Achieving care goals for people with chronic health conditions

Louise Nasmith MD CM MEd FCFP FRCPSC(Hon) **Sonya Kupka** MAdEd RD **Penny Ballem** MD FRCPC **Cate Creede** PhD

In 2009, more than 40% of Canadian adults reported that they had at least 1 of 7 common chronic conditions—arthritis, cancer, emphysema or chronic obstructive pulmonary disease, diabetes, heart disease, high blood pressure, and mood disorders, not including depression.[1]

Caring for people with chronic conditions involves supporting some patients with a single condition, other patients who have comorbidities (issues related to an initial condition, such as diabetes leading to renal failure), and other patients who are dealing with multimorbidity (multiple conditions, some related to one another, some complicating one another, and some that are unrelated but coexisting). A common example of multimorbidity is a person with diabetes, hypertension, and asthma who develops arthritis or dementia.

Because the trajectory of these conditions varies substantially over time, as context, age, life situations, and other factors shift, it is important to consider the goals for people's care. Chronic conditions are with people for the remainder of their lives. The goals of chronic care are generally not to cure, but to enhance physical, cognitive, and social functionality, and quality of life; prevent secondary conditions; and minimize distressing symptoms.[2]

Care models to achieve these goals

Health care approaches for chronic conditions include primary and secondary prevention, acute episodic interventions, and expansion of the care circle to recognize the role of caregivers and family. The Canadian health care system is oriented toward the provision of acute care; it functions well for single disease–focused health issues, but is ill-suited to the management of multimorbidity and chronic conditions.

People with chronic conditions require care that is as seamless as possible as they move between primary, acute, specialty, and community care. From the patient perspective, there is no such thing as primary care, acute care, specialty care, or community care—there is simply health care. A functioning health care system needs to operate just as seamlessly.

In a call to action, the Canadian Academy of Health Sciences identified the following overarching recommendation to transform care for Canadians living with chronic health conditions[3]: Enable all people with chronic conditions to have access to a system of care with assigned clinicians or teams of clinicians who are responsible for providing their primary care and for coordinating care with acute, specialty, and community services throughout their lifespans.

The report recommends that each primary care practice be responsible for a defined population captured in a roster or registry; have appropriate infrastructure and staffing to support the management of individuals with multiple chronic conditions; and coordinate with other aspects of the health system. Thus, primary health care providers and teams act as the critical hub for the comprehensive approach required for person-centred, integrated care that can improve health care system efficiency, patient outcomes and satisfaction, and quality of care.[4,5] This model of care requires a shift from the traditional solo family physician to team-based, interprofessional care that can provide the comprehensive services needed.

While providing a locus for continuity of patient relationships and knowledge, effective primary care also plays an important role in ensuring that people have access to the right care, including acting as a navigation point for an increasingly complex system and providing the site for patients to take on a context-appropriate role in their own health maintenance and decision making.[6,7]

The Canadian Academy of Health Sciences report[3] suggested a number of enabling recommendations to support the development of this model. While all are important, 3 stand out as critical for success. They are appropriate funding models, creating a culture of continuous quality improvement, and supporting patient self-management.

Appropriate funding models. Health system funding and provider remuneration need to be better aligned with desired outcomes. An Ontario report stated that the shift to collaborative, team-based care is a promising move toward "a more cohesive health care system and would move the system towards aligning the incentives of physicians with those of the rest of the health care system."[8] Further incentives are also recommended, such as payment mechanisms to reward effective practice. Currently, funding models in Canada reinforce the fragmentation of the system, particularly

This article has been peer reviewed.
Can Fam Physician 2013;59:11-3

Cet article se trouve aussi en français à la **page 15.**

through governance structures that separate acute and primary care, and a payment system that drives short office visits that often limit patients to discussions of only one issue per visit.

An extensive literature review of innovative models for comprehensive primary care delivery suggests that more flexible funding arrangements for family physicians are required, including funding team-based practices rather than individual physicians, and offering a variety of funding mechanisms for general practices, to accommodate variations in physician working styles.[9] This review also recommended that new funding arrangements be developed between general practices and regional health authorities to allow for local flexibility in service delivery and enhancement of the capacity of the system to directly plan for and effectively address regional needs. In Canada, new funding models are being introduced in various provinces, such as family health teams in Ontario and primary care networks in Alberta.

Culture of quality improvement. A culture of accountability is needed in which primary care providers from all health professions recognize the importance of measuring their performance, comparing their populations' health outcomes to those of their peers' populations, and changing their behaviour. However, a study of 8 Commonwealth Fund countries revealed that Canada's training in quality improvement lags behind several comparable countries.

