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# South East Community Health Centres (CHCs)

## Chronic Disease Prevention & Management Network:

## An Integrated Approach to CDPM

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# SE CHCs CDPM Network Purpose 2008-10

To Establish:

- Collaborative partnerships among CHCs with a focus on Increasing Service Quality and Evidence Based Practice
- Collaborative Partnership CDSMP – *Living Well with Chronic Conditions*
- Stroke Prevention - Health Promotion in Primary Care Goal- improve processes to recognize and address common risk factors in primary health care

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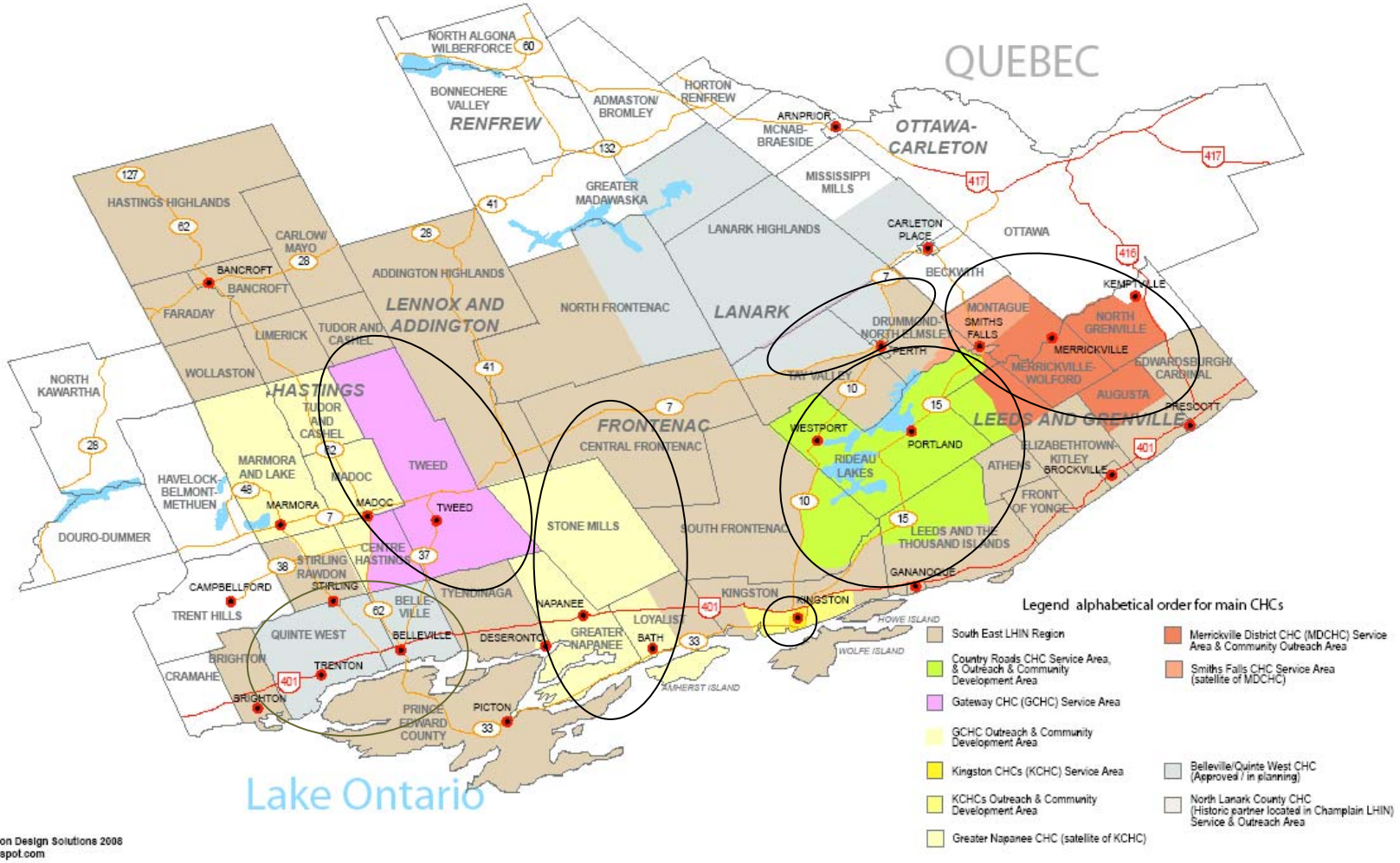
# South East Community Health Centres CDPM Network Community Catchment Areas

*Existing & Under Development*




Created by Charles Johnston Design Solutions 2008
www.johnstoncharles.blogspot.com

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# By the end of the hour we will have…

