



BRITISH COLUMBIA CENTRE for EXCELLENCE in HIV/AIDS

# PARADIGM SHIFT

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# **Faculty Disclosure**

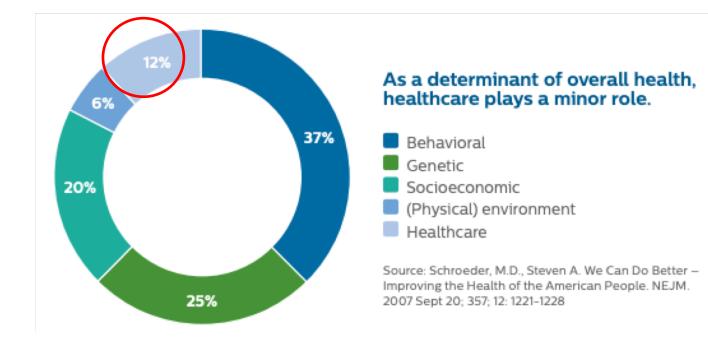
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• No Conflict of Interest to disclose

# Objectives

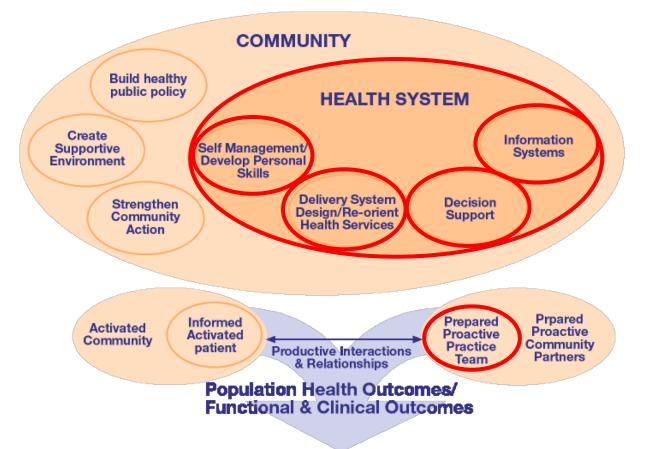
- Review The Determinants of Health
- Review The Expanded Chronic Disease Model
- Changing Paradigms
- OUD Cascade of Care

## **Determinants of Health**



Yet... We have not maximized the benefit of health care

## The Expanded Chronic Care Model



Created by: Victoria Barr, Sylvia Robinson, brenda Marin-Link, Lisa Underkill, Anita Dotts & Dariene Revenadale (2002) Adapted from Glasgow, R., Orleans, C., Wagner, E., Curry, S., Solberg, L. (2001). Does the Chronic Care Model also serve as a template for improving prevention? <u>The Milbank Quarterly, 79(4)</u>, and World Health Organization, Helath and Welfare Canada and Canadian Public Health Association. (1986). <u>Ottawa Charter of Health Promotion.</u>

<u>Hosp Q.</u> 2003;7(1):73-82. The expanded Chronic Care Model: an integration of concepts and strategies from population health promotion and the Chronic Care Model. <u>Barr VJ</u>, <u>Robinson S</u>, <u>Marin-Link B</u>, <u>Underhill L</u>, <u>Dotts A</u>, <u>Ravensdale D</u>, <u>Salivaras S</u>. **Source:** Vancouver Island Health Authority.



