Family & Community Medicine
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A Program of the Northwest Territories

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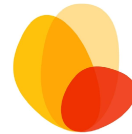
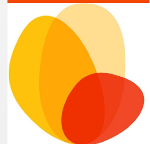
Finding a BETTER Way to Chronic Disease Prevention and Screening



The BETTER 2 Program



DALHOUSIE UNIVERSITY
Inspiring Minds

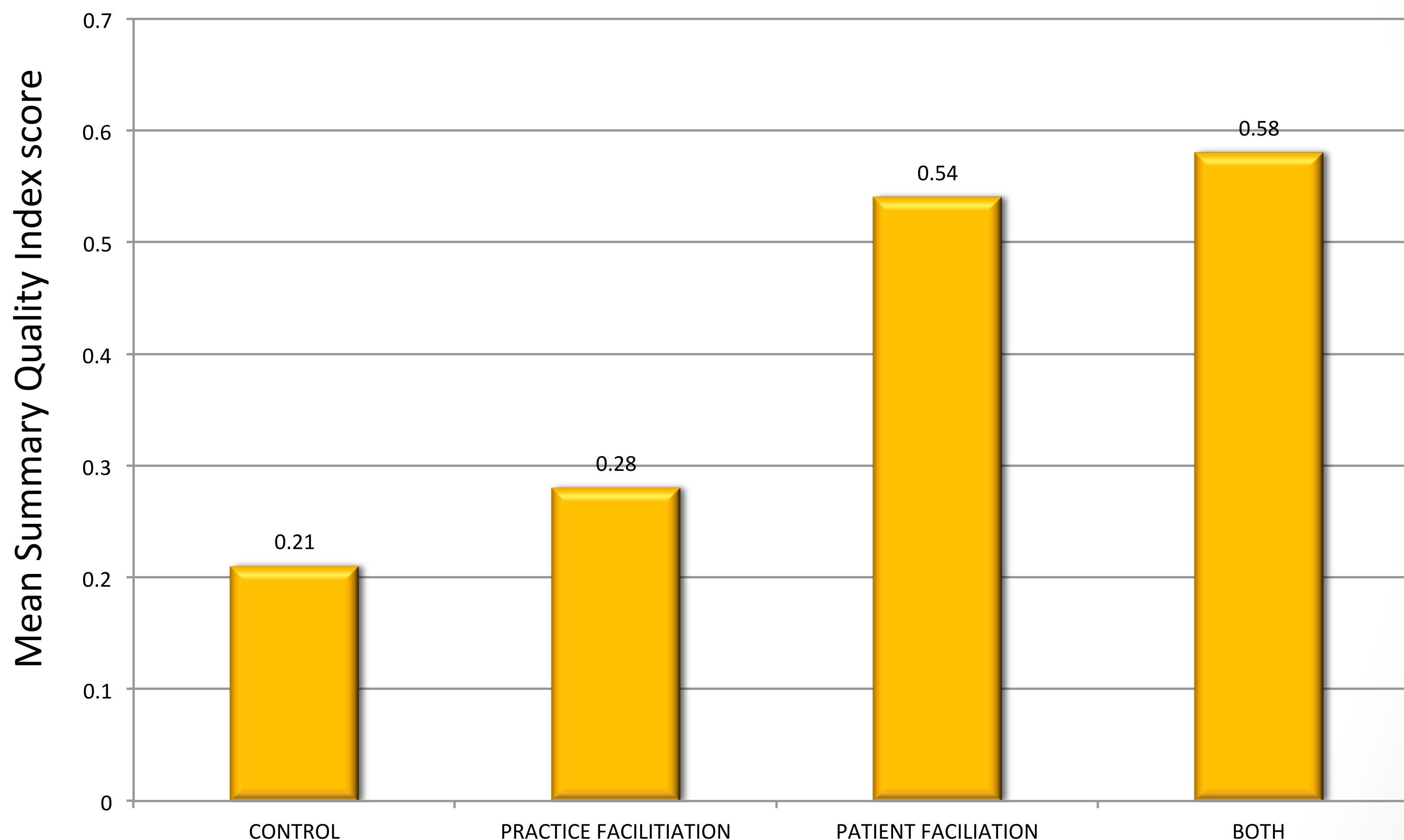
THE BETTER PROJECT
Building on Existing Tools to Improve Chronic Disease Prevention & Screening in Primary Care

