Partnerships for Health

A Chronic Disease Prevention and Management Demonstration Project

The Importance of Care Coordination: The Partnerships for Health Experience

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Mike Hindmarsh: Project Leadership Team

Ontario

Background

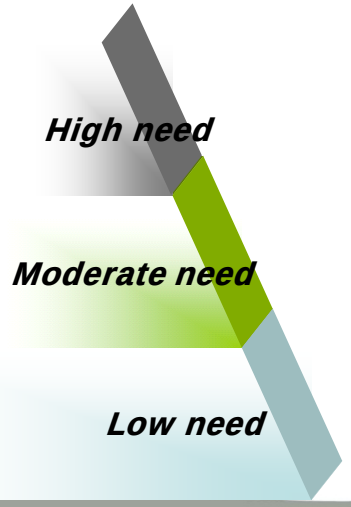
- Funded by Ministry of Finance *Strengthening Our Partnerships* program
- In partnership with MOHLTC
- Sponsored by the South West LHIN

The Goal

- **Integrate** the component parts of the health care system by **sharing information** across the continuum of care, advancing primary care **partnerships** and linkages to tertiary care, engaging the **patient in self-care** and enabling **improved information management**

In other words….

- Building teams – family physicians, home care, community health providers, specialists – within primary care and across organizations to take an integrated approach to the prevention and management of chronic disease



Keeping people at the base of the pyramid!

Why Bother?

- Patient populations are aging and becoming more complex
- Transitions in care are discontinuous and leading to more and more mistakes
- Patients are tired of repeating their stories and feeling like they have to manage OUR broken system
- Providers are increasingly frustrated by poor communication processes across care settings
- Patient outcomes are bad, but we can do better!

Project Participants

- Twelve primary care practices + ~100 +
- South West CCAC
- Diabetes Educators
- Mental Health teams
- Community providers
- Physician specialists
- Thames Valley Family Practice Research Unit
- South West LHIN

Team composition varies according to patient need, patient load, organizational constraints, resources, clinical setting, and professional skills.

A Recipe for Improving Outcomes

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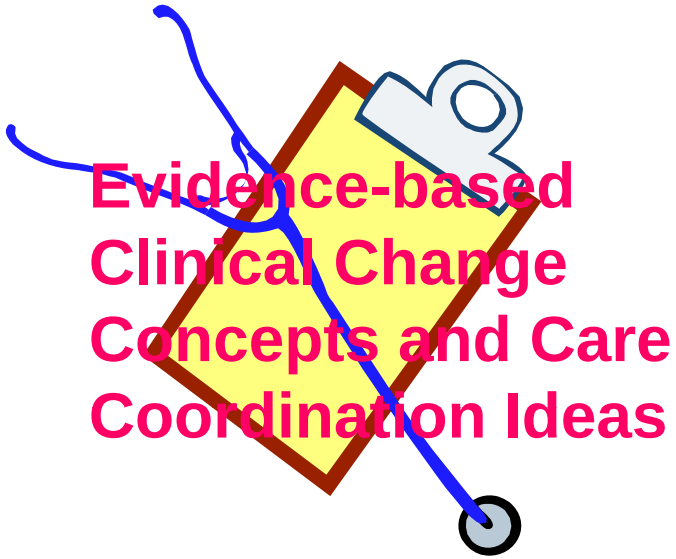

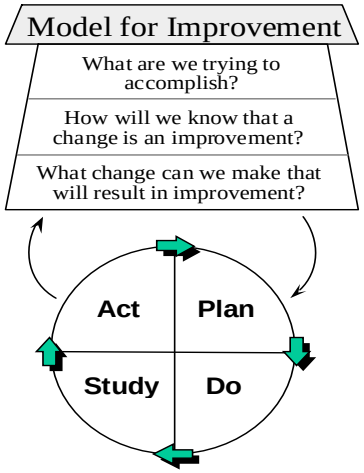

QI strategy

Ontario CDPM Framework

1. **Learning Collaboratives**
2. **Knowledge Transfer Days**
3. **Web-based Tutorials**
4. **Self-directed**

