

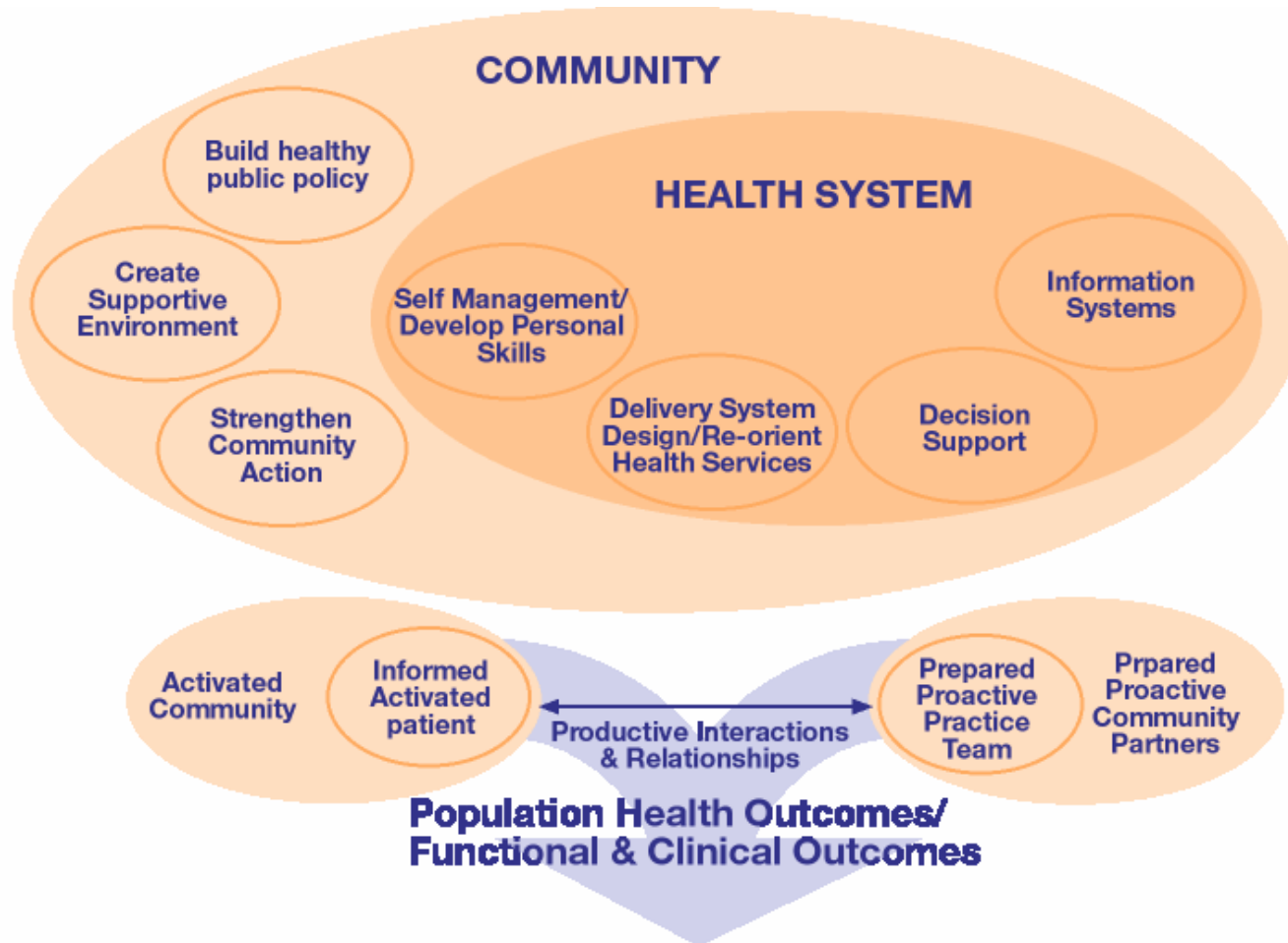
A Shared Care Model for Complex Chronic Disease Care: A Community of Practice

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PHSA

Presentation for the Navigation
Workshop Feb 23, 2004

CDM & P Model



Process of Development

- Builds on success of Family Practice Oncology Network
- Result of consultations with RHA PHC leads & practitioners
- Extend to multiple chronic diseases (Hi5- the 5% of the patient population that consumes 30-40% of health care resources) to build on the success of the collaboratives (CHF, diabetes)

