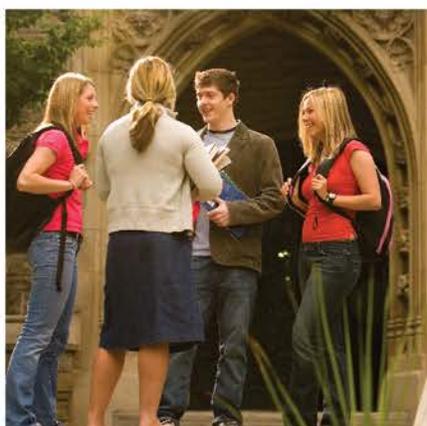




DIALOGUE  
SUMMARY



DESIGNING INTEGRATED  
APPROACHES TO SUPPORT  
PEOPLE WITH  
MULTIMORBIDITY IN ONTARIO



21 OCTOBER 2013

**EVIDENCE >> INSIGHT >> ACTION**

**Dialogue Summary:  
Designing Integrated Approaches to Support People with Multimorbidity in Ontario**

21 October 2013

#### McMaster Health Forum

For concerned citizens and influential thinkers and doers, the McMaster Health Forum strives to be a leading hub for improving health outcomes through collective problem solving. Operating at the regional/provincial level and at national levels, the Forum harnesses information, convenes stakeholders, and prepares action-oriented leaders to meet pressing health issues creatively. The Forum acts as an agent of change by empowering stakeholders to set agendas, take well-considered actions, and communicate the rationale for actions effectively.

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#### Conflict of interest

The authors declare that they have no professional or commercial interests relevant to the dialogue summary. The funders reviewed a draft dialogue summary, but the authors had final decision-making authority about what appeared in the dialogue summary.

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**Table of Contents**

SUMMARY OF THE DIALOGUE ..... 5

DELIBERATION ABOUT THE PROBLEM ..... 6

DELIBERATION ABOUT POLICY AND PROGRAMMATIC OPTIONS..... 7

    Element 1 - Support primary care, community care and other providers to adapt and implement models of care for patients with multimorbidity that improve the patient experience, improve health and keep per capita costs manageable ..... 7

    Element 2 - Enable primary care, community care and other providers to identify and use guidelines (or care pathways) that meet the needs of patients with multimorbidity..... 8

    Option 3 - Enable primary care, community care and other providers to efficiently support self-management by patients with multimorbidity..... 9

    Considering the full array of options..... 10

DELIBERATION ABOUT IMPLEMENTATION CONSIDERATIONS ..... 10

DELIBERATION ABOUT NEXT STEPS FOR DIFFERENT CONSTITUENCIES..... 10



## SUMMARY OF THE DIALOGUE

Dialogue participants generally agreed on the main components of the problem, namely the growing impact of multimorbidity on the health system, the complexity of living with multimorbidity, the difficulties with self-management and treatment, and system-level challenges that are not supportive of integrated and comprehensive approaches to care. While there was agreement on these core components of the problem, three additional considerations emerged through the deliberations among participants, which included: 1) a lack of clarity about the target population for integrated approaches (e.g., people with or at-risk of multimorbidity, low-income people with multimorbidity, complex and vulnerable patients or high-needs patients); 2) a lack of clarity about the goal of addressing the ‘problem’ of multimorbidity (e.g. a goal in itself versus a means to the end of strengthening primary care versus a means to the end of improving the patient journey); and 3) the lack of focus on the full patient journey and the resulting missed opportunity for prevention and for providing person-centred care more generally.

Dialogue participants were supportive of each of three elements of a more comprehensive approach to providing integrated supports to people with multimorbidity. The deliberations made clear that in pursuing any or all of the elements, the status quo in the health system is not an option. For developing integrated models of care (element 1), it was emphasized that there is a need to: 1) support bottom-up, person-centred approaches to developing flexible models of care; 2) focus on how to scale up successful approaches; and 3) build the capacity of health professionals to participate in such models and to work towards their full scope of practice. In terms of the identification and use of guidelines (element 2), participants agreed that disease-focused guidelines are not supportive of the types of care and supports needed by people with multimorbidity. Instead, a person-centred approach that focuses on identifying patients’, caregivers’ and families’ goals was highlighted as being optimal. Lastly, participants emphasized the need to support the development and use of self-management tools and resources (element 3) that: 1) are developed through partnerships between provider and citizen groups; 2) include more proactive approaches (e.g., skill building, direct supports for behaviour change, and supports for system navigation); and 3) use social media and other forms of technology to reach more people.

