CASE: convince, action, support, empower

A tool to help manage follow-up of patients with chronic illnesses in primary care

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In Canada, 16 million people struggle with at least one chronic illness.[1] Chronic illnesses, such as cardiovascular disease, diabetes, chronic obstructive pulmonary disease, asthma, and arthritis, are prevalent in primary care.[2,3] According to the Canadian Health Services Research Foundation, 67% of the national health budget is allocated for patients and families affected by chronic illnesses.[1]

Chronic illnesses pose an enormous challenge because they are progressive and because achieving targets of care requires the active and sustained participation of patients and their families.[4] However, ongoing compliance with treatment constitutes a considerable clinical problem: only an estimated 50% to 75% of patients with chronic illnesses follow treatment recommendations.[5]

Given this context, a new clinical approach, the DaVinci Project, is currently being developed with the interdisciplinary team at the Cité-de-la-santé de Laval in Quebec. This approach is designed to facilitate coordinated interventions by the various health professionals who provide care for patients with 1 or more chronic illnesses. The CASE system, an acronym for *convince, action, support,* and *empower*, is at the heart of this clinical project. It is a clinically relevant classification that calls for distinct actions from health care workers. The categories of the system make it possible to describe both the position a patient adopts toward his or her chronic health problems and the level of clinical intervention the entire team will adopt in their interactions with the patient.

Clinical relevance of the CASE system

Studies in recent decades have identified suboptimal treatment compliance rates that clearly illustrate the difficulty of introducing, and especially continuing, treatment in patients' lives.[5] These data suggest that it would be worthwhile for professionals to use better targeted interventions to encourage patients to take action (ie, start treatment) and to support patients during the process (ie, continue with treatment as agreed).

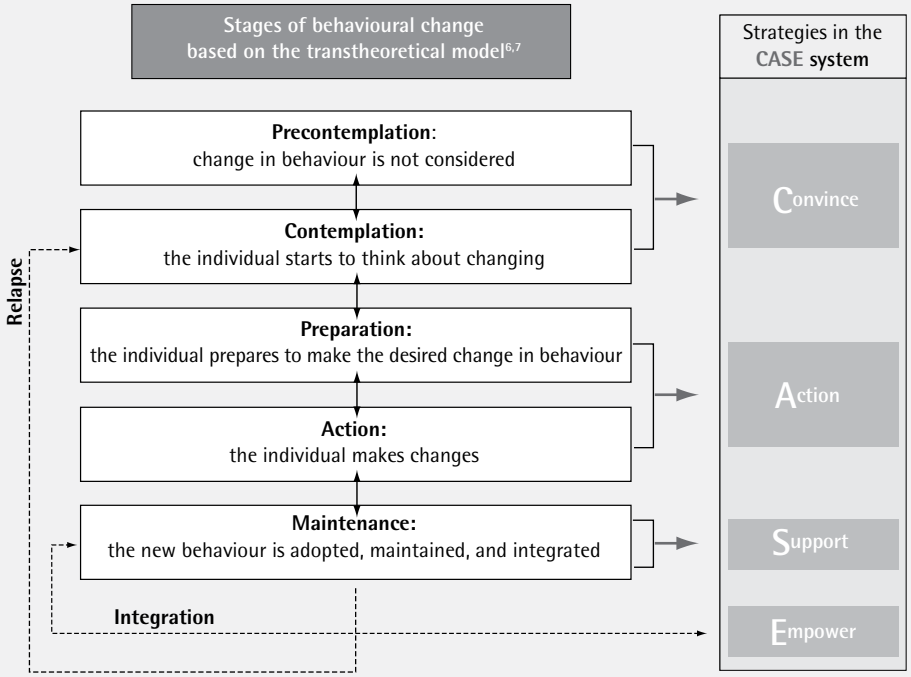
In their transtheoretical model, Prochaska and DiClemente[6,7] suggested that a change in behaviour occurs during a process consisting of various stages: precontemplation, contemplation, preparation, action, maintenance, and termination. Within these stages, they also identified 9 strategies for change that referred to the various mechanisms health care workers use to bring about change in behaviour: consciousness raising, emotional arousal, social liberation, personal reevaluation, commitment, reward management, helping relationships, countering, and environmental control (controlling stimuli).

The interdisciplinary team at the Cité-de-la-santé de Laval has struggled to integrate the classification proposed by Prochaska and DiClemente into its assessment of patients with chronic illnesses. The number of stages complicated the work of our health care professionals, who were unable to agree on the specific classifications to assign to patients. Additionally, it became apparent fairly quickly that there was a considerable difference between the situation of a patient who consulted a doctor about a health problem and that of an individual who was considering a change in behaviour in order to avoid a potential health problem. The transtheoretical model was developed for the latter situation.

During a primary care consultation, it is not uncommon for the patient to learn the diagnosis and the treatment at almost the same time. Thus, precontemplation does not apply, or hardly applies, in this situation. Additionally, some contemplation must necessarily precede the consultation, as it is initiated by the patient or close family. Therefore, these 2 stages are less relevant for the attending team in primary care. Usually, action is suggested to the patient to control a problem that has just been revealed during the consultation. For patients who do not take action immediately, our team has identified a unique strategy. In the first stage, health care workers provide information about the illness and its treatment to *convince* and encourage the patient to think about the treatment. When the patient indicates readiness to undertake treatment, the team changes its strategy to support the patient's *action*. This stage groups together the preparation and action stages of the transtheoretical model. The team then implements treatment and ensures that the patient is able to follow it correctly. Once targets of care have been achieved, the team moves on to the *support* phase, in which care providers ensure that the patient continues to comply with both pharmacologic and nonpharmacologic treatments. The team also identifies those patients in maintenance who might be able to self-manage their illnesses, and whom the team must *empower*. **Figure 1**[6,7] shows the stages of the CASE system compared with the stages of behavioural change in the transtheoretical model.

Within the context of the DaVinci Project at the Cité-de-la-santé de Laval, the CASE classification has been easier to apply than Prochaska and DiClemente's system. Further, it describes the professionals' actions and not the patients' attitudes toward each of their chronic

Figure 1. CASE system for managing patients with chronic illnesses



health conditions. Nurses, pharmacists, and doctors agree more easily on the category to assign to each of the patient's chronic problems. The CASE system makes it possible to orient and unite the actions of all health care workers to optimize management of care. This classification also makes it possible to better manage the limited time of an appointment, especially when a single patient has several coexisting chronic problems. For example, doctors can concentrate their interventions on problems classified as requiring *action,* with targets of care not achieved, by titrating medication for example, while nurses can work to advance the patient toward action for problems for which patients are still at the *convince* stage.

Conclusion

Chronic illnesses require long-term follow-up that can sometimes continue for decades. Given that care takes place over such an extended period of time, it would be surprising if patients always maintained the same position with regard to their health problems. Using a classification like CASE is of considerable use in these circumstances, in which it is particularly important to pay attention to the *process* of the illness and to ensure that clinical actions are in keeping with patients' wishes, aspirations, and ability to change. Our team believes that the CASE system makes it possible to prioritize our actions and ensure that they are unified. The CASE classification becomes the concrete expression of a vision shared among partners in care, it contributes to effective communication among us, and it allows us all to optimize the time we can spend with patients by avoiding conflicting actions and ineffective interventions that are not suited to patients' readiness to act.

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Competing interests

None declared

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