

CARDIOVASCULAR HEALTH NOVA SCOTIA NETWORK MEETING

MEETING REPORT

June 8th and 9th, 2007

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Finding the solution is simple when you know how

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INTRODUCTION

Background on CVHNS

In April 2002, the Nova Scotia Department of Health assumed funding for the ICONS project, which had previously been a five-year public-private research study. The Nova Scotia Department of Health together with provincial stakeholders, including the ICONS Network worked to develop a cardiac program for Nova Scotia. The Cardiac Advisory Council was formed and a Program Manager was hired in 2004. Since that time, the Advisory Council has developed a strategic plan and established several working groups. In late 2005, the program's scope was expanded to include stroke as well as cardiac disease and the program's name was changed to Cardiovascular Health Nova Scotia (CVHNS). The advisory body for the program meets quarterly and is known as the CVHNS Advisory Council.

Purpose of the Meeting

The purpose of the CVHNS Network meeting held June 8th and 9th, 2007, was to inform the development of a provincial approach to disease management and secondary/tertiary prevention for cardiac disease and stroke.

Specifically, the objectives for the meeting were:

- ◆ To increase familiarity with service delivery models from other provinces.
- ◆ To examine planning for service delivery in the context of Nova Scotia's provincial Chronic Disease Management Strategy.
- ◆ To foster collaboration in service delivery to address common risk factors.
- ◆ To develop guiding principles for the development of a coordinated, integrated, accessible and sustainable approach to disease management and secondary/tertiary prevention for cardiac disease and stroke.

OVERVIEW OF THE MEETING

Welcome and Introductions

The Meeting began with a welcome by Dr. Blair O'Neill, Head, Division of Cardiology, QEII Health Sciences Centre and a Clinical Advisor to CVHNS. Dr. O'Neill briefly reviewed the history and purpose of the Network and acknowledged the commitment and participation of the broad-based partnership. Dr. O'Neill noted that the Network has been supported through a partnership with Industry, which has enabled stakeholders from across the province to discuss and provide input into an array of cardiovascular health issues. Specifically, the Network provides the opportunity for stakeholders at the grass roots level to provide input into standards, process of care, health policy, research, and emerging issues. Learnings from previous Network meetings were reviewed along with key research initiatives.

*People consistently overestimate the effect of short term change
and underestimate the effect of long term change.*

(Ian Morrison, former president of the Institute for the Future)

Ms. Lynn Edwards provided a brief overview of the purpose of the current meeting. It was noted that the Network is one of the many vehicles that CVHNS uses to share information, educate, and receive input on relevant program activities. Further, the provincial program acknowledges the contributions from all partners and looks forward to continuing to work with partners on issues that are set forth in the strategic direction of the program.

Presentations

Presentations were given by key note speakers (see Table 1) to provide contextual information to inform discussion during small group working sessions. Two working sessions were conducted to engage participants in: 1) the development of a “picture” of the ideal for disease management services and programs for the secondary and tertiary prevention of cardiac disease and stroke., and principles to guide programs and services; and 2) identifying challenges, opportunities and next steps for the development of a provincial model/approach for disease management programs and services to address cardiac disease and stroke.

Table 1: Presentations by Key Note Speakers

Subject	Presenter
The Provincial Chronic Disease Management Strategy	<ul style="list-style-type: none"> • Mr. Merv Ungurain, Senior Consultant, Primary Health Care, Nova Scotia Department of Health
Current Status of Disease Management for Cardiac and Stroke – Snap Shot from across Canada	<ul style="list-style-type: none"> • Ms. Neala Gill, Program Manager, Cardiovascular Health Nova Scotia
Data: Secondary and Tertiary Prevention for Cardiac Care	<ul style="list-style-type: none"> • Dr. Jafna Cox, Scientific Advisor, Cardiovascular Health Nova Scotia
Data: Secondary and Tertiary Prevention for Stroke	<ul style="list-style-type: none"> • Dr. Gordon Gubitz, Stroke Neurologist, QEII Health Sciences Centre
Description of Initiatives from other Jurisdictions	<ul style="list-style-type: none"> • Ms. Louise Morrin, Program Manager, Living Well with a Chronic Condition & Calgary COPD and Asthma Program • Ms. Alexis Dishaw, Director, Planning and Development, Toronto Grace Health Centre
Key Learnings from other Jurisdictions	<ul style="list-style-type: none"> • Ms. Louise Morrin • Ms. Alexis Dishaw

Initiatives to Address Cardiac Disease and Stroke

The meeting began with a session where representatives from cardiac rehabilitation and stroke risk reduction programs shared their initiatives in small groups, focusing on a description of the program and key learnings. As noted in the evaluation form, meeting participants rated this session very highly and consistently indicated the value of learning from others work.

