# Evaluation of the Partnerships for Health:

## A chronic disease prevention and management demonstration project in Southwestern Ontario

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# dation: Partnerships for Health
# Challenge of Chronic Disease

Chronic diseases have emerged as the leading cause of death worldwide (Yach et al., 2004).

In 2002, cardiovascular disease, cancer, chronic respiratory disease and diabetes were responsible for 29 million deaths worldwide (Yach et al, 2004).

The situation is similar in Canada, where 205,590 deaths were attributable to chronic disease in 2005 (WHO, 2005).

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## Challenge of Chronic Disease

he impact of chronic diseases on the healthcare ystem in Ontario is substantial.

estimated at least 60% of Ontario's healthcare costs are due to chronic disease (Ontario Health Quality Council, 2007)

almost 80% of people those over the age of 45 living with a chronic condition in 2003

Up to 80% of these conditions are preventable when

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# Burden of Diabetes

Contribution of diabetes to the chronic disease burden:

DM costs approximately $2.5 billion in Canada (O'Reilley et al., 2006).

During 1995-2005, the prevalence of DM increased: 4.9 % to 8.9% (Lipscombe & Hux, 2007).

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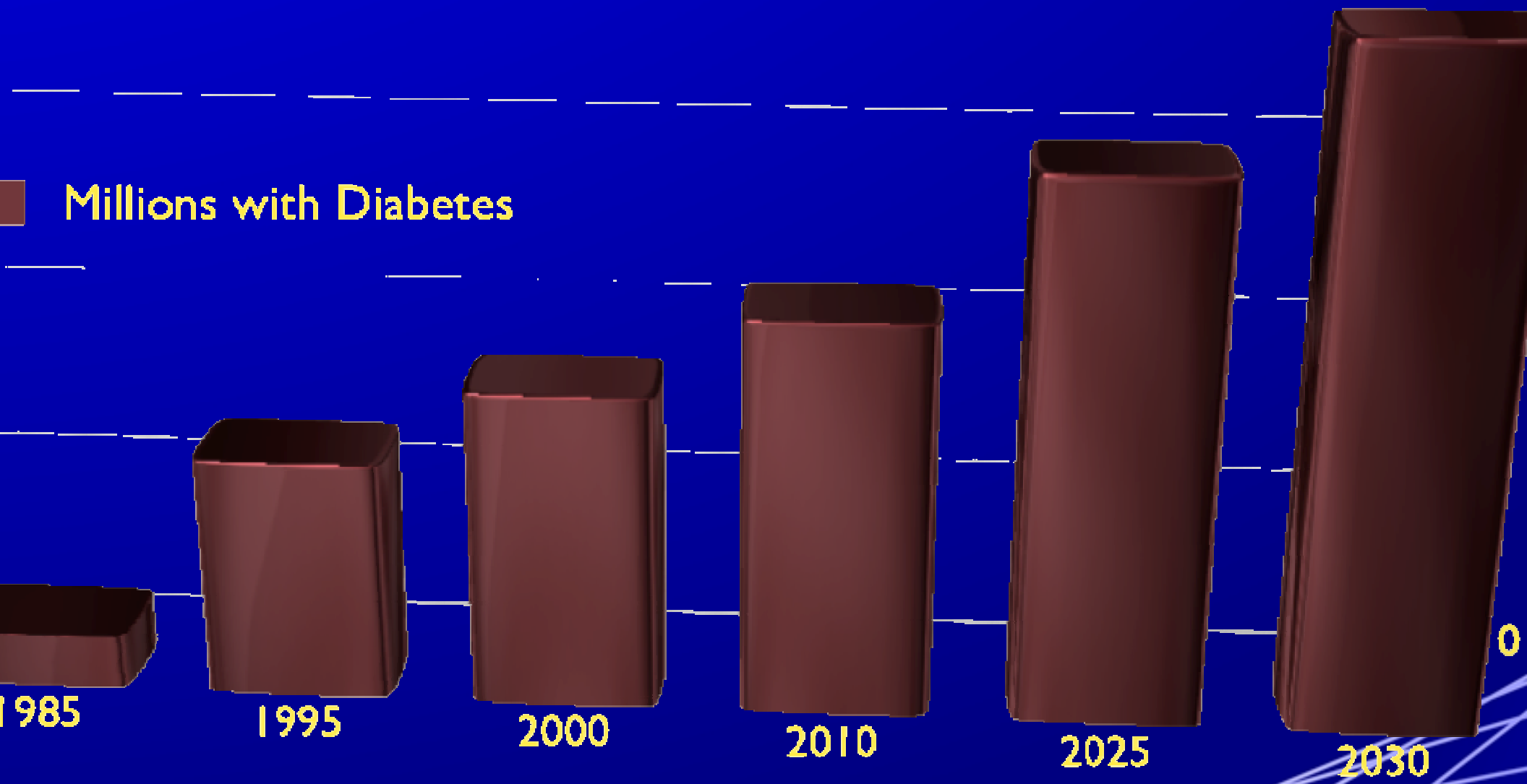
# Worldwide Epidemic: Diabetes Tren



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# Challenge of Chronic Care

he impact of chronic diseases on the health of ndividuals is substantial.

Complications due to diabetes are primary focus of clinical intervention

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# e 2 Diabetes: NOT a Mild Disease

Retinopathy
cause of
s in working-age

Nephropathy
cause of end-
nal disease2

- to 4-fold
in cardio-
mortality and

Cardiovascular
8/10 diabetic pa
from CV events

Diabetic Neurop
Leading cause
traumatic lower
amputations5

et al. Diabetes Care 2003; 26(Suppl 1):S99-S102.
E, et al. Diabetes Care 2003; 26 (Suppl 1):S94-S98.

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# Burden of Diabetes: Ontario

Contribution of diabetes to the chronic disease burden:

- 50,000 new cases of diabetes every year in Ontario (MOHLTC, 2008)
- healthcare costs of DM related conditions (heart failure, stroke, amputations) estimated to rise 48% over the next decade (MOHLTC, 2006)

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# Challenge of Chronic Disease

he management of chronic diseases is still sub-
ptimal:

50% adherence to recommended care for diabetes, high cholesterol, blood pressure, and COPD (McGlynn et al, 2003).

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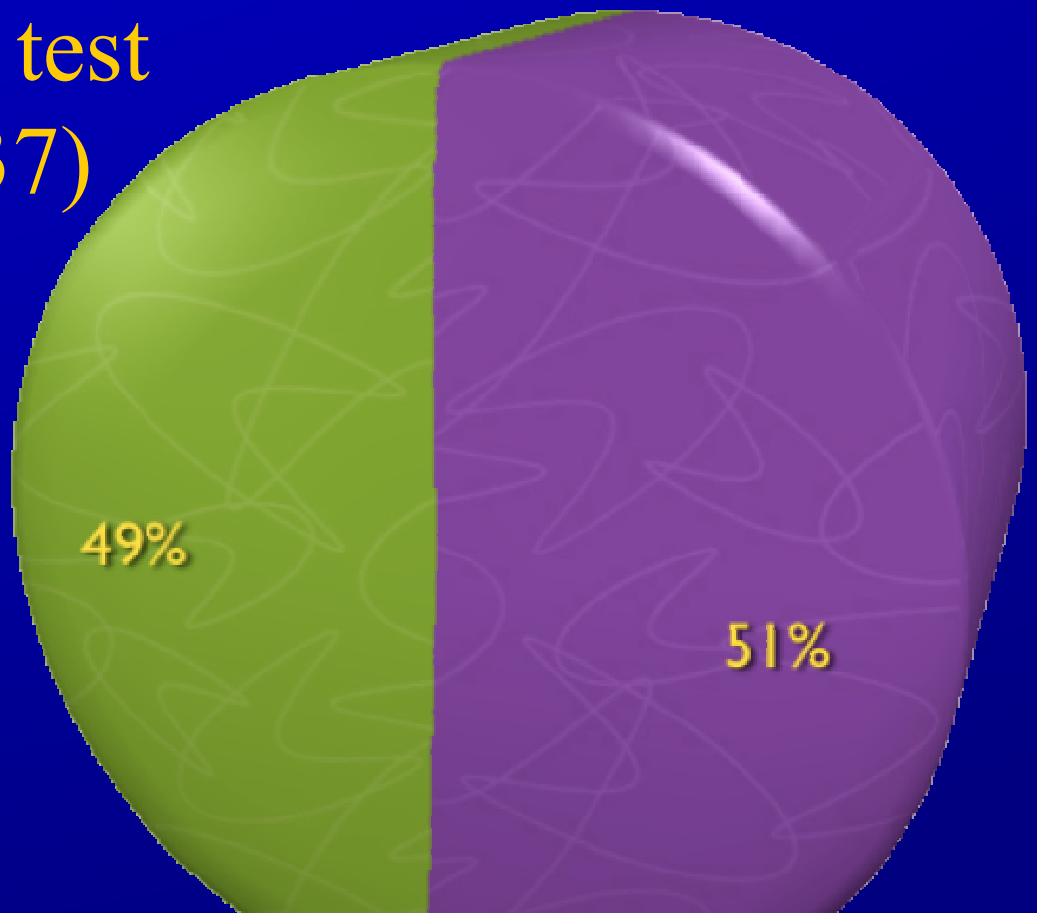
## emic Control in Canada

