Caring for People with Multiple Chronic Conditions:

A Necessary Intervention in Ontario

Presented by:

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Outline

1. Why does chronic care management perform poorly in Ontario?
2. Our methods
    - Evidence-based care for Complex Chronic Adults
3. Model of Integrated Care for People with Multiple Chronic Conditions in Ontario
    - 4 Principles
    - 18 Components
    - 4 Stages of Implementation
4. Closing Remarks

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… in Ontario

Burden of multimorbidity is high ←

→ Care of multimorbidity is suboptimal

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Why chronic care management performs poorly in Ontario?

1. Fragmentation in health care services delivery
2. Fragmentation in financing systems
3. Single disease focus in services and guidelines
4. Lack of medical and social services integration
5. Lack of adequate measures of performance
6. Gaps in preventive care for seniors

Source:

- Engelberg Center for Health Care Reform at Brookings. Achieving Better Chronic Care at Lower Costs Across the Health Care Continuum for Older Americans. Brookings, editor. 2010. Washington, DC.
- Tsasis P, Bains J. Chronic disease: shifting the focus of healthcare in Canada. Healthc Q 2009;12:e1-e11.
- Kodner DL. Integrated care networks for the vulnerable elderly: North American prototypes, performance and lessons [abstract]Kodner DL. International Journal of Integrated Care 2008;8
- Bergman H, Beland F, Lebel P et al. Care for Canada's frail elderly population: fragmentation or integration? CMAJ 1997;157:1116-1121.

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Evidence-Based Care for Complex Chronic Adults

- **GRACE** – Geriatric Resources Assessment and Care of Elders
- **PACE** – Program of all-Inclusive Care for the Elderly
- **Guided Care**
- **SIPA** – System of Integrated Care for Older Adults
- **PRISMA** – Program of Research to Integrate Services for the Maintenance of Autonomy

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Key Model Components

1. GRACE
2. PACE
3. Guided Care
4. SIPA
5. PRISMA

Care Component	GRACE	PACE	Guided Care	SIPA	PRISMA
Interdisciplinary Teams	✓	✓		✓	
Patient enrolment assessment	✓	✓	✓	✓	✓
Individualized care plans	✓	✓		✓	✓
Case management	✓		✓	✓	✓
Patient & family involvement	✓	✓	✓	✓	✓
Continuity of care and transition management		✓		✓	✓
Single entry point		✓		✓	✓
Electronic health record	✓	✓	✓		✓

Study	Model	Performance Measures
Counsell et al. (2007)	GRACE	ACOVE quality indicators. SF-36 medical outcomes. Functional index score created from 7 instrumental and 6 basic ADLs. ED visits, acute care hospitalizations and mortality rates.
Mukamel et al. (2006 & 2007)	PACE	Risk-adjusted outcomes at 3 and 12 months post PACE enrolment: Self-assessed health status; functional status; mortality at 12 months.
Boult et al. (2008)	Guided Care	PACIC (at 0 & 6 months) PCAT (PCP satisfaction, time allocation, knowledge, care coordination) Nurses' job satisfaction instrument (at 12 months)

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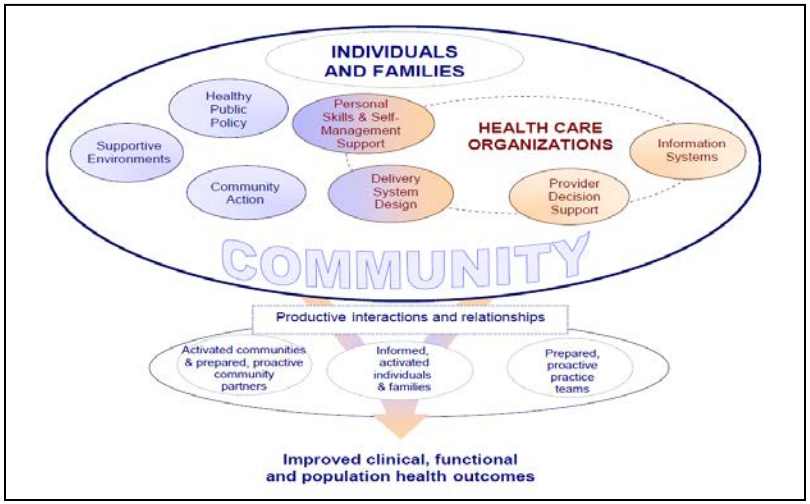
Model of Integrated Care for People with Multiple Chronic Conditions in Ontario

- **4 Principles**
- **18 Key Components**

- Framework of performance measurement for high performer MCC teams

Ontario's Chronic Disease Prevention and Management Framework



4-Stage Implementation

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Model of Integrated Care for People with Multiple Chronic Conditions in Ontario

Principles

1. Population-based patient-centered care
2. Organized in primary care
3. Interdisciplinary collaboration
4. Community embedded (Grounded in the community)

