

Meeting the Challenge of Chronic Conditions in a Sustainable Manner: Building on the AHC Learning

Relever le défi des maladies chroniques de manière pérenne : mettre à profit les acquis de la COSA



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ABSTRACT

The Atlantic Healthcare Collaboration for Innovation and Improvement in Chronic Disease (AHC) set out to achieve three aims: to create a patient- and family-centred approach to manage chronic diseases; to 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; and to promote

the sustainability of the participating health systems. Important elements of all three aims were achieved and the synthesis provides a meaningful contribution to systems working to improve chronic care. This paper explores those achievements as well as some of the areas for improvement, including replicability, expanded outcome measurement, greater detail around patient and family engagement, increased focus on specific outcomes and processes, and further articulation of lessons learned and recommendations.

RÉSUMÉ

La Collaboration des organismes de santé de l'Atlantique en matière d'innovation et d'amélioration dans le traitement des maladies chroniques (COSA) a entrepris de réaliser trois objectifs : créer une approche de gestion des maladies chroniques centrée sur le patient et sa famille ; établir un réseau d'équipes organisationnelles, régionales et provinciales afin de partager des solutions et collaborer en vue d'élaborer, de mettre en œuvre et de pérenniser des initiatives d'amélioration ; et promouvoir la pérennité des systèmes de santé participants. Des éléments importants de ces trois objectifs ont été atteints et leur synthèse apporte une importante contribution aux systèmes œuvrant à améliorer les soins chroniques. Cet article passe en revue les réalisations de la COSA et les domaines appelant des améliorations supplémentaires, notamment sa reproductibilité, l'expansion de la mesure de ses résultats, l'enrichissement de ses détails concernant la participation du patient et de sa famille, un accent accru sur les résultats et les processus spécifiques et une explication plus étoffée des leçons apprises et des recommandations.

GLOBALLY, ONE OF the toughest challenges of current times is the chronic conditions epidemic which is threatening the sustainability of many health systems. The Atlantic Healthcare Collaboration for Innovation and Improvement in Chronic Disease (AHC) was designed to stimulate participating health systems to behave in a patient- and family-centred manner, develop networks for collaboration and design for sustainability. The AHC also promoted the Chronic Care Model (MacColl Center for Health Care Innovation 2002) elements of self-management support, delivery system design, decision support and clinical information systems, community resources and policies. Its key findings are described in “A Collaborative Approach to a Chronic Care Problem” (Verma et al. 2016),

which provides a meaningful contribution to the growing body of documented quality improvement collaborative (QIC) experiences.

The paper references some of the most recent frameworks for designing and executing QICs (Nadeem et al. 2013; Bibby 2014; De Silva 2014) and provides detailed and extensive descriptions of how the AHC was planned and the results it generated. To evaluate the AHC impact, the authors used qualitative as well as quantitative methodologies (Ayers et al. 2005). Its findings, linked to the three original aims of the AHC, can be summarized as follows:

- Did it create a patient- and family-centred approach to manage chronic diseases?
Yes, in some of the participating teams.

- Did it 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? Yes, in part; the sharing, working together and early implementation efforts are evident, although sustainability is not.
- Did it promote the sustainability of the participating health systems? There is no evidence that it did; perhaps the time to assess this dimension (which may be useful to define in a more explicit manner) is in a couple of years.

One could argue that the shared governance and costing models, as well as the reliance on existing regional needs and expertise, are important elements that support the sustainability of the AHC efforts. However, to limit its impact to these three dimensions is to underestimate the achievements of the AHC, which mobilized many key stakeholders to rethink the way they care for those with chronic conditions. The participating teams evaluated the AHC workshops and support positively and were exposed to key spread and scale-up concepts, as well as to the Canadian Foundation for Healthcare Improvement (CFHI) Model (CFHI 2014a; 2014b) as a foundational tool for collaborative efforts now and in the future. For instance, post-workshop surveys show the majority of participants (89%) agreed that workshop materials enhanced their understanding of developing a theory of change, how to design and implement an improvement project, how to redesign healthcare and how to identify challenges and opportunities for patient and

provider engagement. Surveys also show that participants increased their skills related to sustainability and spread (97%) and increased their understanding of methods for spreading best practices (85%).

The scale of the work is impressive, as the AHC planned for participants to learn how to assess, design, implement, evaluate and share healthcare improvements for people living with chronic diseases in 17 health regions across four provinces in Atlantic Canada, under the formal endorsement of each of their provincial departments of health. The intentional approach to moving care from hospital-centric models to more proactive, primary-care-based efforts sparked new levels of collaboration and coordination. The endorsement from the four provincial departments of health, formalized through a charter agreement, was a creative way to build a link to both policy and performance management from the start, fostering a closer relationship between those delivering the services and those planning or funding them. The support network for teams decentralizes the mentoring function, and the coaching model, which includes both academic and improvement coaches, presents a novel approach to addressing the tension that can exist between the two.

It is clear that the AHC generated a high volume of activity, learning, collaboration and Kirkpatrick Levels¹ 1 and 2 results on a large scale. It also served to channel the attention of senior leaders toward chronic conditions, highlighted the importance of having protected time for innovation and improvement, galvanized multidisciplinary teams around a topic, and promoted a culture of quality improvement.

