Integrated Health Clinic

#105-550 Carmi Avenue, Penticton BC V2A 3G6
Phone (250)770-5507 Fax (250)770-5506

"Integrated" Client care

Self Management Focus

Grassroots involvement

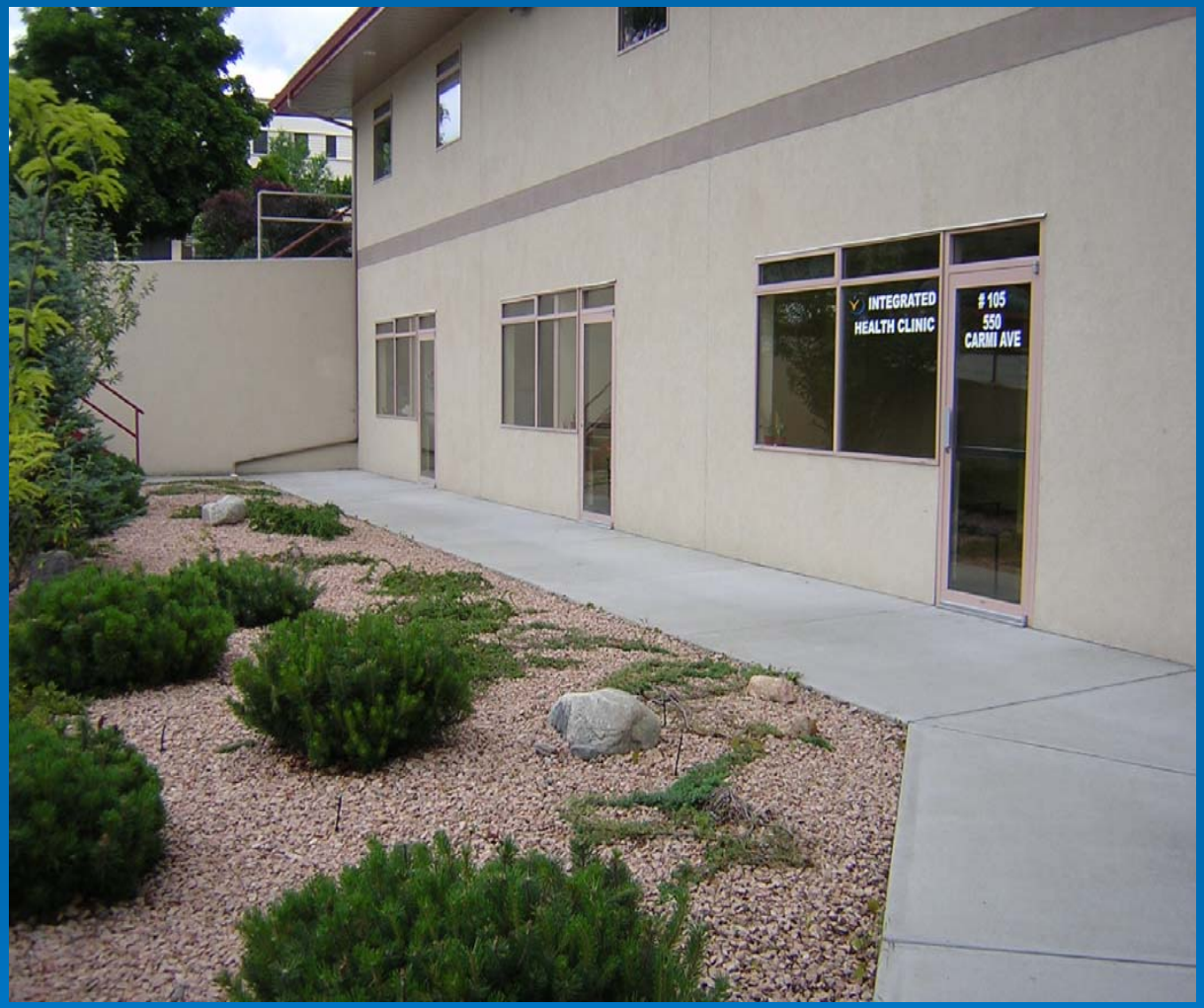
Shared Care

System change

#105 -550

Carmi Ave.

