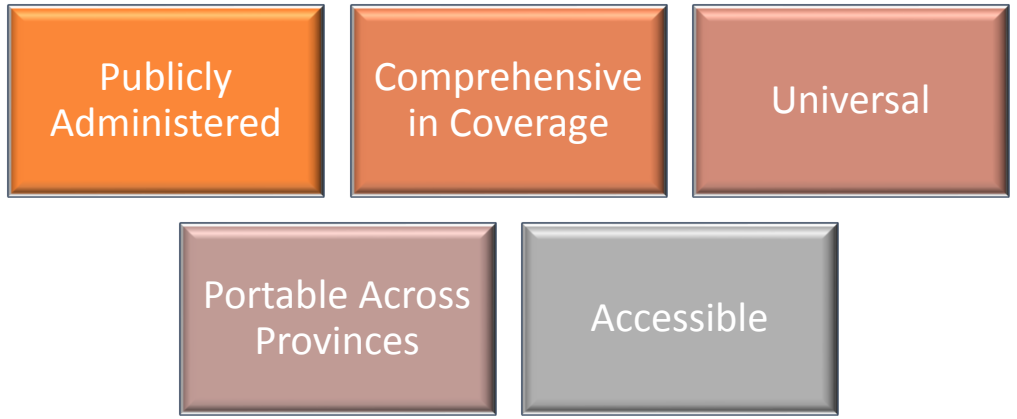
Integrated management of chronic diseases in North America

Perspectives on current status and examples of innovation

July 25, 2016

How care for chronic diseases is organized

- In Canada…
  - Canada's health care system is publicly funded and administered on a provincial or territorial basis.
  - Individuals are provided preventative care and medical treatments from primary care physicians as well as access to hospitals, mental and public health services at no cost.
  - Publicly funded services must adhere to the Canada Health Act



How care for chronic diseases is organized

Primary care physicians are the forefront of Canadian health care and are paid fee -for-service, including specialists.

There are no direct payments from patients to physicians or cost sharing; ***physicians bill provincial governments directly.***

Across provinces there has been a movement towards group practice and alternative forms of payment, such as capitation.

In some provinces networks of GPs work together, share resources and employ interdisciplinary health professionals.

Provincial and territorial ministries of health negotiate physician fee schedules

How care for chronic diseases is organized

- In the US …

Healthcare System

- Health care is provided mostly by private providers and paid by health insurance.
- Health insurance is either purchased or obtained from a social benefit scheme.

Medicare and Medicaid

- Medicare is the federal health insurance program for people 65+ and those with disabilities.
- Medicaid is the country's main public health insurance program for people with low income.

Affordable Care Act

- Prevention, wellness services and chronic disease management are one of the 10 essential health benefit categories that the ACA requires all health plans to offer.
- Each State determines the range and extent of specific services covered under each category.

How care for chronic diseases is organized

- In the US (cont.)…
  - ACA established a Prevention and Public Health Fund to provide grants to states for prevention activities, and increased Medicare and Medicaid payments for preventive services.
  - ACA also contains provisions related to improving quality and system performance
  - Both the government and private insurance moving away from the current specialist-focused health system to a system founded on primary care.

Most important challenges in organizing care and managing chronic disease

Canadian and US perspectives…

Sustainability Challenges	• Moving from grants to imbedding program in organization's infrastructure
Workforce Challenges	• Training and retaining staff, recruiting volunteers to expand activities
Institutional Challenges	• Linking community programs and clinical services, understanding the different cultures

Most important challenges in organizing care and managing chronic disease

Canadian and US perspectives…

Change Management Challenges

Individuals vary in their commitment to change, their ability to make changes and understanding of what needs to change

Time Challenges

Change takes time, there is a learning curve, and often more time is needed than the duration of a grant or project.

Most important challenges in organizing care and managing chronic disease

- Patient Engagement Challenges
  - Not all patients want to engage in self-care or realize their role in their own health
- Upstream versus Downstream Challenges
  - Investing in social determinants of health as well as health services

Major strategies to ensure quality of care for chronic diseases

- In Canada, some examples…

Example: The Canadian Institute for Health Information provides reports on Canada's health system and the health of Canadians.

Example: Accreditation Canada - a not-for-profit organization - provides voluntary accreditation services to health care organizations

Example: The Public Health Agency of Canada conducts a range of chronic disease prevention activities including surveillance, risk factor monitoring and knowledge translation.

