Changing Practice, Changing Outcomes

The Challenge of Individuals Living with Chronic Disease
How Do we Do It Better?

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Presentation Overview

1. Broad context driving initiative
2. VON's Integrated Model of Care for CD Self-Mgmt.
3. Self-Mgmt Support
    1. Education Program for Nurses
    2. Decision Supports
    3. Evaluation
4. Enablers & barriers
5. Lessons learned

Chronic Disease Is an International Concern

- **Chronic disease has become the major cause of death and disability affecting populations of both developed and developing countries.**

- **59% of the 57,000,000 deaths each year**
- **46% of global burden of disease**
- **By 2020, almost *75% of all deaths worldwide* will be from chronic diseases**

Canadian Statistics

- ***16*** million Canadians live with chronic illness
- ***80%* of adults over age 65 have a chronic disease**
- **25%** of Aboriginal people over age 45 have diabetes
- ***Chronic Disease is responsible for***
  - ***60%*** of hospitalizations
  - ***70%*** of all deaths in Canada
  - ***2/3*** of medical admissions via emergency departments
  - ***80%*** of family doctor visits
  - ***60-80%*** of total medical costs

Source: Rapoport, J. et al Chronic Diseases in Canada, 2004 in CDM for the SIMS partnership. Phase 2 – CDM Program Design. CDM working group, April 12, 2006

Significant Challenges Facing Canadians Today

1. **Increasing #'s of people with chronic disease (+ co-morbidities)**
2. **HHR shortages/limitations**
3. **Adopting & sustaining healthy behaviours**

Challenges Manifest At All Levels

System Wide	Provider	Patient
Increase in #s	***model of chronic illness care in which they were trained and still deliver is actually acute care - managing crises as they happen rather than engaging the patient in self-management activities."***	**Resources most accessible when 1st diagnosed & when in crisis**
1 acute episode after another		**"Quick fix" – no care proactively or over time**
Tsunami!		**Pts. Self-manage 8759 hrs/ year**

June 2009

Dr L. Gask, University of Manchester School of Primary Care

There are Gaps Between *What We Know* and *What We Do*...

We say that we…

- Deliver client & family-centred care
- Work with patients as equal partners in care
- Make evidence-based decisions
- Deliver integrated seamless care
- Want right person, right place, right time

…but we don't…

- Develop providers' skills
- Help them develop confidence/skills
- Have easy access to evidence at POC
- Bridge barriers between sectors
- Provide appropriate funding mechanisms

The Starting Point

"*Every system is …designed to produce exactly the results it gets*."

Don Berwick

CEO & President of Institute for Health Improvement

"The significant problems we face cannot be solved by the same level of thinking that created them."

Albert Einstein

VON's Chronic Disease Self-Management Program

- **Grounded in principles of:**
  - **Self-Management**
  - **Interdisciplinary collaboration**
  - **System integration**
- **Technology is an enabling tool**
- **Framework guiding practice based on:**
  - **VON Canada's Care & Service Model**
  - **Wagner's Chronic Care Model**
  - **Fisher's Tri-Level Model of Self-Mgmt & CC**

VON Care and Service Model

HEALTH AND SERVICE IMPERATIVES

VON will be Canada's leading charitable organization addressing community health and social needs.

POPULATION HEALTH, COMMUNITY HEALTH, DETERMINANTS OF HEALTH

VON CARE AND SERVICE

VON VALUES

Respect
Participation
Responsiveness
Courage

PRACTICE
RESEARCH
POLICY

SOCIETY
COMMUNITY
FAMILY/SOCIAL NETWORK
PERSON

Working with individuals, families and groups in homes and communities

PILLARS of VON

Excellence
Learning Culture
Philosophy of Care
Innovation
Leadership
Integration
Partnerships