Products

- Shared Care Report & development of the model
- 'Proof-of-concept' sites
- Evaluation

Purpose

- Improve quality of patient care for those with complex chronic disease: access, satisfaction, appropriateness, competence, continuity/coordination, effectiveness, efficiency & safety
- Improve provider satisfaction
- Reduce inappropriate utilization of tertiary services e.g. cancer care, cardiac, renal transplantation, mental illness, children's' & women's diseases
- Contribute to sustainability of PHSA and other health service delivery

Concepts

- Shared care: an approach to care which uses the skills and knowledge of a range of health professionals who share joint responsibility in relation to an individual's care. This also implies monitoring and exchanging patient data and sharing skills and knowledge between disciplines (Moorehead 1995)
- Self-management: goal-setting, problem solving, medication management

Concepts (cont'd)

- Navigation: generally refers to negotiating a path through the health care system. In cancer, trained 'navigators' assist patients, similar to case-managers in other settings
- Prevention – for patients with multiple complex co-morbidities, primary prevention (such as flu vaccine or falls prevention) is important to reduce the likelihood of further deterioration
- Community of practice – the network of providers, the patients with their families and support groups (IT term)

Shared Care Report

Components:

- Definitions and Models
- Inventory of activities in BC and learning
- Tools for implementation, improvement and evaluation

Definitions

1. “Shared care is an approach to care which uses the skills and knowledge of a range of health professionals who share joint responsibility in relations to an individual’s care. This implies monitoring and exchanging patient data and sharing skills and knowledge between disciplines.

(Moorehead 1995)

Definitions cont'd

2. Shared care is both systemic cooperation, about how the systems agree to work together... and operational cooperation at local levels between different groups of clinicians.

(Copeland and Harris, 2002)

Shared Care Models

Found in:

- Primary Care
- Secondary Care
- Community Based Care
- Mental Health

Common Elements of Shared Care

Inter-professional Relations:

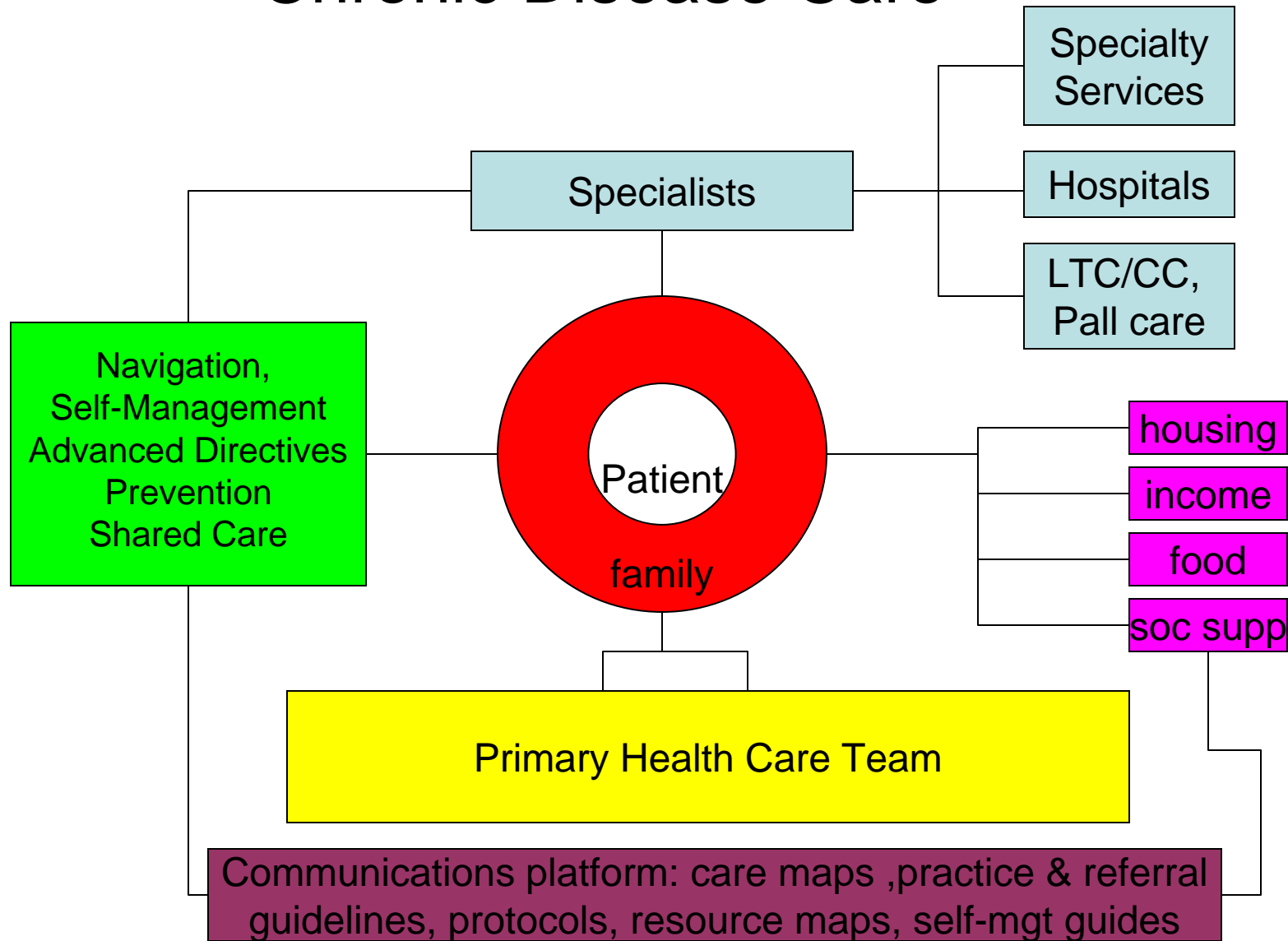
- Joint provision of clinical services
- Use of treatment & referral guidelines
- Shared responsibility for patient care
- Clear differentiation of roles & legal responsibilities between providers
- Regular face-to-face contact
- Communication and information exchange
- Collaborative professional education