Major strategies to ensure quality of care for chronic diseases

In Canada (cont.)…

- Use of financial incentives to improve quality is limited, in some provinces payment incentives to physicians linked to performance and delivering guideline – based care for chronic conditions.
- Most provinces have agencies responsible for producing health care system reports

Major strategies to ensure quality of care for chronic diseases

- In the US, some examples…
  - The Affordable Care Act offers opportunities to speed progress to improving quality of care by creating ways to:

Expand population coverage

Require coverage of effective clinical preventive services

Improve the organization of and payment for care

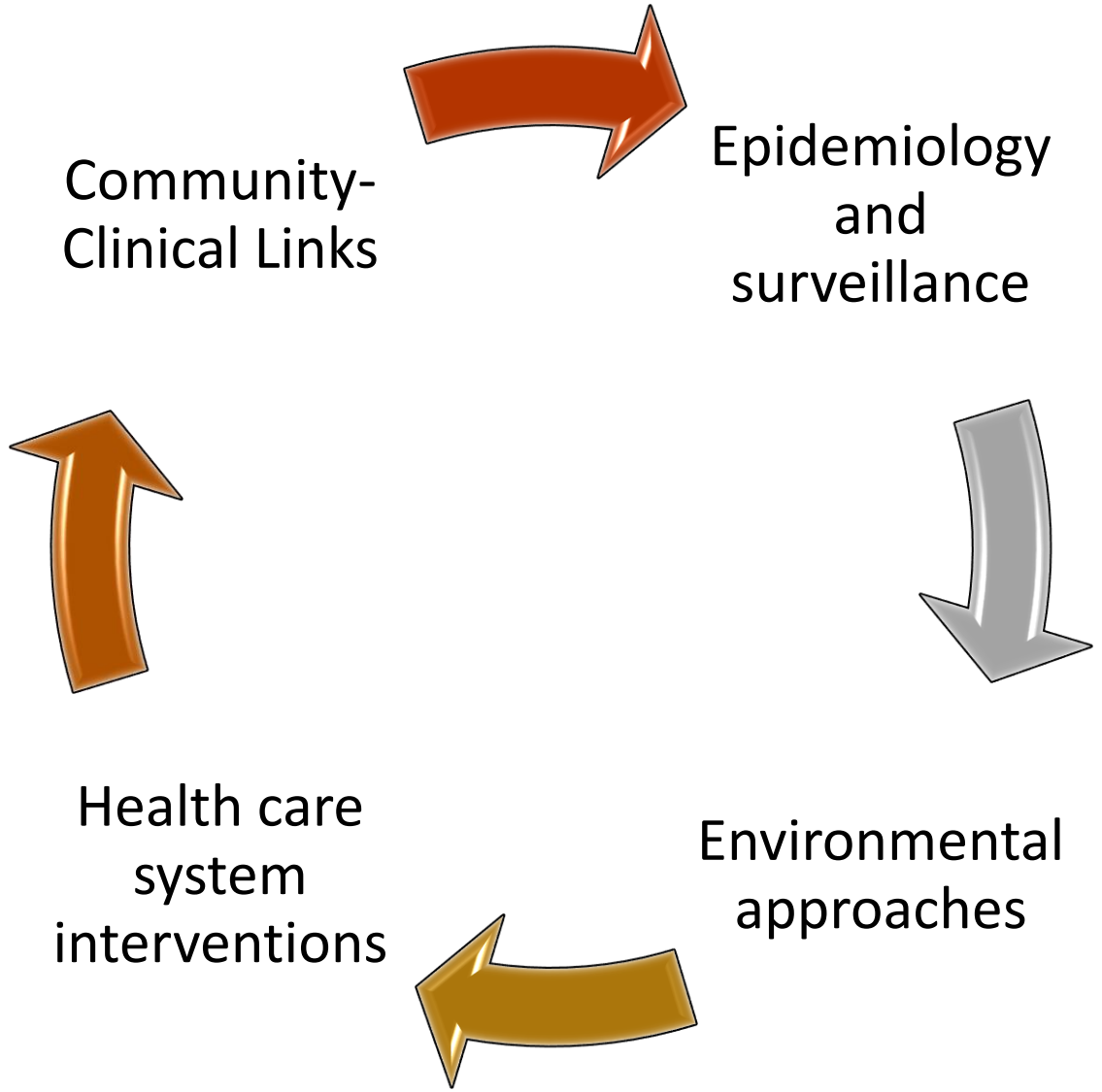
Involve a larger number and broader range of health professionals in delivering care

Increase use of health information technology and tools

Increase measurement and reporting of successes and shortfalls

Major strategies to ensure quality of care for chronic diseases

- In the US (cont.)
  - The Centers for Disease Control and Prevention (CDCs) Chronic Disease Prevention System coordinates chronic disease prevention efforts in four key domains:



Examples of Innovation in Chronic Disease Care

- US – South Florida
- Project – **Healthy Aging Regional Collaborative**

Objective	To improve the capacity of community-based organizations to deliver programs for persons with multiple chronic conditions with the goal of reducing health care costs
Program Components	Programs to develop self-management skills, improve physical activity, prevent falls and decrease depression symptoms
Scope	18 agencies received annual grants over a 5 year period to deliver programs. Agencies had to present implementation plans that showed they were meeting outcome targets to have grants renewed each year.
Results	Over 5 years, 35,000 individuals had particpated in at least program. Programs were offered in over 350 sites across South Florida. Evalaution showed that participants increased healthy behaviours and skills. Funding was obtained to transition program to operations.