In the view of dialogue participants, key implementation features for such an approach include: 1) collaborating within teams and across ‘silos’; 2) engaging patients, caregivers and families; 3) designing funding approaches that are supportive of models of care for people with multimorbidity; and 4) making better use of electronic medical records and computerized clinical decision support. Dialogue participants identified several steps that should be taken going forward, including: 1) ‘staying the course’ by continuing to support bottom-up, person-centred approaches to developing models of care; 2) supporting the development of evidence-based guidance that providers can draw on to achieve goals set by patients; 3) embracing innovative and collaborative approaches to supporting self-management; and 4) articulating a research agenda to address terminology issues and the many unanswered questions in this domain.

## SUMMARIES OF THE FOUR DELIBERATIONS

### DELIBERATION ABOUT THE PROBLEM

Dialogue participants generally agreed on the main components of the problem, namely: 1) the growing impact of multimorbidity on the system (in terms of healthcare utilization and costs); 2) the complexity of living with multimorbidity (e.g., the increased and multi-faceted health risks); 3) the difficulties with self-management and treatment, particularly given the lack of guidelines focused on the person as a whole (as opposed to specific diseases); and 4) system-level challenges that are not supportive of integrated and comprehensive approaches to care (e.g., fragmented approaches to care, as well as funding and remuneration models that are not adjusted for the burden of morbidity in a population or practice).

While there was agreement on these core components of the problem, three additional considerations emerged through the deliberation. The first consideration was the lack of integrated approaches for people with multimorbidity, coupled with a lack of clarity about the target population for such approaches. On the first point, participants noted the lack of integration between primary care (or the health sector more generally) and the much broader range of community and social supports that often help to address the underlying determinants of health. Several dialogue participants argued that without such linkages and coordination between primary care and community supports (e.g., through Community Care Access Centres), care will continue to be complex, fragmented and therefore not fully address the needs and goals of the patient.

Regarding the second point, several dialogue participants questioned whether multimorbidity is truly the ‘population of interest,’ and in so doing highlighted the lack of agreement about terminology. For example, one dialogue participant noted that the focus also needs to be on the 45% of people who are at risk for multimorbidity, in order to prevent them from “tipping over to the 1 or 5%” with the most complex needs. Although supportive of this broader prevention-oriented perspective, others suggested that the existing system can work well for many people living with or at risk for multimorbidity, and instead the focus should be on those with low incomes, the most complex and vulnerable patients and/or high-needs patients (in terms of both health and the full spectrum of the social determinants of health). The reasons provided by dialogue participants for focusing on these populations included the

#### **Box 1: Background to the stakeholder dialogue**

The stakeholder dialogue was convened in order to support a full discussion of relevant considerations (including research evidence) about a high-priority issue in order to inform action. Key features of the dialogue were:

- 1) it addressed an issue currently being faced in Ontario;
- 2) it focused on different features of the problem, including (where possible) how it affects particular groups;
- 3) it focused on three elements of a (potentially) comprehensive approach for addressing the problem;
- 4) it was informed by a pre-circulated issue brief that mobilized both global and local research evidence about the problem, three elements of a comprehensive approach for addressing the problem, and key implementation considerations;
- 5) it was informed by a discussion about the full range of factors that can inform how to approach the problem and possible options for addressing it;
- 6) it brought together many parties who would be involved in or affected by future decisions related to the issue;
- 7) it ensured fair representation among policymakers, stakeholders and researchers;
- 8) it engaged a facilitator to assist with the deliberations;
- 9) it allowed for frank, off-the-record deliberations by following the Chatham House rule: “Participants are free to use the information received during the meeting, but neither the identity nor the affiliation of the speaker(s), nor that of any other participant, may be revealed”; and
- 10) it did not aim for consensus.

Participants’ views and experiences and the tacit knowledge they brought to the issues at hand were key inputs to the dialogue. The dialogue was designed to spark insights – insights that can only come about when all of those who will be involved in or affected by future decisions about the issue can work through it together. The dialogue was also designed to generate action by those who participate in the dialogue, and by those who review the dialogue summary and the video interviews with dialogue participants.

disproportionate number of low-income Canadians living with or at-risk for multimorbidity, coupled with access issues for required care (e.g., prescription drugs), and the broader range of supports that need to be provided and coordinated for complex and high-needs patients (e.g., supports for performing functional tasks, home care, housing, employment and mental health and addictions issues). For example, one dialogue participant highlighted that not everyone with multimorbidity requires complex care and associated community supports (e.g., those with concordant conditions that are more straightforward to address simultaneously), and that there are also many individuals with one or two conditions who require complex care and supports. As a result, the dialogue participant argued that it would be more appropriate to use terminology that highlights those requiring complex and integrated care.