- Canada reported the lowest rates for training in quality improvement methods and tools among primary care physicians (44%), and was least likely to have set formal targets for clinical performance or to have data available on clinical outcomes.[10]
- Of Canadian primary care physicians, 45% had conducted a clinical audit of patient care in the previous 2 years compared with 76%, 82%, and 96% of those in Australia, New Zealand, and the United Kingdom, respectively, and 11% said that they routinely received data about patients' experiences and satisfaction—again, the lowest rate in the countries studied.[10]

A substantial shift is needed in the Canadian health system to ensure that quality drives performance. In Germany, this shift is occurring through a compulsory, nationwide approach to quality improvement using accreditation. One of the systems available to improve management in primary care practices is the European Practice Assessment program. Application of this program substantially improved management scores in a study group of primary care practices in Germany in all domains (infrastructure, people, information, finance, and quality and safety).[11]

A pan-Canadian approach might be feasible provided there is local health region engagement and leadership in the development of core metrics on population-based outcomes, a process for data collection and analysis, and support for practices to implement change. Quality measurement should promote excellence in chronic care management such as timely, comprehensive, and coordinated care, continuity of care, easy access, and attachment.

Supporting patient self-management. Self-management needs to be supported as part of everyone's care. The goal of care for individuals with chronic health conditions is collaboration between informed and engaged patients and their families and a coordinated health care team.[12] The focus on self-management requires person-professional partnerships that involve supports for self-management that are appropriate for people's conditions and circumstances. The Health Council of Canada reported that patients involved in decisions about their care experience better health outcomes.[13] However, in their subsequent report on chronic conditions, they found that sicker patients felt less engaged in their care, which ultimately interferes with their ability to manage their own health.[14]

Summary of recommendations

The expert panel made specific enabling recommendations that addressed funding models, quality improvement, and self-management.

- Shift funding models away from exclusively fee-for-service remuneration of physicians to allow greater regional flexibility, incentives to pursue excellence in chronic condition management, accountability for population-based outcomes, and dedicated budgets for primary care practice infrastructure.
- Develop and strengthen health region quality improvement structures and processes to better support other specialty physician and primary care practices in examining their performance and their population-based health outcomes.
- Assure that all primary care practices have the appropriate infrastructure and staffing to provide effective self-management support, including empowering people to easily access and manage their own health information.

Gaps in knowledge

The challenge in achieving the care goals for people with chronic conditions is not so much determining what do to, but being clear about the priorities and how to provide leadership for the bold steps that are necessary to make it happen. This analysis identifies 3 priority areas (funding models, quality improvement, and self-management) that would have a great effect and would serve as catalysts for further changes.

Key physician stakeholder groups have signaled readiness for change.[15,16] The Patient's Medical Home[16] offers a timely opportunity for the College of Family Physicians of Canada (CFPC) to work with other medical organizations such as the Canadian Medical Association and the Royal College of Physicians and Surgeons of Canada to advance specific elements of the model. The Canadian Academy of Health Sciences report[3] recognized the need for government leadership to ensure a pan-Canadian implementation approach and recommended the following.

- Federal, provincial, and territorial ministers of health should review these recommendations with a view to making them part of the 2014 renewal of the federal-provincial-territorial accord on health care.
- Each province and territory has embarked on primary care renewal initiatives. The CFPC should work with the provincial chapters to influence and "push" their ministries to support the Patient's Medical Home model and with academic departments of family medicine to ensure that graduates have the skills needed to work in this environment.
- The CFPC and its research community need to be proactive in providing strong evaluation data on the effectiveness of this model.

There is a collective responsibility to acknowledge the urgency of the current situation and, more important, to take sustained action to improve care for Canadians living with chronic health conditions.

Dr Nasmith is Professor of Family Practice and Principal of the College of Health Disciplines at the University of British Columbia in Vancouver. **Ms Kupka** is a dietitian and an independent consultant in White Rock, BC. **Dr Ballem** is a hematologist and City Manager for Vancouver. **Dr Creede** is an independent consultant in Toronto, Ont.

Competing interests
None declared

Correspondence
Dr Louise Nasmith, College of Health Disciplines, University of British Columbia, 2194 Health Sciences Mall, Vancouver, BC V6T 1Z3; telephone 604 822-7333; e-mail **louise.nasmith@ubc.ca**

