



Initiating Change in Health Systems ***Lessons Learned***

Taking Charge of Our Health 2009

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Nov 2009

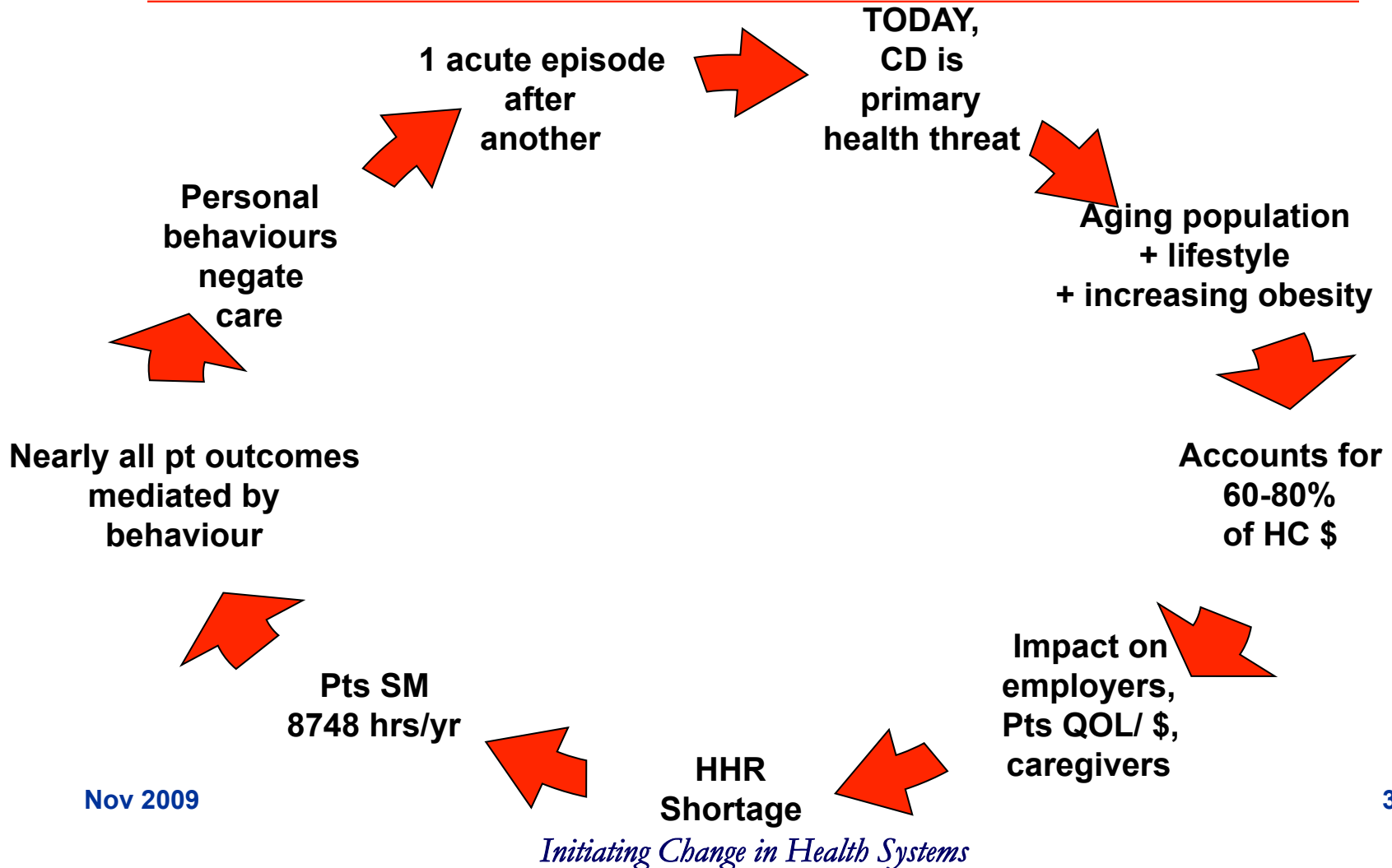
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Initiating Change in Health Systems

Agenda

- **Introduce Project**
- **Respond to PM “Lessons Learned ?”**
 - **What worked well?**
 - **What didn’t?**
 - **What needs to be done differently?**
 - **What surprises did the team have to deal with?**
 - **What project circumstances were not anticipated?**
 - **Were the project goals attained? If not, changes required?**
- **Top 3 Significant Project Successes**
- **Project Shortcomings & Solutions**
- **VON’s Recommendations**
- **Your Recommendations**

