We can do BETTER

BETTER WISE: An innovative, evidence-based program for cancer and chronic disease prevention and screening

AFHTO Conference 2017
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Relationships with commercial interests:

None

The BETTER program and related research activities have received funding from Alberta Innovates; Health Canada, through the Canadian Partnership Against Cancer; and the Heart and Stroke Foundation.

The views expressed herein represent the views of the BETTER Coalition and do not necessarily represent the views of the funders.

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Relationships with commercial interests:

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Disclosure of Commercial Support

This program has not received any other financial or in-kind support

<u>Potential for conflict of interest:</u>

- None of the speakers have received payment of funding nor derived benefits from this program

Mitigating Potential Bias

There have been no biases identified to mitigate

Learning Objectives

- Learn about an innovative approach that integrates preventive care for cancer and chronic diseases in the primary care setting, including for cancer survivors
- Learn how the BETTER approach can be adapted and used to encourage patients to become active participants in their health
- Identify how you can apply this intervention in your practice to improve prevention and screening.

Outline

1. Overview - a BETTER approach to cancer and chronic disease prevention and screening (CCDPS)

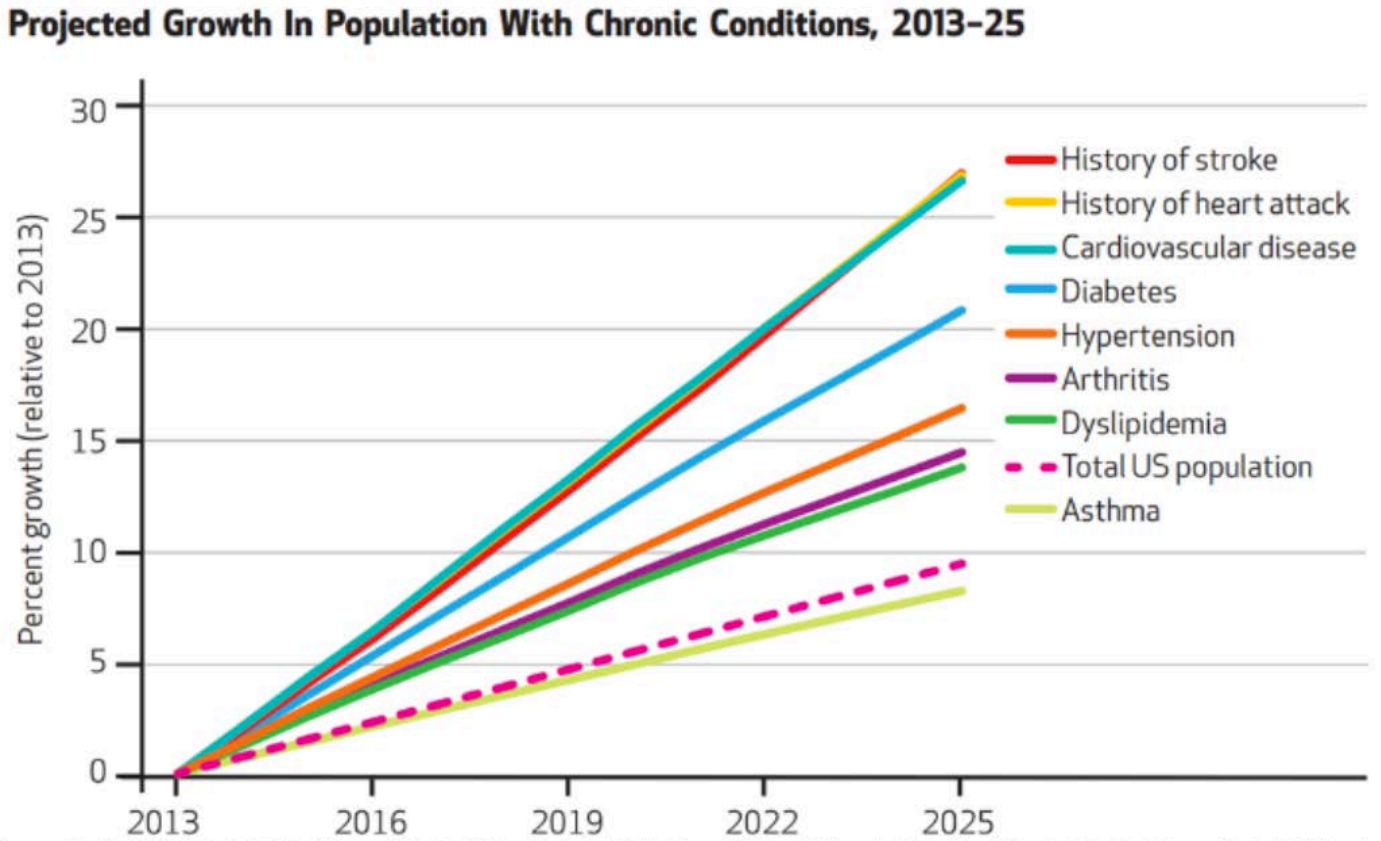
2. Explore:
   - The role of the “Prevention Practitioner”
   - BETTERWISE tools
   - The prevention visit
   - How you could adapt BETTER into your setting
   - Brief word on BETTERWISE research study

3. Time for discussion, comments, questions

Background

- The prevalence of chronic disease is steadily increasing impacting morbidity, mortality, and healthcare services
- Most patients have multiple risks, but guidelines and resources typically focus on one specific condition
- Cancer survivors achieve fewer CCDPS goals despite closer monitoring

Background



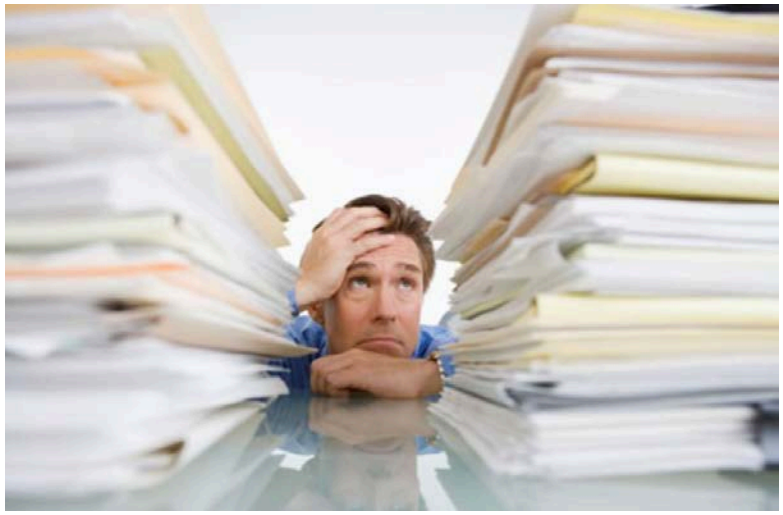
Source: Timothy M. Dall, Paul D. Gallo, Ritasree Chakrabarti, Terry West, April P. Semilla and Michael V. StormAn Aging Population And Growing Disease Burden Will Require A Large And Specialized Health Care Workforce By 2025 Health Affairs, 32, no.11 (2013):2013-2020

Background

- Primary prevention and screening for chronic diseases is the best hope to curtail the rise in chronic disease
- Family physicians lack time, resources & tools to address CCDPS
- To fully satisfy the US Preventive Task Force recommendations, it would take an additional 7.4 hours a day

