

Chronic Disease Management and Programs for Seniors

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Chronic Disease - the Issue

- 66% of Ontarians over the age of 45 have a chronic condition (CC)
- 55% suffer from two or more chronic condition
- 80% of primary care visits are for a CC
- 67% of all hospital admissions are for a CC

Chronic Disease - the Issue

- The Canadian health system doesn't do CDM very well
(Michael Rachlis, Calgary 2005)
 - <30% of hypertensives have their blood pressure properly controlled
 - 60% of diabetics have gone >1yr without an eye examination or a check for proteinuria
 - 60% of asthmatics are not properly controlled
 - ~20% of heart failure patients are readmitted <60 days
- With effective prevention and management of diabetes, asthma, congestive heart failure and depression, Ontario could avoid an estimated:
 - 29,000 emergency department visits
 - 67,300 hospitalizations, and
 - \$200 - \$350 million annually, in hospital costs



Institute of Medicine - “Chasm Report”


“These quality problems occur typically not because of failure of good will, knowledge, effort or resources directed to health care, but because of fundamental shortcomings in the way care is organized”



Traditional Organisation and Culture of Care

- Focus on acute problems
- Emphasis on triage and patient flow
- Short unprepared appointments
- Brief didactic consumer education
- Consumer initiated follow-up
- Emphasis on provider - not system – behaviour
- Treat only those people who reach us
- Can't identify problems earlier
- No prevention of episodes / recurrence
- No consistent after-care

Thought for the day



Systems are perfectly designed to get the results they achieve

CHANGING THE PARADIGM

- Focus on populations
- Focus on longitudinal care / closing the loop (a system of care)
- Requires teams



CHANGING THE PARADIGM

- Focus on populations
- Focus on longitudinal care / closing the loop (a system of care)
- Requires teams
- Identified care co-ordinator
- Patients as partners

- IT support

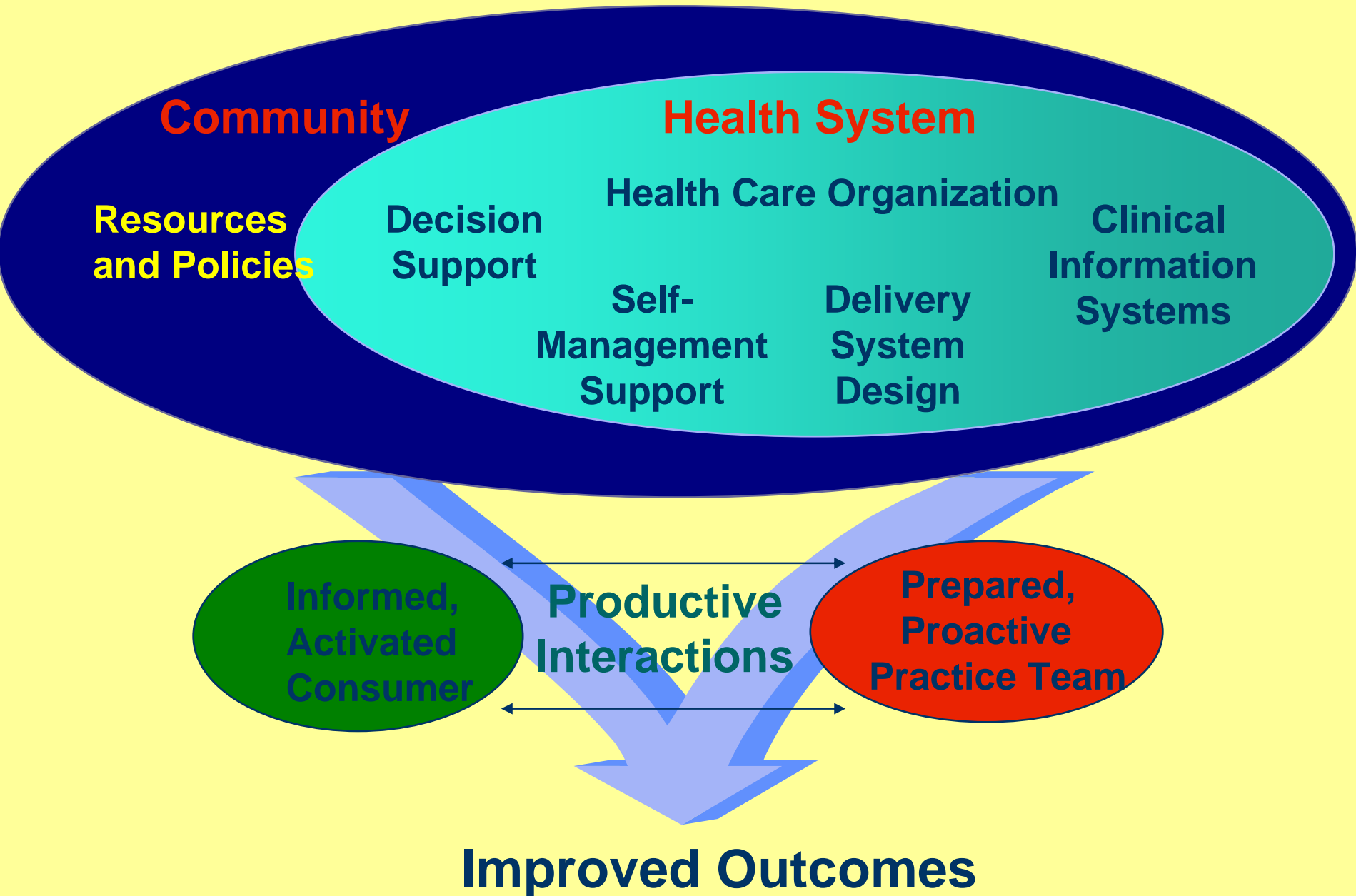


Chronic Disease Management

Better management and outcomes of individuals with chronic diseases requires changes in the ways systems of care are organised



