The Chronic Disease & Medicine Clinics Model at Southlake Regional Health Centre in Newmarket: “One person, one chart, one history”
Research is showing that while there is a large investment up-front, overall, less time is spent per patient than in the traditional one-on-one model, and the outcomes are better. Readmissions for arthritis patients who attended the three-week TAP program dropped from 500 a year, when the program began to just two.
“One person, one chart, one history”

The Chronic Disease & Medicine Clinics Model at Southlake Regional Health Centre in Newmarket

Ieva Fraser is bursting with energy and ideas. She knows that in Newmarket, they’re ahead of the game.

“The Ontario chronic disease model... we’ve been living it.

It’s about really understanding each discipline’s perspective in how to maneuver out of silos into interdisciplinary care while maintaining the scope of practice that’s very specific to each discipline.”

Ieva Fraser manages the Chronic Disease & Medicine Clinics at the Southlake Regional Health Centre in Newmarket. Her department consists of The Arthritis Program, Diabetes Education, the Respiratory Rehabilitation Program, and the Medicine Clinics.

This network of clinics can trace its beginnings to the early 1980s, when a rheumatologist, Dr. Carter Thorne, started a rehabilitation program for people with inflammatory types of arthritis such as rheumatoid arthritis. Like Ieva Fraser, he believed in engaging patients in their own self-management through patient education. They both felt that working in teams across disciplines would also result in better patient outcomes.

At the time, this was a novel idea not only to improve patient care but also to deal with physician overload and shortages. It radically changes traditional hospital practice from the one-on-one approach. According to Dr. Thorne: “More patients can be seen, so it’s economically viable. It fills volume goals while meeting clinical outcome goals.”

Based on this philosophy, The Arthritis Program, or TAP, as it’s known for short, was established at the hospital. It was the first in a series of innovative health care programs and
clinics at Southlake that has given a new lease on life to people like Anna who live with a chronic disease.

Anna W. was a young adult teaching English in Japan when she had a rheumatoid arthritis flare-up that became the most frightening health scare of her life. While in Japan, her joints and extremities swelled to the size of melons and she was hit with the worst pain that she had ever experienced. She was in a wheelchair by the time she got back to Ontario.

Fortunately, Anna found her way to TAP at Southlake. At least 50% of all the patient referrals to the clinics at Southlake are from primary care doctors in the community. Other patients are referred by specialists or are in-patients at the hospital. When Anna arrived at TAP, she had already started thinking of herself as disabled, but her road to recovery began right from her first contact with the program.

In the various Southlake programs and clinics, health care providers, other than physicians, are responsible for patient intake. In The Arthritis Program, Anna saw an advanced practice occupational therapist who specializes in arthritis care. In the other clinics, intake is also done by non-physician specialists; for example, in the respiratory rehabilitation program, the respiratory therapist and physical therapist are responsible for the initial assessment. In the chronic disease medicine clinics, pharmacists are the first key links in the chain.

At Southlake chronic disease programs and medicine clinics, a holistic approach to the patient’s care starts at the initial assessment. Regardless of the reason for the referral, every patient gives a full medical history and gets a physical exam. Anna participated in a thorough interview about her health including her genetic background, past surgeries, the way her mood was affecting her health, all medications, the impact of smoking, alcohol and diet habits; even social supports and financial circumstances were addressed. Such detailed questioning sometimes leads to a different diagnosis than the original referral and always to a more comprehensive view of the patient’s health.

At intake, it was confirmed that Anna had a particular form of inflammatory arthritis called psoriatic arthritis, and that TAP was the right place for her to be. Then, like most of the chronic disease management patients, she entered a multi-faceted, stepped program. First came appropriate medical treatment. The rheumatologist, Dr. Thorne, referred her to the pharmacist, Marie Craig. She worked with Anna to figure out which medications were best for her; she also taught Anna how to inject her own medication and explained the dosage and side effects she might experience.

Anna was delighted with all the treatment and education she received: “I came in here thinking I would be wheelchair-bound for life. Now I realize there’s hope for me.”

The pharmacist felt good about her work too: “It makes you feel satisfied because you know you’ve made a difference by giving patients information they wouldn’t normally get.”
At this stage Anna also saw Dr. Thorne and some of the other members of the arthritis team – the physiotherapist, occupational therapist, and a kinesiologist. If other illnesses had been detected, Anna would have been referred to one of the other Chronic Disease & Medicine Clinics at Southlake. Patients with multiple chronic conditions can be referred back and forth between the clinics. It’s truly one-stop shopping. Here, even the specialists come to the patients. They work out of the clinics at Southlake, as needed.

While her medical condition was coming under control, Anna was enrolled in a three-week education program to learn coping skills to manage her arthritis on a daily basis. She learned more about her medications, orthotic supports, the right shoes, community resources, and exercise programs, like tai chi, for example, that would be appropriate for her condition. For Anna, the course was a godsend.

“This was a wake up call for me. Psoriatic arthritis was the end of a dream. I thought I could never have the teaching career I was hoping for. At TAP, they are so knowledgeable; now I’m not going to worry about my bones disintegrating before they should. They told me if you take care of yourself, that’s not going to happen and they have taught me how to prevent it.”