1. Level 1: What was the participants' experience? (Did the participants have an excellent experience working on the improvement project?); Level 2: What did the participants learn? (Did they learn improvement methods and begin testing?); Level 3: Did they modify their behaviour? (Did they work differently and see change in their process measures?); Level 4: Did the organization improve their performance? (Did they improve their outcomes?)

In addition to the AHC's many strengths, a few areas should be considered for improvement. The first piece of feedback is based largely on maximizing the replicability of the effort, inviting a clearer articulation of the activities undertaken and the participants that were engaged. Without these details, it is difficult to understand the estimated cost and scale of hosting learning sessions or virtual meetings, as well as how to best frame invitations and gauge the planning needed to free up individuals from different professional backgrounds to participate. The article references four face-to-face meetings plus virtual support and coaching over 24 months, but one cannot determine much beyond these basic details. For instance, how much shared learning was there in between sessions and what were the most vibrant pieces of content that triggered interaction? How many coaches or mentors were used to support this effort and what did the central planning team look like? Organizations wishing to replicate activities of this nature will want to understand what investments would be needed to design and implement a QIC. Further, it is difficult to discern how many of the 17 RHAs that signed the original charter participated on the QIC actively – for instance, Table 2a lists eight participating regions, with a high degree of variation in terms of how many of the CFHI Model dimensions were applied. It would be useful to understand broadly the gaps in participation in each stream of work, in order to explore what specific areas attract the most participation.

In addition, the following suggestions are framed as questions for consideration:

- **Measuring outcomes:** Assessing the impact of large-scale efforts is always challenging; the results described in this paper fell largely under Kirkpatrick Levels 1 and 2 – the effort provided a good experience for participants and there was learning. There is some evidence of impact on patient- and family-centred care measures, as well as collaborative indicator examples. However, patient-level and system-level outcome measures would strengthen the case for using QICs that generate impact and contribute to the sustainability of health systems. Developing additional aims or sub-aims to the broad topics of developing networks or sustainability that answer the question, “We will participate on the AHC in the service of what outcome changes?” would help to define measures at Kirkpatrick Levels 3 and 4 (behaviour change and outcomes). For instance, measures under each of the headings of the Institute for Healthcare Improvement's (IHI) Triple Aim (Whittington et al. 2015) provide a useful framework for assessing the experience of care, the health of the population and costs – three dimensions that, pursued simultaneously, help to address the question of sustainability in a comprehensive manner. Developing outcome measures in this way would add to the initial efforts of the AHC; in doing so, areas such as prevention may emerge as new spheres of activity and collaboration.
- **Engaging patients and families:** There is a clear commitment at the core of the AHC to create a patient- and family-centred approach to manage chronic conditions. However, it is unclear how patients and families were actively engaged (beyond being the recipients of care) in the planning, governance or implementation (participation in learning sessions, etc.) of the collaborative. If engagement was lacking, having patients at one or more of these levels would add coherence and strength to the work.

- Breadth:** There is a constant conundrum for QICs that attempt to cover broad topics (e.g., chronic care) versus specific clinical areas – the complexity increases with the scale of the effort, both in terms of reach (number of participating organizations) and stakeholders involved (multi-professionals, patients, families, etc.). The AHC’s aims were broad (creating networks, sustainability and patient- and family-centred approaches). Are there ways of framing the means to the end of improving chronic care, that is, might focusing on a number of specific outcomes and processes to be impacted (conditions or evidence-based interventions), using a framework such as the Triple Aim (Whittington et al. 2015) as suggested above, help us to design systems that engage patients and families, work as networks, and enhance sustainability? One could look at prevalence, acuity, political urgency or other factors in order to choose the specific conditions or processes. This might help organizations invited to participate in a QIC with their internal stakeholders (inviting teams to participate, etc.) and with their external constituencies (e.g., telling a story of improved outcomes may be powerful to taxpayers who provide the funding for public health services). It might also help to develop “micro” communities – specific segments for learning or constituencies that work on similar topics and hence feel a stronger sense of shared learning over time. Although I agree with Davidoff (2014: 526) that “improvement interventions are social treatments, not pills,” I see an opportunity to enhance the strength of the AHC by reconsidering the way aims are framed and measured.
- Communicating what was learned – for action:** The evaluation and lessons

learned section has some great “nuggets” of actionable information (Verma et al. 2016). Given the ambition of this effort to impact the way chronic care is planned and delivered, it might be useful to frame the lessons and recommendations by key constituencies – for example, for primary care, for patients and families, for commissioners of services, for leaders of integrated systems, for policy makers and so on. This may make the accumulated learning even more actionable for a wide range of constituencies globally that are actively working to improve chronic care.

“A Collaborative Approach to a Chronic Care Problem” is a meaningful contribution to systems working to improve chronic care collaboratively and to the QIC literature (Verma et al. 2016). QICs are designed to generate intentional movement toward a shared aim under a structured learning system, and the AHC must be commended for having done so on a large scale. I hope that many around the world learn from its lessons as they strive to meet the challenge of chronic conditions in a sustainable manner and, more importantly, that patients in Canada and elsewhere can benefit from this and similar efforts.

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