1. Reviewed the project purpose and evaluation methods
2. Illustrated the project approach in each CHC
3. Examined most significant project results for providers and clients
4. Examined the project results for CHCs as organizations
5. Synthesized the most important lessons learned

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# STROKE PREVENTION

## Health Promotion in Primary Care

**Project Goals:**

- To increase awareness of risk factors of stroke
- To increase the uptake of health promotion concepts by primary health care teams
- To improve outcomes / reduce risk for clients by identifying risk, providing education & referral to health promotion and community prevention resources

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# The Approach

**Country Roads CHC** –Healthy Heart Clinic

- Target – 50-70 years of age with Dx of hypertension, hyperlipidemia or no recorded BP /Lipid level in past 12 months
- Team of physician, NP, RN – Risk assessment using 10 year CDRA, monitor clinical status using CHEP BPG, education and lifestyle counselling using SM / action planning

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# The Approach

**Gateway CHC** - Co Managed BP Program

- Target – men >40, women >50 with elevated BP but no Dx of hypertension
- Care pathway established delineating roles for physicians/NP and RPN ( clinical, education & SM)
- 4 week educational group program for individuals not meeting age criteria & at risk with hypertension, hyperlipidemia , obesity etc

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# The Approach

**Kingston CHC**

- Target – Aboriginal population with identified risk factors
- 6 week educational group program co-facilitated by aboriginal health professionals
- Content and delivery format developed by aboriginal population

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# The Approach

**Merrickville District CHSC** – Take 10

- Target – women > 50 with Dx of hypertension, hyperlipidemia & obesity
- 10 week program - Combination of group & individual sessions include screening, clinical monitoring, counselling, education and SM

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# Examining Project Evaluation Findings

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# Evaluation Methods

- Review and analyse project docs – proposal, progress reports, group feedback forms
- Review and analyse evaluation tools and indicators
  - pre- and post- provider surveys
  - pre- and post- client surveys
  - project intervention charts summaries
  - Clinical indicators
- Semi-structured interviews with health promotion champions, providers and clients (21 total)

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# Limitations of the Evaluation Process

- Uniqueness means distinctive strengths and challenges across sites
- No easy roll up of results and numbers
- Limitations of evaluation tools
- Highlight common results across sites in three areas: for providers, for clients, for CHCs

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# % of Men over age 40 with a BP measurement in a 24 month period

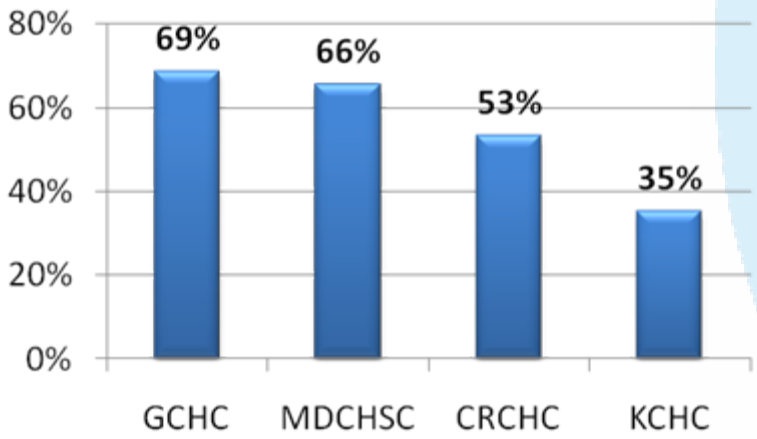
**Numerator**: Primary care male clients, with an active status, over 40 years of age who had a BP measurement recorded in a clinical note using Purkinje.

**Denominator**: Primary care male clients, with an active status, over 40 years of age.

**Calculation**: Numerator divided by denominator times 100.

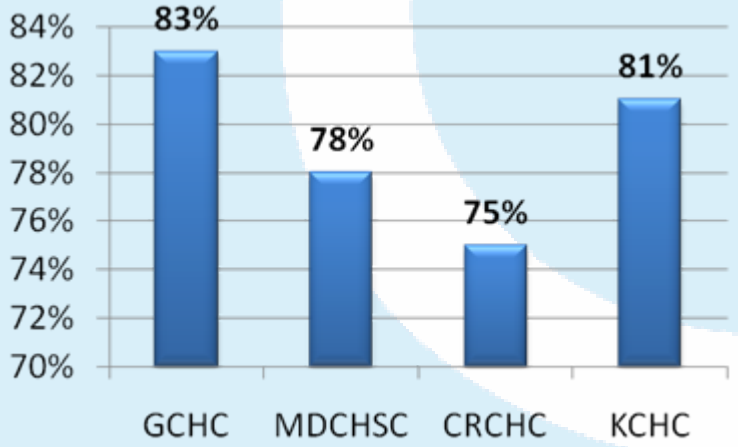
***Timeframe: Oct 1 2007 to Sept 30 2009***

| | Num | Den | YTD |
|---|---|---|---|
| **GCHC** | 758 | 1104 | 69% |
| **MDCHSC** | 741 | 1131 | 66% |
| **CRCHC** | 567 | 1063 | 53% |
| **KCHC** | 324 | 918 | 35% |




