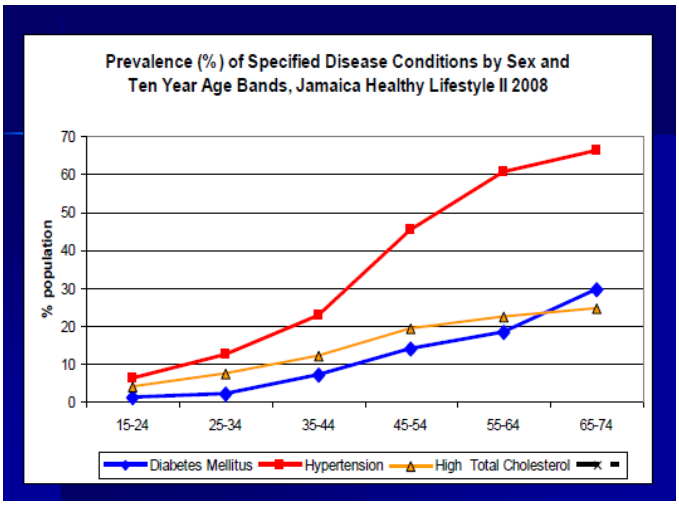


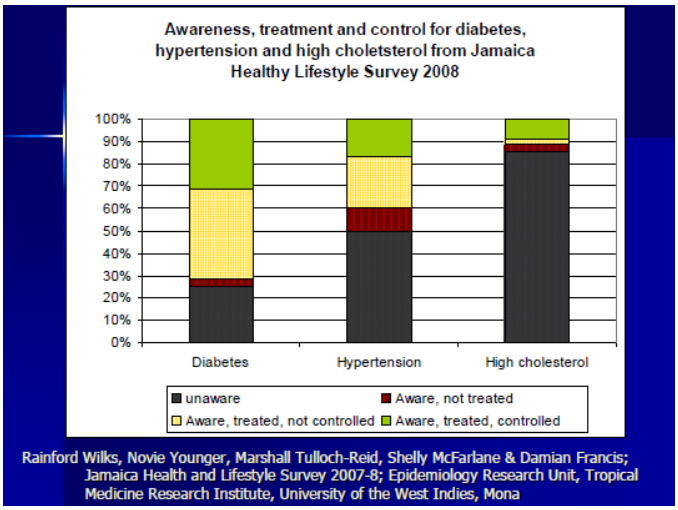
Leading Causes of Death in CARICOM Countries by Sex, 2004

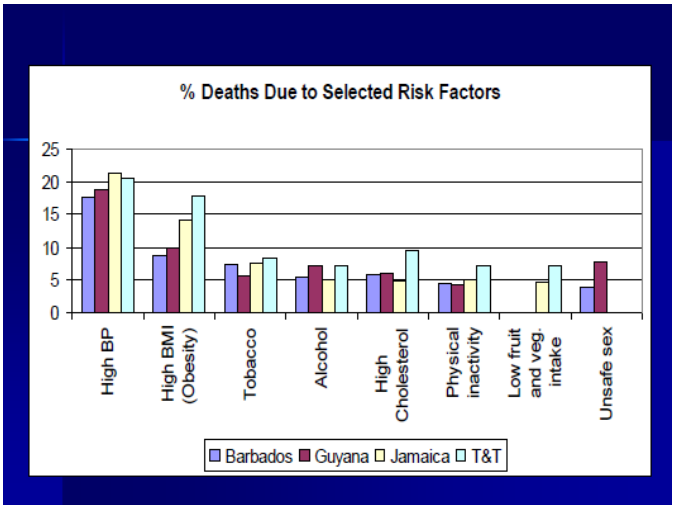
MALES	FEMALES
1. Heart Disease	1. Heart Disease
2. Cancers	2. Cancers
3. Injuries and violence	3. Diabetes
4. Stroke	4. Stroke
5. Diabetes	5. Hypertension
6. HIV/AIDS	6. HIV/AIDS
7. Hypertension	7. Influenza/pneumonia
8. Influenza/pneumonia	8. Injuries and violence

Source: CAREC, based on country mortality reports






Awareness, treatment and control for diabetes, hypertension and high choletsterol from Jamaica
Healthy Lifestyle Survey 2008
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Diabetes
Hypertension
High cholesterol
unaware
Aware, not treated
Aware, treated, not controlled
Aware, treated, controlled
Rainford Wilks, Novie Younger, Marshall Tulloch-Reid, Shelly McFarlane & Damian Francis; Jamaica Health and Lifestyle Survey 2007-8; Epidemiology Research Unit, Tropical Medicine Research Institute, University of the West Indies, Mona


% Deaths Due to Selected Risk Factors
25
20
15
10
5
0
High BP
High BMI (Obesity)
Tobacco
Alcohol
High Cholesterol
Physical inactivity
Low fruit and veg. intake
Unsafe sex
Barbados
Guyana
Jamaica
T&T

Regional Policies

POS NCD Summit Declaration (2007)

WHAT TO DO
- Tobacco control (#3,4)
- Healthy Eating (salt) (#6,7,8,9)
- Physical Activity (#10, 15)
- Treatment (#5)

WHERE TO DO IT
- Workplace (#10)
- Schools (#6)
- Faith based org.
- Communities

HOW TO DO IT
- NCD Secretariat, Plan, M&E (#1, 14)
- NCD Commissions (#2)
- Surveillance, Gender (#11, 13)
- Partners – private sector, civil society (P)
- Media & Communications (#12)
- Sustainable financing (#4)

PAHO and CARICOM support

COMMITTMENT

- NCD Plan (POS # 1,14)
- NCD budget (POS # 4)
- NCD Summit convened (POS # 2)
- Multi-sectoral NCD Commission appointed and functional (POS # 2)
- NCD Communications plan (POS # 12)

TOBACCO (POS #3)

- FCTC ratified
- Tobacco taxes >50% sale price
- Smoke Free indoor public places
- Ban on advertising, promotion & sponsorship
- Packaging and labelling

ALCOHOL

NUTRITION / HEALTHY EATING 1

- Multi-sector Food & Nutrition plan implemented (POS # 7)
- Trans fat free food supply (POS # 7)
- Policy & standards for healthy eating in schools implemented (POS # 7)

NUTRITION / HEALTHY EATING 2

- Trade agreements utilized to meet national food security & health goals (POS # 8)
- Mandatory labeling of packaged foods (POS # 9)
- Salt

PHYSICAL ACTIVITY

- Mandatory PA in all grades in schools (POS # 6)
- Mandatory provision for PA in new housing developments (POS # 10)
- Ongoing, mass Physical Activity (POS # 10)
- New public PA spaces (POS # 10)

EDUCATION / PROMOTION

- Caribbean Wellness Day multi-sectoral, multi-focal celebrations (POS # 15)
- ≥50% of public and private institutions with PA & diet) programmes (POS # 10)
- ≥30 days media broadcasts on NCD control / yr (risk factors and treatment) (POS # 12)

SURVEILLANCE (POS 11, 13, 14)

- STEPS or equivalent survey
- Minimum Data Set reporting
- Global Youth Tobacco Survey
- Global School Health Survey

TREATMENT (POS #5)

- Chronic Care Model / NCD treatment protocols in ≥ 50% PHC facilities
- QOC CVD or diabetes demonstration project

2010 Priorities International Advocacy

- Summit of the Americas April 2009
- CHOGM (Commonwealth Heads of Govt Meeting) November 2009
  - in Trinidad reaffirmed the WHO, PAHO and CARICOM NCD priorities
- CARICOM resolution for a UN High Level Meeting on NCDs *September 2011*

2010 Priorities
NCD Plans, Commissions

FOR COUNTRIES WITHOUT

- NCD plans
  - A model country plan is available, based on the draft regional plan
- Multi-sectoral Commissions
  - Guidelines for the membership, terms of reference and functions needed

2010 Priorities
FCTC

- St. Kitts/Nevis, St. Vincent & Grenadines (and Haiti), to ratify
- Consider using Trinidad & Tobago legislation as a model
- CROSQ packaging and labeling standards
  - COTED for approval May 2010 – objections raised....

2010 Priorities
Sustained Physical Activities

- April 7 – 11th 2010 World Health Day "1,000 cities, 1,000 lives"
  - Focused on urbanization and health
  - Opening up streets and other public places to people for healthy activities
- Caribbean Wellness Day catalyst for sustained physical activities in communities

2010 Priorities
CROSQ supports

- Active follow up with CROSQ on
  - Proposal submitted to set standards to regulate salt in manufactured foods in the region
  - User-friendly food labelling

2010 Priorities
Surveillance, M & E

- Regional Surveillance system, including non-IB countries
- STEPS NCD risk factor surveys or equivalent
- NCD Minimum Data set reporting
- NCD grid annual updates
- Project evaluation
  - funding raised and spent

2010 Priorities
POS NCD Declaration #5

That our Ministries of Health, in collaboration with other sectors, 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 NCDs would receive quality care and have access to preventive education based on regional guidelines;

Potential Impact

- CVD event recurrence reduced 75% by treatment with aspirin, beta blockers, ACE inhibitors, and statins
- Potential 38,000 lives saved in CARICOM over 10 years by evidenced-based treatment to those ALREADY accessing care
- Projected cost < 1% of existing health budget

Potential Impact on Diabetes

- Type 2 diabetes can reduce life expectancy by up to 15 years
- Lifestyle and pharmacological interventions can halve the risk of type 2 diabetes in people with IGT
- Lifestyle interventions as effective as pharmacological interventions

WHO Strategic Approach - Key areas of work for CVD Mx

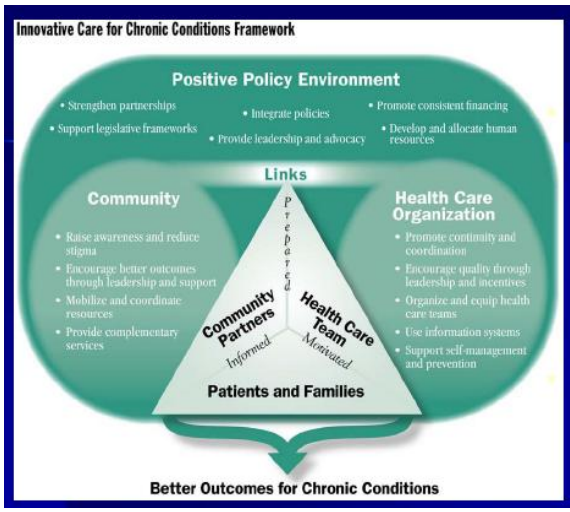
- Develop cost-effective standards of care
- Global action to enhance the capacity of countries
- Surveillance methods of CVDs and risk factors and to monitor programme impact.
- Networks and partnerships for concerted action.

Chronic Care Model and Integrated Care for Chronic Conditions

Cost effective approaches

1. Population
2. High risk
3. Secondary prevention (screening)

- The prevention paradox
  - high risk individuals gain most
  - number of CVD deaths larger in medium-low risk subjects .
- The three strategies should be complementary, not competitive



The ICCC Framework is an expansion of an earlier model, the Chronic Care Model, (Wagner) - a structure for organizing health care for chronic conditions.

http://www.who.int/chronic_conditions/framework/en/.

How would I recognize a productive interaction?

- Assessment of self-management skills and confidence as well as clinical status.
- Tailoring of clinical management by stepped protocol.
- Collaborative goal-setting and problem-solving resulting in a shared care plan.
- Active, sustained follow-up.

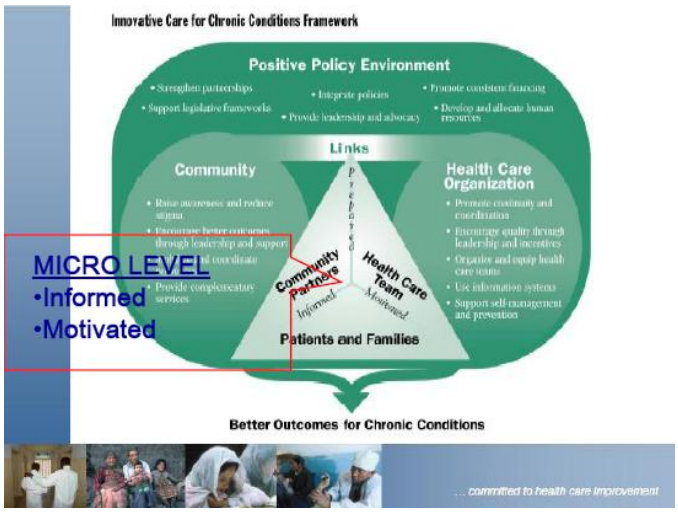
Key Messages

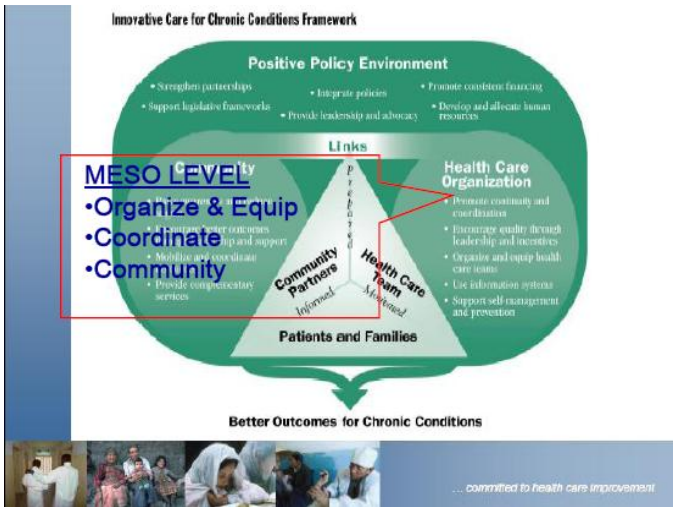
- Burden of chronic disease increasing
- Most health systems not equipped
- Patients do better with integrated system
- Evidence supports organized systems of care
- CCM has been successful in US
- ICCC depicts complimentary process
- CCM & ICCC need to be disseminated, implemented & evaluated

Eppinger-Jordan, JE; Pruitt, SD, Bengoa, R., Wagner, E. Improving the quality of health care fore chronic conditions. Quality Safe Hl Care, 2004.

Building Blocks

- **macro-level**
  - **policy**
- **meso-level**
  - **health care organization & community**
- **micro-level**
  - **the patient**


Innovative Care for Chronic Conditions Framework
Positive Policy Environment
Links
Community
Health Care Organization
MICRO LEVEL
•Informed
•Motivated
Community Partners
Health Care Team
Informed
Motivated
Patients and Families
Better Outcomes for Chronic Conditions
... committed to health care improvement


Innovative Care for Chronic Conditions Framework
Positive Policy Environment
Links
Health Care Organization
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•Organize & Equip
•Coordinate
•Community
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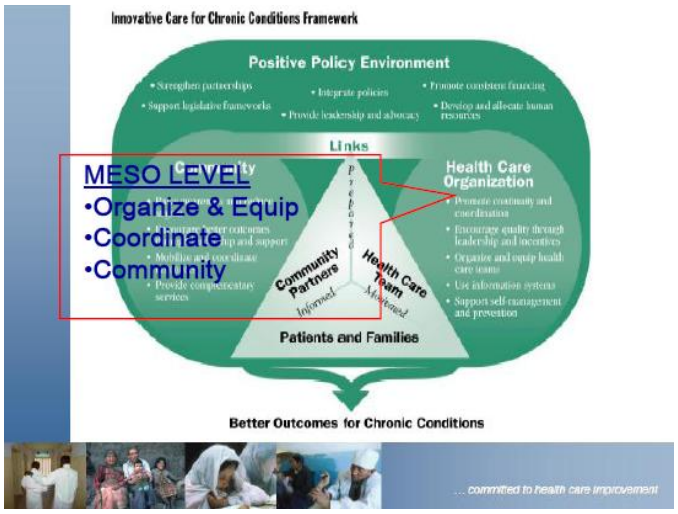
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•Organize & Equip
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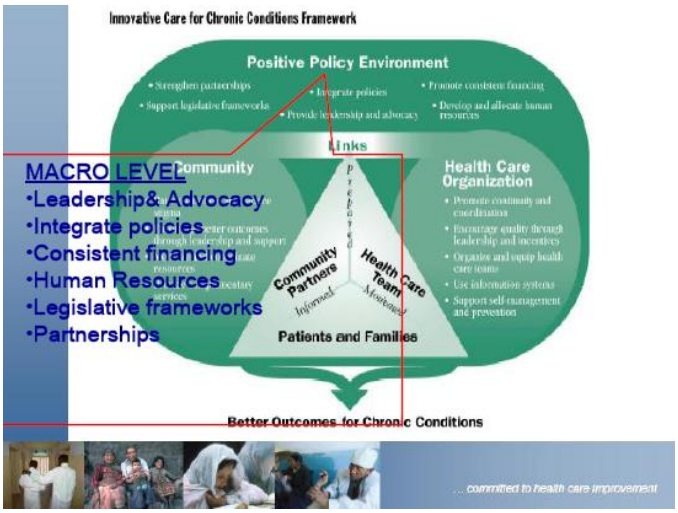


Eight Element for Action

1. Support paradigm shift) Political support,
2. Manage political environment) POS NCD Summit
3. Integrated Health Care
   Information systems
4. Align Sectoral Policies
   Team approach - Partners, legislation, regulations
5. Use Health Care personnel more effectively
   Team approach,
   Guidelines
6. Patient & Family centered care) Patient
7. Support patients in their communities) centered
8. Emphasize prevention) care care

Essential Elements

1. Evidenced based Clinical Guidelines (Decision Support)
2. Team approach
3. Information systems
4. Patient centered care, support for self-management

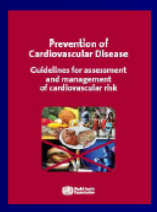
Decision Support – Clinical Guidelines

CARICOM 10 CVD Experts March'08 concluded

- Caribbean region should implement the total risk approach from the ISH/WHO CVD risk charts
  - Align drug therapy to evidenced-based guidelines - statin, aspirin, ACE inhibitor, thiazide or beta blocker
  - treat to target (blood pressure and cholesterol) especially in patients with diabetes
  - Lancet Dec'07 - scaling up evidenced-based treatment to high risk individuals already in the health system averts 20% of CVD deaths (56% < 70 yrs), even with only 40-60% patient compliance.

Guideline with Risk Prediction charts
Use BP or BG as entry points

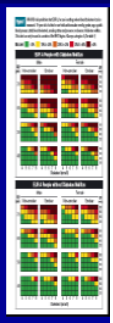
Full guideline



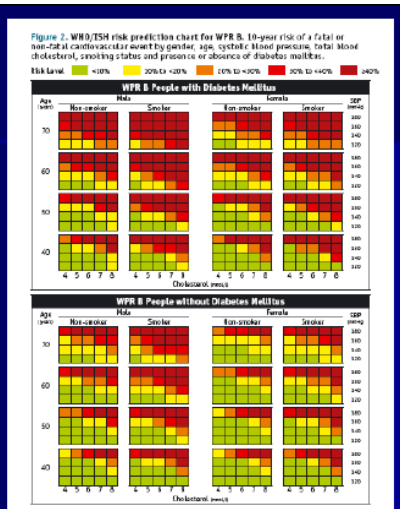
Pocket version

WHO/ISH risk prediction charts

- Predict 10 yr risk fatal/non fatal vascular events
- Charts use 6 variables:
  - Age, Sex, SBP, diabetes, smoking, cholesterol



AMR B
CARICOM



Simplified -Standardized care for heart attacks and strokes prevention

Step down

Smoking cessation/PA/Diet Aspirin/ACEI/BB/Statins Referral	Very High/High risk
Smoking cessation/PA/Diet Aspirin, HCT/ACEI/Statins	Medium risk
Smoking cessation/PA/Diet Low dose thiazide / Aspirin (may be)	Low risk
Smoking cessation/PA/Diet	Very low risk

GL : Diagnose/grade risk with simple indicators & Rx

CAVEATS

- All who need treatment should be treated
- Match the nature and intensity of interventions with absolute risk of a heart attack or stroke
- Low risk does not = no risk
- Low risk group SHOULD NOT be ignore
- Many factors will increase risk rating

Interventions by Risk Category

- All: Lifestyle advise (diet, exercise)
- Low Risk: Conservative management (giving time for lifestyle interventions to work)
- High Risk:
  - More frequent monitoring of risk factors
  - More frequent follow-up
  - More aggressive Rx to control risk factors to target
  - Earlier referral

Priority list of drugs (WHO NCD)

- **Aspirin**
- **Thiazides**
- **Betablockers**
- **ACEI**
- **Statin**

- **Metformin**
- **Glibenclamide**
- **Insulin**
- **Salbutamol**
- **Beclometasone/oral steroids**
- **Aminophylline**
- **Benzathine penicillin**
- **Beta blocker eye drops**
- **Morphine**

(Model list / PHC / minimum monitoring/Safety)

Are there mechanisms to reduce drug prices ?