(all receive Practice Coaching)

System change strategy

Learning Modalities

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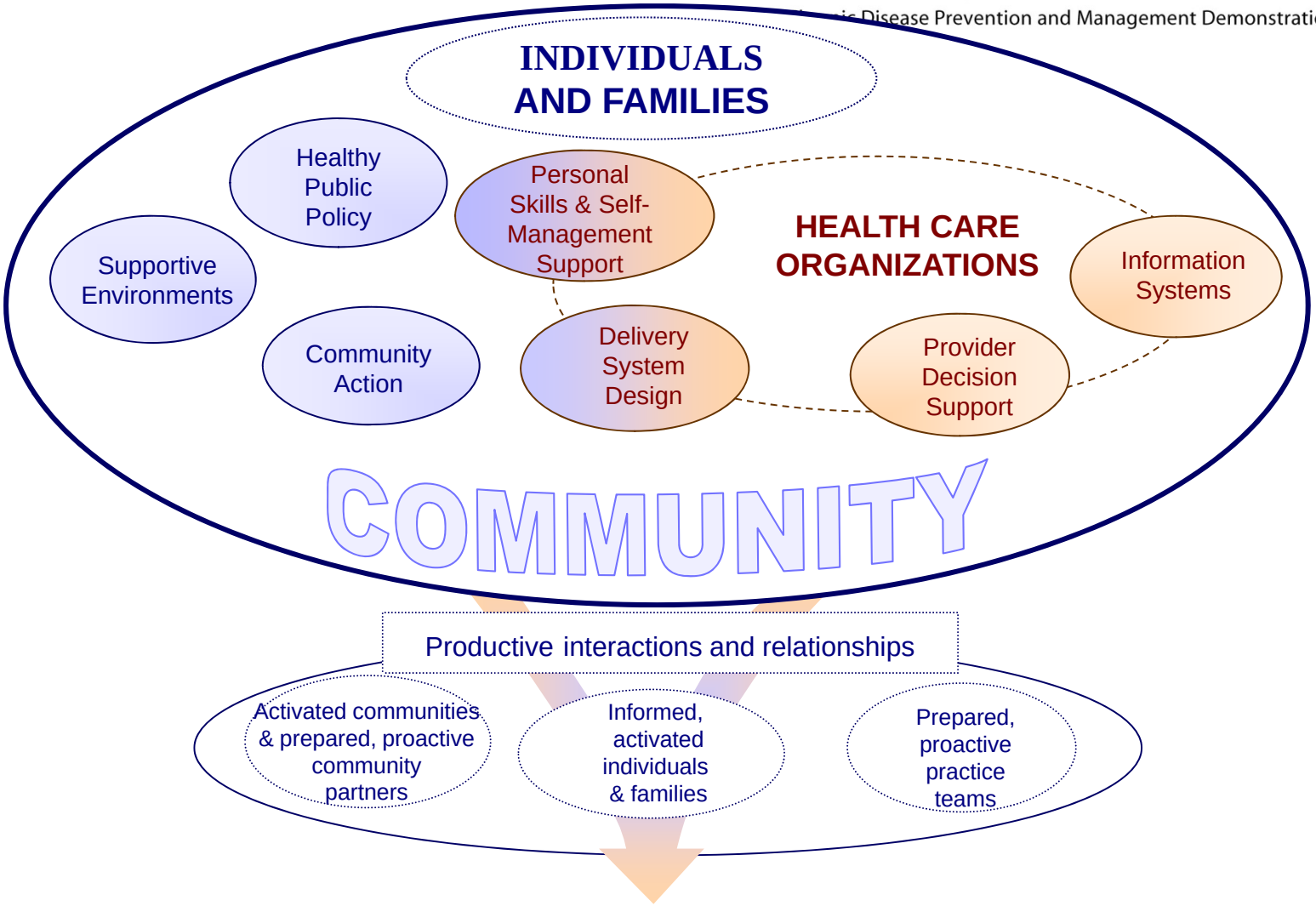
Ontario's Chronic Disease Prevention and Management Framework