Common Elements cont'd

Patient Management:

- Based on explicit individual patient goals
- Inclusion of patient and family in planning and decision-making
- Patient centred focus integrating self-management
- Flexible working arrangements to ensure access
- Mechanisms for confidentiality of records and medical history

'Community of Practice' for Complex Chronic Disease Care



Benefits

- Increased patient access to care
- Reduced fragmentation of care, increased integration and continuity of care
- Strengthened links between primary, secondary and tertiary sectors
- Improved working relationships between providers
- Improved satisfaction among patients and providers
- More efficient use of scarce resources and related cost efficiencies

Challenges

- Power and status differences between health providers
- Professional territorialism and perceived threat to professional autonomy and/or scope of practice
- Current funding arrangements
- Dedicated time and personnel to implement and manage shared care
- Limited methods to measure shared care
- Medicolegal environment

Factors for Success

- Emphasis on shared-care methodologies in training of future health practitioners
- Initiatives need to be based on best practices for all health-related disciplines
- Evaluation of inter-disciplinary care
- Dissemination of information
- Supported at all levels of health care system e.g. financial and infrastructure

PHC Network Development

- About 0.5M over one year to develop communication platforms, tools to support shared care, training in self-management/navigation & shared care
- Focus on testing Navigation & Self-management concepts and SharePoint communication tool
- Sustainability through leverage with HAs
- Evaluation – process, short- term with possible research with longer term outcomes.

'Proof-of-concept' Sites

- Penticton – diabetes, cardiac and renal disease
- Prince George – cancer
- Quensel – diabetes ,cardiac, mental health
- Victoria – cancer
- BC – (BCCDC) – hepatitis
- FH – Fraser Health – diabetes, metabolic syndrome and cardiac

Issues & Challenges

- Remuneration for primary care physicians taking on more complex chronic care
- Role clarification and legal responsibilities
- Developing a team culture
- Sharing of clinical information electronically
- Building relationships between community physicians and remote specialists
- Responding to patients as they become more self-empowered
- Moving from primary care to primary health care

Research Challenge

Hypotheses: Shared Care will

- Improve patient care – access, appropriateness, continuity, effectiveness, efficiency, safety
- Improve patient satisfaction
- Improve provider satisfaction
- Reduce inappropriate utilization – tertiary care – support sustainability