The second consideration raised by many of the dialogue participants was the lack of clarity about the goal of addressing the ‘problem’ of multimorbidity. Without a clear goal, they argued, other activities such as identifying and monitoring indicators of success are more difficult. Dialogue participants highlighted three potential goals. First, addressing multimorbidity could be viewed as a goal in itself. In other words, the goal is to improve the care for and, consequently the health of, those with multimorbidity. Second, some dialogue participants argued that addressing multimorbidity could be viewed as a means to the end of strengthening primary care to make it better equipped to meet the needs of all patients. As one dialogue participant noted, multimorbidity can be viewed as the ‘canary in the coal mine’ that is making the underlying challenges within primary care more apparent. Similarly, another participant remarked that “if we can get primary care right for those with the most complex needs, then it will be of benefit to the rest” of the population. Third, the goal of addressing multimorbidity could also be viewed as a means to the end of improving the patient journey for people with multimorbidity and other individuals. As a parallel to the case with primary care, if we can get the patient journey right for people with multimorbidity then we will have built a more patient-centred health system for everyone.

The third consideration, which relates to this last point, was the lack of emphasis on the patient journey (or trajectory), both for those who live with multimorbidity and those who may be at risk. Instead, as one dialogue participant noted, the focus is typically on issue(s) or disease(s) requiring attention at any given time, with little to no attention given to the broader array of supports that may be needed. Taking a narrow focus on particular issues or diseases was viewed by many of the dialogue participants as a missed opportunity for prevention and for providing person-centred, holistic care focused on the goals of the individual (e.g., functional improvement).

## **DELIBERATION ABOUT POLICY AND PROGRAMMATIC OPTIONS**

Dialogue participants were generally supportive of integrated models of care (element 1) and supports for self-management (element 3), but they deliberated about optimal ways to develop and deliver such approaches. In contrast, the deliberations about guidelines (element 2) were more focused on the value of guidelines and on identifying alternative approaches that would be more supportive of patient-centred (as opposed to disease-focused) care.

### **Element 1 - Support primary care, community care and other providers to adapt and implement models of care for patients with multimorbidity that improve the patient experience, improve health and keep per capita costs manageable**

Dialogue participants agreed with the need to identify promising models of integrated care for people with multimorbidity, the key attributes of these models, and the factors that might influence their adaptation and implementation. Several dialogue participants noted that efforts through Health Links to support local patient-care networks through a coordinating partner constitute promising steps towards integrated models that optimize access to needed services for high-needs users of the health system. Pointing to the generally positive views of the efforts being made through Health Links, some dialogue participants emphasized the

need to continue supporting bottom-up, person-centred approaches to developing flexible models of care. One dialogue participant noted that in the past Ontario has adopted “top-down approaches masquerading as bottom-up,” but that this is the first time that there seems to be a ‘real’ commitment to develop innovative and patient-centred approaches from the ground up. Another dialogue participant agreed that bottom-up approaches are important given that they foster the development of models that are tailored to the context of specific regions, communities and patient populations. However, the same participant also cautioned that higher-level stewardship is still needed across the province to set common goals and to facilitate the sharing of practices that could be adapted and implemented in other regions, communities or patient populations.

Several dialogue participants emphasized that such bottom-up, person-centred and flexible models of care should have common objectives. The first objective, some dialogue participants argued, should be to operationalize patient-centredness by including processes to identify and prioritize the needs and/or goals that are important to patients. The second objective should be to harness available resources to develop customized packages of resources that collectively aim to meet these needs and goals. Lastly, the third objective should be ensuring that this type of approach will work for the full spectrum of primary care models. One dialogue participant emphasized the need to consider whether and how primary care providers will handle the allocation of resources for and coordination of customized packages of resources. The participant wondered, for example, whether primary care providers would, in collaboration with community and other types of providers, be required to allocate a broad array of resources, and in doing so be aware of broader budgetary impacts and ensure that resources are used judiciously.