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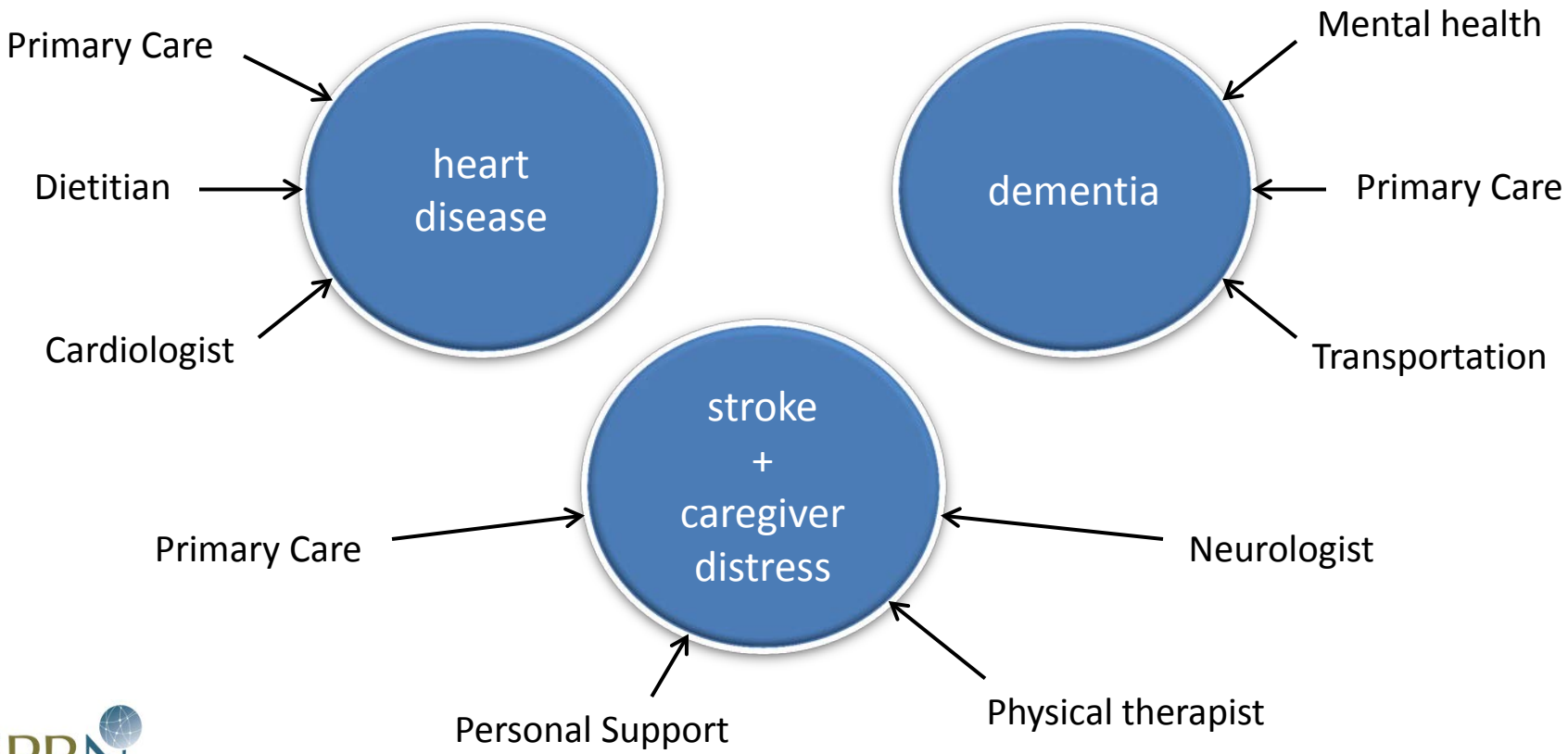
Why Integrated?

Why Patient-Centred?



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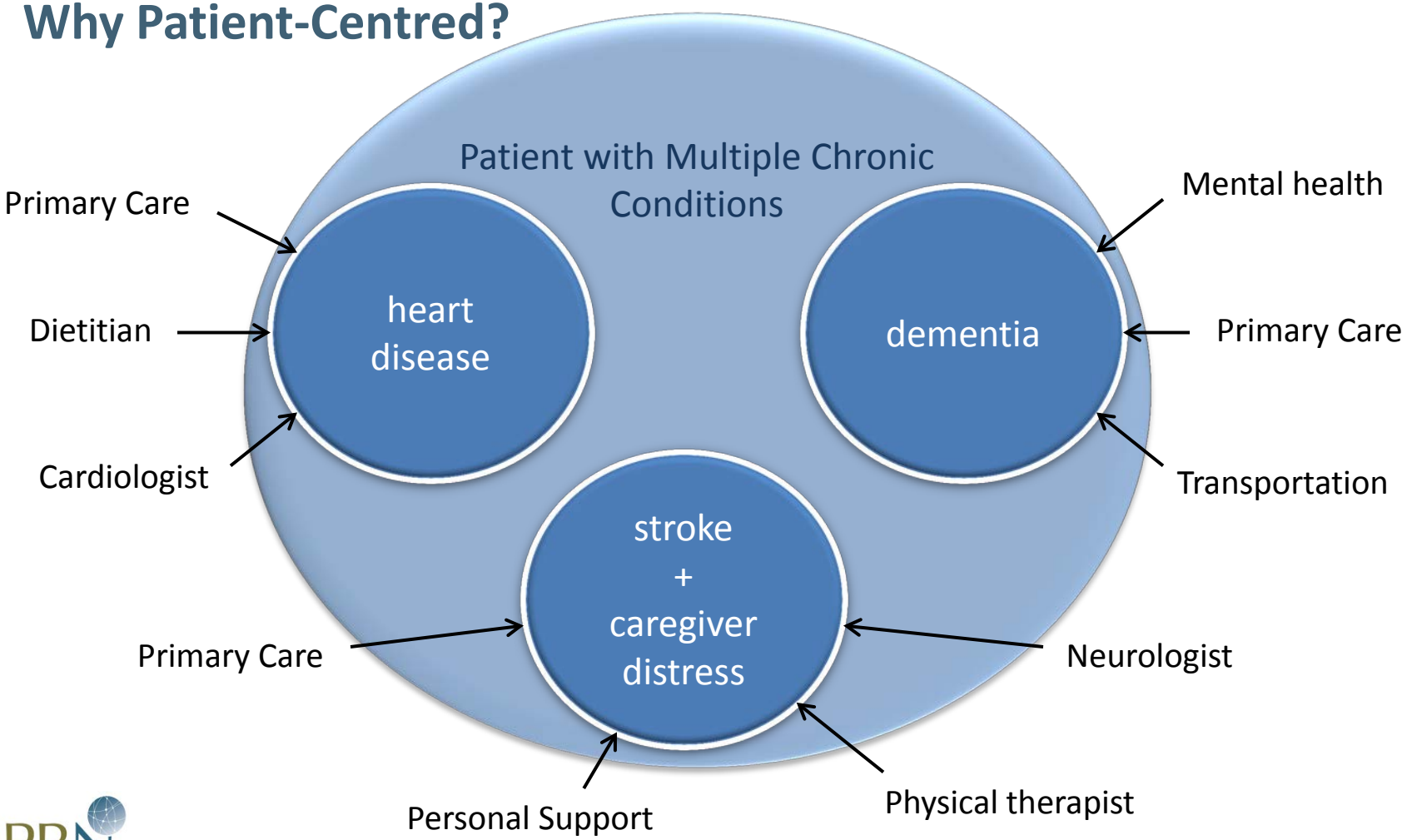
Why Integrated?