One in two type 2 diabetes patients in Canada are n
at target (< 7%). Mean A1C = 7.3%

st recent A1C test
sults (n = 2,337)




Uncontrolled A1C
49%

Controlled A1C
51%

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## PDS: Lower A1C = Lower Risk

ERY
%
ction
A1C

| | |
|---|---|
| Deaths from diabetes | -21% |
| Myocardial infarctions | -14% |
| Microvascular complications | -37% |
| Peripheral vascular disorders | -43% |

*P <

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# Challenge of Chronic Disease

olicy makers:

need to shift focus in healthcare delivery to improve screening and management of chronic diseases

bulk of care takes place in family practice

strategies for CDM in primary care setting

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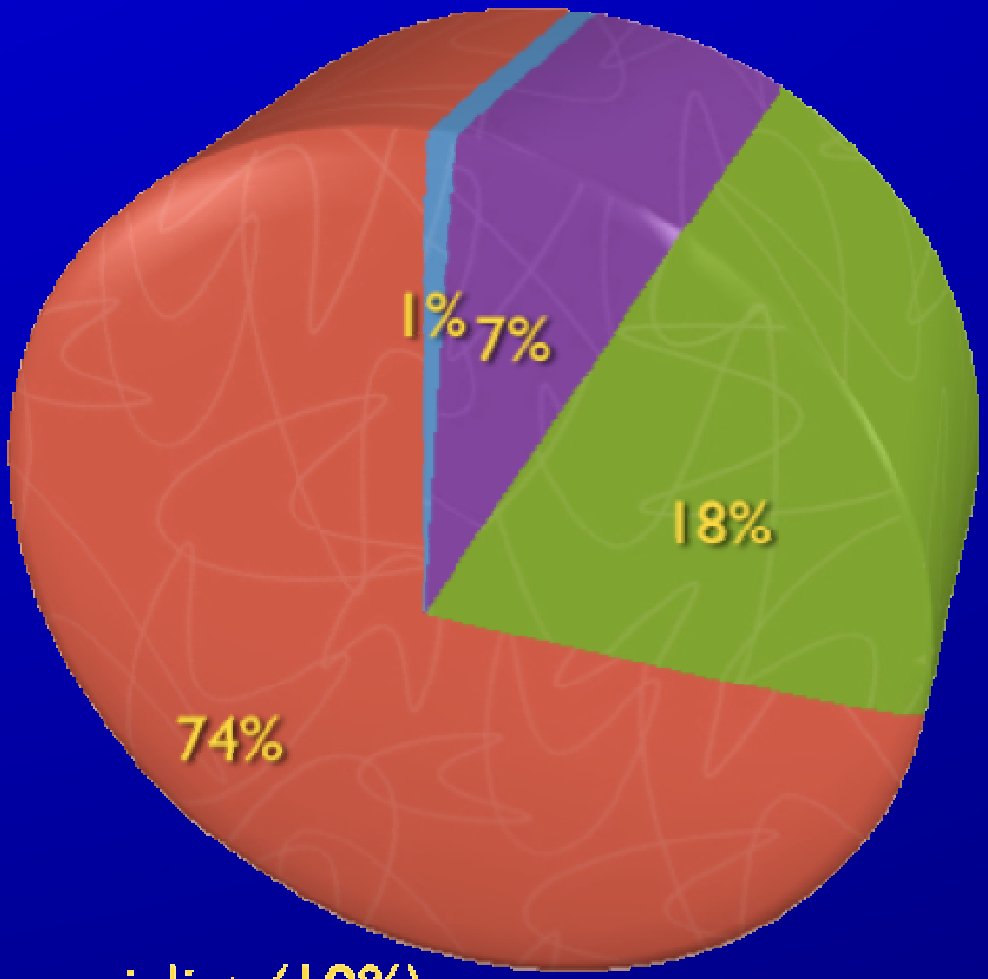
# is Providing DM Care?



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# tact with the Healthcare System in t
# Year

atients averaged 8 FP visits in the past year and 1/2 of visits were for diabetes-related issues

| | Total |
|---|---|
| Mean visits to Family Practice clinic (n = 2,145) | 8.2 |
| Mean visits to clinic for diabetes-related issues (n = 2,136) | 4.3 |
| ercentage hospitalized or visited ER for | |

# dation: Partnerships for Health
# Organization of Primary Care

MOHLTC introduced a Chronic Disease Prevention nd Management (CDPM) framework

target efforts at reducing the incidence of chronic disease

better managing the course of treatment (MOHLTC, 2007)

# dation: Partnerships for Health
# ily Health Teams

OHLTC 2005: strategic initiatives aimed at improving the health status of
ntarians

Included the reorganization of the primary healthcare system

- rostering of patients with family physicians (FPs)
- support of FPs for the conversion to electronic medical records
- encouraging FPs to work collaboratively across practices
- and the expansion of allied healthcare professionals working as 'teams' in the FP setting

50 Family Health Teams (FHTs) were initiated

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# Organization of Primary Care

DPM framework suggests successful chronic disease management
equires changes to:

- the healthcare organization
- community resources and policies
- personal skills
- self-management support
- clinical outcomes
- provider decision support
- delivery system design

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# ly Health Teams

HTs' primary mission:

to improve access to effective, comprehensive, patient-centred, team-based primary healthcare

- supports self-management,
- emphasizes health promotion and illness prevention
- enhances the management of individuals with chronic diseases

Result:

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# ity Improvement

MOHLTC: realized that the shift from the traditional
eactive model of healthcare delivery to a proactive
lanned approach presented significant challenges

n 2008, the MOHLTC championed the formation of a
entralized expert organization

Partnerships for Health (PFH)

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# Details

aunched 2008 to introduce to voluntary teams

the Plan-Do-Study-Act (PDSA) methodology

and Ontario's CDPM framework

# dation: Partnerships for Health
# nerships for Health (PFH)

PFH provides an opportunity to utilize the CDPM framework in Ontario

Aims to enhance the care system by integrating the component parts of the system electronically and augment the capability of care providers within the South West LHIN