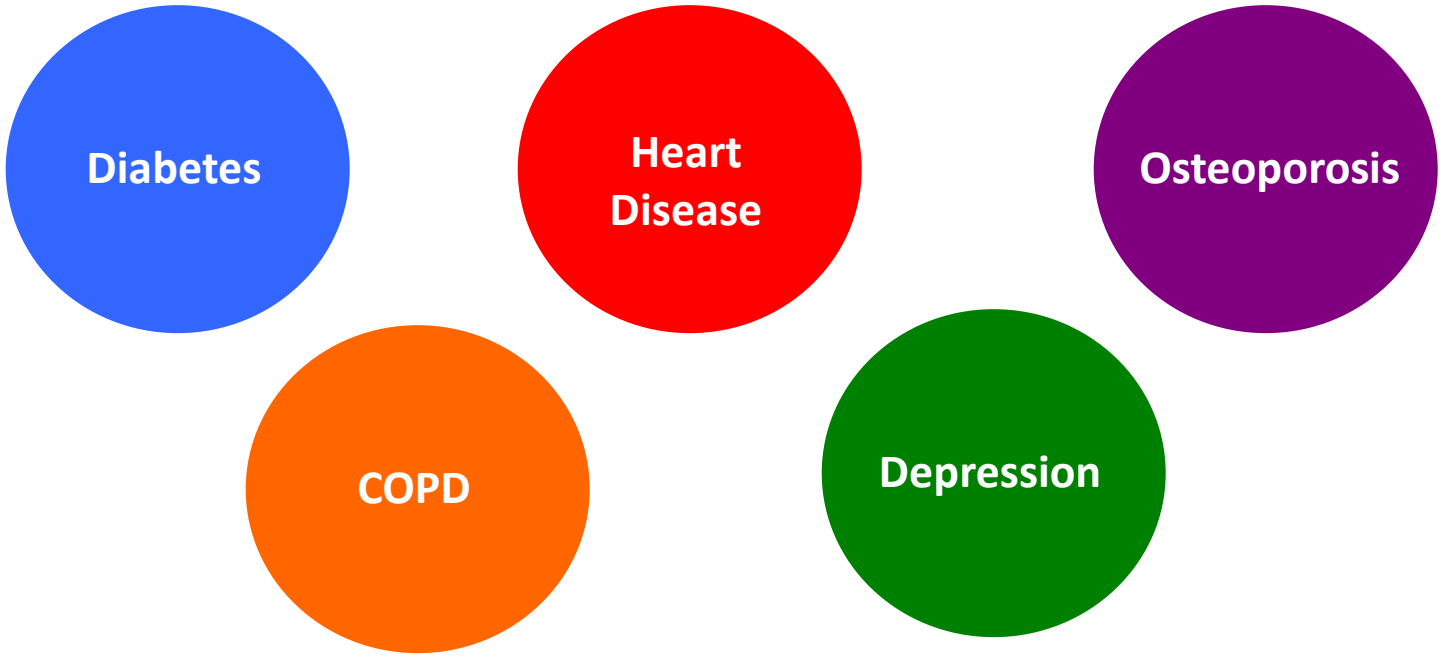
Background

- There are a plethora of guidelines including conflicting guidelines and many that lack rigor, resulting in confused family physicians

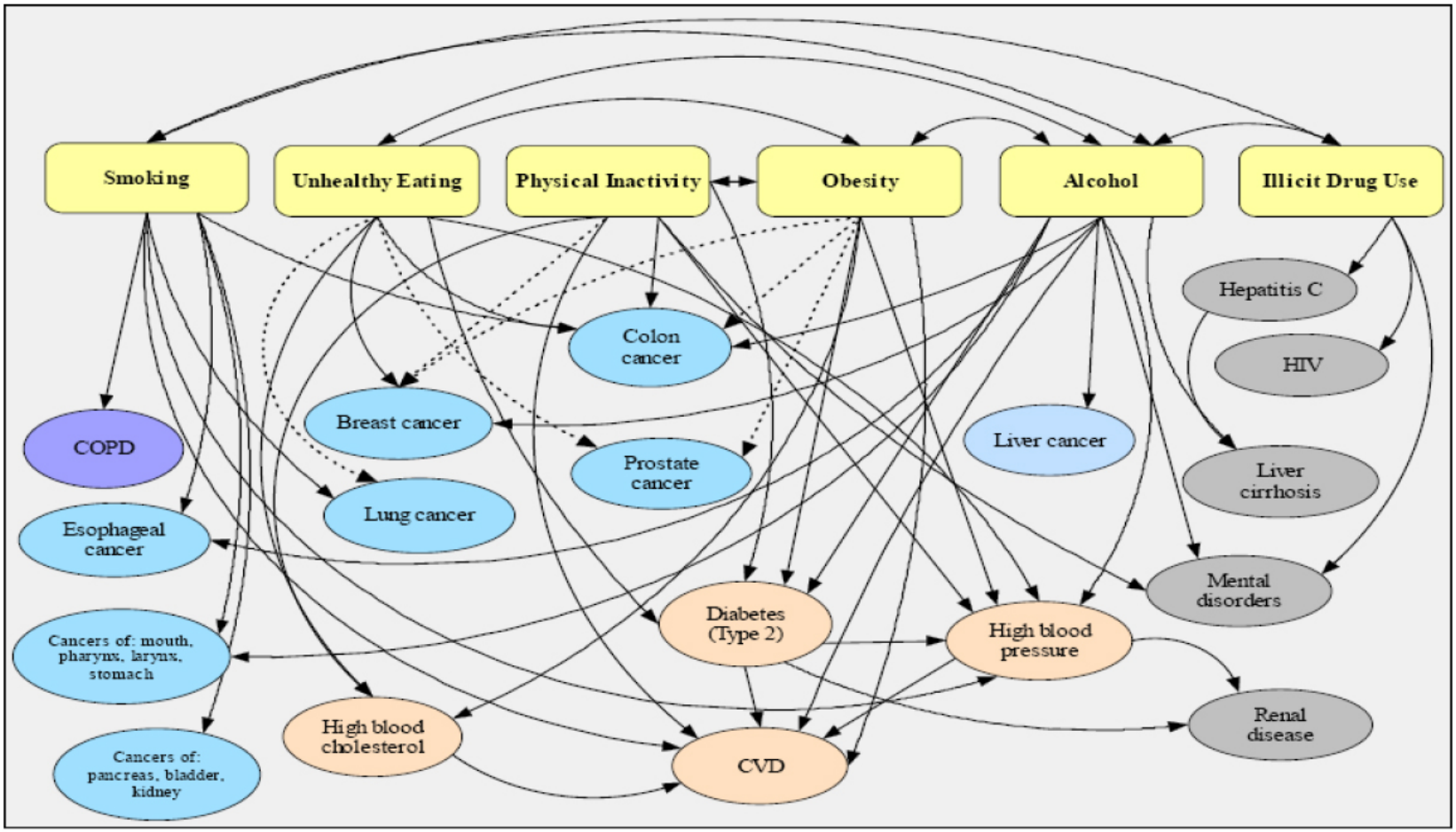


Traditional Health Care Model

Guidelines & resources focus on one disease or cancer



Reality: we need a multifaceted approach



Haydon E, Roerecke M, Giesbrecht N, Rehm J, Kobus-Matthews M. (2006, March). Chronic disease in Ontario and Canada: Determinants, risk factors and prevention priorities: Summary of full report. Prepared for the Ontario Chronic Disease Prevention Alliance & the Ontario Public Health Association. Available from: http://www.ocdpa.on.ca/docs/CDP-SummaryReport-Mar06.pdf

Hence, The BETTER Trial

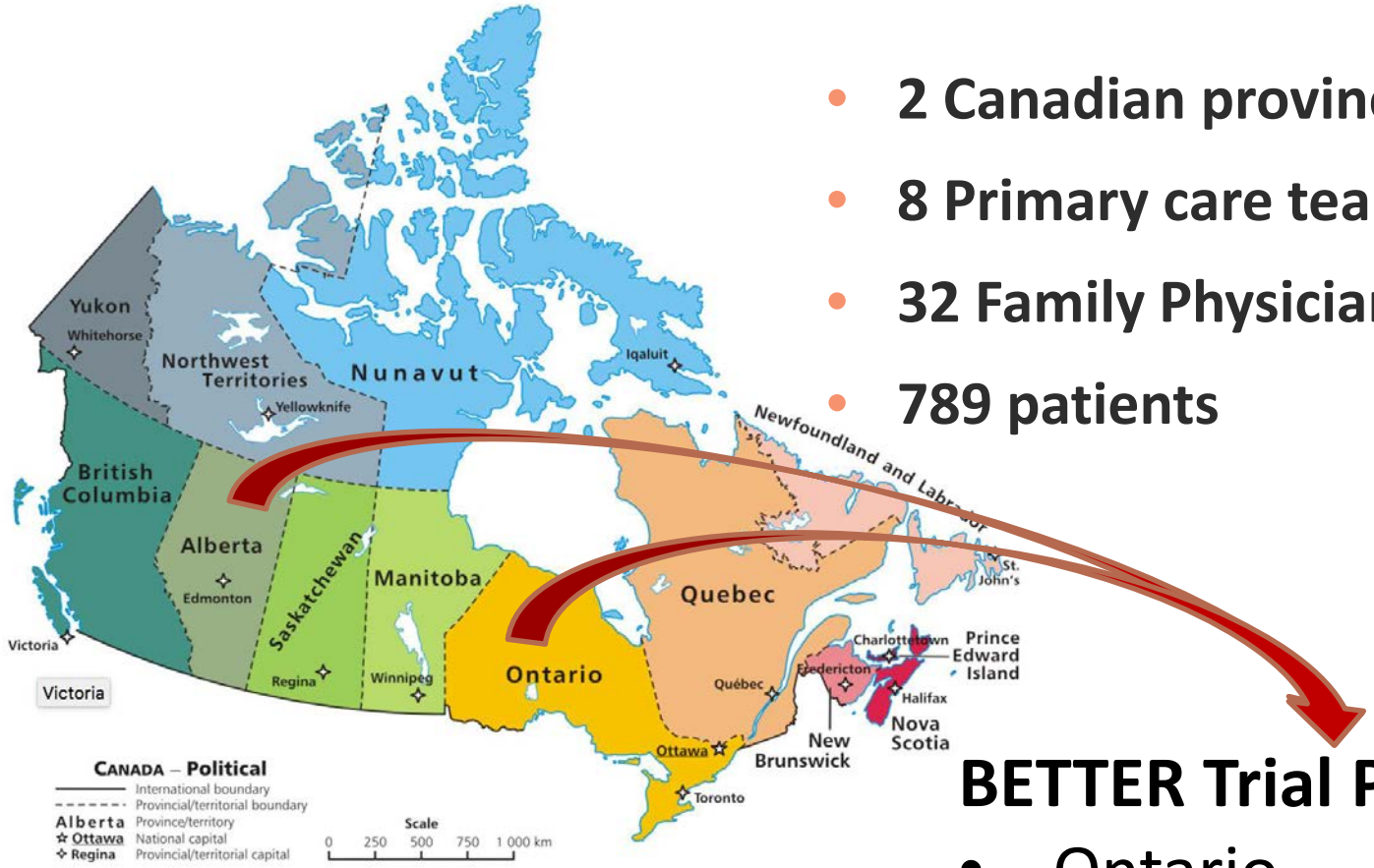
- **Overall Objective:** Improve prevention and screening, *integrated* for chronic disease

