

PACE in MM
PATIENT-CENTRED INNOVATIONS FOR PERSONS WITH MULTIMORBIDITY

Differences and Similarities in Facilitators and Barriers of Chronic Disease Prevention and Management Programs in Two Canadian Provinces in the Context of a Realist Synthesis

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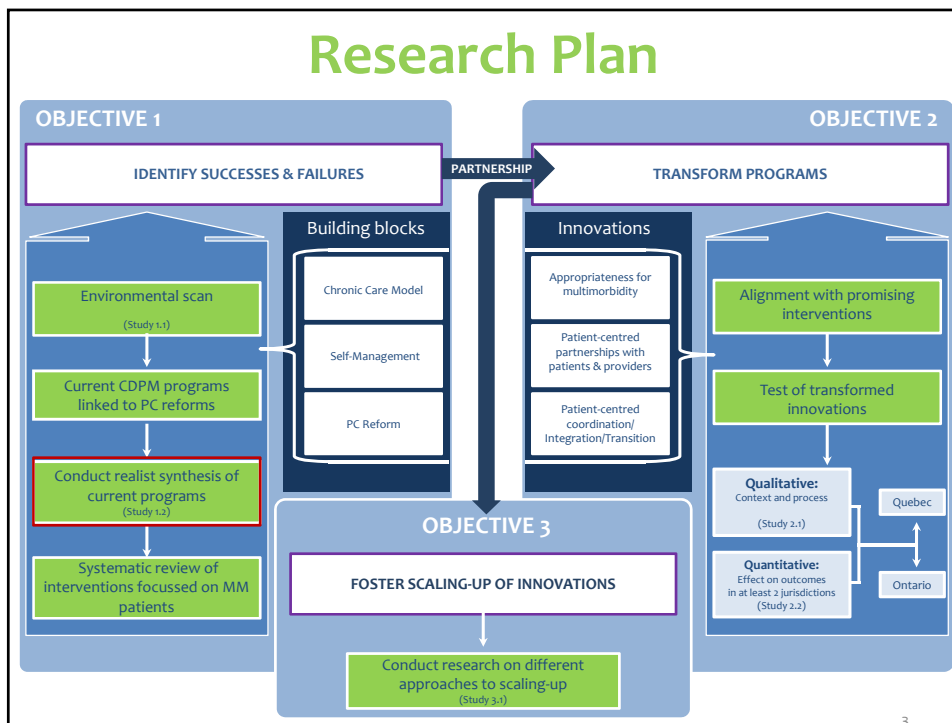


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Overall Objective of PACE in MM:

Reorient primary health care from a single disease perspective to a patient-centred approach for patients with multiple chronic conditions (multimorbidity).

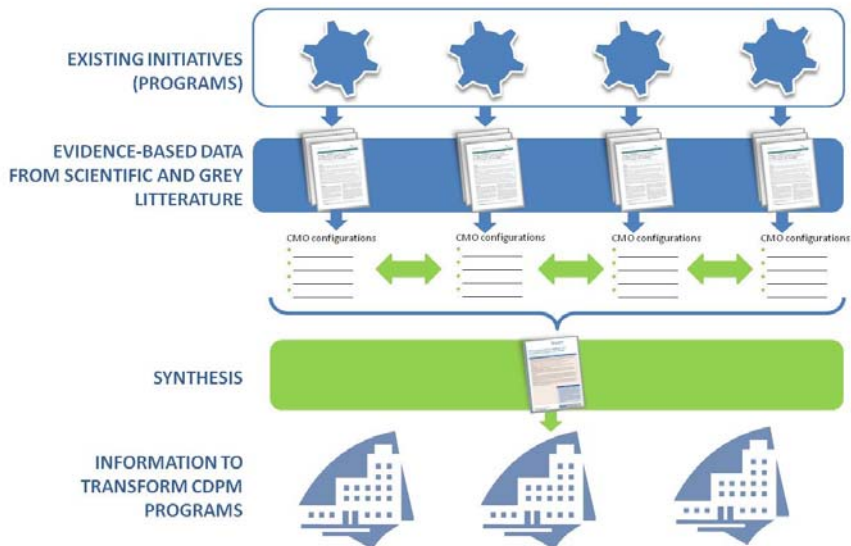




Objective of the Realist Synthesis of PACE in MM Objective 1

- **Objective:** To evaluate Chronic Disease Prevention and Management (CDPM) programs in Ontario and Quebec in order to identify their facilitators and barriers in implementation.
- Realist Synthesis findings would inform future interventions and innovations of CDPM programs participating in PACE in MM.

