Current State Assessment: Health Line Support to Chronic Disease Management

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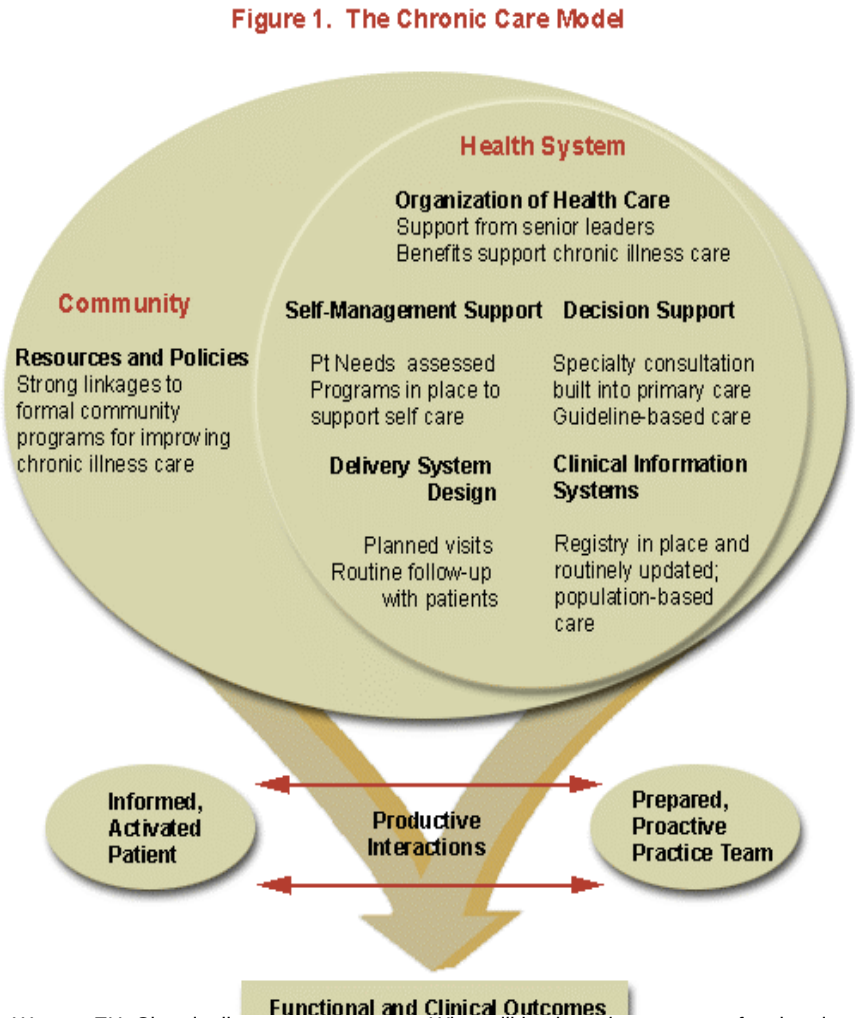
Jeanne Legare for the Quality Improvement of Literacy, Telecare and Self Help *(QUILTS)* Collaborative

Whole Population Approaches to CDM

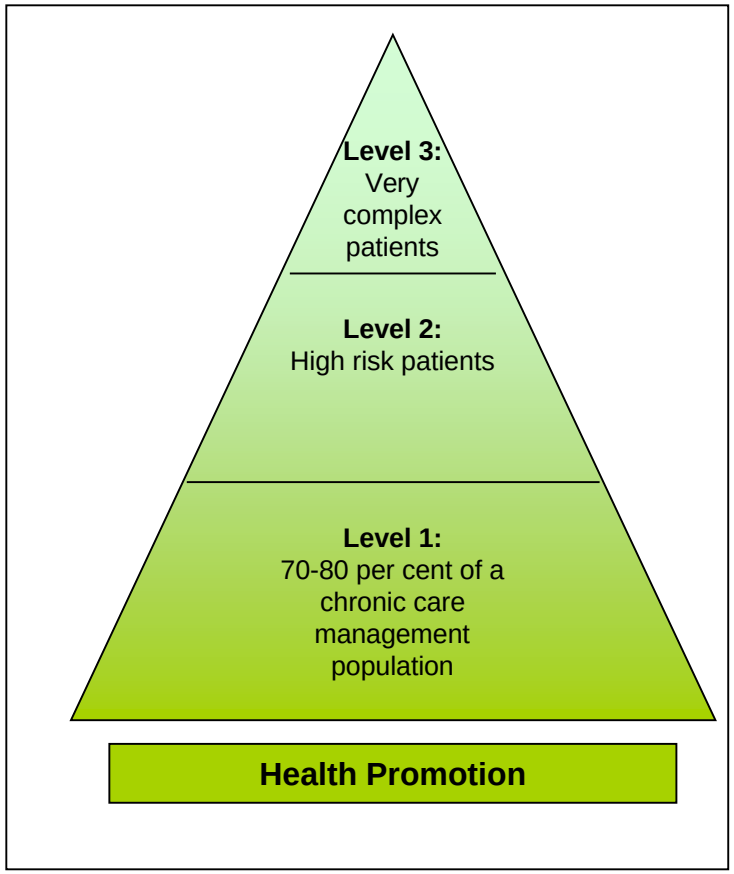
- Disease avoidance, better management
- Integrated programming spanning prevention, early identification and active disease management
- Health system and community interventions ("high tech-low tech")
- Wegner chronic care model



