Implementing components of the chronic care model to improve quality of care for anxiety and depression in Quebec

Pasquale Roberge[1,2], Louise Fournier[1,2]
Denise Aubé[3], Hélène Brouillet[3], Isabelle Doré[3], & Matthew Menear[2]
[1] CRCHUM, [2] University of Montreal, [3] Institut national de santé publique du Québec

2009 Collaborative Mental Health Care Conference
Hamilton, May 29th 2009

CHUM   Université de Montréal   qualaxia   Québec

OBJECTIVES

1. TO OFFER STRATEGIES AND TOOLS to actors involved in primary mental healthcare, in order to facilitate the adoption and the implementation of components of the chronic care model for anxiety and depression (knowledge application program);

2. TO EXAMINE THE ORGANISATIONAL AND CONTEXTUAL FACTORS that may facilitate or hinder the implementation of the components;

3. TO ASSESS THE IMPACT OF THE KNOWLEDGE APPLICATION PROGRAM on the level of implementation of the components.

2
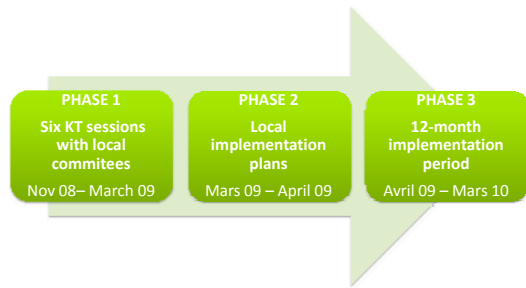

SIX LOCAL SERVICES NETWORKS

- 2 in Montréal
- 1 on the south shore of Montreal
- 1 in Québec city
- 2 in distant and remote regions

POUR UNE MEILLEURE QUALITÉ DES SOINS ET SERVICES DE PREMIÈRE LIGNE EN SANTÉ MENTALE

3

The three phases of the program

PHASE 1	PHASE 2	PHASE 3
Six KT sessions with local commitees	Local implementation plans	12-month implementation period
Nov 08– March 09	Mars 09 – April 09	Avril 09 – Mars 10

4

WHY ANXIETY AND DEPRESSION?

→ Anxiety and mood disorders are **the most prevalent** mental disorders in the general population.

→ They constitute an important source of distress and disability.

→ There is a **high risk of recurrence and chronicity** for anxiety and mood disorders in the absence of treatment.

5

WHY IN PRIMARY CARE?

- More than 80 % of the people consulting for a mental health problem are doing so in **primary health services**, especially with general practitioners.

- 95 Local services networks & Centres de santé et de services sociaux (CSSS) in Quebec with a *populational responsibility*.

- Mental Health Action Plan (2005)
  - o Multidisciplinary *Primary Mental Health Care Teams*
  - o Teams include psychologists, social workers, nurses, and sometimes general practitioners…
  - o One-stop access to mental health services
  - o Hierarchy of services

http://www.msss.gouv.qc.ca   6

PROJET
CIBLE QUALITÉ
POUR UNE MEILLEURE QUALITÉ DES SOINS ET SERVICES DE PREMIÈRE LIGNE EN SANTÉ MENTALE

The knowledge
application program

NEW PARADIGM COHERENT WITH A CHRONIC CARE APPROACH

	BEFORE	CURRENT
ANXIETY AND DEPRESSIVE DISORDERS	Episodic disorders	• Recurrent • Chronic course
TREATMENT GOALS	Reduction of symptoms	• Full Remission • Optimal functioning
CARE MODEL	Acute care	• Chronic care

Source: Keller, 2006
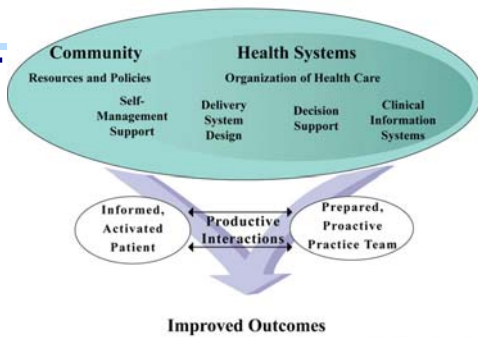
THE CHRONIC CARE MODEL COMPONENTS

