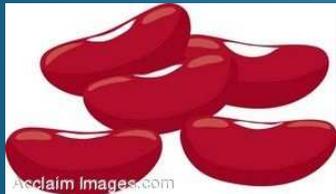


The Pork'n Beans of CDM

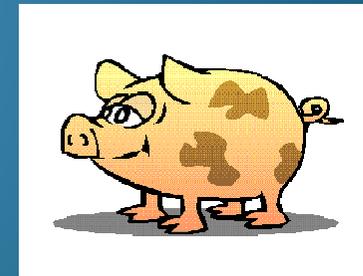
A Pilot Project:

New Innovations and Best Practices in a FHT



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A FHT Family Physician & CDM Nurse Educator are.....

Implementing aspects of The Edmonton
Southside Primary Care Network Chronic
Disease Model

And

Utilization and Customizing Upstream
Approaches to Patient Preventatives

- "Left undiagnosed or untreated, chronic disease may also exact serious health and economic consequences from patients, families, and communities" (Every, 2007, p. 70)

- A patient may see the CDM Nurse Educator, the Family Physician, or both, and spend time discussing disease management. "This team approach frees the physicians to see more patients, to concentrate on those who need them and to take satisfaction from knowing they are doing a good job" (Spooner, 2007, as cited in Every, 2007).
- "This brings the care of patients with chronic diseases back into the family physician's office, where the primary care team works to improve co-ordination of services, as part of an integrated model of CDM" (Every, 2007).



Disclaimers.....we have none:)

- Dr. Tromp receives funding from OHIP☺
- I love free stuff....pens, pedometers, inhaler holders☺



Today's Objectives.....

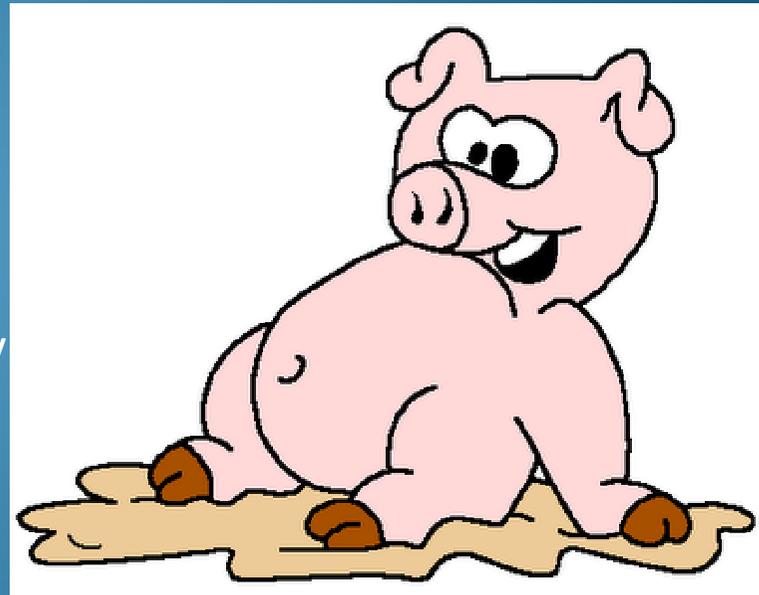
1. Is to provide you with some knowledge, examples, and innovations from this pilot project, that you may then wish to take back and incorporate into your own practice thereby making it your own!
2. Highlights how this pilot project incorporates the MOHLTC's seven themes (aka Beans) of priorities for FHTs; How it correlates with practice management of several chronic diseases and Utilization of upstream approaches to patient preventatives and screening.
 1. Achieving Patient Access: Quality and Targets
 2. Implementing Health Promotion and Chronic Disease Management
 3. Building Team Collaboration
 4. Optimizing EMR/Information Technology
 5. Reducing Hospitalizations
 6. Planning, Measuring and Governing for Quality Improvement
 7. Building Community Linkages and Partnerships

The Pork'n Beans of CDM.....

- THE PIG PROFILE

Instructions:

- 1. Draw a pig
- 2. Do not look at your neighbour's pig
- 3. Your pig must be of the animal variety



BEAN # 1.

