Thank you for joining us today!

12-1:00pm ET, April 1, 2015

We will begin shortly

Shifting Culture, Shifting Care: From ‘Usual Care’ to Chronic Care
Please turn on your computer speakers to hear today’s session.

If you do not hear music, then please confirm your computer speakers are on and check that your volume is not muted.

If you do not have computer speakers, then please dial 1-855-856-8710 to listen to the English audio.
Shifting Culture, Shifting Care: From ‘Usual Care’ to Chronic Care

Speakers:

**Clare Liddy, MD,**
Director of Research (interim), Clinical Investigator at the C.T. Lamont Primary Health Care Research Centre, Bruyère Research Institute (BRI)

**Jeffrey Turnbull, MD,**
FRCPC, O.C., Medical Director, Inner City Health Project; Chief of Staff, The Ottawa Hospital; Chief, Clinical Quality, health Quality Ontario

**Jennifer Verma**
MSc (medicine), BJH, Senior Director, Collaboration for Innovation and Improvement, CFHI

**Claudia Amar,**
RN, BScN, MHA, Improvement Lead, Collaboration for Healthcare Improvement, CFHI

Hosts:
Shifting Culture, Shifting Care: SERIES OBJECTIVES

1. Discuss the challenges we face, along with the requirements to shift our healthcare focus
2. Highlight optimal conditions for chronic care improvement and explore what kinds of changes are needed to improved chronic care
3. Address the unique challenges of providing chronic care treatment in rural and remote areas of Canada – and emerging technologies to support this care
4. Address the readiness of family caregivers to provide chronic care in a home setting
Shifting Culture, Shifting Care: TODAY’S SESSION OBJECTIVES

1. Explore the problems associated with a predominantly acute care model and the barriers in shifting to a chronic care paradigm

2. Highlight some significant challenges we face in shifting our healthcare culture to deliver more coordinated, patient- and family-centred chronic care

3. Share some creative solutions for moving ahead using real-life examples of clinicians who are shifting culture and shifting care
   - Self-management approaches & challenges for people with multiple chronic conditions
   - Caring for the 5% (High-risk, high-needs patients) with a view to health equity
85% of boomers report eating too few vegetables and fruit.

62% say they are overweight or obese.

Nearly 1 in 5 boomers admit to exercising less than once a week.

30% say they are often or always stressed.

80% think their doctor would say they are healthy.
Usual Care

- Fragmented
- Narrow in focus
- Not relevant
- Hospital-based

Good Chronic Illness Care
START WITH WHY

**Why = The Purpose**
What is your cause?
What do you believe?

**How: The Process**
What specific actions will you take to realize the why?

**What = The Result**
What do you do?
The result of the why proof

Simon Sinek (2011) “Start with Why”
Shifting Culture, Shifting Care: From ‘Usual Care’ to Chronic Chronic

Dr. Jeffrey Turnbull
Chief of Staff
The Ottawa Hospital
Our Current System of Health Care is Unsustainable
The Cost of Health Care in Canada
The Quality of Health Care in Canada
Social, Demographic and Political Factors Shaping the Debate

- An aging population
- Utilization
- Fiscal restraint
- Classic federalism
- Rising social inequity
- The prominence of chronic diseases
## Chronic Illness care: From Consensus to Action

### Paradigm Changes

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<th>Patient-centered</th>
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<td>Chronic disease management</td>
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<td>Individual, isolated practice</td>
<td>Group-connected, team-based, accountable practice</td>
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Acute Care to the Health Network: New models of Chronic Illness Care

Patient-centred, integrated, new models of care to address chronic disease within a specific population.
Shifting Culture, Shifting Care: From ‘Usual Care’ to Chronic Care

Challenges of self-management when living with multiple chronic conditions

April 1, 2015

Dr. Clare Liddy (cliddy@bruyere.org)
This presentation will discuss:

• What is self-management?
• Challenges for people with multiple chronic conditions
• Implications for policy and practice
Expanded Chronic Care Framework

The Care Model

Community
- Resources and Policies
- Self-Management Support

Health Systems
- Organization of Health Care
- Delivery System Design
- Decision Support
- Clinical Information Systems

Services
- Patient-Centered
- Timely and Efficient
- Evidence-Based & Safe
- Coordinated

Improved Outcomes

© 2002 The MacColl Center for Health Care Innovation, Group Health Research Institute
Definition of Self-management

“The tasks that individuals must undertake to live well with one or more chronic conditions.

These tasks include having the confidence to deal with medical management, role management and emotional management of their conditions.”

Adams 2004
"I love the future now. I have knowledge, not just a hope. I have a knowledge that I'll be able to cope with the future because I feel much stronger within myself. I have more confidence. I have more self-esteem."

- Workshop Participant
Types of Self-management Programs

- Patient education sessions and motivational counselling in group sessions

- Strategies that address patient motivation in a multi-pronged fashion, including physician and patient education

- Short-term, repetitive sessions focused on a few specific diet and lifestyle behaviour changes

Liddy 2011
Evidence: Effect of SMS Interventions?