CLASP
COALITIONS LINKING ACTION & SCIENCE FOR PREVENTION

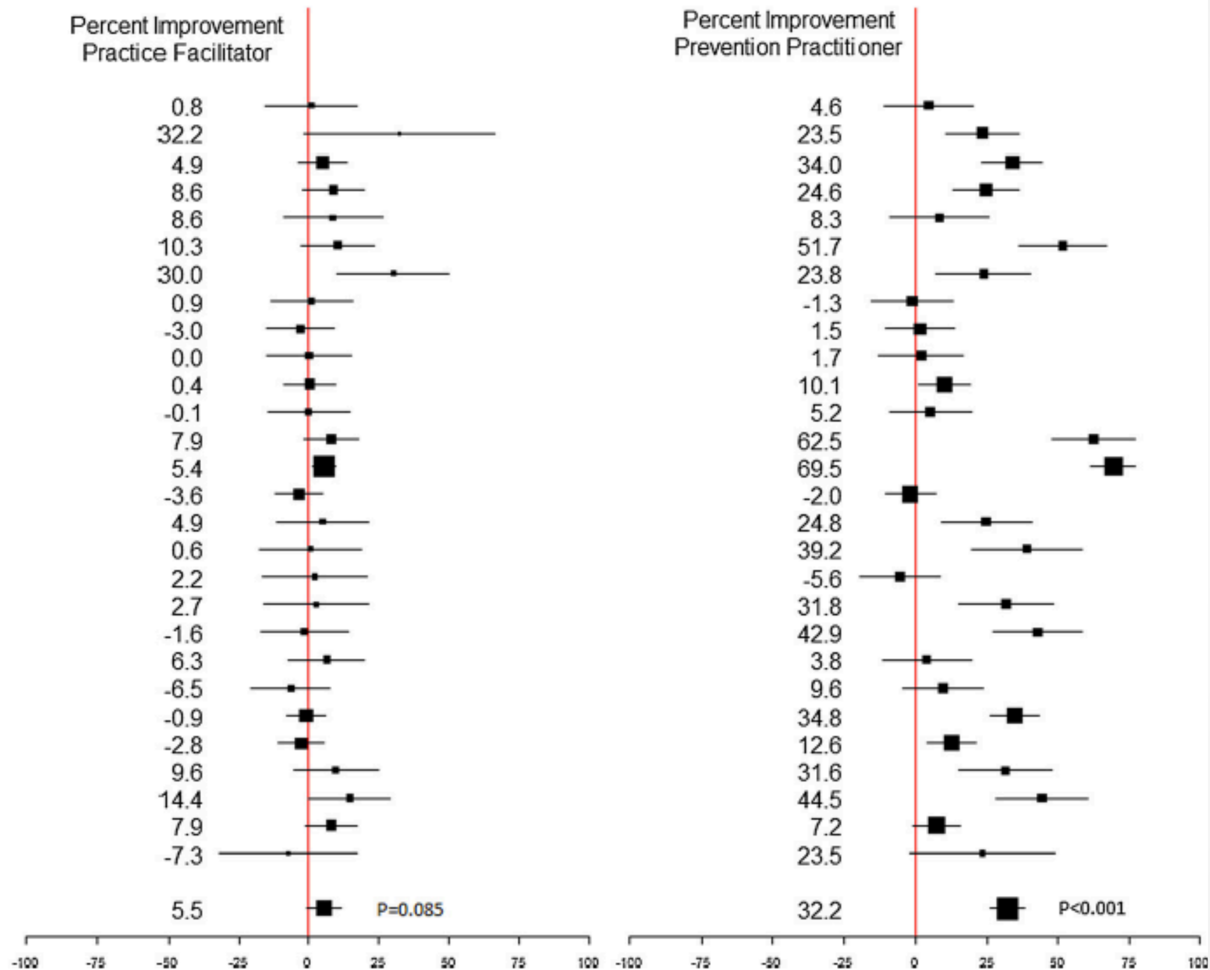
Northern Ontario School of Medicine

BETTER Project Results

Grunfeld E, Manca D, Moineddin R, Thorpe KE, Hoch JS, Campbell-Scherer D, Meaney C, Rogers J, Beca J, Krueger P *et al*: **Improving chronic disease prevention and screening in primary care: results of the BETTER pragmatic cluster randomized controlled trial**. *BMC family practice* 2013, **14**(1):175.



The BETTER Trial Results



Grunfeld E, Manca D, Moineddin R, Thorpe KE, Hoch JS, Campbell-Scherer D, Meaney C, Rogers J, Beca J, Krueger P *et al*: **Improving chronic disease prevention and screening in primary care: results of the BETTER pragmatic cluster randomized controlled trial**. *BMC family practice* 2013, **14**(1):175.

The BETTER framework

- The BETTER Project patient level intervention impacts CDPS by:

1. A newly developed role, the prevention practitioner (PP)
2. A unique combination of internal and external practice facilitation

- Key components identified include:

1. Approaching CDPS in a comprehensive manner,
2. An individualized and personalized approach at multiple levels,
3. Integrated continuity of the patient and the practice in CDPS,
4. Adaptable

Manca, D.P., Greiver, M., Carroll, J.C., Salvalaggio, G., Cave, A., Rogers, J., Pencharz, J., Aguilar, C., Barrett, R., Bible, S., Grunfeld, E. Finding a BETTER Way: A qualitative study exploring the Prevention Practitioner intervention to improve chronic disease prevention and screening in family practice. BMC Family Practice 2014: 15 (66).

Important Features

1. Develops a chronic disease prevention and screening resource for the practice