Examples of Innovation in Chronic Disease Care (US – Northern California)

Project Name	Objective	Program Components
The Kaiser Permanente Northern California Story	Improve hypertension control among Kaiser Permanente Northern California patients	A patient registry; evidence-based practice guideline; simplified drug treatment alogorithm; quality reports containing BP control data for centers and individual physicians; Medical Assistant BP visits; a single-pill combination medication (lisinopril-hydrochlorothiazide)

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Examples of Innovation in Chronic Disease Care (US – Northern California cont.)

Results

- From 2000 to 2013 hypertension control increased from 44% to 90%, rate of heart attacks fell 24% and death from stroke fell 42%. Registry grew from 350,000 (15% of Plan membership) to more than 650,000 (27% of Plan membership). Single pill combination therapy increased efficency and adherence.

Examples of Innovation in Chronic Disease Care (US – South Texas)

Project Name

- Improving chronic disease in a small primary care clinic in South Texas

Objective

- Improve the care of adult patients with type 2 diabetes by focusing on reducing the risk of cardiovascular disease

Program Components

- Baseline data on control of risk factors; improvement teams; toolbox with group visits, registry, point of care testing, clinical reminders

Examples of Innovation in Chronic Disease Care (US – South Texas cont.)

Results

- Six years after the changes were initially implemented, patients scores on the Patient Assessment of Chronic Illness Care Survey increased from 3.0 to 3.3. Patients with A1C under control (under 7) improved from 41% to 50%. Patients reporting that they forget to take their medications decreased from 63% to 57%.

Examples of Innovation in Chronic Disease Care (Canada –Atlantic provinces)

Atlantic Provinces- Newfoundland and Labrador, Prince Edward Island, New Brunswick and Nova Scotia and the Canadian Foundation for Healthcare Improvement

- **Project Name**
  - A Patient-Centred Approach to Managing Chronic Disease in Atlantic Canada
- **Objective**
  - Develop a patient/family centred approach to chronic care; promote sustainability; build a network to share evidence-informed, systems-level solutions.
- **Program Components**
  - 11 teams focused on mental illness, diabetes, chronic obstructive pulmonary disease (COPD) and multimorbidity. Teams carried out a range of projects suited to their region over a two year period.

Examples of Innovation in Chronic Disease Care (Canada –Atlantic provinces)

Results:

Overall - Raised awarenss of need to improve care, increased the motivation to change, increased understanding of how to change.

Each project had its own goals and evaluation e.g. In Prince Edward Island self-management training was provided to over 100 healthcare providers. Evaluation showed higher provider satisfaction and increased confidence in ability to provide self management support to patients.

Examples of Innovation in Chronic Disease Care (Canada – Alberta)

Project Name	Objective	Program Components	Scope
• Addressing Obesity and Inactivity in A Primary Care Network	• Develop strategies to address obesity/overweight and inactivity	• A health education program to support individuals to adopt healthy choices; involving the community in building a culture of active living	• 4,485 people attended the health education program, with 54% completing all classes

Examples of Innovation in Chronic Disease Care (Canada – Alberta cont.)

Results

- BMI- average decrease of .7; waist circumference – average decrease of 3.9cm; weight –average decrease of 1.6kg; increased confidence in making healthier choices; 10 community groups participated in the project; 15 health fairs held with over 1000 community members attending; parternship with local government developed; a culture of active living has developed in community

Examples of Innovation in Chronic Disease Care (Canada – Quebec)

Project Name

- Utilization of local data to improve complex patient care

Objective

- To identify high cost users and develop a model of care to improve their conditions.

Program components

- IT solution to identify high cost users; collaboration of Family Health Teams with hospital to develop care model for high users; case manager; IT solution to integrate services

Examples of Innovation in Chronic Disease Care (Canada – Quebec cont.)

Results

Algorithm developed to identify high users from hospital database; new role for case manager identified; implementation of a leadership committee to facilitate the change process. Result - a 36% decrease in admission rates and 35% decrease in ED visits for the high user population.