

Making Big Changes, a Few Small Changes at a Time

When the *Healthy Heart Society* announced it was recruiting clinical teams to participate in its Province-Wide Congestive Heart Failure Structured Collaborative, Dr. Neil Hilliard – a Fraser Valley family physician – was intrigued.

“Much of what we do in daily practice deals with managing chronic disease,” noted Dr. Hilliard. “And here was an initiative aimed at improving the care of the patients I see, not only for those with congestive heart failure (CHF), but also those with diabetes mellitus, asthma and COPD, depression and cancer. Any educational support or financial incentive towards that end was welcomed.”

Dr. Hilliard is in a group of three, solo fee-for-service full service family practitioners, and organizing a clinical team that consisted of more than just him proved difficult in the short timeframe leading up to the start of the Collaborative. Nonetheless, he joined the collaborative and committed to participating in its three, 2-day Learning Sessions.

At the first Learning Session, Dr. Hilliard was introduced to new ideas and new approaches for making improvements in the quality of chronic care. He learned how to organize patient care using the Expanded Chronic Care Model. From there, he identified the changes he could make to improve care, and then implemented the changes using the “Plan Do Study Act” (or PDSA) approach.

Through the PDSA approach, elements of the Expanded Chronic Care Model are incorporated into daily practice by making small changes, a few changes at a time. Each adjustment is then assessed to determine what works well, and where an alternative strategy is needed.

In the four months following the first Learning Session, the small changes incorporated by Dr. Hilliard had made a significant impact on his practice. He started off by reviewing his patients’ charts, identifying 35 CHF patients. And by using a patient flow sheet, he embedded the BC Heart Failure Clinical Guidelines into his care of these patients.

Dr. Hilliard took it one step at time. “I reviewed two patient charts per week, and each chart review took about 15 minutes,” he noted. “I’ve found the patient flow sheet helps ensure that nothing is missed and that my patients get the proper care they need.”

Guided by the information recorded on these patient flow sheets, Dr. Hilliard set a number of targets he wanted to reach by the end of the 12-month Collaborative. With the help of the practice’s receptionist, he initiated patient recalls to address any current gaps in the care of these patients. “I first started with those at stages 3 and 4 of the New York Heart Association classification (NYHC),” he said. “Getting them on beta blockers was important.” He then ensured that his patients at NYHC stages 1 and 2 were receiving care consistent with the BC Heart Failure Clinical Guidelines.

Dr. Hilliard’s results only four months into the 12-month collaborative speak for themselves!

Dr. Hilliard's Care Target Goals to be Achieved by the End of the 12 Month Collaborative	Achieved by Dr. Hilliard 4 Months into the 12 Month Collaborative
95% of patients with CHF proactively identified	100%
> 85% of CHF patients with LV EF by Echo or LNV	74%
> 85% of CHF patients with ACE-I (or ARB if intolerant)	88%
> 50% of CHF patients on Beta Blockers	54%
50% decrease from baseline in hospital re-admission	35% decrease
75% of patient with self-management goals	23%

Results as of Learning Session 2, Oct 6-7, 2003 – Dr. Hilliard chose to use the targets set out by the CHF Collaborative Steering Committee.

The CHF patient charts have been flagged with a red sticker, and the practice's MOA now routinely takes patient weights. Supporting patients to self-manage their own health is also an intrinsic part of the chronic care process.

Dr. Hilliard found that the BC Heart Failure Guideline's patient information guide to be very helpful when talking to patients about the importance of self-monitoring any changes occurring in their weight, as well as reducing their salt intake. "The reminders that are part of the patient guide have greatly assisted patients to dramatically reduce their salt intake," he noted.

As a result of better self-management and optimizing beta blocker therapy, one patient has gone from nine hospital re-admissions in nine months to no new admissions. "She was in NYHC IV heart failure, on continuous home oxygen, requiring house calls by myself and the lab," he described. "Now she is no longer oxygen dependent, able to walk around her senior's complex and able to come into the office for follow-up visits. Her heart failure has improved to NYHC III, her diuretics have been reduced, and renal function has improved, as have secondary problems with hyponatremia, magnesium deficiency and anemia. Most of all, she is happy with her improved quality of life."

Due to the daily demands of his busy practice, Dr. Hilliard faced challenges in supporting patients to self-manage their health. He therefore worked with his regional health authority to get the help that he needed. As a result, Dr. Hilliard now discusses the importance of self-management with his patients, and provides them with the Heart and Stroke Foundation's Living with Congestive Heart Failure guide, along with the patient resource and reminder sheet that is part of the BC Heart Failure Guideline.

Through help from the health authority, patients can then choose to attend a one-to-one patient visit in their doctor's office with a community-based nurse educator, nutritionist and/or pharmacist. "My patients are very enthusiastic about this," shared Dr. Hilliard.

"This is an example of how physicians, other health care providers, and Health Authorities can work together to improve the management of chronic diseases such as congestive heart failure,"

commented Laurie Gould, Director Primary Care and Chronic Disease Initiatives, Fraser Health Authority.

Upon completion of the planned visit, patients are asked to complete a survey. This helps the practice determine what is working well, and where changes are needed. At the same time, Dr. Hilliard monitors the extent to which his target of having 75% of patients with self-management goals is met.

“Being involved with the Congestive Heart Failure Collaborative has brought fresh life to treating patients with chronic disease,” noted Dr. Hilliard. “Being proactive feels really great. It is so much better than being on the receiving end of visits that could have been avoided through proper chronic disease management. It is rewarding for both myself, and the patients, to see the progress they have made towards their predetermined goals. When I first saw the Chronic Care Model it didn’t make much sense to me – now it does.”

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