2. Proactive targeting of patients at risk for Chronic Disease
3. Dedicated patient appointments for a prevention visit
4. A Tailored Patient Prevention Prescription that
    1. Informs patient of their present status
    2. Identifies actionable goals with a motivational component

The Prevention Practitioner (PP) Role

Participants

- Identify a target population (e.g 40-65 yo)
- Invite to attend a visit with the Prevention Practitioner

Preliminary Assessment

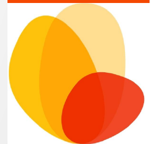
- Participants complete a health survey before the visit
- Participants' surveys and medical histories are reviewed and eligilbe CDPS manuevers are identified

Prevention Practitioner Visit

- Through shared decision making and motivational interveiwing a personalized prevention prescription tailored to the patient is developed and the patient is provided with a copy
- A follow-up visit time frame is identified
- The participant may be linked to community/local resources (e.g. to help with smoking cessation)

Follow-up

- Reasses participant on follow-up
- Participant completes a health survey at 6 and 12 months after the initial visit



Prevention Practitioner (PP) Role

External Prevention Resources (e.g. dieticians, councellors, organizations)

Primary Care Team of Providers

Team members reinforce CDPS

PP brings resources to team & integrates team in CDPS

Other team members begin to focus on CDPS

PP integrates external CDPS resources

PATIENT

PP - patient relationship - patient brings up issues they are uncomfortable sharing with physician

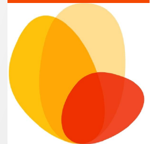
Prevention Practitioner (internal faciliation)