  - **Specific Objectives:** In a Primary Care Team setting, for adults ages 40 to 65, to determine if:
    - a practice level Practice Facilitator intervention is effective
    - a patient level Prevention Practitioner intervention is effective

Why BETTER?

- 4 practices in Alberta + 4 in Ontario participated in the original BETTER trial
- The BETTER trial assessed how well participating patients did at achieving 28 CCDPS evidence-based maneuvers
- Includes items related to diabetes, heart disease, cancer screening and lifestyle factors known to influence health (smoking, alcohol consumption, exercise, weight control)

BETTER Trial



- **2 Canadian provinces**
- **8 Primary care team practices**
- **32 Family Physicians**
- **789 patients**

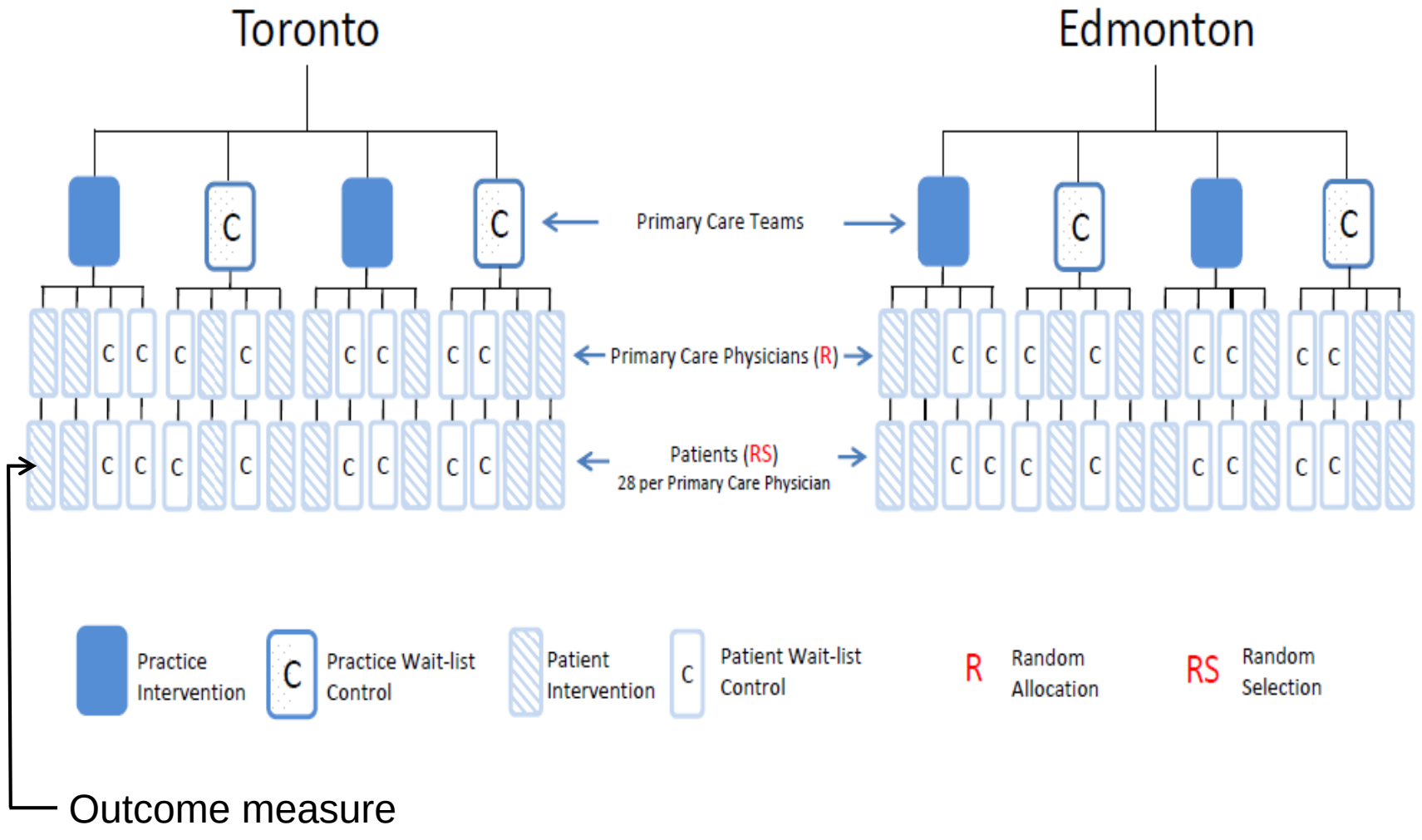
BETTER Trial Provinces

- Ontario
- Alberta

BETTER Trial – Study Design

- Pragmatic Factorial Cluster Randomized Controlled Trial:
  - Practice level Intervention – Practice Facilitator (PF)
  - Patient level Intervention – Prevention Practitioner (PP)
- Randomization at the level of the practice
- Outcome measure at the level of the individual patient

Design Schema



BETTER Outcomes – Measuring change

- Tested interventions could impact multiple domains:
  - Structural changes in practice setting,
  - Process changes in clinical practice,
  - Health-behavioural changes in patients,
  - Physiological changes in patients

BETTER Trial Outcome

Composite index at the patient level

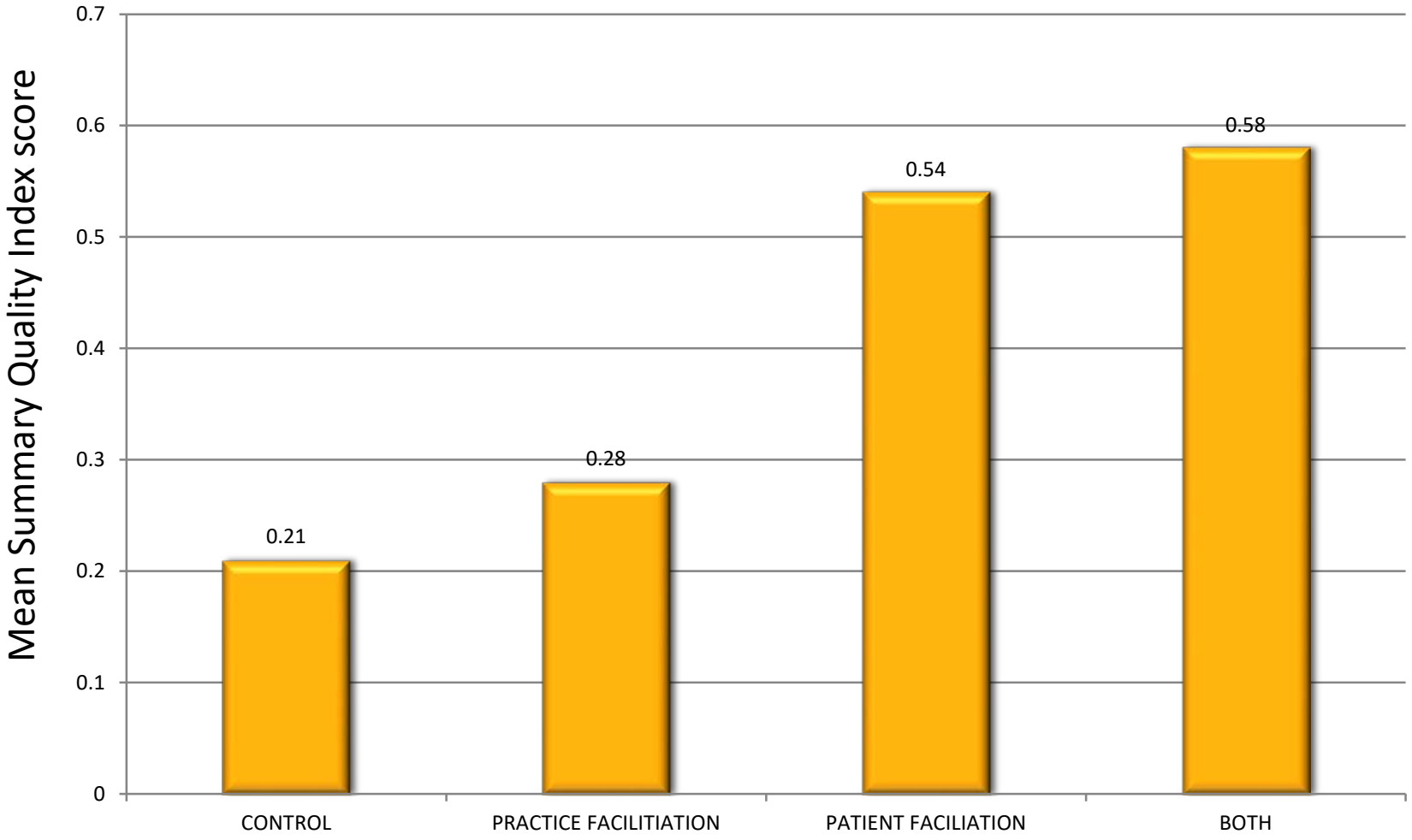
- A composite index of patients' adherence to eligible CCDPS actions at follow-up (6 months later):