Penticton

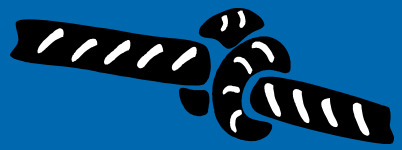


Integrated Health Clinic

"right-siting"

Prevention and Management of chronic conditions

Three Clinics into One



Three clinics with different client flows and commonality of risk factors needed to be melded. We began in 2002.

2003/2004 Knows and Needs

- The system had to change
- Resources were scarce
- Teams work well

- Evidence based care
- Shared care models – system change
- Client self-management

INTEGRATION – Why????

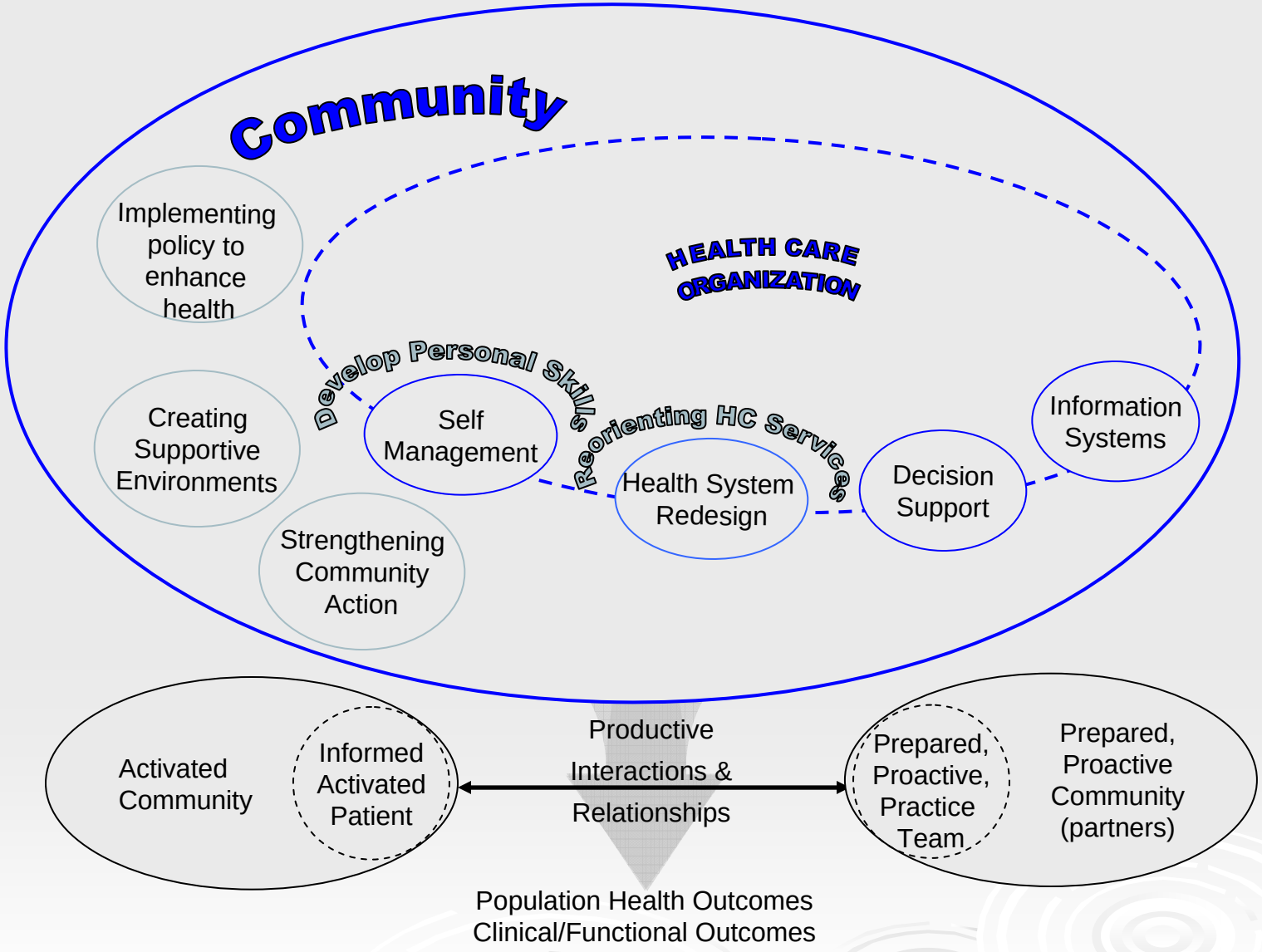
- Break down “silos”
- Reduce costs - Outfitting one center rather than many
- Eliminate duplication
- Evidence supports that chronic disease patients intermingle with great success.