Improved clinical, functional and population health outcomes

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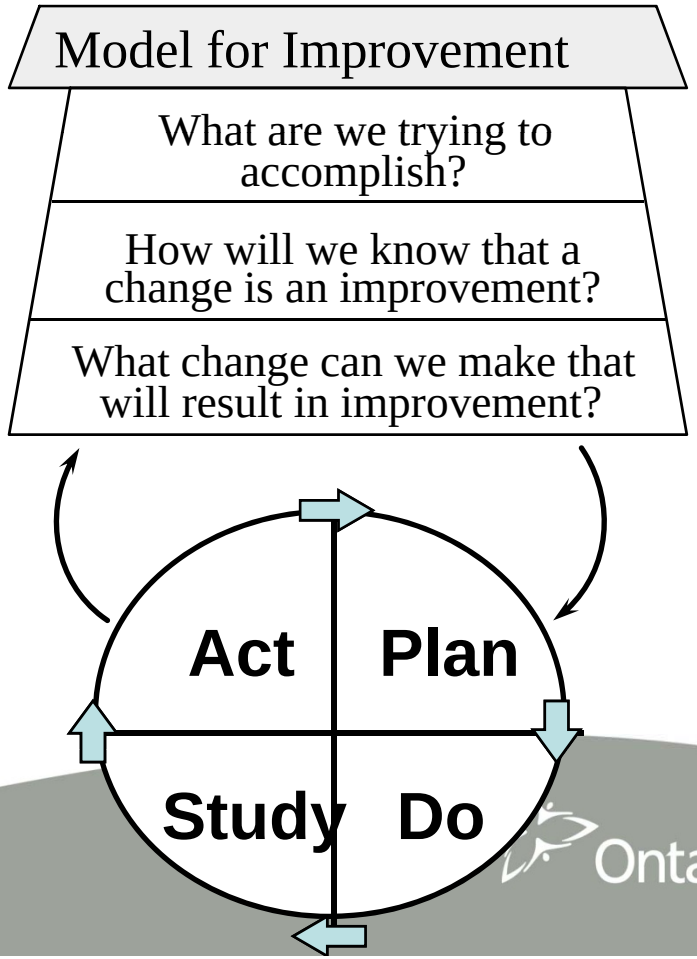
Model for Improvement

Three Questions

- What are we trying to accomplish?
- How will we know that a change is an improvement?
- What changes can we make that will result in improvement?