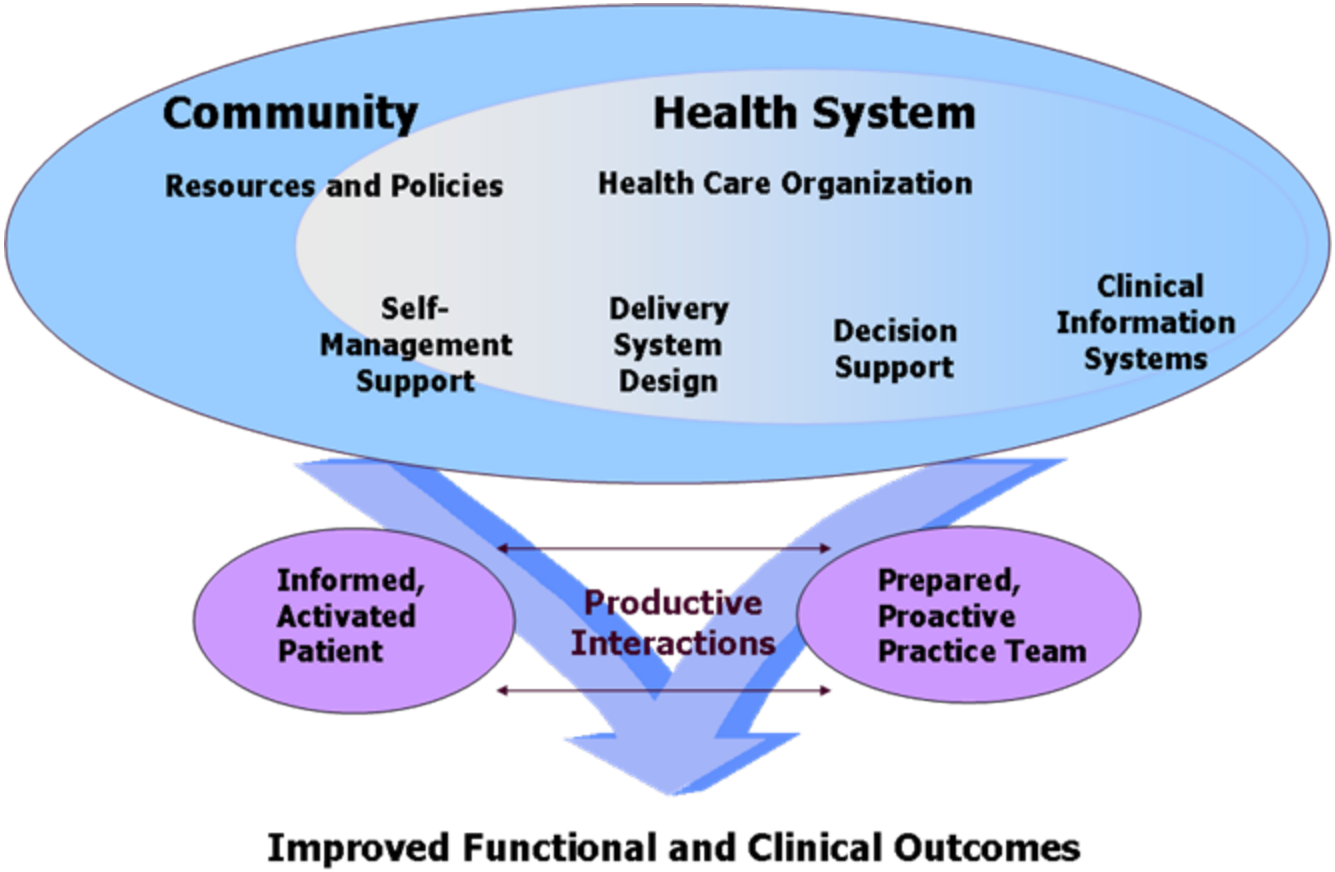
OUTCOMES

Healthy public policy through research, voice, influence and impact.

Positive health and social outcomes for individuals, families, communities and society.

Effective partnerships with clients, caregivers, families, the care and service team, communities, funders and governments.

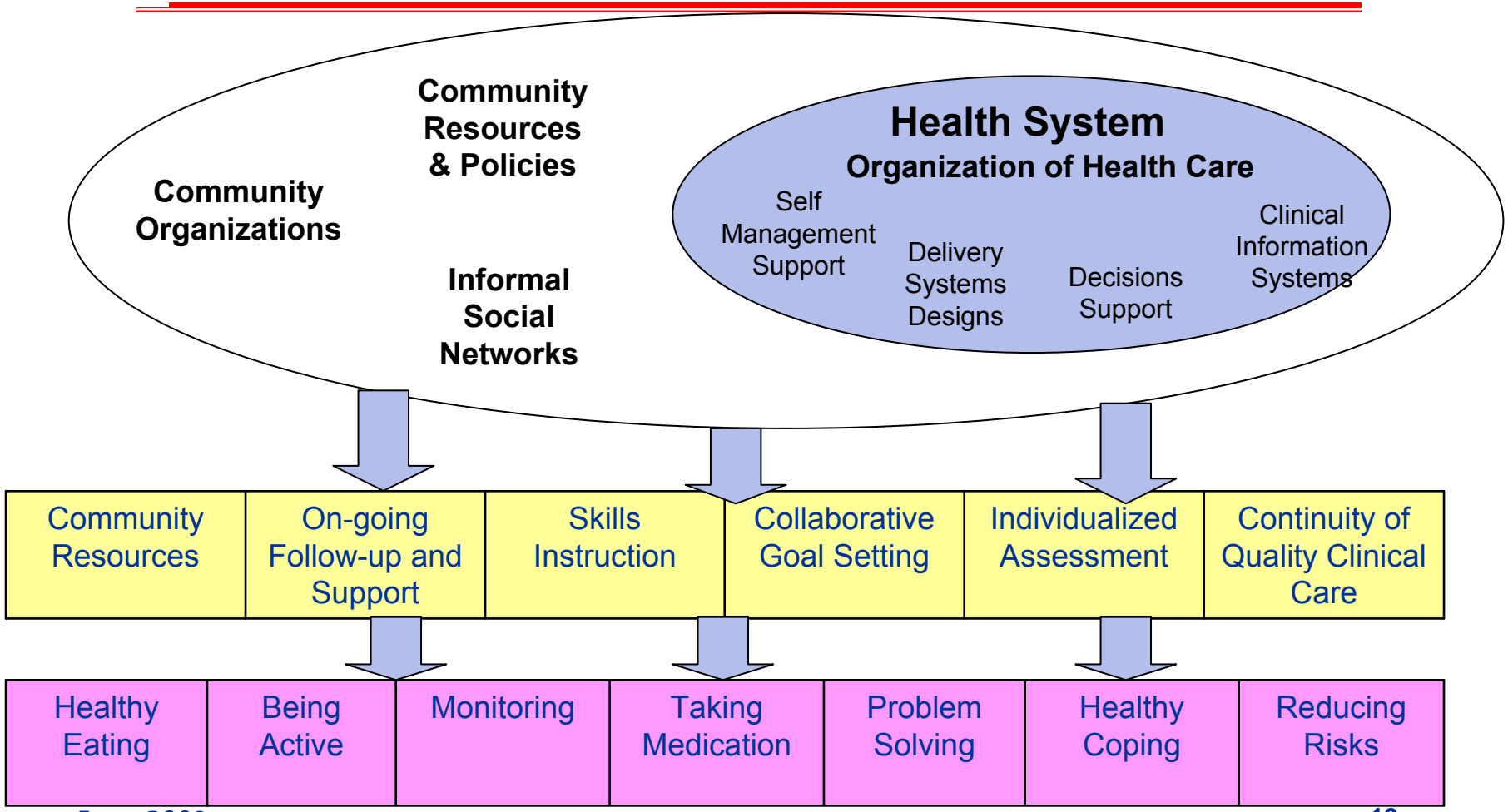
Wagner's Chronic Care Model
A Starting Point