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Table 1       The Chronic Care Model (Wagner et al. 1999)		
MODEL COMPONENTS		EXAMPLES
Health System - Organization of Healthcare	Program planning that includes measurable goals for better care of chronic illness	<ul> <li>Visible support of improvements provided by senior leadership</li> <li>Incentives for care providers</li> </ul>
Self-Management Support	Emphasis on the importance of the central role that patients have in managing their own care	<ul> <li>Educational resources, skills training and psychosocial support provided to patients to assist them in managing their care</li> </ul>
Decision Support	Integration of evidence based guide- lines into daily clinical practice	<ul> <li>Wide dissemination of practice guidelines</li> <li>Education and specialist support provided to healthcare team</li> </ul>
Delivery System Design	Focus on teamwork and an expanded scope of practice for team members to support chronic care	<ul> <li>Planned visits and sustained follow-up</li> <li>Clearly define roles of healthcare team</li> </ul>
Clinical Information Systems	Developing information systems based on patient populations to provide relevant client data	<ul> <li>Surveillance system that provides alerts, recall and follow-up information</li> <li>Identification of relevant patient subgroups requiring proactive care</li> </ul>
Community Resources and Policies	Developing partnerships with community organizations that support and meet patients' needs	<ul> <li>Identify effective programs and encourage appropriate participation</li> <li>Referral to relevant community-based services</li> </ul>

# Make a Change

- Write the word "Change" on a piece of paper
- Switch hands and write "Change" again
- What was it like to change hands?



# Paradigm shift

"An important change that happens when the usual way of thinking about or doing something is replaced by a new and different way" (Merriam-Webster Dictionary)



# What is Urgent vs. What is Important

#### URGENT



VS

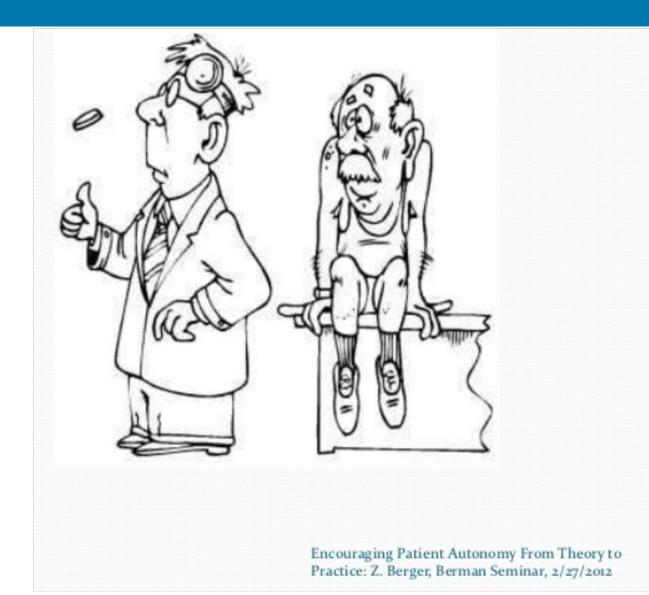
IMPORTANT



## Whirlwind (The Day Job)

Goals (New Activities)

## Patient Autonomy



#### **Reactive Care**

- No intervention until a problem occurs
- Not routinely identifying and assessing patients at high risk

#### **Proactive Care**

- Early identification
- Care protocols/pathways
- Routine assessments and reviews

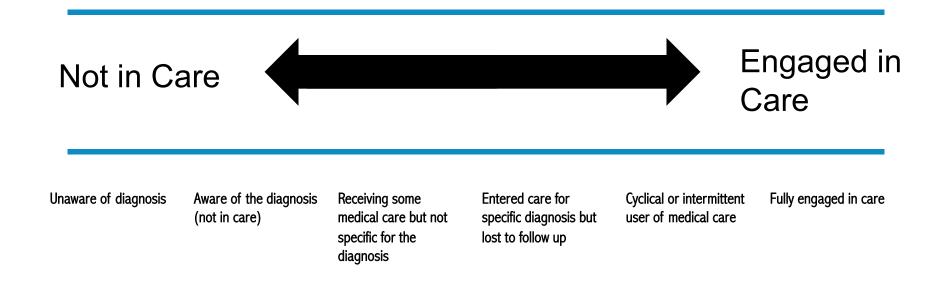


- Increased morbidity/mortality
- Increased health care costs

- Reduced hospital admissions
- Improve morbidity/mortality
- Increases QoL
- Health care savings