Ieva Fraser says that Anna’s feedback is not unique. Data based on patient outcomes at six months after enrollment in the three-week program show significant improvements for all the patients. So much so that Ieva tells new patients entering the program, with certainty: “If you attend more than 80% of this treatment regime, you will have good medical outcomes. We will get this disease under control. If you attend less than that, it will take longer and the disease will have a longer period of time controlling you.”

Patients with complex issues pertaining to their chronic diseases can continue their journey to self-management after the initial group treatment/education by attending a generic chronic disease management group. There are several groups to choose from, each running once per week, for six weeks, focusing either on coping skills, nutrition or exercise. Each session has experiential learning plus homework, and building on the skills of the previous week. Patients can then transition to community self-management programs, such as the partnership Southlake has with Newmarket Parks and Recreation.
“One person, one chart, one history”. The Chronic Disease & Medicine Clinics Model at Southlake Regional Health Centre in Newmarket

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Ieva Fraser

Once she completed the three-week arthritis education and treatment program, Anna was given a rehabilitation plan including physiotherapy, stretching and swimming. Ultimately, the goal was to have her managing her arthritis on her own with a maintenance program in the community.

Throughout the whole process, Anna had access to the services of the full health care team for support and assistance as necessary. Team members vary from clinic to clinic depending on the needs of the patients, but in The Arthritis Program the team includes rheumatologists, dietitians, kinesiologists, physiotherapists, occupational therapists, social workers and pharmacists. Anna was amazed to see that all the health care professionals involved with her case actually worked together under one roof and all in the same room.

According to Ieva Fraser: “The common space is a critical tool that provides opportunities for brainstorming among disciplines, allows new ideas to rise most effectively, and brings down false silos.”

“The trust that I got from the team,” says Anna, “made a big difference to me. I felt they were all really dedicated to getting me healthy.”

But the reality is that bringing different disciplines together is not always seamless. At Southlake, the team works in an informal and collaborative way. Southlake has run team-building exercises to help all the professionals deliver a different kind of integrated health care. At first, in some cases, simple differences in the way individual disciplines worked posed barriers to communication. For example, the TAP team discovered that the phrase ‘medically stable’ meant different things to a physician, an occupational therapist and a physiotherapist. They had to agree on neutral language choices.

But Ieva Fraser says that the creation of interdisciplinary, non-hierarchical teams facilitates patient self-management. It also maximizes the scope of practice for each health care provider, increasing efficiency.

“Chronic disease management cannot survive using the acute care model. In acute care, it’s all about going in and doing something to the patient…and that’s not self-management. In-patients are helpless. We can’t use that model. Self-management and helplessness don’t go hand in hand. Health care providers have to completely function in transfer knowledge mode, so that the patient can truly end up self-managing.”
“Whenever I was dealing with my health before,” says Anna W., “I never knew what was going on. After TAP, I felt that I had a say about what I thought was the best treatment for me. Finally, I knew everything I wanted to know about what was wrong with me. I had an entire team of people working on getting me healthy. I don’t know where I’d be without them.”

Another challenge of integrating the teams was to develop a single patient chart that satisfied the needs of all disciplines. Most health care provider training teaches discipline-specific patient charting. At Southlake, the team identified the key pieces of information each discipline required to make clinical decisions. They created one chart that they all share. One person, one chart, one history.

While the chronic disease patient charts are currently paper-based, Southlake Regional Health Centre is working to implement electronic records to enable better treatment for patients with multiple chronic conditions. This will allow all the health care professionals from any of the clinics to have access to the physician notes about a patient. This also enables better communication with the patient’s family physician. All information added to Anna’s chart at TAP for example, is shared with her family physician. This is critical to ensure the continuity of care for the patient once in the community.

“One of the system rules is that assessment notes must go to the family physician. Family physicians are key team members,” according to Ieva Fraser. “We offer steady and detailed information to them about their patients.”

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Anna W.
The success of The Arthritis Program at Southlake led to the amalgamation of other Chronic Disease and Medical Clinics, which now operate on the same principles as TAP. The Southlake model has resulted in happy patients and happier staff. They now have a lower turnover of health care providers and a very high rate of professional job satisfaction.

Dr. Carter Thorne attests: “It’s the success of team-building which has been so rewarding to me. It has resulted in so many patient successes I can’t count them, frankly! We sit there and we say, look at that person, look how well they did!”

And the data bears out the success: not only is the program cost-effective, it’s also showing remarkable medical outcomes. Research is showing that while there is a large time investment up-front, overall, less time is spent per patient than in the traditional one-on-one model, and the outcomes are better. The Southlake model of chronic disease management and prevention resulted in a staggering reduction of hospital re-admissions for arthritis patients who attended the three-week TAP program. Readmissions dropped from 500 a year, when the program began, to just two according to Southlake internal health records.

Patients like Anna W. can’t say enough about the program. While she still has occasional flare-ups, her perspective on her illness has significantly changed. She has now enrolled in teacher’s college and only occasionally has to use a cane or crutches.

“I can have a completely normal life, but I have to take the steps to make sure that happens. And now I know how. I’m more cautious, but I wouldn’t say that I’m fearful of the future. Not anymore. I definitely feel like all of my options are open again.”

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