$$\frac{\textbf{\# CCDPS action met at follow-up}}{\textbf{\# CCDPS actions eligible at baseline}} \times 100$$

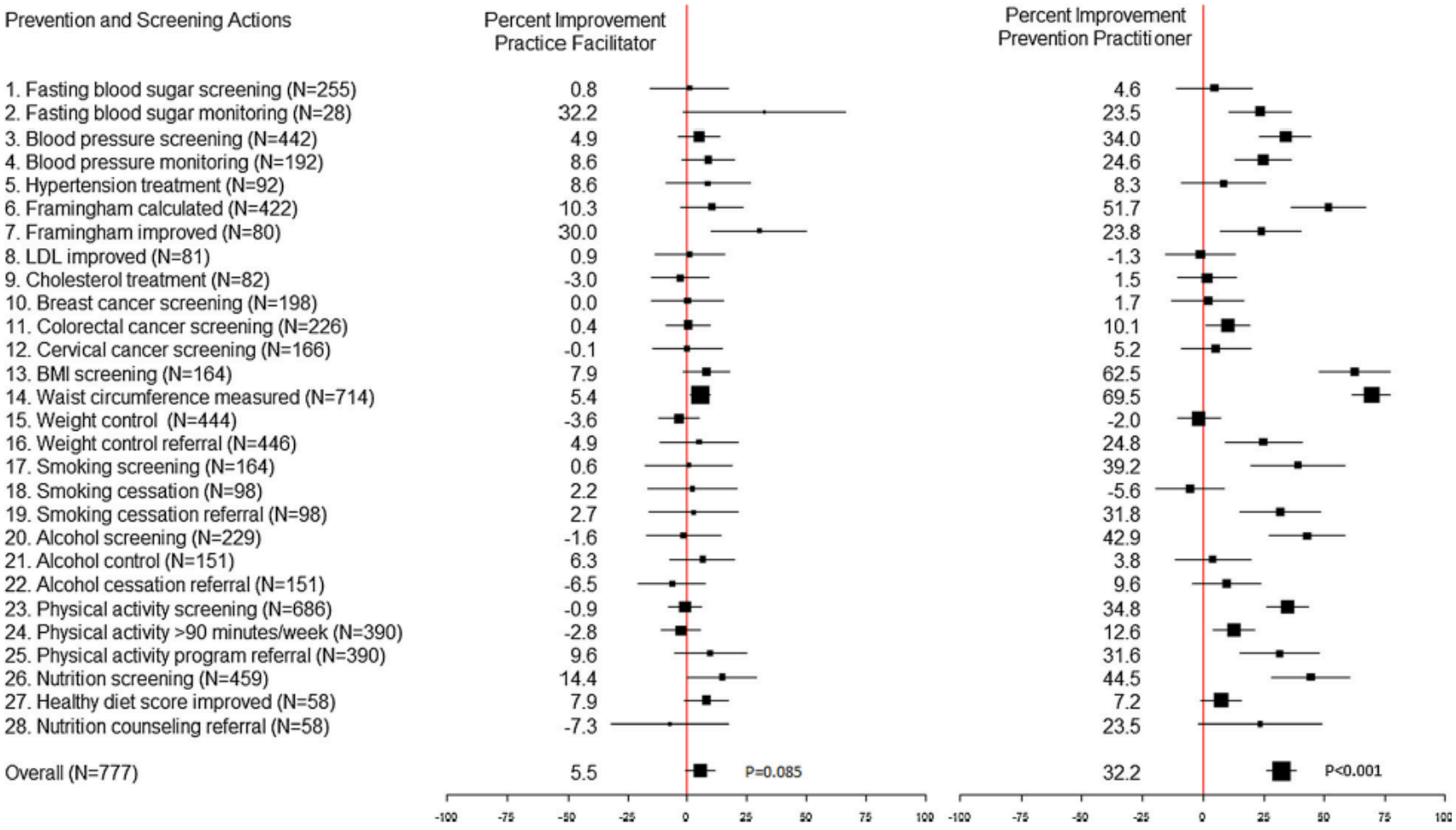
- Includes items related to diabetes, heart disease, cancer screening and lifestyle factors known to influence health (smoking, alcohol consumption, exercise, weight control)

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



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Prevention Practitioner Intervention - Outcomes

Despite not powered for individual outcomes, significant improvement in:

- Fasting blood sugar monitoring
- Blood pressure screening
- Blood pressure monitoring
- Framingham calculated
- Framingham improved
- BMI screening
- Waist circumference measured
- Weight control referral
- Smoking screen
- Smoking cessation referral
- Alcohol screening
- Physical activity screening
- Physical activity >90 minutes/week
- Physical activity program referral
- Nutrition screening

BETTER 2 – Implementation Study

Newfoundland & Labrador Three Settings

St John's – population 106,172

Happy Valley – population 7,552

Rural area – between two towns

BETTER 2 Results

- Recruited 154 patients to meet with Prevention Practitioner
- Patients eligible for average of 12.3 CCDPS maneuvers at baseline and achieved an average of 6.0 = 49% [95% confidence interval 24% - 74%]
- Comparable to the success achieved in the BETTER trial

The BETTER Approach

- The BETTER approach impacts CCDPS by:

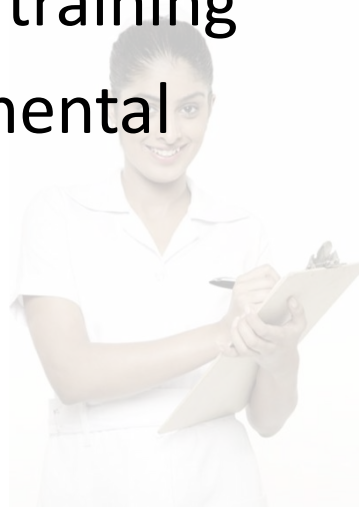
1. A newly developed role, the prevention practitioner (PP)
2. Approaching CCDPS in a comprehensive manner
3. An individualized and personalized approach

Prevention Practitioner (PP)

- An enhanced role with specialized skills in CCDPS
- A member of the practice – e.g. LPN, RN, NP, dietician

Prevention Practitioner (PP)

- Comfortable with practice workflow
- Can set aside dedicated time for prevention visits
- Can take on this role without compromising other roles
- Willing and able to receive better training
- Friendly, approachable, not judgmental
- Passionate about prevention
- Team player



Reflection

- *Who in your Team setting would make a good Prevention Practitioner?*

Prevention Practitioner (PP)

- PP training & PP role:
  - Environmental scan
  - Overview of blended evidence-based guidelines
  - Intensive instruction on the tools
  - A 1 hour prevention visit with patients
    - Producing a “prevention prescription” tailored to the patient

Important Features

1. Becomes 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 informs patient of their present status
5. Identification of actionable goals for patients

The Prevention Practitioner Role

- Armed with the BETTERWISE Toolkit
- Review each patient's eligibility for CCDPS maneuvers
- Meet with patients – prevention visit (30-60 minutes)
  - Assess patient risk and set CCDPS goals
  - Follow-up visits – 15 minutes, in-person or via telephone; review patient's progress on previously established CCDPS goals
- Through shared decision-making, develop an individualized prescription for each patient and help patient set goals