Four Learning Modalities

1. Spread Collaborative

2. Knowledge Transfer

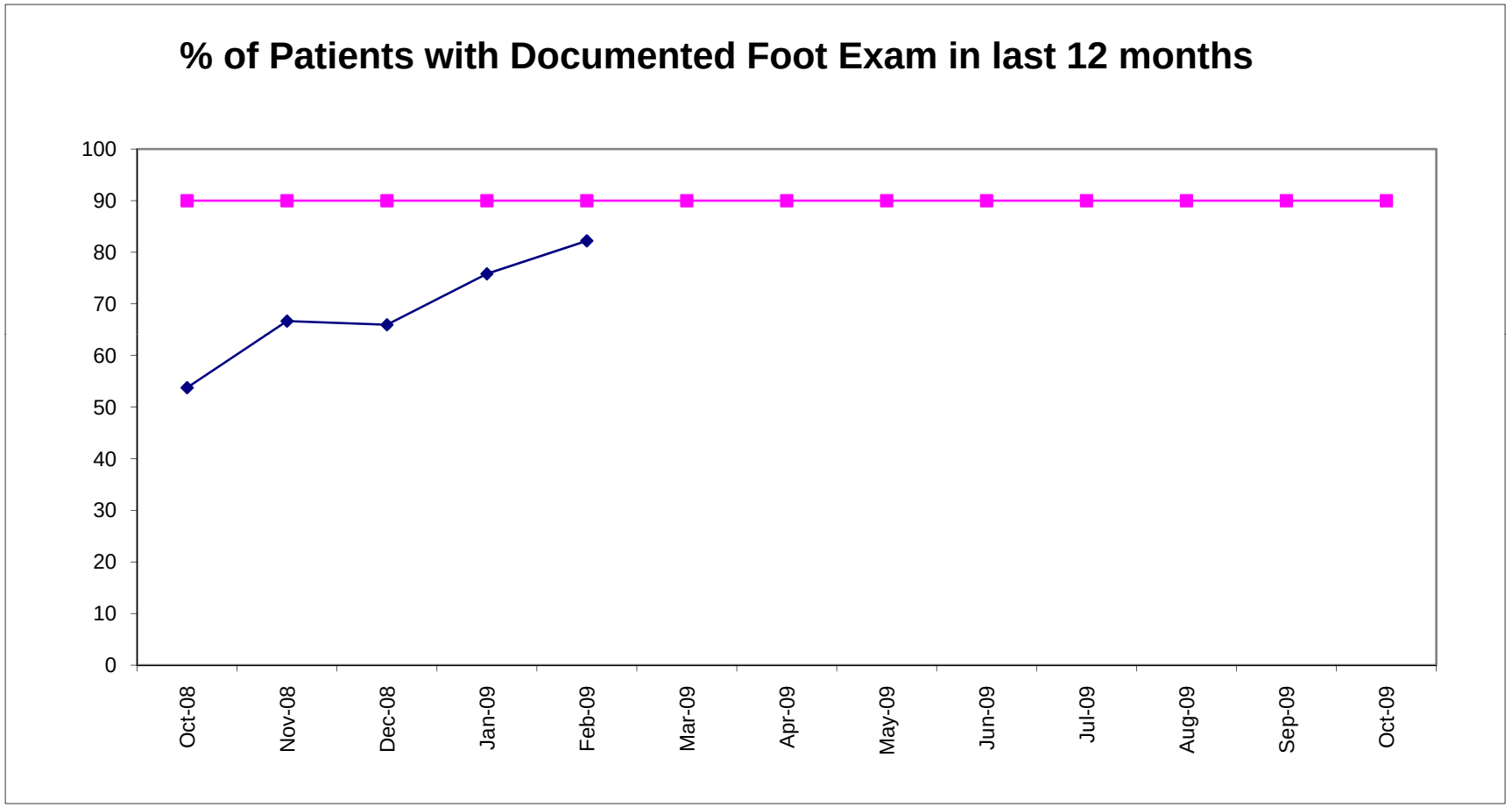
3. Web-based Learning

4. Coaching only

Outcomes Congress

Progress to Date

- Improvements in care processes
  - increased foot, eye and renal screening
  - increases in patients setting self care goals
  - A1C and lipid testing.
- Improvements in business processes
  - Flow mapped
  - Changes tested and implemented
  - Moving toward right work by right team member



