Improving Patient Care by Building Capacity Using an Integrated Approach to Chronic Disease Management

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Overview of Presentation

- Description of Initiative
- High level summary of CDM Framework
- Six Step Strategy for Chronic Disease Management
  - Needs assessment
  - Engage partners
  - Develop strategies for change
  - Create partnerships
  - Measure progress
  - Spread and sustain change
- Summary and Next Steps
Trillium Health Centre

- Large community hospital
- Located in Mississauga, Ontario, Canada
- 2 site model
- 755 beds
- 221 affiliated family physicians
- 400 Asthma Centre visits
- 365 COPD Ambulatory visits
- 19,000 Diabetes Centre visits
Description of 3-Year Initiative

- Innovative, systems approach to Chronic Disease Management for asthma, chronic obstructive pulmonary disease and diabetes
- Broad based stakeholder engagement including Steering Committee
- Demonstration project, not research study
- Private/Public sector partnership
Goals

- To improve health and quality of life for those with asthma, COPD and diabetes
- To enhance coordination and strengthen the continuum of care
- To improve the standard of care
- To develop an organizational strategy for chronic disease management
Chronic Disease Management Framework
Ed Wagner - MacColl Institute Chronic Care Model © 2000

- Four elements measured:
  - Organization of health care delivery system
  - Community linkages
  - Practice level (self-management support, decision support, delivery system design, clinical information systems)
  - Integration of chronic care
Step 1
Comprehensive Needs Assessment

- Literature search, industry standards, site visits
- Inventory of resources
- System self-assessment
- Physician surveys – practice support and format
Self Assessment

ASSESSMENT OF CHRONIC ILLNESS CARE - COPD

Part 3: Practice Level: Part 3b: Decision Support

- Evidenced based guidelines: PRE 5, POST 8.7
- Involvement of Specialists in improving Primary Care: PRE 3, POST 6.6
- Provider Education for CIC: PRE 3, POST 9
- Informing patient about guidelines: PRE 4, POST 8.9

ASSESSMENT OF CHRONIC ILLNESS CARE - DIABETES


- Assessment & Documentation of Self Management Needs & Activities: PRE 8, POST 9.9
- Self Management Support: PRE 9, POST 9.9
- Addressing concerns of patients and families: PRE 9, POST 9.9
- Effective Behavior Change Interventions and Peer Support: PRE 8, POST 9.9
Step 1
Comprehensive Needs Assessment

Two Physician Surveys done

- **Format**
  - Desired time mornings and evenings, on-site, case based learning model

- **Needs to support their practice**
  - Included factors such as enjoyment in treating patients with specific illnesses, training adequacy, ease in diagnosis, amount of time spent with patients, supports that would be helpful
Step 2
Engage Partners in Community Model Development

Steering Committee

- Patient
- Trillium Health Centre leads for asthma, COPD, and diabetes
- Directors, Managers
- Chief of Family Practice, Paediatrician, Respirologist
- Primary Care Coordinator
- CCAC and service providers
- Public Health
- Community Pharmacist
- Private sector representatives
Step 2
Engage Partners in Community Model Development

- Evolved a vision together
- Varied understanding, joint learning
- Diversity of membership
- Alignment with parallel initiatives such as the National Homecare and Primary Healthcare Partnership Project
- Both organizational policy and clinical levels
- New opportunities identified over time
Step 3
Strategies for Change

- Evidenced based patient education tools
- Provider practice and education tools
- Provider education and application of theory and tools
Step 3
Strategies for Change
Chronic Disease Management Series for 3 disease entities highly successful in self identifying practice changes as follows:

- Better disease screening
- Increased use of allied health providers and community resources
- More patient involvement in the development of treatment plans
- Use of patient education materials for consistent messaging
- Promotion of lifestyle changes
- Better use of Best Practice Guidelines and proper treatment regime
Step 3 Strategies for Change
Evaluation of Physician Education

Top 2 ratings on a 5-point scale
Step 4
Create Partnerships that make sense

• Developed as a result of increased knowledge of CDM framework and relationships built

• Check for alignment with internal and external priorities

• Was there sufficient benefit for our patients to support our investment?
Step 4
Create Partnerships that make sense

- Three partnerships that developed over time
  - The Ontario Patient Self-Management Network
  - The Sweet Success Community-Based Exercise Program
  - Community Care Access Centre and their service providers
Step 5
Measure the Change

What did our patients say? Did we really make a difference?

