Proceedings:

March 27, 2002
Strategic Workshop on Chronic Disease Management

May 2002
Vancouver, BC
Proceedings from Strategic Workshop on Chronic Disease Management

The Health Association of BC, with support from the Ministry of Health Services and in partnership with the BC Medical Association and Registered Nurses Association of BC, organized a one-day strategic workshop on Wednesday, March 27, 2002, to review, discuss and develop strategies for the effective management of chronic diseases, with special emphasis on diabetes. The workshop examined the experiences from other jurisdictions in North America that have implemented major changes in diabetes care and other chronic diseases. Participants at this workshop are currently involved in chronic disease management, are planning to undertake future work in the area or recognize the opportunity to work in this area and want more information. There were representatives from all six health authorities.

The workshop included these presenters:
- Dr. Kate Lorig, of Stanford University, on Self-management Techniques
- Connie Davis, of Group Health Cooperative of Puget Sound, on IHI Breakthrough Series Collaboratives
- Vancouver Island Health Authority Collaborative members
- Ministry of Health Services on provincial diabetes strategy and health transition funding
- Expert/learning groups on specific issues

Larry Odegard, CEO from the Health Association of BC, welcomed participants to the workshop.
A. Plenary Sessions

The Emerging Role of Self-Management Programs in Comprehensive Health Care

Presenter: Dr. Kate Lorig, RN, Dr. PH, Stanford Patient Education Research Center.

Once a chronic condition is present, the patient has no choice but to self-manage. However, the questions become “how do they self-manage” or “how to get them to become proactive in self-management,” and “how do patients continue with the best quality of life possible”?

What is self-management?
- Based on patient’s perceived problems.
- Builds patient’s confidence to perform 3 tasks: disease management, role management, emotional management (how do I deal with the emotions that come with the condition).
- Focus on improved health status and appropriate health care utilization.

How does self-management differ from patient education?

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We need to hold self-management programs to the same standards as other evidence-based medicine.

Characteristics of Stanford University’s Self-Management Program:
- Built on structured patient needs assessment.
- Systematically use strategies to enhance self-efficacy (confidence of patient to monitor condition).
  - Skills mastery
  - Modeling
  - Social persuasion
  - Reinterpretation of symptoms
- Characteristics:
  - Peer led small groups
  - Standardized training for leaders
  - Highly structured teaching protocol
  - Standardized participants’ materials
  - Sesame Street approach (revisit subjects, build on knowledge)
  - Evaluated for long term outcomes
- Working on internet-based programs.

Chronic Disease Self-Management Program (6 weeks long, 2.5 hours per week)
• Improved health behaviours
  ▪ Aerobic exercise
  ▪ Stretching and strengthening
  ▪ Cognitive symptoms management
  ▪ Better communication with physicians
• Improved health outcomes
  ▪ Self-rated health
  ▪ Less disability
  ▪ Social and role activities
  ▪ More energy/less fatigue
  ▪ Less distress about state of health
• Participants in program had an average of 0.8 fewer days in hospital in past six months.
• $70 US dollars per patient estimated cost of interventions (although could be higher, if administrative costs considered).
• Trend toward fewer outpatient and emergency room visits.

What is needed for success?
• Dedicated accessible staff
• Expert master trainers (at least 2)
• Leaders trained within 2 months of leading programs.
• Annual leader updates.
• Leader recognition (stipend, etc.)
• Avoid leader burnout

Stanford University is working on a new model whereby the physician does group visits. If required, they will still see the patient individually but will discuss common issues in a group setting.

The National Health Services in Britain will be implementing self-management as part of the primary health care program.
Chronic Disease Management Model

Presenter: Connie Davis, Geriatric Nurse Practitioner, Center for Health Studies, Group Health Cooperative of Puget Sound and the Associate Director for Clinical Improvement of Improving Chronic Illness Care, a national program of the Robert Wood Johnson Foundation housed at the MacColl Institute for Healthcare Innovation at the Center for Health Studies.

The usual chronic illness care provided comprises of short, unorganized visits; a focus on symptoms and diagnosis, and not on prevention; no attention to patient or caregiver skills in caring for condition; a treatment plan limited to prescriptions and calls to the physician as necessary; and no incentives to professionals for the provision of ongoing care.