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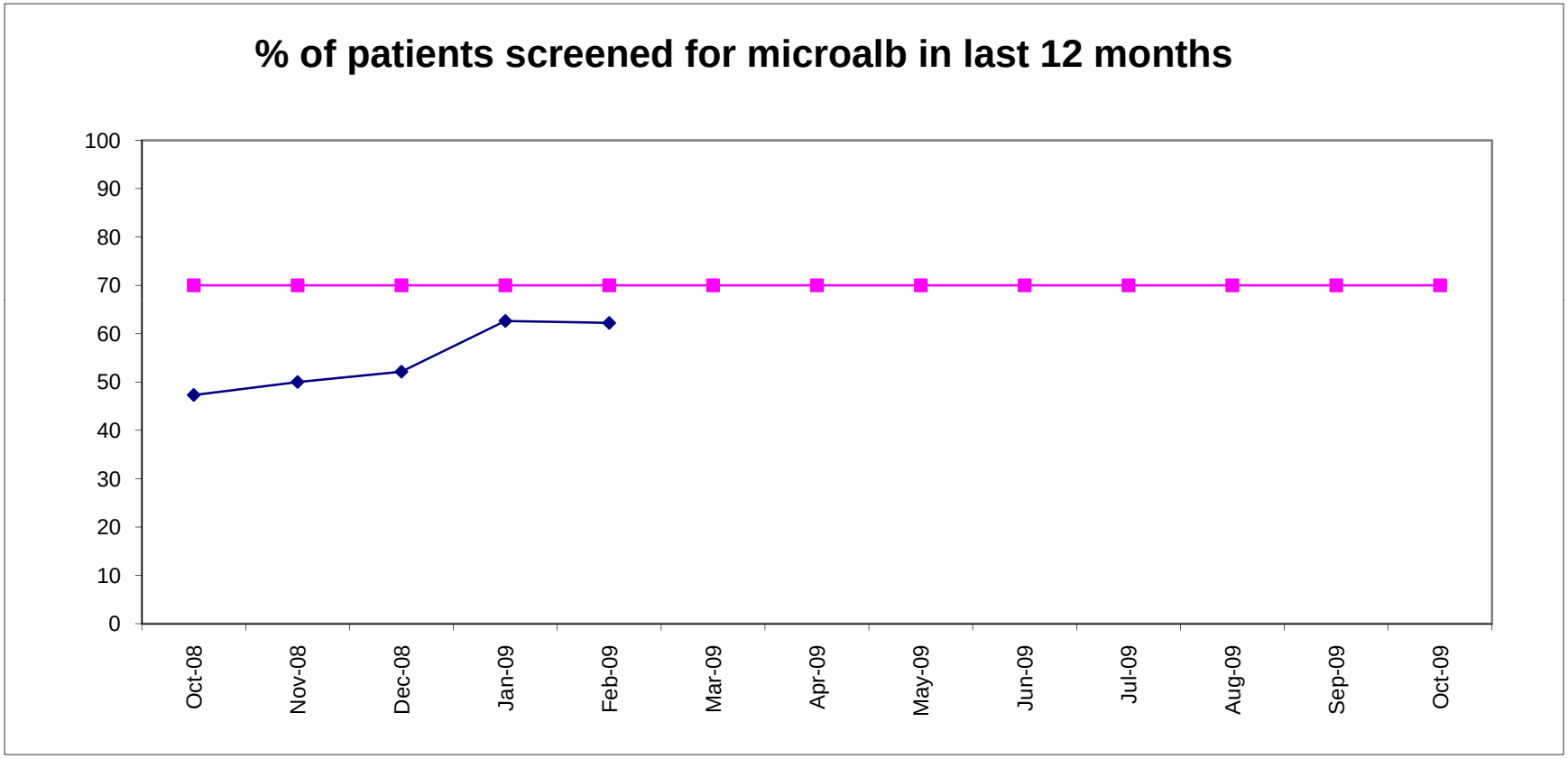