1. **HEALTH SYSTEMS**
   "Create a culture, organization and mechanisms that promote safe, high quality of care"

2. **DELIVERY SYSTEM DESIGN**
   "Assure the delivery of effective, efficient clinical care and self-management support"

3. **DECISION SUPPORT**
   "Promote clinical care that is consistent with scientific evidence and patient preferences"

10

THE CHRONIC CARE MODEL COMPONENTS

4. **CLINICAL INFORMATION SYSTEM**
   "Organize patient and population data to facilitate efficient and effective care"

5. **SELF-MANAGEMENT SUPPORT**
   "Empower and prepare patients to manage their health and health care"

6. **COMMUNITY**
   "Mobilize community resources to meet needs of patients"

11

CONTEXT: A MOMENTUM FOR THE PROJECT

A favorable context for a quality improvement initiative based on the Chronic Care Model
- The Québec reform (local services networks, creation of CSSS)
- The Mental Health Action Plan
- Mental health recommendations from Accreditation Canada
- A culture of quality improvement

12

PROJET
CIBLE QUALITÉ
POUR UNE MEILLEURE QUALITÉ DES SOINS ET SERVICES DE PREMIÈRE LIGNE EN SANTÉ MENTALE

The knowledge application framework: PARiHS
(Kitson et al., 1998)

«Promoting Action on Research Implementation
in Health Services»

13

PARIHS FRAMEWORK (Kitson et al., 1998)

➢ « Succesful implementation of research into practice is a function of the interplay of three core elements –evidence, context & facilitation. » (Kitson et al., 1998, p.149)

Evidence ⟷ Context
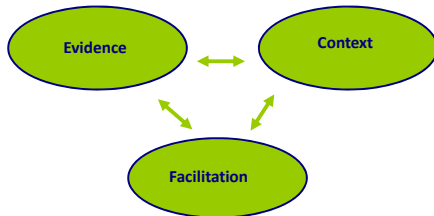
Facilitation

14

External facilitation	Internal facilitation
Researchers and knowledge broker	Local work committees & leader
• Developing the knowledge application program; • Finding and/or adapting material and tools; • KT at the local level; • Animation of the 6 KT sessions (researcher/knowledge broker) • Data collection	• Composed of at least three managers or clinicians, including if possible a primary care physician; • Responsible for the development and implementation of the program in their CSSS; • **Local leader** assumes responsibility of the local group & development of local implementation plan.

15

I – SIX KT SESSIONS WITH LOCAL COMMITEES (Nov. 2008- March. 2009)

- A series of six 3.5-hour sessions, held locally with the knowledge broker & the researcher;

- Objectives:
  - Present all components of the Chronic Care Model and specific strategies for anxiety and depression
  - Devise, in collaboration with the working groups, local implementation plans

16

THE SIX KT SESSIONS

MODULE 1 → Context of the program (2)
- The research project
- PARIHS framework & model for change

MODULE 2 → Components of the Chronic care model (3)
- Decision support & pratice guidelines
- System delivery design & self-management support
- Clinical Information Systems & Community

MODULE 3 → Implementation plan (1)
- Strategies, tools & calendar
- Indicators & evaluation plan

17

II – LOCAL IMPLEMENTATION PLANS (March – April 2009)

Local implementation plans

- Local committees develop improvement plans and obtain feedback from the research team

- One meeting with all local respondents was organized to share:
  - Main targeted implementation strategies
  - Contextual and organizational factors associated with the implementation
  - Indicators of quality
  - Appreciation of the program and the facilitation approach

- Final plan submitted in writing to the knowledge broker

18

III- IMPLEMENTATION OF LOCAL PLANS BY WORKING GROUPS (April 2009 - March 2010)

Implementation of local quality improvement plans by working groups

o   Knowledge broker & researchers provide tools and support when needed;
o   Monthly telephone contact;
o   Three sessions with local committees during the one-year period to monitor the implementation plan;
o   Discussion and revision of the local quality improvement plans.