Connie Davis presented the three models- chronic care model, model for improvement and the collaborative learning model- used at Group Health Cooperative to improve chronic illness care. These models are based on quality improvement strategies and methods, such as the plan/do/study/act cycles, pioneered by the Institute for Health Care Improvement and supported by intensive professional development activities.

I. Chronic Care Model

![Chronic Care Model Diagram]

- **Community Resources and Policies**
  - Self-Management Support

- **Health System**
  - Health Care Organization
    - Delivery System Design
    - Decision Support
    - Clinical Information Systems

- **Prepared, Proactive Practice Team**
- **Productive Interactions**
- **Informed, Activated Patient**

**Functional and Clinical Outcomes**
The key components of the chronic care model are: self-management support, delivery system design, decision support, and clinical information systems.

Key principles of self-management support
- Emphasis on the patient role
- Standardized assessment
- Effective interventions
- Care-planning (patient’s care plan) and problem-solving

Key principles of delivery system design
- Team roles and tasks
- Planned visits (either individual or group)
- Continuity of care
- Regular follow-up (can be telephone calls)

Key principles of decision support
- Evidence-based guidelines (are they hard to follow; are they embedded into practice)
- Specialist expertise
- Provider education (need to look at strategies to enhance provider education)
- Guidelines for patients

Key principles of clinical information system (need information at point of service)
- Registry
- Care reminders
- Relevant subgroups
- Individual care planning

Characteristics of the Health Care Organization that will influence chronic care:
- Goals of the organization
- Benefits
- Provider incentives
- Improvement strategy
- Senior leaders

Community Resources and Policies that should be in place to support chronic care
- Effective programs (i.e. Exercise programs, transportation, etc.)
- Partnerships of community groups with health care organization
- Coordination of programs and resources

What will be expected outcomes:
- Informed, activated patients and prepared practice teams.
- Functional and clinical outcomes, such as:
  - Satisfaction
  - Clinical Measures
  - Cost
  - External Review Measures
Good chronic illness care comprised of:
- Assessment and tailoring of care plan to meet patient’s needs
  - Collaborative problem definitions
  - Evidence-based clinical management
  - Goal-setting and problem-solving
  - Shared care plan
  - Active, sustained follow-up

Connie Davis went through a few examples; such as congestive heart failure and the diabetes nurse care management, to illustrate the applicability of the chronic care model to various illnesses.

However, the implementation of the chronic care model has to be in conjunction with the model for improvement and collaborative learning in order to achieve system change. We need to ask three questions:
- What are we trying to accomplish?
- How will we know that a change is an improvement?
- What changes can we make that will result in an improvement?

II. The PDSA Model
The model for improvement adapted from the PDSA Cycle- plan, do, study, act- used in process improvement is required to do the following:
- Answer questions of “what are we trying to accomplish” and “how will we know that a change is an improvement”
- Develop a change
- Test a change
- Implement a change
- Spread a change
The PDSA cycle is repeated as new data is gathered, and changes are made.

To implement and spread change throughout the organization, an emphasis was placed on starting with people who are enthusiastic and starting with small-scale tests of change. However, intensive professional development activities are required to support staff in this process. The Collaborative Learning Model is based on that premise.
III. The Collaborative Learning Model

The foundation of this model is that participants go through a series of three learning sessions (LS), followed by three action periods (AP).

- **LS#1**: Learn the change concepts for chronic illness care, learn the improvement method, and focus on testing.
- **AP#1**: Test changes, learn to use measurement, look to experts for advice
- **LS#2**: Participants hear detail about the change concepts. Learn about implementation. Introduction to spreading a change, and making the case for the innovation.
- **AP#2**: Implementing the changes, some spreading of successful changes. Participants learn to use each other for information.
- **LS#3**: Customization issues of change concepts, planning for spreading of changes, and participants becoming experts.
- **AP#3**: Continued testing and implementation at pilot sites, successful changes tested in spread sites.

Usually by the time participants reach the stage of LS#3, the planning team is no longer the expert and the action teams have taken over.

During the action period, various supports are in place for the participants: email, visits, web-site, phone, assessments and senior leader reports.

In summary
- The chronic care model provides a framework for designing a better system.
- The model for improvement is an action-oriented way to implement change
- Sharing information through a learning collaborative makes rapid improvement possible.
Implementation and Evaluation of Self-Management Programs in BC and Canada

Presenter: Patrick McGowan, Assistant Professor of Social Sciences at the University of Victoria and a research affiliate at the university’s Centre on Aging.