- **Ensure generic medicines**
- **Seek volume discounts for group purchases**
- **Open competitive purchasing methods**
- **Monitor prices paid by other purchasers**
- **Eliminate duties and taxes and add-ons**
- **Partnership arrangements**

Draft Pocket Guidelines for the Integrated Management Prevention and Control of Cardio-vascular disease

- CVD leading cause of mortality
- Clear evidenced based guidelines
- Poor compliance with guidelines
  - 49% diabetics had foot exam) Aust, NZ UK
  - 47% post MI on BB) Seddon 2001

Essential Elements of ICCC

1. Evidenced based Clinical Guidelines (Decision Support)
2. Team approach
3. Information systems
4. Patient centered care, support for self-management

Integration

- Assess, plan, arrange, monitor numerous services
- Coordination of care between multiple providers and settings – public, private, NGO
- Broader range of skills – expanded role for some members, new types of workers e.g. Community Health Aides
- Work in teams
- Provide services to groups (e.g. Diabetes Clinic with nutritionist, podiatrist, social workers, peer counsellors)

Partners

- Private sector
  - Health, media, food, workplace wellness
- Civil society
  - Health NGOs, UWI

Essential Elements of ICCC

1. Evidenced based Clinical Guidelines (Decision Support)
2. Team approach
3. Information systems
4. Patient centered care, support for self-management

- Disease registries
- Sharing information across organizations and specialists
- Telephone, email, internet
- Computerized support systems
  - Alerts, reminders
- Electronic medical records

Essential Elements of ICCC

1. Evidenced based Clinical Guidelines (Decision Support)
2. Team approach
3. Information systems
4. Patient centered care, support for self-management

SELF-MANAGEMENT SUPPORT FOR CHRONIC CONDITIONS USING 5 As

- Specific actions by all staff to facilitate patient self-management
- Make practice patient centered
- NOT the same as old-fashioned didactic lecturing

5 As SUMMARY SHEET

ASSESS **:**

Evaluate behavior change status (and progress) - ***Beliefs, Behavior & Knowledge***

ADVISE:

Personally relevant behavioral recommendations - ***Provide specific information about health risks and benefits of change***

AGREE :

Set specific collaborative, feasible goals - ***based on patient's interest and confidence in their ability to change the behavior(s)***

ASSIST:

Anticipate barriers, problem-solve solutions, and complete action plan - ***social environmental support***

ARRANGE **:**

Schedule follow-up, contacts and resources

World Health Organization 2004

Improving Evidenced Based CVD Management

- Innovative Care for Chronic Conditions, based on the Chronic Care Model
- CVD guidelines
  - Total Risk Approach
  - Evidenced Based Pharmaceutical Interventions,
- Risk Factors as "Vital Signs"
  - Diet, exercise, tobacco, alcohol abuse
- Exercise is Medicine
  - Write prescriptions for exercise on a prescription pad
  - e.g. Walk 30 minutes 5 days per week

NATIONAL CAPACITY AND RESPONSE TO CHRONIC DISEASES SUMMARY OF FINDINGS

DR. JAMES HOSPEDALES

Senior Adviser, Prevention and Control of Chronic Diseases, PAHO/WHO

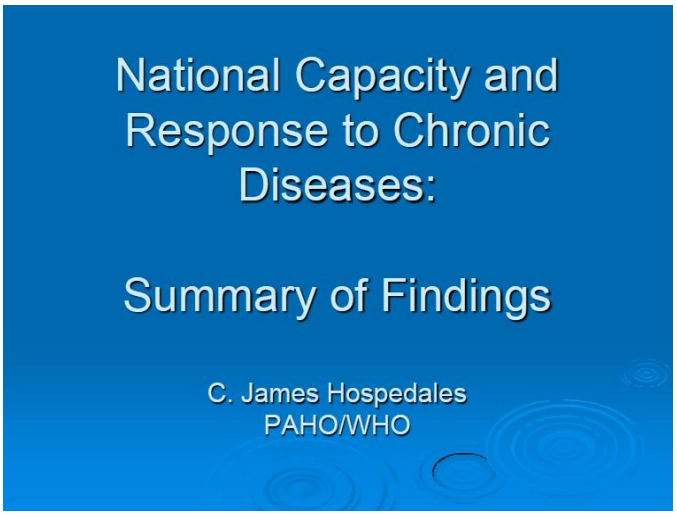
Dr. Hospedales presented the summary of the 3rd Global Survey of National NCD response capacity findings from 31 countries located in five (5) Regions in the Americas. Most countries have infrastructure in place for coordination, implementation and surveillance. Most countries also have policies, strategies, and action plans with a focus mainly on cardiovascular diseases and diabetes. Surveillance is more on mortality factors than on morbidity and risk factors. Registries are not used for prevalence surveillance. Health systems are in place with a focus on primary health care. There is increased attention and investment but still there is a shortage especially for prevention and promotion. Health promotion also was considered weak. Most countries have fiscal policies mainly on tobacco.

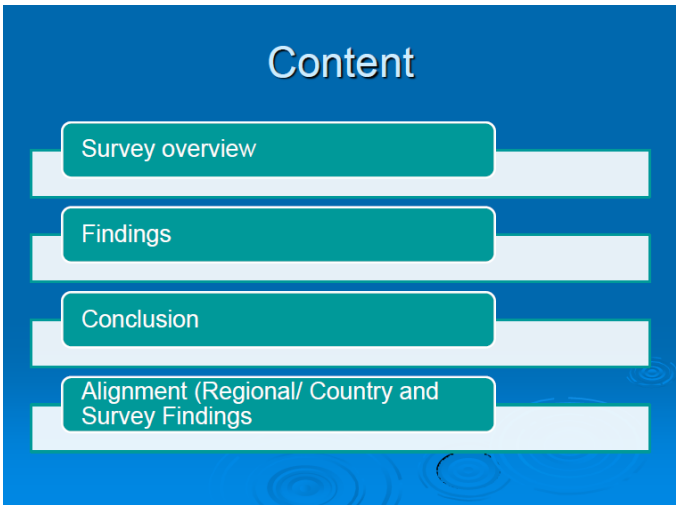
Survey data is expected to be used for national and regional/global planning. However, information emanating out of capacity findings are not used for planning purposes or for the determination of prevalence and risk factors. Most policies address the adult population but the policies for children need to be strengthened. There is an online database with country access, and periodic updating linked to annual/biannual NCD/CARMEN programme managers meetings. The data should be used to feed into the UN Summit in 2011.

Discussion

The representative from Suriname explained to Dr. Hospedales that Suriname experienced problems answering some of the questions because they did not understand the meaning of the questions. She suggested that comment boxes be placed by each question for clarification of questions and also for the countries to supply alternative information, if the country felt that the information is comparable or relevant. She indicated that Suriname liked the questionnaire, especially the software which permitted, while the country was filling out the relevant answers, access to graphs of the data which could immediately be used. Dr. Hospedales also clarified that the questionnaire was sent through the PAHO Offices to the MOH and they were completed by national NCD focal points in collaboration with the PAHO Office.

POWERPOINT PRESENTATION





Survey Overview

- 3rd survey
- 1,192 variables
- AMRO part approximately 50% larger than WHO
- Self-response through a group consensus
- 5 sections
- 31 countries

Acronyms

- A • Andean
- C • Caribbean
- M • Mesoamerica
- N • North America
- S • South America
- T • Total

Countries that have completed the survey

Andean
- Bolivia
- Ecuador
- Peru
- Venezuela

Caribbean
- Aguilla
- Barbados
- British Virgin Islands
- Dominica
- Guyana
- Jamaica
- Montserrat
- Saint Lucia
- Saint Kitts and Nevis
- Suriname
- Trinidad &Tobago

Mesoamerica and Hispanic Caribbean
- Belize
- Costa Rica
- Cuba
- Dominican Republic
- El Salvador
- Guatemala
- Mexico
- Nicaragua
- Panama

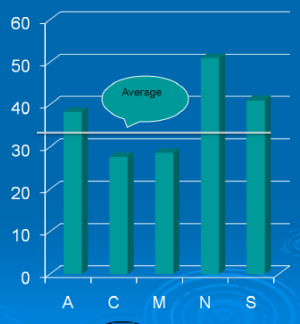
Noth America
- Canada
- United States

Southern Cone
- Argentina
- Brazil
- Chile
- Paraguay
- Uruguay

Summary Survey Variables and Average Distribution by Region

55 variables reviewed in summary

Region	Countries	Min	Max	%
A	4	21	52	38.3
C	11	13	45	27.6
M	9	9	42	28.6
N	2	50	52	51.0
S	5	32	48	41.0
T	30	9	52	33.0



Country Distribution by Average Response Rate(ARR) and NDC:CD Adj. Mortality Rate Ratio

ARR: >85%

	NCD:CD
Canada	17:1
Chile	7:1
Venezuela	6:1

ARR: 65-84%

	NCD:CD
Barbados	6:1
Brazil	5:1
Ecuador	4:1
Guyana	2:1
Mexico	6:1
Panama	4:1
Paraguay	4:1
Trinidad & Tobago	3:1
USA	13:1

ARR: <65%

	NCD:CD
Anguilla	
Argentina	6:1
Belize	3:1
Bolivia	3:1
BVI	
Costa Rica	
Cuba	8:1
Dominican Rep	3:1
El Salvador	3:1
Guatemala	1:1
Honduras	4:1
Jamaica	6:1
Montserrat	
Nicaragua	5:1
Peru	2:1
Saint Lucia	8:1
Saint Kitts and Nevis	8:1
Suriname	4:1
Uruguay	11:1

Policies, strategies and actions plans

Operational

- Argentina
- Bolivia
- Brazil
- Dominican Republic
- Ecuador
- El Salvador
- Guatemala
- Mexico
- Panama
- Paraguay
- Peru
- Trinidad and Tobago
- Venezuela

Non-Operational

- Anguilla
- Belize
- British Virgin Islands
- Canada
- Chile
- Costa Rica
- Cuba
- Guyana
- Honduras
- Jamaica
- Montserrat
- Nicaragua
- Saint Lucia
- Saint Kitts and Nevis
- Suriname
- Uruguay
- United States

Public Health Infrastructure

Questions	A	C	M	N	S	T
There is unit/branch	4/4	9/11	8/9	2/2	4/5	26/31
Includes:						
Planning	4/4	9/11	6/9	2/2	4/5	24/31
Coordination of implementation	3/4	9/11	6/9	2/2	4/5	23/31
Monitoring and evaluation	3/4	8/11	6/9	1/2	4/5	21/31
Funding available for:						
Treatment and control	3/4	10/11	8/9	2/2	5/5	27/31
Prevention and health promotion	3/4	9/11	6/9	2/2	5/5	24/31
Surveillance, monitoring and evaluation	2/4	7/11	5/9	1/1	5/5	19/31

PUBLIC HEALTH INFRASTRUCTURE

Country	ANG	BAR	BEL	BVI	GUY	JAM	MON	SAL	SCN	SUR	TRT
There is unit/branch		1	1		1	1	1	1	1	1	1
Includes											
Planning		1	1		1	1	1	1	1	1	1
Coordination of implementation		1	1		1	1	1	1	1	1	1
Monitoring and evaluation		1			1	1	1	1	1	1	1
Funding available:											
Treatment and control	1	1	1	1	1	1	1	1		1	1
Prevention and health promotion	1	1	1	1	1	1	1	1			1
Surveillance, monitoring an evaluation	1	1	1	1	1		1				1

Policies, Strategies and Action Plans

Questions	A	C	M	N	S	T
Integrated NCD policy/strategy/action plan	4/4	6/11	5/9	2/2	4/5	26/31
but not operational/more info needed for current status	4/4	1/11	5/9	2/2	3/5	15/31
Integrated NCD policy/strategy/action plan combines the following:						
Harmful alcohol consumption	2/4	4/11	2/9	1/1	3/5	12/31
Unhealthy diet	2/2	8/11	4/9	2/2	4/5	20/31
Physical activity	2/2	6/11	4/9	2/2	4/5	18/31
Tobacco	2/2	6/11	4/9	1/1	4/5	17/31

POLICIES, STRATEGIES AND ACTION PLANS

Country	ANG	BAR	BEL	BVI	GUY	JAM	MON	SAL	SCN	SUR	TRT
Integrated NCD policy/strategy/action plan		1		1	1	1		1			1
but not operational/more info needed for current status											1
Integrated NCD policy/strategy/action plan combines the followig:											
Harmful alcohol consumption				1	1			1			1
Unhealthy diet	1	1	1	1	1	1		1			1
Physical activity		1		1	1	1		1			1
Tobacco		1	1		1	1		1			1

Policies, Strategies and Action Plans Cont…

Policies/strategies/action plan combine early detection, treatment and care, rehab						
Questions	A	C	M	N	S	T
Cancer	3/4	4/11	6/9	2/2	3/5	18/31
Cardiovascular diseases	2/2	4/11	4/9	2/2	4/5	16/31
Chronic respiratory diseases	1/4	2/11	3/9	2/2	2/5	10/31
Diabetes	2/2	4/11	5/9	2/2	4/5	17/31
Hypertension	3/4	4/11	5/9	2/2	4/5	16/31
Overweight/obesity	2/2	4/11	5/9	2/2	3/5	16/31
Abnormal blood lipids	2/2	3/11	5/9	2/2	3/5	15/31

Policies/strategies/action plan combine early detection, treatment and care, rehabilitation

Country	ANG	BAR	BEL	BVI	GUY	JAM	MON	SAL	SCN	SUR	TRT
Cancer		1			1			1			1
Cardiovascular diseases		1			1			1			1
Chronic respiratory diseases								1			1
Diabetes		1			1			1			1
Hypertension		1			1			1			1
Overweight/obesity		1			1			1			1
Abnormal blood lipids					1			1			1

Cont…
Policies/strategies/action plan combine early detection, treatment and care, rehabilitation

Country	ANG	BAR	BEL	BVI	GUY	JAM	MON	SAL	SCN	SUR	TRT
Specific policies on:											
Cardiovascular diseases		1						1			
Cancer					1			1		1	
Diabetes/hyperglicemia		1			1		1	1		1	
Chronic respiratory diseases		1						1			
Harmful alcohol consumption					1			1		1	
Unhelathy diets	1	1			1	1	1	1			
Overweight/obesity					1	1		1			
Physical inactivity		1			1	1		1			
Tobacco consumption		1			1	1		1		1	1

Health Information Systems, Surveys and Surveillance

Country	ANG	BAR	BEL	BVI	GUY	JAM	MON	SAL	SCN	SUR	TRT
Cause-specific mortality related to NCD	1	1	1		1	1		1	1	1	1
Morbidity related to NCD	1	1	1		1	1			1	1	1
NCD risk factors		1	1		1	1			1	1	1
Existance of disease registry											
Cancer		1	1		1	1				1	1
Diabetes	1	1			1		1		1	1	1
Cardivascular disease		1			1						
Cerebrovascular disease		1			1						

Health Information Systems, Surveys and Surveillance

Country	ANG	BAR	BEL	BVI	GUY	JAM	MON	SAL	SCN	SUR	TRT
Risk factor surveys on:											
Harmful alcohol use	1	1	1			1			1	1	
Diet		1	1			1			1		1
Physical inactivity		1	1			1			1		1
Tobacco use		1	1		1	1			1	1	1
Raised blood glucose/diabetes		1	1			1	1	1			1
Abnormal blood lipids		1	1			1					1
Raised blood pressure/hypertension		1	1			1			1		1
Overweight/obesity		1	1			1			1		1

Health System Capacity for Prevention, Early Detection, Treatment and Care within the Primary Health Care System

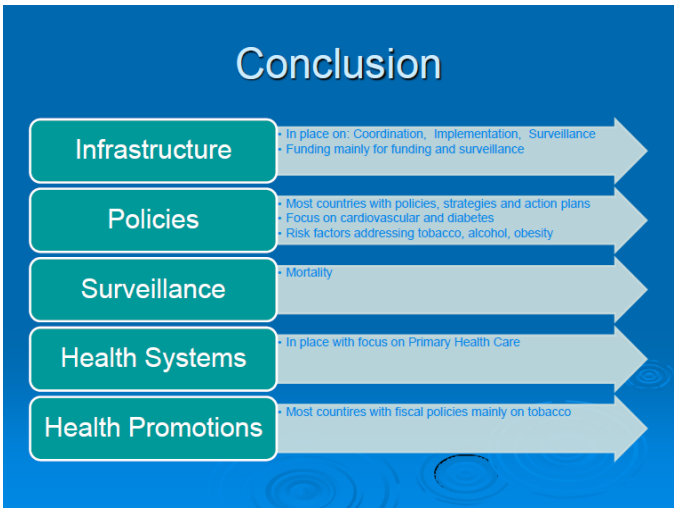
Country	ANG	BAR	BEL	BVI	GUY	JAM	MON	SAL	SCN	SUR	TRT
Primary prevention/health promotion	1	1	1	1	1	1	1	1	1		1
Risk factor detection	1	1	1	1	1	1	1	1	1		1
Risk factor and disease management	1	1	1	1	1	1	1	1	1	1	1
Support for self help and self-care					1	1	1	1	1	1	1
Home-based care	1			1	1	1	1	1		1	1
Surveillance reporting	1	1	1		1		1		1	1	1

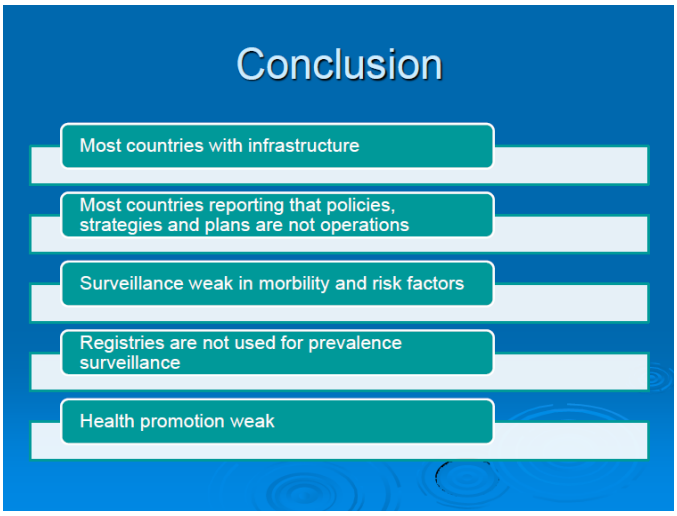
Health Promotion and Collaboration

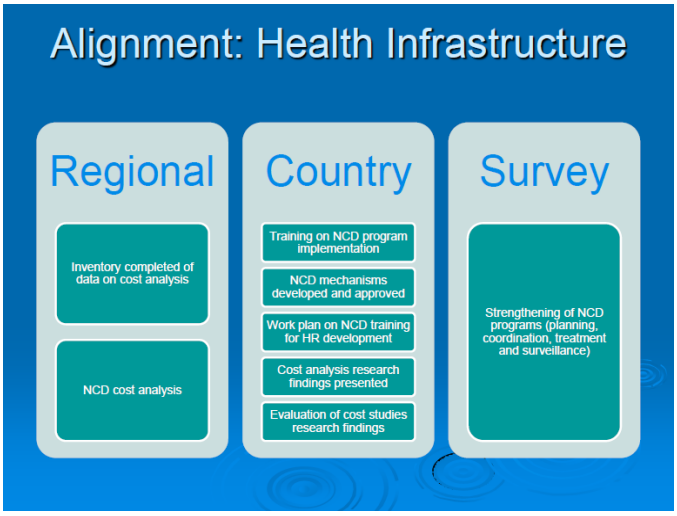
Country	ANG	BAR	BEL	BVI	GUY	JAM	MON	SAL	SCN	SUR	TRT
Partnerships/collaborations for implementing key activities	1	1	1		1	1			1	1	1
Health promotion activities implemented:											
Fiscal interventions to influence behavior change		1		1	1	1			1		
Implementing 1 or more community/empowerment approaches		1	1		1	1		1	1	1	1
implementing 1 or more evaluated health promotion campaigns to change individual behaviors		1			1					1	1
Initiatives that regulate the marketing of foods to children	1			1							

Conclusions

- 3rd Global Survey of National NCD response capacity (2001, 2005, 2010)
- Increased attention and investment, but still far short of need, especially prevention promotion
- Use of survey data for national and regional/global planning
- Online data base with country access; periodic updating linked to annual/biannual NCD/CARMEN program managers meetings
- Use of data for feeding into UN Summit 2010


Conclusion
Infrastructure
• In place on: Coordination, Implementation, Surveillance
• Funding mainly for funding and surveillance
Policies
• Most countries with policies, strategies and action plans
• Focus on cardiovascular and diabetes
• Risk factors addressing tobacco, alcohol, obesity
Surveillance
• Mortality
Health Systems
• In place with focus on Primary Health Care
Health Promotions
• Most countires with fiscal policies mainly on tobacco


