A First Step on the Journey to High-Quality Chronic Illness Care

Un premier pas sur le chemin des soins de grande qualité pour les maladies chroniques

COMMENTARY
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Edward H. Wagner, MD, MPH
Group Health Research Institute Senior Investigator
Director (Emeritus), MacColl Center
Seattle, Washington

Chercheur principal, Group Health Research Institute
Directeur (émérite), MacColl Center
Seattle, Washington

ABSTRACT

The Atlantic Healthcare Collaboration (AHC) conducted a quality improvement initiative to improve chronic disease prevention and management for the four Atlantic provinces and their regional health authorities. Leaders and front-line teams carried out a range of projects, each suited to the needs of that region. This initiative helped build the case for improvement, increased the motivation to change, exposed participants to proven ideas for improvement and supported participating organizations in developing the capacity and culture to test, implement and spread improvements. The AHC also created a politically safe learning community with the potential to support and sustain the work of chronic care improvement over time. In carrying this initiative forward, the greatest challenge will be the magnitude of work to be done.

RÉSUMÉ

La Collaboration des organismes de santé de l'Atlantique (COSA) a piloté une initiative d'amélioration de la qualité en vue de faire progresser la prévention et la gestion des maladies chroniques dans les quatre provinces de l'Atlantique et dans leurs autorités sanitaires régionales respectives. Des dirigeants et des équipes de première ligne ont mené à bien une série de projets, chacun étant adapté aux besoins de sa région. Cette initiative a contribué à prouver la pertinence des efforts d'amélioration, à accroître la motivation en faveur du changement, à exposer les participants à des idées avérées en matière d'amélioration et à aider les organismes participants à élargir leurs capacités et à instaurer une culture de la mise à l'essai, de l'exécution et de la diffusion des améliorations. Par ailleurs, la COSA a créé un environnement où les participants pouvaient apprendre en toute sécurité, à l'abri de considérations politiques, en vue d'appuyer et de pérenniser des travaux d'amélioration des soins chroniques au fil du temps. À l'avenir, le plus important défi de cette initiative consistera à composer avec l'ampleur du travail à abattre.

Many in Canada and elsewhere view it as a strength that provincial and regional governments play the predominant roles in the organization and delivery of Canadian healthcare. Variation across provinces or regions creates opportunities for comparison and learning, but it may also impede the spread of evidence-based best practices. The Atlantic Healthcare Collaboration (AHC) involves the four Atlantic provinces and their Regional Health Authorities (RHAs) in a quality improvement (QI) initiative to improve chronic disease prevention and management for their populations. The AHC encouraged participating RHAs to select QI projects based on regional strengths and weaknesses and population needs but urged that each project should base its intervention on the Chronic Care Model (CCM) (Coleman et al. 2009; Stellefson et al. 2013), an evidence-based framework for redesigning care to improve the health of people with chronic conditions. Helping chronically ill people become more skilled managers of their own illness and more engaged participants in their care was a particular AHC focus. Each RHA team received support and assistance from an improvement coach, an academic mentor, other faculty and the other participating RHA teams in in-person learning sessions, webinars and telephone calls. As expected, the RHA teams chose a wide variety of projects, ranging in scope from an ambitious effort to train all healthcare clinicians in the region in self-management counselling to more localized and focused programs to improve services to high-risk youth and patients with chronic obstructive pulmonary disease.

The decision to emphasize patient engagement and self-management, in my view, was a wise one. Engagement, in the context of the collaborative, refers not only to a patient's participation in his or her own care, but also to patient involvement in the design and improvement of health systems. There are several persuasive reasons for beginning the journey of chronic illness care improvement with patient engagement. First, it applies to all chronic conditions or constellations of conditions. Second, engaged patients manage their illnesses better, which leads to better outcomes (Hibbard and Greene 2013). Third, our QI experience suggests that self-management support is the aspect of the CCM with which practices have the most difficulty making and sustaining improvements over time. Finally, patient involvement in delivery system improvement adds a crucial customer

perspective to the process. Organizations that have made serious efforts to form patient advisory committees and routinely include patients in QI activities generally come to appreciate the constructive impacts of adding patient voices.