Implementation of self-management programs in British Columbia began with the Arthritis Self-Management Program (ASMP) in 1989 through a grant from the Health Canada Seniors Independence Program. Through the Arthritis Society community infrastructure the program was implemented in over 30 BC communities. With immediate consumer enthusiasm for this type of patient education program, the ASMP was soon expanded to the Yukon and Alberta. During the year 1992 nearly 1200 people participated in the ASMP in BC.

Between 1992 and 1994 the ASMP was implemented in every province and in both official languages through the Canadian Arthritis Society infrastructure. During this period, 305 persons were trained as course leaders and approximately 900 people participated in the evaluation activities. The evaluation methodology used pre- and four-month post-program questionnaires for both program participants and program leaders to measure program effectiveness. Following positive evaluation results, in 1994 the Arthritis Society of Canada obtained corporate sponsorship to provide the program on an ongoing basis in each province.

In 1995, through a research grant from Health Canada's Seniors Independence Research Program and Canada's Drug Strategy, a three-year program of applied research grant was received to investigate several aspects of the self-management programs. Research activities included: a) a randomized controlled trial of the ASMP at six-months and at one-year post program; b) an economic evaluation; and c) three qualitative studies investigating participant perspectives.

Implementation of the Chronic Disease Self-Management Program (CDSMP) began in the Yukon in 1996 with a one-year pilot project funded by the Government of Yukon. The evaluation used quantitative and qualitative research methods and found that, at six-months post program, participants: were practicing more ways of coping with their symptoms; had higher levels of self-efficacy to manage their symptoms and to manage their disease; were less bothered by their illness; were less depressed; had more energy; were less distressed about their health condition; were experiencing less fatigue and shortness of breath; were experiencing less pain; were less limited in their daily activities; and had better communication with their doctor. In 1997 the CDSMP was designated a permanent program by Yukon Health and Social Services.

In 2000, the CDSMP was implemented in British Columbia as a one-year pilot funded by the Vancouver/Richmond Community Health Initiative Fund. During the pilot, 80 lay persons with chronic health conditions received the 4-day leader-training workshop and then led 30 CDSMP courses to 314 persons. Evaluation results showed that at 6-months statistically significant changes were observed in 10 of the 17 outcome measures. At six-months post-program, participants: were practicing more ways of coping with their
symptoms; had a higher level of self-efficacy to manage their symptoms; had a higher level of self-efficacy to control/manage depression; had a higher level of self-efficacy to manage their disease; believed they had better health; were less limited in their daily activities; were less bothered by their illness; were less distressed about their health condition; were experiencing less shortness of breath; and were experiencing less pain. With this evidence of success, the program has received ongoing funding from the Vancouver/Coastal Health Authority. To date, 145 leaders have been trained and 71 courses have been delivered to nearly 850 persons in the Vancouver Richmond area.

Beginning in 2001, with a 28-month grant from the Canadian Diabetes Initiative, the Diabetes Self-Management Program (DSMP) is being implemented in approximately 20 BC communities. This program is being targeted to persons experiencing Type 2 diabetes. Evaluation methodology includes pre- and six-month post-program questionnaires, a comparison on participants' hemoglobin A1C levels before they take the program and six months after completing the program, and utilization of health services for the one-year period prior to taking the program compared to the one year period following completion of the program.

Both the Arthritis Self-Management Program and the Chronic Disease Self-Management Program have been implemented in Aboriginal communities in BC. In 1992, through a grant from the British Columbia Health Research Foundation, the First Nations Arthritis Self-Management Program was implemented in 16 Aboriginal communities. During the project, 121 persons were trained as leaders and 28 courses were delivered. In 2002, approximately 40 Aboriginal persons have been trained to lead the Diabetes Self-Management Program.

In 2002, the Chronic Disease Self-Management Program materials were translated into Chinese, Chinese leaders were trained, and courses were delivered in the Chinese community in the Greater Vancouver area through the SUCCESS organization.