Processes of a Realist Synthesis

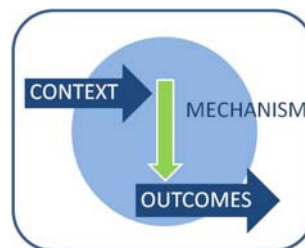


Inspired by Pawson et al. (2004) and Sridharan (n.d.)

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Steps in Realist Synthesis (RS) for PACE in MM

- 1) clarify the scope of the RS;
- 2) search and appraise the evidence;
- 3) detailed quality appraisal;
- 4) data extraction and synthesis;
- 5) synthesis of all the Context-Mechanism-Outcome (CMO) configuration for each CDPM program;
- 6) overall synthesis of the identified 12 programs;
- 7) comparison of Ontario and Quebec CMO configurations.



1. Clarify the Scope of the RS

- Program theories related to the three building blocks and three innovations of PACE in MM first identified during the literature review for the grant proposal.

Three Building Blocks:

- Chronic Care Model
- Self-Management
- Primary Care Reform

Three Innovations:

- Appropriateness for multimorbidity
- Patient-centred partnership with patients and providers
- Patient-centred coordination/integration/transition



1. Clarify the scope of RS





- Program theories were refined:
 - by the RS committee members
 - by consulting the extended team of PACE in MM
 - by consulting members of the other PACE in MM committees (patients, health care providers, decision makers and international collaborators)
- The input was used to modify and adjust the programs theories to be examined



2. Search and Appraise the Evidence

Program #	Target Population	Context	Program objectives	Theory or logic model	Planned evaluations	Resources	Implementation	Results of implementation	Evaluation results
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									

■ Data specified ■ Data partially specified

3. Quality Appraisal, Data Extraction and Synthesis

Data sources included:

- Published research papers (qualitative or quantitative) from the CDPM initiatives (n = 21)
- Grey literature (process and implementation evaluations, presentations, administrative records, annual reports, etc.) from the CDPM initiatives (n = 45)







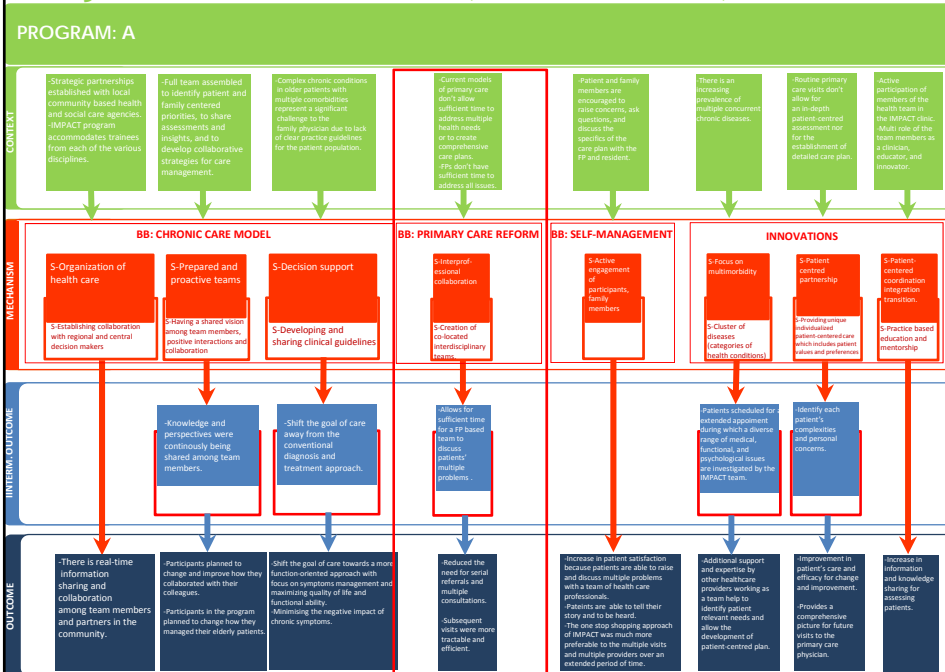
4. Data Extraction and Synthesis

Data extraction and synthesis:

- All this material was analysed (in NVivo) by two research assistants with an ongoing feedback from the RS Committee during biweekly meetings.
- Creating individual CMOs and grouping them in accordance with the 3 building block (Chronic Care Model, Self-Management, Primary Care Reform), and 3 innovations (Appropriateness for multimorbidity, Patient-centred partnership with patients and providers, Patient-centred coordination/integration/transition).



5. Synthesis of Context, Mechanism, Outcomes



6. Overall Synthesis of the 12 Programs

- 49 CMOs identified under the 6 categories (3 building blocks, 3 innovations).
- Determined if outcomes were related to patients, providers, or organizations.

Comparison of Ontario and Quebec CMO configurations

Criteria for selecting main mechanisms:

1. Mechanisms need to be present in the programs from the two provinces (ON and QC),
2. Mechanisms need to be in at least two programs .
3. Mechanisms need to have outcomes in at least two out of three categories (patients/ family members, providers, and organizations).
4. Mechanisms need to be relevant to PC reform.

The List: Eight Main Mechanisms

Interprofessional Collaboration

- Having a shared vision among team members, positive interactions and collaboration (Prepared and Proactive Teams) ⁽ⁿ⁼⁷⁾
- Creation of co-located interdisciplinary teams (Inter professional Collaboration) ⁽ⁿ⁼⁸⁾
- Dedicated point person engaged in interprofessional collaboration with the health team (Interprofessional Collaboration) ⁽ⁿ⁼⁴⁾

External Relationships

- Developing partnerships with local community organizations (Community Resources and Policies) ^(N=4)
- Establishing collaboration with regional and central decision makers (Organization of Health Care) ^(N=4)

Patient-centred partnerships/ Promotion of self-management

- Providing educational resources and skills (Self-Management Support) ⁽ⁿ⁼⁶⁾
- Providing unique individualized care (Patient-Centered Partnership of Patient-and providers) ⁽ⁿ⁼⁷⁾



The Chart: Overall Synthesis of Main Mechanisms for Ontario/Quebec

Sub-Mechanism/Mechanism	Building Blocks	Programs/pr ovince		Outcome		
		ON	QC	Patient	Provider	Organization
Having a shared vision among team members, positive interactions and collaboration (Prepared and Proactive Teams) ⁽ⁿ⁼⁷⁾	Chronic Care Model	6	1	X	X	X
Developing partnerships with local community organizations (Community Resources and Policies) ^(N=4)	Chronic Care Model	2	2	X	-	X
Establishing collaboration with regional and central decision makers (Organization of Health Care) ^(N=4)	Chronic Care Model	1	3	X	-	X
Providing educational resources and skills (Self-Management Support) ⁽ⁿ⁼⁶⁾	Self-Management	1	5	X	-	X
Creation of co-located interdisciplinary teams (Inter professional Collaboration) ⁽ⁿ⁼⁸⁾	Primary Care Reform	5	3	X	X	X
Dedicated point person engaged in interprofessional collaboration with the health team (Interprofessional Collaboration) ⁽ⁿ⁼⁴⁾	Primary Care reform	1	4	X	-	X