Are We Having Productive Interactions?

Informed Activated Patient?

Prepared Proactive Practice Team?



Clinical Status & Quality of Life

Self-Management
How Do You Get From "Here" to "There"?

Usual Care

- EB guideline for care not met by providers or pts.
- Standard educational content for all pts.
- One time activity
- SM stand-alone isolated activity separate from care system

Pilot Care

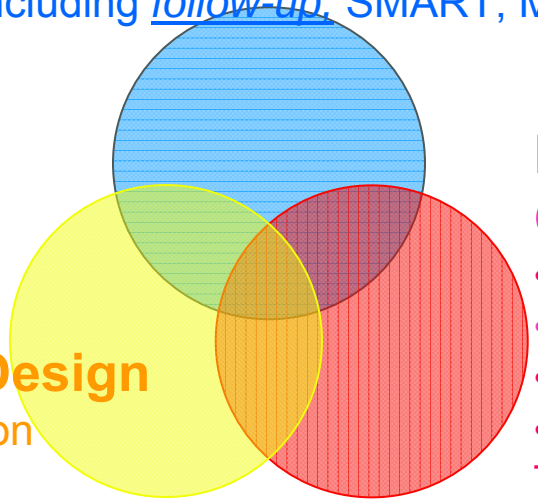
- Provider & client behaviour cued over time from EB
- ***Pt. centred & individualized content***
- Iterative process
- SM integral part of system

Glasgow et al. (2002) SM Aspects of Improving CIC Breakthrough Series: Implementation with Diabetes & HF Teams

Stay@Home with VON
The Big Picture

Self-Management Support

Stanford University CDSMP classes, Disease Specific Education,
1:1 Contact to Assess Clinical Status & 7 CDSM Behaviors,
Self-Mgmt Support including *follow-up*, SMART, Meals Programs, etc.



Delivery System Design

- System Navigation
- Advocacy
- Case Management

Decision Support & Clinical Info Systems

- Self-Management Portal
- EHR
- Tele-home Monitoring
- Triaging Guidelines

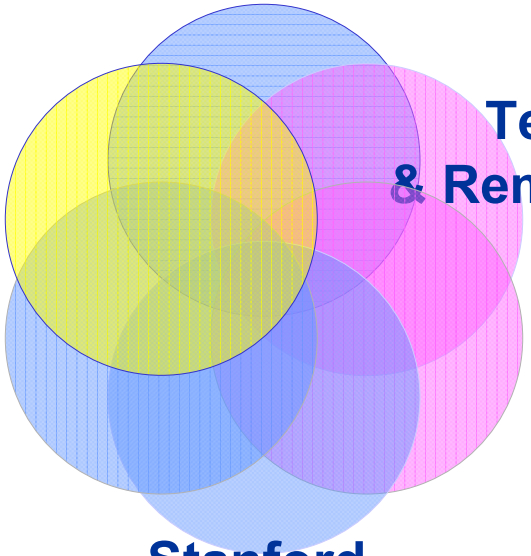
Tools to:

- Cue Practice at POC
- Facilitate Documentation
- Collect Data for Evaluation

CD Self-management in ESC Initiative

One Community-Based Program "Bundle"

1:1 Home Visits
For Disease Mgmt. & Self-Mgmt Support



Advocacy
Navigation
Case Mgmt.