Presently, the Chronic Disease Self-Management Program and the Diabetes Self-Management Program are being delivered through the Centre on Aging at the University of Victoria. For more information on the operation of these programs please visit their websites:

Chronic Disease Self-Management Program  www.coag.uvic.ca/healthyliving/
Diabetes Self-Management Program     www.coag.uvic.ca/diabetes/

Additional information on implementation and evaluation of self-management programs may be obtained from Patrick McGowan at mcgowan@dccnet.com.
Chronic Disease Model – The BC Collaborative Experience

Presenters: Vancouver Island Health Authority Team
- Art Macgregor, Family Physician, recently chief of Family Practice and Director of Continuing Medical Education, now Medical Co-Manager of the Capital Health Region/Vancouver Island Health Authority Community Health Program
- Darlene Ravensdale, Dietitian/Nutritionist, Manager of Regional Diabetes Programs, Community Health Program, Capital Health Region/Vancouver Island Health Authority
- Victoria Barr, Manager Primary Prevention Services, Community Health Program, Capital Health Region/Vancouver Island Health Authority

Art Macgregor presented on the Capital Health Region’s Diabetes quality improvement project. The aim of the project was to study an integrated approach; the management of a chronic disease; a population-based system of care; an improved quality of care; and improved outcomes.

Extensive orientation and education sessions were offered to members of the department of family practice. Twenty-eight physicians participated. With no financial support for registry development or in reporting results confidentially to project team, these physicians participated in the implementation of planned care, with specific monitoring of patients and follow-up visits for one year. They were also asked to develop individual office registries, label all diabetic patient charts, collect four specific data elements on all diabetic patients, and report to project team every six months.

Baseline diabetes management indicators are hemoglobin A1c readings of patients. During this one year period, 81.8% of the diabetic patients from the 28 practices had Hb A1c readings of less than 8.0. The project team concluded that glycemic control is the easy part for 90% of patients. However, the problem for most is the “organization of the whole package of care”. What happens to the hypertension, hyperlipidemia, smoking, depression, microalbuminuria and/or the other conditions that the patient may have?

The lessons learned from the project:
- It was relatively easy to enlist enthusiastic family practitioners for a one year “feel good” quality improvement project. However, involving the other 90% is very difficult.
- Shared care in a fee-for-service system is very hard to develop; “turf” issues are important.
- Not all “legs” of the chronic care model are of equal strength. Nothing meaningful has been done about decision support. Implementation of guidelines is very difficult without appropriate information management and information technology.
- Need a data manager to collect as much data as possible for decision support.
- Need a breakthrough in the development of cost effective information management and information technology.
• Rigidity of the Canadian health care system
  ▪ No shared goals among planners, payers, providers
  ▪ Rewards episodic, unplanned care
  ▪ Has not encouraged a lot of innovation or experimentation
• There are opportunities to improve care, but the leadership needs to be there to support staff in their initiatives.
• Change and improvement require new investment and/or restructuring, although it is difficult to determine how much of each is needed or possible.
• Two requirements in order to achieve improved health outcomes:
  ▪ Development of a useful patient registry
  ▪ Development of a planned approach to care in family physicians’ offices.
• Decisions should be based on evidence from research and quality improvement analysis.
• “Renewal” and “reform” are needed in family practice services in BC.

Darlene Ravensdale talked about the successful partnership Vancouver Island Health Authority has with the Group Health Cooperative of Puget Sound in its implementation of the chronic care model; diabetes information systems and challenges of the chronic care model.

The vision the health authority has for diabetes information systems:
• Central, secure regional database containing data relevant to the care of people with diabetes.
• Accessible to all members of the care team and the client integrating the care information.
• Information used to:
  ▪ Facilitate proactive care of individuals (eg. reminders, alerts, guideline support)
  ▪ Track population health/research
  ▪ Plan service delivery (utilization data)

However, there were many information system challenges:
• Health Maintenance Organization (ie. Group Health) information systems cannot be imported due to differences in:
  ▪ Organization
  ▪ Legislation
  ▪ Standards (ie. units of measure)
• FOIPP
• Lack of a common minimum data set
• Costs
• Complex, changing systems environment
  ▪ New, evolving standards (eg. security, privacy)
  ▪ Organizational priorities and climate
  ▪ Integration of various systems
Data has been critical for:
- Problem identification
- Resource allocation
- Establishing baselines for outcome tracking
- Assessing adherence to guidelines
- Senior management support
- Awareness and motivation building

Some examples of useful data:
- Prevalence of diabetes (age, gender, geography)
- Patterns in the care process (e.g., HbA1c testing rates, eye exam rates)
- Prevalence and cost of complications
- Service utilization
- Service costs