***Timeframe: April 1 2008 to March 31 2010***

| | Num | Den | YTD |
|---|---|---|---|
| **GCHC** | 859 | 1041 | 83% |
| **MDCHSC** | 818 | 1052 | 78% |
| **CRCHC** | 723 | 969 | 75% |
| **KCHC** | 356 | 441 | 81% |

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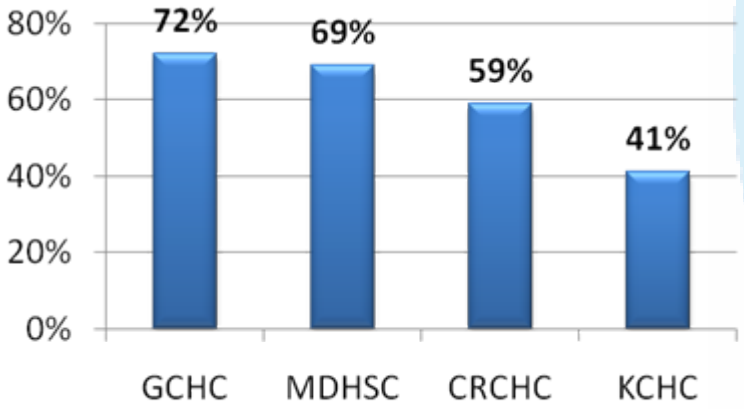
# Indicator: % of Woman over age 50 with a BP measurement in a 24 month period

**Numerator:** Primary care female clients, with an active status, over 50 years of age who had a BP measurement recorded in a clinical note using Purkinje.
**Denominator:** Primary care female clients, with an active status, over 50 years of age.
**Calculation:** Numerator divided by denominator times 100.

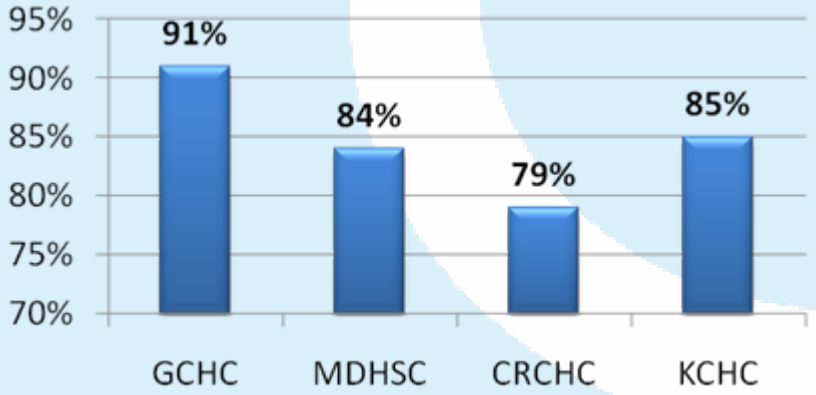
***Timeframe: Oct 1 2007 to Sept 30 2009***

| | Num | Den | YTD |
|---|---|---|---|
| **GCHC** | 667 | 922 | 72% |
| **MDCHSC** | 739 | 1069 | 69% |
| **CRCHC** | 563 | 962 | 59% |
| **KCHC** | 289 | 705 | 41% |




***Timeframe: April 1 2008 to March 31 2010***

| | Num | Den | YTD |
|---|---|---|---|
| **GCHC** | 753 | 827 | 91% |
| **MDHSC** | 787 | 936 | 84% |
| **CRCHC** | 677 | 853 | 79% |
| **KCHC** | 339 | 399 | 85% |

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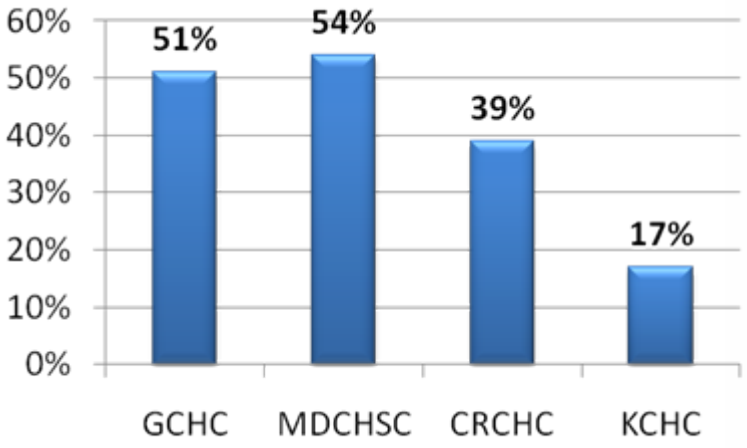
# % of Men over age 40 with a lipid profile in a 24 month period

**Numerator:** Primary care male clients, with an active status, over 40 years of age who had a lipid profile measured and recorded in a clinical note using Purkinje.
**Denominator:** Primary care male clients, with an active status, over 40 years of age.
**Calculation:** Numerator divided by denominator times 100.

