

Building the Case for *Quality*

AN IMPROVEMENT STORY

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BETTER CARE FOR THE CHRONICALLY ILL

Davidicus Wong became a better doctor when he stopped telling his patients how to be healthier. That's when he started listening to them and working with them to develop health goals.

The shift from all-knowing commander to guide in a shared journey to better health is essential in chronic-care management, a new approach to managing long-term illnesses that is gaining popularity in many parts of the country.

There is no question we must all age and die, but chronic diseases – such as type 2 diabetes, asthma and congestive heart failure – shorten peoples' lives and fill the years they do have with disability and pain. While lifestyle, genes and social and economic status all play roles in determining who will suffer from chronic illness, social and health policy can do much to prevent or reduce its impact. When chronic illness does strike, consistent, high-quality care is crucial to keeping people as healthy as possible.

Statistics show Canada has a poor record of ensuring that chronically ill patients get the care they need. A recent Health Council of Canada report says only 14 percent of family physicians regularly provide written information to patients on how to manage their chronic disease at home. Only about 25 percent have the electronic health records necessary to keep track of the tests, treatments and health data essential for looking after chronically ill patients. And yet more than half of the doctors surveyed thought their practice was well set up to care for chronically ill patients.¹

Dr. Wong was one of them. He describes himself as skeptical when he joined the Diabetes Collaborative, a 12-month project launched in March 2004 at 52 general practitioner offices in British Columbia to introduce ways of improving care of patients with diabetes. A family doctor since 1991, he was convinced he was doing a good job for his patients. But when he learned to use all the tools and approaches of chronic-care management, Dr. Wong says, "I found I could do better."

The project was based on concepts such as "advanced access" and "self-management" – just the kind of "organization-speak" calculated to turn physicians off, Dr. Wong says. But it turned out many of those concepts worked. Advanced access is a radical approach to patient scheduling (in essence, very few appointments are booked in advance; people come to the doctor the day they need to). Self-management has patients tracking their conditions themselves and checking in with the doctor if they see any cause for alarm. Changing from a traditional practice mode can be chaotic, but in the long run Dr. Wong finds his practice better organized, and care and follow-up more consistent and effective.

With the new schedule, Dr. Wong can bring patients in regularly for any tests or follow-up that their condition requires, rather than testing their blood sugar only if they happen to come in. "Most people with diabetes are told to come in regularly, but patients come in when they run out of pills or don't feel well. We're not calling them. It's not pro-active, it's reactive."

¹ Health Council of Canada. 2007. *Why Health Care Renewal Matters*.



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As well, busy family doctors can often only manage a quick hit of advice on what diabetes patients should be doing. “You don’t reach patients by yelling at them and making them feel guilty,” Dr. Wong says. Now, with better-planned care and follow-up, he has time to listen to his patients, offer them information on what they need to do to live healthily, and work with them to set realistic goals for their self-management.

Just as important, that discussion is followed up with a call from his medical office assistant, who checks in on how patients are doing with their goals and, if there’s a problem, marks their chart for him to check. The attention and follow-up can make all the difference in their success in keeping healthy, he says.

To support physicians in the program, the B.C. government created the Chronic Disease Management Toolkit,² an online source that gives physicians a series of technological aids for looking after their chronically ill patients, including:

- flow sheets to record data on chronically ill patients;
- links to guidelines for chronic-disease care;
- automatic clinical and administrative reports, including patient profiles, recall reports that keep track of when patients should have tests or follow-up care, and patient-education records; and
- records of chronic care across the province, so physicians can check their work against their colleagues.

Chronic disease management in B.C. is being extended to involve more physicians every year. It’s been given a boost with some new payments for doctors, designed to give financial incentives for practising good care. The province now pays physicians \$125 a year to keep flow sheets for all their chronic-disease patients; not a large sum, but it does encourage doctors to try the system, and generally they stick with it because it helps them deliver care.

Physicians are also paid a block amount of \$325 a year for patients who need “complex care,” those who suffer from two or more of diabetes, asthma, congestive heart disease and high blood pressure. That fee includes sitting down once a year for a lengthy care-planning session, but it ultimately eases the burden on physicians, because they can handle patients by phone or in group sessions if that makes sense. Previously, they were only paid when they saw a patient in person.

Dr. Wong says the new system has given him more time for his family, for his practice and for volunteer activities – and best of all, more satisfying work with patients. He likens the feeling to the difference between tucking his daughter in and reading her a story or checking in on her after she’s fallen asleep. One is doing the job the way it should be done; the other is just playing catch up.

2 Chronic Disease Management [CDM] Toolkit for Practitioners. Retrieved June 25, 2007. www.health.gov.bc.ca/cdm/practitioners/toolkit_facts.pdf

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