Conclusion
Most countries with infrastructure
Most countries reporting that policies, strategies and plans are not operations
Surveillance weak in morbility and risk factors
Registries are not used for prevalence surveillance
Health promotion weak


Alignment: Health Infrastructure
Regional
Inventory completed of data on cost analysis
NCD cost analysis
Country
Training on NCD program implementation
NCD mechanisms developed and approved
Work plan on NCD training for HR development
Cost analysis research findings presented
Evaluation of cost studies research findings
Survey
Strengthening of NCD programs (planning, coordination, treatment and surveillance)

Health Promotion

Regional

- Plans to implement 2009 CARMEN agreements
- Measure implementation of CARMEN agreements
- Ciclovias workshop
- Public health impact of transportation systems
- Campaign of active cities
- Action plan approved on diet health promotion

Country

- Partnerships established
- CARMEN evaluation
- Multisector approach
- Partners Forum
- Document physical activity
- Tobacco prevention
- Strategies and partnerships on nutrition with emphasis on breast feeding

Survey

- Need to strengthen health promotion programs
- More activities needed to promote food marketing for children

Health Promotion

Regional

- Plans to implement 2009 CARMEN agreements
- Measure implementation of CARMEN agreements
- Ciclovias workshop
- Public health impact of transportation systems
- Campaign of active cities
- Action plan approved on diet health promotion

Country

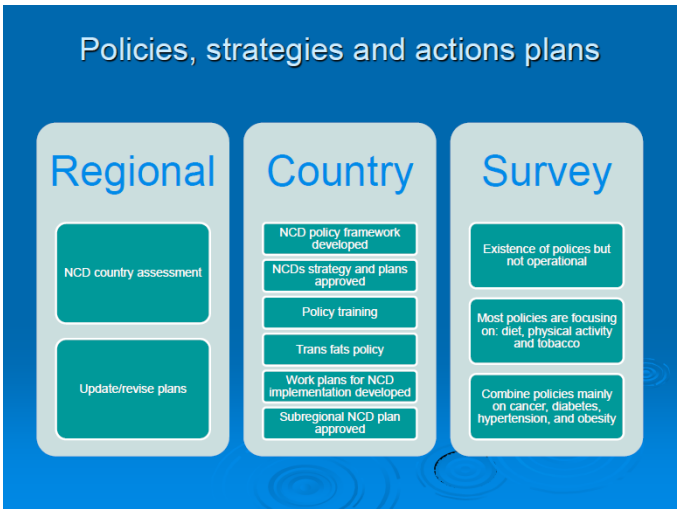
- Partnerships established
- CARMEN evaluation
- Multisector approach
- Partners Forum
- Document physical activity
- Tobacco prevention
- Strategies and partnerships on nutrition with emphasis on breast feeding

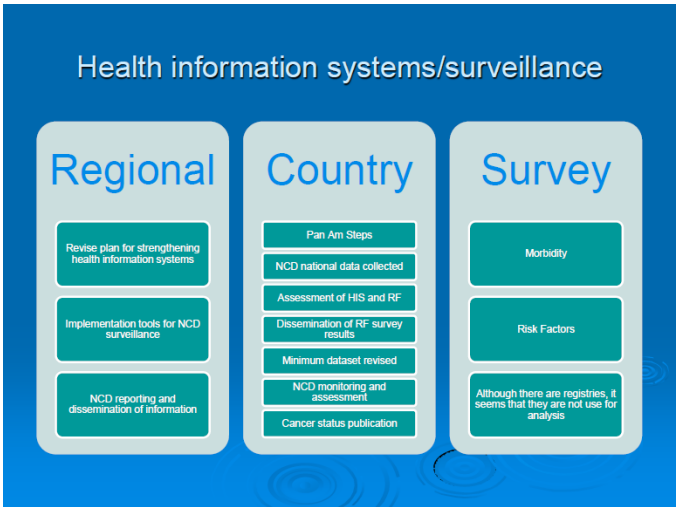
Survey

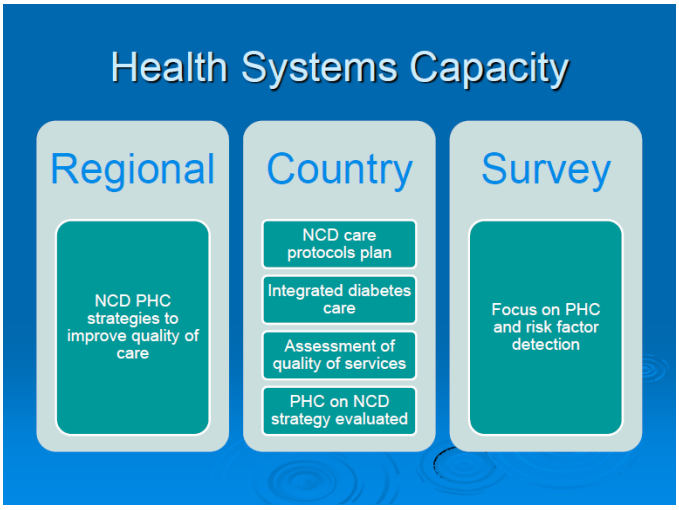
- Need to strengthen health promotion programs
- More activities needed to promote food marketing for children

Thank you

Comments?
Questions?
Answers?
Anything?


Policies, strategies and actions plans
Regional
NCD country assessment
Update/revise plans
Country
NCD policy framework developed
NCDs strategy and plans approved
Policy training
Trans fats policy
Work plans for NCD implementation developed
Subregional NCD plan approved
Survey
Existence of polices but not operational
Most policies are focusing on: diet, physical activity and tobacco
Combine policies mainly on cancer, diabetes, hypertension, and obesity


Health information systems/surveillance
Regional
Revise plan for strengthening health information systems
Implementation tools for NCD surveillance
NCD reporting and dissemination of information
Country
Pan Am Steps
NCD national data collected
Assessment of HIS and RF
Dissemination of RF survey results
Minimum dataset revised
NCD monitoring and assessment
Cancer status publication
Survey
Morbidity
Risk Factors
Although there are registries, it seems that they are not use for analysis


Health Systems Capacity
Regional
NCD PHC strategies to improve quality of care
Country
NCD care protocols plan
Integrated diabetes care
Assessment of quality of services
PHC on NCD strategy evaluated
Survey
Focus on PHC and risk factor detection

Health Information Systems, Surveys and Surveillance

Question	A	C	M	N	S	T
Cause-specific mortality related to NCD	3/4	9/11	8/9	2/2	5/5	26/31
Morbidity related to NCD	1/4	8/11	3/9	2/2	4/5	18/31
NCD risk factors	1/3	7/11	1/9	2/2	1/5	12/31

Health Information Systems, Surveys and Surveillance cont…

Question	A	C	M	N	S	T
Existence of disease registry						
Cancer	4/4	6/11	8/9	2/2	3/5	22/31
Diabetes	3/4	7/11	7/9	1/1	3/5	21/31
Cardiovascular disease	2/4	2/11	6/9	2/2	2/5	13/31
Cerebrovascular disease	2/2	2/11	6/9	2/2	2/5	13/31

Health Information Systems, Surveys and Surveillance cont…

Risk factor surveys on:						
Question	A	C	M	N	S	T
Harmful alcohol use	4/4	6/11	6/9	2/2	3/5	20/31
Diet	3/4	5/11	4/9	2/2	3/5	15/31
Physical inactivity	3/4	5/11	4/9	2/2	4/5	17/31
Tobacco use	4/4	7/11	8/9	2/2	4/5	24/31
Raised blood glucose	4/4	6/11	6/9	2/2	4/5	16/31
Abnormal blood lipids	4/4	4/11	4/9	2/2	4/5	17/31
Raised blood pressure	3/4	5/11	6/9	2/2	4/5	19/31
Overweight / obesity	3/4	5/11	5/9	2/2	4/5	18/31

Health System Capacity for Prevention Early Detection, Treatment and Care with the Primary Health Care System

Question	A	C	M	N	S	T
Primary prevention/health promotion	3/4	10/11	8/9	1 / 2	4/5	25/31
Risk factor detection	3/4	10/11	7/9	1 / 2	5/5	25/31
Risk factor and disease management	3/4	11/11	8/9	1 / 2	5/5	27/31
Support for self help and self care	2/4	7/11	5/9	1 / 2	3/5	18/31
Home-based care	2/4	8/11	3/9	1 / 2	1/5	15/31
Surveillance reporting	3/4	8/11	9/10	1 / 2	1/5	17/31

Health Promotion and Collaboration

Question	A	C	M	N	S	T
Partnerships/collaborations for implementing key activities	2/2	8/11	2/9	2/2	3/5	16/31
Fiscal interventions to influence behavior change	4/4	5/11	8/9	2/2	5/5	24/31
Implementing 1 or more community/empowerment approaches	1/4	8/11	3/9	2/2	3/5	16/31
Implementing 1 or more evaluated health promotion campaigns to change individual behaviors	4/4	4/11	8/9	2/2	5/5	23/31
Initiatives that regulate the marketing of foods to children	0/4	2/11	0/9	2/2	5/5	9/31

IMPLEMENTING THE CHRONIC CARE MODEL
CAPACITY BUILDING FOR CHRONIC DISEASE MANAGEMENT IN BARBADOS

DR. JOY ST. JOHN

Chief Medical Officer, Barbados

Dr. St. John indicated that Barbados used a two-tiered approach of involving communities, partners, and the health care team in order to consider the adoption of the integrated comprehensive chronic care model. Firstly, meetings were held with primary health care staff to identify gaps and priorities for action, to review the quality and management component of the National Strategic Plan on NCDs and to identify the need and scope for external technical partnerships from PAHO/WHO/CAREC and CARICOM. The expected outcomes were to assess the gaps and priorities and to assess capacity in terms of current infrastructure and human resources. Three working groups then looked at **policy, health care organisation and community issues**.

In respect of **policy**, the structure of the National CNCD Commission was examined in order to increase its effectiveness as a mechanism for the promotion, prevention and comprehensive management of CNCDs. In addition, policies are needed to develop linkages to the private health care sector and non-government organizations; to develop regulations to reduce health care risks in relation to CNCDs; and to identify champions to support the reduction of CNCDs.

With respect to the **health care organization**, the group identified strategies to address institutional issues in the public and private sectors; identified strategies to improve information sharing across health care organisations and communities in public, private and non-governmental settings; identified ways of improving access to diagnostic and treatment services for CNCDs; and looked at mechanisms to influence the Faculty of Medical Sciences and other training programmes to promote chronic conditions management.

With respect to the **community**, the group looked for innovative strategies to provide basic information about the management of chronic conditions to patients and families; ways for self management to be promoted, taught and supported; ways of involving community groups and NGOs in providing care for chronic conditions; mechanisms to support the roles of community organisations in policy-making, service planning and delivery; innovative strategies that can be used to make employers, labour unions and employer organisations more aware of the management of chronic conditions and ensure that they

support prevention and self management efforts in the workplace; identification of population-based prevention activities and how these can be supported; and strategies that can be used to ensure that every patient encounter addresses prevention.

The recommendations of the first phase of the process included the following:

- Establish an NGO Desk
- Improve regulatory frameworks
- Implement health passport as a tool for patient empowerment
- Engage in a process of participatory planning
- Improve monitoring & evaluation
- Conduct specialty training for health care team
- Establish a task force to plan for the expanded meeting of public and private sector.

Decisions made by the Government of Barbados include improved regulatory frameworks and improved monitoring and evaluation.

Secondly, a meeting was then held with a second group of expanded stakeholders. The objectives were: to introduce major stakeholders in Barbados to the concept of the application of the ICCCM to Barbados; to explore implementation strategies and possible barriers from the perspective of the various stakeholders; to produce a technical report and implementation proposal which clearly outlines the steps that Barbados will need to take to among other things strengthen the fundamentals of health care organisation and structure and involve the community in decision making.

The agenda for this meeting included technical sessions on chronic care management, and it explored the potential for enhanced CNCD surveillance and the use of registries, the role of the private sector, the expanded Model of ICCCM and the use of chronic care model in diabetes quality improvement.

The group work at the meeting considered the following topics:

- Supporting a paradigm shift
- Sustaining political support and will in the current economic environment

- Building integrated health care
- Align sectoral policies for health
- Using health care personnel more effectively
- Centre care on patient and family
- Supporting patients in their community
- Emphasising prevention.

POWERPOINT PRESENTATION

Capacity Building for Chronic Disease Management in Barbados

Dr. Joy St. John
Chief Medical Officer, Barbados

September 1, 2010

Background

- CNCDs repesent largest burden of illness to the population
- 25% of adult population have a CNCD
- Prevention has been adopted as the hallmark of programmes for quality care and management
- Challenge is to make the PHC more responsive to the epidemiological shift

Background cont'd

- Dynamics of patient care and the supportive environments need to be in place to create change
- A parallel process demanding a PRDS based evaluation of PHC clinicians, would allow an audit of quality of care given to be linked with adherence to the proposed chronic care model

Process

- A two tiered process was adopted in order to consider the adoption of the ICCCM to Barbados
- Phase 1: a meeting of senior PHC staff with the following objectives;
- To identify gaps and priorities for action for implementing the ICCCM
- To review the quality and management component of the national strategic plan for CNCDs

Process cont'd

- To identify the need and scope for external technical partnerships from PAHO/WHO/CAREC and CARICOM
- To prepare for a second meeting with an expanded group of stakeholders-Phase 2

Expected Results

- Assessment of gaps and priorities for action for implementing the integrated approach to CNCDs
- Assessment of capacity in terms of current infrastructure and human resources
- Appointment of a Task Force to plan the expanded meeting, held on July 21st.

Group Work

- The objective of this group work is to consider a number of questions related to the delivery of high quality care, as well as continuity, involving patients, communities, partners, health care teams and policy-makers.
- The outcome of these group discussions will form the basis for the development of a draft framework for the adaptation of the chronic care model for Barbados. The group should discuss and answer the question below and be prepared to present their deliberations to the Plenary.

Group Work

- There were three groups:
- Policy
- Health care organisation
- Community

Policy group

Questions:

1. What changes, if any would you recommend to the structure of the National CNCD Commission to increase its effectiveness as a mechanism for the promotion, prevention and comprehensive management of CNCDs?
2. What policies need to be put in place to develop linkages to the private health care sector and non-governmental organizations?
3. What policies and/or regulations need to be instituted or revised to help to reduce public health risks in relation to CNCDs? Give consideration to policies in the health sector, as well as sectors other than health, e.g. education, transport etc.
4. Identify readily available powerful and credible voices who could be enlisted as champions to support reduction of CNCDs.

Health Care Organisation

Questions

1. Identify strategies to address institutional strengthening in relation to the application of the chronic care model to Barbados, in the public and private sectors
2. Identify strategies to improve information sharing across health care organisations and communities in public, private and non-governmental settings.
3. Identify ways of improving access to diagnostic and treatment services for CNCDs.
4. What can be done to influence the Faculty of Medical Sciences and other training programmes to promote chronic conditions management?

Community

1. What innovative strategies can be used to provide basic information about the management of chronic conditions to patients and families?
2. How can self management be promoted, taught and supported?
3. What can be done to involve community groups and NGOs in providing care for chronic conditions?
4. What mechanisms are needed to support the roles of community organisations in policy-making and service planning and delivery?
5. What innovative strategies can be used to make employers, labour unions and employer organisations more aware of the management of chronic conditions and ensure that they support prevention and self management efforts in the workplace?
6. Identify population based prevention activities and how these can be supported?
7. What strategies can be used to ensure that every patient encounter addresses prevention?

Recommendations Phase 1

- Establish the NGO Desk
- Improve regulatory frameworks
- Implement health passport as a tool for patient empowerment
- Engage in a process of participatory planning
- Improve monitoring & evaluation
- Conduct specialty training for health care team

Recommendations cont'd

- Task Force was established to carry forward the planning for an expanded meeting with a wider range of stakeholders from the private and public sectors

Phase 2 Objectives

- To introduce major stakeholders in Barbados to the concept of the application of the ICCCM to Barbados
- Explore implementation strategies and possible barriers from the perspective of the various stakeholders
- Produce a technical report and implementation proposal which clearly outlines the steps Barbados will need to take to among other things strengthen the fundamentals of health care organisation and structure; and involve community in decision making

Agenda

- Technical sessions on chronic care management
- Potential for enhanced CNCD surveillance
- Use of registries
- Role of the private sector
- Expanded Model of ICCCM
- Use of chronic care model in diabetes quality improvement

Agenda – Group Work

- Eight groups considered the following topics:
- Supporting a paradigm shift
- Sustaining political support and will in the current economic environment
- Building integrated health care
- Align sectoral policies for health
- Using health care personnel more effectively
- Centre care on patient and family
- Supporting patients in their community
- Emphasising prevention

IMPLEMENTING THE CHRONIC CARE MODEL-EVIDENCE-BASED CHRONIC ILLNESS CARE IN SURINAME

DR. VIRGINIA ASIN-OOSTBURG

Deputy Director of Health Services, MOH, Suriname

Dr. Asin-Oostburg stated that the objective of the presentation was to share the experiences and challenges during the transformation process of the health system in Suriname and the philosophy behind the change from the traditional acute care model to a strengthened chronic care model.

Dr. Asin-Oostburg reported that Suriname traditionally operated an acute care model with episodic care, which was weak in its integration of health promotion and health education for self management of illnesses, lacked a good patient monitoring system and had weak information flows across levels of care. She stated that all of these had to be in place for the transformation to a strengthened chronic care model through the integration of prevention and health promotion into the primary health care with treatment services AND improved continuity to secondary care.

She listed the prerequisites for successful delivery of quality care using the evidence-based approach:

- Policies; Plans; Projects; Programs
- Infrastructure
- Public Health System – good and efficient private-public health system
- Network
- Partnerships
- Funding

Suriname reviewed the organization of its Ministry of Health, given its belief that transformation of the heath system had to start with the transformation of the organizational structure so that there could be a more efficient distribution of tasks and responsibilities and more effective policy implementation. This new concept for the organizations structure was developed in 2008.

Suriname recognised the importance of having written policy documents and worked on finalizing policy documents based to a large extent on the recommendations from the IDB studies for Suriname's Health Sector Reform. In 2009, the concept for the Health Sector plan 2010 – 2015 was finalized and the Final document will be presented before the end of 2010. In July, 2010, Suriname finished the first

working draft NCD Policy and Strategic plan 2010 – 2015 and recognized Dr. Alafia Samuel's support in preparing this policy.

Dr. Asin-Oostburg reported that Suriname continued during this period of transformation to do many projects and programs on chronic diseases which were run through the Bureau of Public Health. The Bureau of Public Health historically is the program implementation and monitoring and evaluation institute. These current programs included that for Malaria, TB, Family Health; Nutrition; EPI (expanded program for immunization); NCD; Health Education and utilized funding from the national budget.

Dr. Asin-Oostburg stated that almost all the building blocks for a well-established infrastructure, that is both physical and human resources, are in place in Suriname. However some strengthening/ re-structuring is needed and discussions on the new type of health care worker that would be required to deliver these services had to be held. She reminded participants that at the last CMO meeting in Grenada, the group had discussed the importance of focusing on the re-structuring of the nursing profession, which is one of the key aspects in re-building the region's human resources.

Suriname also upgraded some of its services – initiating one stop health centers strategically located and equipped for variety of health services with improved diagnostic and supportive services. Suriname also started building polyclinics including emergency services, talking about patient-centred care to meet the needs of the patients and operating special services, such as:

- Multi-purpose centers with emergency services,
- Upgrading and improvement of hospitals expanding with more specialty care (low threshold eye care centre etc)

Suriname also re-built, built and/or rehabilitated the physical infrastructure for each level of care from prevention and health promotion to treatment services AND improved continuity to secondary care.

Dr. Asin-Oostburg explained that Suriname has a unique decentralized system of primary care with services provided by the Regional Health Service in the coastal area and the Medical Mission in the interior. In the interior, traditional community health care workers are used given the shortage of doctors and nurses. Regional doctors serve a number of villages and specially trained community health assistants are used to bring the health care services closer to the people.

Dr. Asin-Oostburg stated that critical to implementing the evidence-based primary care model care was networking to identify the capacity that is needed. She acknowledged PAHO's assistance in providing training on professional networking and partnership.

She shared that Suriname has used the evidence-based primary health care model to create and develop the Cardiovascular and Diabetes Care Standards. Through a three year project in partnership with the Dutch Government, using consultation meetings, trainings and workshops, the group worked on the "surinamizing" the existing standards to develop the related care standards. These quality standards will be implemented in the next three months.