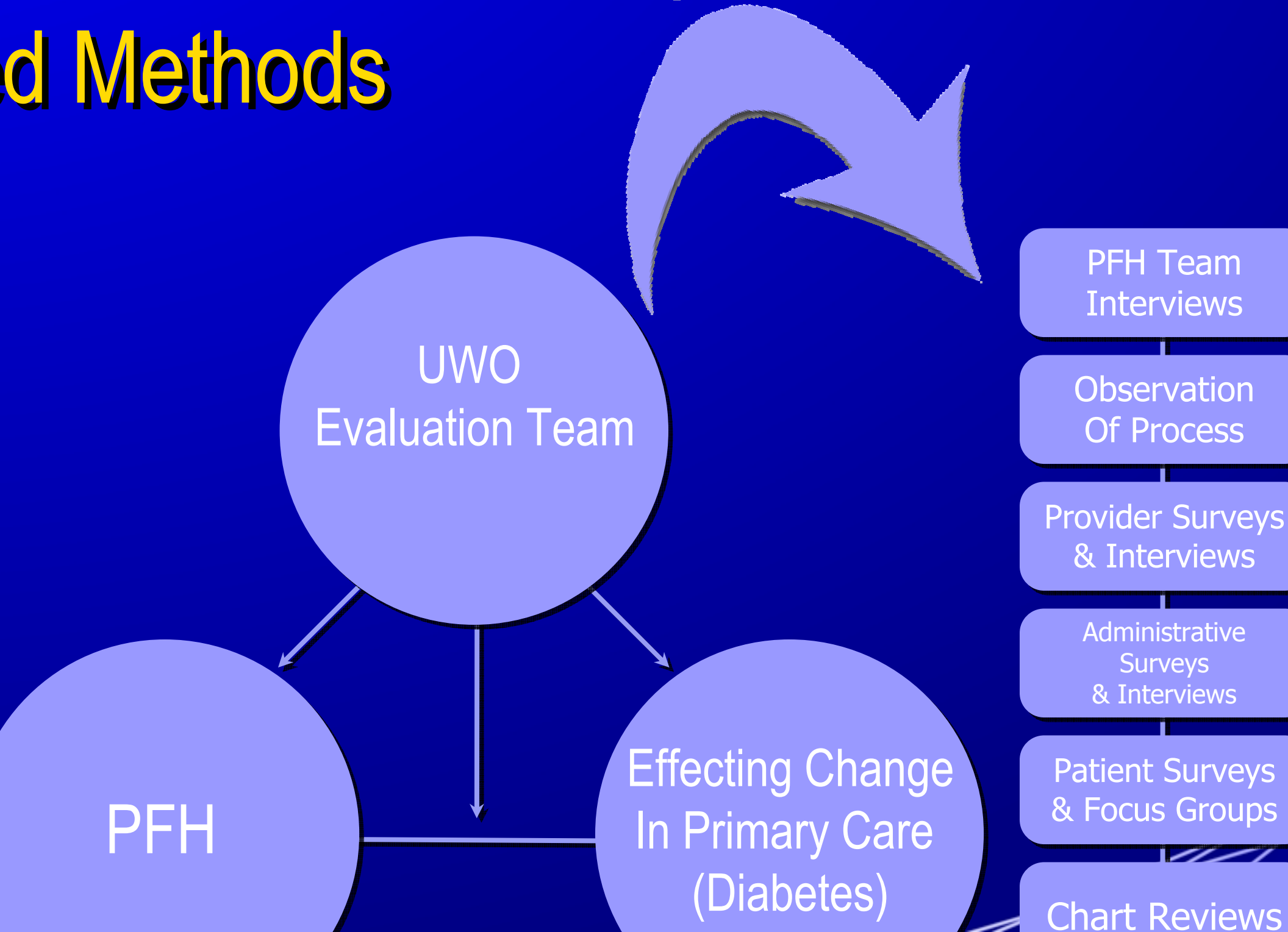
# uation: Partnerships for Health Goals

- ddress the challenges of diabetes prevention and nanagement and improve care outcomes for patients
- ducating providers using learning collaborative ethodology
- ncouraged providers to accelerate change using a lan/Do/Study/Act (PDSA) improvement model to mprove the quality of care

# ...uation: Partnerships for Health ... Goals

- ...ducating health professionals at Learning ...ollaboratives regarding CDPM framework and ...ptimal diabetes care
- ...upporting participants as they incorporated "Plan-...o-Study-Act" initiatives into their practice
- ...ntegrating case workers from the Community Care ...ccess Centres and other health professionals into ...he family practice group

# uation: Partnerships for Health
# d Methods



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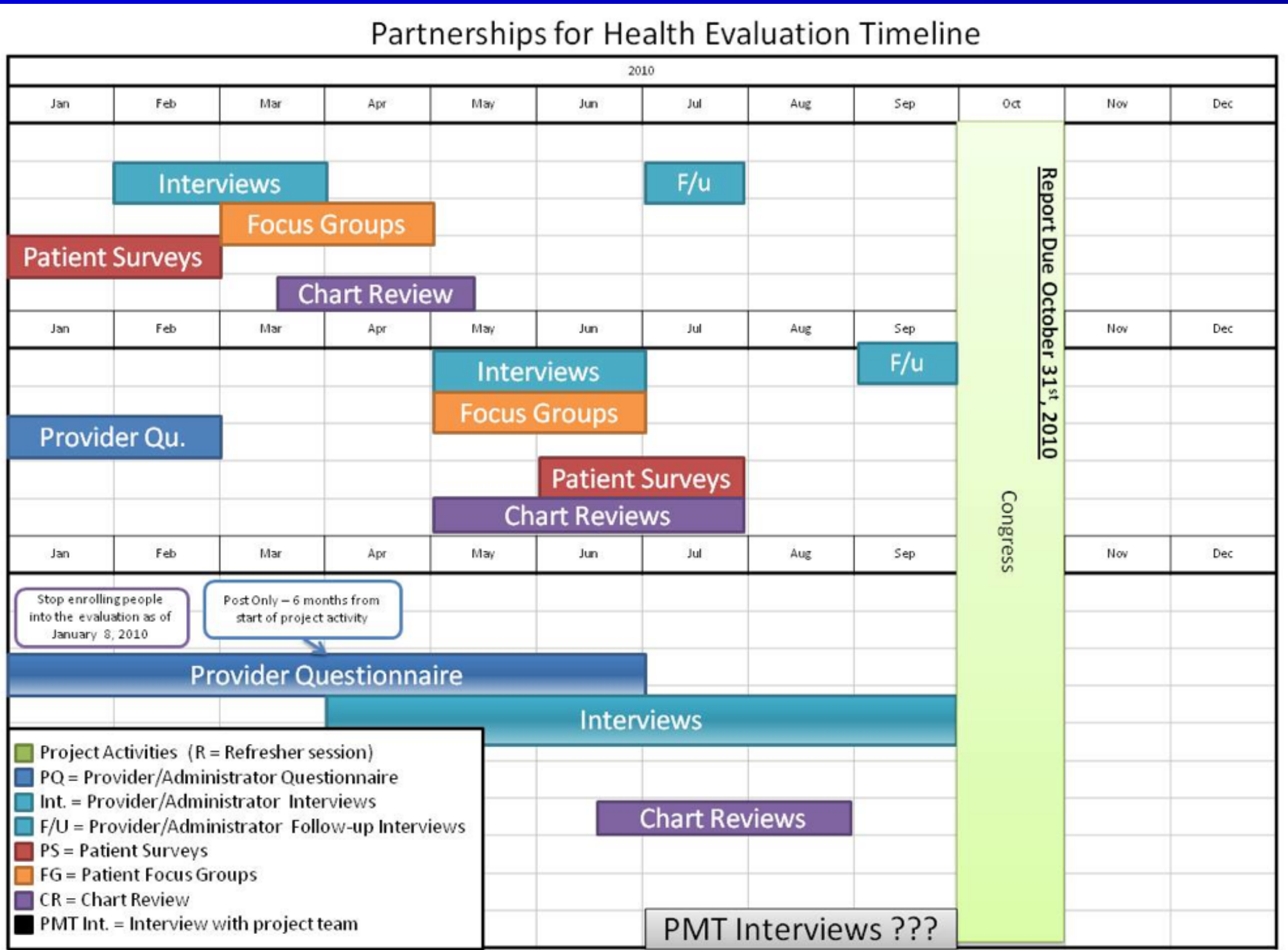

# uation: Partnerships for Health
# ls of the Evaluation

Does the project change how chronic care is elivered?