The Perfect Storm



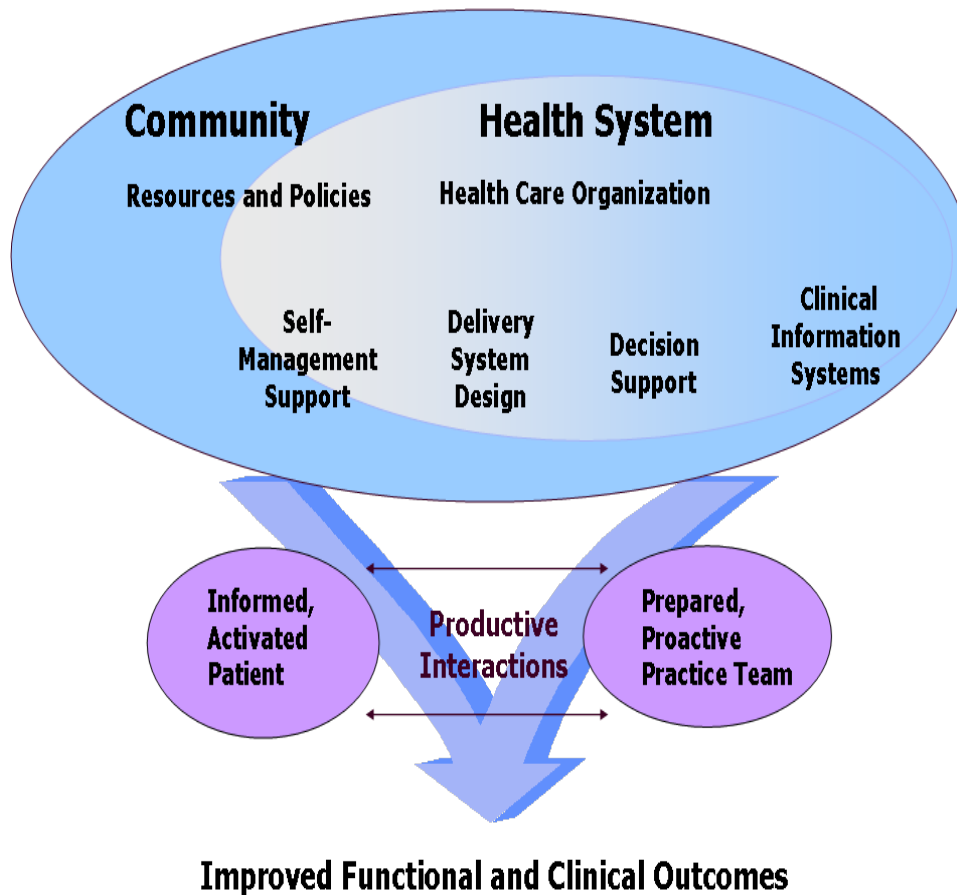


SMS Is Proven Way To Manage CD

- **Evidence demonstrates SM is 1 of 6 essential elements of high quality HCS**
- **Inspiring pts to become informed; manage health & health care; & help them choose healthy behaviours IS CRUCIAL**
- **translation from theory to practice slow and ad hoc**
- **All jurisdictions struggling with how to better prevent & manage CD**
- **Adopting various iterations of CCM**
- **CCM outcomes best when all 6 essential elements of high quality HCS operating**



VON CDPM Projects Designed To Align With Best Practices In Delivery Of Chronic Care



VON's Approach to CDPM

- Provide appropriate services within a community setting to meet client's needs
- Whenever possible, manage chronic conditions through primary and community care
- Promote and enable patient self-management
- Provide sustained, proactive follow-up
- Mobilize community resources to meet client needs
- Facilitate active communication amongst clinicians and other participants
- Utilize health human resources effectively

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VON's Chronic Disease Self-Management Program

- **Aimed at individuals living with chronic disease**
- **Grounded in principles of:**
 - **Self-Mgmt.**
 - **Inter-professional collaboration**
 - **system integration**
- **Enabled by technology**
- **Bundled various services to meet the needs of unique populations and/or funders.**
- **Framework guiding practice based on:**
 - **VON Canada Care & Service Model**
 - **Wagner's Chronic Care Model**
 - **Fisher's Tri-Level Model of Self-Mgmt & CC**