She shared that Suriname used this model in a "fun" way and involved all the stakeholders. She explained that persons in the health services use terminology such as "Comprehensive care/ integrated care/ patient-centred care" and while in the health profession there may not be a common understanding of the terms, persons outside the health services do not know what these terms mean. Suriname therefore took the opportunity to sensitise all the stakeholders – community and all the partners, using the Port of Spain Declaration, on the important factors about health care services.

Through a two year campaign, Suriname used the primary health care model to identify all its partners and used fun activities to introduce the health care model concepts. Suriname took the campaign to all ten districts, involving everybody from the President to the First Lady, Ministers and people in all sectors in the activities. The Minister was always present and participated in almost all the activities. Suriname also promoted sport by inviting popular athletes to travel in the caravan and combined screening, demos, media promotion, fundraising, etc with dancing, aerobics and walking. The health community has often spoken about identifying possible champions for programmes and Suriname did identify champions who could help. Suriname introduced the chronic care model emphasising the risk factors and the need for increased collaboration. It involved the media to get the message circulated and spoke about alcohol, not in a totally negative way which would have been off-putting, but used the message to state the need for careful use of alcohol. Suriname also made commemorative items – shirts, caps, bandanas, wristbands, folders, posters, etc.

Funding came from extra-budgetary funding, sponsors, including IDB and PAHO (technical assistance and funding), ad hoc funding, piggy-backing / partnering with HIV programmes by including in the healthy behaviour messages the need for healthy sexual behaviour. Since there was no substantial

money specifically identified for NCDs, every possible creative mechanism to get funding and to get the messages across was used.

Dr. Asin-Oostburg indicated that the next steps are to continue to implement and monitor and evaluate its programs.

Discussion

In response to a question, the Barbados CMO identified the elements of the road map that were necessary to implement the model. She stated that Barbados took a global look at the major public health issues, identified the persons on the team, and designed/participated in training courses at different levels, including top management to get the skills mix. In terms of the facilities, given the economic crunch, Barbados tried to maximise the facilities with one-stop shops. Barbados also tried to improve how it interfaced with private sector primary care, although addressing the standards of care in the two sectors remains a challenge.

Barbados was also asked whether in using the model, it had been able to identify how to approach the different population segments and gender groups. Barbados indicated that it had not yet received the report from the 2nd evaluation to examine what happened between the 1st and 2nd meeting. When the report is received at the end of September 2010, Barbados should be able to tease out the gender issues. However, going into the meeting, from anecdotes, the Ministry had a concept of some of the deficiencies but wanted to have stakeholder involvement so that everyone would have been heard. The agenda for the 2nd day included the public sector and the private sector primary health care. At this meeting, the Ministry presented as much statistical evidence as was available using the chronic disease registry findings and all stakeholders shared their perspective and experience as well.

One participant wanted to know the current level of coverage received by persons with chronic diseases in Suriname. This information was not immediately available.

Another participant supported Suriname's efforts and urged that the region not get trapped with words such as integrated and comprehensive, as some of these words are put together for the region by developed countries, and the developed countries themselves cannot give examples of their integrated, comprehensive plans. She advised that the region needs to identify what it wants to achieve, what it has now and what it does not have and how it will get where it wants to be and not get hung up on the

words. She shared that at the moment, persons at the UN who included the word "Integrated" in a resolution and what they meant by that is not what the region means when it uses these terms.

The participant also wondered what is meant by "health care" or "health services" or "health care services", and what was the difference between "health care" and "health services." Dr. Asin-Oostburg explained that the different interpretation of the terms was one of the reasons for engaging the other sectors - non-health sectors, public sector/private sector, NGOs, etc in the discussion and this was done during the formulation of the strategic plans, programmes, and policy as much as possible. Suriname thought that it was necessary to know how the non-health sector interpreted what the health sector did and these conversations have been very critical to understand how the health sector is perceived and how it is evaluated. Dr Asin-Oostburg stated that the term "health care" has evolved over the time that she has been CMO and it is evident that for some people the term "health care" refers to alternative medicine, and these are critical conversations for the MOH.

Another participant asked how Barbados has dealt with / or factored into its strategic planning process the increased use of complementary and alternative medicine in its chronic care approach because this has been shown to have increased use in Jamaica and the other countries of the Caribbean. Dr. St. John indicated that Barbados has tried to deal with this sector in a structured way. There are steps being taken to develop a Council for Regulation of providers of alternative medicine. At the moment, the provision of some of these services is acknowledged through the Parliamentary Council. Barbados has also involved this sector during the development of the strategic plan by including them at the discussion table in informal ways for a number of consultations including discussions with the faith-based organizations. The providers are also in discussions with the insurance industry so that they can be recognised for reimbursements for the provision of services.

The Chair noted that the health community has been talking about integrated care, about relating HIV/AIDS to chronic diseases, and the need to obtain funding for chronic diseases by piggy-backing on HIV/AIDS activities, and he wondered if the community is doing these things, why are they then leading a charge specifically for chronic diseases. The Chair saw this as a fairly fundamental issue which needed to be discussed at some level, not necessarily at this forum, but it brought up the whole issue of funding for chronic disease.

Dr. Asin-Oostburg responded that the linking of chronic disease activities to HIV has taken place because the funding is not available for chronic disease activities and one has to be creative in how one

gets funding to do what one wants/ needs to do. But she added that it is evident that funding is still necessary and she advised that this is the time to take the lessons that have been learnt, show what has been tried with the few resources available and therefore extrapolate what would be possible if sufficient funding was available. Dr. Asin-Oostburg was of the opinion that now with some success to show, it has made it a little bit easier to get the extra funding and the special funding that is needed for chronic diseases.

Another participant noted that it is necessary to think more about the patient and the health care systems. Chronic diseases do not stand alone and HIV is also chronic disease and that the same behavioural issues that are attendant to HIV are attendant to chronic diseases. She noted that the same health care system that is "a model of care for chronic diseases" is really "a model of care for any patient who enters and leaves the health system". She advised that whatever funding is available, should be used more efficiently to strengthen the health system, recognizing the nuances and differences that have to be taken into consideration and how to work given the limitations of the resources.

POWERPOINT PRESENTATION

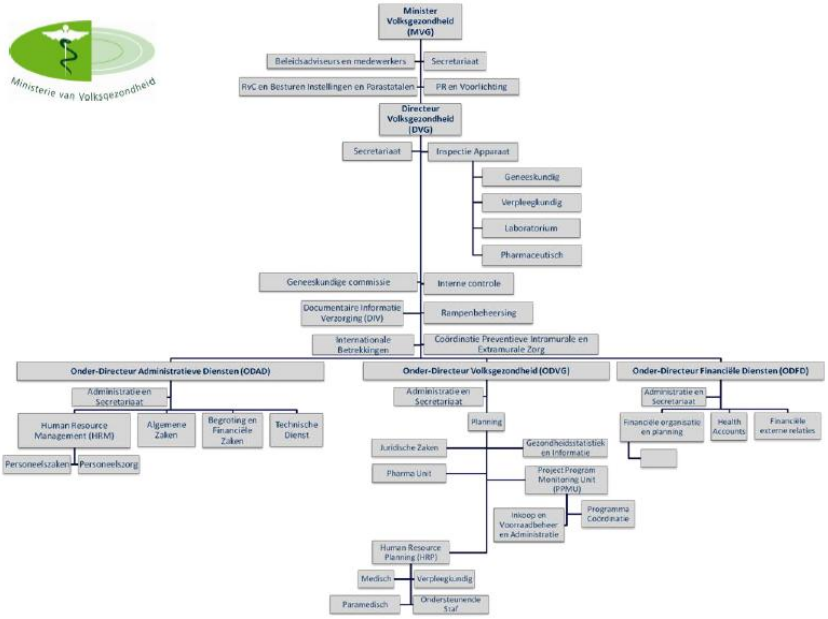
Evidence Based Chronic Illness Care in Suriname

Dr. Virginia Asin-Oostburg
Deputy Director of Health
Department of Planning

Trinidad. September 2010

Conditions

- Policies; Plans; Projects; Programs
- Infrastructure
- Public Health System
- Network
- Funding



Policies and Plans

Bureau of Public Health

Public Health Projects and Programs

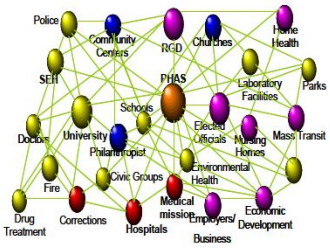
Primary Health Care (MM)

Rebuilding Infrastructure

Upgrading services

Integrated Chronic Illness Care

Public Health System

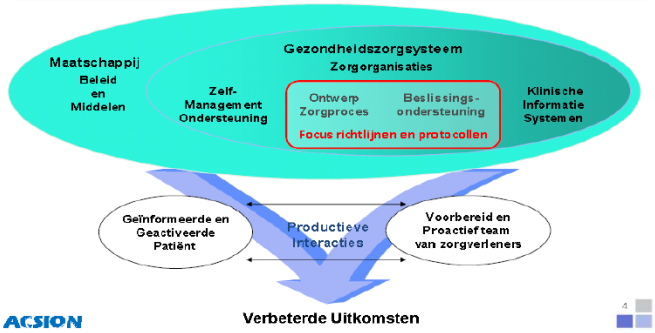


The Chronic Care Model

Chronic Care Model as base for Care Standards

Chronic Care Model is de basis voor Zorgstandaard

Gaat verder dan het klinische besluitvorming



CWD

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Gezondheid s-wandelloop
START
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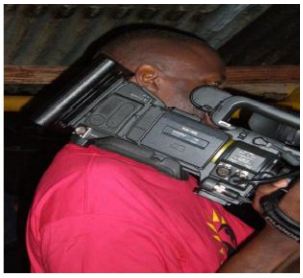


Funding

- REGULAR NATIONAL BUDGET
- AD HOC SPONSORING
- PIGGY BACK ON GRANTS AND LOANS FROM HIV
- NO SUBSTANTIAL GRANTS AVAILABLE FOR NCD

IN ONE WORD FUNDING IS

INSUFFICIENT

NEXT

IMPLEMENT AND SUSTAIN

MONITOR EVALUATE ANALYSE AND DISSEMINATE

OBJECTIVELY STRUCTURED CLINICAL ENCOUNTERS MODEL

PROFESSOR PAUL TEELUCKSINGH

UWI, St Augustine Campus, Trinidad

Professor Teelucksingh began his presentation by noting that by trying to achieve common protocols and common guidelines, the region was making its work easier by not having to duplicate efforts everywhere. He acknowledged the work of CHRC, which has been a pioneer in leading the way to developing common protocols and guidelines.

Professor Teelucksingh explained that his presentation would describe a different approach to the delivery of clinical services for NCDs.

He asked the meeting to refocus its attention on Item 5 of the Port of Spain Declaration which has three prongs i) screening, ii) prevention and iii) the care and management of persons with chronic diseases. He stated that his presentation would deal with the high risk population of those who already have chronic diseases and the secondary prevention of this group of people, whose care cannot be ignored.

Professor Teelucksingh then described the linear care model that currently operates: "People come to our clinics, we think that we provide patient-centred care, have them congregate for hours in the waiting area to see the doctor". He identified the difficulties/ dysfunctionality of this linear model as long waiting times, high levels of idle time when the patient is waiting, with little opportunity for self education. Professor Teelucksingh referred to and supported Dr. Hospedales' statement of the importance of self-management and education and the positive outcomes these have on chronic disease management. Professor Teelucksingh continued that audits and evaluation of the current methods show the inadequacy of care, with less than 5% reporting fundoscopic notes or foot examination. He stated that if these examinations are being done, they are not recorded in the notes.

Professor Teelucksingh then described the circular model of care. The circular model allows the patient to enter the circle at any point with the circle expanding as necessary. The rationale is that any encounter can be broken into a number of smaller encounters, each complete on its own and that when added together gives a value that is greater than the sum of its parts. This immediately indicates the inherent advantage of the circular model.

Professor Teelucksingh stated that the circular model can be applied to HIV, or applied to the metabolic syndromes which really is the burden of what is being discussed here (the combination of diabetes, hypertension, dyslipideamia, the propensity for heart disease, strokes, peripheral vascular disease, kidney disease).

Professor Teelucksingh then described specifically the interactions that can take go into these small encounters.

i) Basic anthropometry (height, weight, BMI and waist circumference) and the inherent value of waist circumference in screening for CNCD diseases is known.

ii) At some stations there can be higher levels of testing – point of care testing for micro-albuminaemia which are predictors of heart disease, albumin urea and creatinine, HbA1C - can be done on site, and this gives added value to your encounter.

iii) The value of fundoscopic examinations being routinely done is well known and these need not be done by doctors. Persons with lesser training can be trained to use a fundoscope or use the visual acuity charts as screening tools.

iv) Specific encounters can include the examination of the feet, feeling the pulses, etc. Again it is not necessary for doctors or nurses to be doing these examinations, since persons with only very low level training can be trained to do these examinations and can produce useful outcomes.

v) The doctor remains an important part of the team. In the region, often the doctor gets called away to do something or has to go somewhere else and the clinic closes down and it is an opportunity lost.

vi) This particular model encounter allows the health system to deliver information and education by setting up stations that are interactive so that down time can be used productively.

Professor Teelucksingh then summarized some of the advantages of the circular model:

- It is gestaltic in that the whole is greater than the sum of its parts.
- It can be adapted to the individual environment. It allows creative solutions to local problems and the health providers can determine relevant interventions.
- There is less idle time for patients.
- There are opportunities for teaching and learning.

- It can be designed to be objective so that if one can define a particular task, it can be evaluated. Objective data can be collected and the system audited.
- The delivery of related care can be organised.
- Finally, it allows for screening. That is someone can walk right off the street and request to be screened. A person does not have to have a disease to be in this model.
- The health system can set the minimum level of encounters that it will deliver and the quality of product that it wishes to deliver. One can have 5 encounters or 7 encounters, or 20 model encounters. One can devise a strategy to achieve the encounters and determine what interventions are relevant.
- The level of training that is required for the persons working in the system is low as are the entry requirements (possibly 5 O' Levels). People doing the same task repetitively can become very good at their tasks. Each encounter can be broken down into small tasks, splitting each into well-defined perfected encounters.
- Portable technology now allows for blood test results in 5 minutes at relatively low cost (USD$5). Using the OECS example of pooling of resources and ordering in bulk could result in even lower costs.
- This system allows focus on foot examination, which the audits have shown are often ignored.
- Emphasis on Physical Exercise. The meeting has spoken about written prescriptions for physical exercise. Professor Teelucksingh felt that if exercise is written into a prescription, it will not be done, but the health system must show how the physical exercise can be done and include a role for a physical exercise therapist and include a small room for training of patients in physical exercise.
- Getting Feedback is critical to build a good, robust system and the system needs to include asking the patient "Tell us what we may do to please you?"

Professor Teelucksingh identified the next steps as follows: Each country would need to look at its local environment and see what is required. He stated that this is a low cost system, a low cost intervention which requires the re-engineering of the processes to deliver care. He also indicated that it has been tried and tested. He said that medicine has been slow to adapt but industry, telecommunications, traffic management also use this model and this is how traffic flow patterns are studied and how traffic is regulated. He stated that if patient flow improves, more patients would be provided with quality care, and that is what has to be achieved.

Discussion

One participant stated that it was an interesting presentation but given the limited opening hours for providing service and usually 8:00 a.m. - 4:00 p.m., he wondered how many more patients can one serve in a day. Professor Teelucksingh indicated that when the circular model is utilised, it will be noted that efficiency will improve and the number of encounters will definitely increase. He stated that he has seen the difference in his 10 years of experience dealing with medical students' examinations. It took three times as long to complete the same exercise when the university used the linear model as when it used the circular model. Thus it is possible to see three times as many people in the same time with the circular model.

Another participant commented on the point made earlier about the missed opportunities, given the limited 8-4 hours of service at most clinics. She explained that Barbados tried extending the non urgent, non emergent care outside of traditional hours and a fast track service that runs in parallel and extended hours from 10 a.m. to 10 p.m. in two locations, but encountered great difficulty with providing sufficient parallel staff. She also observed that the patients self selected so that while the modifications solved the patients' problems for a period, additional problems develop. There is also the difficulty of the interpretation of the staff at the various sites and this re-emphasised the need for standarisation with models of treatment and determination of what services are to be delivered at each location. The Barbados representative stated that it is very costly and that getting the resources – human and financial - are challenges.

A question was asked about the use of an appointment system in the diagram of the circular model, and the participant wondered how this is intended to work and if this would necessitate a telephone call. He also observed that nurses with whom he had discussed the introduction of appointment systems at the clinics were not supportive of this, preferring that persons walk in and are all seen by 12 noon so that the afternoons are free of direct patient care. Professor Teelucksingh responded that an appointment system should not be a barrier to entry for care and its use would depend on local conditions. In Trinidad, for example, the phone system is not used to make appointments in the public sector at the tertiary care system unless these are re-visits. Generally people access the clinics either by a referral system from general practitioners or they walk in off the streets.

A further observation was made that the appointment needed to be more specific than what currently applies (6 May at 8), with the patient being given an hour and minute so that there would be a need to

conduct a time and motion study to know how to make the appointments. This might also require two persons at some stations depending on what length of time it takes to provide each type of service.

Professor Teelucksingh suggested that it was possible to train staff effectively and standardize the procedures, conduct time and motion studies and assess patient flow. He stated that it is possible for simple tasks to use lesser qualified staff and train them to do these simple tasks, standardising the procedure. At the UWI, it has been found that a 5 minute encounter at any one of these stations provides more than enough time to evaluate a patient.

It was noted that the model could work at different settings – primary or secondary care. If this model was operating at the primary care level, and a serious medical problem was identified, then the patient would be referred to a specialty clinic. Another suggestion made was for the model to include a few additional arrows, including showing the community aspect and what would happen when a high risk patient was identified. It was suggested that the doctor may only be needed in a high risk clinic, while in the model for the primary setting, the patient would then be referred to another setting.

It was noted that re-training / re-orientation of health care workers would be critical for the operation of such a model.

A comment was made that it would be useful for best practices in the region to be recorded, because there are a number of interesting initiatives being undertaken in the region. For example, the Clinton Foundation is looking at health initiatives involving studies of patient flows and reconfiguration of the infrastructure. For such a patient flow to work, it would require a substantial amount of reconfiguration of the infrastructure since many of the region's existing facilities cannot manage such a service. It came back to the need for re-engineering of the health services. The challenges that are faced in the health care system have evolved and are often located around opportunities for time spent with patients and the number of patients seen. The challenges include that of work ethic - Staff want to work at specific times and there has to be a change in the work ethic. The health system has lost the community nurses and diabetic nurses and there is need to entirely reengineer many of the structures that are in place, if the health system is to tackle HIV, CNCDs in a more holistic manner.

Another participant observed that in assessing the health services, one often neglects the role of workers over time, that is, if there is a patient care team working in a community looking after a fixed population over an extended period, one often does not need all the steps in the model, since some of these

assessments will only need to be once in six months. A stable health care team would also establish long term relationships with the patients, and this is what patient-centred care means - working as a health care team with a relationship with the patients, as in the relationship model of family medicine which talks about relationship to get change over time. If every time the doctor and nurse work, they meet a patient for the first time, they will not have established a relationship and one cannot change behaviour in the absence of relationships.

A comment was also made that given the estimate of 5 minutes per encounter, it is not possible for one doctor to examine 12 patients in one hour.

A participant shared that a time and motion study conducted in Jamaica showed that a bottle-neck happens for visits to the doctor and then to the pharmacist. With the circular model described, the system would again become a linear one around the doctor and the pharmacy.

A participant provided an example of a patient flow arrangement with a description of a similar service in Japan which might be applicable. This model did not include a doctor as an encounter. The person would go a thorough screening (body check), health education, video presentation, etc, and then there is a decision made but no treatment is provided. If necessary there is a referral to a specialist clinic. This circular model was really a sophisticated diagnostic screening model.

The Chair commented that this model would result in the shifting the doctor's role from fundamentally being a 'gate-keeper' which is an interesting concept.

POWERPOINT PRESENTATION

Yes we can,

Do better.