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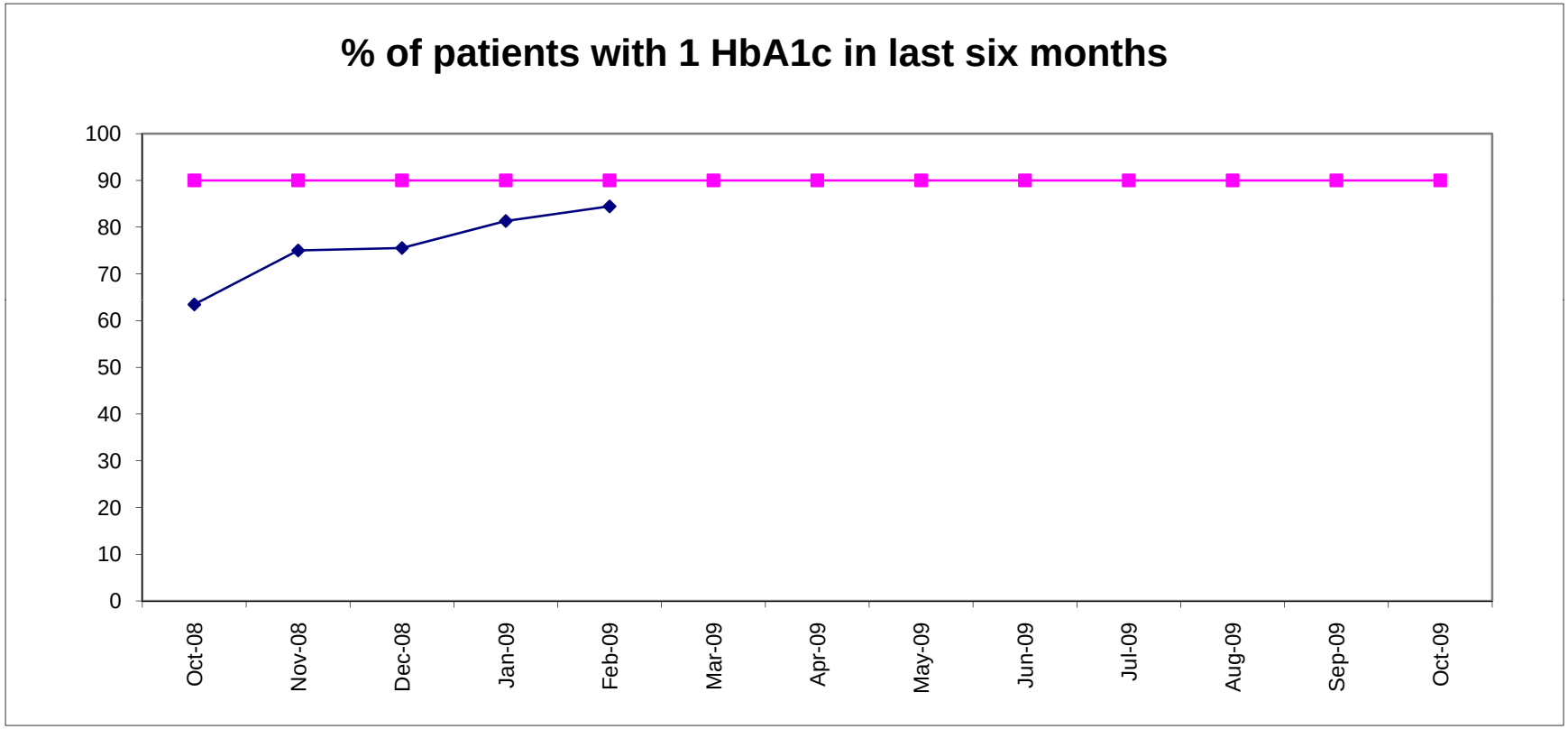

