Integration
Bringing the Pieces Together

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calgary health region

Background

- **Canada has one of the lowest ratios of doctors to population in the western world (Canadian Press)**
- **The increasing prevalence of chronic conditions**
- **Aging Population**
- **People with chronic illness are living longer**

Background

- **Health care system-acute, episodic care**
  "Find it and fix it"
- **Proactive management and coordination**

Evolution of Calgary Model

- **Home Care/Physician Partnership**
- **Multidisciplinary Team Approach to Chronic Illness**
- **Prevention of End Stage Renal Disease**
- **SOAR**
- **Chronic Disease Management**
- **National Partnership Project**

Outcomes

- **Increase Capacity**
- **Sustainable Model**

Principles

- **Integrated Delivery System**
- **Informal caregivers critical**
- **Case Management Model**
- **Primary Care Relationships**

Home Care/Physician Partnership

Geography based model

to

Population Based Collaborative Care Model

Tools

- **Communication Blue Print**
- **Problem Solving Algorithm or “The Divorce Clause”**

PESRD

Model 1: Builds on existing service

- Care across the continuum

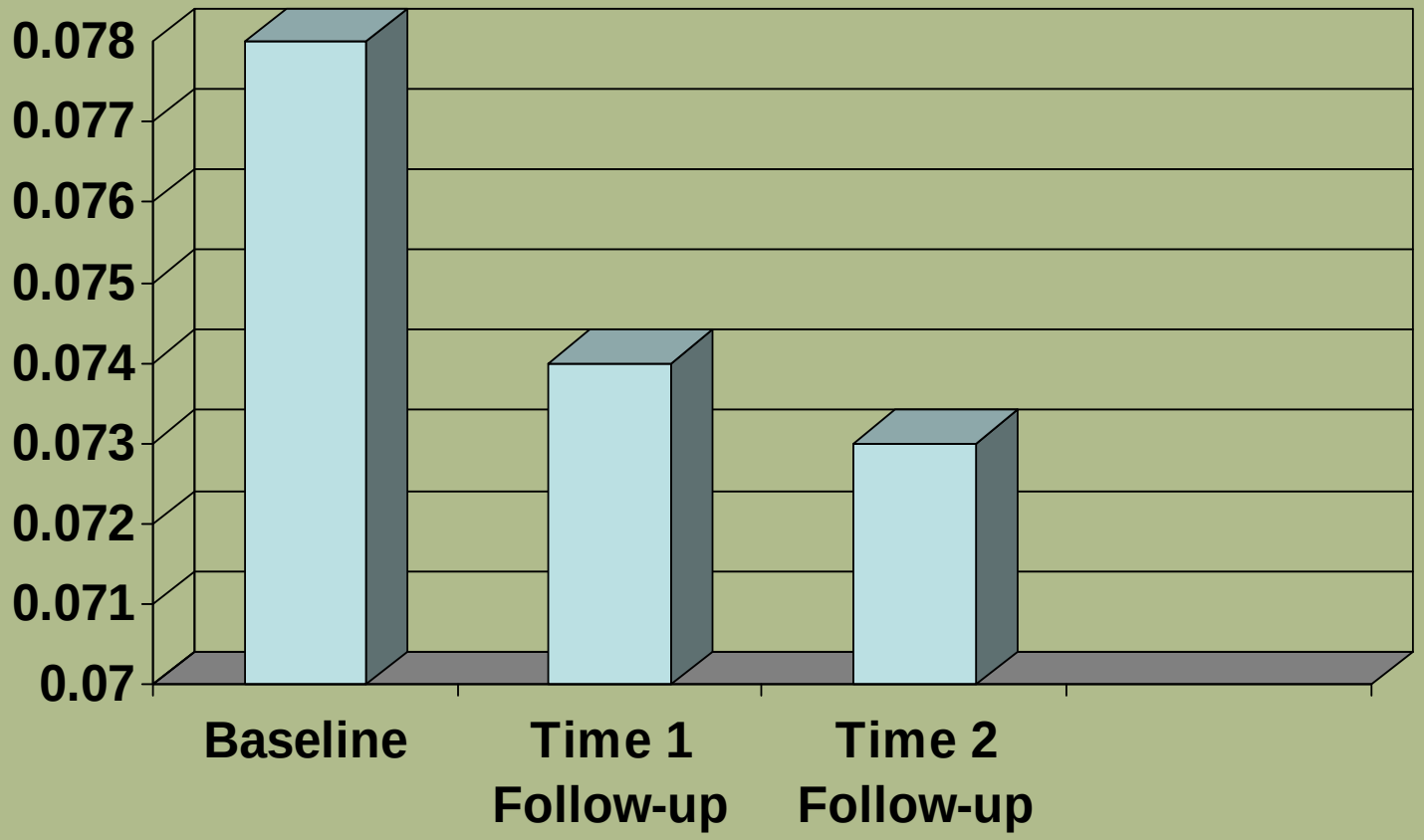
Model 2: Stand alone

- Disease specific

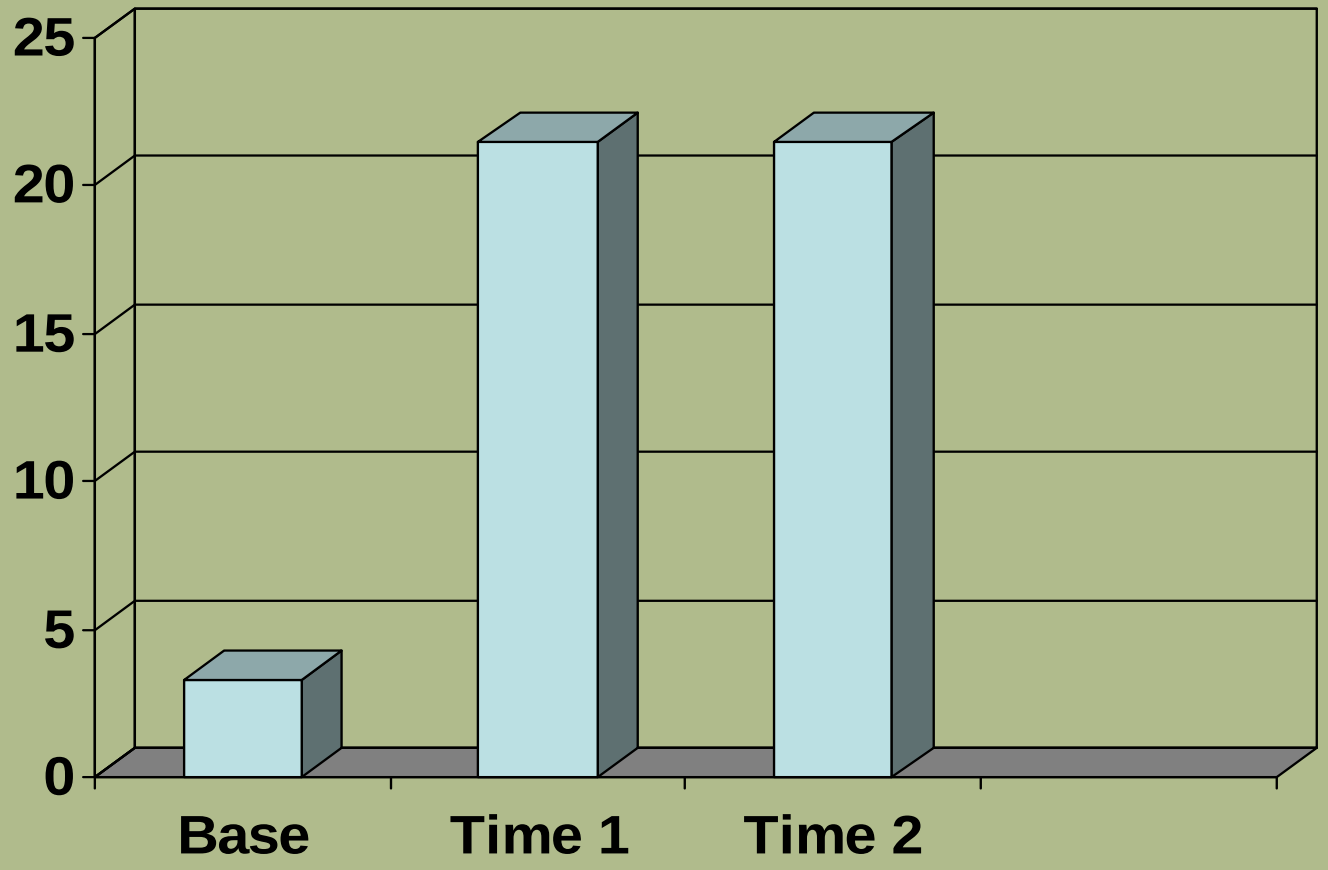
Model 3: Builds on existing service

- Targets high risk

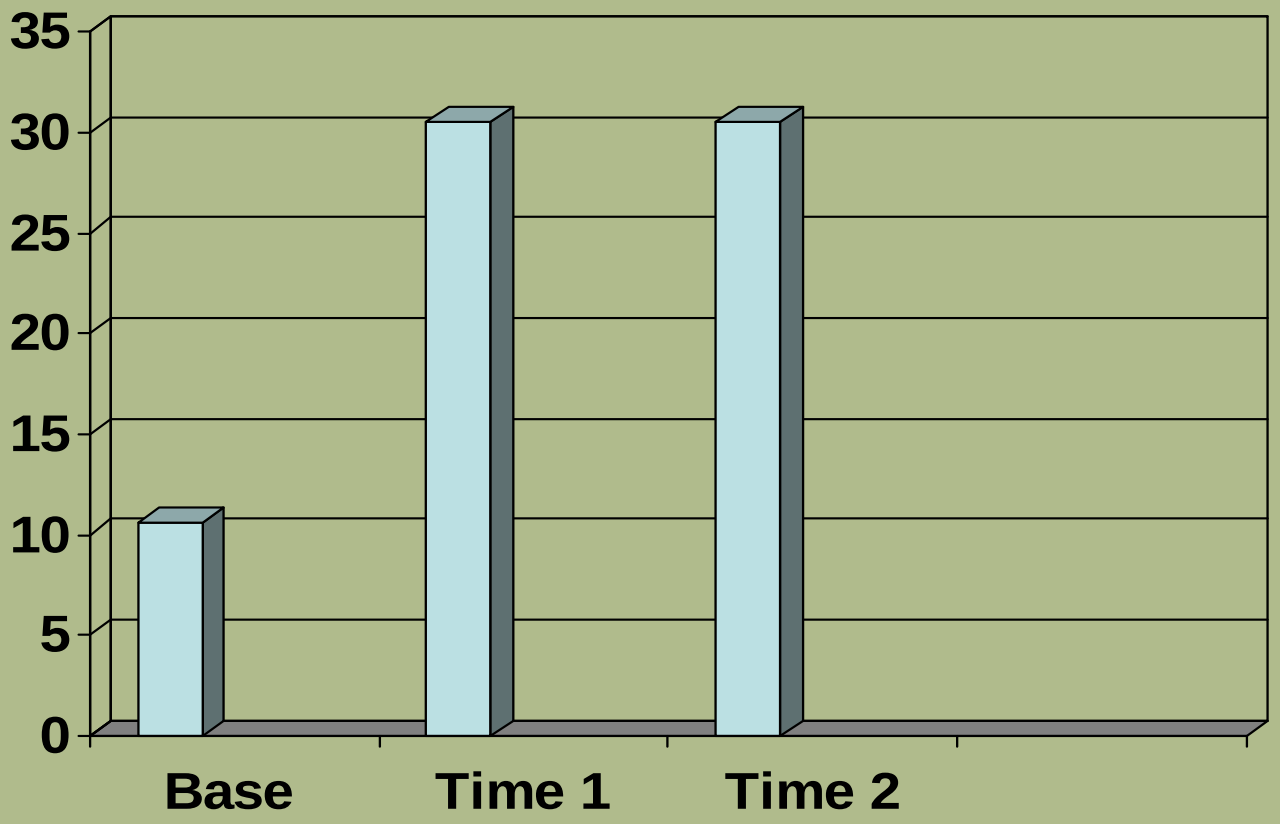
A1C (Mean Levels)