Wagner EH. Chronic disease management: What will it take to improve care for chronic illness? Effective Clinical Practice. 1998;1:2-4.

Disease Management Approaches to CDM

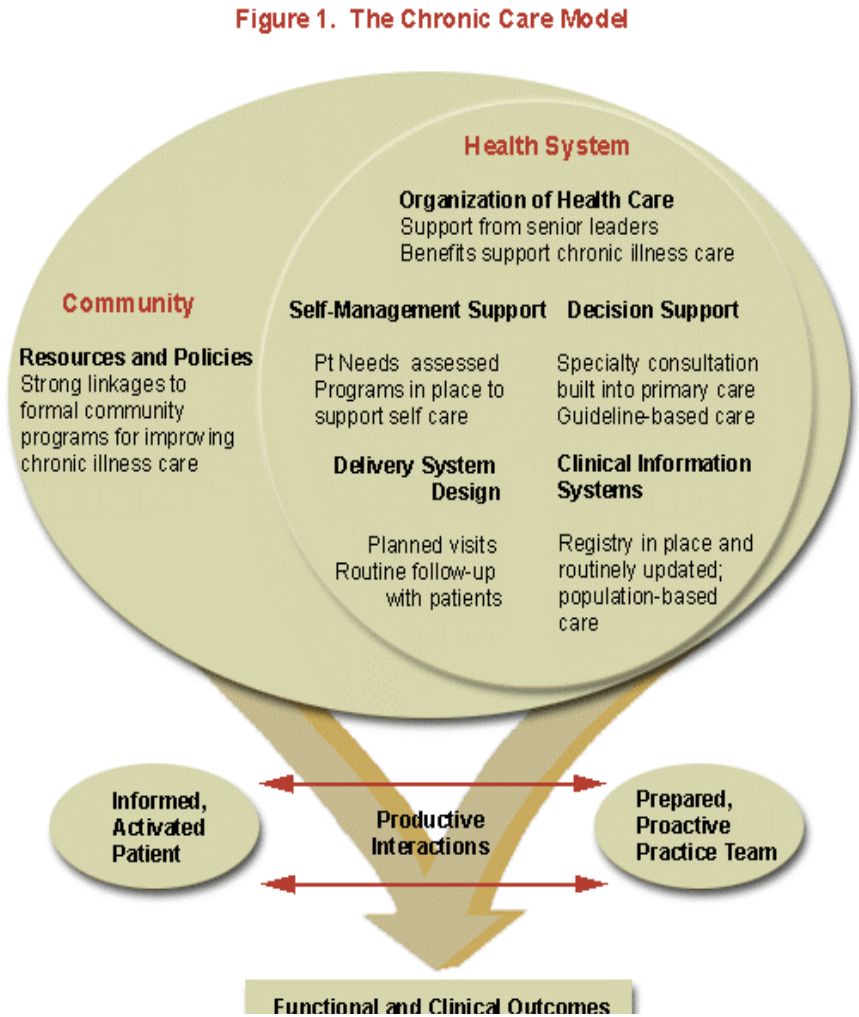
- Better management, slow progression
- Interventions tend to focus on highest risk
- Lends toward high-tech solutions (home technology supports and monitoring)
- Often focused on single disease rather than co-morbid conditions