Penticton - Where we started?

2002

- Clinical staff & Leadership team identified issues around management of chronic illnesses
- Decision to focus on integration of the “vascular cluster” diseases – ie: diabetes, renal and cardiac

THE EXPANDED CHRONIC CARE MODEL* - INTEGRATING POPULATION HEALTH PROMOTION



Created by: Victoria Barr, Sylvia Robinson, Brenda Marin-Link, Lisa Underhill, Darlene Ravensdale & Anita Dotts (2002)

*Adapted from the Chronic Care Model: Glasgow, R., Orleans, C., Wagner, E., Curry, S., Solberg, L. Does the Chronic Care Model Serve Also as a Template for Improving Prevention? The Milbank Quarterly, 79(4), 2001. Also the World Health Organization, Health and Welfare Canada, Canadian Public Health Association. Ottawa Charter of Health Promotion. WHO, Copenhagen. 1986

Vision Statement

December 19,2003

"A multidisciplinary, horizontally integrated, single site clinic for prevention and management of the Cardiovascular Cluster of chronic diseases."

Who will be Our Partners in Integration?

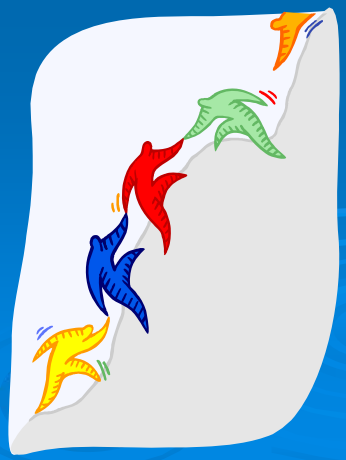
- Provincial Health Services Authority
- *Provincial Renal Agency*
- *IHA*
- *Canadian Congestive Heart Failure Networks*
- *Canadian Association of Cardiac Rehab.*
- *Penticton Active Living Centre*
- *Canadian Diabetes Assoc.*
- *Community Resources*
- **Heart and Stroke Foundation**
- *City of Penticton*
- *Multidisciplinary providers across the continuum of care*

Phase 1: Planning
January to March 2004

- Definition of the program specific requirements.
- Detailed planning phase.