Blood Glucose Testing

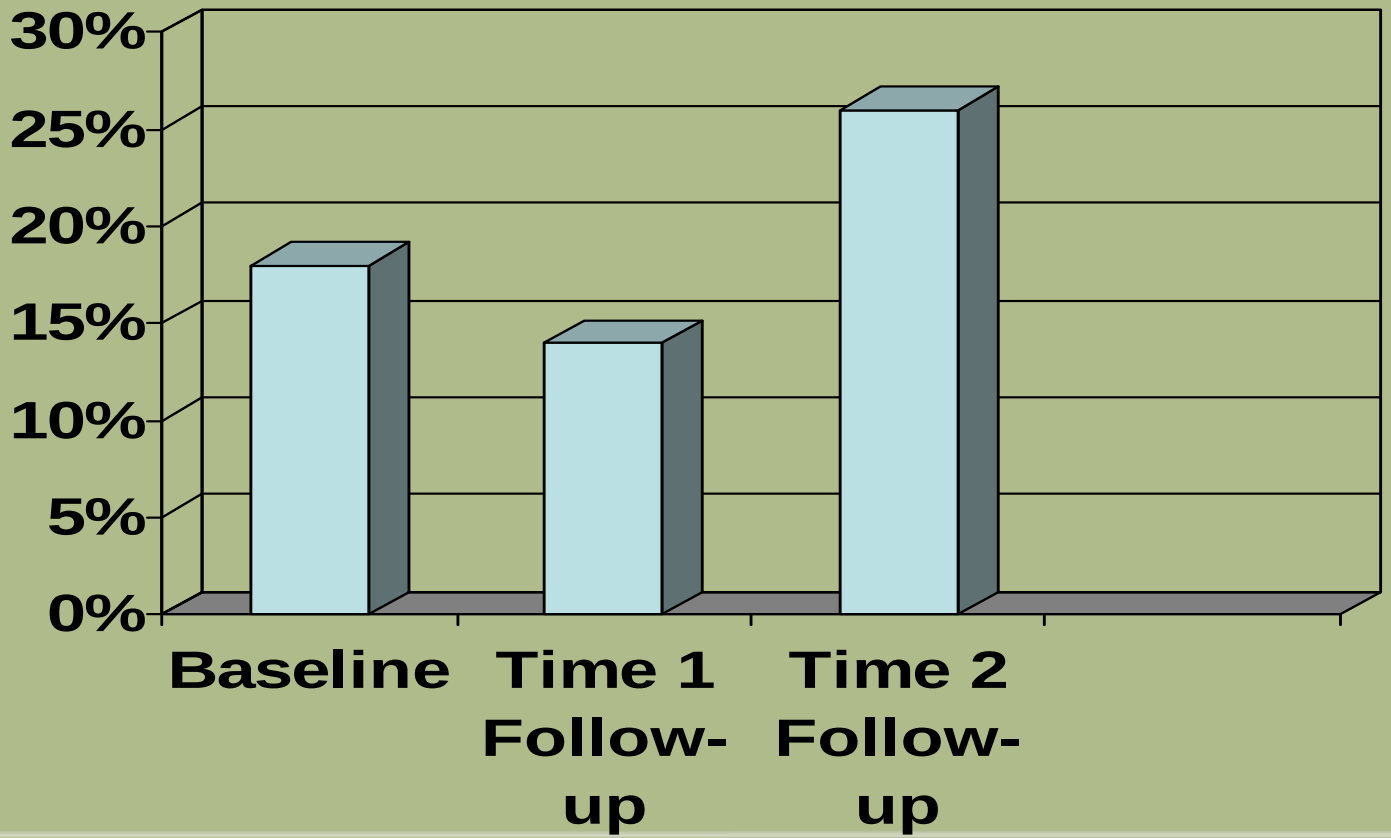


Foot Care

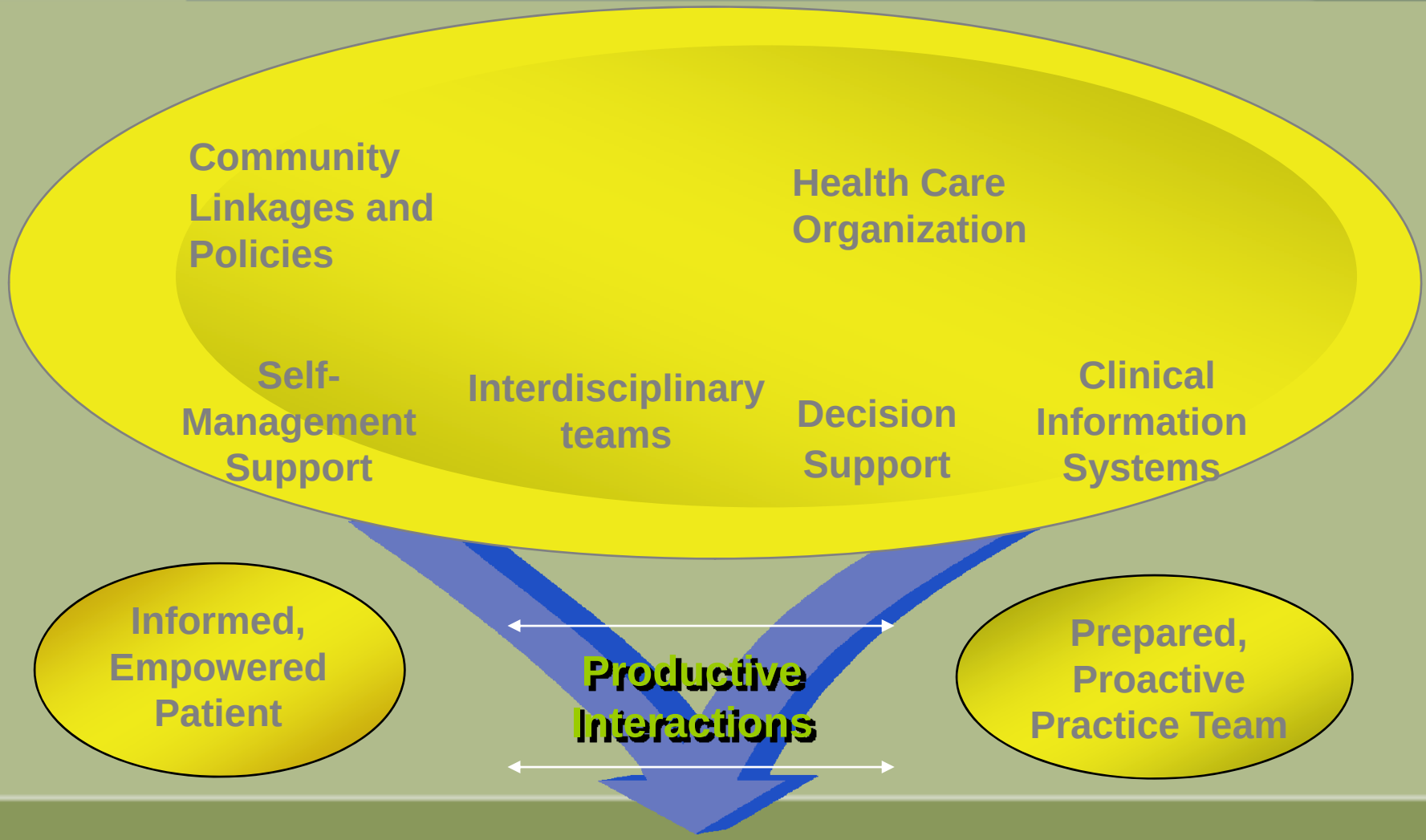


Cheese

percentage eat more than four per week



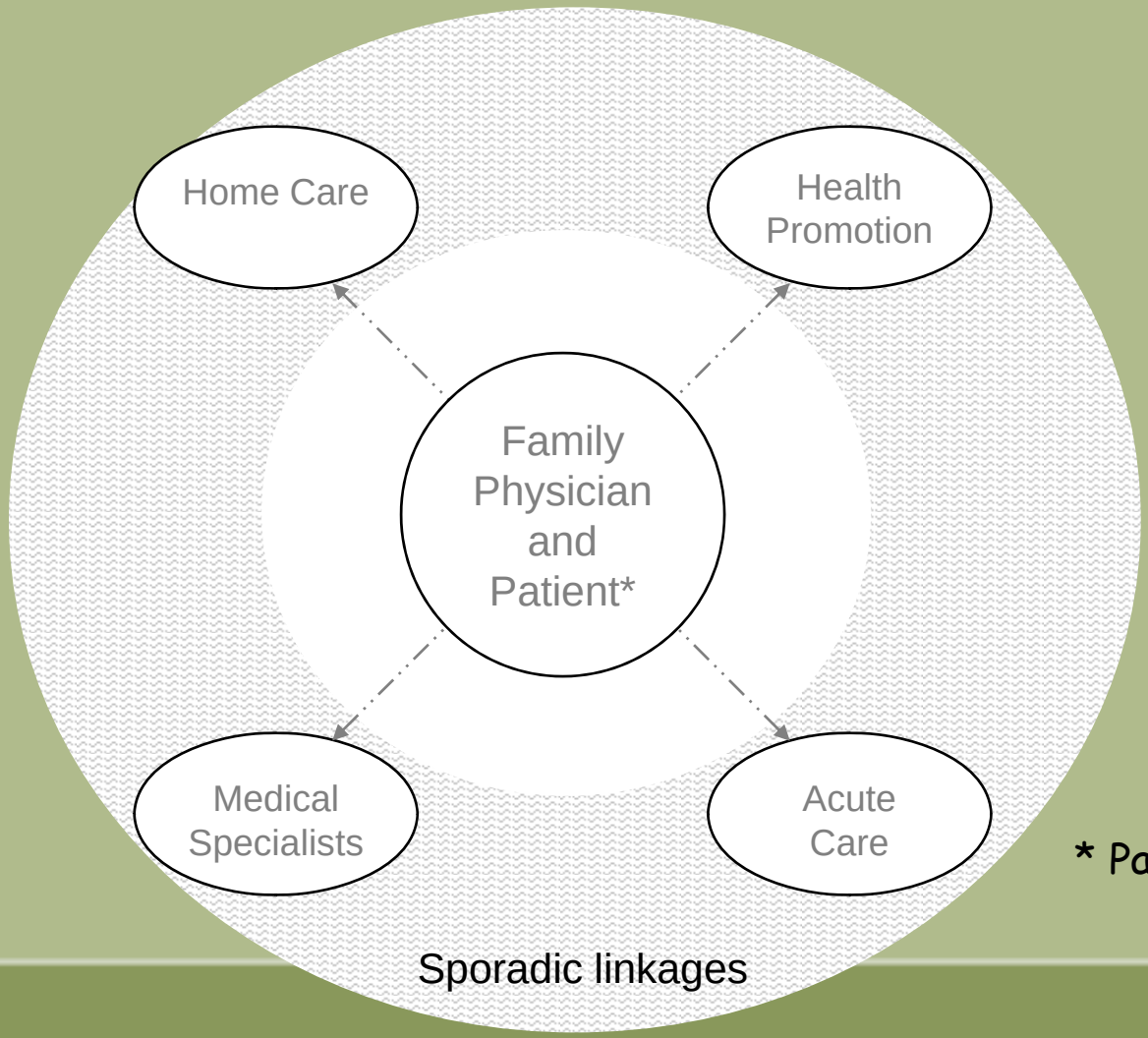
Chronic Care Model



Improved Outcomes

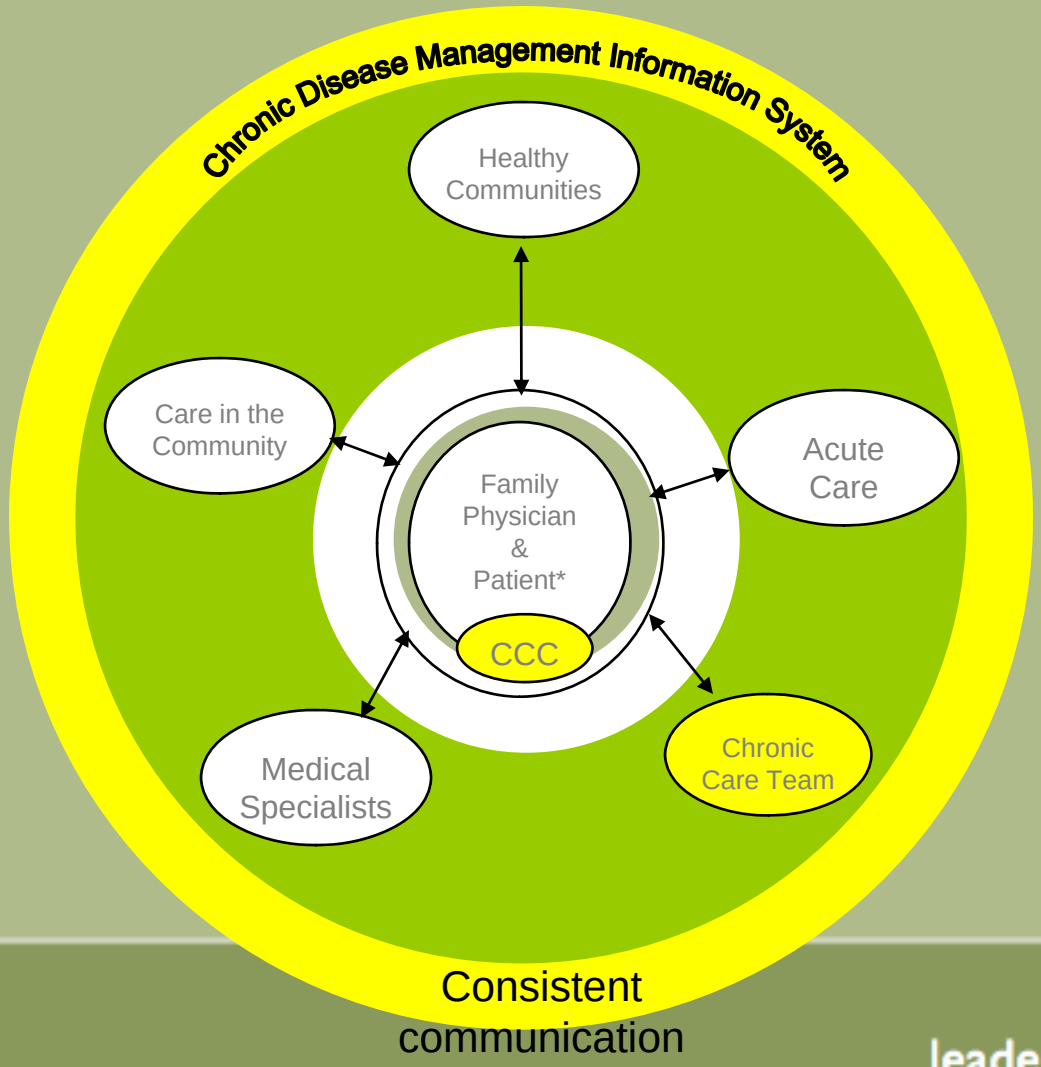
leaders in health – a partner in care

Current Chronic Disease Management in our Region



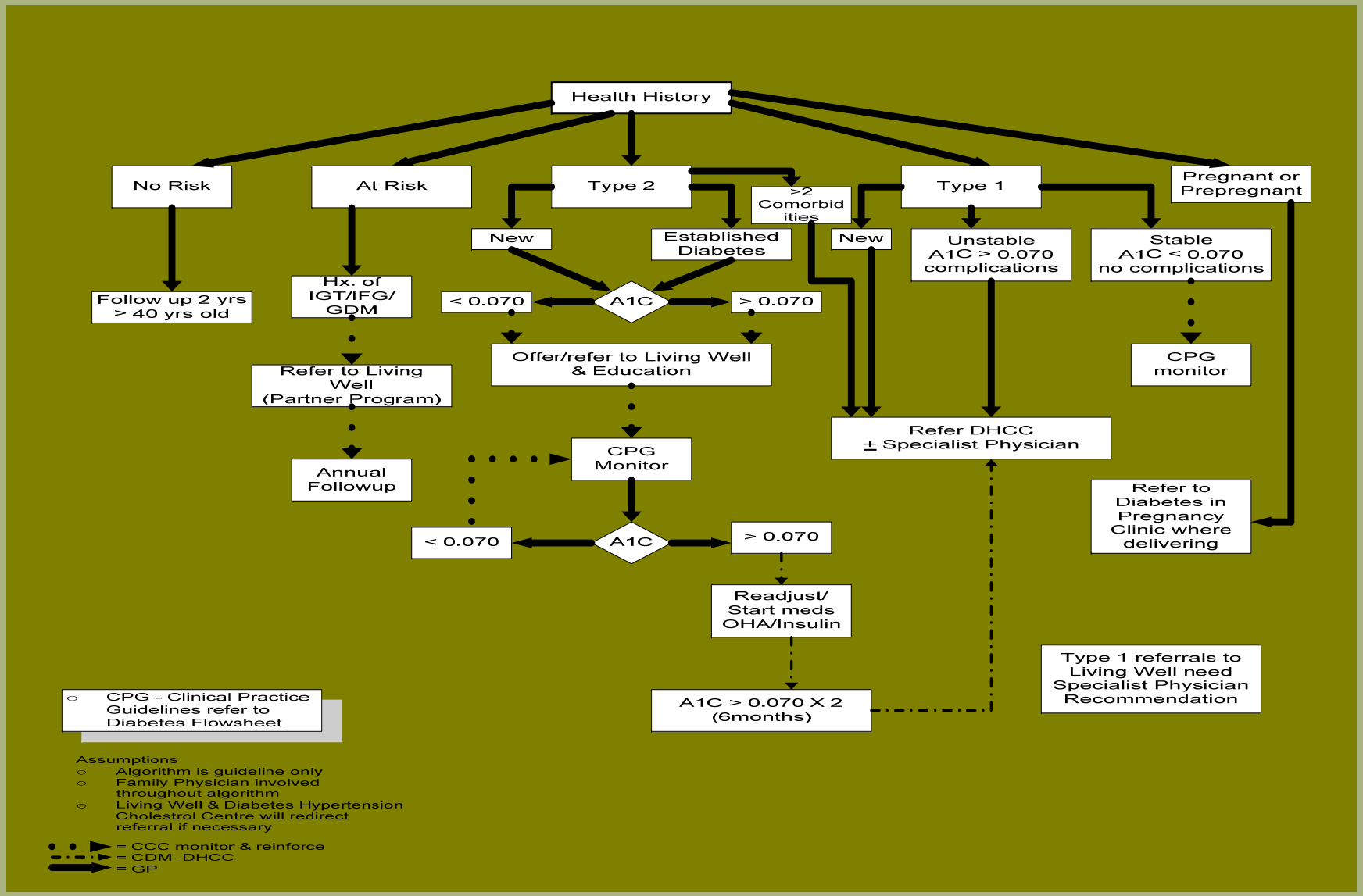
* Patient - includes family

Regional Implementation Strategy



- Patient - includes patient and family

Chronic Disease Management Diabetes Algorithm Role Definition



Key Highlights

Positive patient benefits

- Improved access to resources
- Team reinforcement
- Personalized care
- Increased efficiency

Family Physicians:

- More support through shared care