Building on the need to support bottom-up, person-centred approaches to developing flexible models of care, many dialogue participants identified the need to focus on how to scale up successful approaches. Some participants questioned what evidence is required to make the decision that an approach to (or a model of) care is appropriate to be scaled up, while other participants identified the types of scaling-up activities that would need to be considered. In terms of the evidence required, several participants emphasized that requiring the ‘gold standard’ level of research evidence (i.e., randomized controlled trials and systematic reviews of randomized controlled trials) is not feasible. As one participant explained, researchers lack the tools to be able to evaluate models of care that are evolving over time using these types of study designs, but that evidence can be gathered through other means (e.g., process evaluations and qualitative studies of stakeholders’ views and experiences) to inform whether and how to scale up. Similarly, another participant emphasized that Ontario needs to take the next step from being a home for countless pilot projects to using the available evidence to identify the models that have the best chance at success, and undertaking activities to scale up their use. With respect to the types of scaling-up activities that need to be considered, one dialogue participant highlighted that there is a need to consider how approaches can be scaled up within primary care practices (i.e., horizontal integration), to other parts of the system (i.e., vertical integration), and then across the entire system.

Further building on the importance of scaling up successful approaches, dialogue participants emphasized the importance of identifying key elements of successful approaches to ensure that they can be successfully adapted and implemented in different settings and contexts. One dialogue participant singled out the importance of building the capacity of health professionals to participate in such models and to work towards their full scope of practice. The dialogue participant gave the example of needing to make better use of the skills of nurses by highlighting that nurses are often not used to the fullest extent possible in primary care.

## **Element 2 - Enable primary care, community care and other providers to identify and use guidelines (or care pathways) that meet the needs of patients with multimorbidity**

There was general agreement among dialogue participants that disease-focused guidelines on their own are not supportive of the types of care and supports needed by people with multimorbidity. One participant noted that disease-focused guidelines “don’t work due to variability in disease combinations.” While supportive of this view, several dialogue participants noted that disease-focused guidelines will continue to

have a role to play in informing care, but, as one participant stated, disease-focused guidelines “will only be a piece of the process.”

In considering how to approach guidelines for people with multimorbidity, there was general agreement with the sentiment expressed by one participant about the need to “flip this element upside down and take an approach centred on a person’s goals.” In general, dialogue participants agreed that taking a patient-centred approach means a focus on identifying patients’, caregivers’ and families’ goals. This was understood by many as taking an approach focused on symptom management and functional improvement as opposed to one focused on specific diseases. Speaking from a clinical perspective about how this can be achieved, one dialogue participant outlined that providers would need to: 1) know patient goals (symptom reduction, functional improvement, etc.); 2) review current treatments (including medicines) and support; and 3) adjust, stop, and add treatments and supports that will help achieve these goals. The same participant added that when solid research evidence is not available, this needs to be made clear, and then patients’ views, experiences and preferences are made even more important in choosing an approach to care.

Several dialogue participants suggested that a fruitful contribution to such an effort would be to determine how to provide evidence-based guidance across disciplines about how providers can address non-disease-specific elements of a patient’s needs. For example, this could include resources addressing patient goals that have been developed with the input of patients, caregivers, families and an array of providers. It could also include resources addressing complementary goals, such as how to reduce polypharmacy, which was identified as an area where little to no efforts have been made in guideline development. One dialogue participant questioned whether guidelines are possible for informing decisions about whether and how to provide the types of social supports that are often needed. In response, another dialogue participant suggested that one approach could be to develop guidance that consists of a series of questions to ask, which would be coupled with supports that could be available depending on the types of issues and/or goals identified by patients in response to those questions.

### **Option 3 - Enable primary care, community care and other providers to efficiently support self-management by patients with multimorbidity**

Dialogue participants generally agreed about the importance of supporting self-management (particularly the development and use of self-management tools and resources), but highlighted several considerations for how to develop and deliver supports. First, several participants suggested that self-management supports should be developed through partnerships between provider and citizen groups (or at least with better communication between the two). Second, one dialogue participant highlighted that the types of models included in the issue brief were largely focused on information and education provision, and emphasized the need to move beyond these to also include more proactive approaches, such as skill building and direct supports for behaviour change, among others. Another participant suggested that two important examples of proactive approaches to consider are supports to enable better system navigation and to ensure informed decision-making that takes into account the values and preferences of the patient as well as their caregivers and families. Lastly, several dialogue participants outlined that more people could be reached through social media and other technology (e.g., for online outreach and/or skills building), especially as these tools are increasingly embraced by larger numbers of people. One dialogue participant suggested that social media and other technology would enable the creation of ‘cohorts’ of individuals facing similar challenges (and thereby reach more people), rather than limiting outreach to those who happen to be cared for in a single practice.