Working Teams

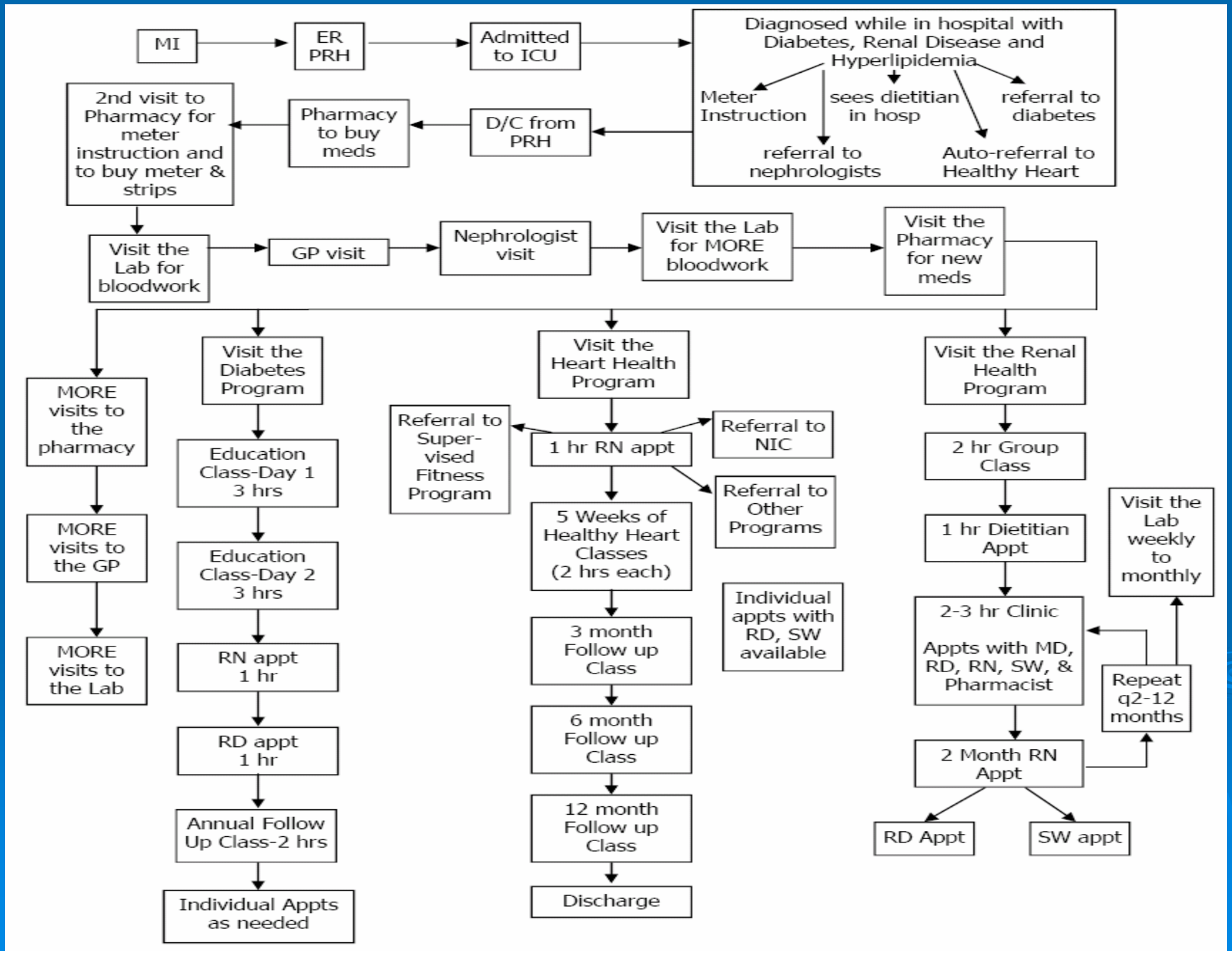
- Decision Support
- Cross Training
- Curriculum Development
- Scheduling