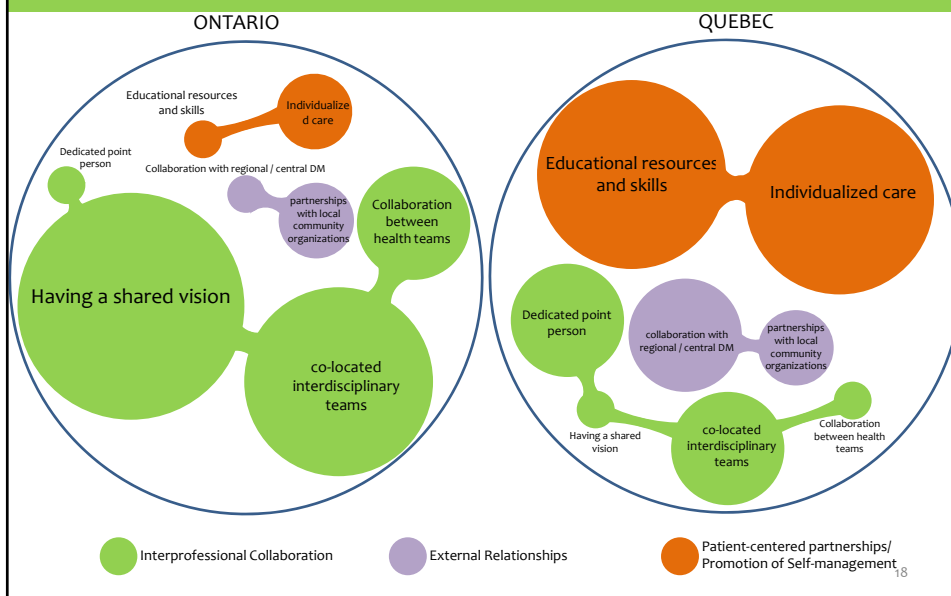


The Chart: Overall Synthesis of Main Mechanisms for Ontario/Quebec

Sub-Mechanism/Mechanism	Innovations	Programs/pr ovince		Outcome		
		ON	QC	Patient	Provider	Organization
Providing unique individualized care (Patient-Centered Partnership of Patient- and providers) ^(N=7)	Innovation	2	5	X	X	X
Collaboration between health teams (Patient Centered Coordination of Innovation) ^(N=4)	Innovation	3	1	X	-	X



The Visual: Main Message



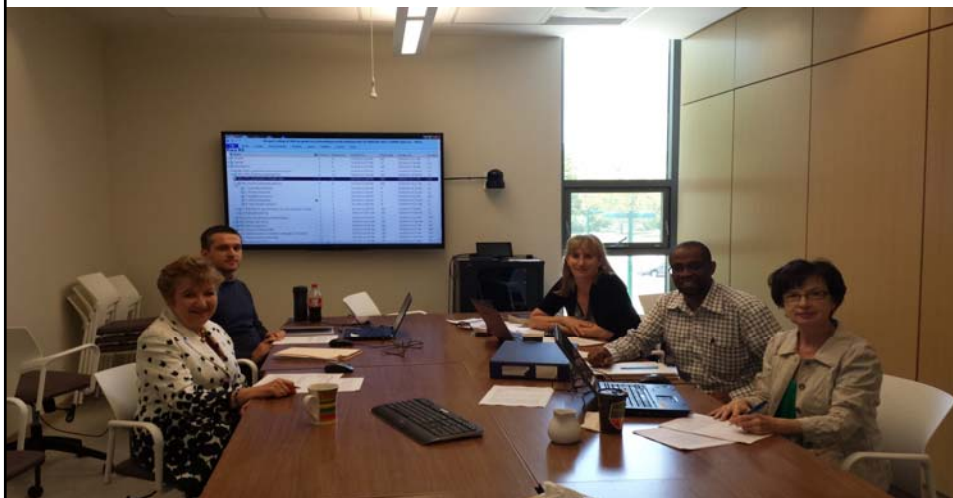
Limitations

- Comparison refers only to the programs identified in Ontario and Quebec as having rigorous evaluations.
- Comparison of programs in Ontario and Quebec do not include all CDPM programs in Ontario and Quebec.
- Can compare the nature of the common CMOs that have been evaluated.
- Learned more about the facilitators than barriers.

Implications

1. Cross-fertilization across provinces
2. Indicates growth, strength and spread of CDPM programs.
3. Need for more rigorous evaluations of CDPM programs.

The RS team is ready for questions!



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