#### **Continuum of Care**

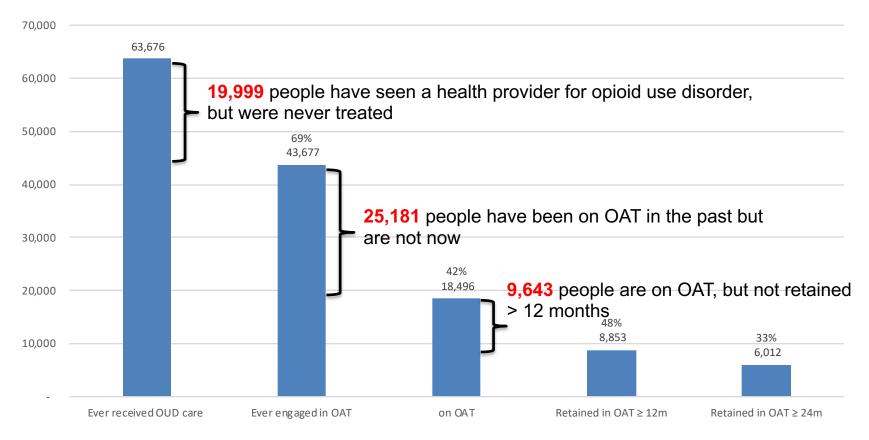


Adapted from: Giordano TP, Gifford AL, White AC Jr, et al. Retention in care: a challenge to survival with HIV infection. Clin Infect Dis 2007; 44:1493–9. Modified from: Eldred L, Malitz F. Introduction [to the supplemental issue on the HRSA SPNS Outreach Initiative]. AIDS Patient Care STDS 2007; 21(Suppl 1):S1–S2.



#### **BC Cascade of Care for PWOUD**

Cascade of care among PWOUD in BC





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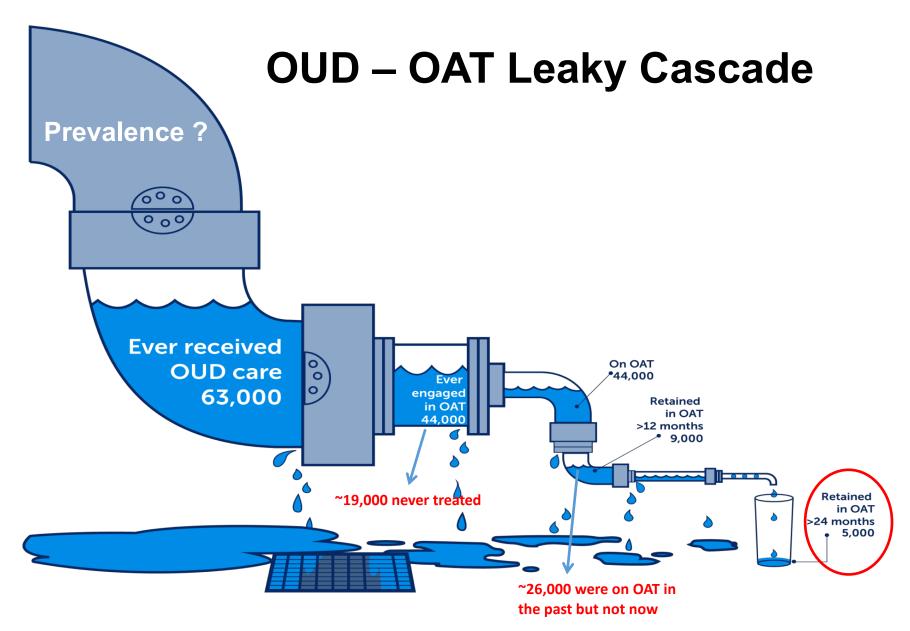