Why Patient-Centred?



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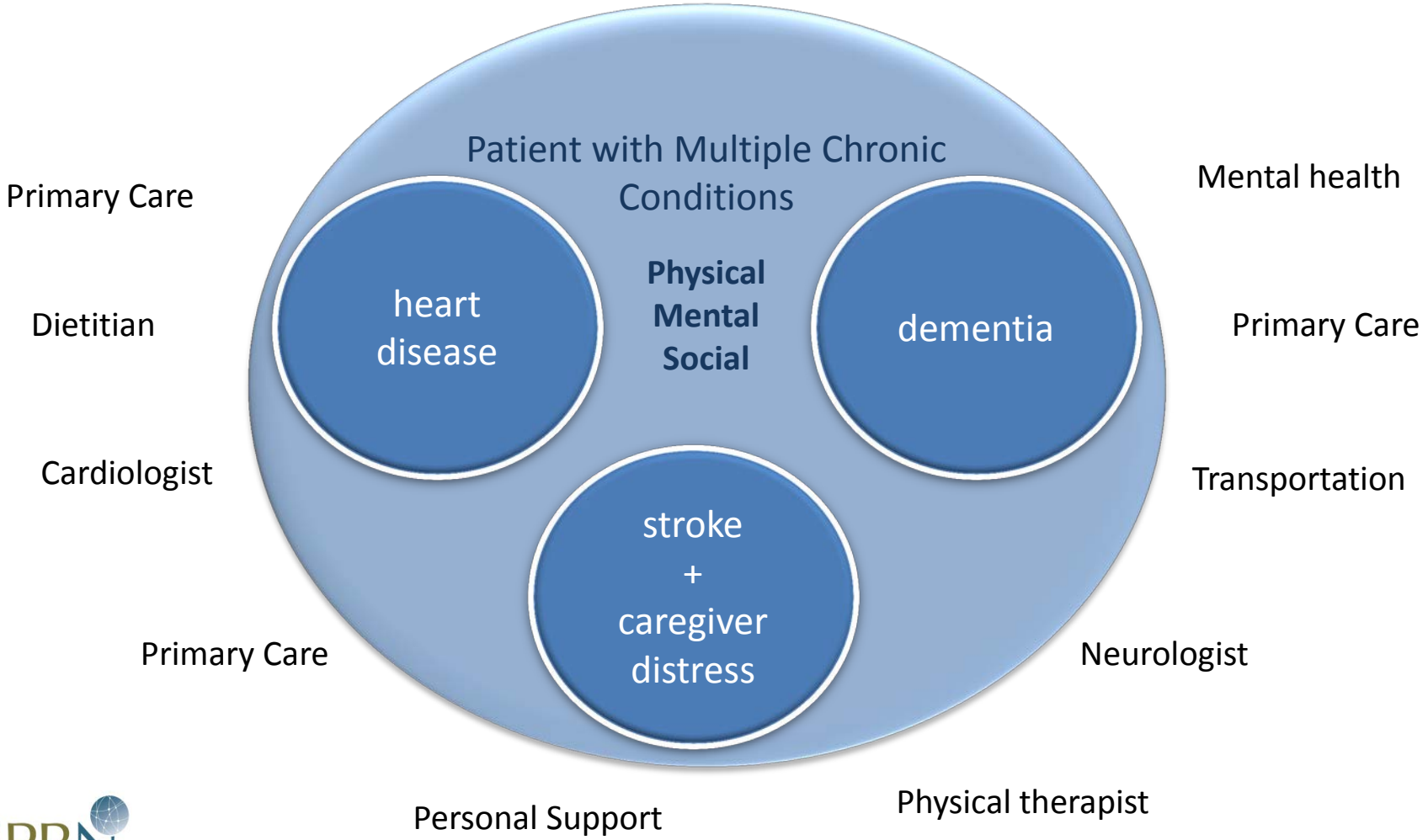
1. Population-Based Patient-Centred