Examples of self-management support programs for patients:
- Diabetes Education Centre (which is client focused)
  - Expansion of hours and days of service to meet patient needs
  - Curriculum redesign (with self-selected modules)
  - Depression screening
  - Community outreach
  - Improved client feedback process in place
- Canadian Diabetes Association’s “What Now?” program
- Activity programs (i.e., recreation centers)

Challenges in management of chronic care:
- Coordination of all the cycles/initiatives in the chronic care management model
- Linking chronic care to other services with different goals
- Team issues, such as roles, turnover, training
- Resources (time/money)

Keys to successful management of chronic diseases:
- Support from senior management/administration
- Dedicated “agents for change”
- Chronic care management model
- Direct caregiver involvement
- Spread the information (network, share, publish)
- Collection of appropriate data
- “Just do it” philosophy

As part of the team from Vancouver Island, Victoria Barr talked about chronic care management and population health promotion (PHP). The current chronic care model does not easily lend itself to prevention and health promotion for the following reasons:
• Scope and depth of community resources and policies component need expansion.
• Chronic care model does not address social, environmental and cultural factors that influence health.
• Population health promotion professionals have difficulty seeing how their work fits into the current model.

There was a need to integrate PHP professionals into the chronic care interdisciplinary team, as effective strategies to promote health and prevent and manage chronic disease are essential. Some of the challenges in making this change are:

- Attitude/practice shift for staff
- Unions
- Turf wars
- Cultural issues
- FOIPPA complexities
- Costs
- Community policies and resources section of chronic care model under-developed.

A group from the Vancouver Island Health Authority has refined the chronic care model to include in the “Community resources and policies” circle, the pillars of population health promotion, such as creating supportive environments and strengthening community action.
Ministry of Health Services Team:

**BC’s Application for the Primary Health Care Transition Fund** - Rick Hudson  
**Chronic Disease Management** - Howard Platt  
**The BC Strategy for Diabetes Prevention and Management** - Brenda Marin-Link

Rick Hudson presented on BC’s Application for the Primary Health Care Transition Fund. Primary care renewal is a collaborative strategy to strengthen family practice and reduce pressure on acute care. Approximately $74 million over four years ($18 million annually) is available to BC as part of Health Canada’s Primary Health Care Transition fund. The objectives for this funding are to:

- Increase the proportion of the population having access to primary health care.  
- Increase emphasis on health promotion, disease and injury prevention, and management of chronic diseases;  
- Expand 24/7 access to essential services.  
- Establish interdisciplinary teams of primary health care providers, so that the most appropriate care is provided by the most appropriate provider.  
- Facilitate coordination and integration with other health services.

As set out by Health Canada, this funding will not be used for direct payment of services insured under the *Canada Health Act*. Funding will be used only for transitory costs needed to assist, and facilitate change in the organization and delivery of primary health care in BC.

The three strategic approaches used will include:

- Supporting a range of practice models  
- Improving health outcomes  
- Professional and organizational development, evidence and evaluation

The funds will flow to the health authorities.

Howard Platt presented on chronic disease management from the medical and pharmaceutical services utilization perspective. The medical and pharmaceutical services division has been involved in work on cooperative approaches, business case analysis, private/public partnership, evidence-based practice guidelines, patient registries, patient surveys, performance measures, and Chronic Disease Management (CDM) website.

Results from a physician survey on chronic disease management conducted in September 2001 indicated that:

- A significant percentage of respondents agreed that CDM tools would be helpful to them in their practices. Comments suggest that CDM can act as a safeguard or benchmark for physicians for assessing if their current approach to care is within an acceptable norm.  
- Of the 8 chronic diseases listed in the survey, diabetes was the most frequently chosen disease, followed by hypertension and congestive heart failure as best candidates for CDM strategies.
• Barriers to chronic disease management include time, complexity, workload, remuneration, and human resources.
• Patient compliance was identified as an integral aspect of CDM.
• Many chronic diseases are associated with other illnesses, and this co-morbidity lends itself to fragmentation of care due to lack of time to properly address each health issue.
• More opportunity for multi-disciplinary teams is required if chronic diseases are to be properly managed.
• Chronic disease management can be discouraging for caregivers, patients and family members.
• Areas of interest in chronic disease management include review and assessment guidelines and protocols or tools; sharing CDM with peers; participate in research on current practices; identify useful information systems; and develop and test outcome measures.