ACHIEVING PATIENT ACCESS:

Principles:

Work at the high end of expertise

- team approach to care
- application of information technology
- alignment of skills with tasks

Align care need and preference

- office appts with physician/
other providers /joint
- telephone appts
- online communication
- home/OPD/Emerg/dialysis visits

Serve when service is needed

- advanced access scheduling

Characteristics:

Availability

- geographic, physical

Appropriateness

- proper level of care

Preference

- provider and service

Timeliness

- receive care when desired



BEAN #2

IMPLEMENTING HEALTH PROMOTION & CDM

- What is a Practice Based Nurse in Chronic Disease Management and Prevention?
- A specialized RN trained in the management & prevention of Chronic Diseases such as COPD, Asthma, Cardiovascular Disease, Smoking Cessation, Chronic Pain, Diabetes, etc., as well as early preventive lifestyle changes/education, who would work from physician offices with physicians and other family practice staff for better CDM. Highest need CDM patients would be seen by our specialized clinics. Some patients would be seen by both, for seamless patient follow up between clinic and family practice visit which would encourage collaborative care (PEFHT Pilot Project, MOHLTC, 2011).



Examples of Implementation

- Meet patient population needs who are unwilling or unable to go to specialized clinics (DM2 videos, Education handouts, Pulmonary Rehab)
- Meet service to specific populations within practice setting who require CDM in **early** stages of chronic diseases or in **preventative** stages of CDM
- Provide proactive lifestyle changes in early stages of diseases in upstream chronic disease management
- Provide chronic disease management education to other PEFHT family practice staff and doctors, for outreaching chronic disease management throughout team settings (e.g. COPD/Asthma/Celiac Disease)

A Few More Examples...

- Provide models of collaborative care to other clinics/practices for community linkages (CCAC, Aging in Place, Community Care for Seniors, Foodbank, CCA, Smile, Alzheimers, etc.).
- Create, Use, Provide and Implement linkages of various Educational Tools for Family practice settings (e.g. Asthma Action Plans, COPD Action Plans, Pulmonary Re-hab At Home, Inhaler Technique handouts etc.).

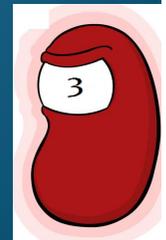
Rationale:

- Offer CDM in Family Practice (Trust, slow and over time)
- Geographical need (aging population (e.g. Pop by Age: 1996 51.2% > 40; 2006 61.8% > 40 (www.pecounty.on.ca, p. 27)
- Service to specialized population (underserviced, rural, accessibility)

BEAN #3

BUILDING TEAM COLLABORATION

- **Remember the Last 3 Delivery Service Objectives?....**To encourage **collaboration** between FHT specialized clinics and office (team management); Provide CDM education to FHT staff; Create education tools in Family Practice setting for sharing
- **Examples of Team Enhancements:**
- **Dieticians:** update all dieticians in Hastings and Prince Edward County, including PEFTH, on current updates to Celiac Disease (Yearly presentation & prn). They share with me, basic lifestyle nutritional resources, and joint care of referrals.
- **Pharmacy:** Joint project of cardiac drugs and associated blood work cheat sheet for office staff and as a learning tool.
- **CCAC:** Both within FHT setting and community linkage. Health Reports for LTC; Better Communication; Collaboration of At Home Pulmonary Rehab (6-8 visits OT/PT). Occas. Home Assessments and MNSE/MOCA



BEAN #3

BUILDING TEAM COLLABORATION

- **Diabetes:** Complicated may go to clinic (insulin adjusting, etc.), but we still see and do office 3 month f/u in collaboration (shared charting)
- **COPD/Asthma:** Correlation with this clinic. Spirometry. Bring different things to the table; share resources as mutual CRE's (NRT/Ottawa SmokingModel/CamTeach).
- **Rounds:** Dr. and team members EMR updates/new templates shared/ e.g. COPD/Asthma Action Plans and how to use them/templates/ICS cheat sheets/updates on Celiac Disease

BEAN #4

Optimizing EMR/Information Technology

EMR

- CPP
- Protocols and prevention
- CDM flowsheets

Med Tools

- improve consistency of message

Website

- improve access



BEAN #5

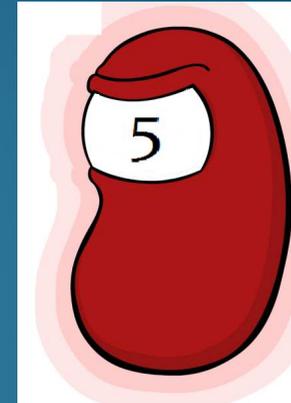
REDUCING HOSPITALIZATION

Initial Interventions and Results:

SMOKING CESSATION:

- CRE Training Used for Stats Below:
- Currently 31 Patients ranging from 16-88 years of age
- 10/31 Quits (32%)
- 9/31 In Progress (29%)
- Now am Camh/Teach Trained; Stop Program; Ottawa SC
- Ottawa SC: Pre: 4-7% & with Program 24-25% (U of Ottawa, p.4)

- “Risk of MI or stroke decreases by 50% within the 1st
- 2 years after Smoking Cessation due to effects on BP and
- Increased benefits of statins” (Circulation, 1997, p.1).
- Sheet: Hour – Week – Month Changes



BEAN #5

REDUCING HOSPITALIZATION

Short Term Examples:

COPD Action Plans (Self-Management Plan after completed areas of education & Standing Orders for Antibiotics & Prednisone).

- Managing 48 Patients
- RON: FEV1% 52%; MRC 3; Multi AECOPD (2008 x 2; 2009 x 1; 2010 x 2); Smoked 1-2 ppd x 30 years
- Last AECOPD required CPAP pending Intubation
- Education/Smoking Cessation/COPD Action Plan/Home 02....Success

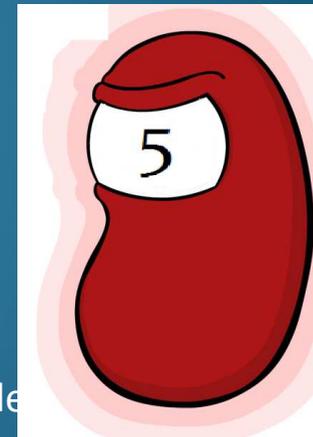
ASTHMA: Action Plans (Self-Management Plan after completed areas of education & Standing Orders for increasing ICS x 14 days)

- Managing 40 Patients
- Brian: Occupational Induced/Toxic Asthma; 7 ER visits < 2 years;
- Followed at large centre; smoked +marijuana (nerves); Trigger: 4 wheeler
- Education/ Asthma Diary- Triggers/Smoking Cessation/ Action Plan/Courses

- OTHER: In office Triage; never turning away (Pt. Access),

Better Case managing/communication. E.g. CCAC (decreased hospital time and duration of stay; stay at home; family meetings

- Lifestyle/Preventive Education - upstream education



BEAN #5

REDUCING HOSPITALIZATION: INCREASING QOL

- Long Term Implications:
- **SMOKING CESSATION:** “The single, most powerful preventative intervention in clinical practice” (Woolf, 1999).
- **COPD:** “4th leading cause of death in men & women. By 2020 : 3rd leading cause of death worldwide” (Resp Trec, 2008, p. 2). “At diagnosis FEV1% is <50% (Med ED, 2010) (exacerbations, treatment for bronchitis/pneumonia/mortality)
- How do we measure better Self Management of COPD Action Plans and avoided ER/Hospital visits? One Visit at a ! E.g. Ron.
- **ASTHMA:** “8.4% (2.2M) under age 12 have Asthma (one of the most common Chronic Diseases in the world) (Resp Trec, 2009, p. 2).
- How do we measure better Self Management of Asthma Actions Plans and avoided ER/Hospital visits? One Visit at a time! E.g. Brian, Rachel
- **DIABETES:** “Canada receives a “C” and ranks 14th out of 16 peer countries on mortality d/t diabetes. 2 million Canadians have diabetes; expectations in next decade are 3 million, (Confb, 2011, p. 1)
- How do we measure DM2 control (HgA1c improvements/control) related to ER visits, hospitalizations, amputation/retina complications/kidney (dialysis), etc.?