Tele-Monitoring
& Remote Assessment/
Intervention

Community
Resources

Decision
Supports

Stanford
University's
CDSMP

Goals of VON CD Self-management Program

1. **Improve client outcomes by:**
    1. **Maximizing quality & efficiency of services**
    2. **Targeting patients at high risk for hospital re-admissions**
    3. ***Maximizing client self-management***
    4. **Facilitating communication between all members of inter-disciplinary team**
    5. ***Developing effective community partnerships & leveraging strengths of each***
2. **Decrease health care costs by reducing ED visits, hospital readmission rates & LOS**
3. **Maximize HHR utilization**

#1 of 6 Components: Nursing "Visits"

- **Nurse & client have 1:1 contact**
  - **Face to face**
  - **Telephone**
  - **E-mail**
- **Focus is disease management & SMS**
- **Needs to be a *planned purposeful* contact**

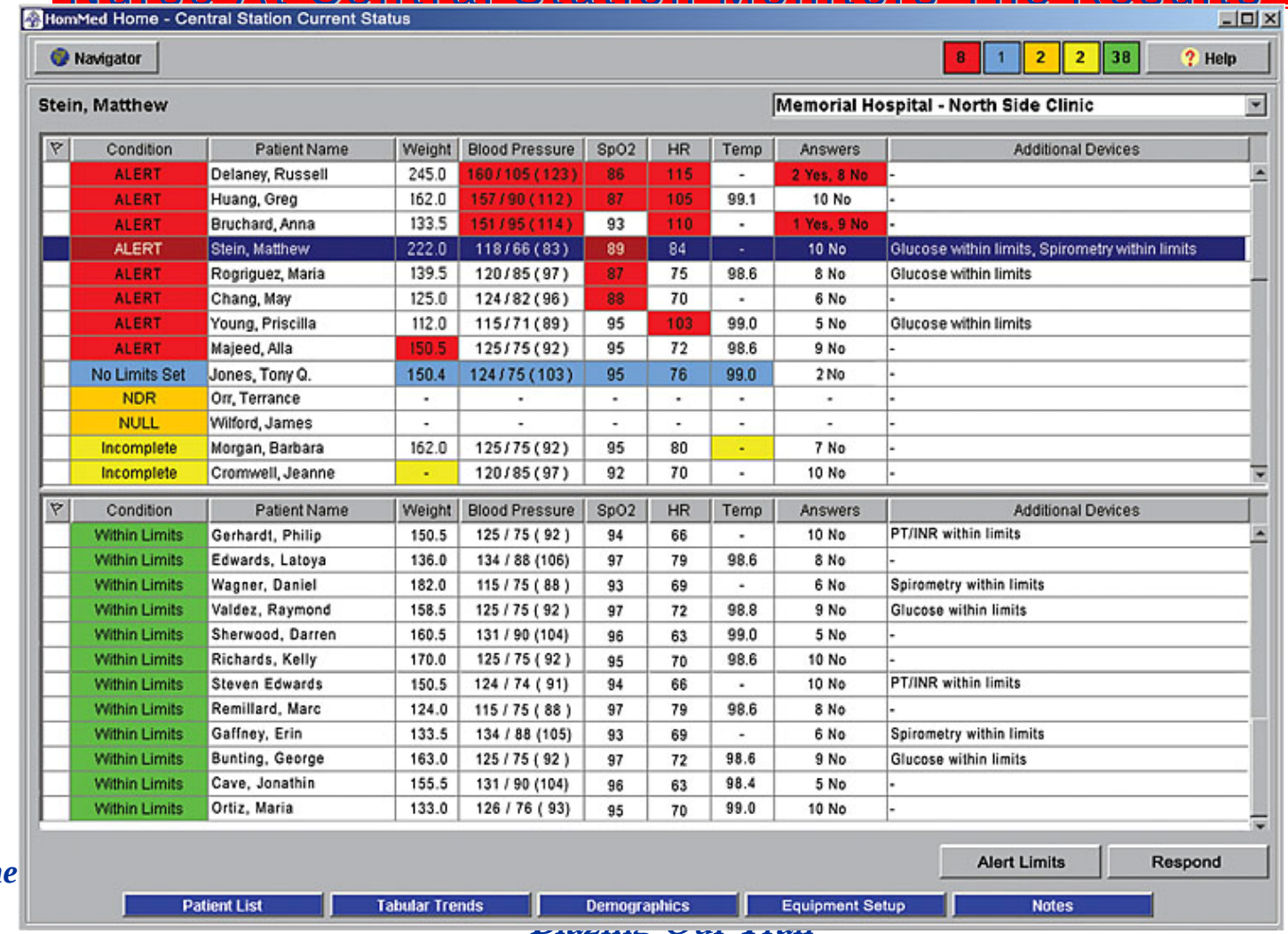
#2 of 6: Tele-Monitoring

- **HC Nurse installs TM in pts home**
- **Tool to:**
  - **Support pt. learning**
  - **Facilitate interdisciplinary decision-making**
  - **Identify & manage deterioration earlier**