The Provincial Chronic Disease Management Strategy

On Friday evening, Mr. Merv Ungurain provided an overview of the provincial chronic disease management model and strategy currently under development. After a review of the challenges, cost implications, and risk factors and conditions for chronic disease management, the history of the development of the model was described. In 1993 the Wagner Model of Chronic Care was developed through research and practice by the MacColl Institute for Healthcare Innovation in Seattle. The model emphasized evidence based, planned integrative chronic care through six key elements including health care organization; community resources and policies; decision support; delivery system design; clinical information systems; and self management. This model has been widely tested and adapted in numerous countries and settings.

In British Columbia, the Chronic Care Model was expanded with the key adaptation being a strengthening of the 'community' component to emphasize the role of the determinants of health and health promotion in influencing individual, family, community and population health. In addition to the elements of the original "Wagner Model" (i.e., the community; the health system; self management support; delivery system design; decision support; and information systems), the community component was expanded to include healthy public policy, supportive environments and community action.

The BC Expanded Chronic Care Model was reviewed by provincial stakeholders in Nova Scotia and embraced as a model to guide the chronic disease management strategy. Two key adaptations were made including the addition of families to the model and ensuring that a population health approach was explicit within the model. Chronic disease Management is a priority for the Department of Health in this fiscal year. Selected activities include:

- ◆ Exploring implementing the Stanford Model Self Management program;
- ◆ Further developing decision support and information systems to support Chronic Disease Management; and
- ◆ Linking information systems to standards, guidelines and provincial indicators.

Current Status of Disease Management for Cardiac and Stroke – Snap Shot from across Canada

Ms. Neala Gill provided a status report and “forecast” on the secondary prevention of cardiac and stroke in Nova Scotia and other jurisdictions from across Canada. National initiatives including the Canadian Heart Health Strategy, Canadian Stroke Strategy, National Wait Time Alliance recommendations and Canadian Council on Health Services Accreditation were reviewed. Initiatives from other provinces were presented with consistency noted in the focus on self management support programs as well as stroke strategies. In addition, other provinces have been developing alternative models for delivering cardiac rehabilitation such as the use of Telehealth, phone and the internet, as well as providing flexible program options to better meet differing client needs.

The work underway in Nova Scotia related to cardiac and stroke disease management was acknowledged (presented at the round table discussions on Friday evening) and the importance of building on this strong foundation was emphasized. Further, the need to build an effective system for comprehensive management of cardiac disease and stroke, given the growing burden of risk factors and chronic diseases in the population was noted. The average District and provincial volume of cases of stroke and cardiac disease

was noted, overlaid by gaps in availability of services at present. The presentation concluded with a review of potential challenges to the development and implementation of disease management initiatives, and recommendations for moving forward in building a sustainable system in Nova Scotia.

Data: Secondary and Tertiary Prevention for Cardiac and Stroke Care

Dr. Jafna Cox presented recent data from CVHNS' ICONS database related to demographics and patient profiles. Specifically, profiles were presented of patients with Acute Myocardial Infarction (AMI) and Congestive Heart Failure (CHF) including hospitalization rates, gender differences, and risk factors. Data related to access issues were reviewed including Acute Coronary Syndrome (ACS) and CHF rates by District, and rates of interventions and procedures. The presentation concluded with a review of outcome data related to readmission rates and mortality.