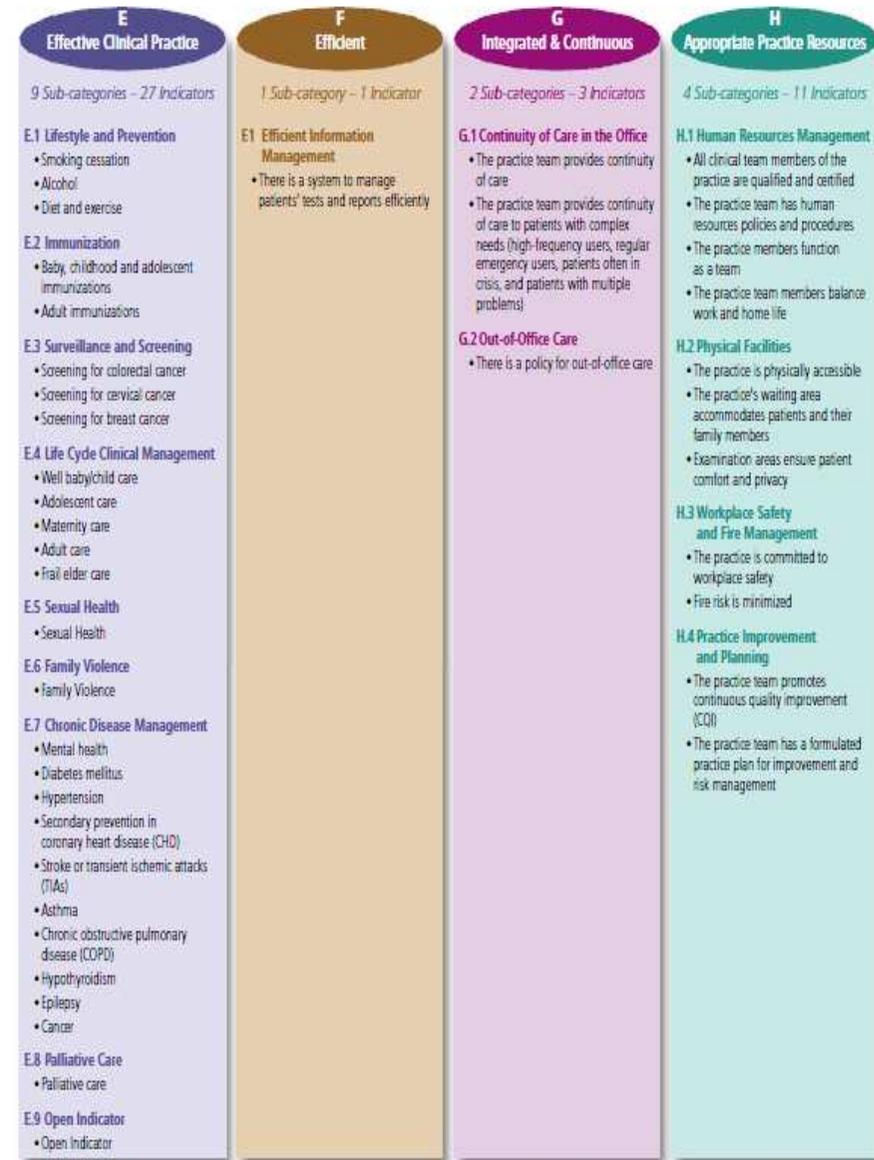
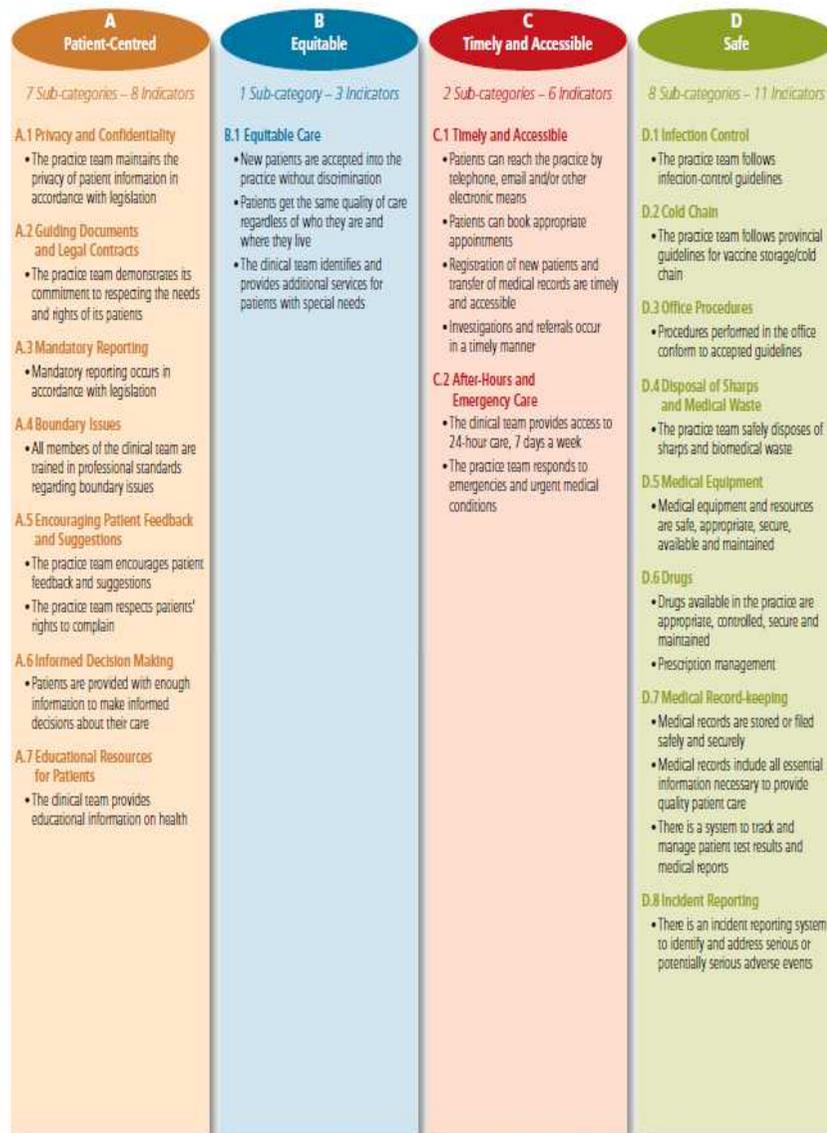
BEAN #6

