A Collaborative Approach to a Chronic Care Problem: An Academic Mentor's Point of View

Une approche de collaboration à un problème de soins chroniques : le point de vue d'un mentor

COMMENTARY
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ABSTRACT

The Atlantic Healthcare Collaboration for Innovation and Improvement in Chronic Disease (AHC) represents a social experiment of sorts. The AHC provided a platform to integrate regions, health issues, healthcare systems, providers and individuals/families living with chronic disease. As such, the scope of the AHC was very broad, providing a rich learning environment but also risking biting off more than it *could chew. I participated in this experiment as an academic mentor to three of the improvement projects (IPs) with Health PEI, Central Health and Western Health and also was a member of the IP extended team at Nova Scotia Health Authority (formerly Capital Health) in Nova Scotia. My professional contribution was from the perspective of health behaviour change – change at the level of the patient and family living with chronic disease, at the level of the healthcare provider working within an expert-based, siloed system, and at the level of the healthcare system – the managers and decision-makers.*

RÉSUMÉ

La Collaboration des organismes de santé de l'Atlantique (COSA) constitue, en quelque sorte, une expérience sociale. La COSA a fourni une plate-forme pour rassembler les régions, les priorités du système de santé, les prestataires et les personnes / familles atteintes d'une maladie chronique. Ainsi, la portée de la COSA était très large : elle offrait un milieu d'apprentissage stimulant, mais courrait aussi le risque d'être victime du proverbe « qui trop embrasse, mal étreint ». J'ai participé à cette expérience en tant que mentor universitaire dans le cadre de trois des projets d'amélioration (PA) exécutés par Health PEI, Central Health et Western Health, et je faisais également partie de l'équipe élargie du PA de Nova Scotia Health Authority (antérieurement Capital Health), en Nouvelle-Écosse. Ma contribution professionnelle se faisait dans la perspective de la modification des comportements de santé : des changements au niveau du patient et de sa famille aux prises avec une maladie chronique, au niveau du prestataire de soins de santé œuvrant dans un système cloisonné, axé sur l'expertise, ainsi qu'au niveau du système de santé, de ses gestionnaires et de ses décideurs.

Verma, Denis, Samis, Champagne and O'Neil have done a nice job of describing the AHC and providing convincing detail of its value. I would highlight the Canadian Foundation for Healthcare Improvement (CFHI) Model as an excellent guide to supporting change at the level of the program and organization. On the quality improvement collaboratives (QIC) criteria specified in the paper, the AHC was extremely successful (Verma et al. 2016, Tables 1 and 2a). Effective engagement of decision-makers, front-line workers and system managers was, in my mind, successful at creating a novel learning environment. Further, CFHI provided innovative, and variably effective, structured support for the IPs.

The accessibility of field-leading academic experts on system change (Verma et al. 2016) was a huge benefit to the AHC. This accessibility provided an opportunity to bootstrap the typical low academic self-efficacy of the modal clinic environment. IPs were provided specific templates that allowed them to fill in any knowledge gaps concerning methodology and procedure and received systematic and regular mentoring on the use of these templates. It is impressive to see the results of this structured support. The unfolding of the AHC was anchored around a series of two-day conferences spread around the region and several webinars. These conferences provided the IPs with necessary reassurance for them to step into a new area.

The roles of the academic mentor and improvement coach embellished this support by providing IPs with ongoing consultation and interpersonal support throughout the project. I must say that the role of the academic mentor and coach blurred substantially as the project unfolded. If this AHC were to be replicated, it is not clear if both roles would be necessary. Clearer differentiation of roles would be useful at a minimum. The AHC also provided an online support tool, but it is my impression that this was under-utilized, which is unfortunate, because this desktop resource was rich. Greater attention paid to increasing access to this type of a resource is warranted.