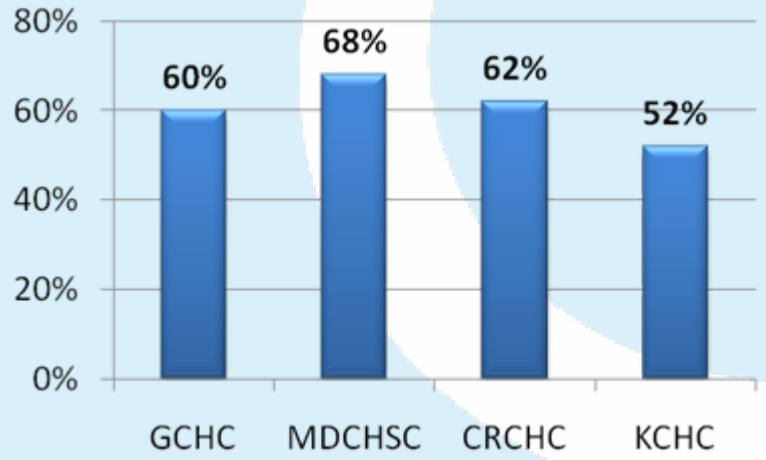
***Timeframe: Oct 1 2007 to Sept 30 2009***

| | Num | Den | YTD |
|---|---|---|---|
| **GCHC** | 564 | 1104 | 51% |
| **MDCHSC** | 608 | 1131 | 54% |
| **CRCHC** | 413 | 1063 | 39% |
| **KCHC** | 158 | 918 | 17% |




***Timeframe: April 1 2008 to March 31 2010***

| | Num | Den | YTD |
|---|---|---|---|
| **GCHC** | 622 | 1041 | 60% |
| **MDHSC** | 715 | 1052 | 68% |
| **CRCHC** | 600 | 969 | 62% |
| **KCHC** | 228 | 441 | 52% |

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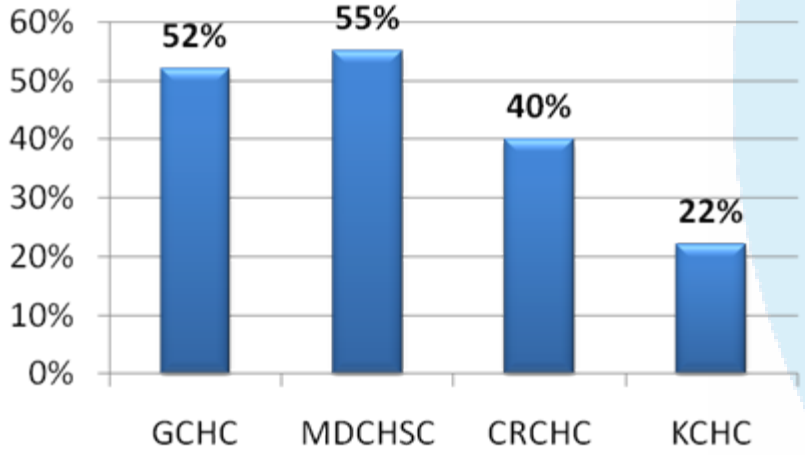
# % of Woman over age 50 with a lipid profile in a 24 month period

**Numerator:** Female clients, with an active status, over 50 years of age who had a lipid profile measured and recorded in a clinical note using Purkinje.
**Denominator:** Female clients, with an active status, over 50 years of age.
**Calculation:** Numerator divided by denominator times 100.