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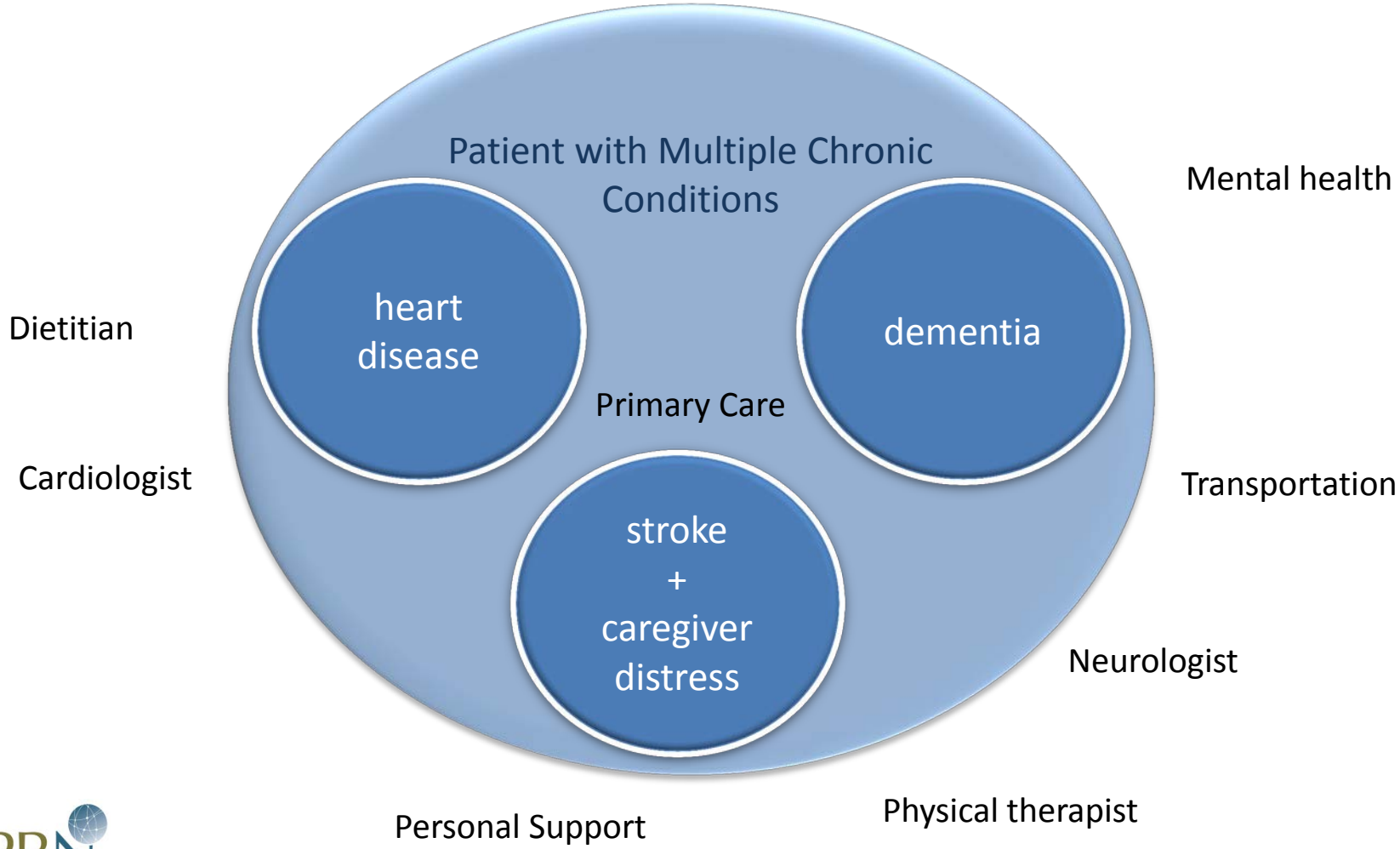
2. Organized in Primary Care



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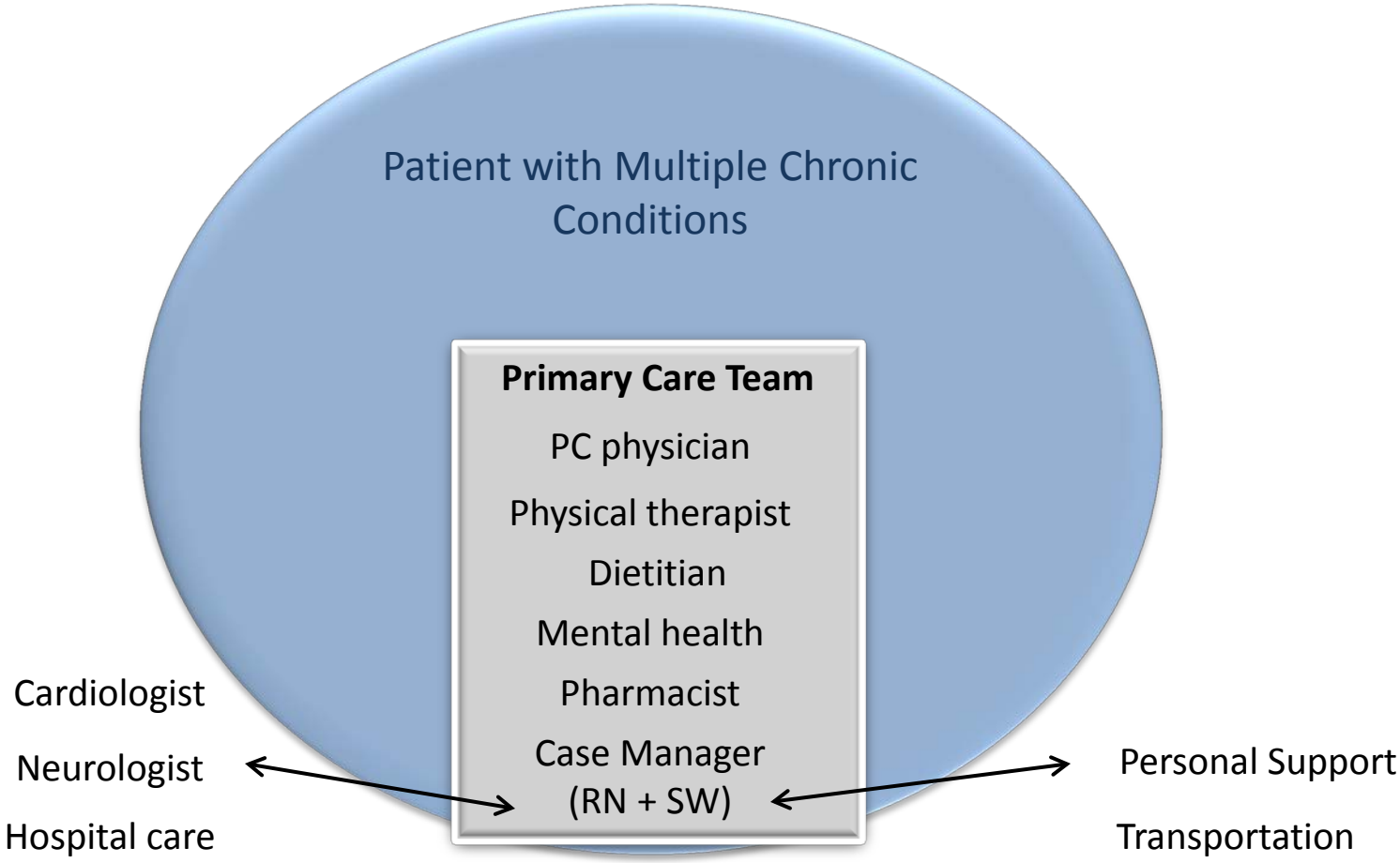
3. Interdisciplinary Collaboration