Dr. Gordon Gubitz provided an overview of the preliminary results of CVHNS' audit of stroke care in Nova Scotia. The purpose of the audit was to identify gaps between current care and best practice recommendations, direct interventions for improving stroke care in Nova Scotia, and test the feasibility of using the Registry of the Canadian Stroke Network for periodic/ongoing stroke surveillance in Nova Scotia. The methodology of the audit was highlighted and key findings presented including: time to arrival in the Emergency Department, Imaging (CT), and treatment with IV t-PA. Also presented were data related to length of stay in acute care, team involvement in care, in-hospital mortality, discharge disposition, and antithrombotics on discharge.

Description of Initiatives from other Jurisdictions

Ms. Louise Morrin (Calgary, Alberta) and Ms. Alexis Dishaw (Toronto, Ontario) provided presentations on disease management initiatives from other jurisdictions. Ms. Morrin presented on Calgary's approach to Chronic Disease Management (CDM) and noted that the CDM model developed by the MacColl Institute and expanded by BC is the

foundation for their work. Key elements of the implementation of the model included academic detailing and nurse case management within primary care, and the development and implementation of a multicultural program entitled *Living Well with a Chronic Condition*. The aims of the *Living Well* Program were reviewed and the fact that the Program is community centred was emphasized. Key elements of *Living Well with a Chronic Condition* include an exercise program, education, self management and follow-up. Ms. Morrin went on to describe *Row Your Own Boat*, their self management support program. The presentation concluded with a review of activities related to the elements of the CDM model including delivery system design, information systems, decision support, and community integration.

Ms. Dishaw provided an overview of the development of a stroke system in Ontario. The presentation began by highlighting the importance of integration and benefits of such an approach for the system. The initiation, objectives and scope of the Ontario Stroke system were presented with a detailed description of stroke prevention clinics provided. The Cardiac Rehabilitation Secondary Prevention Pilot was then reviewed including key areas of the model and its objectives. Ms. Dishaw reviewed the commonalities between the approach to the stroke system and the cardiac rehabilitation model including knowledge translation (applying evidence and policy application); integration; Telehealth for prevention and promotion; and engaging and working with primary care (specifically family practice physicians).

Key Learnings from Initiatives from other Jurisdictions

Ms. Morrin and Ms. Dishaw presented the key learnings from their work related to chronic disease management. Highlights of the lessons learned include:

- ◆ the importance of change management strategies to support the implementation of new approaches and models;
- ◆ the challenges in working in a system that is in flux;
- ◆ the need for broad system changes and a comprehensive approach;

- ◆ the importance of patience as this is a paradigm shift;
- ◆ the need for support from champions and “movers and shakers”, and a network of individuals to promote the work clinically, publically and politically;
- ◆ the need for leadership provincially and locally (within regions);
- ◆ the need for collaboration with varied partners (e.g., government and non-government decision-makers and research leaders) to maximize resource utilization;
- ◆ the importance of integration;
- ◆ the importance of knowledge transfer/exchange;
- ◆ the need for dedicated infrastructure including staff and committees;
- ◆ the need for capacity building approaches to build on existing resources and early successes;
- ◆ the importance of using evidence to inform policy and practice coupled with flexibility to respond to local needs and circumstances; and
- ◆ the importance of evaluation and monitoring including obtaining baseline data.

Reflections and Wrap Up

Dr. O’Neill advised that a report summarizing the input received during the meeting would be prepared and circulated to all participants. Dr. O’Neill and Mr. Peter MacKinnon (Chair of the CVHNS Advisory Council and CEO for Colchester East Hants Health Authority) closed the meeting by thanking participants for their valuable input and emphasized that the work underway related to the development and implementation of disease management initiatives will require transformation change and the need for strong leadership at multiple levels of the health system (e.g., across the continuum of care, provincially, within Districts, and within the community). It was noted that there are tremendous opportunities for moving forward, particularly with the wealth of knowledge and expertise in Nova Scotia (exemplified by the Network participants).

Nothing is more powerful than an idea whose time has come. (Victor Hugo)

SUMMARY OF THE WORKING SESSIONS

The Ideal and Principles for Disease Management Services and Programs for People with existing Cardiovascular Disease

A working session was conducted where meeting participants worked in small groups to develop their ideal “picture” of disease management services and programs for the secondary and tertiary prevention of cardiac disease and stroke. After reflecting on the ideal, meeting participants developed principles or parameters to guide the development of these programs and services.