Client Accountability for Tele-Monitoring

- **Client measures clinical values at mutually agreed to frequency**
- **BP, BG, weight transmitted via telephone line to a central monitoring station at single standard time of day**

Nurse At Central Station Monitors The Results



Condition	Patient Name	Weight	Blood Pressure	SpO2	HR	Temp	Answers	Additional Devices
ALERT	Delaney, Russell	245.0	160 / 105 (123)	86	115	-	2 Yes, 8 No	-
ALERT	Huang, Greg	162.0	157 / 90 (112)	87	105	99.1	10 No	-
ALERT	Bruchard, Anna	133.5	151 / 95 (114)	93	110	-	1 Yes, 9 No	-
ALERT	Stein, Matthew	222.0	118 / 66 (83)	89	84	-	10 No	Glucose within limits, Spirometry within limits
ALERT	Rogriguez, Maria	139.5	120 / 85 (97)	87	75	98.6	8 No	Glucose within limits
ALERT	Chang, May	125.0	124 / 82 (96)	88	70	-	6 No	-
ALERT	Young, Priscilla	112.0	115 / 71 (89)	95	103	99.0	5 No	Glucose within limits
ALERT	Majeed, Alla	150.5	125 / 75 (92)	95	72	98.6	9 No	-
No Limits Set	Jones, Tony Q.	150.4	124 / 75 (103)	95	76	99.0	2 No	-
NDR	Orr, Terrance	-	-	-	-	-	-	-
NULL	Wilford, James	-	-	-	-	-	-	-
Incomplete	Morgan, Barbara	162.0	125 / 75 (92)	95	80	-	7 No	-
Incomplete	Cromwell, Jeanne	-	120 / 85 (97)	92	70	-	10 No	-

Condition	Patient Name	Weight	Blood Pressure	SpO2	HR	Temp	Answers	Additional Devices
Within Limits	Gerhardt, Philip	150.5	125 / 75 (92)	94	66	-	10 No	PT/INR within limits
Within Limits	Edwards, Latoya	136.0	134 / 88 (106)	97	79	98.6	8 No	-
Within Limits	Wagner, Daniel	182.0	115 / 75 (88)	93	69	-	6 No	Spirometry within limits
Within Limits	Valdez, Raymond	158.5	125 / 75 (92)	97	72	98.8	9 No	Glucose within limits
Within Limits	Sherwood, Darren	160.5	131 / 90 (104)	96	63	99.0	5 No	-
Within Limits	Richards, Kelly	170.0	125 / 75 (92)	95	70	98.6	10 No	-
Within Limits	Steven Edwards	150.5	124 / 74 (91)	94	66	-	10 No	PT/INR within limits
Within Limits	Remillard, Marc	124.0	115 / 75 (88)	97	79	98.6	8 No	-
Within Limits	Gaffney, Erin	133.5	134 / 88 (105)	93	69	-	6 No	Spirometry within limits
Within Limits	Bunting, George	163.0	125 / 75 (92)	97	72	98.6	9 No	Glucose within limits
Within Limits	Cave, Jonathin	155.5	131 / 90 (104)	96	63	98.4	5 No	-
Within Limits	Ortiz, Maria	133.0	126 / 76 (93)	95	70	99.0	10 No	-

Graphics: www.hommed.com

#3 of 6: Decision Supports

- **Standardized triaging guidelines for TM RN**
- **Drs & NPs provide target goals & parameters for notification**
- **Prescribed Practice Guidelines for RNs e.g.**
  - **CDA for diabetes**
  - **Whooley's Two Question Screening Tool for depression**
- **Prescribed patient learning resources**
- **Field resources that cue nursing AND client behavior at POC**
- **TM summaries inform decision-making**