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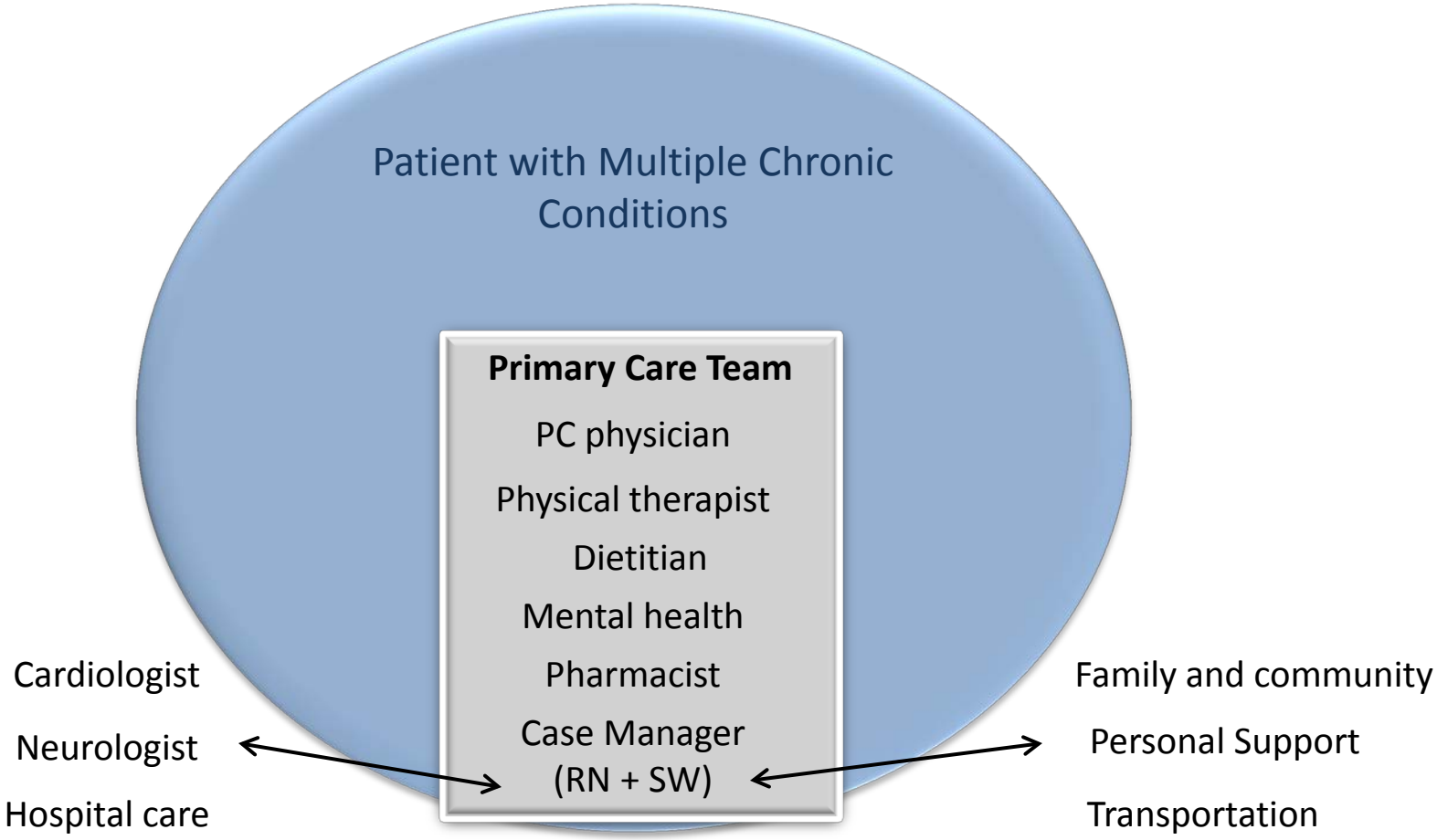
4. Community Embedded



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Key Components of Standards care for people with MCC

Program and team work

1. Interdisciplinary Primary Care Teams
2. Patient enrolment and assessment
3. Interdisciplinary Primary Care Team Meetings
4. Individualized care plans
5. Single entry point
6. Mental health management
7. Medication management

Care coordination across the continuum

8. Case management
9. Involvement of patient and family in decision making
10. Integration of home and community-based services
11. Support for self-management
12. Caregiver education and support
13. Continuity of care and transition management

Support structure

14. Electronic health records
15. Guidelines for MCC
16. Performance measurement
17. Blended capitation remuneration system adjusted to patient need
18. Team-based financial payments