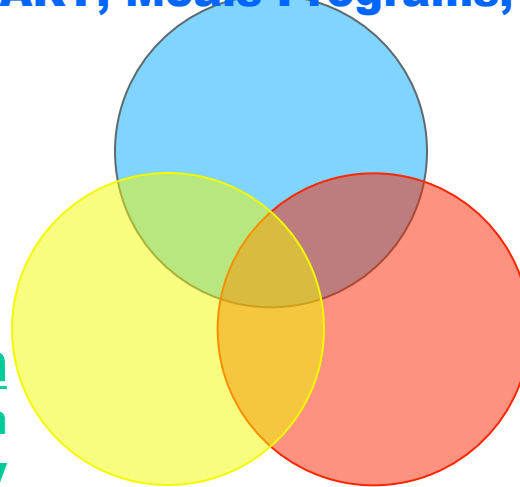
Stay@Home with VON The Big Picture

Self-Management Support

Stanford University CDSMP classes, Disease Specific Education,
1:1 Home Visits to provide SMS including follow-up,
SMART, Meals Programs, etc.

Delivery System Design

- System Navigation
- Advocacy
- Case Management



Decision Support & Clinical Info Systems

- Tele-home Monitoring
- Triaging Guidelines
- Tools to:
 - Cue Practice at POC
 - Facilitate Documentation
 - Provide Data Base for Evaluation



Program Goals and Objectives: To Pilot a Community-based CDM Program that...

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

Pilot: Erie St. Clair CDPM Project

Project Objective

- Prevent health care crises before they occur and improve daily management of disease through teaching of self-management strategies and daily monitoring of blood glucose, blood pressure and weight

Project Approach

- Tele-monitoring
- Up to 12 nursing visits over 12 weeks
- Self-management classes using Stanford Model
- Disease specific education & Self-management support

Target Audience

- 20-25 Adults over the age of 18
- Diabetes, with or without co-morbidities
- History of 4 diabetes related emergency room visits and/or 2 diabetes related hospitalizations over the course of previous 12 months
- Eligible for the CCAC services

Benefits/Outcomes

- Improved health care indicators (e.g. blood glucose, weight, blood pressure)
- Improve overall quality of life
- Decrease use of acute care services

Partners

- Erie St. Clair Community Care Access Centre



Pilot: Guysborough Antigonish Strait Health Authority CDDM Project

Project Objective

- Prevent health care crises before they occur and improve daily management of disease through teaching of self-management strategies and daily monitoring of peak flow, oxygen saturation, blood glucose, blood pressure and weight

Project Approach

- Disease specific education & Self-management Support
- Tele-monitoring
- 12 nursing visits for 9 months
- Self-management classes using Stanford Model (Govt. of Nova Scotia)

Target Audience

- 20-25 Adults over the age of 18
- Heart failure
- COPD/Chronic bronchitis

Benefits/Outcomes

- Improved health care indicators (e.g. Peak Flow, oxygen saturation, BP, and weight)
- Improve overall quality of life
- Decrease use of acute care services

Partners

- GASHA
- Department of Health



What Worked Well?

- **Support of SM for dedicated team to develop program**
- **Internal collaboration between Home Care, Community Support Services & Corp. Centre**
- **Networking > involvement with organizations e.g. Optimizing Health**
- **External partnerships e.g. ESC CCAC & GASHA**



What Worked Well in Project?

- **CQI > Self-management Support Education Program developed called EMPOWER**
- **Decision supports**
- **Stanford's CDSMP**
- **Inclusion of volunteers**

What Didn't Work Well in Project?

- **Expanded role for remote nurses i.e. Intake Nurses at Corporate Health Centres**
- **Return on SMS Education investment e.g.**
 - **consolidating SMS skills**
 - **Dedicated mentors/ coaches**
- **“Engaging” source of referrals**
- **Competing priorities for internal & external partners**



What Surprises Did We Have To Deal With?

- **Client Recruitment**
- **Client Recruitment**
- **Client Recruitment**
- **Diabetics do not use EDs or hospital beds (*until very advanced complications*)**



What Surprises Did We Have to Deal With?

...our original construct was we could prevent ED admissions for high blood sugar and ineffective diabetes management -- only to find that this was not an ED admission issue.... This led us to believe that individuals were routinely living with abnormally high blood sugar levels and were perhaps not being alerted to this as being an issue by the primary care resource.