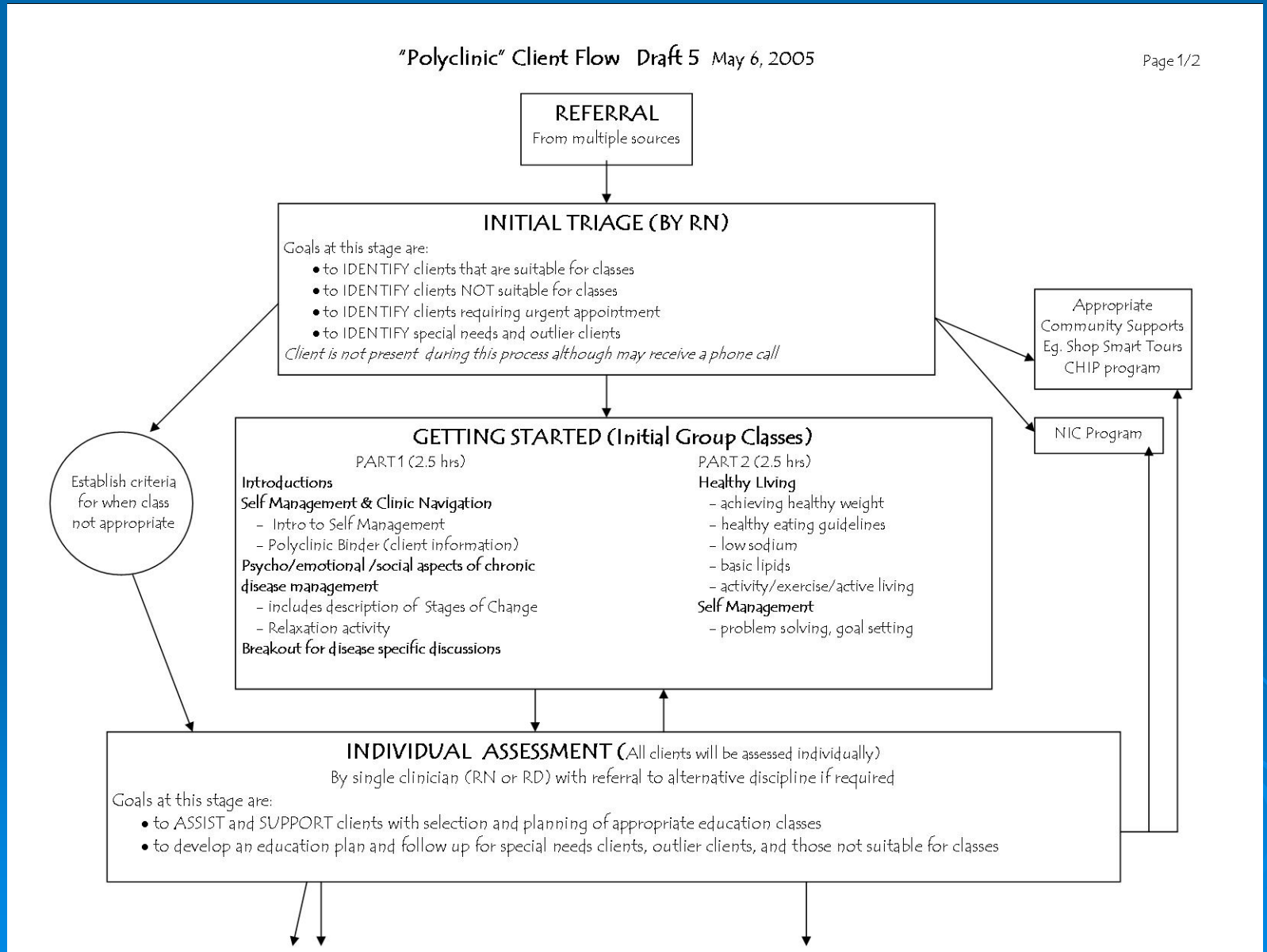
Meetings, Meetings, Meetings

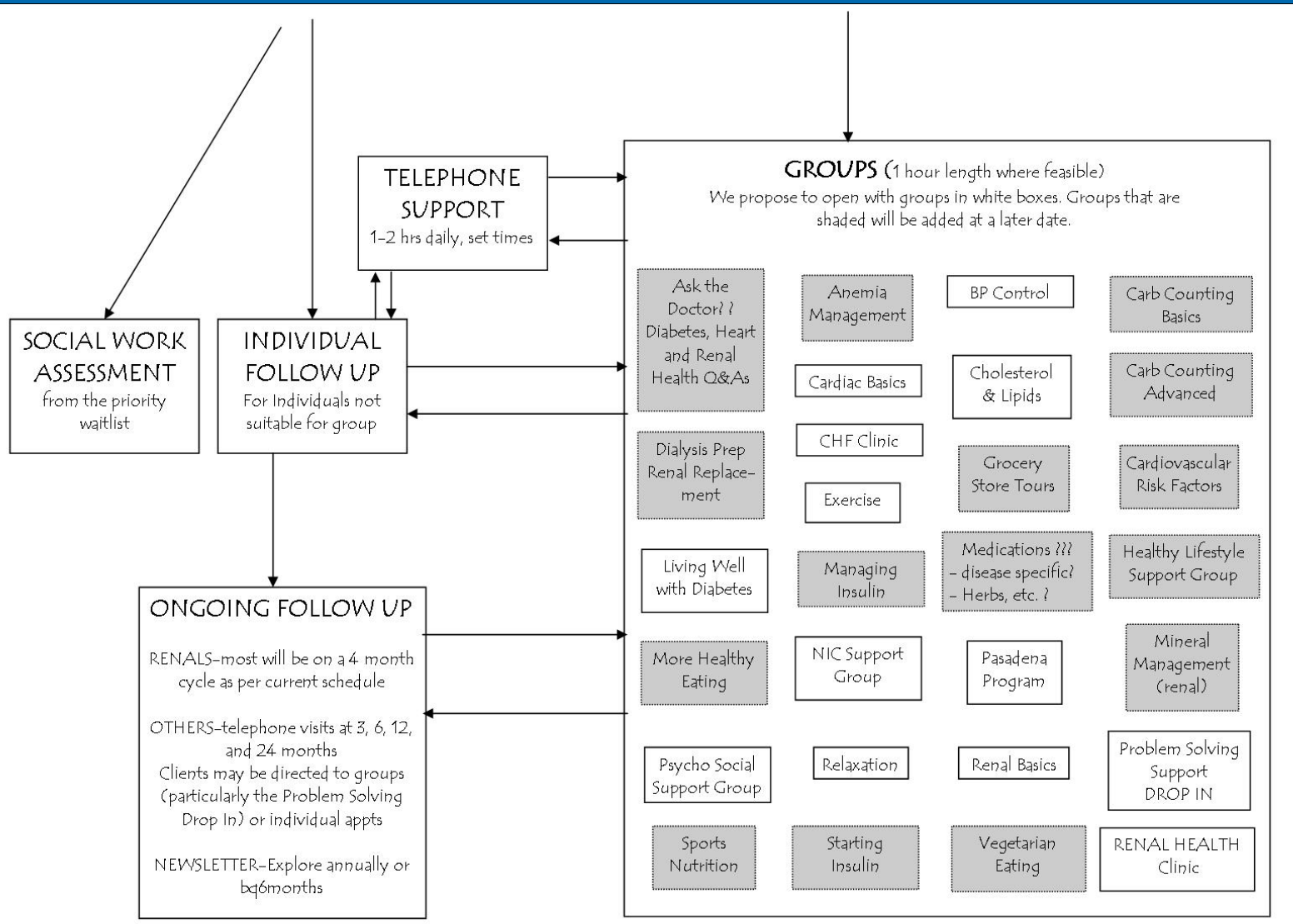
- Referral process/ format/client triage
- Forms – flow sheets, assessment, etc.
- “the Name Game” – what will the clinic be called?
- Client visits – individual vs group
- Cross-training of professionals
- Bookings?
- Current clinics – how to’s?
  - Process mapping : current vs integrated
  - “OH What a Tangled Web we weave!”

The Heart Attack Journey with Chronic conditions



The Integrated Journey….Individual choices & partnerships




SOCIAL WORK ASSESSMENT
from the priority waitlist
TELEPHONE SUPPORT
1-2 hrs daily, set times
INDIVIDUAL FOLLOW UP
For Individuals not suitable for group
ONGOING FOLLOW UP
RENALS-most will be on a 4 month cycle as per current schedule
OTHERS-telephone visits at 3, 6, 12, and 24 months
Clients may be directed to groups (particularly the Problem Solving Drop In) or individual appts
NEWSLETTER-Explore annually or bq6months
GROUPS (1 hour length where feasible)
We propose to open with groups in white boxes. Groups that are shaded will be added at a later date.
Ask the Doctor? ? Diabetes, Heart and Renal Health Q&As
Anemia Management
BP Control
Carb Counting Basics
Cardiac Basics
Cholesterol & Lipids
Carb Counting Advanced
Dialysis Prep Renal Replace-ment
CHF Clinic
Exercise
Grocery Store Tours
Cardiovascular Risk Factors
Living Well with Diabetes
Managing Insulin
Medications ??? - disease specific? - Herbs, etc. ?
Healthy Lifestyle Support Group
More Healthy Eating
NIC Support Group
Pasadena Program
Mineral Management (renal)
Psycho Social Support Group
Relaxation
Renal Basics
Problem Solving Support DROP IN
Sports Nutrition
Starting Insulin
Vegetarian Eating
RENAL HEALTH Clinic

Common Materials

- Client Questionnaire
- Intervention Tracking Form
- Referral Form
- Class Descriptions

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Class Descriptions

Getting Started Classes
These introductory classes are offered in 2 sections. In Part 1, participants learn about the stages people go through when making changes, and how to manage stress and emotions.