While most dialogue participants were supportive of self-management approaches, others expressed some skepticism about how valuable it can be in some situations. For example, one participant cautioned that self-management is not right for everyone and, as a result, providers need to be aware of when supporting self-management makes sense and when it does not. Agreeing with this idea, another dialogue participant indicated that it should be “self-management where appropriate”, and supports should be available on a “sliding scale” based on patient preferences and skills. Similarly, another participant stated that self-

management needs to be a collaborative and shared approach, and that without this ethos there is a possibility that emphasizing self-management could be viewed as a “blame the victim” approach.

### **Considering the full array of options**

Overall, dialogue participants were supportive of each of the three elements being a part of a more comprehensive approach to providing integrated supports to people with multimorbidity. The deliberations made clear that, in pursuing any or all of these elements, the status quo in the health system is not an option, and the goals of patients, caregivers and families need to be made the focus of models of care, guidelines and supports for self-management.

## **DELIBERATION ABOUT IMPLEMENTATION CONSIDERATIONS**

Dialogue participants highlighted several key implementation features for such an approach. First, collaboration was emphasized by many dialogue participants as being a fundamental part of any implementation plan. Specifically, collaboration was highlighted as being important within teams as well as across ‘silos.’ For collaboration within teams, one dialogue participant emphasized that questions about whether to adopt team-based approaches in primary care are no longer relevant given that working in teams is now accepted as being essential. Instead, the participant argued, the focus needs to turn to determining the optimal approaches for working in teams. Several participants also noted the importance of working across silos because, without such collaboration, efforts toward supporting person-centred care will continue to be fragmented. However, while generally agreeing with this idea, one dialogue participant suggested that the typical language of ‘breaking down silos’ needs to be avoided. The participant suggested that it should instead be thought of in terms of more effectively drawing on the unique value and wealth of expertise in different sectors by putting mechanisms in place to facilitate better and more consistent interaction and coordination between silos. Second, and related to collaboration, several dialogue participants also placed significant emphasis on the need to consistently and meaningfully engage patients, caregivers and families in the planning and provision of care and supports. Doing so was argued to be fundamental for supporting person-centred care by ensuring that individuals’ goals are the focus of care, and that customized packages of resources can be developed to help meet these goals.

The remaining key implementation features are health system ‘levers’ that can be used to make primary care better able to provide optimal care for people with multimorbidity. One dialogue participant highlighted the need to design funding approaches that are supportive of models of care for people with multimorbidity. The specific example provided by the participant was the need to include morbidity adjustments for blended capitation and fee-for-service remuneration models, which garnered overall agreement from the group about its importance. Another dialogue participant emphasized the importance of making better use of electronic health records and computerized clinical decision support systems as means to support integrated approaches to care within teams and across settings, and also to support the use of recommendations from guidelines.

## **DELIBERATION ABOUT NEXT STEPS FOR DIFFERENT CONSTITUENCIES**

Dialogue participants identified several types of next steps. But the first and most fundamental activity going forward was, in the view of most dialogue participants, to ‘stay the course’ by continuing to support bottom-up, person-centred approaches to developing models of care and working across silos, and in doing so, to:

- establish how best to identify those at risk, particularly in vulnerable and hard-to-reach populations;
- focus on how to monitor and evaluate models of care using agreed indicators of success;
- scale up successful approaches (but, as one participant noted, “don’t pick the fruit before it’s ripe ... Health Links will eventually bear fruit”); and
- build capacity among providers to participate fully in such approaches.

In relation to next steps in supporting evidence-based approaches to care, some dialogue participants prioritized the development of evidence-based guidance that would (in contrast to traditional clinical guidelines) focus on helpful processes that providers can draw on to achieve the goals set by patients, caregivers and families. And in relation to next steps in supporting self-management, there was a general sense among participants of the need to embrace innovative and collaborative approaches to supporting self-management. Lastly, several dialogue participants noted the need to articulate a research agenda to address terminology issues and the many unanswered questions in the emerging field of multimorbidity.



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