

A Doctor's Eye View


How four family physicians experience Partnerships for Health

Partnerships for Health (PFH) supports a team-based approach to care for people with diabetes, involving not only family physicians, but also nurse practitioners, nurses, social workers, diabetes educators, pharmacists and others. It's a very different model of primary care, one that offers a new way forward for over-burdened family physicians.

Dr. Kim Gilmore of the Happy Valley Family Health Team (FHT) is enthusiastic about the team approach. "We feel that our Nurse Practitioners (NPs) are adequately trained to provide full diabetic care," she says. "At the end of the appointment, I pop my head in, say hello, and the NP tells me how the patient is doing and what she suggests." Dr. Fred Veenstra of the Owen Sound Family Health Team says the PFH approach al-

lows him to focus on the most complex patients and leave most of the care for less complex patients to the team. "I'm basically doing what I was trained to do."

Dr. David Graham of the East Elgin FHT agrees working as a team is the only way to deal with the pressures of a modern family practice. "There's simply too much at stake, and too much work to do, for a single family physician to be able to cover all the bases." He also believes that the PFH approach encourages patients to pay attention to their diabetes. "When patients see the diabetes educator, the NP, the nurse and then me in the office setting, they clue in to the fact that they have to manage their disease or something bad will happen."

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Dr. Graham finds that reviewing patient data can be a valuable eye-opener. “A lot of the patients I thought were not well controlled were better than I thought, and some of the ones I thought were doing well, were actually doing very poorly. It’s important to have this information.” He now spends half an hour a week with his team, focusing on the three patients on his roster who are having the most difficulties with their diabetes.

Ultimately, physicians involved in the PFH initiative are looking for better outcomes for their patients. And that’s what they’re seeing. “I was quite surprised by all the changes that had occurred,” Dr. Veenstra says. “And when we did satisfaction surveys, it was clear that people were quite happy with what’s going on.” Says

Dr. Paul McArthur of the Brockton Family Health Team, “I have seen the numbers improve and heard patients say how much they appreciate the extra time, teaching and attention to detail. I’m hopeful these benefits can be sustained and expanded.”

“It’s exciting to be part of this. It’s just more fun practicing this way.”

For Dr. Veenstra, the innovative Partnerships for Health approach has re-invigorated his commitment to family medicine. “It’s exciting to be part of this,” he says. “It’s just more fun practicing this way.”

Analyzing the Data

The evaluation team of the Centre for Studies in Family Medicine at the University of Western Ontario will help assess the success of PFH

“Thorough.” In a word, that’s how Dr. Sharon Roberts describes the ongoing *Evaluation of the Partnerships for Health Project*, which is led by Dr. Stewart Harris.

Roberts is a researcher and project coordinator at the Centre for Studies in Family Medicine, which is conducting the project evaluation. The Centre, renowned for its diabetes research, offers expertise in mixed-methods research. “We’ve put together a great team to support the assessment of this project,” she says.

The role of the Centre is crucial in assessing the PFH’s initiative, which is to apply the Ontario Chronic Disease Management (CDPM) framework and improve diabetes-related primary health care. To ensure credibility, the Centre works independently from the PFH Project Management Team. “In evaluative research we strive for objectivity,” says Roberts. “Being rigorous ensures that there is veracity in the statements we make at the end of the project.”

The Centre uses a research design that includes pre- and post-questionnaires of physicians, other health professionals, and patients involved in PFH. The Centre’s research team also interviews care providers, conducts patient focus groups, performs longitudinal chart analysis, and

observes participant sessions. “We will be able to say yes, no, or to what degree the objectives of the project have been achieved,” says Roberts.

With so much data collection, a big challenge is logistical – making sure that everything stays on schedule. That’s why good communication with all parties is important. “The project management team and participating teams have been great,” says Roberts. “We’ve been very fortunate that the contact people at the sites are very generous in accommodating us into their busy schedules.”

There’s still a lot of work to be done before the research team can draw any conclusions. The “pre” data has been received and baseline data is recorded, but the “post” surveys and the longitudinal chart reviews are still to come.

After all the data is collected and assessed, a final report will be prepared and submitted to the project team and the Ontario ministries involved. Roberts expects that the project will also produce several peer-reviewed journal articles so that the work of PFH can be shared more broadly. “There’s a lot to be learned – what has gone well and what hasn’t, and the project’s limitations and successes,” she says. “This project and its evaluation make a contribution to knowledge.”

Helping Patients Help Themselves

The South West LHIN introduces Self-Management Toolkit

When it comes to caring for people with diabetes, one member of the care team does the majority of the work.

The family doctor? The Nurse Practitioner? No, it's the patient. After all, patients spend a relatively small amount of time interacting with health professionals, and more than 95% of their time dealing with the day-to-day reality of their condition on their own. That's why self-management is so important.

The South West LHIN's Priority Action Team for chronic disease prevention and management identified self-management as a key strategy in the management of any chronic disease early on. The group recognized that many health professionals need information on the latest self-management theories and strategies. "This is not necessarily the way that all practitioners have practiced in the past," says Kelly Gillis, Senior Director, Planning, Integration and Community Engagement with the South West LHIN. "Managing someone with a chronic illness is quite different from responding to acute needs. And supporting patients to make behaviour changes can be very challenging."

