A Collaborative Approach to a Chronic Care Problem: Evaluative Results from the Atlantic Healthcare Collaboration

November 25, 2015
12:00-1:00pm ET
WHO’S ON THE CALL TODAY

MEGHAN ROSSITER
Regional Liaison, Collaboration for Innovation and Improvement, CFHI

JENNIFER HENNEBURY
Regional Chronic Disease Prevention and Management Manager, Diabetes Services, Western Health

ANNETTE HARLAND
Clinical Liaison, PEER 126

LYNN EDWARDS
Senior Director, Primary Health Care and Chronic Disease Management, NSHA

PATTI DARLING
Area Manager, Addiction and Mental Health Services, PEER 126

TARA SAMPALLI
Assistant Director, Quality and Research in Primary Healthcare, NSHA
SERIES OBJECTIVES

1. Demonstrate solutions...
2. Profile team experience and lessons learned...
3. Assess strategies for disruptive change...
SESSION OBJECTIVES

Share improvement intervention case examples to understand the:

1. Process undertaken for improvement
2. Mechanisms for sustainability/spread
3. Integration of patient-centred frameworks
4. Lessons learned
Western Health’s Journey....
Self Management Support Project

- Pre Test
- Identification of Priority Areas
- Identification of Strategies
- Implementation of Strategies
- Evaluation
Primary Care Resources and Supports for Chronic Disease Self Management

- Individualized Assessment of Education Needs
- Self Management Education
- Goal Setting/ Action Planning
- Problem Solving Skills
- Emotional Health
- Patient Involvement
- Patient Social Support
- Linking to Community Resources
- Continuity of Care
- Coordination of Referrals
- Ongoing Quality Improvement
- Documentation of SMS
- Patient Input
- Integration of SMS into Primary Care
- Patient Care Team
- Team Education and Training in SMS

Tool available at:
http://diabetesinitiative.org/support/primaryCare.html
Improving Self Management Support within Local Diabetes Teams

**Emotional Health**
1. Identified a standardized screener for depression that is used on intake for all new clients.
2. Developed a treatment algorithm to support the screener.
3. Policy developed and implemented supporting the screening and treatment algorithm.

**Patient Input**
1. Developed and implemented a poster campaign.
2. Encouraged clients to provide compliments or complaints about the service they received.
3. Developed and piloted a client survey for active clients to share their experiences.

**Staff Training & Education**
1. Identified core competencies for staff related to self-management.
2. Initiated several training sessions including a two-day workshop with the Behaviour Change Institute.
3. Developed a community of practice to support integration and ongoing learning.

"With all the improvements made my wait list has significantly improved to allow me to respond to referrals in a more timely fashion. I think overall there has been a great job done with revamping the program."

Corner Brook/Bay of Islands
Western Memorial Regional Hospital
Phone: 637-5000, Ext: 5388

Bonne Bay
Bonne Bay Health Centre
Phone: 458-2211, Ext: 260

Deer Lake/White Bay
20 Farm Road
Phone: 635-7830/7831

Stephenville/Bay St. George
Sir Thomas Roddick Hospital
Phone: 643-8728

Port Aux Basques
Dr. Charles LeGrow Health Centre
Phone: 695-4619

Burgeo/Ramea
Calder Health Centre
Phone: 886-3360

Port Saunders
Rufus Guinchard Health Centre
Phone: 851-9126

Canadian Foundation for Healthcare Improvement
Atlantic Healthcare Collaboration
Embedding Self Management into our Approach

Managing Diabetes

“I made a plan. It wasn’t easy... But I did it. So can you.”

Regional Diabetes Services

Our Vision

The vision of Western Health is that the people of western Newfoundland have the highest level of health and well-being possible. Your health is our priority.

Call the Diabetes Services Team nearest you.

If there isn’t a Diabetes Services Team in your community, you may be able to link with the team by way of telehealth.

Ask us for the details.

1. Bay St. George (709) 643-8747
2. Bonne Bay (709) 438-2211
3. Burgeo (709) 886-1550
4. Corner Brook (709) 637-5388
5. Deer Lake (709) 635-7830 (709) 635-7831
6. Port Saunders (709) 861-9126
7. Port aux Basques (709) 695-4625
Outcomes/ Impact

- Client survey
- Team Confidence/ Skill
- Team PCRS Post test
## Team Members Skills/Confidence