- Increased level of knowledge

Key Highlights

Team Members

- Increased case management
- Increased knowledge level

Barriers

- Space
- Duplication of documentation
- Reimbursement

Web Based Communication

"Hi Guys, sitting in my exam room, plugged into nothing, accessing the ESRD patient database…… Thanks Guys! I'll start populating data as Cheryl populates with people☺."

(Dr. Chris Bochmuehl, personal communication, 2003)

Key Learnings

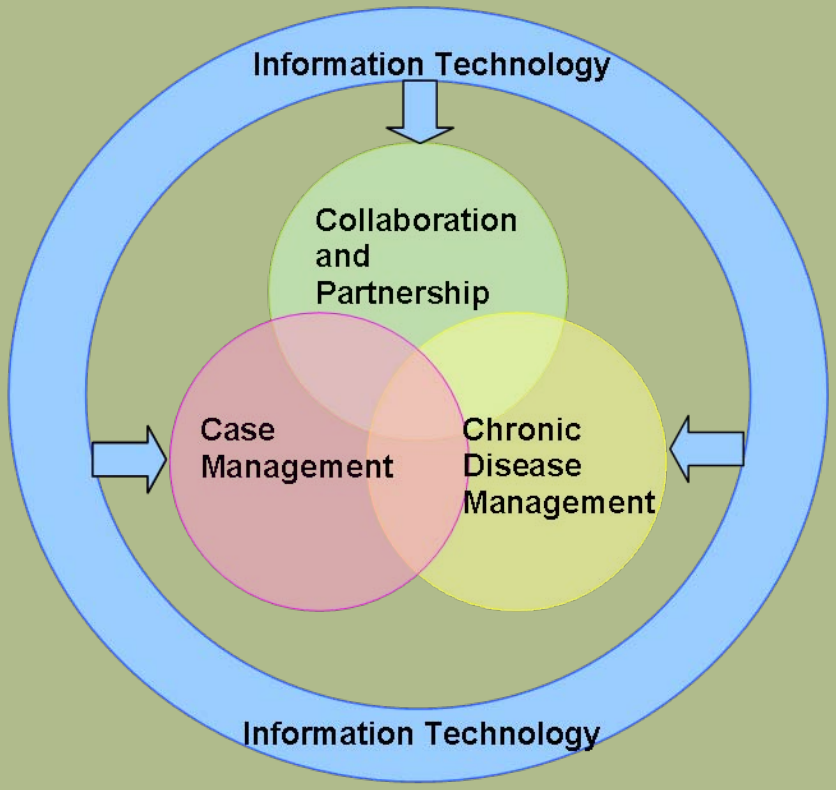
- **Co-location crucial**
- **PCT approach = improved clinical indicators**
- **PCT approach = increased self management**
- **Shared Care = increased QOWL**

Challenges

- **Restructuring**
- **Partnership support in co-located space**
- **Resource allocation**
- **Duplicate charting**

National Partnership Project

Priorities



Chronic Disease Management

Clinical Practice Guidelines =

Improved Outcomes

- Standardize Care
- Support Interdisciplinary Approach
- Proactive planning
- Minimize duplication

Partnership

"….teams have been reported to reduce hospitalization time and costs, improve service provision, enhance patient satisfaction, staff motivation and team innovation".

(2001, Borrill et al (1) published a report entitled "The Effectiveness of Health Care Teams in the National Health Service")

Duplication of interventions and Documentation

How?

☑Process Mapping - RRIT

☑IT

- *CDMIS*
  - Shared Care Pathway
    - o Shared Assessments
    - o Text Box Messaging
  - Different Methods of Case Management
- *Goldcare RAI-HC Tool*