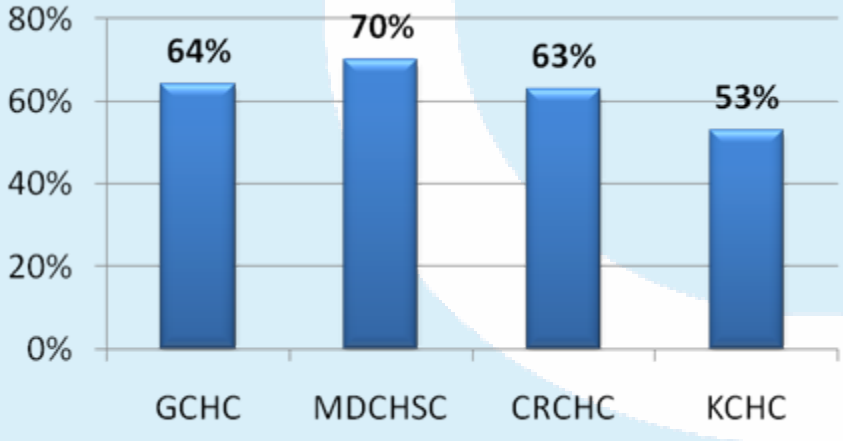
***Timeframe: Oct 1 2007 to Sept 30 2009***

| | Num | Den | YTD |
|---|---|---|---|
| **GCHC** | 475 | 922 | 52% |
| **MDCHSC** | 590 | 1069 | 55% |
| **CRCHC** | 387 | 962 | 40% |
| **KCHC** | 157 | 705 | 22% |




***Timeframe: April 1 2008 to March 31 2010***

| | Num | Den | YTD |
|---|---|---|---|
| **GCHC** | 528 | 827 | 64% |
| **MDHSC** | 654 | 936 | 70% |
| **CRCHC** | 537 | 853 | 63% |
| **KCHC** | 238 | 399 | 60% |

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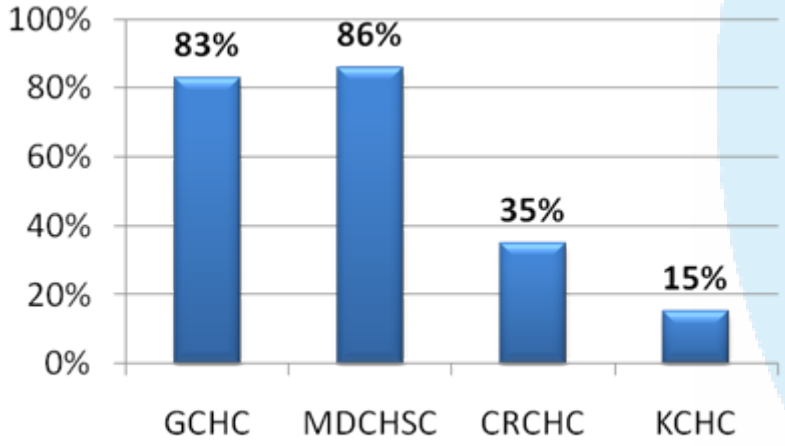
# Clients over age 18 with obesity screening in 24 month period

**Numerator:** Primary care Clients, with an active status, over 18 years of age who had obesity screening done and recorded in a clinical note using Purkinje.
**Denominator:** Primary care clients, with an active status, over 18 years of age.
**Calculation:** Numerator divided by denominator times 100.

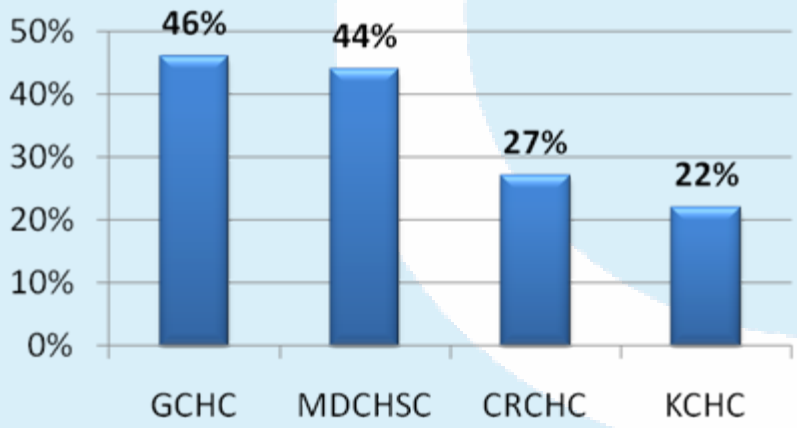
***Timeframe: Oct 1 2007 to Sept 30 2009***

| | Num | Den | YTD |
|---|---|---|---|
| **GCHC** | 2458 | 2946 | 83% |
| **MDCHSC** | 3410 | 3959 | 86% |
| **CRCHC** | 965 | 2752 | 35% |
| **KCHC** | 432 | 2873 | 15% |




***Timeframe: April 1 2008 to March 31 2010***

| | Num | Den | YTD |
|---|---|---|---|
| **GCHC** | 1369 | 2991 | 46% |
| **MDHSC** | 1551 | 3491 | 44% |
| **CRCHC** | 740 | 2,767 | 27% |
| **KCHC** | 477 | 2155 | 22% |