Other work done by the utilization management branch at the ministry include
• Diabetes performance measures at the physician level
• Guidelines and protocols for diabetes care
• Identification of management information from accounting data. Guidelines for the care of people with diabetes recommend that some services should be provided on a regular basis. Accounting data collected by Medical Services Plan is being analyzed to explore the care of people with diabetes and then calculate the proportion of those who appear to have received the recommended care over a certain period.

Brenda Marin-Link presented on *The British Columbia (BC) Strategy for Diabetes Prevention and Management*. A vision and a comprehensive set of goals and objectives in the framework of primary, secondary, tertiary prevention, and surveillance, evaluation and research are identified. The chronic care model and chronic disease self-management are acknowledged. The goals for the provincial strategy are:
• To prevent new cases of type 2 diabetes by modifying the underlying causes and modifiable risk factors for diabetes.
• To detect diabetes early.
• To prevent, delay, manage or minimize the impact of complications of diabetes.
• To support planning and monitoring of primary, secondary and tertiary prevention of diabetes by including surveillance, evaluation and research.
B. Expert Learning Groups

In the afternoon, participants had the opportunity to attend two expert learning groups, facilitated by the plenary speakers, to learn more about the topics presented in the plenary sessions.

All the sessions followed a “question and answer” format, and were conducted in an informal setting.

I. Self-Management Expert Learning Group

This session was an informal discussion on the various aspects of the self-management programs presented earlier by Kate Lorig and Patrick McGowen. Discussion focused on the following questions:

What happens in communities?
- How do we link public health with acute care and continuing care

What are the key behaviours?
- What are the key things to do
- Keep it simple

Does this model work with children?
- some do

Does the model work for both men and women? What kinds of gender imbalances?
- Must recruit trainers in ways that interest men
- Some strategies work better for one gender

II. Chronic Disease Model Expert Learning Group - Connie Davis

Questions raised in the discussion:
- Diabetes Model- Group Health Cooperative: how it happened; how it works
- Assessment of patients
- Chronic Care Model- cardiac population- MI, others
- Other care models- MS
- Public health- continuity of care with acute care
- Team- prepared, proactive- how, who
- Episodic care versus planned care. Contradictions
- Primary care physician focused. What about nurses and others?
- Reducing acute care days for any chronic disease
- Roles of patients/caregivers using information not evidence-based
- Barriers to implementation
- How big is the model- province, region, and clinic
- Emotional/social problems in Chronic care model
- Providers’ turf:
- Relieve of responsibility
- Show outcomes
- Involve in process
- Recruit a champion
- Show them the defined root cause; address the root cause
- Re-train
- Share your information
- Have a dinner
- Tie billings to appropriate outcomes

III. Chronic Disease Management - BC Experience Expert Learning Group

Now that there is money in the pipeline... (Health Transition Fund to Health Authorities), what will you do differently?
- Ideas will come forward (there are interested and informed people)
- Example of collaborative between physicians (20 to 50) in practice linked electronically, with professional development (how to work in a collaborative, information technology, etc.)
- Would ask that home care nurses be seconded to relate to the group (same work, organized differently).
- Empowerment of the patient to organize his or her own healthcare.
- Information technology difficult- how to link the physicians (probably not much money for information technology)
- Difference from last time- paid, information technology support.
- Monitor in a collegial, supportive way
- Want people to share information.

Key difference:
- Increased community involvement
- 30 physicians, 40 patients each (1200 patients with diabetes)
- Work with nurses: can they reorganize work with respect to chronic disease model; case management meetings.
- Adding a human dimension.
- If you can’t have a dedicated person, what about another tool?
- See nurses taking on a more advanced role.
- Expand capacity of everyone in system...nurse practitioners; medical office assistants.

Addressing:
- Information Technology
  - What is the purpose of the collaborative?
  - Initially focus on diabetes, and then expand to include other diseases, such as hypertension.
  - Need to make information management/information technology system work. For example, physician on call would have access to information, patient records, etc.
• If a WOLF system can look after 12 physicians, can 3 work for 36 physicians/
• Not waiting for information technology- must serve the function of serving the patient.
• Confidentiality issue- access by the right person at the right time.
• Group visits- need to work with Ministry of Health Services/Health Planning with respect to billings.
• Need informed consent specialist
  - Doctor/nurse not enough
  - Need to understand philosophy, law, technique
• Links with Acute Care?
  - Try to identify patients who need follow-up and education.
  - Try to identify patients who go to the emergency ward often.
  - Paged
  - Not currently a 24/7
  - Working at health authority level means information available to population
• Medication Management
  • Community pharmacist
  • If there are 20 to 50 physicians involved, need a “floating pharmacist” as part of the team.
  • Home visits, initial medication check, medicine cabinet check.