In describing the ideal, there was consistency among the groups in that components of the provincial model for CDM were embraced including the need for: self management support (therefore client-centered and including the family), interdisciplinary teams, linkages with community resources, education and team building of health providers, and committed leadership. In addition, the small groups consistently highlighted the need to:

- ◆ Focus “up stream” on prevention (e.g., healthy public policy, supportive environments, etc.);
- ◆ Embed the model in the community (not just linking with the community) with less of a focus on hospitals and more focus on primary care;
- ◆ Build intersectoral partnerships;
- ◆ Build on existing programs such as Diabetes Centres to expand education and behavioural counselling services to other chronic diseases; and
- ◆ Support research and knowledge exchange and transfer.

Below is a synthesis of the guiding principles developed by the small groups.

- ◆ Be patient centered with a focus on self management support; not disease, provider or system centred
- ◆ Be integrated and coordinated across diseases with a focus on chronic disease management
- ◆ Recognize the determinants of health and a population based approach including addressing cultural diversity
- ◆ Be equitable and accessible for all Nova Scotians (geographic, financial and timing)
- ◆ Explore innovation and alternative service methods
- ◆ Foster collaboration across the continuum of care and build interdisciplinary models
- ◆ Build on existing infrastructure, programs, services and assets, and recognize disparities
- ◆ Be evidence based and include best practices with measurable outcomes and the ability to measure cost effectiveness
- ◆ Be sustainable with a long term plan and accountability mechanisms
- ◆ Be developed through a participatory approach and meaningful dialogue with front line providers

- ☑ Guiding principles are a general set of guidelines that set the foundation for how an organization/structure will operate.
- ☑ Guiding principles are more than just a set of statements about values; they also describe the actions the organization/structure will take based on the values.
- ☑ Guiding principles serve as a basis of reasoning and action, a personal code of conduct that leads, shows the way and directs the movement of an

Opportunities, Challenges and Next Steps

Meeting participants worked in small groups through a “carousel activity” to identify and discuss opportunities, challenges and next steps for the development of a provincial model/approach for disease management programs and services for the secondary and tertiary prevention of cardiac disease and stroke. Following is a summary of the small group work.

Opportunities

- ◆ The work underway at a provincial level related to the development of a CDM Strategy is something that CVHNS can build on and link to in the development of a provincial approach for disease management services and programs for the secondary and tertiary prevention of cardiac disease and stroke.
- ◆ There is funding available for self management strategies which aligns with the provincial CDM model, and there are best practices and evidence from other jurisdictions that Nova Scotia can build on.
- ◆ There is a need and opportunity to implement self management support across existing programs.
- ◆ Although investments are required there may be resources locally and provincially to support disease management programs and services that address cardiac disease and stroke; there is a need to identify these existing resources (e.g., within District Health Authorities, Community Health Boards, community resources, etc.).
- ◆ Through the Primary Health Care Transition Fund and other initiatives, interdisciplinary teams and resources have been created; there is a need to build on these resources and strengths, and further strengthen the Primary Care system.
- ◆ There are opportunities to improve communication between providers and across the continuum of care to better support disease management for cardiac disease and stroke.
- ◆ Collaboration with other sectors is critical and there are opportunities to build these partnerships.
- ◆ The sense of urgency to develop and implement strategies to address CDM provides an opportunity to formalize commitment from leadership within various organizations including the Department of Health, Nova Scotia Health Promotion and Protection, District Health Authorities, Provincial Programs, etc.
- ◆ There are champions and “ambassadors” both locally and provincially who can advocate for an integrated approach to CDM based on the provincial model.

- ◆ There are success stories and local examples that can be used to build awareness and commitment.
- ◆ There are opportunities for cost savings through less duplication and a more cost effective use of resources.
- ◆ There is data available to “make the case” and illustrate that an integrated approach depicted in the CDM model works.
- ◆ There are opportunities to maximize existing human resources to address CDM and apply the model such as more effective use of paramedics and fire fighters in offering community programs and services (e.g., visiting and follow-up with seniors after discharge from the hospital).
- ◆ Information management systems and the availability of data for planning are growing through the implementation of the Primary Health Care Information Management system, creation of patient registries, etc.
- ◆ There is growing readiness to address CDM among the diverse stakeholders needed to effectively implement the model as well as from the public.
- ◆ Opportunities with private partners are growing and there is an opportunity to be innovative in exploring required investments.