The BETTER Tools

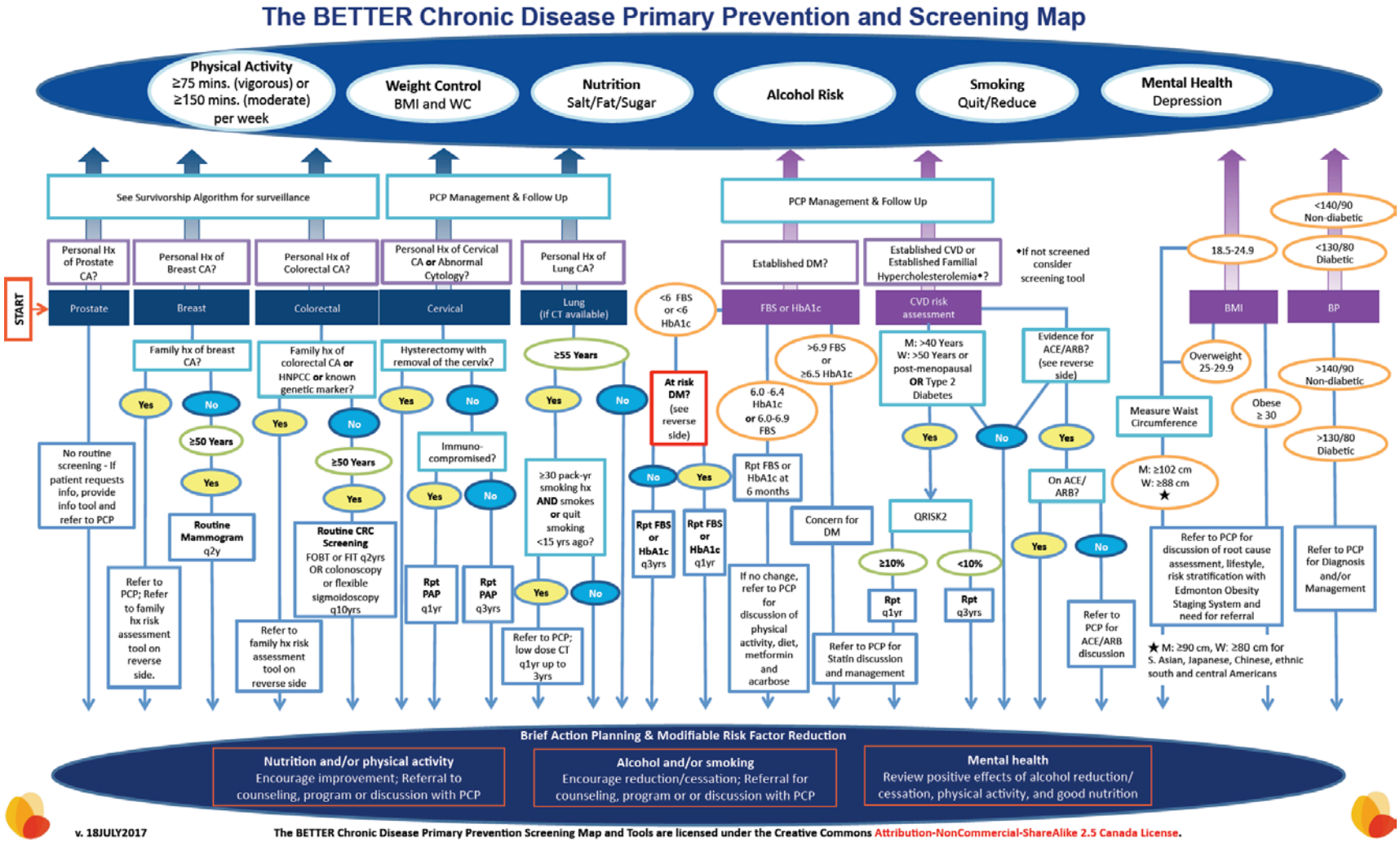
- **TOOLS Specific to BETTER**
  - The BETTER Chronic Disease Primary Prevention and Screening Algorithm
  - The BETTER Health Survey
  - The BETTER Prevention Visit Form
  - Bubble Diagram
  - Goals Sheet
  - Prevention Prescription

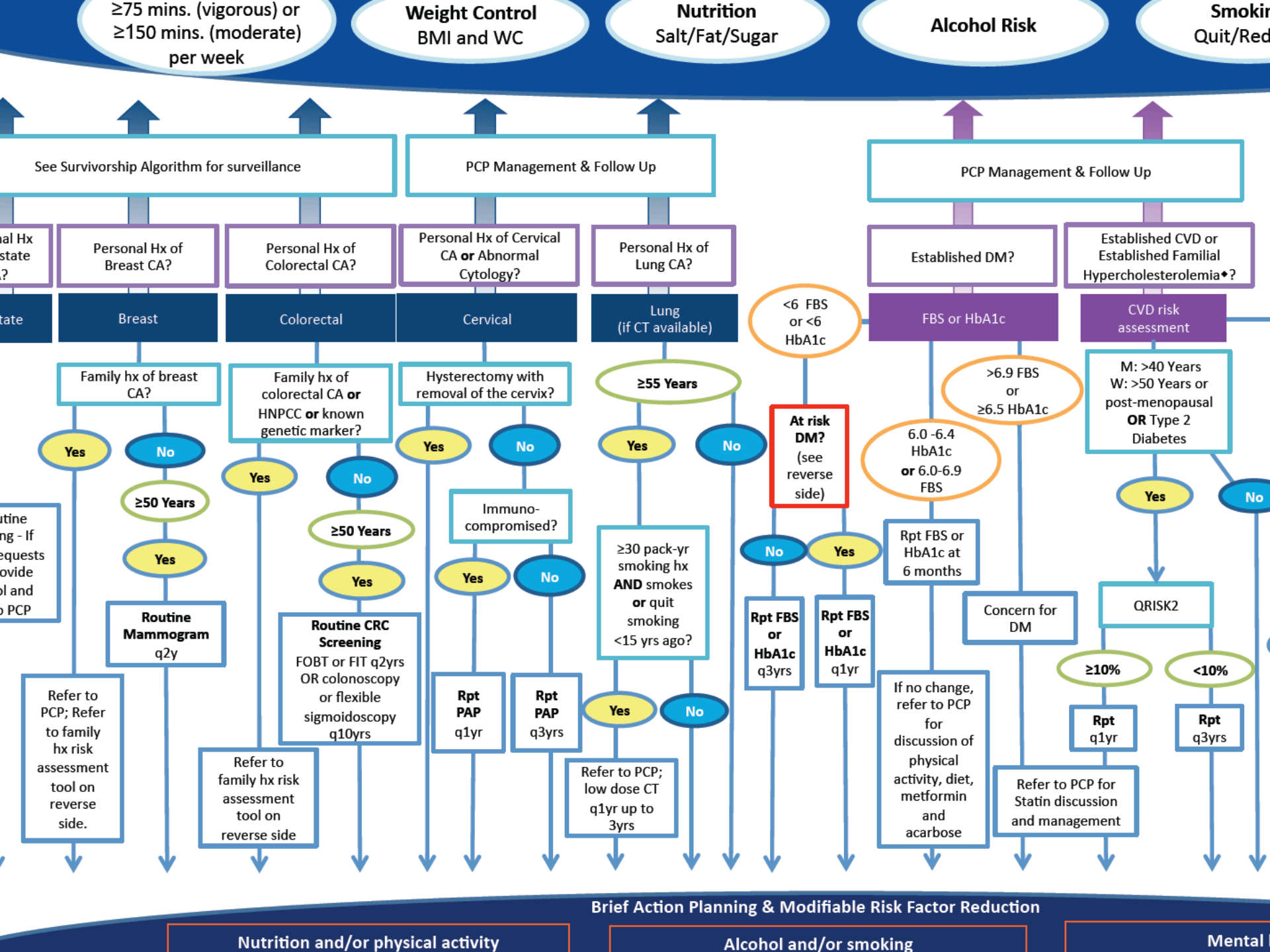
- **TOOLS identified for use in BETTER**
  - Special Topic Tools (Diet, Physical Activity)
  - Cardiac Risk Factor Tools
  - Family History Tools
  - Jurisdictional Tools

The BETTERWISE Algorithm

- National Clinical Working Group reviewed high level evidence-based guidelines and tools for a *comprehensive and integrated* approach to CCDPS in patients aged 40-65 years.
  - developed **actionable high level CCDPS items** that can be applied in practice settings
  - identified **quantifiable high level CCDPS outcomes** for inclusion in a composite Index of CCDPS
  - updated **original BETTER tool kit** to include cancer survivorship actions for use in BETTER WISE tool kit