PLANNING, MEASURING AND GOVERNING FOR QUALITY IMPROVEMENT

We Decided To Use: Quality in Family Practice Book of Tools
(McMaster University)



Figure 1. Categories and Indicators



This chart illustrates the categories, sub-categories and indicators of the Quality Book of Tools. There are 70 performance indicators: 43 practice management and 27 clinical indicators

Two Examples

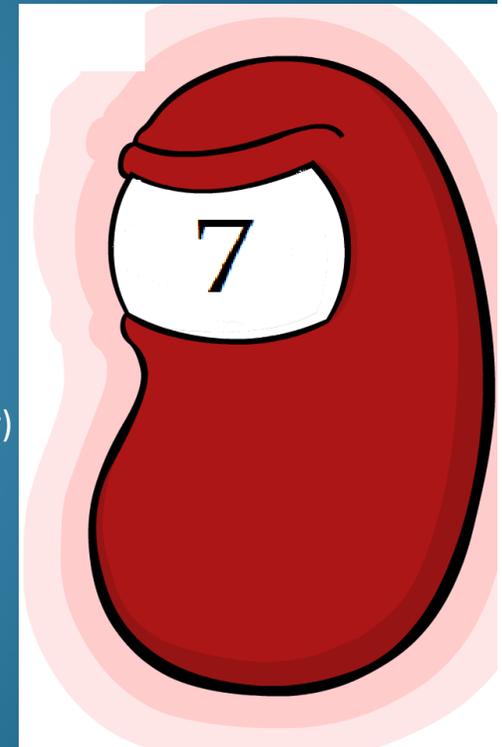
BEAN #7

Building Community Linkages & Partnership

- Remember Objective #5?...Provide models of Collaborative Care for Community linkages...

FOR THE PATIENT:

- Community Care for Seniors (referrals/services)
- CCAC
- First Link
- Alzheimers Society
- VON Alzheimers Day Program Moms & Tots Program (e.g. Toy Library)
- Lung Association (Breathworks, Resources, Tools,)
- Retirement Home (locations/contacts/prices)
- Nursing Home (locations/contacts/prices)
- Quinte Access
- Medigas/Vital Aire (oxygen, cpap, pedometer)
- CAS



