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Advancing Improvement in Primary Care in Ontario

No One Can Whistle a Symphony: Success Strategies for Patient Self-Management and Quality Improvement

THE PATIENT

"I'm not a big fan of medication," says Darin Stevens, a 48-year old father with borderline diabetes. Darin has been a patient of Dr. Cathy Faulds at the London Family Health Team (FHT) for over 10 years, and originally started seeing her because he was looking for a different way to manage his health. His father shared his previous doctor, and was on a regimen of insulin and medications for his diabetes and heart condition that greatly affected his quality of life, which left a major impression on Darin in his father's final years. "It got up to the end, and it was just too late to do anything for him," he says of his final motivation to change.

Going from a habit of drinking eight cans of soft drinks each day to cutting all extra sugar out of his diet, Darin has managed to successfully keep his borderline type 2 diabetes in check with lifestyle changes alone. "Basically, [Dr. Faulds] and Mary Ellen [the chronic disease nurse at London FHT] left it up to me. They said if I could handle the diabetes with diet, then that's good. If you can't, here's what's going to happen — but it was my decision."

THE MEDICAL TEAM

Dr. Faulds has worked under a philosophy of patient self-management for many years, empowering patients with the ownership of their own health. Patients with chronic diseases have regularly scheduled visits at the clinic, and are asked to get their blood work taken before the appointment so that they can go through the results together at their appointments. "We give [patients] copies of their blood work, and we try to teach them about what [it] means so that they're well versed," Dr. Faulds says of her team's approach to patients managing their own chronic diseases.

"It's about our team," she says, of their group of 10 physicians, 2.5 chronic care nurses, 1 nurse practitioner, 2 social workers, and a half-time dietician. Rather than referring her patients out to specialist clinics, she would rather bring that help into her practice to help nurture relationships with patients through continuous care. "It's just powerful," she says of the resulting relationships she has developed with her many long-standing patients, and lives by the expression that "you can't care for people until they know you care." She has also found that she can learn more about the patients' stories through the team model: "patients will tell Mary Ellen, as a nurse, things they wouldn't tell me, and vice versa. Between us and with our social worker added in, I think we get a better whole picture than I would ever get by myself."

THE QUALITY IMPROVEMENT PROGRAM

Just as importantly, she emphasizes the effects of the program itself: "it's not necessarily the physician or the chronic disease nurse, but rather the program. I think that patients will always attribute it to the provider of care rather than the steps the provider has put in place to improve the outcomes that have happened."

In 2008, Dr. Faulds started participating in quality improvement training offered then by Quality Improvement and Innovation Partnership (QIIP), which later amalgamated with other quality improvement organizations to form Health Quality Ontario (HQO) in 2011. "As a solo physician to be able to

understand and do quality improvement – I could not have done that alone, and the mentorship by Karen Palmer [the Quality Improvement Coach provided by QIIP/HQO] was essential," says Dr. Faulds. "When I felt like I didn't have the time to do it, Karen would remind me that I had to stop and measure or I couldn't improve anything." While Dr. Faulds says patient self-management is a philosophy of care that long preceded her time with QIIP, she believes that the quality improvement training "has helped improved the delivery a lot."

THE CUMULATIVE OUTCOME

The successes in Dr. Faulds' practice and among her patients have been obvious. Darin is quick to recognize the support of Dr. Faulds and Mary Ellen, but he knows that his health is ultimately his responsibility. In fact, Dr. Faulds had recently suggested cutting his visits down from every three months to every six months because he was doing so well, which he flatly turned down: "I said I'd rather stick with the three months because I'm more comfortable if something comes up to have it addressed earlier than later." The team seemed surprised that he would choose to come in more often, but it is be encouraging that he is taking control of his health. "If I'm not looking after myself, I know what's going to happen, and I don't want it to go that way," Darin says, bringing the orchestrated efforts of primary care teams, quality improvement programs, and of course, the patients themselves, into harmony.

Darin's Chronic Disease Visit (20-30 minutes, once every 3 months)

Mary-Ellen, chronic disease nurse:

- Takes 2 resting blood pressure readings
  - o If this is high, he is asked to come back in a month to get his blood pressure taken again with Mary-Ellen. If it remains high at that visit, Dr. Faulds would come in to talk to him and they would work out a plan together
- Pulls up lab results from blood work done prior to visit and goes over it with him
- Identifies any areas that may need improvement
- Gives him a copy of his lab results to take home
- Flags anything that may be of concern for Dr. Faulds before she sees him

Dr. Faulds, family physician:

- Goes over any of the flagged results
- Reviews self-management goals
- Discusses whether there are any adjustments that need to be made to meet his goals (lifestyle, medication, referrals to dietician, social worker, etc.)
- If all is well, as it has been, they encourage his success and tell him to keep it up

Questions? Contact us at: learningcommunityinfo@hqontario.ca or 1-877-794-7447, ext. 201.