The BETTERWISE Algorithm




≥75 mins. (vigorous) or ≥150 mins. (moderate) per week
Weight Control
BMI and WC
Nutrition
Salt/Fat/Sugar
Alcohol Risk
Smokin
Quit/Red
See Survivorship Algorithm for surveillance
PCP Management & Follow Up
PCP Management & Follow Up
Personal Hx of Breast CA?
Personal Hx of Colorectal CA?
Personal Hx of Cervical CA or Abnormal Cytology?
Personal Hx of Lung CA?
Established DM?
Established CVD or Established Familial Hypercholesterolemia◆?
Breast
Colorectal
Cervical
Lung (if CT available)
<6 FBS or <6 HbA1c
FBS or HbA1c
CVD risk assessment
Family hx of breast CA?
Family hx of colorectal CA or HNPCC or known genetic marker?
Hysterectomy with removal of the cervix?
≥55 Years
At risk DM? (see reverse side)
>6.9 FBS or ≥6.5 HbA1c
6.0 -6.4 HbA1c or 6.0-6.9 FBS
M: >40 Years W: >50 Years or post-menopausal OR Type 2 Diabetes
Yes
No
≥50 Years
Immuno-compromised?
≥30 pack-yr smoking hx AND smokes or quit smoking <15 yrs ago?
Rpt FBS or HbA1c at 6 months
QRISK2
Routine Mammogram q2y
Routine CRC Screening FOBT or FIT q2yrs OR colonoscopy or flexible sigmoidoscopy q10yrs
Rpt PAP q1yr
Rpt PAP q3yrs
Rpt FBS or HbA1c q3yrs
Rpt FBS or HbA1c q1yr
Concern for DM
≥10%
<10%
Refer to PCP; Refer to family hx risk assessment tool on reverse side.
Refer to family hx risk assessment tool on reverse side
Refer to PCP; low dose CT q1yr up to 3yrs
If no change, refer to PCP for discussion of physical activity, diet, metformin and acarbose
Refer to PCP for Statin discussion and management
Rpt q1yr
Rpt q3yrs
Brief Action Planning & Modifiable Risk Factor Reduction
Nutrition and/or physical activity
Alcohol and/or smoking
Mental

The BETTERWISE Algorithm

Family History (FH) Risk Assessment Tool

Disease	Elevated Risk	Screening Action
Breast Cancer (BC)	• Person has known mutation (BRCA1, BRCA2 or other gene predisposing to a markedly elevated BC risk) **or** • Untested 1st degree relative of a carrier of above mutation **or** • FH consistent with a hereditary BC syndrome **+** estimated personal lifetime cancer risk >25% **or** • Women who received chest radiation (not chest x-ray) age <30 **+** ≤8 yrs ago	Annual screening with MRI in addition to mammography starting at 30.
	• Ovarian cancer any age (epithelial) **or** • Family member with BRCA1/BRCA2 mutation **or** • High-risk ethnicity (e.g. Ashkenazi Jewish, Icelandic) **+** personal and/or FH of hereditary breast and ovarian related cancers (breast, ovarian, male breast, pancreatic, prostate with Gleason Score ≥7)	Consider referral to a genetics clinic.
	• One or two 1st degree relatives with invasive BC but does not meet the criteria for referral to genetics or MRI screening	Annual mammography starting 5-10 yrs younger than youngest diagnosis – screening to start at 25-40. Annual clinical breast examination starting at 25.
Colorectal Cancer (CRC)	• One 1st degree relative with CRC > 60	**ON**: Colonoscopy q5yrs or as directed starting at 50, or 10 yrs younger than youngest diagnosis; **NL**: FIT q2yrs starting at 50; **AB**: FIT q2yrs starting at 40.
	• One 1st degree relative with CRC < 60 **or** • Two 1st degree relatives with CRC at any age	**ON, NL:** Colonoscopy starting at 50 or 10 yrs younger than youngest diagnosis; **AB**: Colonoscopy starting at 40 or 10 yrs younger than youngest diagnosis
	• 2nd degree relative with CRC diagnosis <50 years	Colonoscopy at 50 – repeat as dictated by findings
	• Personal history of Crohn's, UC, FAP, HNPCC, Lynch Syndrome (LS*) *Refer patients with suspected LS to PCP to discuss genetics referral	Colonoscopy at discretion of GI
	• Carrier of mutation in LS gene **or** • Untested first degree relative of a LS mutation carrier	Colonoscopy q1-2 yrs starting at 20-25 or 2-5 years younger than youngest diagnosis if that diagnosis was made <25 yrs, whichever is earlier.
CHD	• Angina or heart attack in a 1st degree relative < 60	No specific action, modifies QRISK2 calculation
Diabetes	1st degree relative	q1 year

Diabetes Mellitus Risk

Elevated Risk

- Family History - 1st Degree **or**
- Past Impaired FBG ***or*** HbA1C **or**
- HTN ***or*** Elevated BP ***or*** on HTN medication **or**
- History of Gestational DM **or**
- Obese/High waist circumference **or**
- Ethnicity **or**
- Chronic Kidney Disease **or**
- Cardiovascular Disease **or**
- Hyperlipidemia **or**
- Polycystic ovarian disease **or**
- Medications (glucocorticoids, atypical antipsychotics, HAART)

Evidence for ACE/ARB

Conditions for ACE/ARB

- Patient >55 ***and***
- DM ***or*** CAD ***or*** CVD ***or*** PVD ***and***
- HTN ***or*** elevated TC ***or*** low HDL ***or*** smoker ***or*** microalbuminuria

Abbreviations

- ACE = Angiotensin Converting Enzyme inhibitor
- ARB = Angiotensin Receptor Blocker
- BP = Blood Pressure
- CAD = Coronary Artery Disease
- CHD = Coronary Heart Disease
- CVD = Cardiovascular Disease
- DM = Diabetes Mellitus
- FBG = Fasting Blood Glucose
- HNPCC = Hereditary Nonpolyposis Colorectal Cancer or Lynch Syndrome
- HAART = Highly Active Antiretroviral Therapy
- HTN = Hypertension
- PVD = Peripheral Vascular Disease

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BETTER Health Survey

- **Obtained before the prevention visit:**
  - Helps determine what CCDPS maneuvers the patient is eligible to receive
  - Takes about 30 minutes

- **Specific information obtained on (*including readiness to change):**
  - Colorectal screening
  - Cervical screening
  - Breast cancer screening
  - Medications
  - Smoking*
  - Exercise quantified & tool*
  - Diet habits – tool “Starting the Conversation”*
  - Alcohol – quantified*
  - General health & two question screen for depression (PHQ 2)
  - Family history
  - General questions – SES