<table>
<thead>
<tr>
<th>How confident are you that you could:</th>
<th>Average Level of Confidence</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Baseline</td>
</tr>
<tr>
<td>(a) Teach people to identify and solve their own problems.</td>
<td>7.5</td>
</tr>
<tr>
<td>(b) Assist a client to focus on one problem a day.</td>
<td>8.8</td>
</tr>
<tr>
<td>(c) Assist a client to develop a goal and personalised action plan.</td>
<td>8.3</td>
</tr>
<tr>
<td>(d) Use reflective listening, that is, reflecting back to the person the meaning of what they have said.</td>
<td>8.8</td>
</tr>
<tr>
<td>(e) Use open-ended questions to explore a person’s readiness to change.</td>
<td>9.3</td>
</tr>
<tr>
<td>(f) Ask appropriate questions or use scaling techniques to elicit readiness for change.</td>
<td>8.8</td>
</tr>
<tr>
<td>(g) Match interventions and/or questioning to readiness.</td>
<td>8.3</td>
</tr>
<tr>
<td>(h) Challenge people that are defensive, resistant or aggressive about changes in their health whilst maintaining a therapeutic relationship.</td>
<td>7.5</td>
</tr>
<tr>
<td>(i) Use a depression screening tool during assessment.</td>
<td>7.3</td>
</tr>
<tr>
<td>(j) Know what questions to ask people you think may be at risk of suicide.</td>
<td>2.9</td>
</tr>
<tr>
<td>Average overall confidence for items a-j</td>
<td>7.8</td>
</tr>
</tbody>
</table>
Team Attitudes/ Beliefs

- Providers beliefs changed!
  - More importance on client self management actions
  - Decrease in importance of providers actions
  - Less importance in “traditional medical/educational” interventions, more importance on client self management supports
Changes in PCRS Scores

- Assessment
- Education
- Goal Setting
- Problem Solving
- Emotional Health
- Pt Involvement
- Social Support
- Community resources
- Continuity
- Coordination
- Quality Improvement
- Documentation
- Patient Input
- Integration
- Team
- Education
- Average

Pretest
Posttest
PACIC Scores

Score

Score

Score

Score
Organizational Outcomes

- Delivery System Redesign
- Decision Support Tools
- Supporting Spread to other areas
Reflecting on Our Journey
In January 2012, Horizon Health Network entered into a partnership with Medavie Health Foundation to support the development of a youth recovery program in Saint John, NB. The funding commitment is for five years.
PEER 126 is designed to ensure youth with addiction and mental health concerns have the support needed to live productive and fulfilling lives.
A team of Addiction and Mental Health professionals, Human Service Workers and Trained Peer Supporters provide services and support to members with their recovery plan.
PEER SUPPORT WORKER

- Is an individual who is living in recovery with a mental health or substance use issue who provides support to people who can benefit from their lived experiences.
- We currently have 1 full time and 1 part time Peer Support Worker
- Facilitate activities
- Provide one on one support
- Act as a role model for recovery
MEMBERS AT P.E.E.R. 126

- Ages 16-29
- Have an addiction or mental health concern
- Attempting to live a life of recovery
P.E.E.R. 126 is:

- Peer led
- Part of the continuum of services within the Addictions and Mental Health Program
- Community based
- Recovery based
- Links members to both formal and informal services (as desired)
Not everyone needs a counsellor, but everyone benefits from peer support.
RECOVERY

Expectations

Reality
LESSONS LEARNED

- Peer Support Workers
- Location
- Linkages
- Age Criteria
- Programming
For Further Information:
126 Duke Street
(506)658-5374
OR
Pick up a brochure on your way out.

When “I” is replaced by “We” even illness becomes wellness.

HealthyPlace.com
Questions and Discussion

Please submit your question using the chat box on the bottom of your screen.
The Chronic Disease Prevention and Management Corridor
Improving care and care experiences for individuals with chronic conditions and multimorbidities

Lynn Edwards, Senior Director, Primary Health Care and Chronic Disease Management
Tara Sampalli, Assistant Director of Research, Primary Health Care, Nova Scotia Health Authority
The Improvement Opportunity

*Canadian Foundation for Healthcare Improvement (CFHI) and Atlantic Collaborative*

Four CDPM areas participated – Community Health Teams, Diabetes Management Centres, INSPIRED COPD Outreach Program, Integrated Chronic Care Service

**System-level approach** to improving care for individuals with multimorbidities and chronic conditions

**Team** included members from the four service areas (clinicians and administrative staff), Primary Health Care leads, Performance Excellence, Process Engineer, patient and family advisors.
Objectives

- To improve care and care experiences by reviewing and changing care delivery process at a system-level
- To standardize elements of care and improve system-level supports for chronic disease prevention and management

Key questions

- What is our current state?
- What are our opportunities?
CDPM Corridor Approach®: Patient-centred Redesign Framework to Support Service Delivery Redesign