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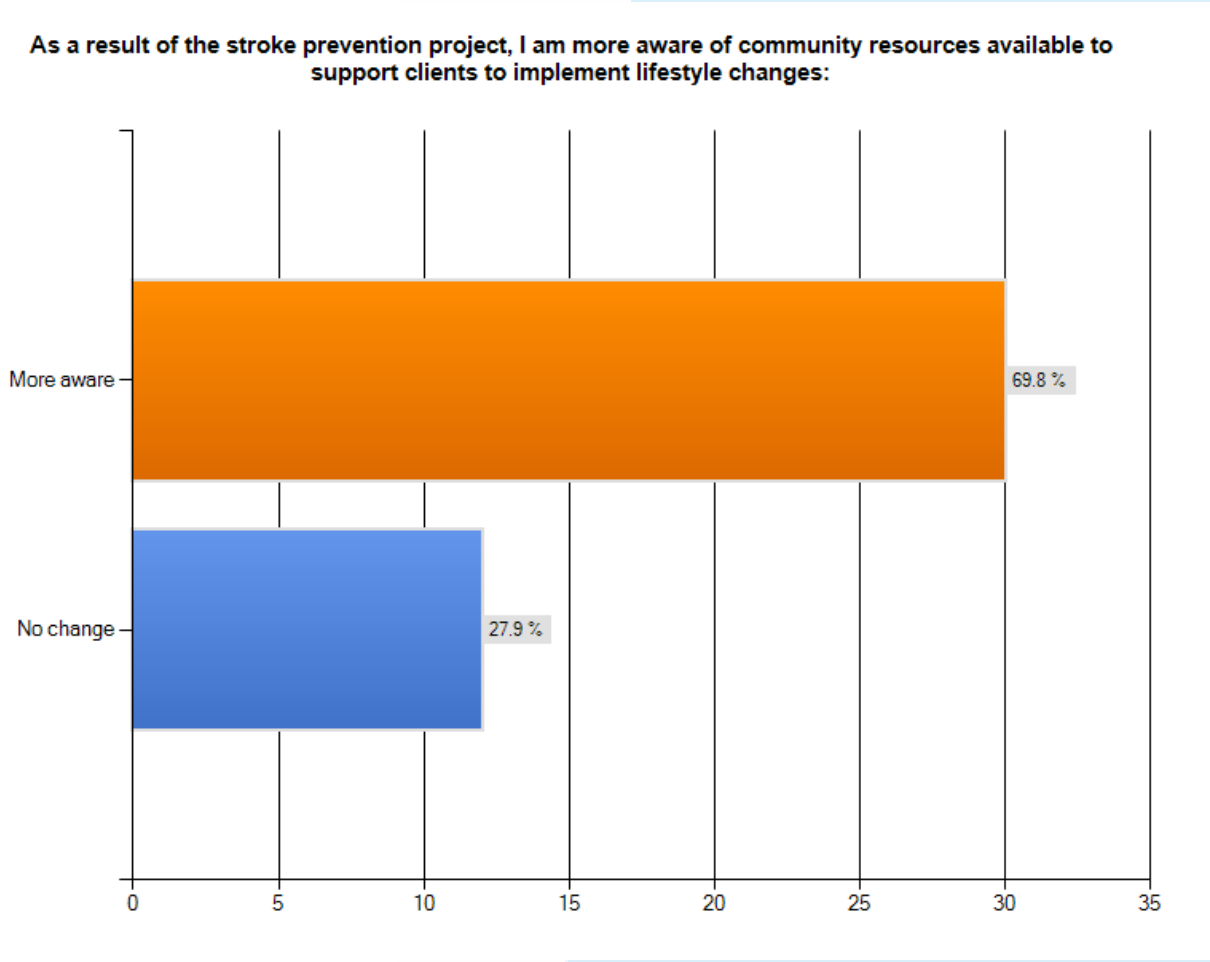
# Results for providers

- Increased awareness of community resources

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# What did primary care providers say?