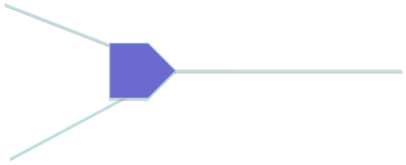
S. Teelucksingh
MBBS (UWI), MBA (UWI), PhD (Edin.), FRCP(E)

THE UNIVERSITY OF THE WEST INDIES
AT ST. AUGUSTINE, TRINIDAD AND TOBAGO

Friday 27th August, 2010

Current Situation

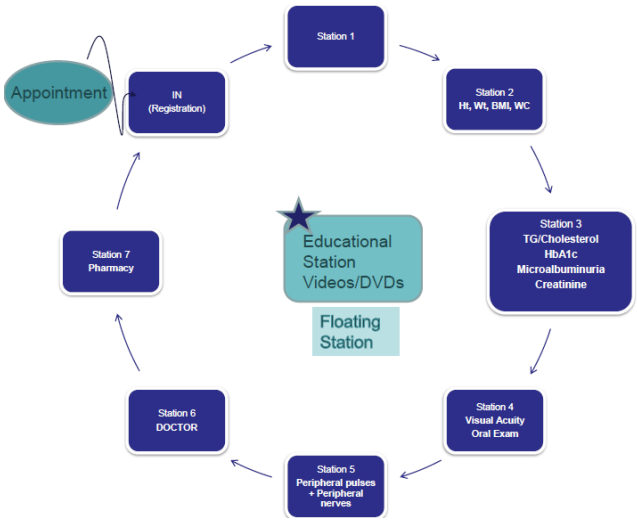
- Linear Model



Disadvantages

- Long waiting times
- High level of idle time
- Little opportunity for learning/self-education
- Incomplete Evaluation

Gulliford et al; Pinto Pereira et al



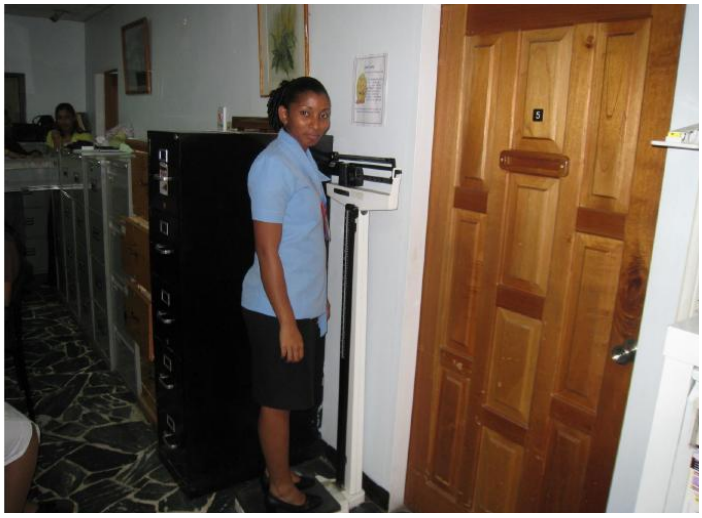
Advantages

- Whole becomes greater than the sum of its parts
- Adaptable to most environments
- Allows creative solutions to local problems / local constraints
- Less idle time
- Opportunity for teaching/learning
- More thorough evaluation
- Objective data collection allows audit
- May be enhanced by technology but not necessary
- Allows for screening

Encounters of between 7 to 20

Obligatory Encounters

- Registration / Appointments
- Blood pressure
  Height
  Weight
  Waist Circumference
- Foot Examination
- Eye Examination
- Doctor
- Pharmacist



Amaryl

Feedback

The next steps

- Retraining / Recertification
- Re-engineering
- IT Platform
- Audit

IDB-FUNDED REGIONAL PUBLIC GOOD PROJECT

Regional Non-Communicable Diseases Surveillance System for the Caribbean

Dr. Rohan Maharaj
Public Health and Primary Care
UWI, St Augustine Campus, Trinidad
and
Ashish Bhatt
Consultant Software Engineer, CARICOM NCD

The general objective of the project is to develop a Caribbean Regional Non-Communicable Diseases Surveillance System to better plan, deliver and monitor programmes and protocols targeting chronic disease prevention, control and health promotion.

The project focuses on NCD component of the Caribbean Cooperation in Health (CCH) initiative, and the mandate of Declaration of Port of Spain: Uniting to stop the Epidemic of Chronic NCDs, which states that:

> *"we will establish, as a matter of urgency, the programmes necessary for research and surveillance of the risk factors for NCDs with the support of our Universities and the Caribbean Epidemiology Centre/Pan American Health Organisation (CAREC/PAHO)."*

The IDB-funded Regional Public Good project is based on three pillars: data, IT infrastructure, protocols and policy and protocols. The Chief Medical Officers of the six participating countries decided on the main focus of the project during a videoconference in August 2007. The CMOs form the project's Steering Committee. The project agreement was signed between The University of the West Indies and the IDB in May 2008 and a Project Coordinator was hired in September 2008. By February 2009 letter agreements were signed by the six participating countries and CAREC, signalling the start of the implementation phase of the project.

The project facilitated CAREC's work with the six countries on the development of a Minimum Dataset, and also hired Dr. Juan Carlos Zevallos, Consultant Epidemiologist, to undertake a gap analysis with respect to NCD surveillance in the six countries.

Key findings from gap analysis

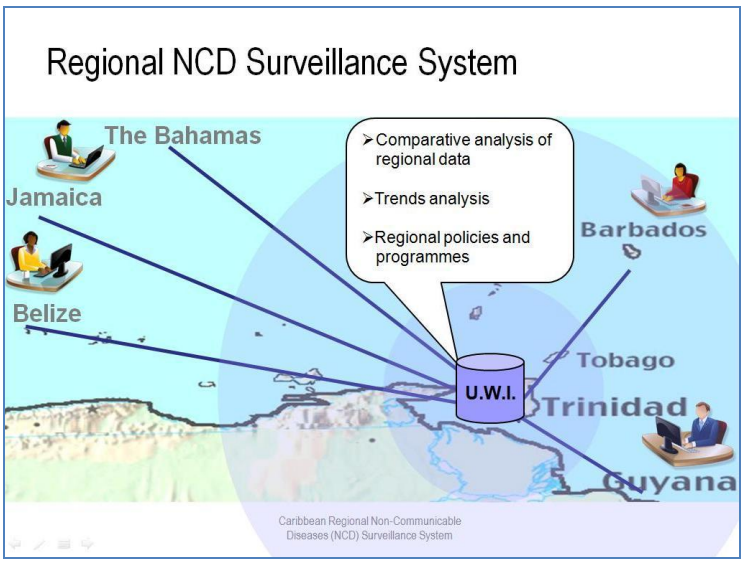
- Lack of data; reliability and validity
- Paper-based (manual) data collection, processing and reporting
- Lack of standard instruments for NCD collection and reporting
- Data management system not integrated

The Consultant Epidemiologist also recommended the development of an interactive web-based surveillance system for the region.

The third pillar of the project relates to the development of Policy and Protocols, and this Regional Consultation is part of that pillar. The Declaration of Port Of Spain provides that:

> *"our Ministries of Health, in collaboration with other sectors, 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 NCDs would receive quality care and have access to preventive education based on regional guidelines".*

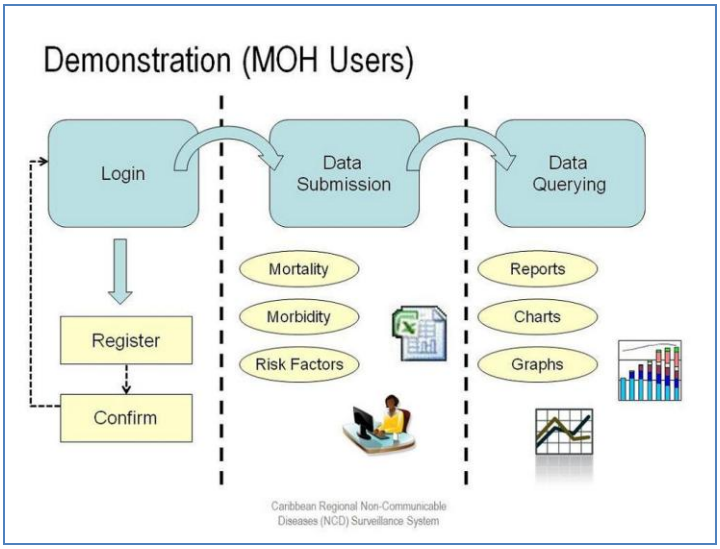
IT Component



An overview of the IT system was given. At the core of the system is a central data repository, residing in the UWI St. Augustine campus in Trinidad. All beneficiary countries will access this repository via a web based user interface for submitting and querying data.

A review of the specification of the IT system was provided. The initial specification had some general requirements including: being a web-based regional surveillance system to promote usability and accessibility, whereby the system could be accessed from virtually anywhere in the world, national data capture, national and regional data reporting, and having a user-friendly, methodological and intuitive user interface.

A high level project plan was presented. The IT component of the project started in February 2010. Design and development of the IT system has been completed, and maintenance and support will continue until May 2011. The IT system is currently entering the implementation and evaluation phase, and simultaneously it is expected to go through evolution as the system grows and is used over time.



A demonstration of the system was given from the perspective of the Ministry of Health (MOH) users. The demonstration goes through a three step process: starting with online registration and login, confirming registration is done via email, and logging into the system is done using a valid email identification, once registration has been confirmed. On login the MOH user will have access to various data submission tools, where it was demonstrated that data can be manually entered via an online form, or uploaded using a spreadsheet upload tool. Once data was submitted into the system it was

demonstrated that data can then be queried using a methodological and intuitive data query tool for generating reports.

Additional administrative features were also presented including: online forms creation tool (accessible to system administrators) used for creating additional data submission forms, in the event that the system may need to cater for an increase in the scope of data being captured in the future, data access permissions tool (accessible to all users) used for granting privileged access to the data submitted to user groups and individual users, and user group management tool (accessible to system administrators). The system data security framework was also presented, where the various levels of data security were outlined and it was shown that the ownership of data submitted into the system remains with the user groups submitting the data.

A review of the features demonstrated was given as follows:

- Web-based system
  - Allowing for user accessibility
- Central data repository
- Secured user access
  - Online registration & confirmation
  - Access via login Id and password
- Online data capture forms
  - User friendly data reporting
- Spreadsheet data upload tool
  - Facilitating the data submission process
- Ad-hoc, interactive and intuitive query tool
  - Allows registered members to build and save queries
- Data access permissions tool (security feature)
- Online data capture forms creation tool
- Group membership administration tool (security feature)

A "wish list" of features that have been generated through the interactions with the project steering committee were presented as follows:

- Graphical representations for data reporting
- Online forms to capture "raw" data
- Geographical Information System (GIS) type reporting

- Suggestive analyses and trends across categories
- Integrated communications platform

Discussion

One participant expressed excitement at knowing that the Caribbean would have its own database on NCDs. Introducing this system in the Caribbean would highlight the weaknesses of data collection in the 6 countries. It was therefore important to strengthen the national surveillance system for NCDs. The region has less than a year to come up to speed since the project ends in May 2011. One participant wondered whether there were there adequate resources for this, and what assistance would the project lend to that effort, and what would happen after that. Who was going to lead the initiative of strengthening and streamlining the national systems? We need to provide a standard for national NCD surveillance system. The project was a wonderful idea.

A member of the UWI project team responded that the project has recognised and built on CAREC's work with countries on collecting data. The Project team will look for future funding to assist countries in improving their national data collection systems.

A participant from Barbados stated that has used the results of the Gap Analysis to study the weaknesses of its internal surveillance systems and see where improvements are required. The gap analysis carried out by this project along with another evaluation carried out by CAREC have provided the business case to source the resources and funds to initiate improvements at a national level.

One participant wondered whether an interactive communications platform could be integrated into the online system to facilitate discussion and comparisons of data within countries.

One participant from an OECS country stated that that OECS countries were "left out", and he wondered whether they could have access to the web-based surveillance system it or benefit from it in any way. A member of the UWI project team responded that the Project would like the system to become a CARICOM one. What data goes in is the same data that CAREC receives from the countries. It is housed at present at UWI St Augustine.

It was clarified that data ownership resides with Ministries – those who put the data in. The public will be able to use that data.

It was suggested that this project provides the opportunity for all CARICOM countries to standardise their data collection and validation processes, and training across the public health sector to collect valid and reliable information the first time.

Participants wondered about version control. Someone has to be the arbitrator or validator who would give the final sign-off. i.e. who would say that this is valid data. One participant enquired about the security of the data management processes – how is this going to be managed. He pointed out the possibility of persons hacking into the system or corrupting the data. The project's IT professional responded that several different levels of security were built into the system. At this stage the project is not expecting or requiring the countries to change their internal IT systems and conform to any new standard of data submission. The IT system developed by this project intends to interface with the existing national surveillance systems. Any further requirements especially with respect to sharing and communicating information between countries within the region will be considered as the system evolves.

One participant commented that Universities do not often become involved in surveillance. He wondered whether the system would go to CARPHA or CAREC after the project ended. He added that there was obviously a need for a system such as this. He also raised the issue of further funding after this project ended in May 2011. He suggested that severe morbidity (renal failure, blindness, amputations) and risk factors could also be incorporated into this project at a later stage.

The representative of CAREC stated that at the moment countries submit data to CAREC/PAHO. PAHO then forwards this information to WHO. Only then does the data become public domain. CAREC is not at the stage where it allows countries to input data directly into any system. The issue of quality control is critical. CAREC works with the countries to ensure the validity of the data before that data can be reported to PAHO. Independently of this system, CAREC will still require countries to continue to report data to CAREC through the existing mechanisms that are in place at this time. Most countries have already reported on the Minimum Dataset and CAREC is now in the process of validating this data. Systems are being developed so that data can be seamlessly transferred between CAREC, PAHO and WHO.

Participants stressed the importance of information ownership policies. The Chairperson of the project's Steering Committee (the CMO Barbados) stated that the Steering Committee has considered

these very questions. The Steering Committee saw the power of this tool. It also saw the disconnect between UWI as a learning institution, and CAREC being the lead institution in the region for surveillance. The Steering Committee wanted ownership to reside with CARICOM. Barbados has a national policy framework which allows it some flexibility within limits. The Barbados CMO stated that the power of this tool fascinated her more than its dangers. She stated that the 6 countries that have enjoyed the process this far have recognised the benefits it can bring to the region as a whole. Barbados wanted more clarity on the regional perspective on ownership.

The CMO Jamaica agreed with CMO Barbados. She hoped that eventually there could be agreement on a single repository, which may not be located where it conventionally resides. She agreed there should be clarity not only on ownership but also on its operation and management.

The project's IT professional pointed out that there could be synergy between 2 systems, keeping in mind that each would be customised to the needs of their particular organisations. Both would evolve in their own directions.

It was suggested that there should be established a single regional standard by which all countries can submit data, irrespective of their own customised models for data collection. A forum to agree on such a standard should be established.

Participants wondered how this information was going to be used for improvements at a national level. They stated that assistance is required to define policies and legislation at the national level. One participant stated that this is an excellent system but it must merge to some extent with the existing CAREC system. He stated that a merger between this system and the existing CAREC systems seemed a natural progression that should be considered by the project.

The University of the West Indies

Regional Non Communicable Diseases Surveillance System Project

An IDB Regional Public Goods (RPG) project

CARIBBEAN REGIONAL NON-COMMUNICABLE DISEASES SURVEILLANCE SYSTEM PROJECT

Overall Objective

To develop a Caribbean Regional Non Communicable Diseases Surveillance System to better plan, deliver and monitor programmes and protocols targeting chronic disease prevention, control and health promotion.

CARIBBEAN REGIONAL NON-COMMUNICABLE DISEASES SURVEILLANCE SYSTEM PROJECT

The UWI's Mission

To propel the economic, social, political and cultural development of West Indian society through teaching, research, innovation, advisory and community services and intellectual leadership

CARIBBEAN REGIONAL NON-COMMUNICABLE DISEASES SURVEILLANCE SYSTEM PROJECT

The UWI's Core Values

- Commitment to the pursuit of excellence
- A keen sense of individual and social responsibility
- Respect for cultural diversity and the rule of law
- Multidisciplinary and interdisciplinary collaboration
- Ethical values, attitudes and approaches
- Community service, involvement and dedication to regional development

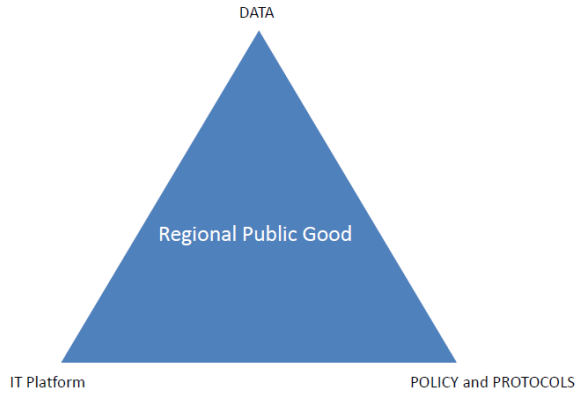
CARIBBEAN REGIONAL NON-COMMUNICABLE DISEASES SURVEILLANCE SYSTEM PROJECT

DECLARATION OF PORT-OF-SPAIN: UNITING TO STOP THE EPIDEMIC OF CHRONIC NCDs

That we will establish, as a matter of urgency, the programmes necessary for research and surveillance of the risk factors for NCDs with the support of our Universities and the Caribbean Epidemiology Centre/Pan American Health Organisation (CAREC/PAHO).

http://www.caricom.org/jsp/communications/meetings_statements/declaration_port_of_spain_chronic_ncds.jsp

CARIBBEAN REGIONAL NON-COMMUNICABLE DISEASES SURVEILLANCE SYSTEM PROJECT



CARIBBEAN REGIONAL NON-COMMUNICABLE DISEASES SURVEILLANCE SYSTEM PROJECT

MILESTONES

- 2007: Convergence of ideas- UWI; MOH's; IDB; Sir George Alleyne
- AUG 2007: Teleconference- agreement on need for data generation and use
- APRIL 2008: Inaugural Steering Committee
- MAY 2008: UWI and IDB sign agreement
- SEPT 2008: Project Coordinator hired

CARIBBEAN REGIONAL NON-COMMUNICABLE DISEASES SURVEILLANCE SYSTEM PROJECT

MILESTONES

FEB 2009: The 6 participating countries and CAREC/PAHO signed agreements with the UWI

APRIL 2009: 2nd Steering Committee meeting, St Lucia

JUNE 2009: Commencement of Gap analysis

FEB 2010: Commencement of IT platform

APRIL 2010: 3rd. Steering Committee meeting, St. Augustine

APRIL 2009: 2nd Steering Committee meeting, St Lucia

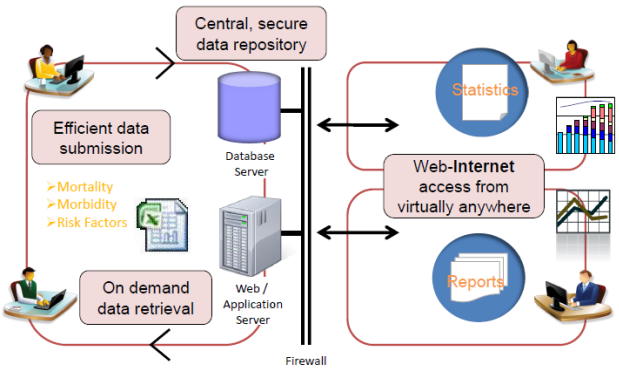
CARIBBEAN REGIONAL NON-COMMUNICABLE DISEASES SURVEILLANCE SYSTEM PROJECT

DATA

- Minimum Data Set
  - CAREC/PAHO
- Six country Gap analysis
  - Lack of data; reliability and validity
  - Paper-based (manual) data collection, processing and reporting
  - Lack of standard instruments for NCD collection and reporting
  - Data management system not integrated

CARIBBEAN REGIONAL NON-COMMUNICABLE DISEASES SURVEILLANCE SYSTEM PROJECT

IT Platform



CARIBBEAN REGIONAL NON-COMMUNICABLE DISEASES SURVEILLANCE SYSTEM PROJECT

POLICY and PROTOCOLS

Declaration of Port Of Spain

That our Ministries of Health, in collaboration with other sectors, 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 NCDs would receive quality care and have access to preventive education based on regional guidelines

http://www.caricom.org/jsp/communications/meetings_statements/declaration_port_of_spain_chronic_ncds.jsp

CARIBBEAN REGIONAL NON-COMMUNICABLE DISEASES SURVEILLANCE SYSTEM PROJECT

POLICY and PROTOCOLS

- September 2010: Regional Consultation hosted by the UWI St. Augustine Campus
- **Objectives:**
  - produce the first draft of a Chronic Care Model of care for the region
  - produce the first draft of an updated CARICOM Primary Health Care policy
  - identify mechanisms for implementation of POS Declaration Item#5 (improving quality of care for persons already living with NCDs)

CARIBBEAN REGIONAL NON-COMMUNICABLE DISEASES SURVEILLANCE SYSTEM PROJECT

RPG/IDB PROJECT

- **Opportunity to build *de novo* a regional data system**
- **Opportunity to involve all CARICOM nations**

CARIBBEAN REGIONAL NON-COMMUNICABLE DISEASES SURVEILLANCE SYSTEM PROJECT

GOVERNANCE OF PROJECT

- "Ownership" by Chief Medical Officers of Health
- Focal Points nominated by each CMO
- Project Coordination Unit at the UWI
- Communication:
  - Consultation and feedback mechanisms
  - Decision-making by consensus

CARIBBEAN REGIONAL NON-COMMUNICABLE DISEASES SURVEILLANCE SYSTEM PROJECT

OPPORTUNITY TO DEMONSTRATE WILLINGNESS TO COOPERATE

NOT AN END.. *BUT A BEGINNING!*

CARIBBEAN REGIONAL NON-COMMUNICABLE DISEASES SURVEILLANCE SYSTEM PROJECT

FRAMEWORK FOR REVIEW OF PRIMARY HEALTH CARE POLICIES IN THE CARIBBEAN

First Draft - Chief Medical Officers

Background

Although CARICOM Member States have made important advances in health and in implementing Primary Health Care (PHC), persistent health challenges remain among and within the countries of the Region.