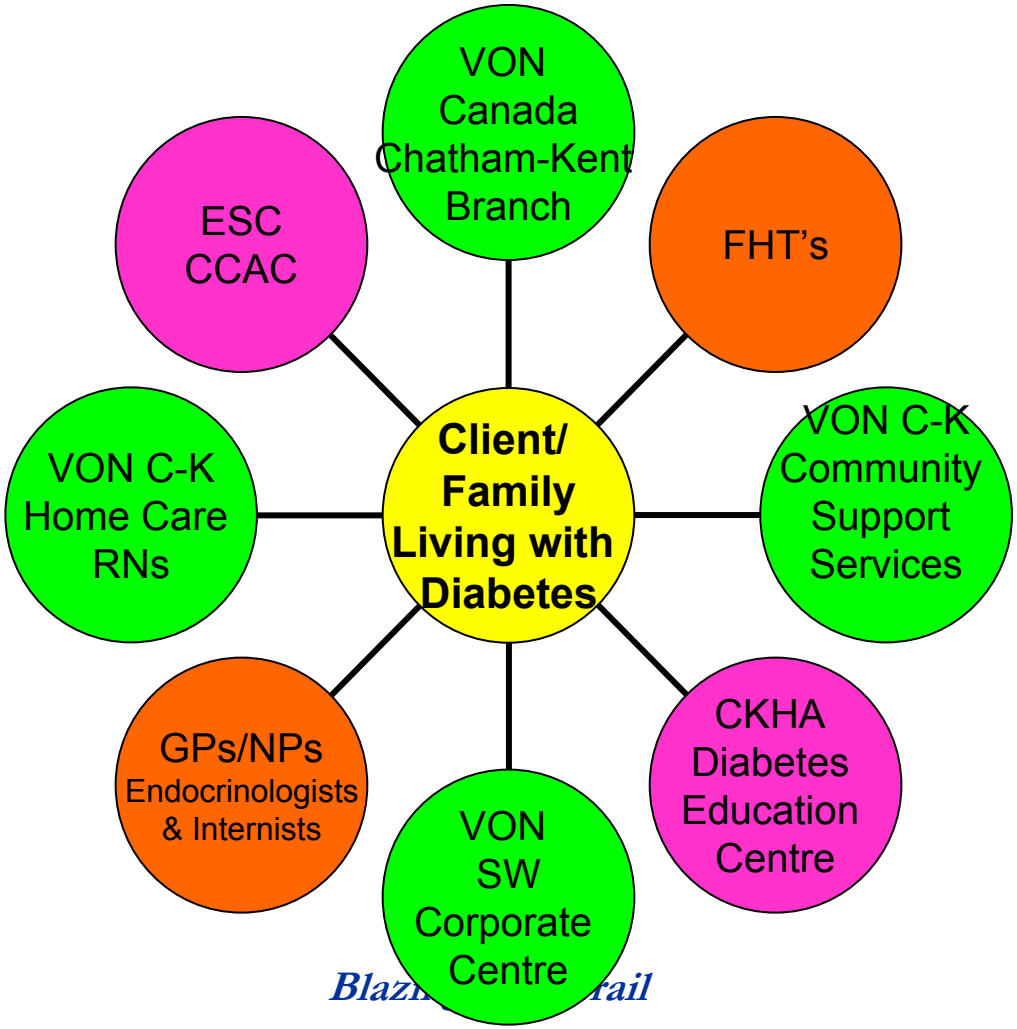
#4 of 6: Stanford University's CDSMP

- **Peer-led group program**
- **Helps individuals develop problem-solving skills & confidence they need to:**
  - **become more engaged in care**
  - **Find new ways to set goals, develop actions plans & sustain behaviour change**

#5 of 6: Community Resources

- **Organizational partnerships**
- **HC Nurses knowledgeable about community resources**
- **Inform about resources RT CDSM behaviours and/ or barriers e.g.**
  - **SMART, YM-YWCA, Parks & Rec**
  - **Transportation Services**

Cross Sector Partnerships & Collaboration



#6 of 6: Advocacy, Navigation & Case Mgmt

Shared by:

- **CCAC Intake & Case Managers**
- **TM Nurses**
- **Home Care Nurses**
- **Interdisciplinary Team**
- **Clients/ Families**

What is Self-Management Support?

Self-Management Support

Vs

Self-Management

Vs

Education

Definitions: 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.

The US Institute of Medicine 2004

Definitions: Self-Mgmt vs. Self-Mgmt Support

- **Self Management**
  - **Actions taken by *patients* in caring for their chronic conditions**
- **Self Management Support**
  - **Actions by *health care providers* that strengthen and support self-mgmt**

Essential Elements of Self-Management

- **Both individual with chronic disease & HCP are Experts**
- **Two-way information exchange**
- **Both state preferences**
- **Consensus to decide treatment/plan of care**
- **Collaborative relationship**

Patients & HCPs Have New Responsibilities in Order to Have Productive Interactions

***Informed Activated Patient*:**

Needs to be:

1. **Engaged**
2. **Interested**
3. ***Confident enough to manage chronic disease:***
   - **Medical management**
   - **Role management**
   - **Emotional management**

Prepared Proactive Practice Team?

Assess:

1. **Indicators – metabolic, anthropomorphic, etc.**
2. **7 Self-Management Behaviors**

Provide:

1. **Information**
2. **Self-Mgmt Support**
3. **Follow-up**

VON Canada's

Self-Management Support Skills *Education* Program

Self-Mgmt Support Education Program for Regulated Health Providers

- **Is interactive & varied e.g.**
  - **Didactic presentation**
  - **Videos**
  - **Experiential learning e.g. practice, practice, practice**
- **Is Incremental**
- **Introduces tools for:**
  - **Supporting patients**
  - **Cuing practice, facilitating documentation & collecting data for evaluation purposes**