All this being said, as is true of many well-run experiments, the replicability of the AHC may be in question. Also, how sustainable is this model? Without the level of expert support, can health units and systems sustain the efforts started or initiate new efforts? I suspect that some of the IP teams progressed to the point where they could self-manage. These teams began the AHC ahead of the curve, however. They typically had strong commitment and infrastructure already in place to achieve their goals. For these IPs, the AHC was opportune. Other teams may struggle with follow-through, as the AHC was needed to build the structures required to initiate programs. In some ways, the AHC was of most benefit to the teams that began the initiative with higher levels of readiness to change. Sustainability within teams that are less ready to change is more of a challenge. These are difficult issues to deal with. Verma and her colleagues (2016) are not naive to these issues, but the issues remain "steep hills to climb".

The above comments notwithstanding, I would like to focus on the issue of self-management. One of the cornerstone goals of the AHC was to "create a patient- and family-centred approach to managing chronic disease," using primarily the Chronic Care Model, within which self-management plays an integral role. The AHC, in my opinion, has done an excellent job of helping to uncover the scope of the issues regarding self-management and self-management support in chronic disease management. A number of specific self-management issues can be highlighted. My intent in highlighting these issues is to aid in realizing the potential of the self-management model. Implicit in this statement is the acknowledgement that the AHC did not achieve all of its goals. The objectives were as follows:

i. Create a patient- and family-centred approach to manage chronic diseases
ii. Build a network of organizational, regional and provincial teams to share evidence-informed, systems-level solutions and work together to develop, implement and sustain improvement initiatives
iii. Promote sustainability of health systems (CFHI 2012a; 2012b)

Significant progress was made on the first two objectives but not the last. The AHC can be considered a work in progress. The AHC helped us to clarify exactly what we are getting into in regard to self-management at a systems level, as is explained below. I consider this clarity to be a value-added outcome of the AHC.

First, the AHC helped to uncover what self-management in the medical system really means. There is, in my opinion, a real danger that clinicians and systems will simply pay lip service to the concept of self-management. Self-management refers to the actions taken by individuals living with chronic disease and explicitly defines the role of the system and the healthcare provider as that of self-management support. In other words, we need to go from a lead role to a support role.

This is easier said than done, and this issue arose in all of the IPs that focused on self-management. That is, team members fell into a tendency to try to control the process of change, often expressed as "we are looking for a tool to change behaviour." An explicit illustration of this issue occurred at a recent CFHI-sponsored session in the Atlantic region in which a presenter stated, "We used motivational interviewing to convince patients to change." Even a cursory familiarity with the principles of motivational interviewing (Miller and Rose 2009) will alert professionals to the fact that it is about helping the patient discover his or her own reasons to change, not to convince the person that our reasons should dominate. Striking the balance between the roles of the person living with chronic disease and the healthcare provider is challenging and is best seen as an ongoing dynamic rather than a static protocol.

Second, promoting the role of the patient and family effectively requires a change in the balance of power in relationships. Currently, healthcare providers are seen, and see themselves, as the experts whose job it is to diagnose, determine/implement treatment and evaluate outcomes (Vallis 2015). But taking the position of expert has very specific implications in regard to relationship dynamics, that is, the way that people establish and maintain their connectedness.

The interpersonal circumplex model of relationships is an empirically supported model that describes how humans maintain connectedness (Markey et al. 2003; Wiggins 1996). In this model, there are two orthogonal dimensions of interpersonal functioning: dominance and affiliation. The healthcare expert is clearly taking charge, that is, adopts the dominant role. In doing so, this puts the patient in the position of becoming submissive. That is, when one person assumes dominance, the other person reacts with submissiveness in order to stay connected. If both people in a relationship adopt the dominant role, conflict – a breaking of the connection – is inevitable. Similarly, if both people adopt a submissive role, no decisions get made and the relationship cannot move forward. On the dimension of affiliation, connectedness is maintained by both parties collaborating. But are systems and providers really willing to give up their power? Shifting from "teach and tell" to "collaborate and empower" requires a fundamental shift in how providers see themselves. Greater attention is needed to this issue to better understand how to shift from acute to chronic care models. I have recently published a paper describing an alternative to the "diagnose, treat and evaluate outcomes" approach (Vallis 2015). This alternative is based on the concepts of describe, predict and focus on choice (the choice of the patient and family, not the provider or system).