**Tricia Khan, Dipl. PT, MBA
Sr. Director, Strategic Planning & Integration, Privacy Officer
Erie St. Clair Community Care Access Centre**



What Project Circumstances Were Not Anticipated

- **Different researchers/program evaluators across pilots**
- **Client Recruitment:**
 - **Extended length of project significantly**
 - **Failure to consolidate SMS skills**
 - **Attrition rates of staff trained (or failure to consolidate skills)**



Were Project Goals Attained? “YES”

- **Maximizing client SM opportunities**
- **Targeting pts at high risk for hospital re-admissions**
 - YES in GASHA
 - NO ESC in short-term, but YES in longterm????
- **Developing effective community partnerships & leveraging strengths of each**
 - ESC CCAC & GASHA – shared vision/ effort
 - VON funded development & evaluation, partners paid for client visits
 - CKHA & GASHA NPs – Disease Mgmt. expertise



Were Project Goals Obtained? “To Some Degree”

- **Improving client outcomes > TBD**
 - **Anecdotal evidence of improved outcomes e.g. behaviour change & A1c Decreasing health care costs by reducing ED visits and hospital re-admission rates > TBD**
- **“Maximizing” (vs. improving) quality of services**
- **Facilitating communication between all members of intra-professional teams**
 - **Varied by role & local circumstance**
 - **Drs., endocrinologists, NPs, FHTs,**



Were Project Goals Attained? “Under Review”

Decreasing HCS costs by reducing ED visits, hospital readmissions rates & LOS

- **TBD**
 - **Relevance of goal for some CD populations?**
- **“Maximizing” efficiency of services**
 - **Sample size too small**
- **Maximizing HHR utilization?**
 - **Can include more providers**



What Changes Need to be Made to Meet Goals in Future?

- **Move from pilot stage to embedding in organization**
- **Shared view of client record**
- **Strengthen HHR capacity & maximize contributions of providers**
- **Integrated models of health**
 - **System not ready to support working outside of HCS silos (foundation to enable)**



Top 3 Significant Project Successes

Have developed:

- **a comprehensive technology-enabled model to support CD SM in the community**
- **an educational program (EMPOWER) to educate professional providers re knowledge & skills required to work with individuals living with CD**
- **Significant “lessons learned” to shape implementation more cost-effectively and care-efficiently across organization**



Project Shortcomings & Solutions

Shortcomings

- VON does not have the 'status' in the health system to make the needed changes i.e. viewed as a third party service provider rather than a government entity. This was a barrier to engaging the inter-professional collaboration required for comprehensive programs
- Have not used technology to the fullest extent possible to enable CDSM

Solutions

- Partnering at a higher level
- "Informal" leadership e.g.
 - Knowledge & Innovation
 - Advocate: VON Canada's Vision for Home & Community Care in Canada
- Partnership with IBM to develop tools that facilitate/enhance optimal utilization of HHR



Recommendations re Improving Client Outcomes

- **Standardized measures to evaluate outcomes**
- **Funding needs to reflect commitment to SM**
 - **challenging to fund & grow without system supports**
- **EHR required to facilitate communication**
- **Look outside HCS for client supports**



