



## College Confessional

"Our primary care system is outdated. It was designed in the '60s for a population in their 20s," says Dr. Drummond, MD, FCFP, who has seen those changes over the years as Director of Geriatric Services at the Prince George Regional Hospital. "The system of primary medical care was developed at a time when the population of B.C. was much younger and most people needed simple episodic management of acute illness. Today the situation is much different. We have an aging population which increasingly struggles with chronic diseases." In Dr. Drummond's estimation, the biggest challenges to change the primary care system are issues around the design, the delivery, and the funding. The idea that "a broken system is breaking us" prompts the need for change. But how to begin?

In March 2003, a unique opportunity arose to begin to address some of the problems, especially around chronic diseases. The College of Physicians & Surgeons of British Columbia received a grant of \$800,000 from the Ministry of Health Services to "promote competence in the management of chronic diseases," and further to "develop self-audit processes to assist general practitioners to improve the care they provide" to patients with such problems. In other words, doctors were going to take time to examine their own practices to see if they could make improvements.

The College asked Dr. Drummond to develop a program and curriculum to implement those goals, and he took up the challenge. In his introduction to the course, Dr. Drummond highlighted the importance of the task that lay ahead with this reminder:

"Chronic disease is the largest cause of death in the world. In developed nations, an aging population combined with obesity and sedentary ways have pushed chronic illness to the front of our health care agenda. In Canada chronic disease affects 16 million of our 37.5 million population and accounts for 67% of direct health care spending and an additional \$52 billion in indirect costs."

Dr. Drummond designed a program for change using a professional development, full-day workshop format in small group sessions (between 6 and 12 physicians) with a facilitator over a period of a few months. "We know from studies that have been done about continuing medical education that putting 1000 doctors in a room and giving them a lecture accomplishes very little in terms of getting them to change their practice habits," says Dr. Drummond. Instead of a large lecture, over 200 doctors attended small-group workshops that were organized at twenty-nine sites around the province, from Victoria to Fort St. John. Not every doctor in the province attended, but Dr. Drummond likes the demographics of those who did. "These are the physicians who are prepared and want to change and they are going to become the opinion leaders for a larger group of physicians. In turn, they will spread the word among the others."

Physicians attending the workshops used a self-audit approach, examining their own patient records and comparing their performance to disease management recommended in current clinical practice guidelines (CPGs). Local doctors who had participated in the CDM Collaboratives on either CHF or Diabetes facilitated the program in the various regions. The facilitators were Dr. Robert Baker of Richmond; Dr. Stephen Barron, Port Coquitlam; Dr. Neil Hilliard, Chilliwack; Dr. Ed Kroll, North Vancouver; Dr. Paul Mackey, Fort St. John; Dr. Ian Schokking, Prince George; and Dr. Sue Turgeon of Vancouver.

The facilitators' purpose was to guide the doctors in a self-learning process, rather than instructing "dos and don'ts." From the comments expressed by the participants, this approach was successful. "Excellent workshop," commented one physician, "because it required more thinking and involvement. It solidified learning points more than other workshops."

There were six modules to the workshop: four modules using self audit forms, one on how to use personal digital assistant devices (PDAs) as an aid to managing chronic disease, and one module on the use of the CDM tool kit provided by the Ministry of Health. The self-audit modules that were selected are for diseases that have a large and strong evidence base for Clinical Practice Guidelines - along with indications that patients are not achieving optimal outcomes because of failure to adhere to those guidelines. The diseases selected were **Hypertension, Heart failure, Asthma, and Diabetes**. While noting that there are other chronic diseases which also require a new approach, Dr. Drummond explains his choices, "these are common diseases, chronic diseases, and diseases for which there is good clinical evidence about treatment, and for which there is a **gap** between what we could be doing for patients and what we are doing for patients."

The workshops re-enforced the principles of CDM, which include:

- The value of evidence based guidelines
- Care by flowsheet or protocol
- Planned visits
- Establishing a disease registry
- Active self-management
- Team approach

Physicians were encouraged to leave comments about their learning process. They shared anonymously but openly. "The workshop provided a good review of all the things one needs to do to manage chronic disease well – but forgets to do, or gets distracted by the patient's agenda, or the patient doesn't present to the office," noted one doctor. Another observed, "Even when you think you are doing a great job, without a checklist you are bound to miss a few important things."

Dr. Drummond understands their feelings. "I myself had done a self audit, and although I fancied myself as being a good and conscientious physician, when I actually went through a self audit I realized just how far short of the ideal that I had fallen. Other physicians had that same experience."

In addition to the comments from physicians that indicate a real understanding of how to introduce CDM strategies into their practices, statistical results indicate an improvement across the board. A follow-up survey with physicians six weeks after the workshops showed that:

- 88% of doctors are making more use of the guidelines and flowsheets
- 60% of doctors are making more use of guideline directed care
- 79% are scheduling planned visits
- 54% are managing hypertension differently
- 59% are managing heart failure differently
- 37% are managing asthma differently
- 52% are managing diabetes differently
- 66% are using patient self-management more often

Moreover, nearly 26% of the doctors have started using a PDA in their practices.

As he looks back on all the hard work, Dr. Drummond is pleased with the outcome. "I believe that the results exceeded my expectations. Feedback from the physicians was very good." When asked about how to duplicate the success of the program he offered this advice. "We thought it through carefully. We had the right approach and we had an excellent group of facilitators who really made the program successful."