

It Works!

Wave I Teams report exciting results at latest Learning Collaborative



Kim Van Wyk of the Clinton Family Health Team started her presentation on May 5 with a personal story. She told the assembled Wave I teams that during the past week her brother-in-law, a father of four, had gone into a diabetic coma and almost died. “For me, diabetes isn’t just another chronic disease,” she said. “In my family, it’s life and death.”

The story helped to remind everybody in the room of the importance of the work they are doing to improve diabetes care. The May Learning Collaborative was an opportunity to report on experiences, activities and results over the previous eight months. And the news was good, very good. “The real accomplishment for these three teams was to be able to move the clinical outcomes as well as the process outcomes,” says Mike Hindmarsh, a member of the Partnerships for Health leadership team. “That’s exactly the kind of success we were looking for, because it means that the process changes they’re making are resulting in better health for their patient populations.”

Each team has initiated new processes to improve self-management, care coordination, decision support, and other aspects of diabetes care. The Strathroy team, for example, has introduced a “Diabetes Progress Record” with information about blood pressure and A1C measures. Reports from the Community Care Access Centre and the Diabetes Education Centre

(DEC) have been integrated directly into the FHT Electronic Medical Record, and physicians are reviewing CCAC assessment reports for information on shared patients. Local pharmacies are supporting the project with education and medication compliance efforts.

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In Brockton, the team has begun creating a Healthy Living Plan for each patient and providing a comprehensive diabetes education package. They have also launched an Intensive Insulin Management Clinic. Patients are now reminded by phone or letter if they need blood work done, and collaborative visits with a nurse and dietician or nurse and social work have started. The team holds diabetes screening clinics at local pharmacies and the Family Health Team, DEC and CCAC are all now using the same education materials. The local optometrist has been engaged in the improvement process and will be sending screening results to the team.

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... continued from page 1 The Clinton team has also been busy. It now has automatic medical directives for immunization, standing orders for yearly blood work and reminders for quarterly and annual appointments, cholesterol testing and retinal screening. Communication has been improved between the DEC and the CCAC, and the team now makes referrals to both for insulin starts. Because the DEC is only open two days a week, patients sometimes had to wait several days to start their insulin. Now a nurse from the CCAC can begin the regime in the client's home, with follow-up at the DEC.

The results are remarkable. There are sharp upswings in key measures such as how many patients are having regular retinal and foot exams, A1C screening, flu and pneumonia vaccines and screening for depression. Clinical outcomes are also improving. In Brockton, for example, 85% of clients reported fewer hypoglycaemic incidents and overall clients decreased their A1C by up to 1%.

Physicians are also responding positively to the integrated team approach and its impact on their patients. "I have seen numbers improve and heard patients say how much they appreciate the extra time, teaching and attention to detail of the diabetes care," says Dr. Paul McArthur of the Brockton FHT. "I am hopeful that these benefits can be sustained and expanded to all practices in our Family Health Network."

The Wave I teams will continue working on improvements with the support of practice coaches until the Outcomes Congress scheduled for October 2010. "This is just the beginning," says Hindmarsh. "The next challenge is to sustain this change. A lot of our work over the next few months will be helping the teams hold these gains and then spread them to other practices in their Family Health Teams."

www.partnershipsforhealth.ca for more info >>

Living Laboratory

Partnerships for Health advances LHIN and provincial priorities

Kelly Gillis, Senior Director of Planning, Integration and Community Engagement for the South West LHIN, is one of Partnership for Health's biggest fans.

"Partnerships for Health is on the ground delivering the improvements in outcomes that have been identified as part of the LHIN strategy for chronic disease and the provincial strategy for diabetes," she says. "It's a living laboratory, an opportunity to work with teams and individuals to support real improvements in the care process."

Chronic disease prevention and management was identified as a priority by the South West LHIN in its first Integrated Health Service Plan three years ago. "We recognized the growing prevalence of chronic disease in an aging population," says Gillis. "We also recognized the health system was really designed to provide crisis response and acute care rather than support for individuals with ongoing illness. We saw a huge opportunity to re-think how care is coordinated and delivered."

The LHIN chose to focus on diabetes, which was a perfect match with the Ontario government's Diabetes Strategy, announced in July 2008. "By improving the way we prevent, treat and manage diabetes, thousands of Ontarians

will benefit from a better quality of life," said David Caplan, Minister of Health and Long-term Care in making the announcement. "This will ultimately save more lives and ease hospital wait times."

Gillis says the impact of Partnerships for Health goes far beyond the remarkable clinical outcomes that are already being achieved. She is also excited about the process of improvement – the Quality Improvement Model and PDSA cycles. "This really provides a unique opportunity for the LHIN to look at different ways of transforming the health care system, alternatives to the traditional top-down system-wide planning approach. That will still be important, but we're also interested in exploring bottom-up processes for aligning care to meet the needs of individual clients."

Another valuable part of the project, she says, is the focus on looking at other conditions that patients with diabetes may have, such as depression, a common co-morbidity with many chronic diseases. Gillis believes this is the first step in looking more broadly at how to support people with other chronic diseases.

Ultimately, Partnerships for Health supports not only specific LHIN priorities, but also the overall direction of health care in Ontario – a direction driven by the challenges of growing demands and an aging population. "We need a health system that is based on best practice, coordinates resources well, is consumer-friendly and supports patients to be more accountable for their own care," says Gillis. "Partnerships for Health is leading the way."