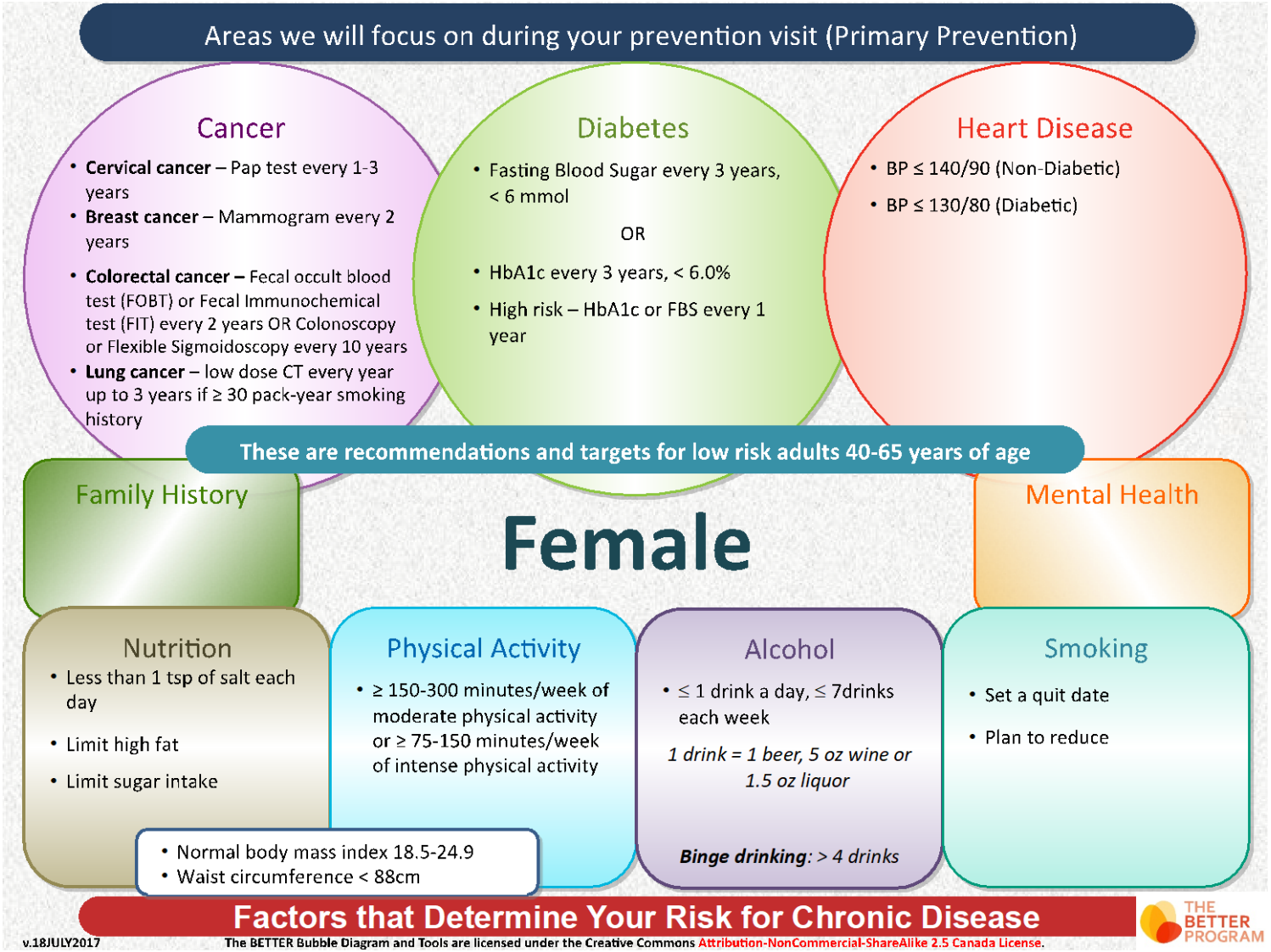
Reflection

- *How would you administer the survey to patients in your setting?*
- *By mail? By email? In waiting room right before visit? Visit dedicated to completing survey? Paper/tablet?*

BETTER Prevention Visit Form

- Before the visit
  - Pulls information from the survey + patients' chart to identify what CCDPS maneuvers patients are eligible to receive

The Bubble Diagram



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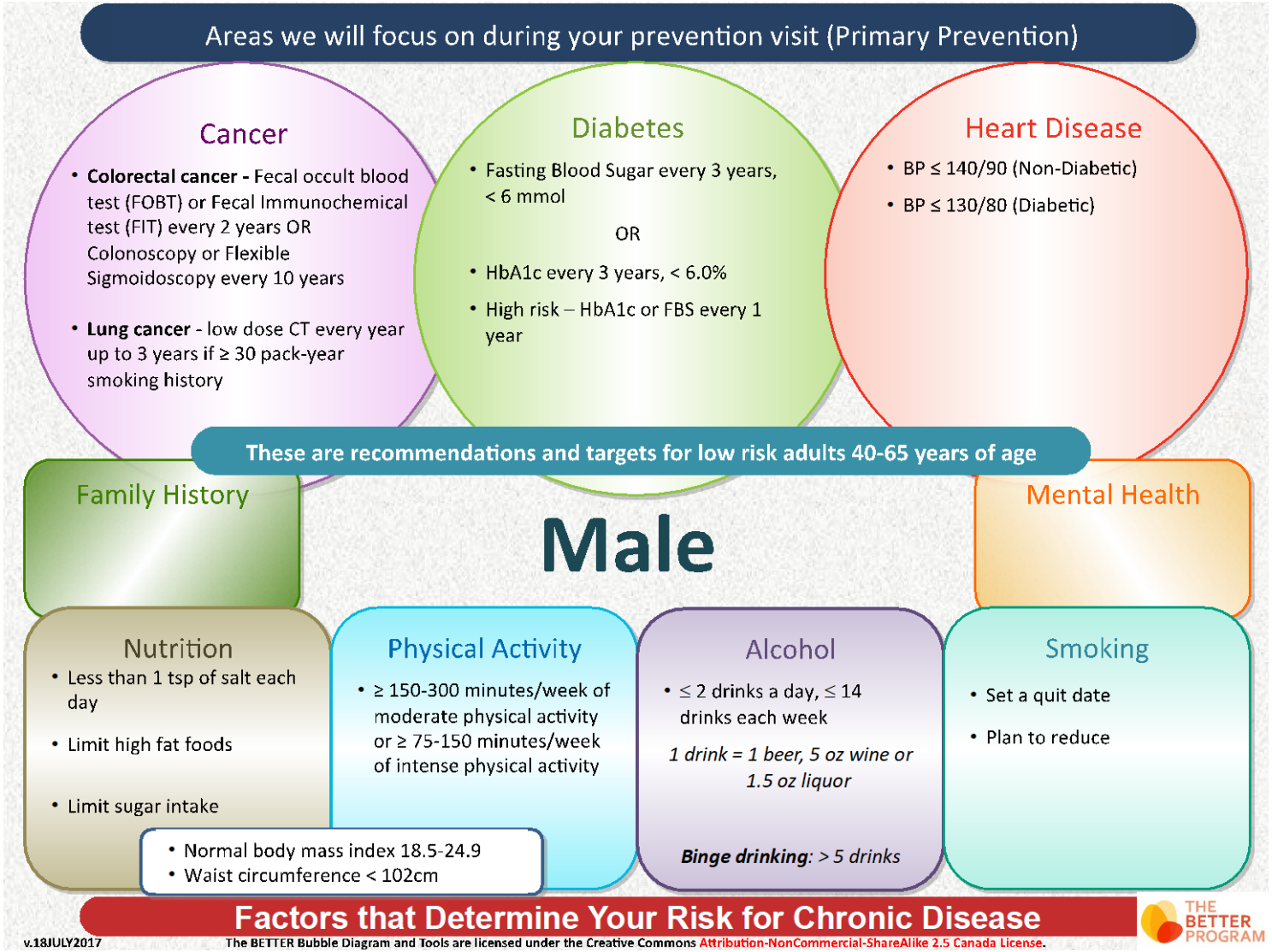