Recommendations re Decreasing Health Care Costs

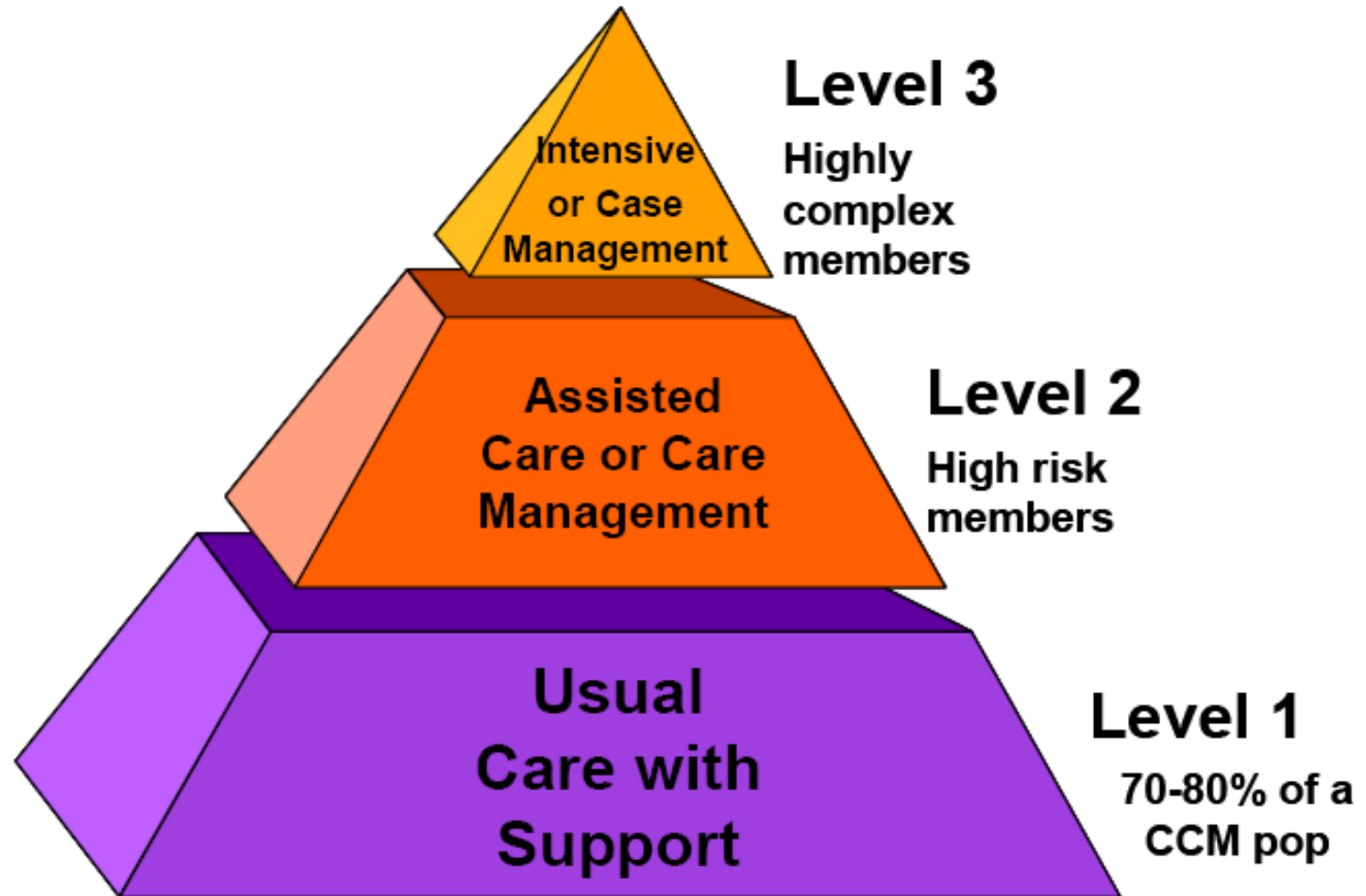
- **Policy issue**
 - **Where can you make largest impact?**
 - **HF, chronic bronchitis, asthma in short term**
 - **Diabetes in long term**
 - **\$ saved x # of clients**
- **Look outside HCS for expertise**

Recommendations Re HHR

- **Expand role of “remote” nurse**
- **Dedicated CD Nurse**
- **Expand members of team & clearly define roles**
 - **Non-regulated workers**
 - **TM**
 - **Follow-up**
- **Nurses need to be able to move fluidly from acute to chronic care & use right skill at right time**
- **Stratify risk to triage service intensity**
- **Look outside HCS for expertise & client supports**



Figure 3: Kaiser Permanente's Risk Stratification Pyramid



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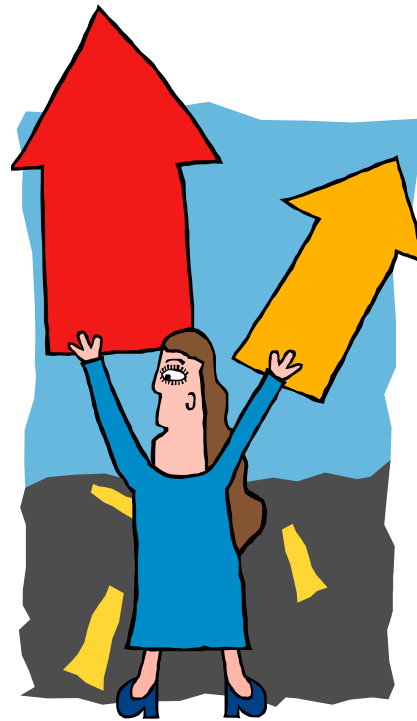
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Lessons Learned

- **Barriers to implementation are significant when HCS at preliminary stage of transformation**
 - Govts, orgs., providers at different stages of change
 - Some elements of CCM available...but “work-arounds are cumbersome for “missing” elements
- **Collaboration crucial within complex health care organizations & systems**
- **Anticipate resistance to change within intra-professional teams for multiple reasons e.g.**
 - Lack of incentives
- **Never underestimate the power of teams!**

What Recommendations Can You Offer?

- **Yes, you!**



- **Can't wait for comprehensive CCM implementation**
 - **Make change where you have influence**
 - **Partner where you do not**
 - **Just “Do it!”...lessons learned will help advance HCS change**