Physician champion at each site

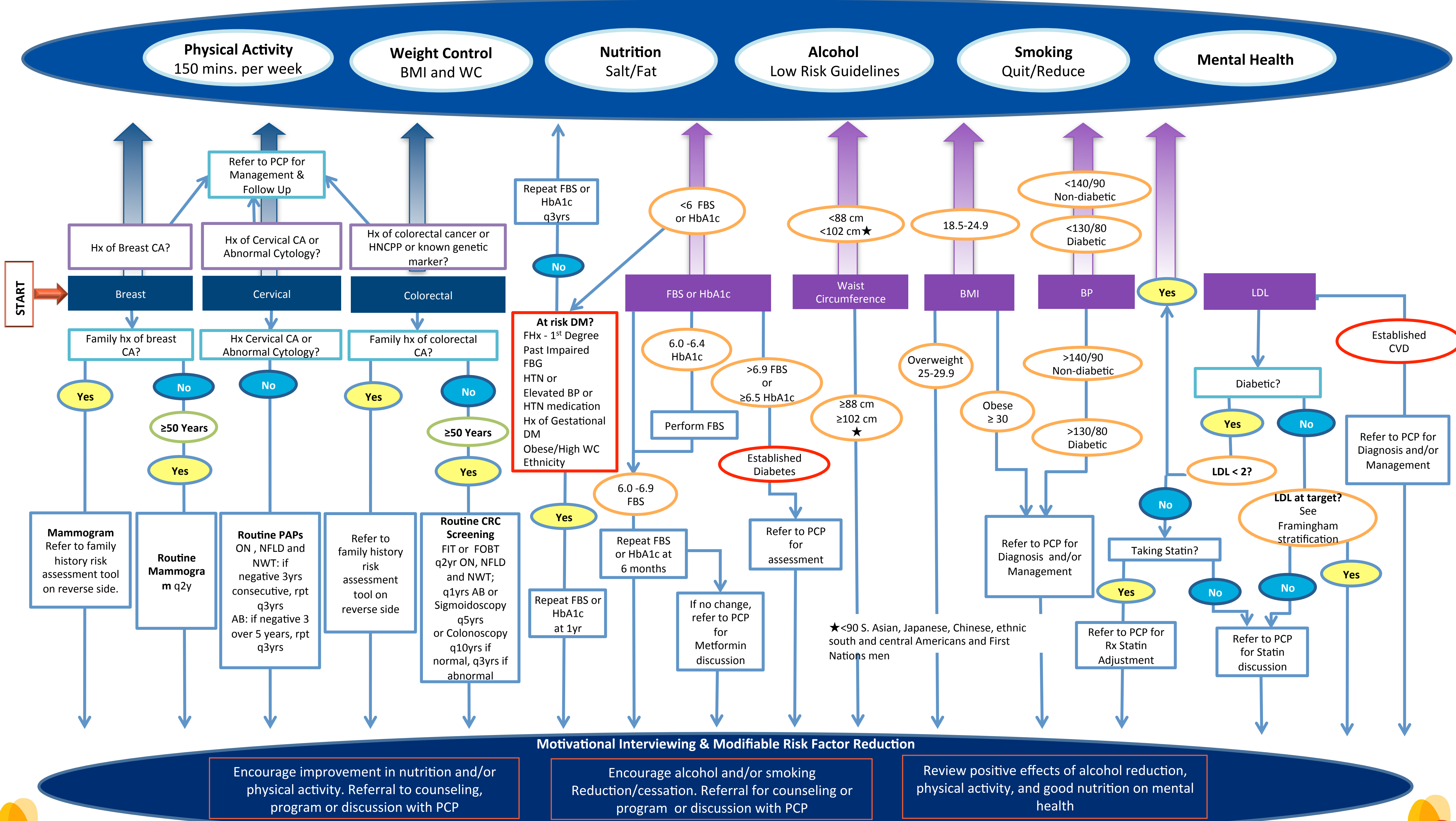
Primary Care Provider

PP collaborates with BETTER to develop skills and tools individualized to the practice