Challenges

- ◆ There are a lack of resources and a need to identify potential resources to support implementation of disease management programs and services, including existing resources for reallocation and new opportunities for investment.
- ◆ The implementation of disease management based on the CDM model is complex and will require an investment in change management strategies to address key issues such as integrating across programs and disciplines, power sharing, enhancing and changing scopes of practice, etc.
- ◆ There is a lack of accountability and an action plan for the implementation of disease management initiatives based on the CDM model.
- ◆ There is a lack of leadership at all levels to support implementation of disease management programs based on the CDM model.

- ◆ Engaging some providers is challenging, particularly those in primary care.
- ◆ There is need to continue to build public awareness about the importance of self management support, etc.
- ◆ There is a lack of incentives to motivate some providers to participate.
- ◆ Ensuring equal access for all across Nova Scotia (the geography of Nova Scotia).

Next Steps

- ◆ Conduct an inventory and environmental scan of chronic disease management initiatives provincially and locally to identify existing work that can be supported and built upon.
- ◆ Build and secure leadership and commitment for disease management among multiple stakeholders including the Department of Health, Provincial Programs, District Health Authorities, etc.
- ◆ Develop an implementation plan with action steps including the identification of priorities for action, timelines and responsibilities, and incorporate these within business planning.
- ◆ Build awareness and commitment for disease management and the CDM model among various stakeholders (e.g., conduct a “Manager’s Summit”; build commitment among Community Health Boards, physicians, Doctors Nova Scotia, Provincial Programs, etc.).
- ◆ Establish outcomes with targets and monitor these on an ongoing basis.
- ◆ Engage stakeholders from various disciplines and across the continuum of care to support the implementation of disease management programs and services based on the CDM model/framework (e.g., home care).

MEETING FEEDBACK

At the conclusion of the meeting participants provided feedback on a short questionnaire, with 40 questionnaires returned.

Participants were asked to reflect on the success of the meeting given its purpose: *to inform the development of a provincial approach to disease management and secondary/tertiary prevention for cardiac disease and stroke* (based on a five point likert scale with “1” being unsuccessful and “5” being successful). The responses were overwhelming positive with 95% of respondents indicating 4 or higher (mean score 4.6).

When asked to explain their rating some consistent themes emerged including that the meeting:

- ◆ Provided an opportunity for networking, sharing and interaction, and engaged a range of providers and partners.
- ◆ Provided important information related to the topic including high quality presentations and content that was thought provoking.
- ◆ Generated ideas for action and appeared to stimulate energy and commitment for change (although it was noted that “the key to success will be if we use this information to move forward”).
- ◆ Built on both local work and resources as well as learning from other jurisdictions.
- ◆ Engaged participants and was focused and positive.
- ◆ Was well planned.

Probably the best network meeting yet! Very informative, flowed well. We seem to be on the right track and have a better sense of what we are trying to accomplish and why.

(Meeting participant)

When asked, “if the meeting could happen again, what parts would you want to remain the same”, the following themes emerged:

- ◆ The Friday evening round table discussions where local work was shared
- ◆ The small working group sessions
- ◆ The presentations by the guest speakers
- ◆ The good mix of participants
- ◆ The presentations on the data

Round tables to learn about various pieces of work in our province – excellent idea; further presentations from folks who have worked with the model of care...lessons learned...we can learn so much from those who have 'been there, done that'.

(Meeting participant)

The following themes emerged when participants were asked for suggestions on how the meeting could be improved:

- ◆ No improvements suggested as it was a good meeting
- ◆ There was a lot of information to digest (“information overload”) and fewer didactic presentations would have improved the meeting
- ◆ A commitment to action (versus brainstorming about the model/approach and challenges and opportunities – it is time to move to action)

Have been through this repeatedly by different programs. Time to move from model to action plans. I have been chronic disease modeled to death. Let's now start planning the change.

(Meeting participant)