What is being done for the whole diabetic population in Vancouver Island Health Authority?
• Looking at data.
• Some project initiatives- food security for low income, First Nations, etc.
• Canadian Diabetes Association project (education, etc.) is very large.
• Monthly 2 hour sessions, 2 to 10 people, interest nationally.
• Different seminars/sessions.
• 50% of the diabetes population in the Capital Health region is over the age of 65. They often don’t go out at night-structural barriers.
• Pharmacare- patients required to attend an annual education session at a diabetes education center in order for pharmacare to cover glucose monitoring supplies and equipment. However some patients don’t attend and pay for those supplies out of pocket.
• A suggestion was made that perhaps other incentives, such as prescription dispensing benefits, should be offered to participants.
• It is always the patient’s choice to attend or not; they know about the diabetes education center.
• A high proportion of the diabetic population has been to the diabetes education center at least once.
• Some people can do well with self-management.
• Some people living in remote locations will not travel to Victoria to attend the sessions.
• Cultural barriers are dealt with in the approach and materials used. Language limitations; translator barriers.
• Doing some work with street people.
• Aboriginal population not using the diabetes education center.
• Need to capture people who have not been diagnosed, and who do not visit their doctors.
• Linking Diabetes Quality Improvement Project to Pharmacare Renewal.
• Role of pharmacist
  ▪ Assisting in earlier detection.
  ▪ Source of information
  ▪ Contact point

• How do you get interaction between collaborative/pharmacists
  ▪ Infrastructure
  ▪ For example, home visits for patients such as determining if it is a medication-related problem or not.
  ▪ Great opportunity for relationships.
  ▪ Project = New rules
  ▪ Grant applications
  ▪ Traditionally no funding; people volunteering
  ▪ Funding usually becomes available after people see the outcomes and benefits of diabetes education center.

• Use alternative payments to find funding.
• If job is worthwhile, why won’t the system fund it?
• Seems to be a lag time between diagnosis and start of care in Vancouver/Richmond area.
  ▪ How has Vancouver Island shorten time?
    - By offering 2 hour modules to groups of approximately 8 people, instead of day and a half sessions.
    - Choice to sign up for one-on-one dietitian’s time

• When project started to show successes, center received more money and staff; waitlists dropped.
• Outcome measures coming from the government, ie. Days of stay
• May shift resources.
• Need to catch people early when they are receptive to making changes.
  ▪ Sign them up at the diabetes education center the day they are diagnosed.
  ▪ Give information to bridge gap until session.

• Why wait for group education for people with impaired glucose readings.
  ▪ Supporting people with self-management strategies while providing education.
• Challenge for educators is that patient arrives with questions/different agenda than that of the educator—taught to listen to patient.
• For those with type 1 diabetes, are there any programs available in the transition period from the pediatrician to general practitioner.
  ▪ Complicated.
  ▪ Health care delivery problems
    - Have had care from pediatrician, specialist, etc. and now “set loose”
    - Set up a transition clinic.
    - Low follow-up rate.

• Canadian Diabetes Institute guidelines for physicians.
• Education
  ▪ Group, information packets, agendas, chronic disease management.
  ▪ How do you know if patient is ready to get information and be referred to a self-management session versus group information sessions?

• Is there leeway/flexibility to change program from Canadian Diabetes Association standards?
  ▪ Changed structure
  ▪ More adult education
  ▪ More flexibility/choice
  ▪ Follow-up is more of an issue
  ▪ Patient driven

• Lions Gate Hospital
  ▪ Treatment, education, home care, pharmacist
  ▪ Does everyone need to attend 2 and a half day session
  ▪ Looking at internet learning
  ▪ Good base to move forward
  ▪ Need for multiple interventions and information/repetition

• Any problems with accreditation of Diabetes Education Centers?
  ▪ Recent government changes may have impacted; no team in place that will issue accreditation.