BETTER Project Framework (external facilitation)



The BETTER Chronic Disease Primary Prevention and Screening Map



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Framingham Risk Stratification

Risk Level	Initiate treatment if:	Primary treatment target: LDL-C
HIGH (10-year CVD risk ≥ 20%)	CAD, PVD, Atherosclerosis*, Most patients with diabetes**	< 2.0 mm/L ***or*** 50% ↓ LDL-C
MODERATE (10-year CVD risk 10-19%)	LDL-c > 3.5 mmol/L ***or*** TC/HDL-C > 5.0 ***or*** hsCRP > 2 mg/L in men >50 years and women >60 years	< 2.0 mm/L ***or*** 50% ↓ LDL-C
LOW (10-year CVD risk < 10%)	LDL-C ≥ 5.0 mmol/L	50% ↓ LDL-C

Note: In patients with a family history of CVD in a first-degree relative before age 60, the calculated 10-year CVD risk should be **multiplied by 2**.

*Evidence of atherosclerosis = vascular bruits, ABI <0.9, documented CAD, CVA, (TIA or evidence of carotid disease) or peripheral vascular disease
**In men > 45 years, women >50 years with diabetes, as well as some younger people with diabetes who have additional risk as per CDA guidelines.

Source: Pfizer Inc., Cardiovascular Risk Assessment. CA0109LI024E.

Family History (FH) Risk Assessment Tool

Disease	Elevated Risk	Screening Action
Breast Cancer (BC)	≥ 2 cases of BC on same side of family, especially: • In closely related relatives • In more than one generation • When BC is diagnosed < age 50 ***or*** Any case of ovarian cancer ***or*** Bilateral BC ***or*** BC in male relative ***or*** BC age < 60 in Ashkenazi Jewish women ***or*** Identified BRCA1 or BRCA2 mutation in a 1st degree relative and patient has not had genetic testing	Consider referral to a genetics clinic. Annual screening with MRI in addition to mammography starting at age 30
Colorectal Cancer (CRC)	Any family history of: CRC ***or*** Multiple cancers (CRC or associated cancers) ***or*** Cancers at a young age (< 50, particularly if <35) **OR** Personal history of inflammatory Bowel Disease (chronic ulcerative colitis or Crohn's disease)	One 1st degree relative with CRC > 60 ***or*** ≥ two 2nd degree relatives with CRC ***or*** One 2nd/3rd degree relative with CRC – FOBT or FIT q2 years. One 1st degree relative with CRC < 60 ***or*** ≥ two 1st degree relatives with CRC any age – Colonoscopy q5 years beginning age 40 or 10 years earlier then youngest dx of cancer, whichever comes first. One 1st degree relative with CRC < 50 – consider referral to genetics Personal history of inflammatory bowel disease – Colonoscopy beginning 8-10 years after diagnosis
CHD	1st degree relative diagnosed with CHD* age < 60	No specific action, modifies Framingham
Diabetes	1st degree relative	q1 year

***CHD = angina, MI and CHF.**

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Chronic Diseases We Will Focus on During Your Prevention Visit

Cancer

- **Colorectal Cancer**
  Fecal occult blood test (FOBT) or Fecal Immunochemical test (FIT)
  Sigmoidoscopy
  Colonoscopy

Diabetes

- Fasting Blood Sugar every 3 years, < 6 mmol

OR

- HbA1c every 3 years, <6.0%
- High risk – HbA1c or FBS every 1 year

Heart Disease

- BP ≤140/90 (Non-Diabetic), Framingham risk score <10%
- BP ≤130/80 (Diabetic), UKPDS score
- LDL (Diabetic): < 2 mmol/L
- LDL (Non-Diabetic):
  - <3.5 mmol/L (moderate risk)
  - <5 mmol/L (low risk)

