



### **It's About Time – New Relations for Family Physicians**

She set the appointment for 10 pm to talk about the new self-management approach for Chronic Disease which the B.C. College of Family Physicians recently developed. As a busy physician in general practice in Victoria B.C., Dr. Carol Williams' daily work routine often extends from early morning until late evening. She apologized for the late hour, "The great challenge today is that family doctors are already too busy."

So, getting her response to the three-month pilot collaborative meant adding an extra hour onto Dr. Williams' already overlong day. Nevertheless, she volunteered. "This program is something that physicians can readily learn – and it really doesn't take any more time once it is set up."

The purpose of the program is to aid physicians, their Medical Office Assistants, and patients in developing a new approach to chronic disease self-management. Dr. Williams, who is the College's Medical Director for Chronic Disease Management and headed up the steering committee on its behalf, explained how they developed their plan of action, "We were looking for a change package that is efficient, effective, and patient centred, and we think we have developed something that meets those objectives."

The goal of the pilot project was to identify physician leaders and their staff, who will be instrumental in perpetuating a self-management strategy in the province. Self-management programs have been shown to be successful when a coordinated approach to patient and physician education is undertaken and resources are accessible in the community. The project hired Ms. Connie Sixta, a consultant with extensive experience in chronic disease management with both the Diabetes and Congestive Heart Failure Collaboratives in British Columbia.

The initial task was to identify physicians in the various health authorities throughout the province who have a keen interest in chronic disease management. They drew from a variety of medical practice settings including Physician/MOA practices, Physician/Nurse practices, and Community Chronic Disease Clinics.

Dr. Williams and her steering committee found eight doctors from various regions of the province to participate. The project provided two training seminars for these physicians and their staff at their practice locations, followed three months later by a think tank session to review. The training seminars taught the Chronic Care Collaborative Model. In the training seminars, the physician teams learned four important elements of that model:

- To accept and understand patient self-management. A description of the evidence related to Diabetes self-management served as an example to prove the case for accepting and understanding patient self-management.
- To learn and use behavioral strategies to support patient self-management – including the use of open-ended questions in interviewing their patients and helping the patient set targets for improvement.
- To develop office models that support patient self-management which meant including MOAs more directly with patients, initiating recalls, charting patient progress, and sometimes helping patients with goal-setting.
- To build a self-management office structure to maximize the doctor/patient relationship and the coordination role of the physician - including developing plans for group visits and consultations with other Health Care Practitioners.

“Surprisingly, it was quite easy to implement, once we learned how,” says Dr. Williams. Nevertheless, it means new roles and relationships for the family care practitioner.

Each of the eight physicians implemented self-management procedures into their practices in a variety of ways and with a range of success, but all the physicians who participated found that the entire process helped them move toward patient-centred interactions. They changed from focusing on their own agenda to focusing on the patient's agenda. Dr. Thorsteinson, the Executive Director of the BC College of Family Physicians describes the added value of the self-management process, “After all, our patients are experts in their own lives. It makes sense to use that expertise.”

Using the self-management process helped patients with difficult situations begin to change their behavior. “Generally, these are motivated learners. We work with them to help them start from where they are to overcome barriers, build capacity, and introduce changes into their lives,” observed Dr. Williams.

The B.C. College of Family Physicians conducted two monthly conference calls with each physician team to support implementation and obtain reports. After participants tested the change package for three months, the College followed up with think-tank meetings. The meetings discussed self-management changes, results with patients, and policies and related procedures. As a result of the think-tank suggestions, the B.C. College of Family Physicians produced a self-management training manual for staff, tools for physicians and for patients, and a self-management script and video for the doctors and their staffs.

Interestingly, each one of the physicians who participated in the project was successful at implementing at least some of the self-management concepts into their practice and every one of them felt that the change in approach increased their job satisfaction. “Seeing change happen brings a deeper human connection, says Dr. Thorsteinson. “It is why we practice medicine.”

Dr. Thorsteinson was also pleasantly surprised by the conclusion that changing the way family care is practiced does not need to take more time. “Time is a huge issue for us, but doctors are telling us that the new program doesn't take more time, but rather a similar amount of time on a different path. Moreover, he believes it is also about time doctors made changes to the way they practise medicine. “For years, so much of our health care has been ‘reactive’. As family practice physicians, we respond to the immediate problem that the patient presents. With this model, we are moving to a much more pro-active behaviour, addressing a more comprehensive view of the patients' situations and ultimately giving us better results.”

Dr. Thorsteinson believes that the long-term solution is empowering patients to create the change themselves. “In a self-management approach, the interaction with the physician is just one piece of information in the patient's life, which is a continuum of decisions which they make related to their disease, all of which happen outside the doctor's office.”

Ideally, in the next phase the pilot project will extend to most family practice doctors in the province through the Regional Health Authorities. “Phase two will use a ‘train the trainers’ system,” says Dr. Thorsteinson. “The original ‘expert’ teams of physicians and staff already trained will provide support in this expansion mode. We hope to engage Health Authorities to set up meetings to interest more family doctors and their support staffs.” Current plans are for the original eight self-management trained family physicians and support staff to lead the next programs.

If they can find the time!