• Definition of “what is a diabetes education center” may change.
• Opportunity to change how curriculum is delivered.
• Having a curriculum on self-management helps.
• Follow-up is an access issue for some
  ▪ Patient choice
  ▪ Travel/distance
  ▪ Parking
• Would be good if educator knows who the pharmacist is (supportive role for each other).
• Referring patients with difficult cases to home care nurses- no formal system.
• Some patients need minor follow-up, not sure who to go to.
All team members need to be hyper-aware and sensitive at beginning.
Pharmacists have to know what patients get/learn in order to better support the patient.
Most centers using CDA guidelines for materials, but very different programs.
Going to demonstration modules to home care/support nurses; can extend to pharmacists.
Professionals don’t always know about available resources in all areas.
Physician, who has type 1 diabetes, giving information sessions is very effective, especially to teenagers.
Doing away with group sessions can be isolating.
On-line support groups.

IV. Ministries Expert Learning Group
- Is there a place for pharmacists in chronic disease management? In the morning sessions, there was no mention of the role or involvement of pharmacists in the ministries’ plan for chronic disease management. Although they are not currently part of the plan, there was assurance that pharmacists are key partners and that discussions were underway.

- Are the ministries looking at making the pharmacare policy more flexible to improve access for people with chronic diseases?

- How will interdisciplinary team members be paid in a primary care setting? No decisions have been made. The following questions need to be explored further: what is appropriate practice; where are the gaps; need to change “how we pay for services”; consideration of physicians’ fee schedules, what are the restructuring plans of health authorities and their implications, etc.

- Population based funding- money will follow the patient.

- Has consideration been given to dementia care? Often there are difficulties in discharging patient to the appropriate setting.

- The funding structure is not in place to implement shared care models. BCMA is open to discussions on alternate funding models. Ministries need to work with stakeholders to resolve these funding issues. Need to find ways to bring group practice/shared care models to the attention of physicians. Ministries will try to ensure that collaborative learning takes place, and that ideas are shared. Different funding models should be considered for interdisciplinary team settings, ie. similar to that found in mental health centers.

- Health authorities need funding support to test various models and experiment with innovative ideas.

- Ministries should not just tinker at the system; need to make substantial changes.
• Need to consider a population health perspective. Diabetes can be preventable. For example we need to tackle members of the food industry who are promoting fast foods, especially in schools. Fast food companies have a lot of power and influence over eating habits of youth. It was noted that the ministries would be developing prevention and wellness strategies with health authorities.

• With respect to public-private partnerships, the ministries are working on a framework to build a platform of accountability. Currently, they are exploring the issue of public–private partnerships with AstraZeneca on the management of congestive heart failure, and with Telus on the development of information technology systems.

• How flexible is the chronic disease model for the “smaller groups” of diseases. The Chronic Disease Model is applicable to a range of diseases.

• We need to find ways of dealing with transportation issues for those living outside the Lower Mainland. Ministries said that a transportation subsidy is not part of the chronic disease management strategy.

• Although telehealth capabilities are a real benefit for rural communities, it was also noted that those capabilities could work for long term care facilities that may not have sufficient medical expertise on hand

• Newborn screening practices are considered to be a chronic disease management strategy. Is there a gap between what is happening versus what ought to happen?

• South Fraser Service Delivery Area has used the chronic disease management model in urinary incontinence cases—it works! South Vancouver Island Health Services will also be trying the model in some of their programs.

• Participants feel that the clinical expertise and motivation are there; we just need to organize work around the model.

• Information flow is important. How does one access patient-related information? What information should be transferable amongst service providers? Health record maintenance is an enormous task.

• Focusing on diabetes is the first step in chronic disease management, but we also need to look at other diseases, such as hypertension, depression, etc.

• How will we integrate physicians and primary care with the rest of the health system?
• Is there a core minimum data set for diabetes? Is there consistency in the collection of data at diabetes education centres, since data can be manipulated in different ways to get different answers? The ministry has drafted a tool for the collection of consistent data set for diabetes education centres. In the future, the Leadership Council (of health authorities’ CEOs) and not the ministries will have more say in the standardization of data.

• Ministries are working on a business case for congestive heart failure. The end product will support the work of health authorities.
Action Plans and Next Steps

Participants brainstormed the following next steps.

- Need to have 100 to 200 people, including caregivers, at a meeting to hear about the chronic care model.

- Break down the “policy barriers” (Health Association of BC, BC Medical Association, Ministry of Health Services/Health Planning)

- Good to hear from groups in other geographic areas.

- Need good strategy documents.

- The ministries and the Health Association of BC need to play a coordinating role in the development of outcome measures and standards.

- Set up Listserv for networking purposes.

- Try to have a strategy that involves consumers.