Conference Abstract

Assessing implementation variations of a disease management program in daily practice: the RECODE case study

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Abstract

Background: The implementation of a disease management (DM) program in primary care is expected to vary across general practices. This variation may be caused by differences in "adjusting" the DM interventions to fit the context of each general practice and by practice-specific barriers and facilitators influencing the implementation. These causes of variability in implementing a DM program are important to understand the conditions for a successful implementation of a DM program.

Aims: The purpose of this study was to examine how one DM program was implemented in several general practices and underline the facilitators and barriers to its successful implementation. The RECODE trial, a two-year cluster-randomized control trial in which 40 clusters of primary care teams were randomized to a Chronic Obstructive Pulmonary Disease (COPD) DM program or usual care, is used as a case study.

Methods: The sample consisted of 20 general practices that had implemented the RECODE program and recruited a total of 554 COPD patients. Variations in program implementation were measured by taking 2 different perspectives: a) the patients' perspective, measured with the Patient Assessment Chronic Illness Care (PACIC) and b) the healthcare professionals perspective, explored by conducting interviews with the primary care teams. To quantify the level of disease management at the starting-point and the reported change in integrated COPD care due to the RECODE intervention, an indicator-list was developed including 19 interventions on 5 components of the Chronic Care Model.

Results: The starting level of COPD care ranged from ad-hoc COPD care (53%), structural diagnosis of COPD (24%), to structural diagnosis and follow-up of the COPD patients (24%). The number of implemented interventions varied from 3 to 15 across the 20 general practices. The

general practices with the highest implementation scores on the indictor-checklist were not the same practices as the ones that had the greatest increase in PACIC scores. Barriers and facilitators of the implementation of integrated COPD care encountered on different domains: individual domain (e.g. (un)motivated healthcare providers), social domain (e.g. variability in adoption of DM between team members), organisational domain (e.g. time, starting level of COPD care), and societal domain (e.g. reimbursement).

Conclusion: The implementation of the RECODE program varied remarkably across different general practices. This is explained mainly due to variations in the starting point of integrated care before the implementation of DM program, the specific context of the general practices and the individual factors (barriers and facilitators) that influenced the successful program implementation. Furthermore, the perception of improvements in integrated COPD differed between patients and professionals.

Keywords

action, program

Powerpoint presentation:

http://www.integratedcarefoundation.org/content/making-transicion-towards-integrated-care-implementation-sciences

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