- Process
- Outcomes

We measure variables before the project begins and hem measure again after the projects completion

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## mes in Patient Survey

- Demographics
- Self-management
- Quality of life (e.g., depression)
- Knowledge of Diabetes
- Treatment satisfaction
- Quality of life

Approximately 338 variables

# uation: Partnerships for Health
# mes in Provider/Admin. Survey

- Demographics
- Knowledge CDPM framework/PDSA improvement
- knowledge of Diabetes
- team functioning
- use of electronic health records
- variables: 300

# uation: Partnerships for Health

ick Snapshot of early findings….

# uation: Partnerships for Health
# ey Response Rates

- dministrators: completed surveys n=49/96 (51% esponse rate)
- roviders: completed surveys n=142/167 (85% esponse rate)
- atients: completed surveys n=917/1339 (68% esponse rate)

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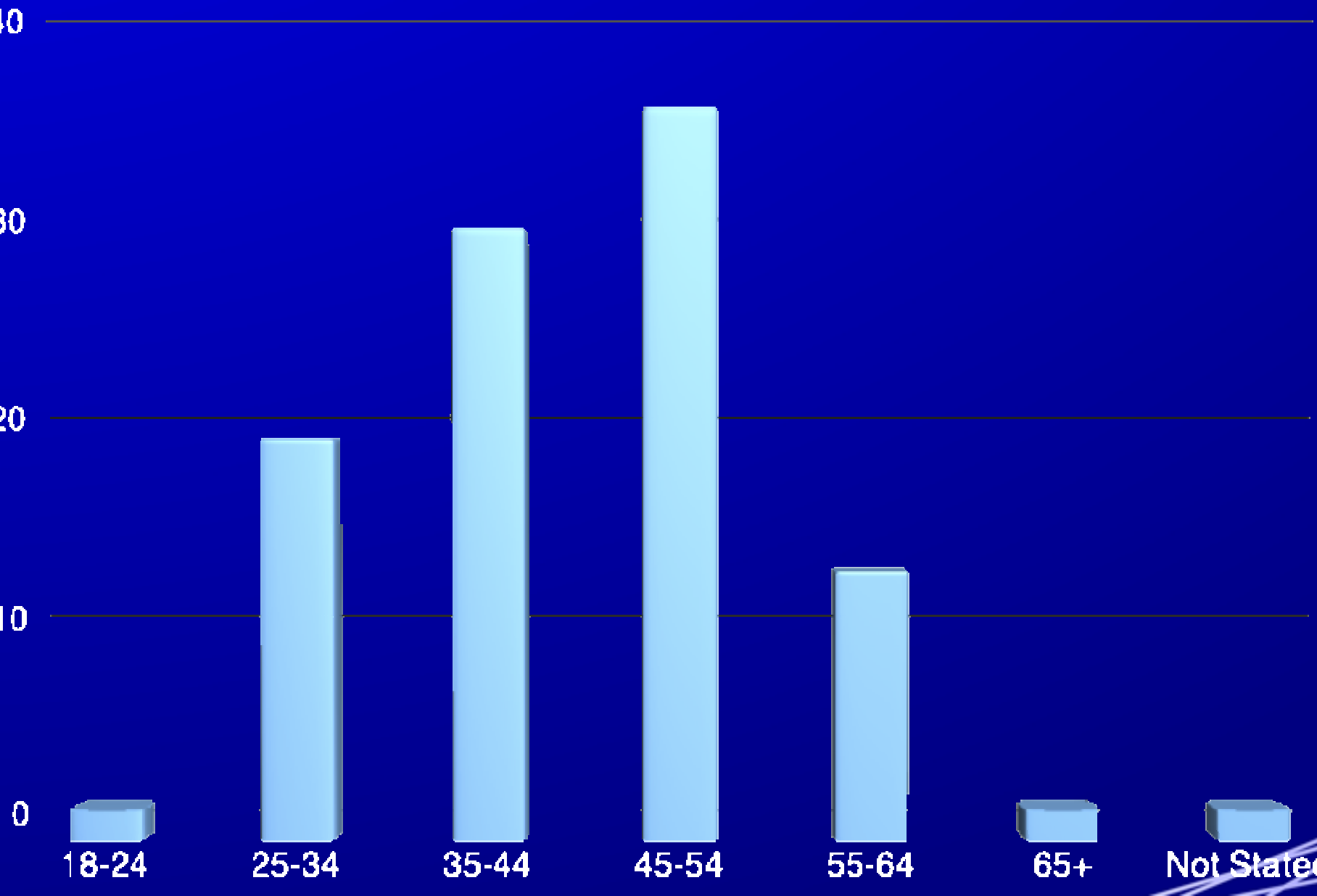
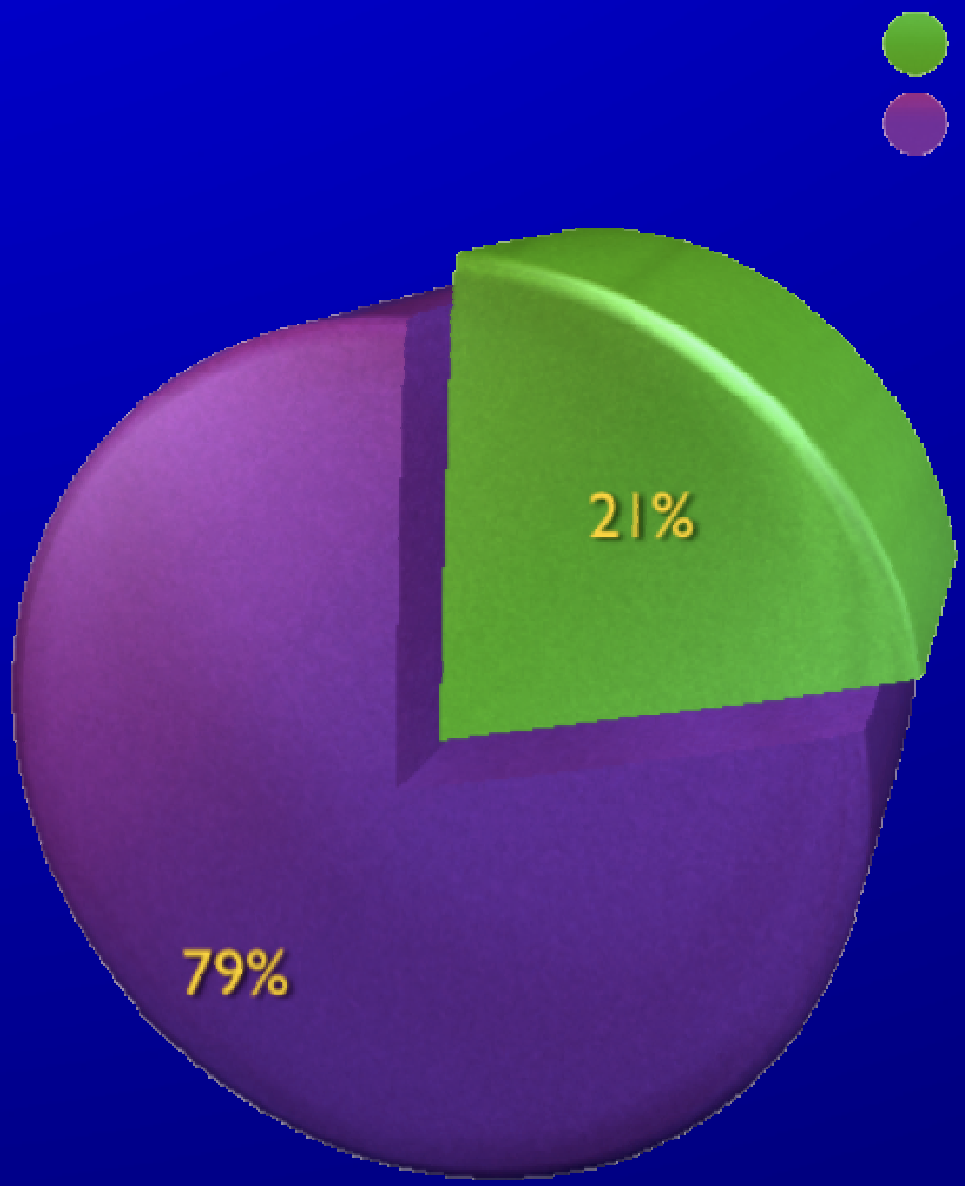
## of Providers