Despite the high level of support given each RHA, only four of the eight participating teams in the AHC implemented their planned projects over the two-year period. Was bringing together RHA leaders and front-line teams a promising start on the journey to better care for the chronically ill or a well-intentioned waste of time? Evaluations of QI collaboratives generally find weakly positive effects (Nadeem et al. 2013; Schouten et al. 2008). The modest success of most collaboratives is a function of the broad variation in the extent of changes to care delivery made across participants. Participants in all collaboratives, whether small practices or large organizations, vary widely in their commitment to change, their understanding of what changes to make, and their ability to make changes to entrenched systems. As a result, a substantial percentage of participants (20–50%) in most collaboratives report little to no improvement over the course of the initiative. Nutting and colleagues, in their evaluation of a major primary care transformation effort, proposed that practices that failed to change lacked the leadership, communication and trust needed to disrupt traditional ways of doing things (Nutting et al. 2011). In a study of primary care practices that made major improvements in a collaborative, we too found that engaged leadership was critical, but so too was a well-established QI strategy (Wagner et al. 2014). Organizations without a trusted measurement system and process-change approach floundered even if their leaders were committed.

Nolan has described three essential elements for successfully improving the quality of healthcare: will, ideas and execution (Nolan 2007). Will is the motivation to engage in the difficult work of altering established ways of organizing and delivering care. Ideas are specific interventions or system changes derived from research or from successful exemplar organizations. Execution is the capacity to actually make system changes and sustain them over time. Leaders are central to building will and helping staff see the ideas for change as the basis for a better future. But without a robust QI strategy based on regular performance measurement, and QI teams using rapid-cycle change methods to test and then implement new ideas, a health system of any size will have difficulty making meaningful changes that improve its performance.

A well-run collaborative such as the AHC helps build the case for improvement, increases the motivation to change, exposes participants to proven ideas for improvement and tries to help participating organizations develop the capacity and culture to test, implement and spread improvements. This takes time, often more time than the duration of the collaborative allows. For example, in their evaluation of the Health Disparities Collaborative (HDC), a US nationwide effort from 1998 to 2004 to use the CCM to improve diabetes care in safety net practices, Chin and colleagues (2007) found that HbA1c levels were not significantly improved among HDC practices two years after the start but were so when assessed four years after the start. In our recent work with safety net practices (Sugarman et al. 2014), several of which had participated in the HDC, we often heard that it took practices several years to fully integrate and implement what they learned in the HDC.

For many teams, the AHC brought together individuals and organizations without much experience collaborating, so team building and finding common ground amidst disparate interests were essential early steps. Policy makers and regional leaders

wrestling with balancing budgets and/or reducing waiting times and queues needed time to see the relevance of focusing on the less visible needs of people who are chronically ill. But the major challenge for participants in the AHC, as for most QI efforts, is deciding where to begin. Those teams that progressed to intervention tended to have specific interventions in mind that they wanted to spread and/or evaluate. For less advanced RHAs, the AHC has provided a supportive and safe environment in which to learn and plan. It enabled regional and provincial leaders, healthcare providers and academics to work together to tackle the major public health and clinical issues of their region. Perhaps most importantly, the AHC created a politically safe learning community with the potential to support and sustain the work of chronic care improvement over time. That said, the ultimate impact of the AHC won't be known until this phase of the project is long past.

Despite their limited immediate success, participants in multi-organizational QI initiatives such as collaboratives consistently confirm the value to them of doing QI in groups. The group format provides ideas, a support structure and opportunities to compete with and learn from similar organizations facing similar challenges. Such approaches seem particularly well suited to Canada, where decision-making about the organization and design of healthcare delivery is so strongly influenced by provincial governments. But the journey to high-quality chronic illness care across the population is a long and arduous one. Most chronic illness care is delivered in primary care. Even a small province like Prince Edward Island has approximately 1,000 primary care providers; therefore, improvement at the regional and provincial levels will require interventions that involve and ultimately reach hundreds of practices. The AHC is an important first step, but it is only a first step.

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