**PROJECT LAUNCH AND PLANNING**
- Working Group Establishment
- Purpose Statement Development & Alignment
- Project Management Tools/Methodologies

**EVIDENCE**
- Literature Review
- Jurisdictional Scan/Best Practice Identification
- Understanding Local Population Data

**ESTABLISH BASELINE**
- Baseline Data Analysis Based on Alignment with Chronic Care Model and Identification of Phases of Care

**CURRENT STATE REVIEW**
- Referring Physician/Provider Feedback
- Value Stream Mapping of Current State
- Patient/Client Feedback

**WORKING TOGETHER**
- How will you Work Together with other CDPM Programs and Services?

**FUTURE STATE DEVELOPMENT**
- Future State Value Stream Map and Identification of Process Oriented Changes

**FUTURE STATE IMPLEMENTATION**
- Process Orientated Changes Implementation Supported by the CDPM Corridor® Hub of Supports
- Evaluation Framework and Standardized Outcome Measures

**SUSTAINABILITY OF THE PROCESS AND SUPPORTS FOR TEAMS TO ADOPT STANDARDS AND APPLY TOOLS IS SUPPORTED BY THE CDPM CORRIDOR® “HUB” OF SUPPORTS & COMMON ELEMENTS PLATFORM**
Novelties of our approach

• Applying the Expanded Chronic Care Model, in service redesign
• Patient-centered redesign approach
• Modified value stream mapping
• Applying the Working Together Framework, in service redesign
• System-level (across programs/services) and service level process changes identified for participating services
• Spread: CDPM Corridor and Toolkit
Measuring success:

**Immediate outcomes:** (18 month intervention 2012 – 2014)
Engagement strategies – number of teams, clinicians, and patients engaged
Value-stream mapping – Development and validation of current and future state improvements
Identification of service level and system level process changes
Uptake of proposed changes/intervention

**Short-term outcomes:** (2015-2017)
Patient/provider outcomes – Experience and satisfaction
Knowledge translation and spread - # of workshops, presentations, publications, number of teams engaged in the organization, alignment with provincial strategy

**Long-term outcomes:** (2017-2020)
Health outcomes – clinical outcomes of relevance to patients/services, functional health outcomes, health system efficiencies in chronic disease management (reduction in redundancies, resource costs)
The Integrated Chronic Care Service (ICCS) – Participating service

- Part of provincial health authority in Nova Scotia, primary health care portfolio
- Individuals with **multiple chronic conditions** and other complex conditions, no diagnosis, poor functional health status
- ~ 10,000 patient visits each year, over 350 new referrals each year
- Service focus – functional and workplace rehabilitation
- Interdisciplinary team approach
- Referrals from within province, out-of-province and out-of-country
- Accept referrals from physicians, NPs and specialists

**Case Presentation**

**Corridor – System Related Changes**

**My Care My Voice – Service Specific Changes**
My Care My Voice Initiative – Service specific initiative

- Wait times – frustrating for referral source and for patients
- Front load of information was too much for our patient population
- Many patients did not know why they were being referred to ICCS
- Patients struggled to understand their involvement in care offered at ICCS
- Patients didn’t feel included in care delivery processes
Understanding opportunities to improve

**Table 1. PACIC**

<table>
<thead>
<tr>
<th>Category</th>
<th>Mean value (SD)</th>
<th>Maximum score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient activation</td>
<td>3.8 (1.1)</td>
<td>5</td>
</tr>
<tr>
<td>Delivery system design/decision support</td>
<td>4.2 (1.2)</td>
<td>5</td>
</tr>
<tr>
<td>Goal setting/tailoring</td>
<td>4.3 (1.1)</td>
<td>5</td>
</tr>
<tr>
<td>Problem solving/contextual</td>
<td>4.4 (1.3)</td>
<td>5</td>
</tr>
<tr>
<td>Follow up/coordination</td>
<td>3.1 (1.1)</td>
<td>5</td>
</tr>
</tbody>
</table>

PACIC = Patient Assessment of Chronic Illness Care

**Table 2. Referring Physician Satisfaction Survey**

<table>
<thead>
<tr>
<th>Category</th>
<th>Mean value (SD)</th>
<th>Maximum score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial consultation</td>
<td>3.2 (1.3)</td>
<td>5</td>
</tr>
<tr>
<td>Referral process</td>
<td>4.1 (1.1)</td>
<td>5</td>
</tr>
<tr>
<td>Treatment</td>
<td>4.2 (1.2)</td>
<td>5</td>
</tr>
<tr>
<td>Care transition</td>
<td>2.4 (1.1)</td>
<td>5</td>
</tr>
</tbody>
</table>