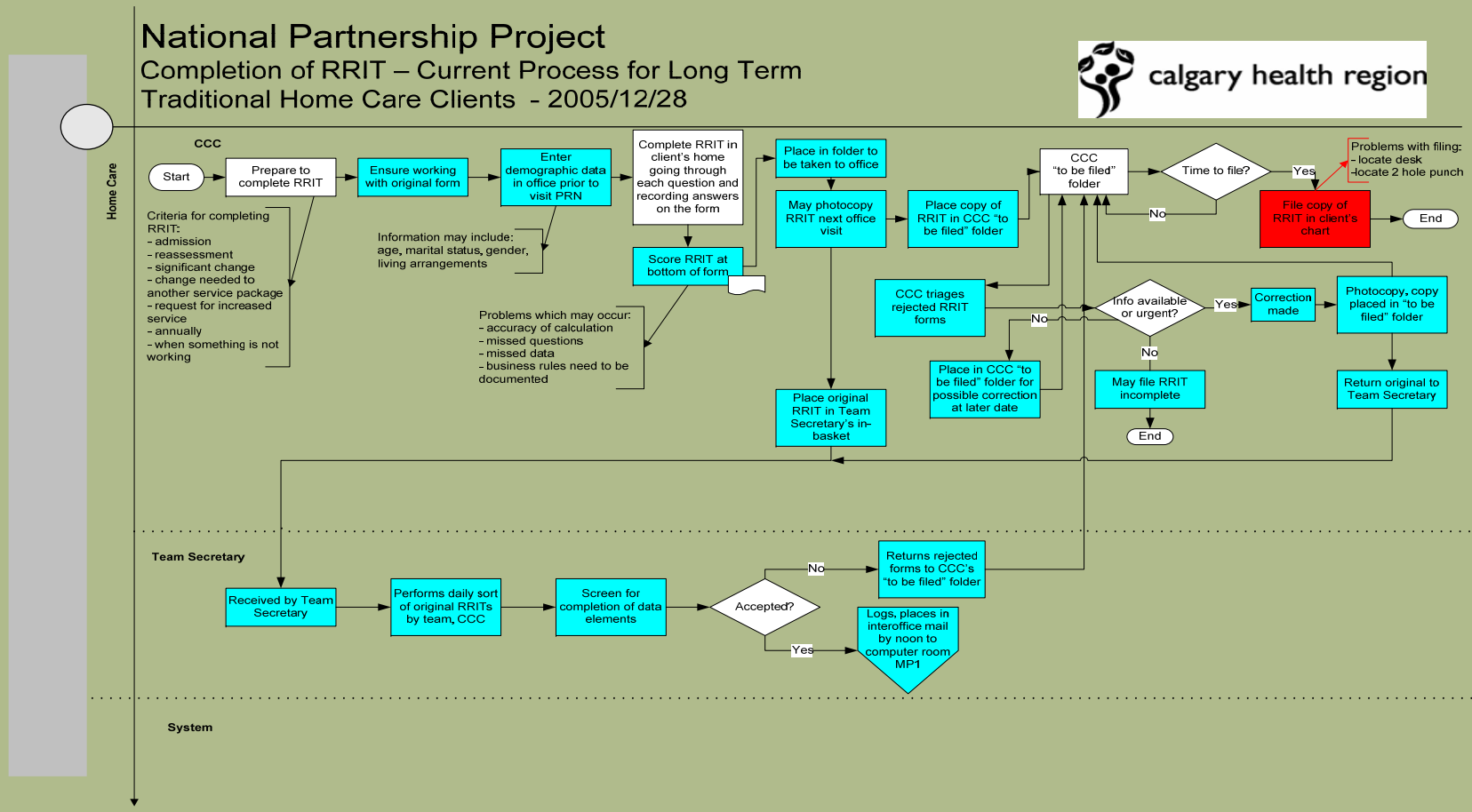
Case Management

- **Most recognized framework for community based support for chronic disease**
- **Role Clarity**
- **Technology supports role & function**

Function Analysis

	Baseline	Time 1	Time 2
Treatment	**22.50%**	**1.10%**	**3.20%**
Administration **e-calendar** **e-mail**	**16.20%**	**16.30%**	**21.60%**
Travel	**15.30%**	**15.50%**	**14.10%**
Care Planning	**4.00%**	**2.00%**	**0.40%**
Technology Problems	**0.20%**	**0.10%**	**0.40%**

Lessons Learned - RRIT



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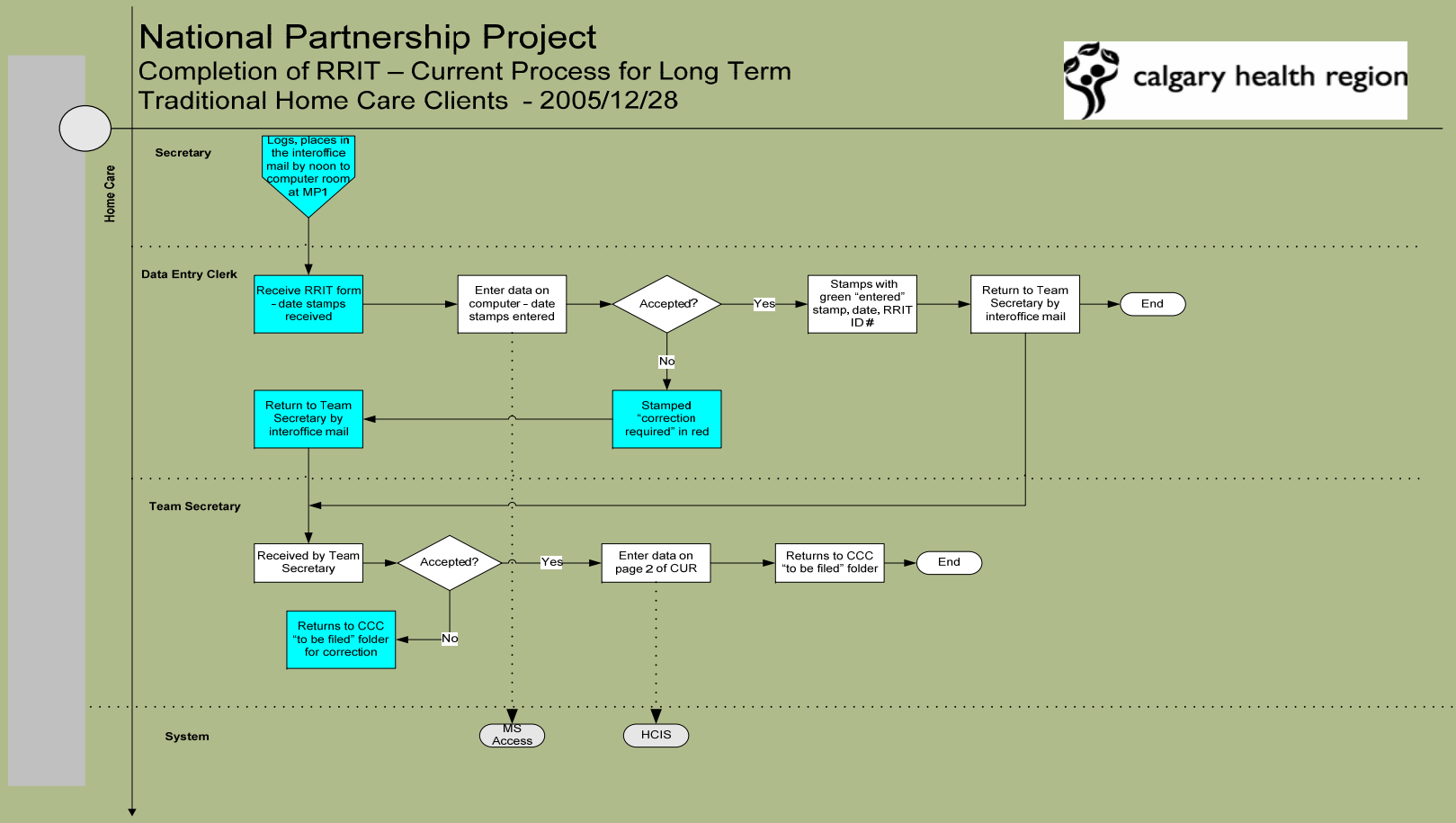