19

PROJET
CIBLE QUALITÉ
POUR UNE MEILLEURE QUALITÉ DES SOINS ET SERVICES DE PREMIÈRE LIGNE EN SANTÉ MENTALE

Assessment

POUR UNE MEILLEURE QUALITÉ DES SOINS ET SERVICES DE PREMIÈRE LIGNE EN SANTÉ MENTALE

20

EVALUATION

Implementation analysis

Qualitative assessment of *the facilitation approach* as well as the *contextual and organizational factors* associated with the implementation of the program

▪ Recording and summary of work sessions & other interactions with local work committees
▪ Data from Dialogue project

Effects analysis

Assessment of the level of implementation of the six components of Wagner's chronic care model for anxiety and depression

▪ ACIC *(Assessment of Chronic Illness Care)- adapted*

21

PROJET
CIBLE QUALITÉ
POUR UNE MEILLEURE QUALITÉ DES SOINS ET SERVICES DE PREMIÈRE LIGNE EN SANTÉ MENTALE

FIRST OBSERVATIONS

GENERAL OBSERVATIONS

About the project
- Helps establish a culture of quality improvement in mental health care;
- The project is complementary to ongoing work in the CSSS

About the implementation approach
- Appreciation of the participatory approach of the program
- The numerous sessions with the local committees facilitate discussion on:
  - Quality of mental health care
  - Roles and responsibilities of the primary mental health care teams within their CSSS

About the actors:
- The multidisciplinary local committees interested on anxiety and depression patients allow for:
  - The recognition of skills and knowledge of various actors in the CSSS
  - Encourages support and appropriation of the project   23

THE CHRONIC CARE MODEL

The chronic care model is well perceived by local committees
- Systemic vision of the intervention
- Shared responsibility
- Acknowledgement of the therapeutic alliance

1. Health System
- The population approach needs to be explained and integrated
- The project is in line with *the Mental Health Action Plan (MSSS, 2005)*
- Other departments within the CSSS can contribute to change (Quality, Nursing)

2. Community
- There is a strong interest towards linking with partners in the community (support groups, practitioners in private practice, schools, workplace).

24

PROGRAM CONTENT

3. Delivery system Design:
- Systematic follow up of clients
- Case management
- Hierarchy of care & stepped care

4. Decision support
- Practice guidelines are not well known
- Worry concerning evidence-based psychotherapy

5. Clinical Information Systems
- Difficult to work on CIS if the infrastructure is not in place;
- Interest for moving from an accountability tool to a patient registry.

6. Self-management support
- Promising strategy
- Interest in the self-management guide for depression

25

LOCAL IMPLEMENTATION PLANS: COMPONENTS OF THE CHRONIC CARE MODEL

- Components of the chronic care model most often targeted by the CSSS:
  - *Delivery System Design*
  - *Decision Support*
  - *Self-management support*
  - *Community*

- *The Health Care System* supports the implementation of the program

- *Clinical information Systems:* complexity of their implementation

- Complex quality improvement programs generally meet 3 or 4 of the chronic care model compotents (Williams et al., 2007).

26

CHALLENGES

- Evidence-based psychotherapy, including cognitive-behavior therapy, is a major issue in local committees;

- Difficulty to establish collaboration between Primary Mental Health Care teams and:
  - Secondary mental health care
  - GPs in the community

- Patients seen in primary mental health care teams often present with co-occurrence of mental disorders;

- The lack of human resources and movement of employees due to the reform add to the difficulty of improving clinical practice.

27

CONCLUSION

- The facilitation offered in our program helps structure the quality improvement process;
- The local implementation plans ensures the identification of clear improvement targets / strategies.
- Collaborative care with physicians is a major issue;
- Primary mental health care teams appreciate the support in improving the organisation and delivery of care for anxiety and depression, sometimes more globally than what we propose.

28

Thank you!

CONTACT:

Pasquale Roberge Ph.D.
Researcher
pasquale.roberge@inspq.qc.ca

Louise Fournier, Ph.D.
Researcher
louise.fournier@inspq.qc.ca