"We've been finding that [nurses] have been doing a good job of identifying other external resources – there are things I don't know about, and they've been doing a good job of plugging people in to external resources." – Physician

"I know medically what the patient needs, but they also need to get to access that, improve their motivation through education, and know that someone is there who knows all the resources. For physicians it's confusing, what was there six months ago is not there now. This is where I found the [health promotion champion] very valuable." - Physician

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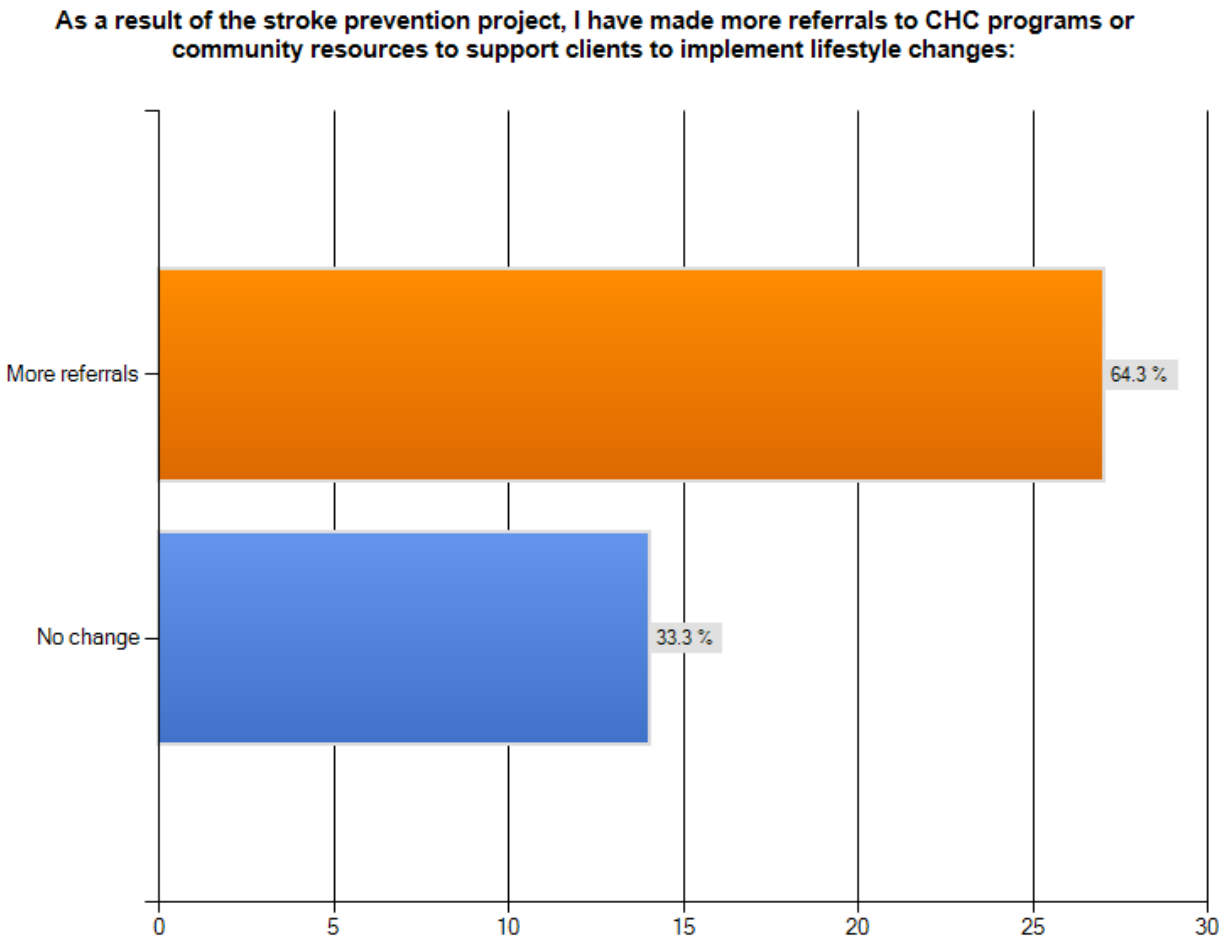
# Results for providers

- Increased referrals to CHC programs or community resources



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# What did providers say?

"We have learned to rely more on other paramedical players in the team. I don't have to be responsible for all the indicators, all the lifestyle changes. I can refer to other people and they can do their thing... It hasn't changed how I treat the patients in the situation. It's just that I am more aware of how I can get patients to access resources that might be helpful to them." – Physician

"The project was centred around primary care, but it also involved the whole interdisciplinary team – social workers, dieticians and so on. This is not unusual for CHCs, but through the project, I have upped my referrals for sure." – Nurse

"I refer more to [the health promotion champion] now. I'm referring younger people with risk factors – smokers, people with high cholesterol, people who are overweight – more so that before…The net is cast wider." – Nurse Practitioner

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# Further results for providers

- No evidence from provider survey of increased awareness on modifiable risk factors or of change to how providers discuss risk factors with clients

- More hesitance to discuss alcohol abuse with clients than any other risk factor

"There are so many risk factors, you just can't cover them all in a minute. This is why I found what [the health promotion champion] was doing was so valuable. If we went over everything with every patient, we'd never get everything done, it's too much."

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# Results for Clients

- Increased awareness and behavior change, particularly on healthy eating and physical activity

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# What did clients say?