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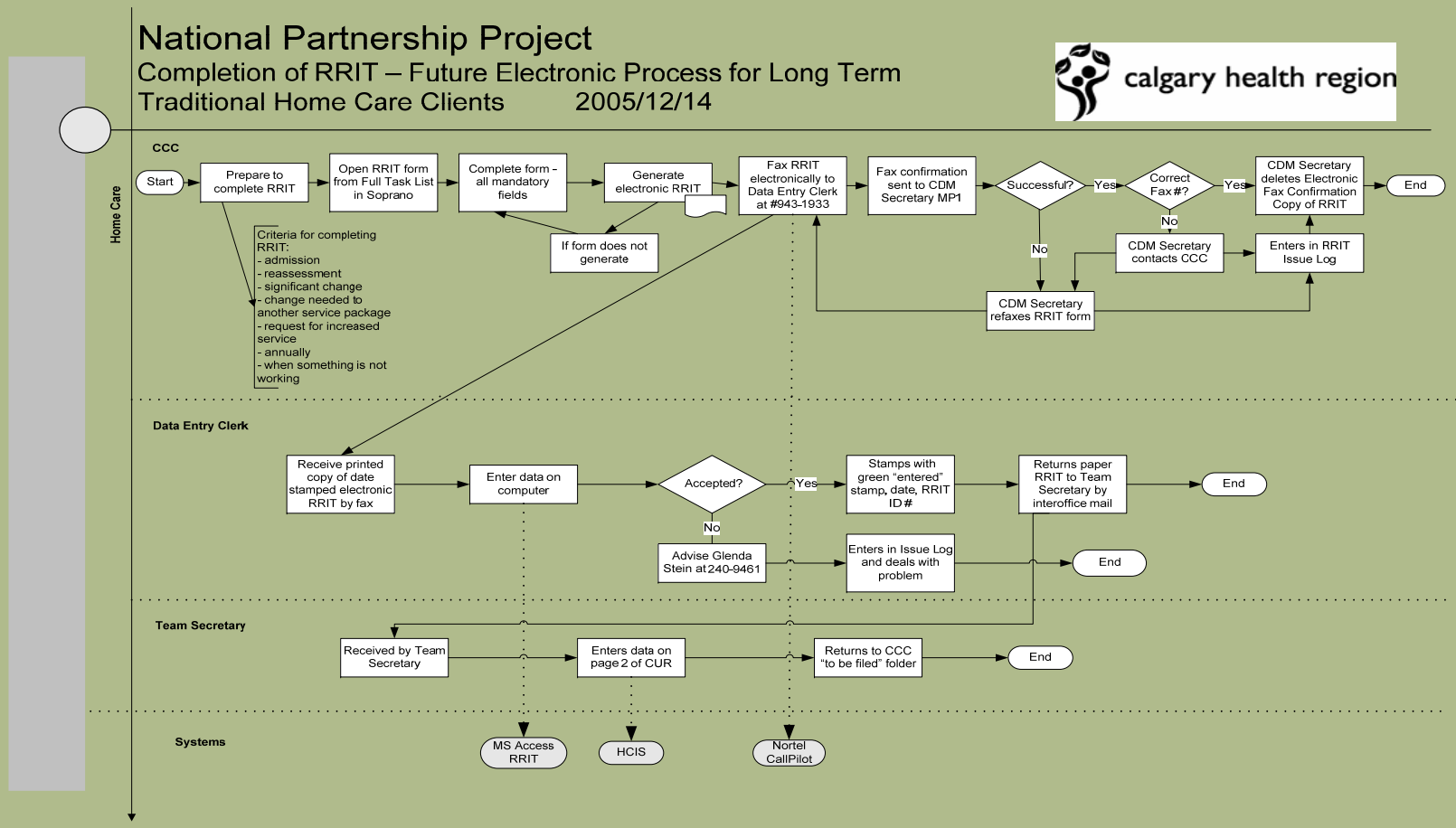
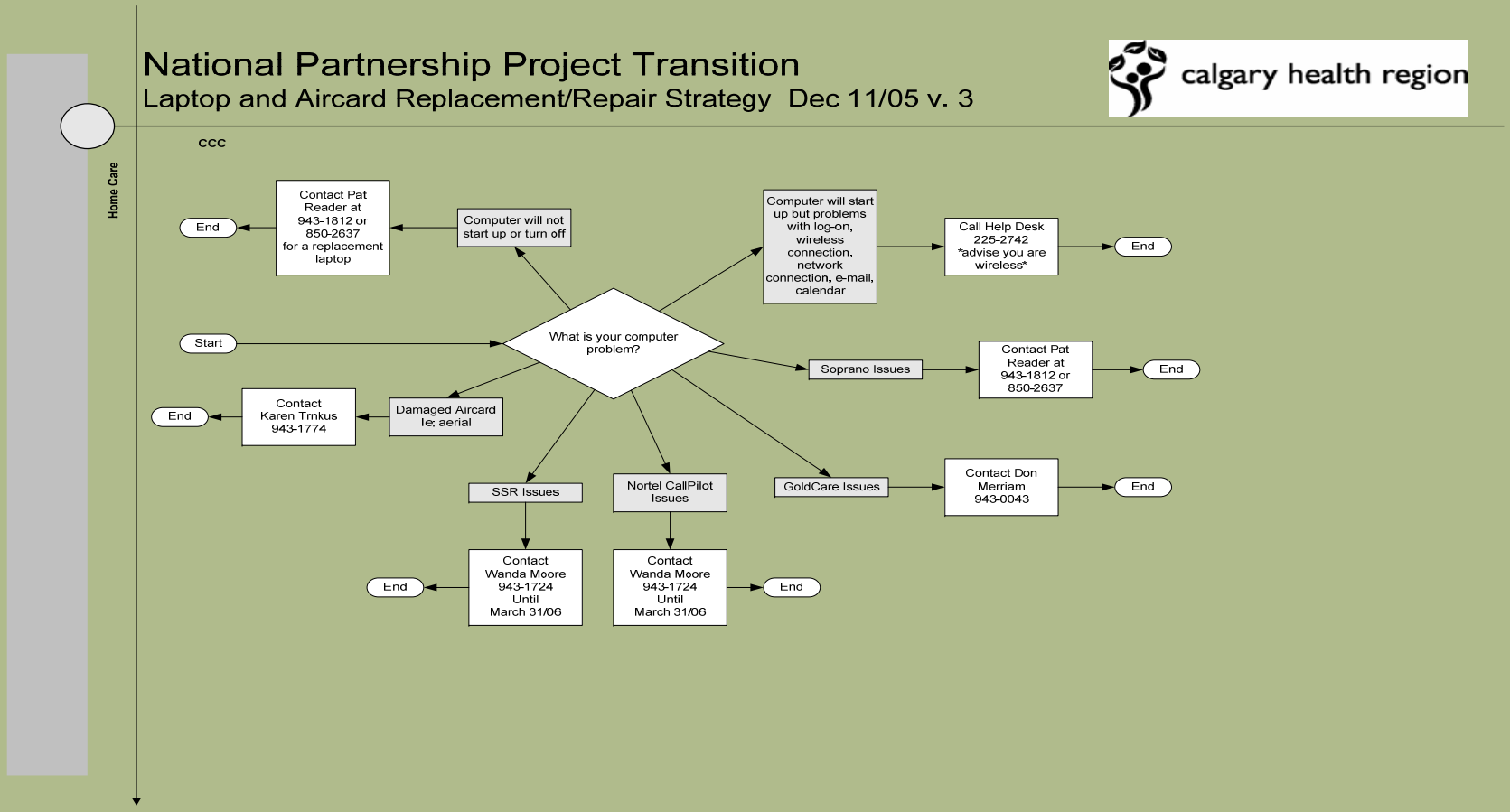