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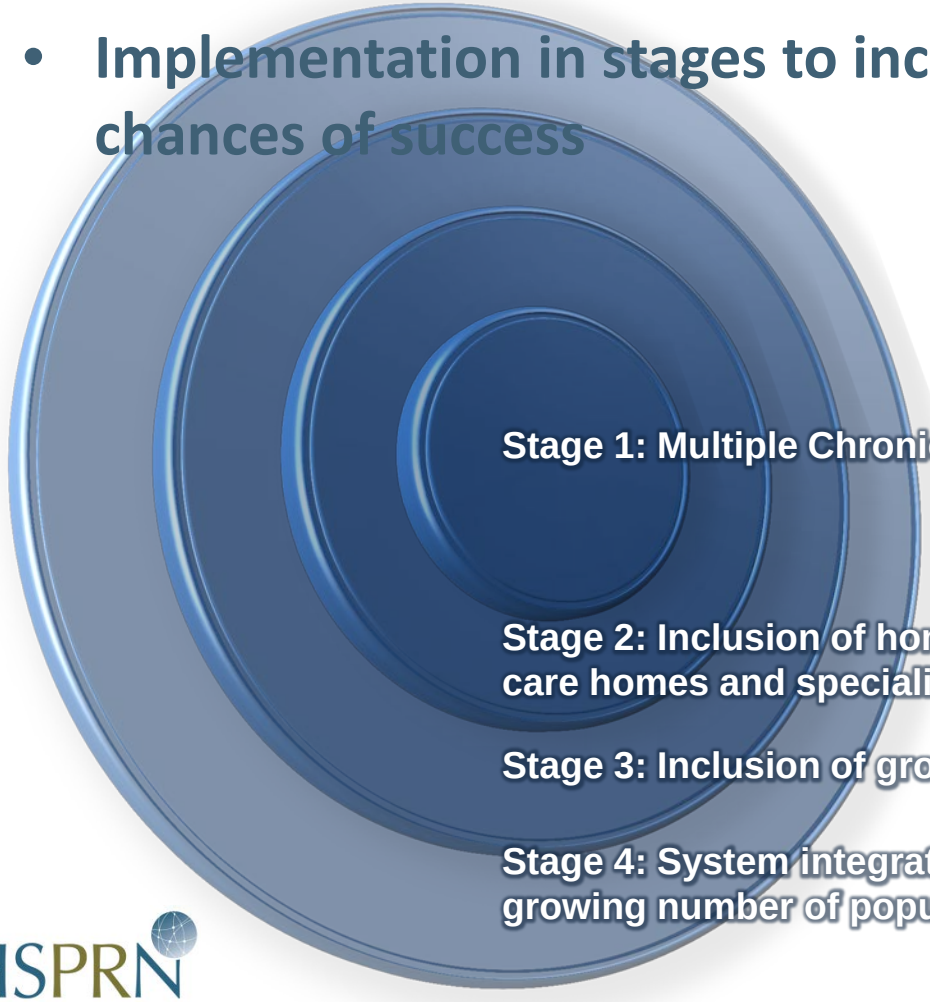
Implementation Process

- **Changing paradigms of health care delivery**
- **Implementation in stages to increase acceptability and chances of success**



Stage 1: Multiple Chronic Disease Management in CHC/FHT

Stage 2: Inclusion of home care and community services, long-term care homes and specialized rehabilitation services.

Stage 3: Inclusion of growing number of medical specialties

Stage 4: System integrated in the community with inclusion of a growing number of population groups

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Stage 1: Multiple Chronic Disease Management Programs in Primary Care

- Multiple Chronic Disease Management programs (MCDM) in All Primary Care Teams in Ontario (CHCs, FHTs, others).
- Every older adult with MCCs should receive primary care by an interdisciplinary team and within a MCDM program (minimum standard of care in Ontario).

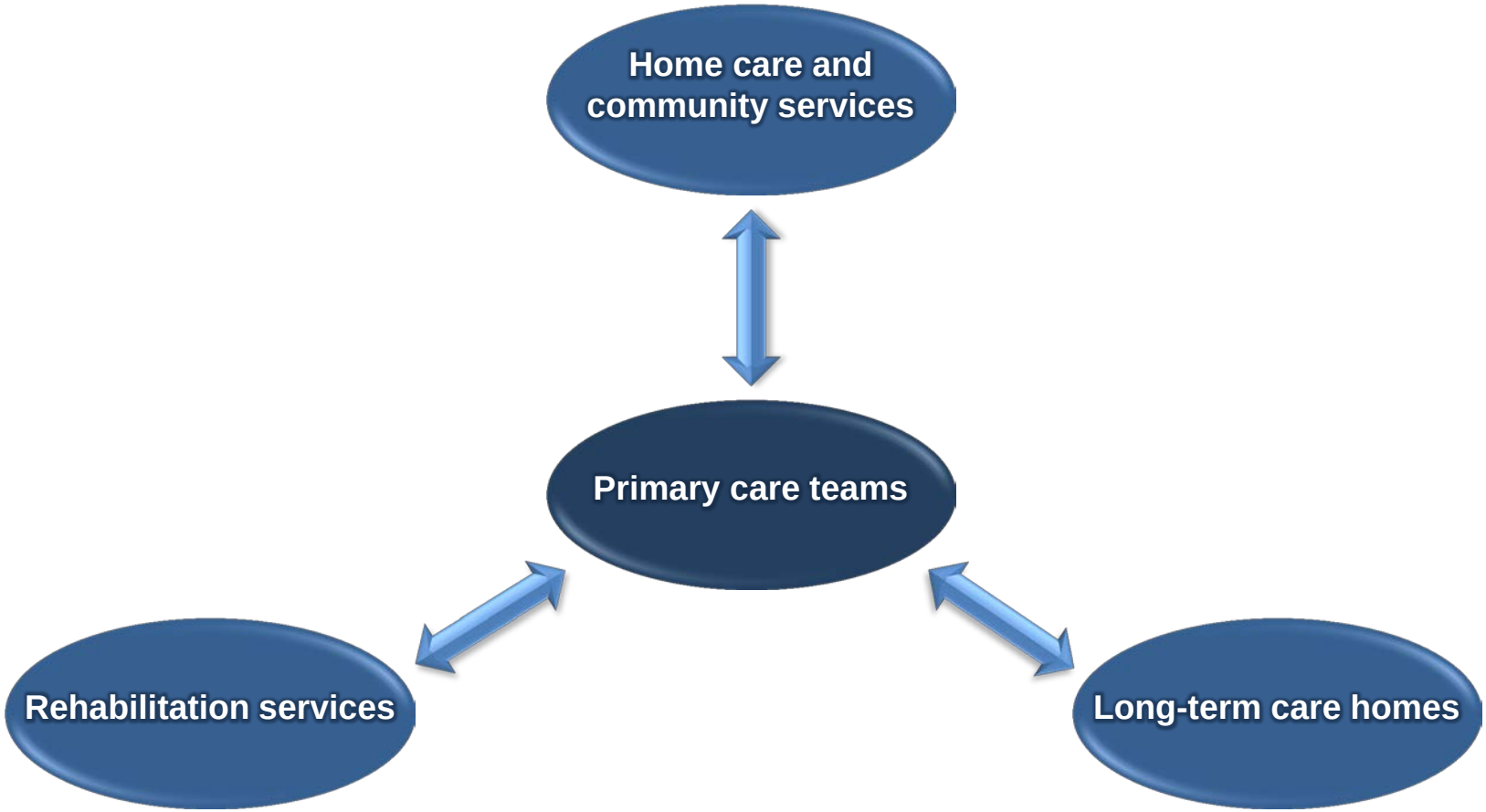
Interdisciplinary teams:

- GP, nurse case manager, SW case manager, PT, OT, mental health provider, dietician, pharmacist, and geriatrician, among others.

Case managers:

- Can be based at primary care centres or CCACs, but need to be part of the same team → Is key to achieve real integration between these organizations
- Case manager nurse: Coordination of care and transition management
- Case manager social worker: Facilitating home and community-based services and caregiver education and support

Stage 2: Inclusion of home care and community services, long-term care homes and specialized rehabilitation services



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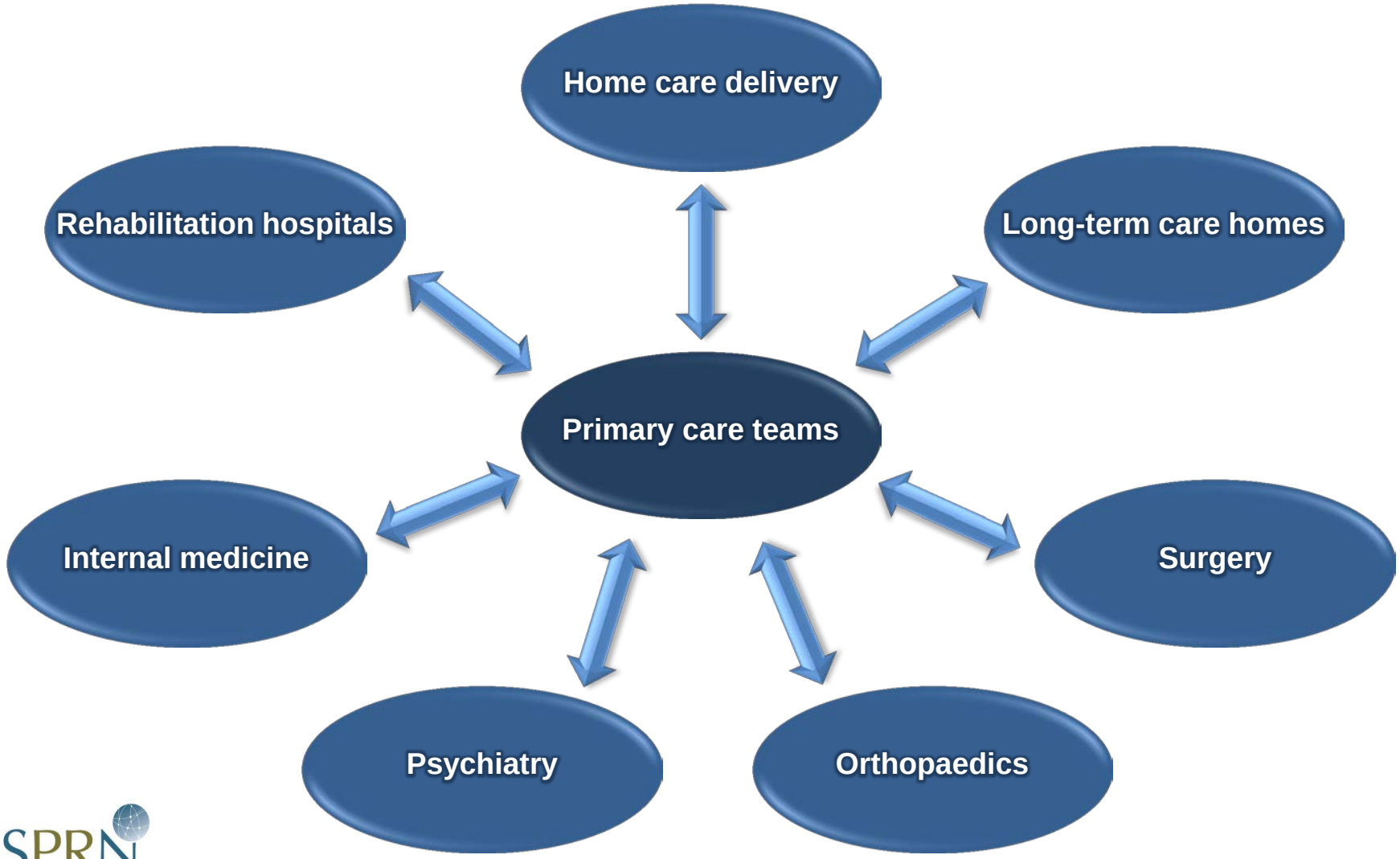
Stage 2: Inclusion of home care and community services, long-term care homes and specialized rehabilitation services