"Managing someone with a chronic illness is quite different from responding to acute needs."

The group decided to develop a toolkit to help professionals learn more about this important area. The result was *Self-Management in Theory and Practice: A Guide for Healthcare Providers*, by Gina Tomaszewski and Christina O'Callaghan. The Guide brings together the literature, theory and background around self-management and provides tools for health professionals to use.

To ensure that the toolkit was easily accessible, the group also developed a website, www.selfmanagementtoolkit.ca, which provides a lively interactive learning experience. Finally the effort was supported by in-person sessions, three held in June 2009. There were over 130 attendees at the June sessions which were held in London, Mitchell and Owen Sound. Feedback was overwhelmingly positive with many appreciating the relevance to their work.



The Five A's of Self-Management

Assess the patient's beliefs, behaviour and knowledge

Advise by providing specific information about health risks and the benefits of change

Agree by collaboratively setting goals based on the patient's interest and confidence

Assist by helping identify personal barriers, strategies, techniques and support

Arrange a specific plan for follow-up

To learn more, visit www.selfmanagementtoolkit.ca >>

Gillis says the toolkit is a valuable resource for PFH teams. "Whether it's the book, the website or the in-person sessions, this is another resource that teams can use to support improvement in diabetes care." She notes that the percentage of clients with articulated self-management goals is one of the performance measures for PFH.

Supporting self-management doesn't have to involve a significant time commitment and can involve other members of the care team, she adds. "It doesn't always have to be the physician who is spending the bulk of the time with the patient on self-management. It may be the Nurse Practitioner, the social worker, or another provider."

Nancy Dool-Kontio, Senior Director, Strategic Planning and Integration with the South West CCAC, sees the toolkit as an innovative way to support chronic disease management broadly, across health care sectors and across the region. "Whether it's diabetes or other chronic conditions, the toolkit provides professionals with a valuable understanding and approach. This is all about getting all members of the care team, including the client, talking the same language." The CCAC is coordinating additional learning sessions on behalf of the LHIN as part of ongoing strategies to support self-management.

From the LHIN Perspective

Debra Woods talks about PFH in the broader context of health care planning

“In our Integrated Health Service Plan, we have committed to leveraging the success of the PFH project,” says Debra Woods, Planning and Integration Lead for chronic disease prevention and management with the South West LHIN. “That’s because PFH embodies all the components of a successful population-based integrated health service approach.”

Woods says the LHIN recognizes the importance of primary care in chronic disease management and welcomes any opportunity to support it. “Family practices are seeing increasingly complex patients living with chronic disease. PFH is a way for them to come together and learn from one another.”

She says the initiative is already a success, having recruited more than 60 family practices. PFH, she adds, provides space for care teams to talk about their patients and focus on total health management, in an inter-professional and cross-organizational context. “The great thing about PFH is that it extends beyond the doctor’s office, bringing the South West Community Care Access Centre (CCAC), Diabetes Education Centres (DECs), and community health providers including those who support individuals with mental health and addiction conditions to the table, so that they can look at how they’re coordinating care.” She is also excited about the potential of process mapping in reducing duplication and streamlining processes.

An important success factor for PFH, Woods says, is the coaching support that teams are getting to apply quality improvement methods and maximize the use of their Electronic Medical Records (EMRs). “EMRs are notorious for being easy to put information into, but hard to

get it out of! The work of Gavin Giles and his team is responding to the needs of the participating practices.”

So what happens when the initiative is over in a year’s time? Woods believes PFH will leave a valuable legacy. For the teams involved, she sees ongoing quality improvement work, transferrable across disease conditions and patient populations. “It’s like the difference between a diet mentality and a lifestyle change when you’re trying to lose weight,” she says. “My hope is that they will continue to improve their practice and achieve balance, and that the learnings will be shared with other health care providers in the same practice.”

For her part, she will be looking for ways to sustain and spread the PFH experience across the South West by linking with LHIN and province-wide initiatives. The self-management toolkit will live on too, and there are plans to develop self-management resources for patients.

“I firmly believe that quality improvement initiatives like PFH are the way we will move forward,” she says. “This evidence-based approach offers one of the most viable ways to make much-needed improvements to our system.”

Debra Woods joined the South West LHIN team in 2009. She holds a Masters and PhD in Applied Social Psychology and has 16 years of practical experience in quality improvement methods, planning, and analysis in health, education and community settings. Most recently, Debra held the position of Quality Improvement Specialist at the Barrie and Community Family Health Team. As part of her role within the South West LHIN, Debra is the Team Lead for CDPM and Primary Care.

In the News

PFH was highlighted in an article in the Seaforth Huron Expositor in late December. The article quoted Kelly Gillis, Barb Major McEwan, Executive Director of the Huron Community FHT, and Lorraine Deveraux, a diabetes educator. “We’re now looking at the big picture and able to monitor it electronically, keeping a close eye on the patient. Rather than waiting a year, patients can be seen right away,” said Deveraux in the article. “It’s better problem solving all the way around.”

For information about becoming a partner, visit www.partnershipsforhealth.ca.

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