Lessons Learned - IT Support



Learnings

IT implementation - triple the time

- Education
- Ripple effect

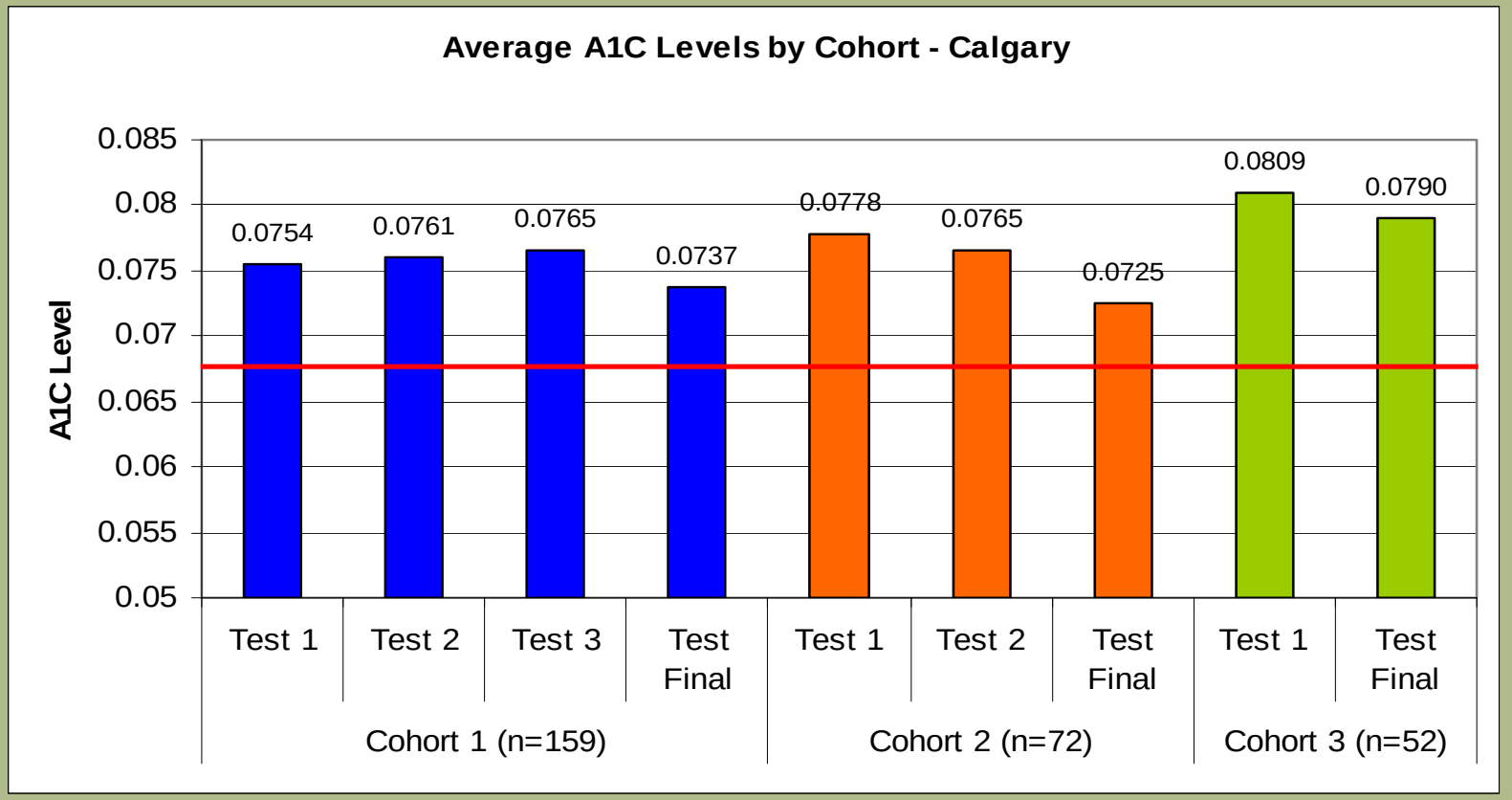
Change management

- Role
- Reassignment

Refining tools

Further Model Enhancement

Average A1C Levels by Cohort - Calgary



Home Care Strategic Plan

Themes

- Literature
- Accreditation
- Questionnaires/Focus Groups/Interviews

Home Care Strategic Plan

Primary Health Care

Case Management

Information Technology

Home Care Service Plan 2007 - 2012

Calgary Health Region Strategic Service Plan: Integrate, Integrate, Integrate

Home Care Vision: Integrated client focused community care

Definition of Integration: a well-planned and well-organized set of services and processes, targeted at the multi-dimensional needs of an individual client, or a group of clients with similar needs

Integration

Seminal work: Shortell et al. (1993,1994)

Characteristics of a well organized delivery system:

- Focus on community
- Match service to needs
- Coordinate and integrate across the continuum
- Information systems
- Information on costs, quality, outcomes and consumer satisfaction
- Aligns with partners to achieve objectives
- Continuously improves services
- Works with others to ensure objectives are met

Case Management

Integration

Shift emphasis to become more client centered and increase focus on healthy aging and prevention

Model Development

Based on the Calgary Health Region document, Framework for Case Management (2004)

Design characteristics based on evidence

Assumptions

Case management models differ depending on context, and the needs of the target population.

Case management is a method of achieving integrated health care for Home Care clients.

Assumptions

The simple broker model that involves assessment of needs and the identification of appropriate services will not provide job satisfaction to Home Care staff.

Purpose

Enable the client to achieve and maintain their highest functioning, independence and well-being.

Definition

Case management strategy is a client-centered strategy for the provision of quality health and social services. Case management is used to manage the provision and coordination of care across the continuum and to balance potential client outcomes with effective use of available resources.

Principles

- Case management is client centered.
- Case management is proactive and preventive in that it seeks to enhance health-promoting behaviours and the client's capacity for self-care and independence.
- Case management involves respectful and collaborative relationships.
- Case management engages the family and community networks to provide needed support.
- Case management involves advocacy.
- Case management is guided by ethical principles.
- Case management is committed to the coordination and integration of services across the continuum of care.
- Case management is focused on quality of service.
- Case management is accountable.
- Case management involves innovation.

Direct Care

- **The assigned case manager is the primary contact and the most consistent member of the team. Relationships are built over time.**
- **Palliative Team and the Pediatric Team: intensive case management model**
- **Context: small teams, few resources, large geographic areas, clients with high medical needs**
- **Geographic teams: face to face client contact but not hands on direct intervention.**
- **Context: large caseloads, large knowledge area/difficult to do both jobs well**

Caseload

Caseload sizes will reflect interdisciplinary team approach

Caseload sizes reflect:

- Degree to which direct services are provided
- Acuity: clinical indicators, psychosocial caregiver indicators, quality and cost indicators
- Case manager experience

CM Acuity Tool (Huber and Craig)

Case Management –Next Steps

- **Home Care Case Managers**
- **CDM Case Managers**
- **Systems Case Managers**
- **PCN Case Managers**
- **Home Care/Physician Partnerships**

Thank You

More information at :

www.calgaryhealthregion.ca/cdm

www.cdnhomecare.ca

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