Adapted from: Learning Distillation of Chronic Disease Management Programmes in the UK, MATRIX Research and Consultancy, 2004

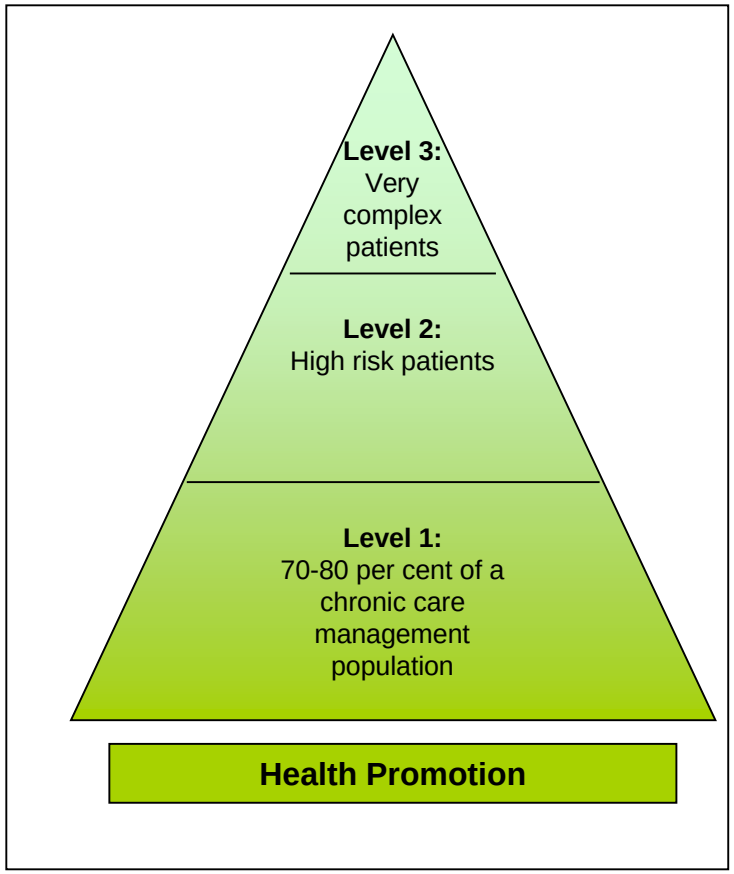
Health Lines Support

- Navigation and linkage
- Patient self-management
- Decision-support
- Delivery system redesign (new roles in identification, assessment, triage, monitoring, follow-up, education, case management…)
- Share in clinical information systems



Health Lines Can Support

- Identification of chronic care patients
- Risk assessment
- Low intensity interventions such as assessment, education, follow-up and linkage
- High-intensity interventions such clinical monitoring



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What Does the Evidence Say?

- Lots of evidence on effective chronic disease strategies (disease management, education and behaviour change literatures)
- Health lines are part of multifaceted interventions: no specific evidence on HLs alone
- Look to the intervention (Is it evidence based? Is the health line role supported by evidence?)
- Look to the population (Are they connected to health lines?What scope/range of benefits is achievable/acceptable?)
- Look to the partners (are they ready to make the commitment to a joint health line service solution?)

Lessons Learned

- Integrate – health lines are not a stand-alone solution
- Establish credible relationships with primary care teams **before** the intervention
- Avoid “silo effects” from isolated strategies or single disease management approaches
- “Off the shelf” modules and protocols **will** need to be customized
- Information management supports are key!

Lessons Learned (2)

- Identification, retention and recruitment of patients for health line programs is challenging
- High intervention programs can create dependencies – have a transition strategy
- Patient outcomes will depend on the overall quality of care received
- Outbound calls have a different dynamic than inbound – can require additional layers of organizational support and infrastructure

Looking Forward

- Recognize opportunities to leverage existing infrastructure to create or take on new roles within regional chronic care initiatives
  - 24/7 access
  - Trained virtual health professionals
  - Telephony infrastructure
  - Electronic connectivity (web/internet, etc)
  - Multilingual and TTY capacity

How?

- Building on core capacities
  - Education, standard assessment, follow-up, triage, navigation
- Expanding to new capacities
  - Clinical care supports - integration with local health services is essential
  - EMRs, shared care plans – the key to integrated patient management

Thank You

Jeanne Legare

jeanne.legare@shaw.ca

604-738-6914