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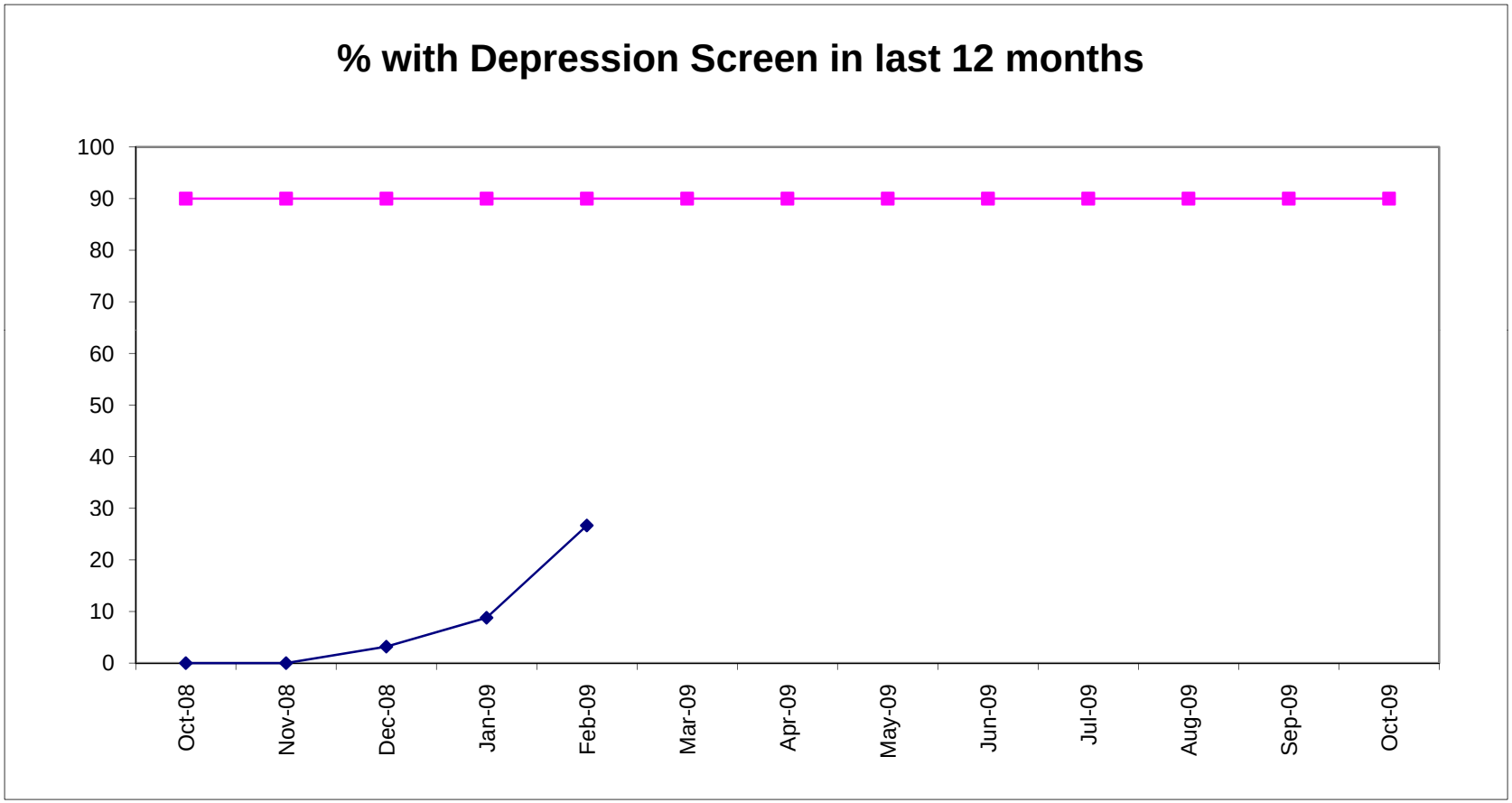

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Care Coordination Progress to Date

- DEC RNs reviewing patients in common with their primary care partners
  - Targeting education to patient needs
  - Handling o-morbidities
- CCAC case managers are case conferencing with primary care
  - Conducting home visits with at-risk patients
  - On-site consultations
- Mental health social workers are treating depression in conjunction with primary care

Anticipated Long Term Outcomes

- Patients will experience highly coordinated care
- Less chaotic practice
- Role satisfaction – physician can delegate with confidence
- Partnership sustainable
- Improved clinical outcomes / quality of life
- Improved patient self-management
- Appropriate system utilization

What Current Participants Are Saying

The best part….. is using the experience of many partners to improve outcomes.

The initiative focuses on how to improve communication and teamwork

We're not letting people fall through the cracks and in fact we are helping them manage better.

What Participants are Learning

- Organizing team
- Choose an area of practice for improvement (diabetes!)
- Obtain guidelines for care and determine measures to monitor improvement
- Collect baseline data – identify gaps and opportunities
- Conduct planned care
- Experiment with self-management support
- Test changes small and fast and observe what happens!
- Move to other components of the CDPM

Learning (cont'd)

- Start one patient at a time until processes are stable and efficient
- Create follow-up processes
- Monitor measures regularly
- Test changes small and fast and observe what happens!
- Move to other components of the CDPM

What does it take?

- Commitment to improvement, make it a priority, be prepared to give up old activities
- Committed community partners wiling to work outside of siloes
- Patient centredness is hard, needs a lot of focus
- External facilitation support is helpful
- Strong physician leadership, and nurturing of all leaders is a must
- Step wise approach to chronic disease management … concrete resources give each team member a role to support clinical care

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Want more information?

www.partnershipsforhealth.ca

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