MacColl Self-Management Surveys - Asthma (40), COPD (38), Diabetes (80)
Step 5
Measure the Change

What did our patients say? Did we really make a difference?

MacColl Self-Management Surveys
Asthma (40), COPD (38), Diabetes (80)
Step 5
Measure the Change

- Answers where there was >20% higher response to “Almost Always” from patients of physicians attending the education series
  - Asked what I would like to discuss about my illness at that visit
  - Asked how my work, family or social situation related to taking care of my illness
Step 5
Measure the Change

- Answers where there was 15-20% higher response to “Almost Always” from patients of physicians attending the education series
  - Given choices about treatment to think about
  - Given a written list of things I should do to improve my health
  - Shown how what I did to take care of my illness influenced my condition
  - Asked how my visits with other doctors were going
  - Helped me to make plans for how to get support from my friends, family or community
Step 5
Measure the Change

- Answers where there was a lower response rate to “Almost Always” from patients of physicians attending the education series:
  - Encouraged to go to a specific group or class…
  - Asked questions….about my health habits
  - Sure that my doctor or nurse thought about my values and traditions…

- When answers were combined for “Almost Always” and “Most of the Time”, the percentages were overall higher for patients of physicians attending education
Step 5
Measure the Change

Pre and Post Self-Assessment

ASSessment of Chronic Illness Care

Asthma

Part 3: Practice Level - Part 3a: Self-Management Support

<table>
<thead>
<tr>
<th>CIC Elements</th>
<th>PRE</th>
<th>POST</th>
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<tbody>
<tr>
<td>Assessment &amp; Documentation</td>
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<td>8</td>
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<tr>
<td>Management Needs &amp; Activities</td>
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<td>3</td>
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<tr>
<td>Effective Behavior Change</td>
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<td>Intervention and Peer Support</td>
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COPD

Part 3: Practice Level: Part 3b: Decision Support

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<th>CIC Elements</th>
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<td>Evidenced based guidelines</td>
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<td>Involvement of Specialists</td>
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<td>Improving Primary Care</td>
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<td>Informing patient about guidelines</td>
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Diabetes

Part 2: Community Linkages

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<tr>
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<tr>
<td>Linking Patients to Outside</td>
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<td>Resources</td>
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<td>Partnerships with Community</td>
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<tr>
<td>Organizations</td>
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<tr>
<td>Regional Health Plans</td>
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Spread and Sustain Change

- **Capacity building**
  - Taking care of partnerships, continuing education
- **Expanding our model to other groups**
  - Family Health Teams, Congestive Heart Failure, Diverse cultural groups
- **Sharing information**
  - Conferences, Best Practices web site, local regional planning teams
- **Involving patients in on-going evaluation**
  - Surveys, focus groups
- **Incorporating changes into current operations**
  - Orientations, tool maintenance, referral patterns, documentation forms,
  - Assign person to be responsible for on-going responsibilities
Summary

- Created capacity
- Improved our approach to chronic disease management
- Increased our consistency in evidence-based practice across the continuum
- Patients experienced a difference
Next Steps

- We are sharing our experiences and participating in our Local Health Integrated Network Detail Planning and Action Team.
- We are currently exploring our therapeutic role within the system and planning for an integrated model of CDM.
- We continue to look for opportunities to strengthen elements identified in the CDM framework e.g. clinical information system enablers.
Thank you!

We would like to acknowledge GlaxoSmithKline for being part of the solution and for their generous support of this project including expertise, human resource and project model support.

Together:
...we have improved patients’ knowledge of their conditions and self-management skills
...we have improved patient care
...we have increased health care providers knowledge of evidence based guidelines