These are regular screening intervals and healthy targets

Family History

Male

Mental Health

Nutrition

- Less than 1 tsp of salt each day
- Limit high fat foods

Physical Activity

- Engage in 150 minutes (cumulative) of moderate physical activity each week

- Normal body mass index 18.5-24.9
- Waist circumference <102cm

Alcohol

- Low-risk drinking guidelines: 1-2 drinks a day, total 14 drinks each week

1 drink = 1 beer, 5 oz wine or 1.5 oz liquor

Smoking

- Set a quit date
- Plan to reduce

Factors that Determine Your Risk for Chronic Disease

THE BETTER PROGRAM

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Chronic Diseases We Will Focus on During Your Prevention Visit

Cancer

- **Pap Test** every 1-3 years to screen for cervical cancer
- **Mammogram** every 2 years to screen for breast cancer
- **Colorectal cancer**

  Fecal occult blood test (FOBT) or Fecal Immunochemical test (FIT)
  Sigmoidoscopy
  Colonoscopy

Diabetes

- Fasting Blood Sugar every 3 years, < 6 mmol

OR

- HbA1c every 3 years, <6.0%
- High risk – HbA1c or FBS every 1 year

Heart Disease

- BP ≤140/90 (Non-Diabetic), Framingham risk score <10%
- BP ≤130/80 (Diabetic), UKPDS score
- LDL (Diabetic): < 2 mmol/L
- LDL (Non-Diabetic):
  - <3.5 mmol/L (moderate risk)
  - <5 mmol/L (low risk)

These are regular screening intervals and healthy targets

Family History

Female

Mental Health

Nutrition

- Less than 1 tsp of salt each day
- Limit high fat

Physical Activity

- Engage in 150 minutes (cumulative) of moderate physical activity each week

- Normal body mass index 18.5-24.9
- Waist circumference <88cm

Alcohol

- Low-risk drinking guidelines: 1 drinks a day, total 7 drinks each week

1 drink = 1 beer, 5 oz wine or 1.5 oz liquor

Smoking

- Set a quit date
- Plan to reduce

Factors that Determine Your Risk for Chronic Disease

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Date:_____/_____/_____ **Your Initials:**_____/_____/_____
(month) (day) (year)

Your Health Care Team and You Working Together:
THE PREVENTION PRESCRIPTION

At your visit, we worked together to identify a number of important actions you can take to help prevent chronic disease. **This tool can be used to increase your understanding of the recommended guidelines for regular screening around some of the following potential lifestyle concerns and chronic diseases. Together, we can take steps to support and improve your health and well-being!**

Screening For:	Your Status/Results	When to Re-Check	Referral's/Actions
Cardiovascular Disease			
BMI			
WC			
Blood pressure			
Cholesterol			
Diabetes			
FBS/HbA1c			
Cancer Screening			
FOBT/FIT			
Sigmoidoscopy			
Colonoscopy			
Pap test			
Mammogram			
Lifestyle Concerns			
Physical activity			
Diet			
Alcohol			
Smoking			
Other lifestyle concerns:			

Resources available to help you (websites, handouts etc.):

Your next prevention appointment is in ___ months with: ______________________________

Your health care provider's signature: ______________________________

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THE BETTER PROGRAM

Date:_____/_____/_____ (month) (day) (year)

Your Initials:_____/_____/_____

	1	2	3	4	5	6	7
	WAYS I CAN IMPROVE MY HEALTH – WHAT? (Set Your Goal)	WHAT WILL STOP YOU?	HOW MUCH?	HOW OFTEN?	WHEN?	WHERE?	RATE YOUR CONFIDENCE (Choose One per Goal)
Goal #1							*How Confident Am I That I Can Reach This Goal?* ❍ 0 – Not at all confident ❍ 1 ❍ 2 ❍ 3 – A little confident ❍ 4 ❍ 5 – Somewhat confident ❍ 6 ❍ 7 ❍ 8 – Very confident ❍ 9 ❍ 10 – Totally confident
Goal #2							*How Confident Am I That I Can Reach This Goal?* ❍ 0 – Not at all confident ❍ 1 ❍ 2 ❍ 3 – A little confident ❍ 4 ❍ 5 – Somewhat confident ❍ 6 ❍ 7 ❍ 8 – Very confident ❍ 9 ❍ 10 – Totally confident
Goal #3							*How Confident Am I That I Can Reach This Goal?* ❍ 0 – Not at all confident ❍ 1 ❍ 2 ❍ 3 – A little confident ❍ 4 ❍ 5 – Somewhat confident ❍ 6 ❍ 7 ❍ 8 – Very confident ❍ 9 ❍ 10 – Totally confident