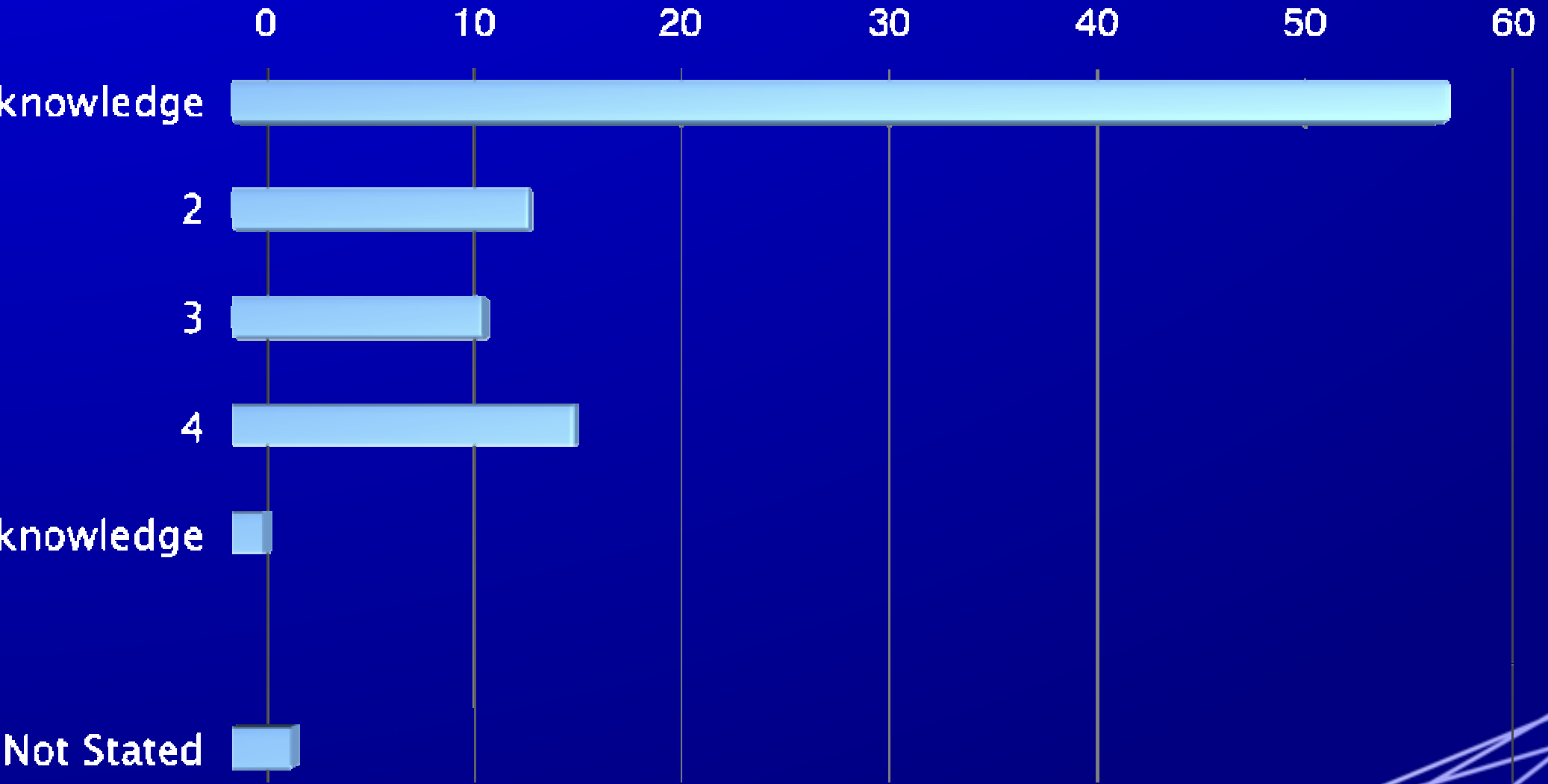
# uation: Partnerships for Health
# ors vs. Allied Healthcare