**Table 3. Interviews with various stakeholders**

<table>
<thead>
<tr>
<th>Interviews</th>
<th>Sample feedback</th>
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</thead>
<tbody>
<tr>
<td>Patients</td>
<td></td>
</tr>
<tr>
<td>(n=4)</td>
<td>I am still a patient of your clinic because I am still waiting to access your psychologist for a year. Long wait times to see your psychologist. Why do I have to wait so long to access your group programs. I do not want to be discharged because I have to again wait a long time to receive care. My opinion is not included in my care.</td>
</tr>
<tr>
<td>Referring physicians (n=5)</td>
<td>No longer interested in this referral. Patient is receiving care elsewhere. Long wait times for care. Initial consult process is not effective. Discharge and follow up process is not effective.</td>
</tr>
<tr>
<td>Wait list individuals (n=5)</td>
<td>Improve access to care, reduce wait times. Waiting to receive care is not helpful, can anything be done to change this. Distress of managing my condition is increasing while I wait. Unable to function. I just want to know my diagnosis. I would benefit from receiving some education and support while I wait.</td>
</tr>
</tbody>
</table>
Opportunities – engage patients, provide a voice

- Improve process at intake and transition points
- Improve engagement of patients in care
- Better readiness assessment process at intake, discharge and at key phases of care delivery
- Co-design process changes with patient involvement
Process changes based on feedback

**REFERRAL**
- Future process and state
  - We are glad not to wait: We can learn about ICCS care, understand your approach, tell you our specific needs, help develop supports in the community.
- What are patients saying about future state?
- What is the impact?
  - No wait times to care: Patients are better engaged and better informed, community supports are better aligned, team can focus on specific needs.

**INTAKE**
- Patients express their readiness for psychosocial and dietary intervention through care coordinator and hope and needs form. Group treatments are offered first.
- I have a choice to express my needs and tell you about my readiness. I may not be ready for this treatment yet. I would like to learn more in a group intervention.
- No wait times to care: Timely psychosocial and dietary interventions for those ready to receive care.

**INTERVENTION**

**TRANSITION**
- Patients readiness for discharge is assessed, new re-referral process with LPN triaging patients to timely and relevant care without wait times.
- I feel confident about being discharged. My readiness is being assessed. New re-referral process is helpful.

**DISCHARGE**
- Discharge rates improved: Duration of care average at 6 months versus 2+ years.

**Figure 3. Future state process.**
• Organization provides stability and support for initiative
• Patients have better care experience
• Secondary outcomes – reduction in wait times to care
Service Delivery Redesign

Establish Baseline
- Evidence review (environmental scan, literature review, service standards)
- Alignment with the Corridor Approach© and team establishment
- Analysis of baseline data for your program/service

Current State Review
- Key stakeholder surveys and interviews – patients and referring physicians
- Value stream mapping and current state

Working Together
- How integrated with other CDPM programs and services should your service be?

Future State Development
- Value stream mapping of future state and identification of process-oriented changes
- Feedback and input from key stakeholders – patients and the team
- Evidence standards and guidelines

Future State Implementation
- Implementation of process-oriented changes
- Evaluation and outcomes
- Ongoing alignment with the Corridor Approach©
Community
Self-management Supports
Functional Health Management Supports
Clinical Information Systems
Decision Support
CDPM Competencies
Adult Education and Health Literacy
Coordinated Care pathways

Adapted from: Barr, et al. (2003); Wagner, et al. (2002); Institute of Medicine (2012), Kaiser Permanente, Koh, et al. (2013)
Leadership, governance and quality
- Organizational Quality committee for CDPM

Guiding frameworks and core curriculum
- Coordination of programming across program areas and settings

Expertise and mentor pool
- Across organizational units, programs and settings

Program Elements
- Coordination of resources that support across program areas and settings
Next steps and spread:

• The three components of the Corridor are being used in planning for province wide Health Services Planning related to Chronic Disease;
• Common Clinical Intake and Electronic Progress Note receiving favorable consideration by the province
• Capacity building activities – Performance Excellence, Process Engineers, IT
• Toolkit under development
Recent publications and relevant articles

Peer-reviewed journals


Questions and Discussion

Please submit your question using the chat box on the bottom of your screen.
Upcoming Webinars

• **December 11, 2015** * – A Collaborative Approach to a Chronic Care Problem in Canada: Evaluative Results from the Atlantic Healthcare Collaboration – *Part 3*


* Part of the Chronic Care Series
Thank you!

Merçi!