v. 03MARCH2013

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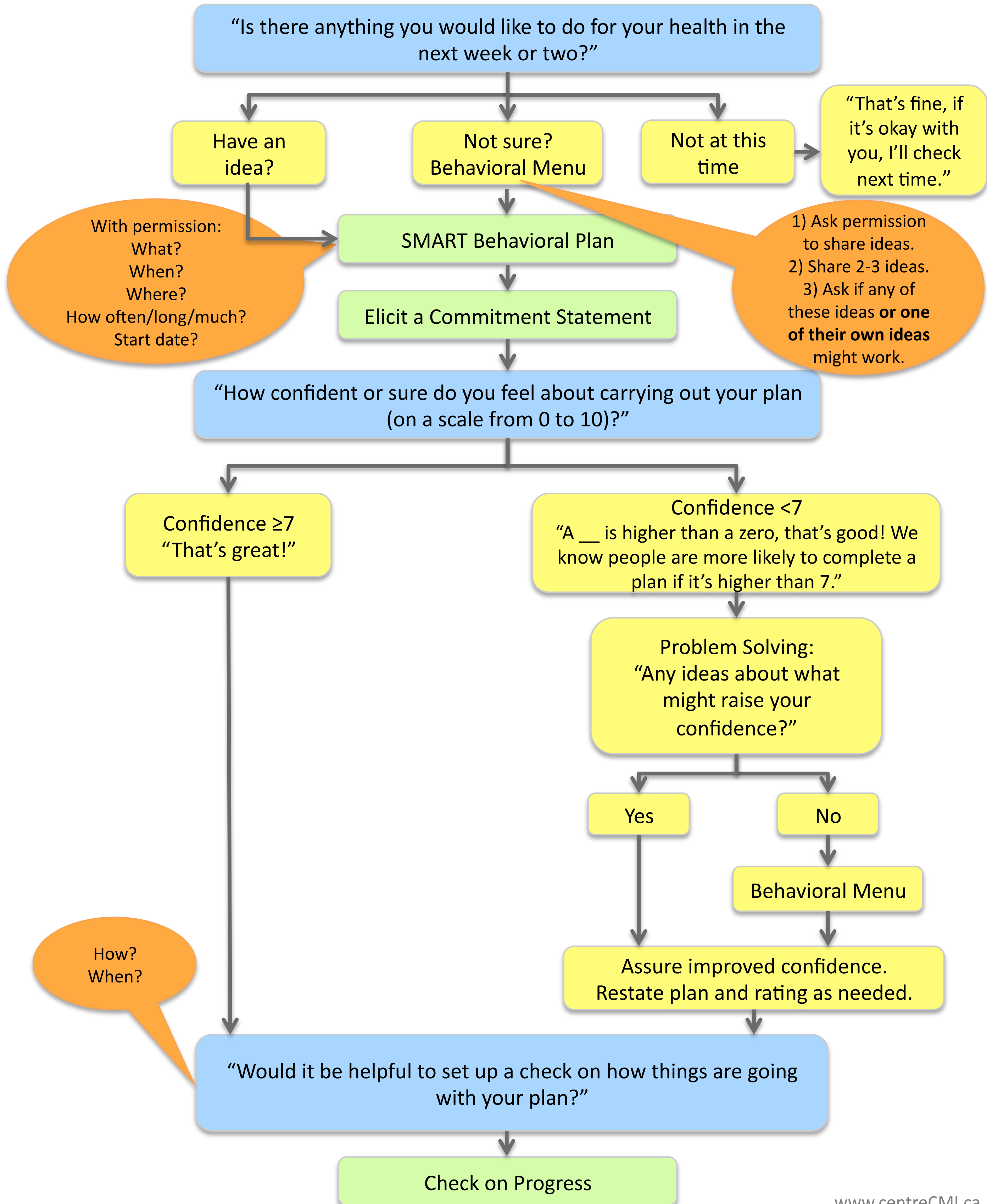
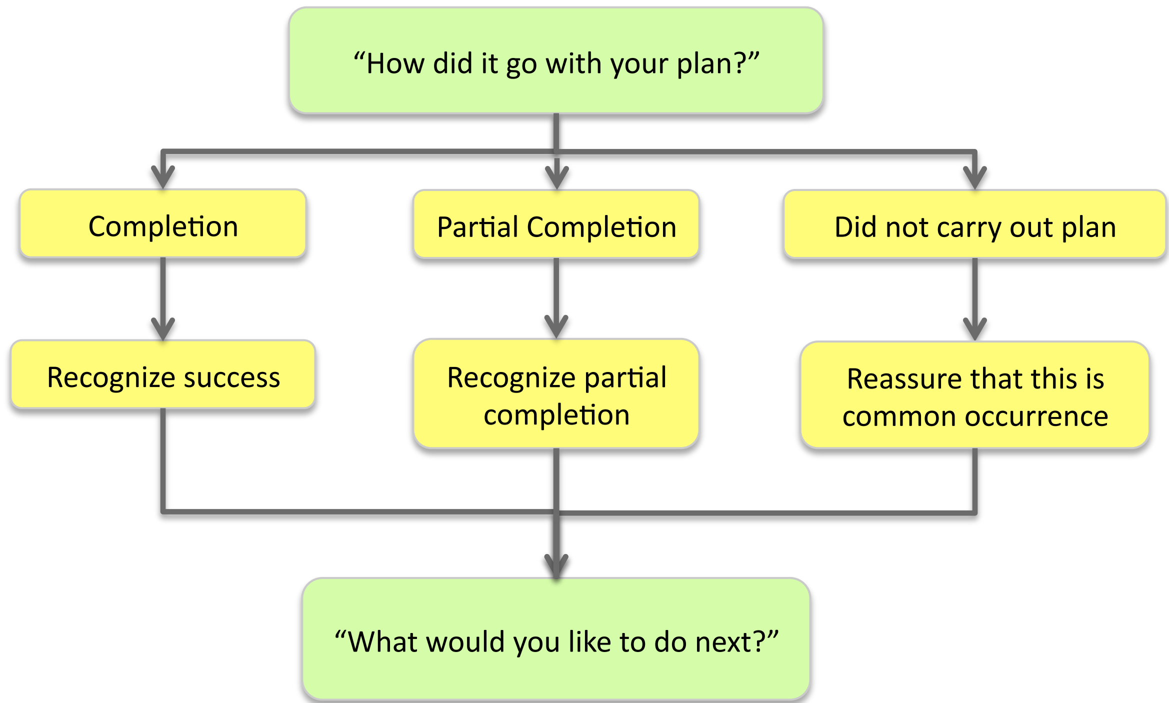
Brief Action Planning Flow Chart

Developed by Steven Cole, Damara Gutnick,
Connie Davis, Kathy Reims



Checking on the Brief Action Plan



The Spirit of Motivational Interviewing is the foundation of Brief Action Planning

Compassion

Acceptance

Partnership

Evocation

Miller W, Rollnick S. Motivational Interviewing: Preparing People for Change, 3ed. 2013.

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1 Mar 2014

Questions?

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