BEAN #7

Building Community Linkages & Partnership

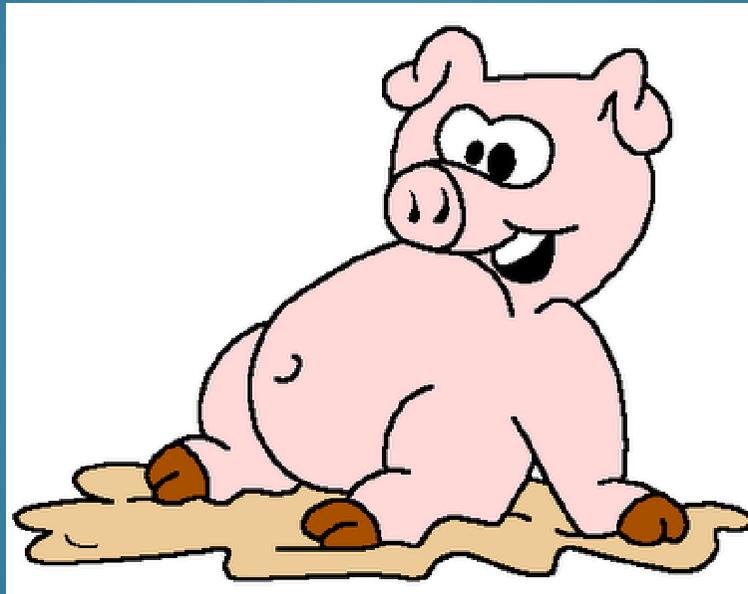
- Local Foodbank (recent promotion)
- Legion (free equipment/walks/commodes (affordability) e.g. copd pt/walking)
- Life-line
- Hospice/Respite//Cancer Society/MS Society, etc.
- Quinte Access (transportation - Rural issues)
- CCA
- Local Health Clubs (discounts/services/indoor walking)
- Health Unit (services)
- Analphylaxis Course (School Education)
- Loyola College Advisory: PSW education - yearly
- St. Lawrence and Loyalist College Preceptorship
- Community Police Officer (Drug abuses/handouts, trends)

OUTSIDE: THE INTERNATIONAL BOUNDARY:

- Quote from newspaper 2010
- Recent Project: Samaritan's Purse: Operation Christmas Child & Wellington Storehouse Food bank: (staff/patients - knitting/crafts/barbie doll clothes/toys/summer sales -- filling boxes. COPD patients knitting wash clothes for boxes/sitting and helping fill them (CDM (finding what you can do!)).

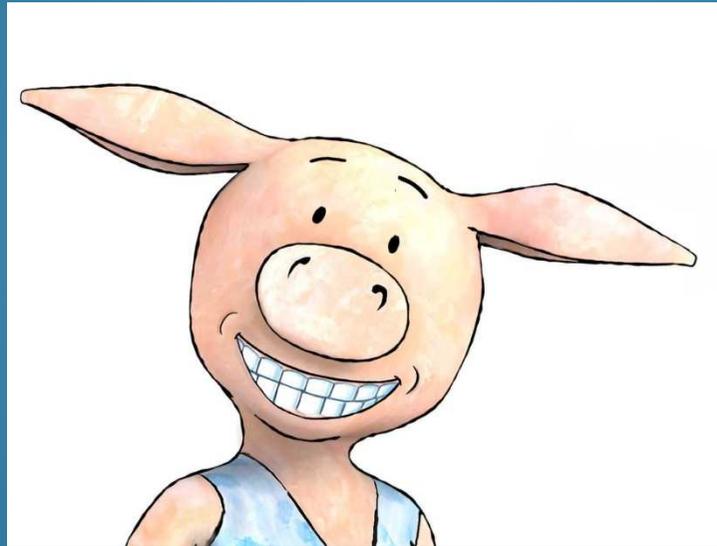
SUMMARY:

- LET'S GO BACK TO THE PIG.....



WHAT DOES YOUR PIG LOOK LIKE????

INTERPRETING THE PIG PROFILE.....



WHAT ARE YOUR UNIQUE QUALITIES???

Plug in your pig



- "A nurse trained or specialized in the management & prevention of Chronic Diseases such as COPD, Asthma, Cardiovascular Disease, Smoking Cessation, Chronic Pain, Diabetes, etc., & early preventive lifestyle changes/education, who would work from physician offices with physicians and other family practice staff for better CDM. Highest need CDM patients would be seen by our specialized clinics. Some patients would be seen by both for seamless patient follow up between clinic and family practice visit which would encourage collaborative care."(PEFHT Pilot Project, MOHLTC, 2011)



- AND ADD IT TO THE 7 BEANS (MOHLTC'S PRIORITIES) FOR FAMILY HEALTH TEAMS TO EQUAL "THE PERFECT RECIPE....."

THE PORK'N BEANS OF CDM....



MAKE THE RECIPE YOUR OWN!

- **QUESTIONS OR COMMENTS???**



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