Self-management Support Education

- **"Helping People to Become *Ready, Willing and Able*"**
- **3.5 – 4 hours of initial training**
- **pre & post implementation quiz**
- **Follow-up re ongoing learning needs, debriefing experiences, case conferences, etc.**

At the end of SMS Training Program

Home Care Nurses will be able to:

- **Distinguish between acute & chronic care**
- **Name 7 chronic disease SM behaviors**
- **Describe their role in SMS**
- **Identify key components of SMS**
- **Demonstrate SMS skills**
- **Describe how to use SMS Tools**

Self-Mgmt Support is an *Adjunct* to Education

Education

- **Most relevant during acute stages e.g.**
  - **Newly diagnosed**
  - **In crisis**

Self-Mgmt Support

- **Most relevant during chronic stage e.g.**
- **Challenge of changing & maintaining behaviour over long haul**

Does it matter what people know…
…or what they do?

- **Interventions *may* include patient education, *but more often involve*:**
  - **behavioral contracting**
  - **situational problem-solving**
  - **skill training**
  - **confidence building**
  - **goal-setting**
  - **barrier resolution**

Samples of Decision Supports

1. **Clinical Framework/ Guiding Principles/ Prescribed Practice Guideline**
2. **Client Record Forms**
   - **Admission & Assessment Protocol**
   - **Engaging & Action Planning Form**
   - **Flow Sheet: AADE Impact7**
3. **1 page outline of 5 step SMS process**
   - **What, Why, & How**
4. **Tele-monitoring Data**

VON Canada's "Partners in Care" Model

Self-Management Support for Health Professionals

START WITH Assessment of Clinical Status & the 7 Chronic Disease Self-management Behaviours

Why?	What?	How?
Step #1: Engaging the Patient		
1. You can engage the patient by asking questions and giving *relevant information*. 2. Including the patient's agenda, and not just focusing on your own helps to engage the patient.	1. Include patient's agenda by asking questions 2. Focus on areas of possible behaviour change 3. "Seek to understand" patient's perspective by listening actively.	What worries you most about your condition? What do you want to make sure we address about your diabetes today? What's been troubling you about your diabetes lately? To make this visit worth your time today, what would we accomplish?

Tools of Engagement

Self-Mgmt Support Steps

1. Assessment
2. Engaging pt.
3. Exploring importance
4. Collaborative action planning
5. Follow-up

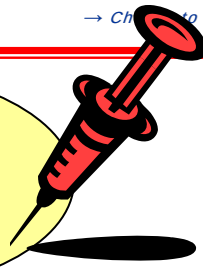
Tools of Engagement

- Client-specific data
- Bubble Diagram
- Importance Ruler
- Action Plan
- Confidence Ruler
- Mutually Negotiated Date

If you have DIABETES, here are some things you can talk about with your health care provider.

→ Ch[illegible]lk about changing any of these and add other concerns in the blank circles.

Taking Meds

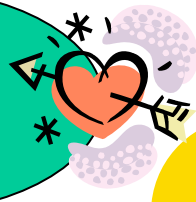


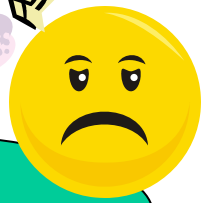
Solving Problems

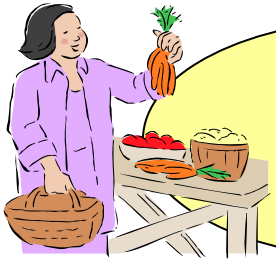
Healthy Coping

Being Active

Your love life





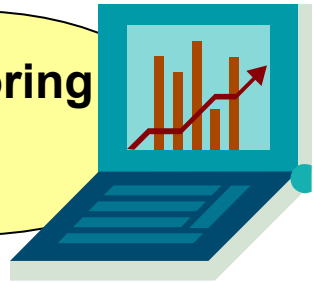


Eating Healthy

Depression ☺

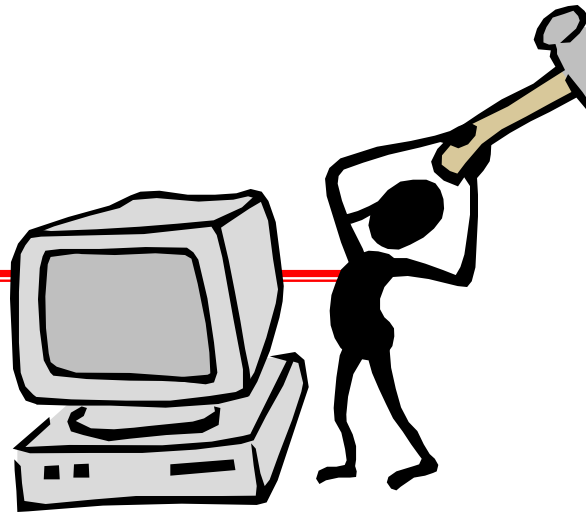
Reducing Risks

Monitoring



- **Developed & pilot tested *Education Program & Resource Manual* for *professional* staff**
- **Completed 4 QI cycles**
  - **ESC, GASHA (2 provinces, 3 CD)**
  - **Nursing Faculty at Trent**
  - **Windsor Wellness Program**

So What Do We Know?