The Declaration of Alma-Ata continues to be valid in principle; however, rather than PHC being implemented as a separate program or objective, its core ideas should be integrated into the health systems to address new challenges such as epidemiological and demographic changes, social determinants of heath and increasing health care costs.

We must recognize the complexities of multiple determinants of health status, the impact of societal attitudes and values, the diversity and sociopolitical and historical contexts, and the socio-political-environmental interplay between the individual and society. Thus there is the need to address basic health determinants within communities (e.g., nutritious food, primary education, safe water, decent housing, secure employment, adequate income, and a non-violent community)

History of Cooperation

The Caribbean already has a strong history of successful cooperation in health including the eradication of poliomyelitis, measles and rubella. The Caribbean Cooperation in Health now in its third iteration (CCH3), is a mechanism to unite CARICOM countries in a common goal and strategy to improve health and wellbeing.

The goal is a coordinated, effective and sustainable strategy to tackle existing health problems, meet new health challenges and improve health equity.

CARICOM member countries (CMC) should strengthen PHC within their national health systems, health management, organization, financing, and care to contribute, in concert with other sectors, toward comprehensive and equitable human development, to effectively address the mandates from the

CARICOM Heads of Government and the from COHSOD (Council for Human and Social Development), Caribbean Cooperation in Health (CCH3) and health-related Millennium Development Goals (MDGs).

CMC should prepare a PHC action plan within a stated time frame including criteria for its evaluation.

Elements of the PHC Policy and Plan

I) Commit to facilitate social inclusion and equity in health.

a) Universal access to high-quality care for the highest attainable level of health.
b) Eliminate organizational, geographic, ethnic, gender, cultural, or economic barriers to access, and develop specific programs for vulnerable populations.

II) Recognize the critical roles of both the individual and the community in the development of PHC-based systems

a) Strengthen local-level participation in the health system by individuals and collectively by communities to provide them a voice in decision-making,
b) Strengthen family-oriented health polices and services over time.
c) Make information on health programmes and outcomes and PHC performance available to communities for exercising oversight of the health system.

III) Utilize health promotion, and comprehensive and integrated care approaches.

a) Include health promotion, disease prevention, population-based interventions and comprehensive integrated care.
b) Health care models based on effective primary care systems, have a family and community orientation, incorporate the life cycle approach, be gender and culturally sensitive,
c) Strengthen bidirectional linkages between primary, secondary and tertiary levels and work for the establishment of health care networks which include the private sector
d) Strenghten the coordination among social services in and out of the health system that ensures continuity of quality and effective use of resources .

IV) Develop intersectoral work.

a) Facilitate coordinated and integrated contributions from all sectors at all levels including the public, NGO and private sectors, involved with the determinants of health

V) High Quality Service Delivery - Orientation toward quality of care and patient safety.

a) Provide appropriate, effective, and efficient care including the dimensions of patient safety and consumer satisfaction.

b) Enhance processes of continuous quality improvement and quality assurance for clinical, preventive, and health-promoting interventions.

VI) Strengthen of human resources in health.

a) Incorporate PHC practices and modalities in the development of all levels of educational and continuous training programs

b) Recruitment and retention practices (paying attention to WHO code) to include motivation, employee advancement, stable employee-centered work environments, and facilitate contribution to PHC.

c) Utilize a team approach including professionals and paraprofessionals, formal and informal workers.

VII) Strenghten Institutional Capacity that allow PHC renewal.

a) Implement appropriate policies, legal and institutional frameworks for a streamlined, efficient ,effective and responsive health sector organization including the response to disasters, epidemics, or other health care crises.

VIII) Guarantee financial sustainability.

a) Achieve sustainable financing for PHC systems

b) Provide a basic package of essential services sufficient to meeting population's health needs, with the support of international cooperation agencies.

IX) Research

a) Research to support evidence-based planning and management of health systems, ongoing monitoring and evaluation, sharing of best practices,

X) Utilization of Appropriate Technology including e-Technology

a) Development of information systems platform applicable to national context

b) Surveillance needs in NCD risk factors, communicable diseases, injuries, occupational health and mental health

XI) Strengthen international partnerships in support of PHC.

a) PAHO/WHO and other international cooperation agencies can contribute to the exchange of scientific knowledge, development of evidence-based practices, mobilization of resources, and better harmonization of international cooperation in support of PHC.

Strategic Reforms

The PHC reforms necessary to refocus health systems towards health for all

- ***Universal coverage reforms***: Health systems contribute to health equity, social justice and the end of exclusion, primarily by moving towards universal access and social health protection

- ***Service delivery reforms:*** Reforms that reorganize health services as primary care, i.e. around people's needs and expectations, so as to make them more socially relevant and more responsive to the changing situations while producing better outcomes

- ***Public policy reforms:*** Reforms that secure healthier communities, by integrating public health actions with primary care and by pursuing healthy public policies across sectors

- ***Leadership reforms*** : Reforms that are inclusive, participatory and utilize negotiation-based leadership required by the complexity of contemporary health systems

- **Community Participation reforms:** Reforms that are inclusive of fostering Public – Private Partnerships in planning and implementation

Programme Management and Coordination

1. Revise and implement national PHC plans and programmes within an integrated health system approach, emphasizing intersectoral action, and an organized system of care.

2. To develop participatory services and programs, health care professionals must embrace the value of multidisciplinary and interdisciplinary approaches for individuals and communities.

Health Policies

- Health Policies and Plans
- Social Exclusion and Social Protection
- Ministry of Health Steering Role Capacity

Health Investment and Financing

- Strategic Fund
- Health Economics and Financing
- Health Legislation

1) **Types of services provided**
   a) health promotion, health education, screening and health care interventions, rehabilitation) to the individual, family, community
   b) rights of access must be balanced with protection from unsafe, ineffective, and poor quality services and products.

Technologies and Medicines

- Blood Services
- Radiological Health Program
- Essential Medicines and Biologicals

Health Services and Programmes

- Health Services Physical Infrastructure and Technology
- Patient Safety

2) **Target populations**
   a) by age / life-cycle, vulnerable groups (poverty, sex workers, prisoners, long term institutionalized persons, differently-abled persons, migrants, indigenous and other sub-cultures)
   b) Educate and facilitate patients to shift from being passive recipients of care to becoming empowered, active participants recognizing their individual responsibility for health

c) maximize their relationships with providers across disciplines in the health care system and embrace partnership relationships with clients and their communities

d) use of participatory methods throughout the educational, practice, research process for the purpose of empowerment and emancipation

3) **Type of provider**

a) Public Health Nurse, Midwife, RN, physician, nutritionists, dental, podiatrist and community health worker, traditional healers, Complementary practitioners

i) appropriate numbers, training and mix of staff

ii) improve teamwork and knowledge sharing across disciplines

b) leadership and vision

Development of Human Resources for Health

- Virtual Campus in Public Health
- Medical, Nursing and other Health Professionals curriculum and education
- Regional Observatory of Human Resources in Health

4) **Mode / setting of service delivery**

a) health facility, Health NGO facility, private sector, community, home, school, faith-based organizations, workplace, institutions

- Integrated Networks, including hospitals
- Organization and Management
- Emergency and Disaster Response
- Mental, Dental and Eye services

5) **Measurement criteria and issues**

a) Accessibility, affordability, availability, applicability, acceptability, equitability

i) Access – cultural, physical, structural - geographical, physical (ramps) temporal, literacy level, risk of violence

b) Methodological issues (qualitative, quantitative, evaluation, or methodology)

i) ownership of the data

ii) evaluation of both inputs, processes, as well as the short- and long-term outcome

Health Research

- ssential Public Health Functions (EPHF) Evaluation
- Health Systems Performance Analysis
- Health Research Promotion and Development
- Comparative Analyses of Health Sector Reform
- Health Sector Analysis
- Health Systems Country Profiles

Primary Health Care Policies and Model of Care for the Caribbean Community

CMO Discussion Points

The CMOs felt that, in spite of the many similarities in health concerns in various Caribbean countries, sufficient diversity exists in terms of health financing/access to care; geographic distribution of population (hinterland populations and their peculiarities); adoption of other policies locally etc. Therefore, rather than prescribing a "one-size-fits-all" model to be adopted by all countries, work should focus on producing a "Framework for Renewing Primary Health Care Policies in the Caribbean" whose goals include

- Improved Health, Enhanced Equity, Sustained Development
- Resource Mobilization

Member states could use this tool to initiate or augment or modify the policies which currently determine national *Primary Health Care* priorities.

In conceptualizing the Framework, CMOs felt it was important to

- Recall the health gains in the region driven by PHC
- Note the transitions in epidemiology and demography
- Reaffirm the value solidarity and the history of regional cooperation in health now articulated in a "projectized" phase 3 of the Caribbean Cooperation in Health
- Identify key constraints to the performance of national health systems such as leadership styles and decision-making methods, relatively weak information systems, and gaps in available human and financial resources relative to prevailing health needs.
- Reaffirm the benefit of a PHC-based health system and acknowledge the global momentum towards the same

CMOs agreed that strengthening Primary Health Care was the most effective and efficient way of improving the health of the population. Achieving that goal requires an investment of public funds plus intersectorial and community action. Other line ministries of government and civil society are indispensable partners in primary health care and health promotion implementation. Nevertheless, it is the Ministry of Health's role to lead in the implementation of the following activities that empower and individuals, families and communities to improve healthcare behaviours and status thus reducing the burden of ill-health:

- Addressing Social Determinants
- Use of Health Promotion strategies to prevent and control priority health burdens
- Use of Primary Health Care elements in health service development, management and coordination
- Benchmarking performance against the Essential Public Health Functions (system performance monitoring and evaluation)

Discussion on guidelines for the establishment of Chronic NCD Commission

The discussion focused on the following key issues:-

- Why is it after 3 years there are so few Commissions in the region?
- What was the purpose and intent of the Commission?
- And therefore, is a commission the best mechanism?
- Why should it be a one size fit all?
- Can each country support a commission and like Barbados, in separate Commissions for Chronic Disease, mental health etc,?
- Where is the critical mass to drive it?
- Where is the interest to drive it?
- What does the country needs to push the issues related to chronic disease?

A suggestion was made that the countries could consider an Inter-sectoral Commission on Health and given the particular health focus, use some of supports from the Inter-sectoral Commission to drive some initiatives, e.g. for chronic diseases.

The relationship between Commissions and MOH was also discussed. The Jamaica example was seen as a useful option where there is a **Central Board of Control** which is recognised in the legislation and is

therefore a powerful supporting tool to insert the issue of chronic diseases so that there is a commission that works.

To be effective a commission would require considerable resources:
Human Resources - with limited human resources available – time and energy – it is necessary to consider whether the commission should be an Execution or Advisory commission.

It was suggested that supporting the Commission should be a Secretariat, which takes the advice given, distils it from the policy level and implements one or two specific programmes or policies that resonate with general public.

It was recommended that the Commission use the media effectively to advocate for the commission.

Funding support for commission has to be addressed. There would be need for a Strategic Plan which resonates with MOH, donor and general public.

The group decided to develop a discussion paper rather than guidelines so that countries have the flexibility to select what works for them. The paper would contain options for a Chronic Disease Commission or Intersectoral Commission, with the Commission being either Advisory or executive. This template would give flexibility especially in smaller countries which can adapt the mechanism.

Discussion on UN Summit on NCDs

The meeting reinforced that the CMOs and Focal points need to seize this opportunity, be active, and build linkages with foreign service officers in country and to those assigned in New York. The CMOs and focal points need to educate the foreign service officer about what this summit means for health, given them the national and regional perspective. They also need to advocate for the issue of chronic disease to be included into many agendas, including that of trade, agriculture, education, and more.

Specific action will include the preparation of a one page document prepared for the Caucus of Ministers of Health Meeting in September in Washington. This will be an information document with resolutions outlining action at the technical and Ministerial level on how the Ministers can assist with the orientation of the Minister of the Foreign Affairs, including a strategic point for ensuring that chronic diseases comes onto the world agenda.

CMOs WORKING GROUP

PHC PROTOCOL

CLARIFICATIONS

- Not to write the documents sentence by sentence
- Recommend amendments in formatting and emphases
- Writing team

TITLE AMENDMENT

- Framework for Renewing of Primary Health Care Policies in the Caribbean
- N.B.
  - The reference to model in the title removed; models arise out of the system elements (goals)
  - This is a Guidance Framework with a goal

GOALS

- Improved Health, Enhanced Equity, Sustained Development
- Resource Mobilization

FRAMEWORK BACKGROUND

- Acknowledge
  - The global momentum to reaffirm PHC
  - Health gains in the region using PHC
  - History of cooperation now articulated in a "projectized" CCH3, its strategic rationale and direction
- Contexts
  - Health is wealth; is equity
  - Social Determinants
  - Health Promotion
  - Primary Health Care
  - Essential Public Health Functions

FRAMEWORK BACKGROUND

- Ongoing Assessments identified
  - Transitions in epidemiology, demography
  - Systems have performance gaps
- Merge
  - "History of Cooperation" into "Background".

STRATEGIC REFORMS

- Replace title "Models of Care" with "Strategic Reforms"
- Purpose
  - To reorient the health system towards health for all (barrier-free access including financial protection)
- Recommendations:
  - Add 5th "Reform" to incorporate
    - Community Participation, Intersectoriality, Whole of Society Approaches

ESSENTIAL ELEMENTS

(Deliverables)

- Amendments
  - # 9: Split Research & Technology
  - # 9 becomes Research
    - Research to support evidence-based planning and management of health systems
  - Technology become # 10: Title: *Utilization of Appropriate Technology including e-Technology*
    - To develop of information systems platform applicable to national context
    - To capture surveillance data re NCD risk factors, communicable diseases, injuries, occupational health and mental health
  - 12th: An element speaking to *Service Effectiveness, Efficiency, Impact*
- Other changes made to text

EXAMPLE OF TEXT CHANGES

III: Utilize health promotion, and comprehensive and integrated care approaches

- Health care models based on effective primary care systems, have a family and community orientation, incorporate the life cycle approach, be gender and culturally sensitive, and work for the establishment of health care networks and social coordination that ensures adequate continuity of care.

❖ Strengthen bidirectional linkages between primary, secondary and tertiary levels and work for the establishment of health care networks which include the private sector

❖ Strengthen the coordination among social services in and out of the health system that ensures continuity of quality and effective use of resources.

REPORT ON THE FOCAL POINTS INAUGURAL MEETING

The participating countries and organizations were from St. Vincent and the Grenadines, St. Lucia, Dominica, St. Kitts and Nevis, Belize, Suriname, Trinidad and Tobago, Barbados and Jamaica and from CAREC, PAHO/ WHO, Washington, ECC- PAHO, UWI, Cavehill and St. Augustine, Chronic Disease Research Centre and Barbados Chronic Disease Commission.

The meeting began with Dr. Hospedales, PAHO, Washington providing an overview and describing how the Expanded Programme for Immunisation (EPI) is structured and how managers have managed their roles as programmes managers and used its annual meeting for programme planning and training. The NCD Focal Points can consider the utility of a similar arrangement for developing the NCD Programme. It would be necessary to institutionalise the meeting, obtaining the necessary resources and inputs from partners to coordinate such a meeting. Dr. Hospedales also emphasized the need for health care workers need to become strong advocates for NCD programmes and to hold the political directorate accountable for what they have signed on to. POS Declaration applied or implemented and support from higher levels in applying the POS Declaration.

Guidelines for NCD Focal Points and Meetings

The group also discussed the Terms of Reference for such a meeting including guidelines for identifying the focal point. It was noted that each EPI meeting had clearly defined responsibilities and functions each meeting addressing areas of weakness, training, showcasing of work of managers with focused interventions including capacity building, and information on monitoring and evaluation tools. Training including field trips should be included in these meetings to enhance what needs to be done in each country. Continued training of focal points would continue at CARMEN Network and School.

The importance of having identified or appointed focal points who are not the CMOs in each country was raised. If there is no dedicated focal point, for continuity of representation for each meeting the same person should attend the focal point meeting.

The need to institutionalize the meeting including the identification of regional funding was important and this funding needed to be set aside and dedicated for this activity. This meeting can be either an annual or biennial meeting. Tele-conferencing can be used in between meetings to maintain contact and support for each other.

Discussion on the NCD Commission

Issues examined included the structure, purpose of the Commission. Some countries still have to set up these commissions and can use the models used in Trinidad and Tobago, Barbados Jamaica and St. Lucia. Alafia to share template to the other islands.

Funding Options

Ideas for funding of NCD initiatives was discussed with countries sharing options used including piggy-backing of HIV/AIDS activities, using the language/ interests of project funders, e.g life style related illnesses rather than chronic diseases, and more generic issues/ groupings common to HIV programmes (e.g. big picture) including programmes addressing life styles, family, women.

Country Priorities for the next two years

a) Increased Technical Cooperation Collaboration (TCC) between PAHO and focal points, instead of the use of grants and attachments. PAHO will follow up.

b) Not all countries have NCD policies, while some countries do have and the CMOs are working on draft for region.

c) Some countries do have NCD Plans while others have NCD plans integrated into overall health plans. Countries will determine which is more relevant. Plans will be circulated but specific areas need to be addressed.

d) Risk Factor Surveys using STEPS have been done in many countries. Jamaica will share its broader risk factor survey which include more than chronic diseases.

e) In country research - public sector, UWI, and MOH will need to decide on areas for research.

f) NCD Multi-sectoral Commission need to be set up or Partners Forum which ever name is preferred. The CMO are working on guidelines.

g) FCTC Legislation - Trinidad to circulate legislation.

h) Salt reduction - some Caribbean want to be included in current research on salt.

Regional Priorities

a) NCD Commission guidelines.

b) Intergrated NCD Surveillance.

c) Capacity Grant writing - professional assistance needed, TOMO from PAHO ECC to identify possible funding options.

d) Food Labelling - Alafia will pursue activity for that next week.

e) Bulk Drug Purchasing and Lab technical supplies and equipment.

f) PAHO and CARICOM as a vehicle to build capacity and networking for TCC Model Legislation.

g) PAHO Project documentation - Toolkit and brochure received from PAHO are in PDF format. Countries need documents in word format so as to include local logo, without changing message and crediting PAHO. PAHO agreed.

h) Health Promotion – Suggestion to approach insurance companies for funding and expertise and also UWI Mass Communication Unit. Reorientation may be needed to modify the usual PR style to Social Marketing concepts.

i) Partnering with LIME and Digicel (Spamming criticism from St. Kitts and Nevis CMO)

j) Funding through PAHO/WHO Representatives and the biennial Planning Programme (BPP).

k) Coordination needed for this meeting - Alafia is willing but needs resources for this activity – Dr. Gerardo De Cosio of PAHO Washington should be approached.

l) Washington PAHO has PAHO NCD Focal Points Meeting at which some regional Focal Points already participate, so this presents an opportunity for interaction.

Working Groups

PORT OF SPAIN NCD#5: QUALITY OF CARE FOR PERSONS LIVING WITH NCDS

The participants were placed in groups, primarily by choice. The groups were given background documents with recommendations that needed to be answered in the groups. The intention of the output of the working groups was to provide a road map for the implementation of the Port of Spain NCD #5.

Overall workgroup objectives

1. To produce the first draft of a Chronic Care Model of care for the region
2. To identify mechanisms for implementation of POS #5 (improving quality of care for persons already living with NCDs)

All working groups were given the following source documents:

1. Report of the CMO Meeting April 2010 NCD update – Appendix XXX
2. Declaration of Port of Spain; Uniting to Stop the Epidemic of Chronic NCDs.

GROUP 1

REVIEW AND REVISE CHRONIC CARE MODEL FOR THE CARIBBEAN

Specific Objectives of Working Group 1:

To edit draft chronic care policy and models of care

Questions to be addressed by Working Group 1 were:

- What policies are needed to support the chronic care model?
- What are the components of models of care that could be adapted in the different countries?
- Group should edit the draft chronic care policy and model of care document.

Source Documents were:

1. First Working Draft of the "Chronic Care Policy and Models of Care for the Caribbean
2. WHO Improving Care for Chronic Conditions
3. Chronic Care Model (CCM)

The Approach taken was to review the working first draft of the "Chronic Care Policy and Models of Care for the Caribbean" (Appendix 1). Also shared with this group is the document on Improving Care for Chronic Conditions (Appendix 1).