Moving Upstream

The South West CCAC welcomes the opportunity to get involved in keeping clients healthy longer



In the past, patients with diabetes were referred to the CCAC primarily for wound care or because of some functional decline – in other words, when they were already dealing with complications. That’s changing, says Nancy Dool-Kontio, Senior Director of Strategic Planning and Integration for the South West CCAC, in part because of the CCAC’s involvement with Partnerships for Health. “We are moving toward a wellness orientation, so that we’re engaging with clients when they are living well with their disease. We are moving upstream so that we’re part of a team to keep people healthier longer.”

There are now 11 CCAC case managers and two Project Managers working with PFH teams in primary care practices across the region. Project Manager Catherine Statten is excited about the potential of the team approach. “We have the opportunity to get everyone around the table and solve problems as a team,” she says. “It allows us to think outside the box because we don’t have the same barriers and limitations we would have if we tried to tackle it on our own.”

Dool-Kontio says family physicians in the project are getting a better sense of the knowledge base CCAC case managers bring to diabetes management. “Case managers have proven that they know how the health care system works and what community resources are available. They also provide a window into the home environment – a sense of whether clients are following through with their self-management goals and what family supports are available.”

Working in partnership with primary care ensures that family physicians and their nurses know more about what services the CCAC can offer. “We know the need is there,” says Statten, “but some of our services are actually under-utilized. Being involved in a project like this opens eyes to what we have available and how we can link people to the appropriate services.”

Dool-Kontio hopes the work with Partnerships with Health will help the CCAC prepare to work upstream with other common chronic conditions, such as arthritis, COPD and cardiovascular disease. She is currently developing a communication plan to share some of the experiences and lessons of Partnerships for Health with other case managers.

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In addition to helping patients live better and stay healthier, moving upstream has important implications for the health system as a whole. “When we focus on prevention and management, people can stay in their own homes longer and have fewer complications requiring specialist care,” says Dool-Kontio. “This is all about delivering the right level of care by the right person at the right time. If we can get that figured out, we’ll be light years ahead.”

For more information visit www.sw.ccac-ont.ca. >>

Riding the Wave (II)

Nine new teams have joined Partnerships for Health in 2009

“Improvements used to come from the top down, sometimes from people who didn't understand the frontline clinical experience. With Partnerships for Health, change is happening at the grassroots level by people who know the clients and can bring improvements into their workdays.”

That's Cathy Babin-Niven, explaining why she is excited to be part of Wave II of Partnerships for Health. Babin-Niven is a Nurse Practitioner with the Owen Sound Family Health Team, one of eight that started work on Partnerships for Health this year. The other teams are East Elgin, Happy Valley (in St. Mary's), London Inter-Community Health Centre, Southwest Middlesex Health Centre (in Mount Brydges), and additional practices at the Strathroy Medical Clinic.

The Owen Sound team, which meets weekly, includes team leader Dr. Veenstra, office manager Sue Byers, a dietician, a diabetes educator, a clinical pharmacist, a CCAC project manager and case manager, and a physiotherapist. The team also hopes to attract a person involved in mental health or a social worker.

Babin-Niven appreciates the expert, up-to-the-minute information about diabetes care that team members receive at the Learning Collaboratives. “It's a synthesis of everything that's out there, without having to research all the literature. There are always pearls of wisdom you can take away.” She is also impressed by the potential of the Quality Improvement Model and PDSA cycles. “It doesn't have to involve diabetes: it's an approach you can use on a day-to-day basis in your clinical practice,” she says. “It's a way of working through challenges, developing potential solutions and testing them.”

Her team is already beginning to make some changes – integrating a Ministry diabetes flow sheet into the Electronic Medical Record so that data can be retrieved quickly, introducing the PHQ9 depression screening tool, improving communication between the CCAC and the doctor, and introducing a self-management action plan.

Ultimately she believes the project will improve care for people with diabetes, and for those with other chronic diseases. “If we follow the clinical guidelines we've been provided, we are well on our way to making care better for our diabetic population. It's just a good way to approach primary care, whatever the issue.”

Don't Miss the Wave (III)

Join the FINAL PHASE of Partnerships for Health

Wave I teams are reporting significant improvements in both processes and outcomes, and Wave II teams are also hard at work. Now there's an opportunity for up to 100 other practices throughout the South West to build on what's been done by joining Wave III.

Wave III offers four ways to be involved:

- through a collaborative similar to but less strenuous than Waves I and II
- through lecture-based learning
- through web-based learning, or
- with coaching only.

Regardless of the learning method they choose, all teams in Wave III will have the opportunity to work with experienced practice coaches. Partnerships for Health recently hired three outstanding health care leaders – Diane Koz, Linda Hebel and Sally Boyle – to provide information, expertise, support and encouragement to the teams.

Another clear advantage, says Mike Hindmarsh, is the support teams receive from Gavin Giles, the project's E-Health expert, in using their Electronic Medical Records. Giles goes on-site to train staff in using EMRs for population care. He also provides off-site support and works closely with the practice coaches to identify problem areas.

Other benefits include exposure to the latest research on diabetes and diabetes management, better team work, improved business processes, a better understanding of how to make improvements, and better support for patients to care for themselves.

“This is the last chance to take advantage of Partnerships for Health,” says Hindmarsh. “It's an opportunity to position your practice as a leader, and ultimately, to improve the health of your patients.”

For information about becoming a partner, visit www.partnershipsforhealth.ca >>

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