S.M.A.R.T. Goal Setting

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

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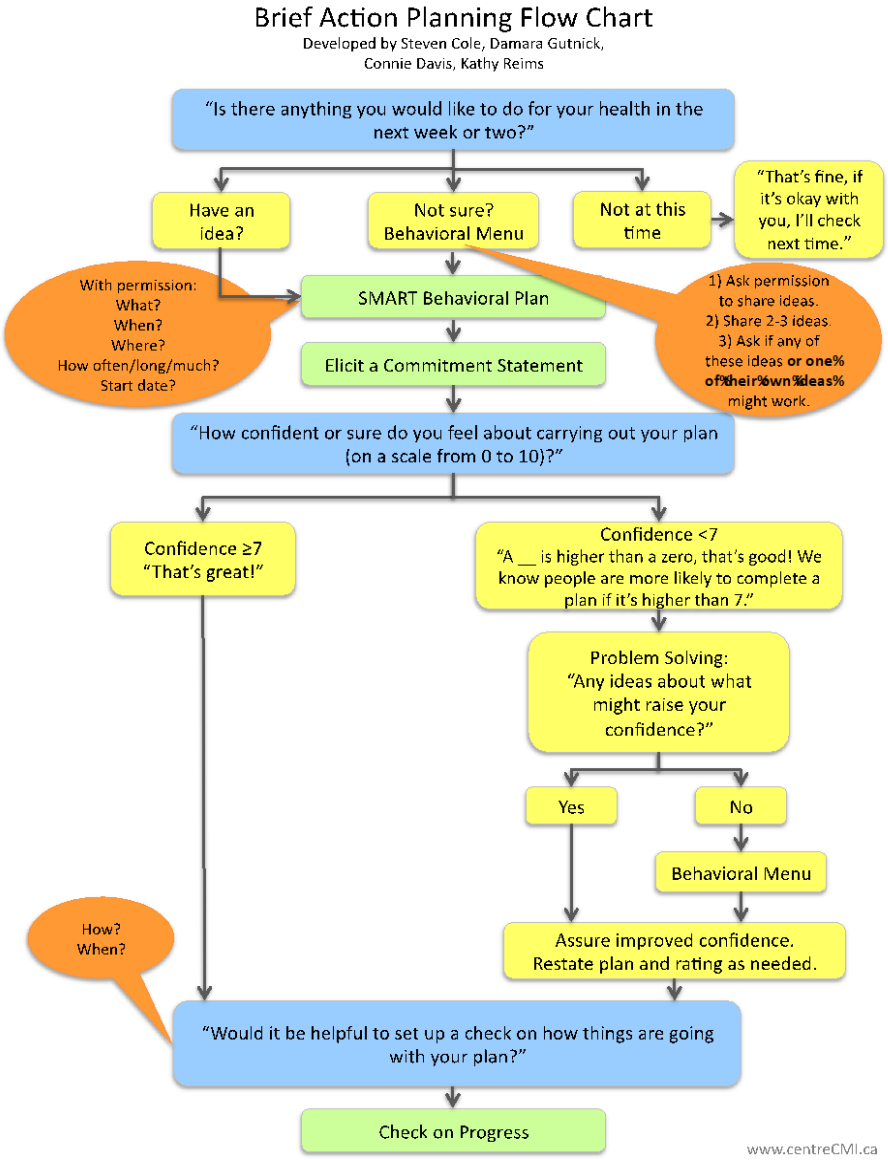
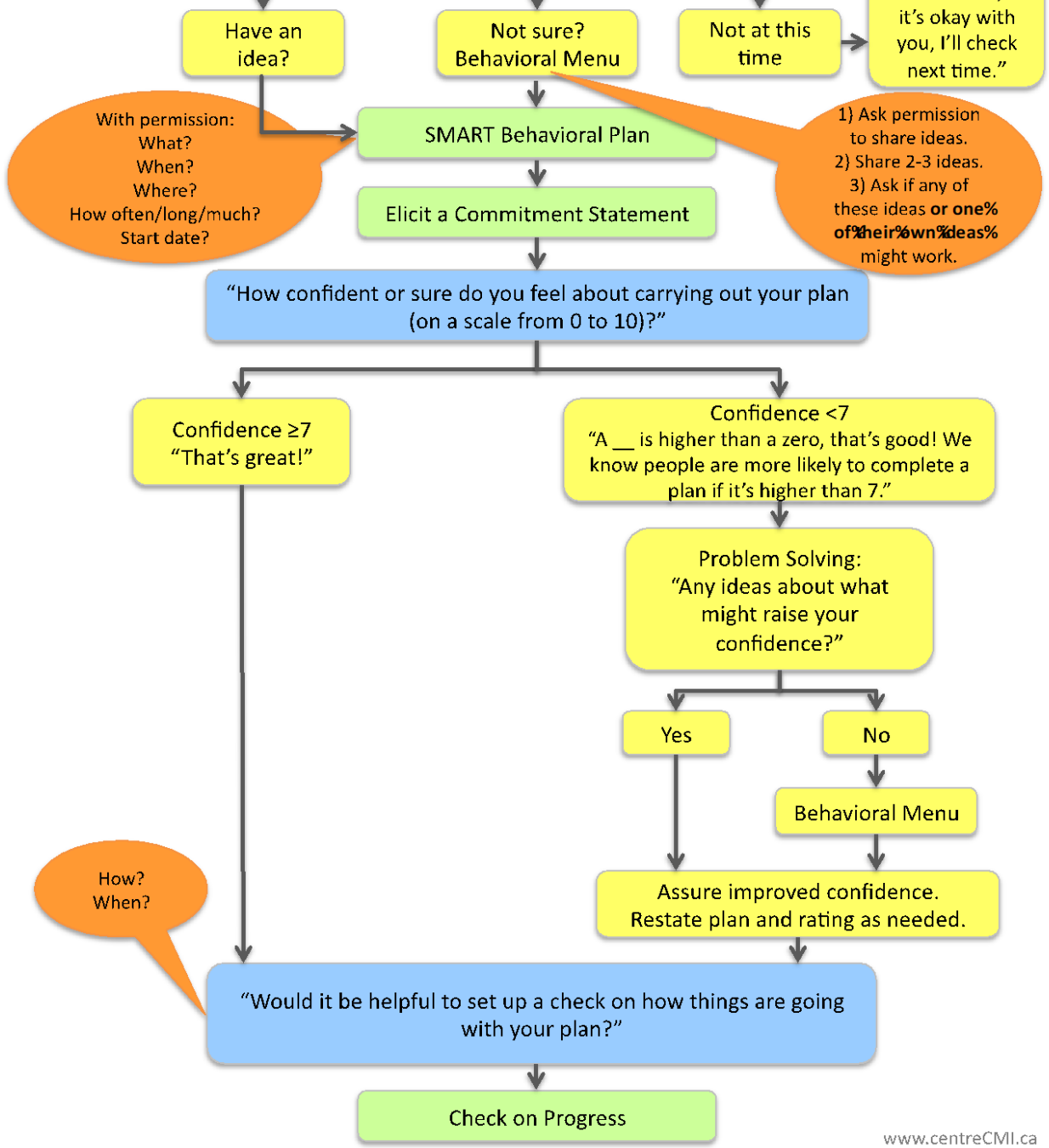
SMART Goals – Brief Action Planning




"Is there anything you would like to do for your health in the next week or two?"
Have an idea?
Not sure? Behavioral Menu
Not at this time
"That's fine, if it's okay with you, I'll check next time."
With permission:
What?
When?
Where?
How often/long/much?
Start date?
SMART Behavioral Plan
Elicit a Commitment Statement
1) Ask permission to share ideas.
2) Share 2-3 ideas.
3) Ask if any of these ideas or one% of%their%own%ideas% might work.
"How confident or sure do you feel about carrying out your plan (on a scale from 0 to 10)?"
Confidence ≥7
"That's great!"
Confidence <7
"A __ is higher than a zero, that's good! We know people are more likely to complete a plan if it's higher than 7."
Problem Solving:
"Any ideas about what might raise your confidence?"
Yes
No
Behavioral Menu

SM ng



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Brief Action Planning

- https://www.youtube.com/watch?v=w0n-f6qyG54

- http://www.comprehensivemi.com/about/brief-action-planning (first hit with a Google search)

- Info on evidence for BAP, BAP training and certification, example videos

Reflection

- *Are there other opportunities in your FHT to use Brief Action Planning?*

Prevention Prescription

Screening For:	Status/Results	Target	Re-Check	Referrals/Actions
Cardiovascular Disease	Enter measurement value or lab value		Enter year or time frame	Enter referrals made or action items for patient or clinician
BMI	kg/m2	18.5-24.9 kg/m2		
WC		males <102 cm females <88 cm		
Blood pressure	/	diab - <130/80 non-diab <140/90		
Cholesterol	/ /	diab - LDL <2mmol/L non-diab - LDL <5mmol/L*		
Diabetes	Total LDL HDL			
FBS/HbA1c	/	FBS <6mmol/L HbA1c <6.0%		
Cancer Screening	FBS mmol/L HbA1c % Enter Month and Year of last test		Enter year or time frame	Enter referrals made or action items for patient or clinician
FOBT/FIT	/	Every 2 years**		
Sigmoidoscopy	/	Every 5 years**		
Colonoscopy	/	Every 10 years**		
Pap test	/	Every 3 years**		
Mammogram	/	Every 2 years**		
Lifestyle Concerns	(e.g. mins/week, drinks/week, area of concern)		Enter year or time frame	Enter referrals made or action items for patient or clinician
Physical activity		>=150 mins/week, limit sedentary behaviour (sitting or laying down for long periods)		
Diet		Fruits &Vegetables (7-10 servings/day), Low Salt, Limit Fat		
Alcohol		M <=14drinks/week F <= 7 drinks/week		
Smoking		Quit/Reduce		

(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:	Status/Results	Target	Re-Check	Referrals/Actions
Cardiovascular Disease	Enter measurement value or lab value		Enter year or time frame	Enter referrals made or action items for patient or clinician
BMI	kg/m2	18.5-24.9 kg/m2		
WC		males <102 cm females <88 cm		
Blood pressure	/	diab - <130/80 non-diab <140/90		
Cholesterol	/ /	diab - LDL <2mmol/L non-diab - LDL <5mmol/L*		
Diabetes	Total LDL HDL			
FBS/HbA1c	/	FBS <6mmol/L HbA1c <6.0%		
Cancer Screening	FBS mmol/L HbA1c % Enter Month and Year of last test		Enter year or time frame	Enter referrals made or action items for patient or clinician
FOBT/FIT	/	Every 2 years**		
Sigmoidoscopy	/	Every 5 years**		
Colonoscopy	/	Every 10 years**		
Pap test	/	Every 3 years**		
Mammogram	/	Every 2 years**		

Reflection

- *How would you use the prevention prescription in your practice? Where in the chart would it be kept?*

Reflection

- *How would you identify patients in your practice best suited for BETTER?*
- *How would you schedule visits with the Prevention Practitioner?*
- *How would you follow up on outstanding issues identified by the PP?*

BETTERWISE:
Quick Word on the Research

- National study: 8 practices in Alberta, 4 in Newfoundland, 4 in Ontario
- Randomized trial: PP intervention vs. wait-list
- Randomized at the physician level
- Aiming for ~25% of patients to be cancer survivors
- Outcome at 12 months
- Also looking for *maintenance* of benefits
- Qualitative component: feedback from patients, providers, policymakers

Reflection

- *What outcomes would matter to your family health team? How would you measure success?*

Questions?