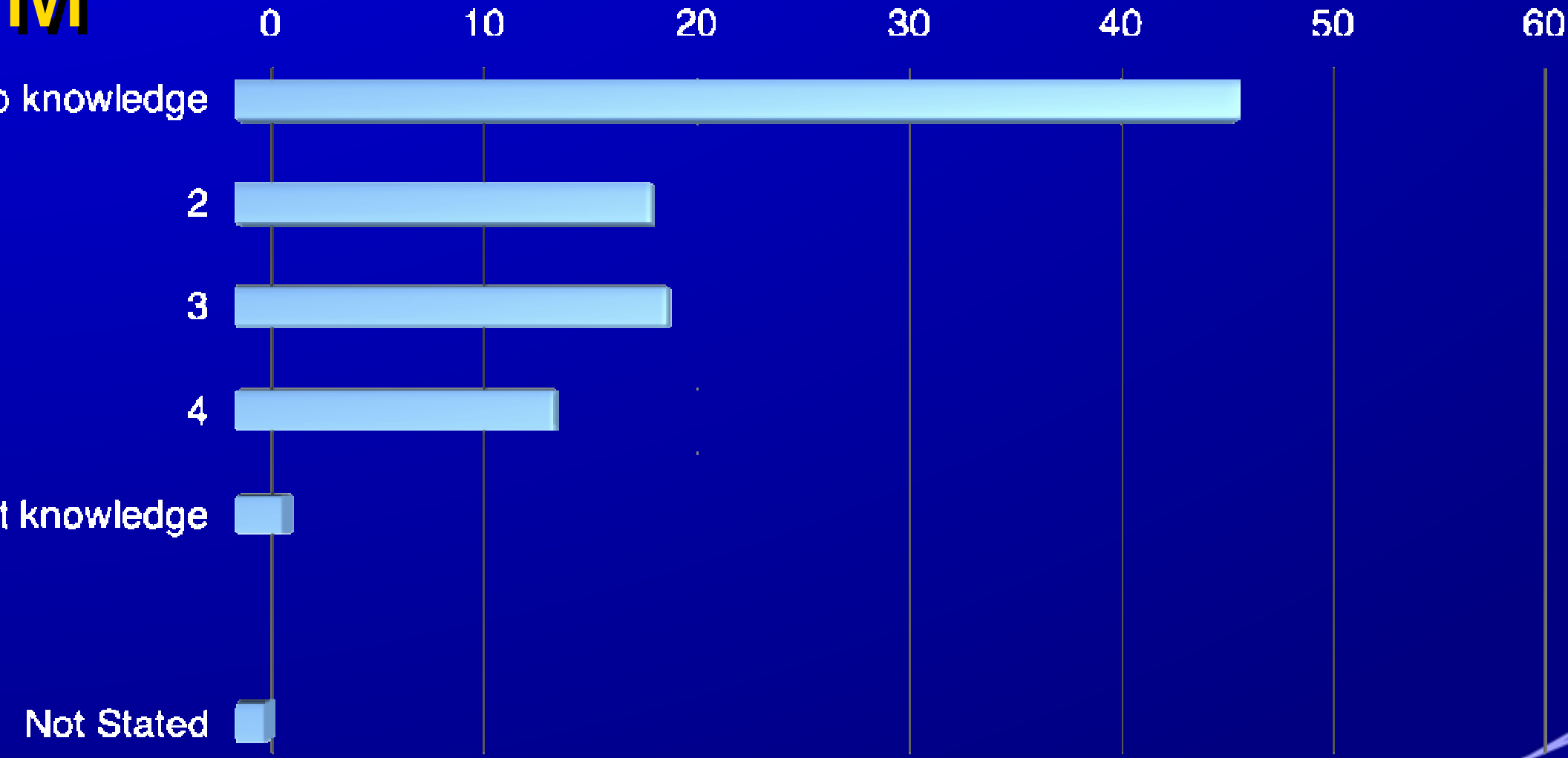

n=141

# dation: Partnerships for Health
# iders' Sex

# dation: Partnerships for Health
# -Data: Providers' Knowledge of
# As



# uation: Partnerships for Health
# -Data: Providers' Knowledge of
# PM



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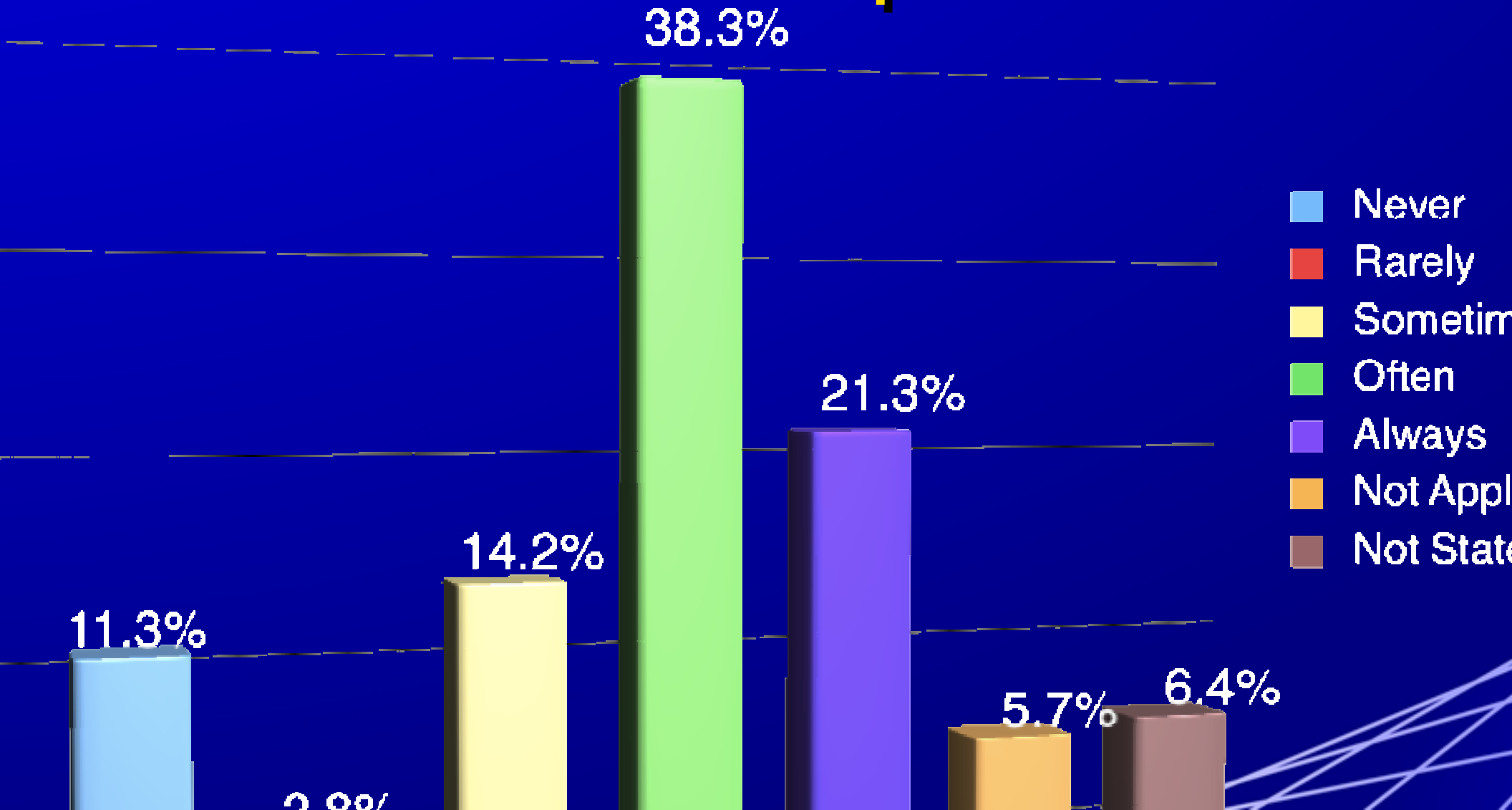
# -Data: Uses Evidence Based

# elines for Clinical Improvement



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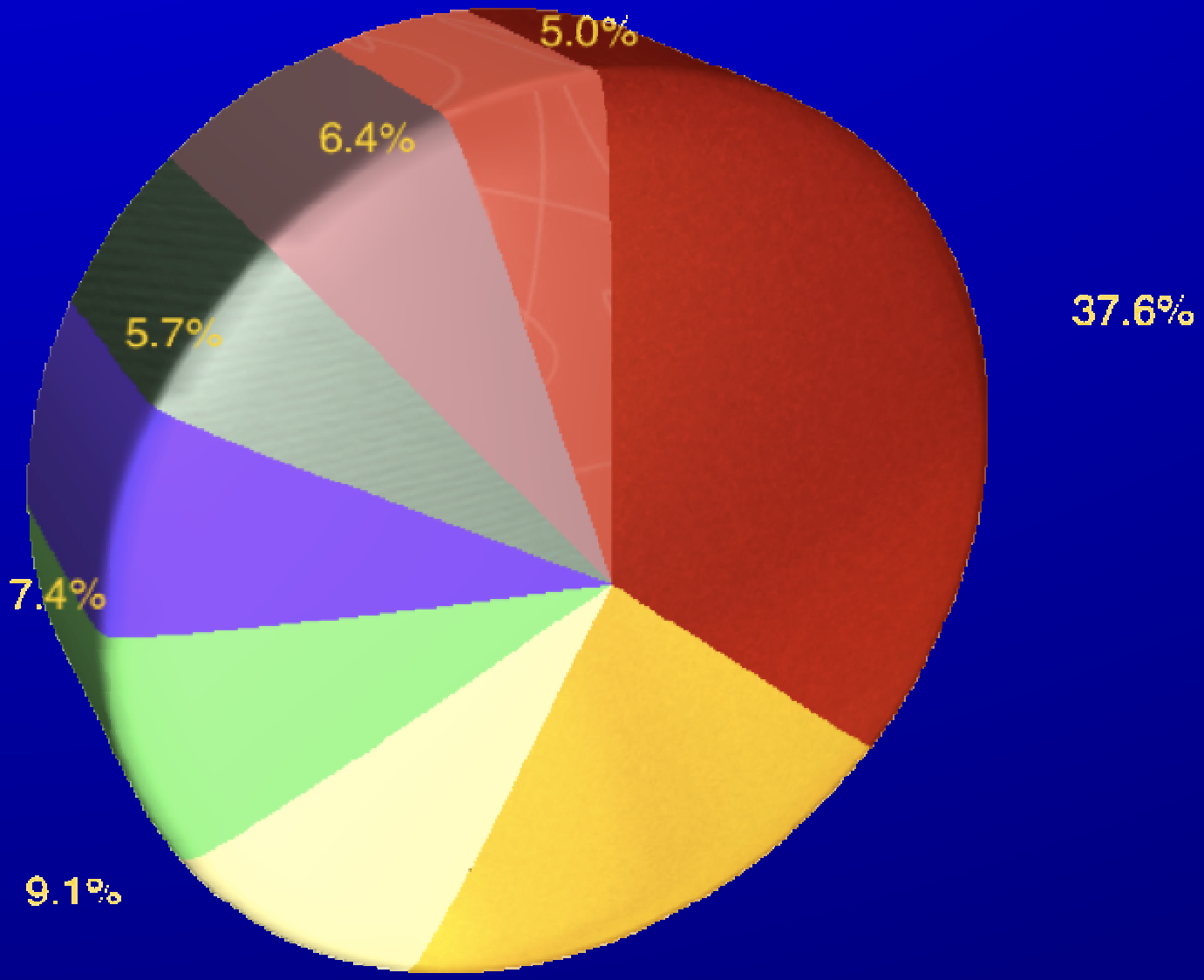
## es of Allied Healthcare Workers