Changes were suggested to the section on Background, so that it is restructured to define "the Caribbean" or "CARICOM population", include the burden of NCDs, and the framework for action referencing the Nassau Declaration and the POS Declaration.

The GOAL was defined as "To improve the quality of lives of the Caribbean by reducing the burden of NCDs, morbidity and mortality, through improved screening and management of the chronic diseases and their risk factors."

The group discussed whether the model should focus on NCDs or priority NCDs or select NCDs and whether the model addressed chronic disease as a whole, or communicable and non-communicable diseases.

The objective was defined as "To promote the accelerated development and implementation of evidence-based policy and action plan, and the prevention and control of chronic disease, their risk factors and their determinants. Secondly, the creation and support of an enabling environment for the policy implementation."

The group reviewed several models:

i) The older model which is the standard **Chronic Care Wagner Model** which looks at six components, divided into two sections a) health system and b) community. The six components are health care organization, self management, delivery systems design, decision support, clinical information system, community resources and policies to produce the interaction between productive, prepared and proactive team and an informed and empowered patient leading to better outcomes. The group found this model to be deficient in that it did not address public policy and social determinants of health.

ii) The next model reviewed was the **WHO model**, **Innovative Care for Chronic Conditions Framework** which focused on three areas that is: a) a positive policy environment, b) community and the c) health care organization interacting to produce an informed motivated patient and family. And whilst this model is supposed to be an expanded version of the standard Wagner model, involving the community and policy environment, the group found that this model was difficult to work with and to operationalize in the Caribbean setting.

iii) The group reviewed the **Expanded Chronic Care Model** which comes out of British Columbia, Canada. This model looks at a) disease prevention and health promotion, b) the social determinants of health and c) involved community participation. The group recommended this model as it would provide a better framework for the region. The group reviewed the broad areas of health system and the community. But other areas still to be reviewed include the clinical information system, the decision support, the delivery system design and self management. At the Community level, the group looked at building healthy public policy, creating a supportive environment, and strengthening community action so that one gets interaction between patient, practice team and activated community, a proactive community partnership to improve population health outcomes, functioning and clinical outcomes. The group also began to review the policy elements.

Discussion

One participant indicated that the deficiency identified in the Wagner model, in that it did not address the social determinants of health and public policy, is not a real deficiency in the model because these are captured in the decision support component. The problem arises from the implementation of the public policy and community involvement.

It was observed that the working group actually used the framework at each level and at each level recognised that a policy decision would be needed to support each aspect of the framework.

POWERPOINT PRESENTATION

GROUP 1

CHAIRPERSON:

OBJECTIVE:

- Review and revise chronic care model for the Caribbean
- Approach to exercise – We decided to review the working document prepared

Recommended changes

Background

- Define Caribbean/CARICOM region and pop
- Burden of NCDs
- Framework for Action

Rationale

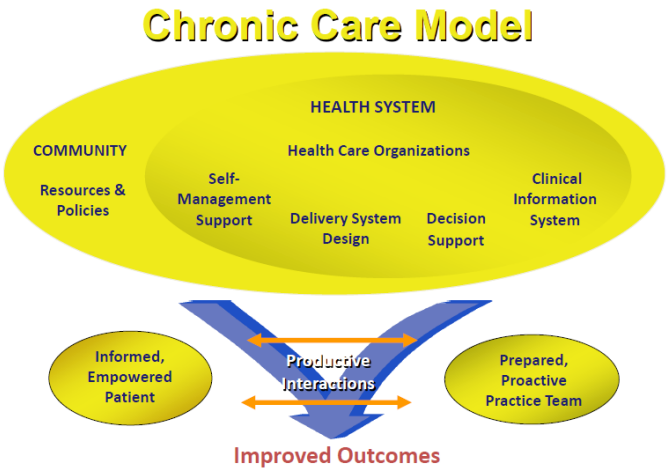
Redefined the GOALS & OBJECTIVES

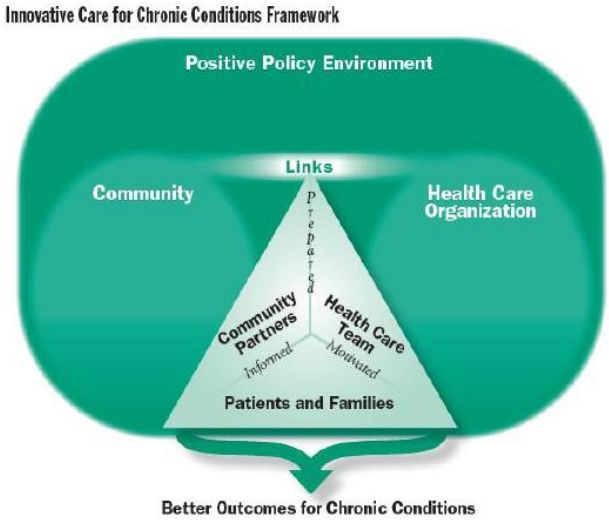
GOALS

- To improve the quality of life of the Caribbean peoples by reducing the burden of NCD morbidity and mortality
- To improve the screening and management of chronic diseases and their risk factors

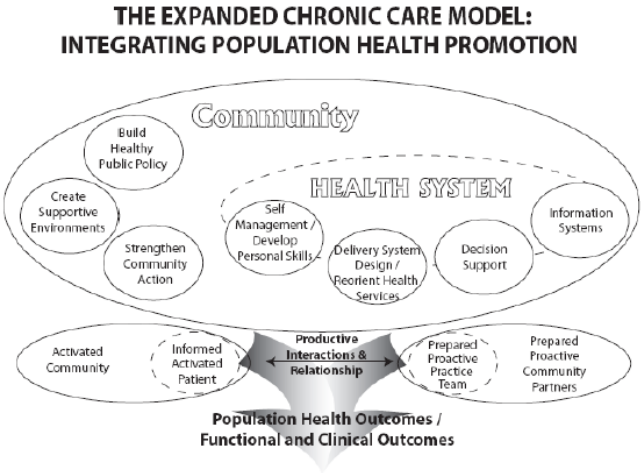
OBJECTIVE

- To promote the accelerated development and implementation of evidence-based public polices and action plan for the prevention and control of chronic disease, their risk factors and determinants.
- To create a supportive and enalbling environment (policies, regulations, protocols standards and guidelines)





- Proposed Model – The Expanded Chronic Care Model developed in British Columbia Canada
  - Includes disease prevention and health promotion
  - Recognizes social determinants of health
  - Involves enhanced community participation



GROUP 2

IDENTIFY TRAINING AND OTHER SUPPORTS NEEDED TO IMPLEMENT MODEL

Specific Objectives of Working Group 2:

To identify what skills are needed, who needs to be trained, how others will be trained, and available training opportunities

Questions to be addressed

How will capacity building be rolled-out for Primary Care workers?

Which categories of workers need to be trained in the public, private and health NGO sector?

How can this be funded?

Source Documents

Dr. Asin Oostburg recommendations -CARMEN School and PAHO online training documentation

The group was asked to do a blind task to identify the supports and define the training in a context that was not quite complete. The group was asked to identify the skills needed, how others will be trained and the available training opportunities. It was also asked to identify the capacity for rolling out with respect to primary health care workers and which category of workers needed to be trained in the public, private, and NGO sectors.

The group looked at the chronic care model acknowledging that there were gaps. It accepted that the chronic care model is a tool to be used as a primary care based approach in the Caribbean which cuts across all levels of care from the community right through and loops back. It was recognised that CCM calls for reengineering of the health care system and the training of people, that is, all the necessary stakeholders not just health care workers. The profile of the patient needs to be looked at – What are their conditions? What are the social implications? The mix of skills and the competencies required to deliver the services would need to be aligned as well as the different settings. Countries would determine the entry point. The CCM model and the circular models discussed earlier during the consultation were also taken into consideration. One would need to define what approach each country would take and how it would implement the model as every country has its idiosyncrasies. The population structure would need to be considered as well. There was also discussion about Type 2

diabetes and obesity occurring in children, as we have an aging population and by Caribbean 2050, the population would look completely different and there is an association between chronic diseases and ageing.

There are some best practices and the region should observe how these practices are successfully implemented. There are tools, including the HRH 20 Goals (Human Resources for Health) in the Caribbean region that can be used and the development of a gap analysis tool. There is also the human resource 2007 resolution from PAHO which seeks to address various issues including primary health care and human resources for health care. The group felt, in relation to Capacity-building for primary care workers, that a useful model was the 'train–the-trainers' approach. At the same time, however, it was also necessary to engage academic institutions and NGOs, as well as local and regional consultants to help support the various types of training. A gap analysis is needed to identify new or additional skills or expanded roles and competencies needed. Some of the soft skills including negotiation, advocacy, leadership and managerial skills need to be addressed. Inter-personal relationship skills are important for customer care and patient care. This is very necessary if the health sector is to become patient-centred. Some of the specific training in Applied Epidemiology and competencies and that training should be brought right down to the community level where communities could be taught to use epidemiology to identify the issues and to strategize; population issues, behaviour change model, health education, how to navigate through the system, social political, social and environmental determinants, grant proposal writing, use of the guidelines that are developed by the region, and public policy, for example. The group also included monitoring and evaluation, budgeting, and health financing as well as health promotion, health literacy, how to approach the client, median risk communication and nutrition. Those are things that the patient needs to know, quality of care, clinical care, clinical management, compliance and community participation and many others.

Other institutions including universities need to help through the process, especially to achieve change, providing the skills for change management and possibly a tool kit to support the implementation. The group identified change management for nursing profession, but this also applies to physicians - if the health sector is going to change how nursing operates in the new system, many of the physicians may have a mindset about how a system should operate and may not be willing and able to adapt to the new paradigm.

Who should be trained? Primary health care workers, secondary and tertiary in the public health sector, public health specialists, university training (but they need to be sensitised), private practitioners,

pharmacists. Insurance companies are critical, laboratories, etc. Everyone should be sensitized to what is happening. It is important to strengthen the public-private sector nexus and to develop private public policies. The region's data is public sector oriented and both areas need to be bridged. It is necessary to train advocates, faith-based organizations, diabetic associations, medical associations, cancer associations, etc.

Later, the training can be divided into two groupings - Patient centred and public sector related. The region needs to build capacity of doctors and nurses on how to use the CCM. The same applies to the NGO sector, health related support professions and those sectors outside of health – the finance sector, social services, education, and so on. Training of family and community groups to help patients in maintaining their health is also required.

When the results of the Gap analysis are received it will determine the levels of training and skills needed and resources for the training. The presentation illustrates the complex situation and the multiple skills required and persons that need to be trained. Training will be staggered but the key stakeholders would include police, correction services, mental health staff and transport.

Support would be needed from the legislation, guidelines, manuals (the manuals have to take a life style approach), curricula design specialists, and more. Instruments that may be useful guides include Integrated management of childhood illnesses, Integrated management of adolescent needs, and the Integrated Manual of adult illnesses.

Human resource planners to do needs-based analysis so as to adequately define the new health care team. Linkages with other programmes such as HIV and gender based interventions are required. It is important to remember that programmes such as EPI and MCH have a female focus and so should be adjusted appropriately.

It was noted that the region's men have high rates of prostate cancers and they are not seeking care at the primary care level. They are dying at an increasingly early age. One of the first open seminars needed should be about Men and Viagra, because the region's men are not recognising that there may be underlying chronic conditions that need to be addressed.

The Jamaican Ministry of Health is addressing the Energy drinks issue though not without resistance from the "Redbull" brand but the Ministry is giving it a fight.

The need to involve the Community based organisations – that is taking a risk based approach so as to engage the relevant groups – Youth, Schools, Senior citizens and the Media, was suggested.

Funding

National budgets need to be prepared to include chronic diseases, and there may be a need to return to limited programme budgeting to address chronic diseases. It may also be useful to piggy-back on the other grants, especially those that seek to strengthen the health system.

NGO funding should be considered. Churches might be asked to support a community health worker. There is a need for specific NCDs grants or other HIV grants. There is a need to optimize human resources in a cost-efficient manner, so that there is indirect benefit, though not direct funding. There are also taxes, co-sponsors and support from the business sector as other possible funding sources.

Discussion

One participant congratulated the group on the good job of providing strategies that can be applied no matter which model is chosen.

Another participant noted that the Surinamese model discussed had highlighted the training needs of the elected officials and the importance of increasing the awareness of officials.

The information was also shared with the meeting that the EU Commissions are interested in funding a massive training programme for Latin America and the Caribbean to bridge the gap technically between where the region is and where it needs to be.

POWERPOINT PRESENTATION

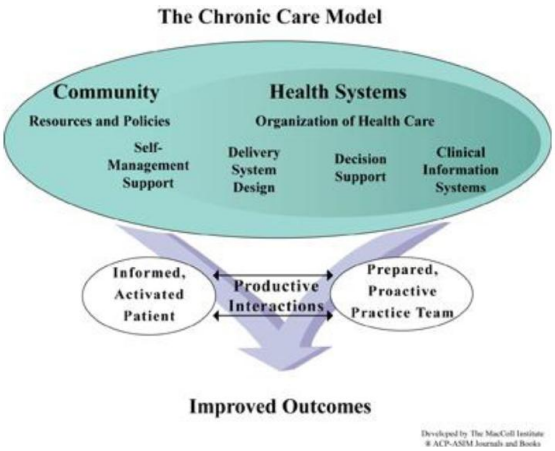
Group 2

- Dr. Martin Christmas
- Dr. Karen Sealy
- Dr. Virginia Asin-Oostburg
- Dr. Merlene Fredrick
- Dr. Sheila Campbell-Forrester

Task

- Identify training and other supports needed to implement the model
- To identify the skills needed, how others will be trained and available training opportunities

- How will capacity be rolled out for Primary Care workers ?
- Which categories of workers need to be trained in the public, private and health NGO sector?
- How can this be funded?



Preamble

- Assumption is that we accept the chronic care model (CCM)as a tool to be used as a primary care based approach in the Caribbean
- We note that CCM calls for a re-engineering our health care system and training of people will be based on this.
- The profile of the patients will be aligned to skills mix of health care workers required in different settings
- Countries must identify an entry point and the design (CCM, circular model etc) that will be used and methods of implementation
- Countries exist where CCM has been successfully implemented and we need to observe best practices
- Countries need to do a gap analysis (consider the HRH 20 goals as a tool)

Capacity Building for Primary Care workers

- Trainer –of-trainers who will lead the rolling out of CCM
- Use gap analysis to identify new/ additional skills/expanded roles and competencies needed
- Engage academic institutions and NGOs to support training
- Training in soft skills (negotiating, advocacy, leadership, managerial, customer care) for those who will be implementing the CCM
- Specific training in applied epidemiology competencies, population issues, behaviour change models, navigation through the ssystem social/political/economical/environ. Determination, Grant proposal writing, use of guidelines, public policy etc , health promotion, health literacy, approaching the client/patient, media and risk communication, nutrition etc., quality of care, clinical care including compliance, community participation.

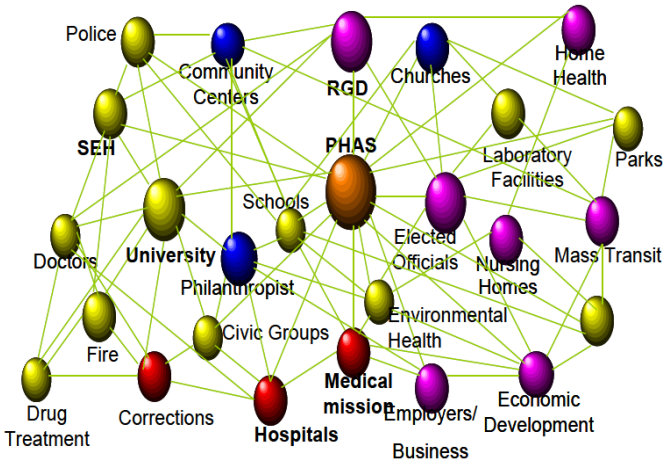
- Recommend that Universities or other institutions organize Change management programmes to support the CCM implementation
- Training in evidenced based chronic illness care
- Build on the work done by HIV sector in capacity building

Who should be trained

- Primary care workers and secondary/tertiary care in the public health sector must be trained in how to deliver CCM
- Private practitioners, Internists, Gynaecologists, Nurses, pharmacists, insurance companies, laboratories etc. (Strengthen the Private sector-public sector nexus and public private policy)
- Advocates, Faith based organizations, diabetic associations, medical associations, cancer associations, HIV advocacy groups etc.

Categories of workers and partners for training

- Training of health care providers (doctors and nurses) on how to use the CCM
- Capacity building for NGOs and related health professionals
- Training of family and community groups for support of patients to prevent and maintain health
- Results from the gap analysis will determine the levels and skill requirement needed as well as the resources of training



- Legislation, Policies and guidelines/manuals
- Curriculum design specialists
- Instruments such as IMCI, IMAN, IMAI
- Human Resource planners
- Linkages with institutions and other programmes e.g HIV, Gender based interventions, WHO Collaboration Centers
- Community based organizations
- Youth serving organizations, schools, senior citizens
- Media

Funding

- National budget
- Piggy back on what is going on in the community and on other grants that seek to strengthen health systems
- NGO funding
- Grants NCD specific grants or HIV grants
- Cost efficiency in optimizing HRH
- Taxes, co-sponsors and business sector

GROUP 3

QUANTIFYING THE TARGET POPULATION

Specific Objective of Working Group 3

To determine how to estimate the denominator and numerator for the POS NCD Summit mandate "80% of persons with chronic disease to receive quality care...."

Questions to be addressed

What data would be required in country to make a reasonable estimate of

a) the denominator? and

b) the numerator?

What resources would be required?

How could this be implemented and in which countries?

Source Documents

STEPS surveys from BVI, Dominica, St Kitts, Barbados

Jamaica Healthy Lifestyle Survey 2000 and 2008

WHO/ISH Risk Charts

This group had to answer specific objectives to determine how to estimate the numerator and denominator for the NCD Summit mandate #5 which states:

"Eighty percent (80%) of the persons with chronic disease to receive quality care."

Firstly, the group discussed what data was required to make a reasonable estimate for the denominator. There was much discussion on what is the adult population who are most at risk to contracting chronic diseases. Some members of the group felt that the population 25 years and over should be used, while others wanted to go even below 25 to 20. The country / region would need to decide what is most feasible.

Some members wondered whether it was necessary to limit it to the most productive sector of the population, in which case it would go up to the age group of 70. However, most persons felt that the whole age spectrum should be used.

Recommendation: Either of the two options was recommended - Equal to or greater than 25 or equal to or greater than 20.

In the case of the numerator, the best information could be the use of chronic disease prevalence information from population-based survey, although many countries may not have that kind of information available. The group discussed countries which may have health information systems with unique identifiers and incorporate information from public, private and NGOs so that the total numbers of persons accessing care for chronic disease is available. Belize has such a system, but Belize is the only country in the region with such a comprehensive system.

The group also discussed the usefulness of information in countries which have chronic disease registries. For example the group spoke about the stroke registry in Barbados and whether this information can be used to extrapolate the number of projected cases or persons with chronic diseases in the population, and this can be used as a proxy where the other two sources are available.

The group spoke about the critical need for a consistent and unique identifier though not used in most countries and the use of this to control for patients who move from one health provider to the other or one health facility to the other.

What resources are needed? Accurate population estimates from recent national census data is critical. It was noted that while census data is available, this could be very dated (20 years old) and there would be significant changes in the population which need to be taken into account.

The health information system would provide the most reliable numerators but these systems require considerable finances. There is also the need for considerable finances to conduct the population-based risk factor survey. It is suggested that these can be piloted in three different countries with different sizes, capabilities and capacities and different means of identifying the numerators so that the best proxy that can be used could be determined.

Discussion

One participant disagreed with the group's use of the age limitation in the methodology suggested. The participant suggested that age should not be a consideration, since what is being measured is the number of persons with chronic disease who received care. It was explained that the total population by age groups was used to quantify the burden of illness. It was again suggested that the indicator should refer to the number of persons with chronic diseases. However, the group's presenter felt that there was an inherent error since it is estimated that 80% of persons who have chronic diseases are unaware of it. It was also pointed out that children under the age of five have chronic diseases and by the time they are teenagers they have complications.

Another participant explained the rationale for the measure and how these estimates should be obtained. The intention is to measure is the burden of the disease in the population and the true burden can only be obtained by screening, by surveillance and prevalence studies which would then provide the data to advise the health care providers and policy makers on what the true burden of the disease is. But a key point is that to deduce the numbers of new cases and risk factors, there is a need to do risk factor surveys to get true estimates. He continued that while some diseases start at mid-adulthood (breast cancer) and that adolescents do get Type 2 diabetes, the important point when one is measuring disease burden, is that population-based estimates for all age groups have to be used.