- Improves quality of life, knowledge of condition, and self-efficacy
- Improvements in clinical outcomes for diabetes, hypertension, congestive heart failure
- Lowers hospitalization rates, less ED use, and fewer follow-up visits in the US

Johnston 2012; Ory 2013
Self-management policies often imbedded within other initiatives

A disease-specific approach still persists

Focus on a more generic approach (dealing with fatigue, action planning for a healthy lifestyle, etc.) is critical to a successful self-management policy

Let’s Go Back to the Patient…

Goal:

• To understand the perspectives of patients who live with MCCs as they relate to the challenges of self-management

  – What barriers do they face?
  – What strategies do they adopt to overcome these barriers?

Study Strategy

• We conducted a systematic review of the qualitative literature on self-management

• Articles were analyzed using a thematic synthesis method

• We applied Hudon and colleagues’ conceptual framework of patient-centred care as an explanatory guide for the important themes
Hudon Conceptual Framework

- Patient-as-person
- Sharing power and responsibility
- Bio-psycho-social perspective
- Therapeutic alliance

**Depressive Symptoms**

- Living with undesirable physical and emotional symptoms (*chronic pain, fatigue*)
- Consider the whole person (*cognitive, social, financial*)
- Finding the common ground (*tailored care plans, mutual agendas, improved listening*)
- Patient-doctor relationship (*conflicting knowledge, poor continuity of care*)

**Self-management Support**

Hudon 2011
Key Themes

Patient-as-Person

• Physical and emotional symptoms of MCC can prevent patients from successful self-management

• Symptoms can build off of one another

• Many people with MCC experience depression
Key Themes

Bio-psychosocial Perspective

• Changing cognitive approach helps many patients deal with their symptoms

• Access to social support is a strong enabler of self-management, though intended support from family/friends can sometimes hinder patients

• Lack of financial resources creates barriers (e.g. cost of medications, unemployment)
Key Themes

Therapeutic Alliance

• Doctor-patient relationship is not always therapeutic

• Patients cite several barriers to care:
  – Contradictory knowledge
  – Poor access
  – Challenges with medication
Key Themes

Sharing Power and Responsibility

• Important to find common ground between patients and providers

• Patients need:
  – To feel “listened to”
  – Assistance locating resources
  – To feel comfortable asking doctors questions
  – Access to individualized care plans
Conclusion

• Main challenges to self-management are dealing with physical/emotional symptoms and accessing clear and accurate knowledge.

• Patients can clearly identify challenges associated with self-management and develop strategies to address them.

• Self-management support should be better aligned with patients’ perspectives and adopt a patient-centred approach.
Key messages

• Self-management activities should be an integral part of ongoing chronic disease care
• Patient centered approach is needed
• Less focus on disease and more on symptom management
• Policy and program funding needs to be more inclusive of this approach and less anchored in diseases
Useful Resources

Relevant Publications


Inner City Health: Chronic Illness Care focused on health equity

Canada’s Most Vulnerable
Chronic Illness Care: High-Risk, High-Need Populations

Often entails…

• Lack of access to effective care and entitlements
• Receiving care that is fragmented, episodic, crisis driven and not integrated
• Vulnerability, isolation, resilience and voicelessness
• Poverty
Social Inequity and Health Inequity: Health Outcomes
Chronic Illness Care Through A Health Equity Lens

- Define the nature and extent of the community involved
- Consider systems based barriers to access
- Engage patients, families and communities in effective solutions
  - Care on their terms
- Mitigate underlying social factors through partners and advocacy
- Define and measure success on their terms
Homelessness in Ottawa

- 7308 individuals

- 381 Youth
- 1125 families
- 1097 women
- 3296 men
Homelessness in Ottawa

Adults

Youth

Women

Mental illness & Addictions

Families
Inner City Health: Chronic Illness Care, A Health Inequity Mitigation Strategy
Engagement & Access

The right care, at the right time, in the right place
Integrated Case Management with Alignment of Goals for Health and Health Care
Integrated & Connected Team-Based Care

New roles, new providers, new partners
OICH Members

- Ottawa Hospital
- University of Ottawa
- Royal Ottawa Hospital
- Community Care Access Centre
- Community Health Centres
- The Mission
- The Salvation Army
- Options Bytown

- Anglican Social Services
- Cornerstone
- Shepherds of Good Hope
- Canadian Mental Health Association
- Wabano Centre for Aboriginal Health
- Centre for Addiction and Mental Health
- Carefor Health and Community Services
- Youth Service Bureau
Enabling effective access to care and Setting Goals Appropriately
Manage Performance with Realistic Goals
Questions?

Please submit your questions using the chat box on the bottom right of your screen.
Upcoming sessions in the Chronic Care series:

- May 8, 2015 – The Chronic Care Model: Designing Care with “Chronic” as the New Norm
- June 3, 2015 – Supporting Carers of Patients Living with Chronic Disease
- June 10, 2015 – Bridging the Gap between Patients and Providers through Telehealth in Rural and Remote Regions
Thank you!