In addition to a major shift in relationship dynamics, imagine the provider in a situation where the person at risk chooses, after careful deliberation, to not change. In a self-management model this is an acceptable outcome, which means that providers would need to "sit with" the distress associated with patient choices that are inconsistent with their recommendation, i.e., distress tolerance. The AHC IPs were effective in uncovering discomfort with both of these issues – giving up the power of the expert as well as the stress of situations where patients choose suboptimal treatments. As an academic mentor, I clearly heard the theme "but it's our job to change the patient."

Third, any discussion of self-management of chronic disease should be placed into the context of the still-dominant acute care model. As Verma and her colleagues touch on in their paper (2016), acute care priorities crowd out a patient-centred chronic disease prevention and management approach. What will it take to change the attitude of decision-makers and funders to support self-management? Currently, "hard" outcomes are seen as the most worthwhile. Self-management support would require the acceptance of a different model of evaluation. Jones and colleagues (2015) have recently raised this issue in regard to diabetes, i.e., a call for prioritization of quality of life and functional health measures as primary outcomes in diabetes management (see also Halliday et al. 2015). In the self-management model, improvements in self-management, perhaps even quality of life or functional ability would be acceptable outcomes.

Fourth, it is worth commenting on the self-management perspective vis-à-vis the high-risk, high-need patient with multimorbidity (Sampalli et al. 2012). The system appears to be becoming aware of this subgroup of individuals who are high system users. But are we ready for the changes required to aid these individuals from the perspective of self-management support? Clinical programs still tend to focus on disease states and medical specialties. This focus results in those with multimorbidity being involved in a number of programs in which there is much duplication, low likelihood of provider-to-provider communication and high potential for confusing or contradictory information. Placing the person with high risk, high needs and multimorbidity (a growing population) at the centre of care will be challenging indeed.

Finally, fully embracing the self-management perspective has specific implications for accepting complexity. The current healthcare system can be fairly labelled as a reductionistic, deterministic system (Plsek and Greenhalgh 2003). The randomized controlled trial (RCT) and clinical algorithms dominate. Yet there is reason to believe that human behaviour is too complex to fit with a reductionistic model. Kessler and Glasgow (2011) have recently called for a 10-year moratorium on RCTs in clinical research. They base this argument on what are described as "wicked" problems – problems that are complex, interacting, multi-determined and unable to be decontextualized and mechanistically taken apart.

Wilson and Holt (2003) recently presented an easy-to-understand conceptualization of this issue. They propose two dimensions from which to consider a field – degree of understanding and degree of agreement. If, in a particular field, there is high agreement on how to intervene and a high degree of understanding of the issues, then this is a simple system, where reductionism and explicit treatment algorithms work well. If the level of agreement and level of understanding are low, this describes a chaotic system, where information should be sought to identify patterns. If the level of understanding and agreement are moderate, this describes a complex system. In complex systems, boundaries are fuzzy rather than discrete, actions stem from internalized rules, systems are embedded within each other, tension and paradox do not resolve and interventions lead to new behaviours. Self-management support interventions fit nicely within this notion of complex systems.

We might know that behaviour is likely to occur in situations where the following conditions are met: capability (knowledge, skill), opportunity (access, support) and motivation (readiness to change) – what is called the COM-B model of behaviour change (Michie et al. 2011). Exactly what interventions lead to these conditions is not clear, however. Different providers have different views on which interventions work best, and any given intervention will have different effects on different people. Given this diversity, establishing an informed approach to behaviour change that is endorsed by the broad care team, and then collaborating with patients to evaluate and revise the plan as implementation unfolds, would allow programs to make the most out of self-management support. The exact procedures and evaluation methods can vary from program to program and yet at the same time remain true to self-management support (see Hawe et al. 2004).

These comments are offered in the spirit of collaboration. Projects such as the AHC go a long way toward laying the foundation necessary to get us where we need to go.

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