A comment was made on the manner in which the health sector sets its targets, since if the health sector thinks that it will never achieve 100%, it will never approach 100 %. It was stated that is intended as a measure of the burden of disease. The numerator once ascertained becomes the denominator of the next question, that is, what percentage of the population is receiving care. It is possible to make estimates of how many persons that need treatment from some other source. The denominator is the population estimate and this gives an estimate of how many persons need treatment through screening. The indicator will give a percentage of the population that is being treated given the estimate of those needing treatment. There will always be persons not captured from both the numerator and the denominator.

A participant suggested that the region needs to focus on the Quality of care indicators.

The meeting also discussed how HIV epidemic estimates the size of the HIV Epidemic and whether this would not be a methodology that NCDs could follow. It was noted that the question of how many HIV positive persons were accessing care is part of the HIV surveillance system.

It was also suggested that to obtain an estimate of how many persons are actually living with chronic disease, this proposal is being put forward but it does require that an assumption is made that the approximate number remains stable from year to year for a period of time. The number of persons who have died in any given year would be equal to the number of new cases, plus new immigrants. Then the percentage of those who have died to the percentage of new ones gives an idea of the total population with the illness. It will not be an exact figure but it gives an indication.

POWERPOINT PRESENTATION

Working Group 3

Glennis Andall (CAREC), Englebert Emmanuel(BEL),
Tomo Kanda (PAHO ECC)

Specific Objectives

To determine how to estimate the denominator and numerator for the POS NCD Summit mandate "80% of persons with chronic disease to receive quality care.."

Q1: What data would be required in country to make a reasonable estimate of a) the denominator? b) the numerator?

One senario will be:

a) Denominator: total population of age group ≧ 25 , or ≧ 20 years

b) Numerator:

1. Use of chronic desease prevalence information from popuation-based survey.
2. For countries which use unique identifiers and have a health information system incoorporating information from public-private and NGO sectors: total numbers of persons accessing health care services for chronic diseases by ICD-10 code ?
3. # of existing chronic desease ceases from populatin-based disease registry (ex. Stroke Registry) ?

Q2: What resources would be required?

1. Accurate population estimates from recent census data
2. Reliable health information system with unique identifiers
3. Finance to support conducting population-based RFs survey

Q3: How could this be implemented and in which countries?

Method:

Vía pilot study

Countries:

Barbados, Belize, Jamaica

GROUP 4

UPDATING AND IMPLEMENTING EVIDENCED-BASED SCREENING AND TREATMENT GUIDELINES

Specific Objectives

To review the implementation of the decisions of the CVD Experts meeting of March 2008

To determine the process to production, dissemination and training around pocket guidelines

Questions to be addressed

What is the mechanism and time line for development of CARICOM CVD pocket guidelines?

What training and other supports are needed to implement guidelines?

What of pocket diabetes guidelines?

Source Documents

Conclusions of CVD Experts Meeting Montego Bay March 2008

CHRC Diabetes, Hypertension Guidelines

JNC7 Pocket Guidelines

WHO Total risk Pocket guidelines

Draft CARICOM CVD pocket guidelines

Group 4 was requested to consider 3 questions:

What is the mechanism and timeline for the development of CARICOM CVD pocket guidelines?

What training and other support would be needed?

What about the pocket diabetes guidelines?

The group was given the CVD Risk predictor chart developed for AMRO B which is a sub region of Caribbean and Latin America, grouped by per capita income. AMRO A includes be USA and Canada. AMRO B includes Brazil, and in terms of population, the Caribbean has a very small population in this group compared to that of Brazil.

The group then asked itself this question: What data from the Caribbean contributed to the development of this chart for AMRO B? Several countries in the Caribbean have done STEPS Risk factor surveillance – would this data have been used? The group wondered if the NCD situation and

characteristics of the Caribbean would have played a part. The group also wondered about the set of risk factors that were selected, and what led to the selection of one over another. The group wondered if the Caribbean needed a much more sensitive measure for risk factor. Given the obesity epidemic, the use of BMI and waist circumference as risk factors whether waist circumference might not be a much more sensitive measure. Some countries around the table do not even have cholesterol screening machines in the health centres and this is a barrier to the assessment whereas a tape measure would be readily available. It might be true, and this is subject to correction, that for cardiovascular risk, cholesterol may be the more sensitive measure.

The risk predictor guide shared was developed by WHO and is currently being used in Africa and would be very useful, but the group supports the development of a Caribbean model based on the particular situation that was shared. The group felt that in the past CHRC has been used to produce the NCD guidelines for the Caribbean and therefore CHRC, the CARICOM Secretariat, and the Ministries of Health should be engaged in a process to develop this guideline.

What is the mechanism and what are the timelines for developing such guidelines?

Mechanism and Timeline

a) The group suggested an in-country critical review of the risk predictor guideline led by Chief Medical Officers in stakeholder consultations that will involve public and private health sector, NGOs, multi-disciplinary health professionals, and other key stakeholders. – 3 months.
b) CARICOM can establish regional technical expert committees that can collect the country reviews (6 weeks review period) and finalize a first draft of the regional risk predictor factor. The technical expert committee would include the public and private health sector, the universities, and regional and international experts including WHO. This panel would review the evidence and best practices internationally.
c) Field testing – 3 months
d) Finalisation – 3 months
e) Production and Dissemination
f) Ongoing Monitoring and 5 year review and evaluation

The whole process from review of WHO draft to production and dissemination should take 12 months.

The next question was: What training and other support are needed to implement the guidelines?
The review of the guidelines would involve widespread stakeholder consultations in-country, so that support for the in-country consultations would be needed. For the Field testing, there will be a need for equipment and for the finalization, there will be a need for a face to face meeting so travel will be necessary. The production and dissemination of the Caribbean Risk Factor Guidelines would require some finances and will need to be budgeted.

Who needs to be trained to utilise the guide? The whole multi-disciplinary health professionals, doctors, nurses, nutritionists, NGO and allied health personnel, personnel from the physical activity fraternity.

Sensitization is another level of training and this should include Ministers of Health, probably Prime Ministers, persons at the policy-making level, the Parliamentarians, NCD Commissions, and other Ministries of Government. Other Ministries would include Ministries of Social Development with Divisions of Ageing and social workers. In each country there are critical ministries that would be need to be included in the sensitisation process. Sensitization of the population and the chronic disease clients are needed in respect of the risk factor predictor guide and also with respect to targets for self-management.

The guide has many targets for self-management in terms of physical activity, other targets with respect to weight and blood pressure, and a full sensitization of the population with respect to these things would be important.

For public education, a social marketing campaign must be developed. This is a totally new tool and the Caribbean public is now familiar with the BMI chart that is produced by CFNI. For a new guide, a health education material, IEC material would be needed. The Caribbean has come of age with technology and there is need to consider the new media tools.

What about the pocket diabetes guide?

The group recommends a pocket diabetes guide. There are two comprehensive diabetes management guides in the Caribbean - CHRC guide that is now utilized, and comprehensive diabetes guidelines that have been produced by Jamaica. CHRC is currently working with Johns Hopkins University to

produce a pocket diabetes guide. The caveat of the group is that the pocket diabetes guide should be in alignment with the existing comprehensive diabetes management guidelines for the Caribbean by CHRC and by Jamaica.

Discussion

The meeting was asked to note that there are also pocket and comprehensive hypertension care guidelines.

A participant requested an explanation on the methodology suggested to review the guidelines. He queried why a retrospective or a prospective cohort study was not used. He suggested that there will be a need for a retrospective cohort study to get the information on the survival of a population. With the methodology suggested the region will simply be guessing, so in that case, why not just use the WHO version?

The group explained the rationale. What is the purpose of guidelines? They are to give the best practice for the management of various conditions based on the combined knowledge (of disease management – best knowledge and practice) from the rest of the world. Since not every country can replicate this in its own local settings, it makes sense to use what is known out there and developed from a multiplicity of clinical studies, methodologies, etc. and try to put it all together and apply it to your populations. There is little prospective outcome data in the Caribbean and collection of this data is expensive to collect, the human resources and financial resources are simply not available, so it is best to be pragmatic and adopt the practices from the major federations out there which have been shown to be relevant and useful.

Clarification was sought on what the group was recommending. Was the group suggesting the revision of the risk predictor chart? Or rather the modifications of the treatment recommendation guidelines associated with the chart? The population needs to be followed for 10 years in order to get outcomes to develop a risk predictor chart. The WHO risk predictor chart was based on the Framingham study. The group clarified that it was proposing the modification of the treatment guidelines.

Another participant suggested that it would be useful to review the documentation of the under-pinnings that went into the development of the risk predictor chart and what led to the development of the guidelines. For example, if the dataset was the Framingham Study, what were the factors that

determined the guidelines for AMRO A versus AMRO B or Africa? Why are there different cut-off points for each area? The fact is also that when given the comparable populations of the Caribbean and Brazil and Mexico, etc. the Caribbean data becomes subsumed. So the methodology needs to be examined and the region needs to get more information on the development of the chart.

It was also noted that WHO produces guidelines that are supposed to fit all. But the health sector knows that one size does not fit all and the region should plan to start now to collect the data so that 20 years from now it would not be saying that it has no resources so it has to use the plan that is supposed to fit all. The region needs to put things in place so that it has the relevant Caribbean data down the road and put systems in place so that the region can modify the guidelines going forward.

It was also suggested that while the group did not mention the use of the notes in the patients' dockets to capture the data required to monitor, this data could be used to monitor and evaluate the use of the guidelines and lead to modification at a later stage.

It was also noted that the region might not be able to afford cholesterol tests for all patients, but other parameters e.g. waist circumference can be used so that five years later, the region will have the information on what is relevant to the Caribbean.

It was suggested that the region examine to what extent the data from the St. James Cardiovascular Study is at least a starting point to see how far off it is when compared to the larger regions. The St. James study database is supposed to be comparable to the Framingham study and stratified ethnically. The participant wondered whether this could be a possible start and whether the region could obtain more funding to take the analysis further. This is actual data with risk factors with respect to cohorts.

It was further suggested that risk factor data is obtained from a retrospective study and there are data sets all over the Caribbean. The region needs to go back, make a list of criteria and obtain the morbidity and mortality data from the listing. This should not be hard to do and should not be too expensive.

Another participant supported the CHRC and UWI review of the data and the methodology used to produce the risk predictor guides but said that this review needs to be done in a very timely fashion – not five years to develop Caribbean guidelines. PAHO is anxious to introduce this risk predictor guide and would like to do this shortly, even in less than a year. If the treatment recommendation guide needs

to be "Caribbeanized", then this needs to be done also in a timely fashion. There are companies who are willing to fund the production of the risk predictor charts and circulate to all households.

It was also shared that Chile has produced a more user friendly guide and the Caribbean should consider doing this also.

GROUP 5

SHARED TREATMENT SERVICES FOR TERTIARY CARE

Specific Objectives

To identify the priority conditions needing shared regional services

To identify the barriers to achieving shared services

Questions to be addressed

What diagnoses most commonly need referrals for tertiary care?

How could the obstacles to shared care be addressed

a) in the short term;
b) medium term;
c) long term?

How can we manage pain in persons with terminal cancer?

Source Documents

CARICOM mortality and morbidity profile

This group looked at shared regional tertiary services and identified the barriers for operationalising shared services. First of all, the group defined how to determine which priority conditions will require shared regional services. The basic principle that the group adopted was that geographic location or socio-economic condition should not determine the level of access to services that could improve the length or quality of one's life. It should not matter who the patient is and the income of the patient, all should have access to the services.

The other question which the group discussed was "what were the tertiary services requiring referrals and how to address the obstacles?" The concepts that hinge around the 'Centre of Excellence for diagnostic and treatment capacity' were which countries have the ability to provide these services and make these services available to other countries. The group acknowledged that in order to provide these services, the countries would have to possess excess capacity, in terms of beds, human resources

and in order to make all of this feasible, it would be necessary to operate a human resources bank in order to have information on exactly which country can provide what service. In order to define what excess capacity is, the issue arose that when one is dealing with small countries, certain specialties are by definition excess capacity, because it takes a certain amount of volume to maintain one's proficiency. So if one lives in a small country and there is not that volume, by definition, the capacity is excess. So in order to maintain one's proficiency in the service area, it really makes sense to see how one can offer that capacity across the region.

The group noted that in order to provide shared services, one needs an economic and a social context and CSME provides the context in which this becomes feasible because it is supposed to provide free movement, and the accessing of financial services that are required to make this possible. Everything has to be paid, it is only free when defined to be free to the client, but somebody has to pay for it. There need to be mechanisms to determine how everything is paid for or some countries will end up being disadvantaged. The main challenges are therefore the movement of information, the movement of people, and movement of the health service providers or patients. This is the Amazon.com concept. Amazon does not have to sell you anything except information. What they do is to connect people with a specific service need WITH the user who provides the service. Information is critical to manage these shared services, and the processes and procedures have to ensure that everything gets paid for, and to manage how everything gets paid for in a fair and equitable manner. The patients that need to access services in each of the countries need access to the information on what services are available in every other country. Similarly, there cannot be restrictions to access of services. All of these things need to be within the context of quality management and a regulatory framework to ensure that things happen to a certain standard and a certain level of efficiency.

In terms of looking at the feasibility a study was done by a consulting firm
(DAH Consulting) and presented at the CMO's 2010 meeting which looked at the possibility of shared services. The first tier was the Cardiology, Ophthalmology, Oncology and the second tier will be Neurosurgery/Neurology, Urology, Dialysis, Obstetrics & Gynaecology, General Surgery. These were the top identified referral services. These are the things people that will go and seek somewhere else.

In terms of the cost, there are about USD $300M of referrals abroad, both in terms of within the region and outside, and the private referrals outnumber public referrals by 4.5:1. The group tried to determine which Caribbean it was speaking about. There are very different versions of the Caribbean,

depending on the political and other kind of affiliations. The group determined that they would refer to the CSME countries and look at where the referrals come in.

How can the region make it efficient? The region needs to know who is located where, what kind of skills are available, how to access these skills and who needs what kinds of interventions and how soon. The region needs to have information - what skills are available and where they are located. A live data bank that is up to date and reliable has to come out of that kind of assessment and this databank used to contact people. The region needs to know that the payment mechanisms to deal with currency exchange issues and other issues preventing the movement of money to pay for services are clarified and implemented by different countries. There needs to be harmonized administrative decisions and fee structure so that it should not matter if you try to access the same services in Barbados or Trinidad and Tobago. There is need for some harmonization.

The group identified the prerequisites as policy, legal and the programme frameworks to coordinate the entire thing to make it possible. In addition, there would be need for a quality management framework, accreditation of the providers and facilities, the structures for oversight and the resources for sustainability.

The group emphasised that to make this all work there needs to be a little less emphasis on the competition and mistrust between the private and public health centres. One of the issues that has to be acknowledged is that health is a business, and there are certain vested interests that complicate people's access to proper health care. For example, access to pain management means that some people will sell less of their pain killer drugs and this could be seen as a negative impact to the sellers. One therefore has to consider all of this and put in place a system that will allow everybody to survive but would allow any end user, customer, client, or patient to get access to the care that they actually need. Since a lot of people are accessing the private health sector, the region cannot have a public sector only or a private health sector arrangement only. There must be a partnership. The region cannot have it completely driven completely by one or the other. It needs to identify which niches are appropriate and have a system that revolves around patient access to the service, whether it is public sector or private sector. There are some things that will never be profitable in the private sector and the public sector has to provide these services but they should be part of the basket of services.

The group illustrated a Framework for Pain management requiring people, skills resources, protocols, and the right money. One has to look at the framework for physical resources, and trained providers.

The group believed that as long as the right money was available, the right people will be available to provide the services. However, one needs to have the regulatory and quality management framework to ensure that the people are in fact, the right people.

Discussion

One participant indicated that this issue has been discussed often before, from as long ago as 1989 and she asked what is going to be different this time? What needs to be different as the region moves forward? How will the Quality management issues in sovereign states be addressed? How will it be determined what shared services are offered in each country? How do we address the issue given that a lot of the services are high-risk services with patients who cannot afford to pay for the services and the governments will need to pay the bill?

In response to these questions, the group representative responded that the issue rests with political agreements. There are mechanisms which can be put in place and these are known. He felt that it is necessary to maintain the pressure on various governments to adhere to the documents that they have signed. They have signed on to CSME and CCH and they need to put things in place to make things happen. Unless the people begin to hold the governments collectively responsible, the situation will remain unchanged. If the health sector has a strong reason for this to happen, then we need to have a very, very loud voice on a permanent basis to lobby the politicians.

Another participant questioned what role NGOs might play to become more involved at the policy level. In response to this, it was noted that many of the situations that have arisen in the Caribbean result from the politicians not following through on their commitments and are exacerbated by the fact that the region does not have strong civil society bodies and organisation, although it was acknowledged that they are becoming stronger every day. The speaker stated that he truly believed that the region will not make **fundamental change** in the foreseeable future, unless and until, civil society is strong. He gave the example in Barbados where the Barbados Association of Retired Persons is 25,000 strong and in this age group, chronic diseases have to be a major area of concern. If only that organization can become galvanized around that issue, politicians will have to respond.

Another participant questioned whether there is a role for the insurance industry from a Caribbean perspective. In response, a participant noted that health care delivery is a business and governments are notoriously weak at running businesses so the governments should restrict themselves to oversight and

regulatory and quality framework. Entrepreneurial doctors and providers are moving ahead and shared services is now more likely to happen in the OECS.

Another member shared that the group had discussed the role of the private insurance systems and it was agreed that certainly in Barbados the private health sector needs to have a legislative framework that allows the sharing of information with the public sector. The private sector would have the systems which allow portability within the region and for shared services and in countries without public health sector insurance, the volume and costs for the shared services will be in private health sector.

It was noted that if the private sector is successful in putting up services and sustaining them effectively, they are important part of the health service delivery. The Government has to recognize that it has a responsibility for regulating the private health sector, since they are part of the health care delivery system for the country. The governments have to recognise their role and take a firm stand and be able to determine and enforce the standards and procedures including the availability of information for health situation analysis since if most of the delivery of health care delivery takes place in the private sector then if that information is not available, the government does not know the health situation in their country.

It was again noted that in the absence of public health sector insurance and limited private health care insurance, it is important to put in place systems for those without private health care insurance to access services. It as also noted that given the entrepreneurial health provider, it is critically important for oversight policies and standards to be put in place.

GROUP 5

Regional Consultation
on
Health Policies and Protocols for
NCDs

GROUP 5

TERTIARY CARE: SHARED TREATMENT SERVICES

GROUP 5 OBJECTIVES

- Identify Priority Conditions Needing Shared Regional Services
- Identify Barriers to Achieving Shared Services

QUESTIONS

- Tertiary Care: Most Common Diagnoses Needing Referrals
- How Can Obstacles Be Addressed

SHARED SERVICES: DEFINITION

- Centers of Excellence (diagnostic and treatment)
- Excess Capacity
  - Beds, Providers (HR Bank)
- Minimum volume to maintain proficiency

SHARED SERVICES: POLITICAL, ECONOMIC, & SOCIAL CONTEXT

- CSME
  - Free movement
  - No barriers to accessing needed services
  - To Be Done: The Financing Mechanism

SHARED SERVICES: CHALLENGES

DOMAINS

- Movement of Information
- Movement of Money
- Movement of People
  - Providers, Patients

Background: DAH Consulting Study on RHI Feasibility

Presented to 2010 CMOs Meeting

Possibilities in Shared Services

- 1st Tier - Cardiology, Oncology, Ophthalmology
- 2nd Tier - Neurosurgery/Neurology, Urology, Dialysis, Obstetrics & Gynecology, General Surgery.

Cost Issues

- Expenditure – US $300 million on referrals abroad, both intra- and extra-regionally.
- Private referrals outnumbering public referrals by at least 4.5 : 1.

THE MARKET

(DAH Study)

- CSME COUNTRIES
  - ~ 7 MILLION
- SPENDING ON REFERRALS (intra-, extra regional)
  - US $ 300 MILLION

OBSTACLES

- Movement of Information
- Movement of Money
  - Payment Mechanism
    - Portability
    - Harmonized administrative procedures & fee structures
- Movement of People
  - Skills Bank
    - Who has what competencies and where
    - Provider Availability and (Is LIAT, Caribbean Airlines on strike?)

PREREQUISITES

- Policy, Legal and Program Frameworks
- Quality Management Framework
  - Accreditation of Providers, Facilities
  - Oversight Structures
- Sustainability

SHARED SERVICES: PUTTING IT TOGETHER

- Public Sector: Owner & Regulator
- Service Delivery: Public-Private Partnerships

PAIN MANAGEMENT: FRAMEWORK

- Right Knowledge
  - Treatment Protocols
- Right Resources
  - People
    - Trained Providers (Including CAM)
  - Essential Medical Products & Technologies
- Right Money