"In a pilot of this size, it is only reasonable to find out if:

1. *We were able to do what we said we would do*
   - *Did VON deliver components?*
   - *Did nurses deliver service as per protocol?*
2. *we made a difference?"*

Souraya Sidani
Ryerson University

SMS Evaluation: Fisher's Model

Community Resources	
On-going Follow-up & Support	
Skills Instruction	
Collaborative Goal-Setting	
Individualized Assessment	
Continuity of Quality Clinical Care	

Evaluation of SMS Support

- **Workshop Evaluation**
- **Focus Group Discussions**
- **Client Record Review**
  - **Nursing Behaviours**
  - **Client Outcomes**

The one new change in my practice as a result of this workshop is:

The one idea that will stay with me the most from this workshop is:

SMS Education

The one thing I recommend changing to improve this workshop is:

The one thing I liked best about this workshop is:

"Everything old is new again"

This isn't anything new, we learned all about this in school, but now we'll be able to actually do it 'cause you've showed us how and given us the tools.

Graduate Nurse in 2nd Pilot Site

Ruth's History

- 46 y.o. female with Type 2 x 18 yrs
- BG from 2.1 to 20.1
- MI March 2004
- Triple Bypass August 2005
- On insulin x 2 months

Behavioural Assessment

- Taking medication
- Reducing risks
- Monitoring
- Problem-solving
- Being active
- Healthy eating
- Healthy coping

Goal-Setting & Action Planning

- **Ruth set goal to reduce BG through:**
  - **Taking medication**
  - **Healthy eating**
  - **Active living**

Interdisciplinary Collaboration

- **Dec 9th:**
- **RN asked Dr. if client could give oral meds, diet and activity another try**
- **Dr. responds *"this patient is destined to failure, but it's her choice"***

Outcomes of Self-Management Support

Interdisciplinary Team Experience

- **Dec. 21st: RN sent report & data summary to Dr.**
- **Dr. responded:**
  - *Ruth doing better*
  - ***Reduced OHA* after reviewing data summary**
  - **Started diuretic because *weight gain RT failure***

Is Ruth a Good Self-Manager?

- **Ruth's Discharge Summary**
  - **had seen dietitian**
  - **swimming weekly**
  - **no signs of failure**
  - *BG 3.9!*
- **Dr. suggested follow-up every 3 months, but Ruth *asked for* every *month***
- ***"I'm happy that Dr. and I are on same wavelength now & I can be honest about how I'm doing & talk about things I never thought I could bring up before…."***

Ruth's A1c Results

Date	Time	A1c
Oct 2006	1 month before 1st visit	12%
Feb 26, 2008	6 weeks after 12-week intervention	7.5%
June 18, 2008	5 months after 12-week intervention	7.5%
Oct 24, 2008	10.5 months after 12-week intervention	10.6%

Enablers

- **Political appetite for change**
- **Quality & strength of cross sector partnerhips**
- **Breadth of evidence**
- **Access to resources**
  - **Improving Chronic Illness Care**
  - **AADE Impact 7**
  - **Kaiser Permanente**
  - **Dr. Bob Anderson**
  - **Mike Hindmarsh**

Barriers: Challenges Included

1. **Client Recruitment**
   - **Registries**
   - **Buy-in of system gatekeeprs**
2. **Provider Skill development**
3. **Financial Disincentives**

Discussion

- **Technology Issues:**
  - ▲ access to services
  - ▲ efficient use of HHR (right person/ skills/ time)
  - Cost/benefit?
- **HHR utilization**
  - How to increase? (e.g. access to clinical data, not action plan)
  - How best to provide follow-up?
  - Acute trumping chronic
- **Ethical Dilemmas**
  - Funding models that prohibit access e.g. clients with no NP/Dr.
  - Reimbursement for Interdisciplinary team members

Valuable Outcomes/Lessons

- **Evaluation Framework: Revised, new tools added**
- **Interdepartmental/ Cross-sectoral work**
- **Partnerships e.g. sharing vision + will**
- **Growing practice**

Growing Nursing Practice

Self-Mgmt Support Steps

1. Assessment
2. Engaging pt.
3. Exploring importance
4. Collaborative action planning
5. Follow-up

Steps for Changing Practice

- Reflective Practice
- 1 Practice Behaviour for Change
- Level of Importance
- Action Plan including barriers
- Level of Confidence
- Case Conferences, Debriefing Practice, Focus Groups, Exploring Barriers, etc.

Was It Worth The Resources/Effort?

Canada is a great place to try something and see if it works.

June 11th, 2009, Ottawa

(Re Low Hierarchy//High Collectivism)

Malcolm Gladwell, Author or Tipping Point, Blink & Outliers

A crisis is a terrible thing to waste!

Economist Paul Romer

BLAZING OUR TRAIL…

June 2009

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