References

1. Canadian Institute for Health Information. *Experiences with primary health care in Canada*. Ottawa, ON: Canadian Institute for Health Information; 2009.
2. Grumbach K. Chronic illness, comorbidities, and the need for medical generalism. *Ann Fam Med* 2003;1(1):4-7.
3. Nasmith L, Ballem P, Baxter R, Bergman H, Colin-Thomé D, Herbert C, et al. *Transforming care for Canadians with chronic health conditions. Put people first, expect the best, manage for results*. Ottawa, ON: Canadian Academy of Health Sciences; 2010. Available from: **www.cahs-acss.ca/wp-content/uploads/2011/09/cdm-final-English.pdf**. Accessed 2012 Nov 28.
4. Kringos DS, Boerma WG, Hutchinson A, van der Zee J, Groenewegen PP. The breadth of primary care: a systematic literature review of its core dimensions. *BMC Health Serv Res* 2010;10:65.
5. Scobie A, MacKinnon NJ, Higgins S, Etchegary H, Church R. The medical home in Canada: patient perceptions of quality and safety. *Healthc Manage Forum* 2009;22(1):47-51.
6. Health Council of Canada [website]. *Beyond the basics. The importance of patient-provider interactions in chronic illness care. (Canadian Health Care Matters, Bulletin 3).* Toronto, ON: Health Council of Canada; 2010. Available from: **www.healthcouncilcanada.ca/tree/2.16-HCC_CHCM_FINAL_ENGLISH.pdf**. Accessed 2012 Nov 28.
7. Standing Senate Committee on Social Affairs, Science and Technology. *The health of Canadians—the federal role*. Ottawa, ON: Parliament of Canada; 2002. Available from: **www.parl.gc.ca/Content/SEN/Committee/372/soci/rep/repoct02vol6-e.htm**. Accessed 2012 Nov 28.
8. Drummond D, Burleton D. *Charting a path to sustainable health care in Ontario: 10 proposals to restrain cost growth without compromising quality of care.* Toronto, ON: TD Economics, TD Financial Group; 2010. Available from: **www.td.com/document/PDF/economics/special/td-economics-special-db0510-health-care.pdf**. Accessed 2012 Nov 28.
9. Naccarella L, Southern D, Furler J, Scott A, Prosser L, Young D. *SIREN project: systems innovation and reviews of evidence in primary health care: narrative review of innovative models for comprehensive primary health care delivery.* Canberra, Australia: Australian Primary Health Care Research Institute; 2006. Available from: **http://aphcri.anu.edu.au/sites/aphcri.jagws03.anu.edu.au/files/research_project/247/final_25_naccarella_pdf_58898.pdf**. Accessed 2012 Nov 28.
10. Schoen C, Osbor R, Huynh PT, Doty M, Peugh J, Zapert K. On the front lines of care: primary care doctors' office systems, experiences, and views in seven countries. *Health Aff* (Millwood) 2006;25(6):w555-71. Epub 2006 Nov 2.
11. Szecsenyi J, Campbell S, Broge B, Laux G, Willms S, Wensing M, et al. Effectiveness of a quality improvement program in improving management of primary care practices. *CMAJ* 2011;183(18):E1326-33. Epub 2011 Oct 31.
12. Law S, Flood C, Gagnon D, Listening for Direction III Partners. *Listening for direction III. National consultation on health services and policy issues 2007-2010*. Ottawa, ON: Canadian Health Services Research Foundation, Canadian Institutes of Health Research, Institute of Health Services and Policy Research; 2008. Available from: **www.cfhi-fcass.ca/Libraries/Listening_for_Direction/LfDIII-FINAL_ENG.sflb.ashx**. Accessed 2012 Nov 28.
13. Health Council of Canada [website]. *How engaged are Canadians in their primary care? Results from the 2010 Commonwealth Fund International Health Policy Survey. (Canadian Health Care Matters, Bulletin 5).* Toronto, ON: Health Council of Canada; 2011. Available from: **http://healthcouncilcanada.ca/tree/2.30-Commonwealth5_EN_Final.pdf**. Accessed 2012 Nov 28.
14. Health Council of Canada [website]. *How do sicker Canadians with chronic disease rate the health care system? Results from the 2011 Commonwealth Fund International Health Policy Survey of Sicker Adults. (Canadian Health Care Matters, Bulletin 6).* Toronto, ON: Health Council of Canada; 2011. Available from: **www.healthcouncilcanada.ca/docs/rpts/2011/Commonwealth6/HCC_CW6_EN_120911.pdf**. Accessed 2012 Nov 28.
15. Canadian Medical Association [website]. *Health care transformation in Canada. Change that works. Care that lasts.* Ottawa, ON: Canadian Medical Association; 2010. Available from: **www.cma.ca/multimedia/CMA/Content_Images/Inside_cma/Advocacy/HCT/HCT-2010report_en.pdf**. Accessed 2012 Nov 28.
16. College of Family Physicians of Canada [website]. *Patient-centred primary care in Canada: bring it on home*. Mississauga, ON: College of Family Physicians of Canada; 2009. Available from: **www.cfpc.ca/uploadedFiles/Resources/Resource_Items/Bring20it20on20Home20FINAL20ENGLISH.pdf**. Accessed 2012 Nov 28.