Home care and community services

- Primary care and home and community-based care should be close partners for providing care to complex chronic adults.
- Case managers currently practice in CCACs → first step of integration across sectors.
- Processes of care should be integrated:
  - Home and community-based services staff and CCAC case managers should be part of Interdisciplinary Primary Care Teams.
  - Participate in enrolment assessments, team meeting and individualized care plans
  - Implementation of common individualized care plans
  - Team-based performance measures and financial incentives
- Home and community care staff are essential for an integrated system grounded in the community (community embedded)

Stage 3: Inclusion of growing number of medical specialties



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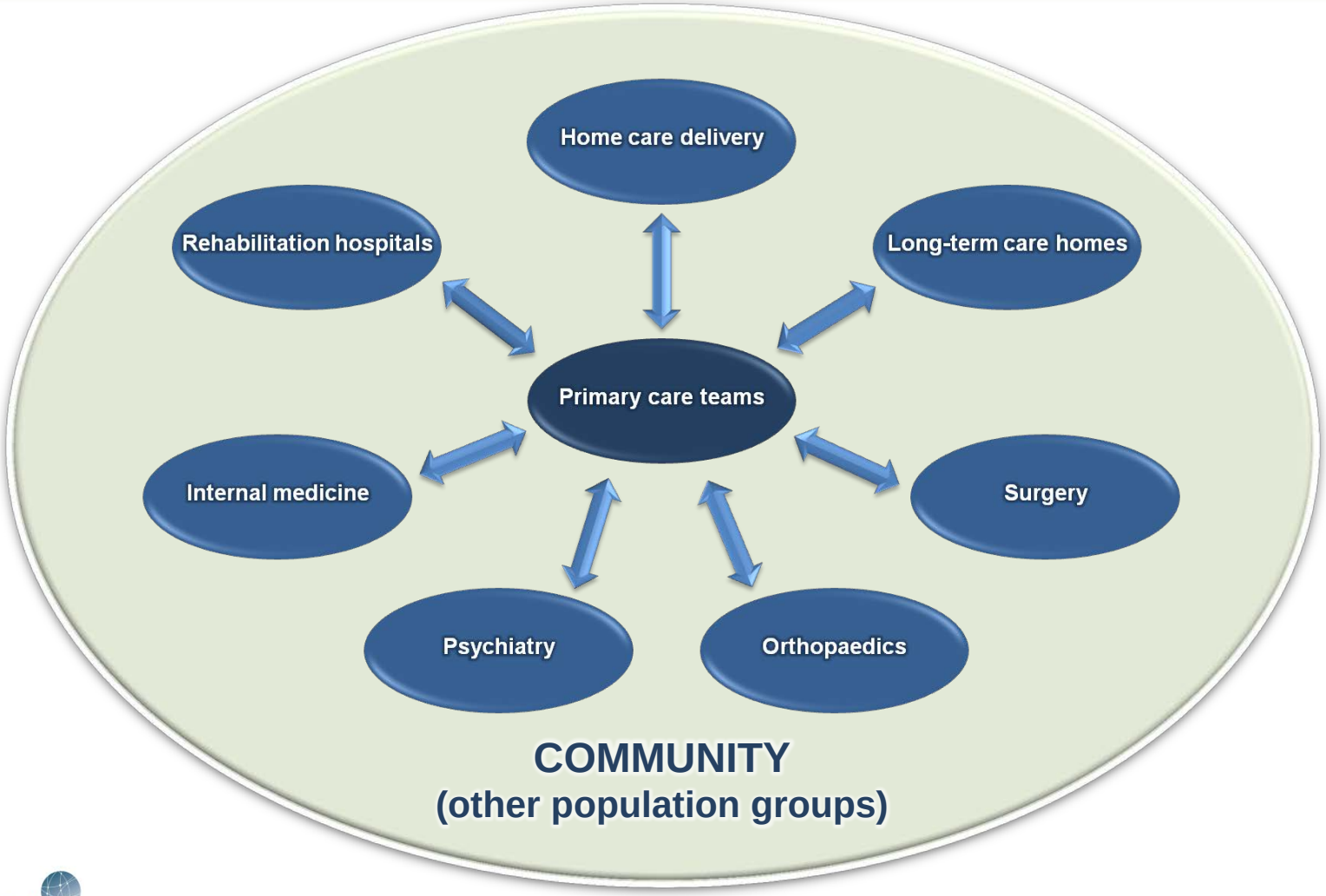
Stage 4: System integrated in the community with inclusion of a growing number of population groups



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Closing Remarks

1. Care for People with Multiple Chronic Conditions should be provided by an interdisciplinary care team.
2. Models of integrated care set primary care at the centre of the system of care for Complex Chronic Adults.
3. This is because a truly patient-centred model requires health – social – mental approaches simultaneously.
4. Case Managers are an essential piece of models for integrated care.
5. They have a double role of care coordination across the care continuum and bring closer the social context of the patient and their families.

Closing Remarks

6. The model of care should be flexible to provide different intensity of care depending on individual needs (e.g. different intensity of case management).
7. Different patient cohorts may be identified and stratified according to risk. These cohorts may be targeted with different packages of services.
8. Performance measurement, electronic records, adequate remuneration systems and team-based financial incentives are essential for effective integration; they should be acknowledged and taken into consideration from early stages of policy development, model design and implementation.
9. A flexible integrated health care system should also create value to other population groups.

QUESTIONS AND COMMENTS ?

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