"I learned that [even] minimal physical activity will improve our health, and that nutrition is so important. Garbage in, garbage out!"

"My eating has changed a lot for the better – lots of fruit and vegetables. I find that I go after the salt and the fat. I'm finding since I've lost the weight that I can garden better, do stairs better. I'm more active than I used to be… I'm really thrilled that I've lost weight." – Female client

"I am a totally different person. I watch everything I eat. I've broken the sugar addiction. I'm reading labels again. I watch my salt intake. I joined the gym and work out five times a week. I walk whenever I can. It's like I have a new lease on life. I am 100% feeling fit and healthy. I feel alive. I feel like the years have been washed away from me." – Female Client

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# Results for Clients

- Self-management matched with provider follow-up and support has been an effective tool to promote lifestyle change


"A strength of the project is when the clients are very involved in the learning process, self-management" - Dietician

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# What did clients say?

"Planning. The goal plan for the week. Holding yourself accountable. 'I will do this, this many times, this is my intent.' I had copies of the blank paper made and use them at home." – Female client

"Since being part of the project, I think I am a bit more motivated now." – Male client

"It's a combination of a number of things I learned over the weeks. It started easy – just taking my blood pressure and getting the Canada Food Guide. The most important thing I got was the support from the [health promotion champion]. She sat with me and said, 'I'm going to help you with this'." – Female client

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# Results for CHCs

The project intended to touch:

- Interdisciplinary primary health care teams - increased use of health promotion concepts
- Clients – better outcomes and reduced risk
- CHCs/Organizations – new and more effective ways (systems, practices, norms) to do health promotion that will continue after the project

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# Results for CHCs

- Mixed impact on ongoing health promotion practices from high to low on the continuum

Highest ongoing impact in CHCs who began with a plan to integrate project activities into ongoing work and who used both individual and group approaches

Lowest ongoing impact in CHCs who used a group approach only and did not effectively link individual clients with primary care providers

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# Results for CHCs

- Nurses empowered to do deeper health promotion – time, resources, support from management and primary care providers

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# What did nurses say?

"The project has really changed my practice. I focus more not on my agenda but on their agenda. We look at their goals and how they want to achieve them."

"Before, I wasn't always comfortable with what I should or should not be saying. Now, it's opened the door of 'Yes, we want you to do this health teaching.' We don't feel like we're stepping on toes. It's totally changed how I am with clients. Before I would feel, 'Should I or shouldn't I? What does the doctor want me to say?' Now, it's given me a broader comfort zone with health teaching… We have increased our awareness on health teaching. We've had a learning curve as well."

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# Lessons Learned

1. Provide consistent upper management support and attention

"There wasn't much direction at the beginning of the project. We were told, find a champion. Other than that, you had to figure what you were doing on your own. I had no guidance from my manager, and no oversight once I started."

"If you're going to take on a project of this magnitude, make sure you have the resources to do it. And don't keep changing the key players. If you have someone designated at two days a week to support the project, they can't be called out to other work."

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# Lessons Learned

2. Consider an integrated sustainable approach rather than an "add-on" approach to new health promotion project activities

"We wouldn't have been able to do it without the money – the time to integrate the principles and support the employee… [But] there's no point in doing a project if you're not going to integrate it."

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# Lessons Learned

3. Involve primary care providers at the front end to get their input and ownership

> "If I could do it all over again, I would do a better roll out than we did. I'd have a meeting and tell all the providers, this is what it's about, this is what we think will work, but what do you think? I'd get buy-in and input from the providers, and then take that info and decide. I would like their input, which I didn't get."

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# Lessons Learned

## 4. Empower nurses to work to their scope of practice as health promoters

"How do you get doctors to respect the work of the RPN? They are used to seeing them in a particular scope of practice. With this project, they begin to see the critical thinking and the health promotion they can bring. The RPNs can work in meaningful ways, in a way that supports physicians, and ultimately, the client."

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# Other Lessons Learned

5. Embrace an interdisciplinary team approach

6. Use a regional approach to add value to project design and implementation

7. Keep evaluation tools useful and consistent

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# Evaluation

## Process Evaluation

- Importance of engaging the team in planning and delivery of new practice
- Value of regional collaboration and learning from each others experience
- Importance of sensitivity to cultural differences and adapting programs to respond to those differences
- Benefits of professionals working to full scope of practice

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# Achievements

- Common risk assessment screening tool for stroke
- Provider survey –demonstrated change in awareness and referral practices
- Client survey –demonstrated evidence of behaviour change
- Motivational interviewing training for over 90 practitioners – to be repeated in 2010/11
- Client education tool kit
- Integrating early identification, self management and life style counseling into practice

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# Questions and Discussion!

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