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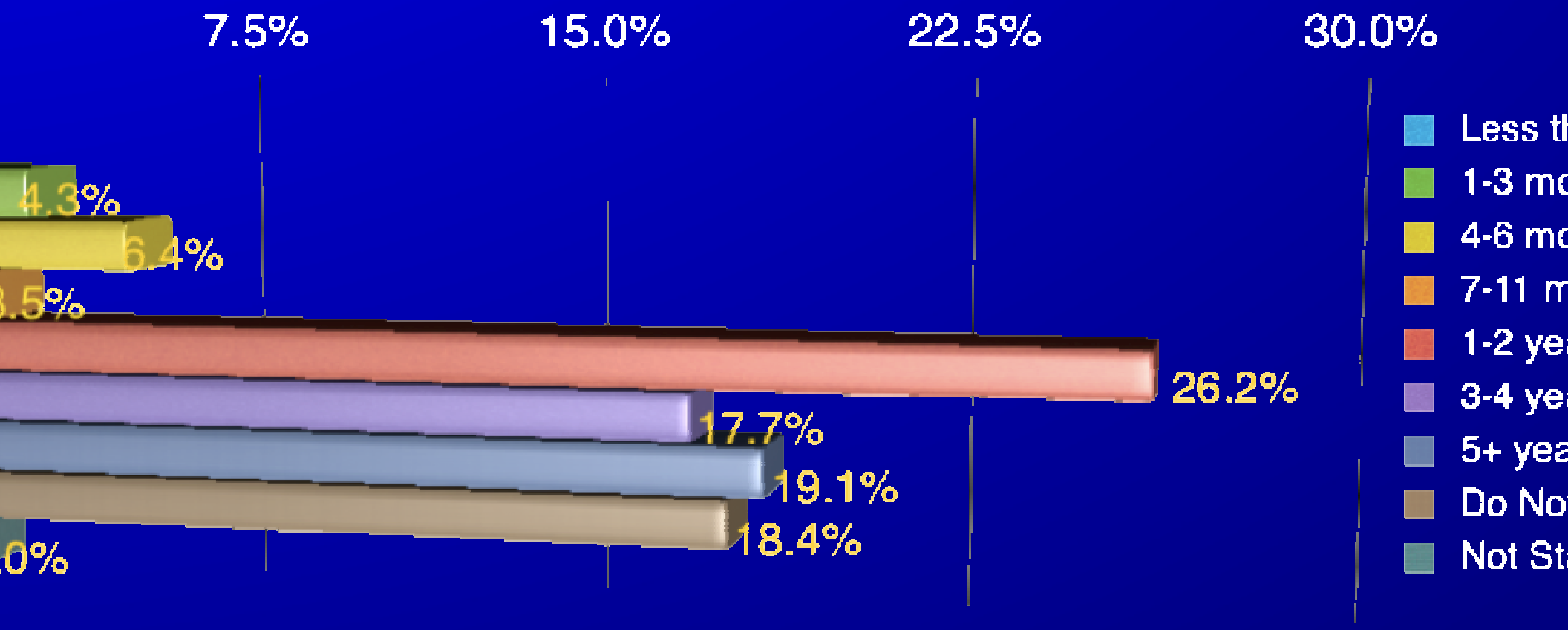
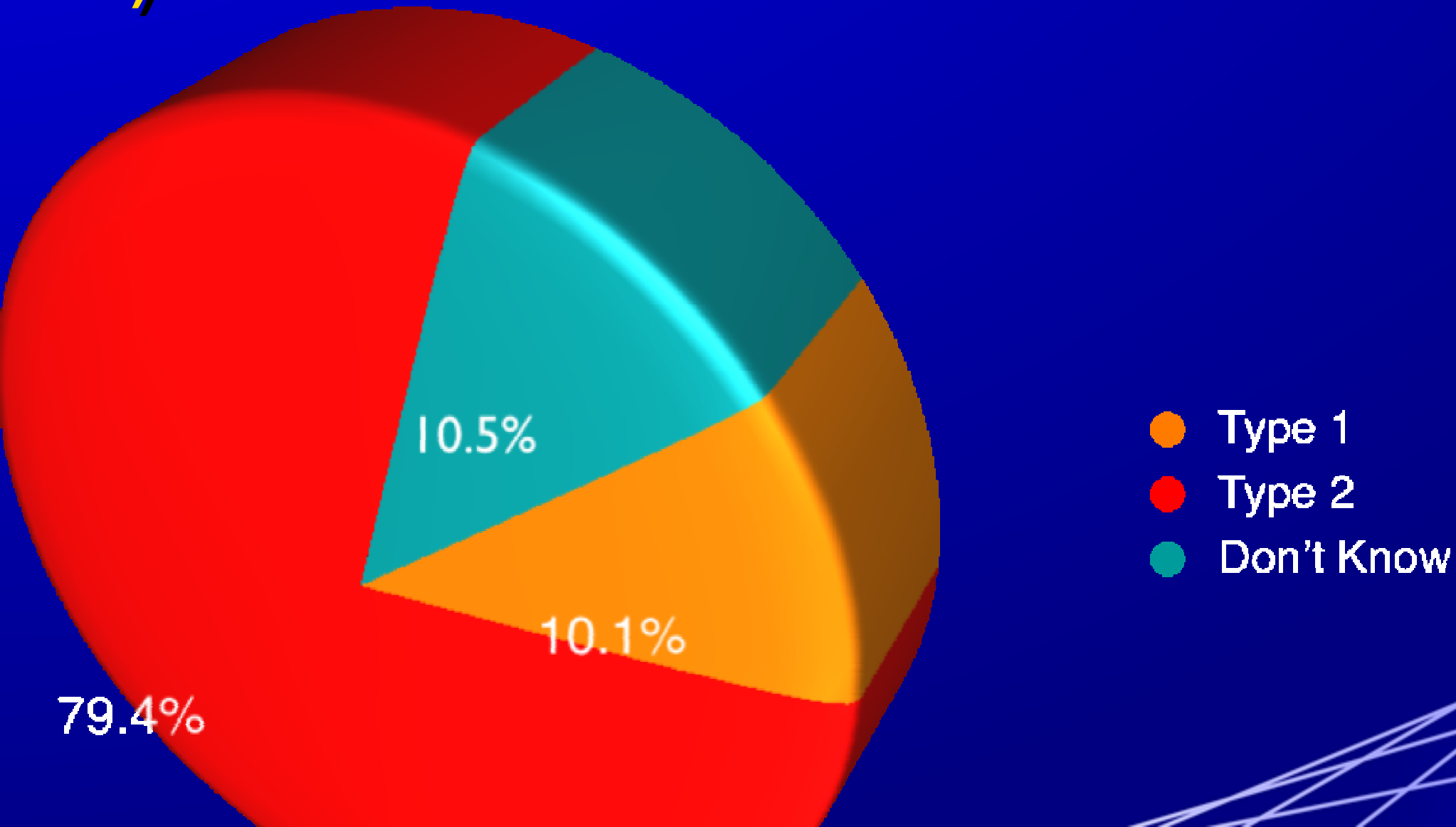
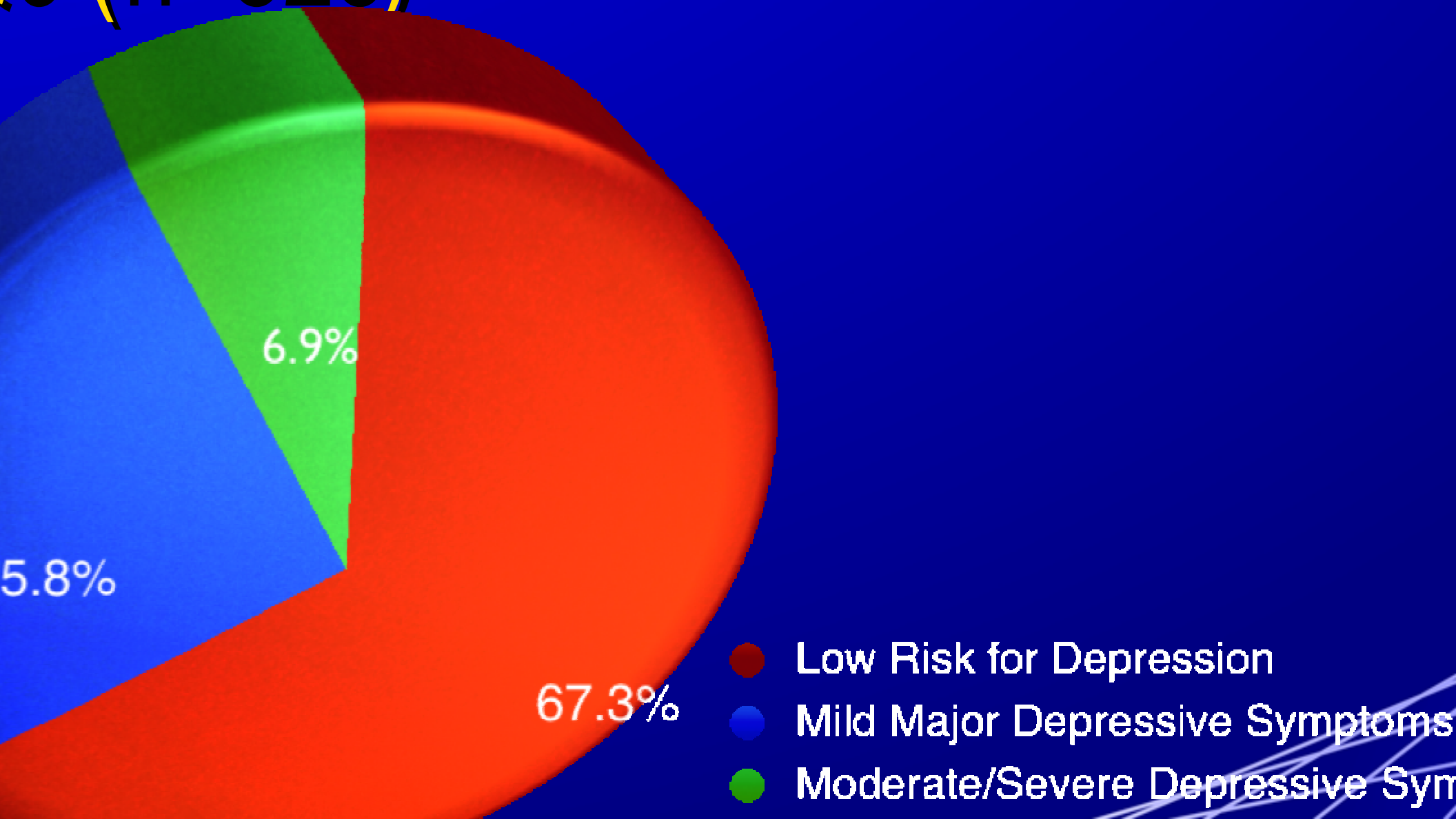
## gth of time using EHR