In Part 2, you will hear about how healthy eating and active living can help you manage your condition.

We encourage all clients to register for these 2 sessions.
Each session is 2.5 hrs

Blood Pressure Management
Is your blood pressure higher than 130/80? In this class, we will discuss blood pressure readings, goals, and different ways to lower blood pressure.
1 hour

Carbohydrate Counting
Learn more about counting carbohydrates in your meals and ways to improve blood glucose control. **2 hours**

Cardiac Basics
Understand more about how the heart works, and learn about steps to take control of heart conditions.
1 hour

Diabetes Basics
This class highlights steps for taking control of diabetes. Register for this class if you are new to diabetes or looking for a "refresher". **1.5 hours**

Exercise and Active Living
Getting more active? Learn more about warming up and down, how often to start exercising, resistance training, and much much more! **1 hour**

Healthy Lifestyles for A Healthy Weight
This is an education group to support people in reaching their weight loss goals. Both men and women are welcome and "weigh-in's" are optional. Drop Ins are also welcome. **1.5 hours**

Insulin—Things You Should Know
Administering insulin is one way to get blood sugars on target. Topics include how to inject insulin and how to prevent and treat hypoglycemia.

Just curious? Come to the class to learn more about using insulin. **1 hour**

Living Well with a Chronic Condition
This is an education and support group for people living and managing chronic conditions. Topics include whole person health, communication, acceptance and adjustment and caregiver issues. Drop Ins are-welcome. **1.5 hours**

Managing Cholesterol & Lipids
Participants will learn more about how food and an active lifestyle can affect the levels of cholesterol and other fatty substances in the blood. **2 hours**

See reverse side

Phase 2: Implementation
April 2005

Implementation of new program and move to the new site.

Consolidation of program to include:

- Diabetes Education Program
- Cardiovascular Program
- Renal Program

Bumps along the road…

- Turf protection
- Getting the docs involved/engaged/informed
- Resistance - Why change what works?
- How to combine current evidence-based protocols?
- Flowsheets -?
- Meetings, meetings, meetings
- Construction timelines…
- Siloed budgets

Lessons Learned

- Grassroots involvement!
- Partnerships are key!
- Evaluation must begin at the beginning!
- Keep the client at the centre – revisit the vision.
- Focus on process/system change
- Don’t reinvent the wheel!
- Remember “ it’s always a work in progress”
  - ANY PLAYERS MISSING?.....

Any players missing?

- IT – Essential!
  - Integration of client data
  - Scheduling and booking
  - Common database for all 3 programs

Above All: *Collect Outcomes*

- Establish a set number of data points that you will collect
- Track the data points over time, at least one year
- Treat your data points statistically
- Know how much each session, each program costs per patient.

Phase 3: Long Term Strategy

Incorporate other programs, potentially

- visiting podiatrist
- pain management clinic
- gait disorders
- COPD clinic
- community asthma clinic
- Smoking cessation clinic

Phase 3

- April/05 – March/06
  - Evaluate phases 1 and 2
  - Implement integrated programs – Prevention and management
  - Expand/incorporate other programs

Fall/05 -Where are we at now?

- SEEING MORE CLIENTS more “holistically”
- Working as a Shared Care team…
- Feeding more info back to Doctors
- Changing processes/education classes/ appts based on feedback….daily
- Working on protocols ie: combining lab work
- IMIT – PROMIS platform –working with PRA
- SHAREPOINT/Navigation with PHSA
- Starting the Client Evaluation piece
- Creating a community “presence”
- Still….A “work in progress”


JJ's
Side

THE POSSIBILITIES

ARE

ENDLESS

How can YOU access the Integrated Health clinic?

- Referral from your physician
- Self referral for our classes