Chronic Care Model



CDM / PROGRAM PLANNING GRID FOR THE HAMILTON FHT

Screening / Detection	Treatment	Follow up / Monitoring	Self Management	IT Support	Decision Support	Community Links	Organizational Change
Provider preparation	Algorithm	Telephone	Goals	Registry	Algorithm	Key Partners	Goals
Screening Instruments	Case Management	Registry	Plan / relapse prevention	Templates	Provider education	Agencies in primary care	Team creation
Assessment Tools	System navigation	Routine recall	Access to Records	Reminders	Specialist Access	Links with agencies	Evaluation
Patient Inform.	Specialist Consultation	Reminders	Education		Targets	Policy	EMR
Practice review	Prepared Appointment.		Provision of resources / aids				Training
			Health Passport				Change Management
			Groups				
			Website				

Screening / Detection	Treatment	Follow up / Monitoring
Provider preparation	Algorithm	Telephone
Screening Instruments	Case Management	Registry
Assessment Tools	System navigation	Routine recall
Patient Inform.	Specialist Consultation	Reminders
Practice review	Prepared Appointment.	

Self Management	IT Support	Decision Support
Goals	Registry	Algorithm
Plan / relapse prevention	Templates	Provider education
Access to Records	Reminders	Specialist Access
Education		Targets
Provision of resources / aids		
Health Passport		
Groups		
Website		

Community Links	Organizational Change
Key Partners	Goals
Agencies in primary care	Team creation
Links with agencies	Evaluation
Policy	EMR
	Training
	Change Management

FRAIL ELDERLY PROGRAM PLANNING GRID FOR THE HAMILTON FHT

Screening / Detection	Treatment	Follow up / Monitoring	Self Management	IT Support	Decision Support	Community Links	Organizational Change
Provider preparation	Algorithm	Telephone	Goals	Registry	Algorithm	Key Partners	Goals
Screening Instruments	Case Management	Registry	Plan / relapse prevention	Templates	Provider education	Agencies in primary care	Team creation
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Patient Inform.	Specialist Consultation	Reminders	Education		Targets	Policy	EMR
Practice review	Prepared Appointment.		Provision of resources / aids				Training
			Health Passport				Change Management
			Groups				
			Website				

FRAIL ELDERLY PRIORITIES PROGRAM PLANNING GRID FOR THE HAMILTON FHT

Screening / Detection	Treatment	Follow up / Monitoring	Self Management	IT Support	Decision Support	Community Links	Organizational Change
Provider preparation	Algorithm	Telephone	Goals	Registry	Algorithm	Key Partners	Goals
Screening Instruments	Case Management	Registry	Plan / relapse prevention	Templates	Provider education	Agencies in primary care	Team creation
Assessment Tools	System navigation	Routine recall	Access to Records	Reminders	Specialist Access	Links with agencies	Evaluation
Patient Inform.	Specialist Consultation	Reminders	Education		Targets	Policy	EMR
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			Website				

Managing Chronic Diseases Improves Outcomes and Decreases Costs

- Kaiser Permanente achieved the following results over a 10 year period by using: a multidisciplinary steering group, physician champion for each guideline; registries, reminders, outreach programs, and empowering local clinicians:
 - 30% lower heart disease mortality than other plans
 - 15% decrease in death rates from CHF between 1996-2001
 - smoking rate among N. California KP members was 12% compared to 18% for state as a whole
(Kaiser Permanente)

EXAMPLE

CDM

DETECTION

Wife initiated

Practice initiated

EARLIER
DETECTION

Not possible

Registry
Regular contact
? Risk factors

SCREENING
INSTRUMENTS

Used

Routine

FOLLOW-UP

Not scheduled
Wife initiated
Deterioration

Routine / Phone
Practice initiated
Regardless

EXAMPLE

CDM

LINKS WITH
COMMUNITY

First Link

Someone

CASE
CO-ORDINATION

First Link
?Need more

Someone

SYSTEM
NAVIGATION

First Link

Someone

CAREGIVER
SUPPORT

First Link

Someone

	EXAMPLE	CDM
EVIDENCE-BASED ALGORITHM	No evidence	Algorithm
SPECIALISED CONSULTATION	No evidence	In place
GOALS	No evidence	Developed (Pts.)
PLAN	Through First Link	Routine (comprehensive)
TREATMENT	Medication	Algorithm

EXAMPLE

CDM

PATIENT
EDUCATION

First Link

Someone

PROVIDER
EDUCATION

None

Built in

ACCESS TO
RECORDS

No evidence

Health passport
Copies of reports

EXAMPLE

CDM

PATIENT
EDUCATION

First Link

Someone

PROVIDER
EDUCATION

None

Built in

ACCESS TO
RECORDS

No evidence

Health passport
Copies of reports

PRACTICE
APPROACH

Individual providers

Practice goals

SUMMARY

- Fantastic opportunity
- Change the paradigm for primary health care in Hamilton / Ontario
 - Staff
 - Programs
 - Changes to system delivery
- Need for real system changes
- Better outcomes