# uation: Partnerships for Health
# ents' assessment of Diabetes
# 392)



# uation: Partnerships for Health
# ents' Assessment of Depression,
# 9 (n=825)



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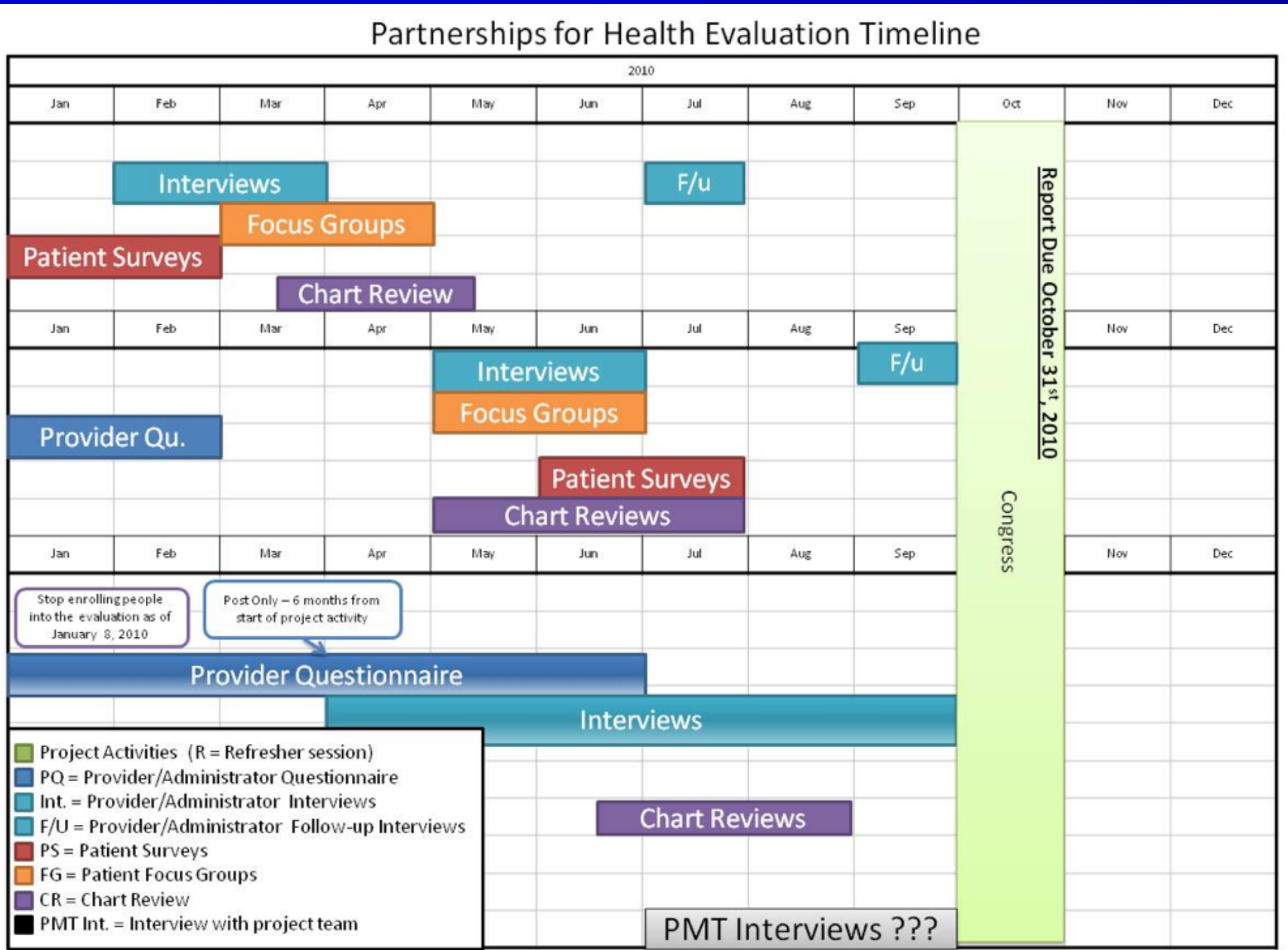

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ANK YOU