#### As of November 30th, 2017



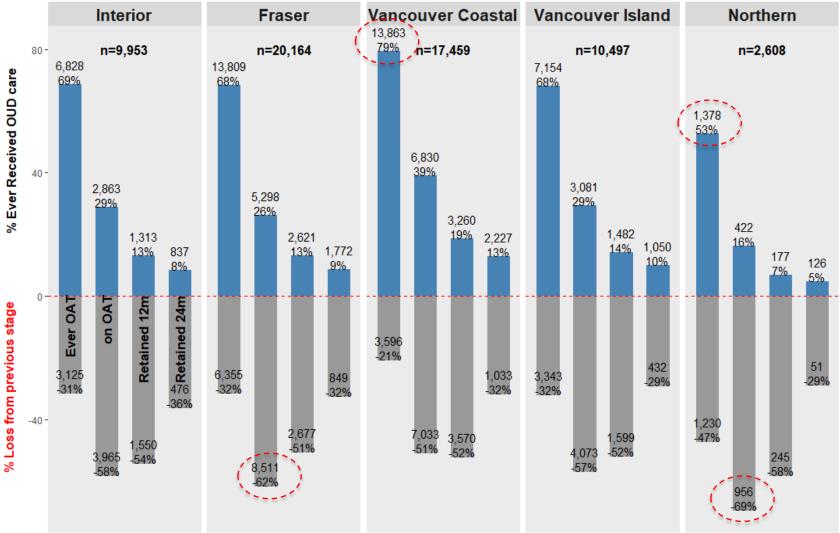






Adapted from Nosyk, et al

## **Comparing Across HAs**





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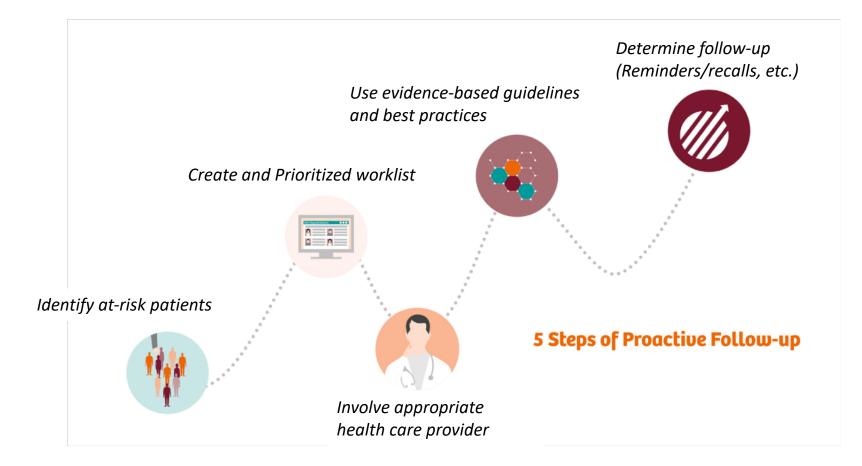








# **Basic Steps of Proactive Follow-up**



# **Key Points**

- Change is difficult and takes time
- •The health care system is a small contribution to the overall health of the individual and population
- •OUD is a chronic disease
- •The Expanded Chronic Disease Model is a useful framework to address OUD
- •There are many opportunities to stop the leakage of the cascade of care for OUD

## **References and Resources**

- Schroeder MB, Steven A. We Can Do Better Improving The Health of the American People. NEJM 2007. 357(12):1221-1228
- Giordano TP, Gifford AL, White AC Jr, et al. Retention in care: a challenge to survival with HIV infection. Clin Infect Dis 2007; 44:1493–9. Modified from: Eldred L, Malitz F. Introduction [to the supplemental issue on the HRSA SPNS Outreach Initiative]. AIDS Patient Care STDS 2007; 21(Suppl 1):S1–S2.
- <u>Hosp Q.</u> 2003;7(1):73-82. The expanded Chronic Care Model: an integration of concepts and strategies from population health promotion and the Chronic Care Model. <u>Barr VJ</u>, <u>Robinson S</u>, <u>Marin-Link B</u>, <u>Underhill L</u>, <u>Dotts A</u>, <u>Ravensdale D</u>, <u>Salivaras S</u>. Source: Vancouver Island Health Authority.
- Nosyk B., et al (unpublished) Nov 2017.
- Merriam-Webster Dictionary (online access at <u>www.merriam-webster.com/dictionary/paradigm%20shift</u>)