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BEST ADVICE

Chronic Care Management in a Patient's Medical Home

JUNE 2016

INTRODUCTION

Within the **Patient's Medical Home*** (PMH), the following guiding principles¹ promote comprehensive care and response to the public's needs:

- The patient's personal family physician should work collaboratively with the other team members to provide a comprehensive range of services for people of all ages, including managing undifferentiated illness and complex medical presentations
- The PMH should prioritize delivering evidence-based care for illness, injury prevention, and health promotion, reinforcing these priorities during each patient visit
- The health care system should support PMHs to ensure their key role in managing and coordinating care for patients with chronic diseases, including mental illness
- Self-managed care should be encouraged and supported as part of each patient's care plan

Illness and disease in Canada have shifted dramatically from acute, communicable illnesses to a prevalence of chronic diseases. Chronic care management of diseases—including diabetes, hypertension, osteoarthritis, and mental illness—is a significant challenge facing Canada currently and in the future due to projected growth in our seniors' population.¹ As populations age, the prevalence of chronic disease in society rises.²

Chronic diseases are non-communicable, long-lasting illnesses that can be influenced by health-related behaviours. In recent years, evidence has shown that these diseases are at epidemic proportions.³ In Canada, the number of deaths attributed to chronic disease is rising, and chronic disease rates are increasing at approximately 14% each year.⁴ There is an increased prevalence of people living with multiple chronic diseases (comorbidities), due to an increase in our seniors' population.²

Although chronic diseases occur most often in older adults, they are not exclusive to that age group. Chronic diseases are increasing faster among Canadians between the ages of 35 and 64, compared with those age 65 or older. Children and younger adults are showing increasing rates of chronic disease, and as a result are living with chronic diseases for a longer period, making chronic care management extremely important.⁴

Chronic diseases can have a significant impact on child development. Children and adults experience different types of diseases. The most frequently

Eighty-three per cent of Canadians age 65 and older report having at least one chronic disease.⁷ Nearly one-quarter of all Canadian seniors are living with comorbidities, reporting three or more chronic diseases. The estimated prevalences reported for the following diseases among adults are:

Diabetes: 9.3%⁸

Hypertension: 22.7%⁹

Osteoarthritis and arthritis: 15.3%¹⁰

*Patient's Medical Home: <http://patientsmedicalhome.ca>.

reported chronic diseases among seniors are high blood pressure and arthritis.⁵ Children, on the other hand, more commonly face asthma, diabetes, and cancer.⁶

Providing patient-centred primary care can contribute to improved clinical health outcomes for patients with chronic diseases. PMH family physician-led teams are the cornerstone of effective chronic care management.

OBJECTIVE

The objective of this guide is to provide actionable advice to family physicians about chronic care management in family practice settings. The goals are to improve quality of life, prevent secondary conditions, minimize distressing symptoms, and prevent the onset of diseases for those who are at risk.¹¹

While this guide applies to all types of family practices, the strategies described involve many important components of the College of Family Physicians of Canada's (CFPC) PMH model.

BACKGROUND

Chronic diseases, while complex, share common risk factors. While some background risk factors, such as age and genetic composition, cannot be changed, others can be modified.¹¹ Common behavioural risk factors for chronic diseases include tobacco use, unhealthy diets, physical inactivity, and alcohol abuse.¹² Compelling evidence suggests that unhealthy behaviours and excessive body weight are associated with many chronic diseases, including hypertension, type 2 diabetes, coronary heart disease, osteoarthritis, and some cancers.

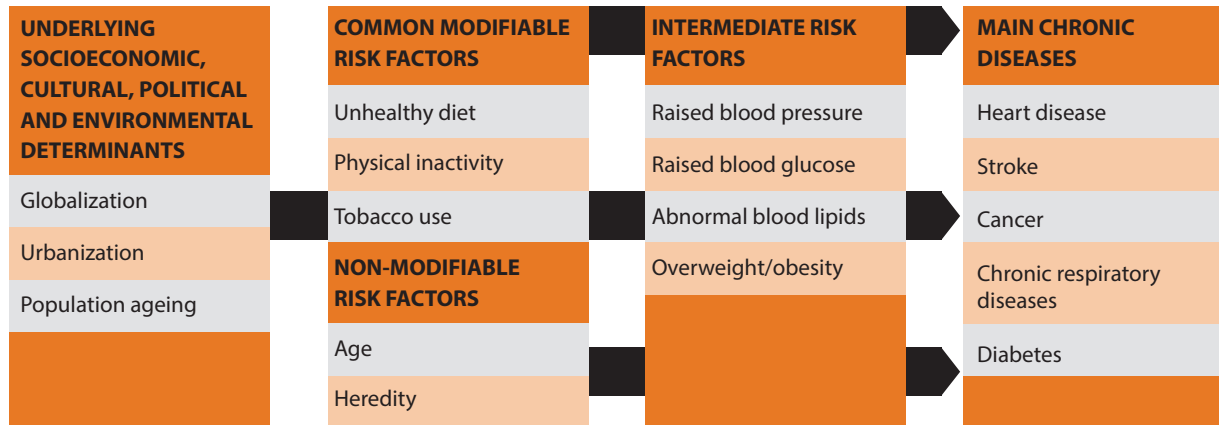
More than 60% of Canadian adults are overweight or obese,¹³ and 25% of Canadian children are overweight or obese, placing them at a higher risk to develop chronic diseases.¹⁴ Indigenous communities are at an even greater risk, reporting higher rates of diseases such as heart disease, diabetes, cancer, and asthma.⁴

Social determinants of health shape behavioural risk factors. Poverty can be a primary cause of chronic diseases, as it increases the risk of poor nutrition, tobacco use, low levels of physical activity, and alcohol abuse. This is supported by evidence that the impact of chronic conditions on quality of life is most pronounced for Canadians with the lowest socio-economic status.¹⁵

The relationship between chronic diseases and social determinants of health is closely linked—some people experience poverty due to their illness, while others are ill because of their socio-economic conditions.² Figure 1 shows the complex drivers that interact to influence the rates of chronic disease.

Figure 1: Drivers that influence chronic disease

Causes of chronic diseases



Reproduced with permission from World Health Organization¹⁶

According to the Commonwealth Fund, health care providers often miss the opportunity to engage chronically ill patients and help them manage their own health care. Chronic care management can prevent, delay, and control chronic diseases to mitigate their profound social and health consequences. At least 80% of premature heart disease, stroke, and type 2 diabetes, as well as 40% of cancers, could be prevented with active management interventions.¹⁷

The role of family medicine

Family physicians can help address the incidence of chronic diseases and influence the effects by implementing practical chronic care management strategies in their practices. Evidence demonstrates that well-organized family practices have a significant role to play in mitigating many of the risk factors and costs associated with chronic diseases, contributing to better outcomes and helping patients navigate the health care system.^{18,19,20,21}

Active management strategies can help prevent or delay immediate or long-term complications. For example, chronic care management of patients with long-term depression can benefit their health-related quality of life. By working with other health care professionals to deliver the most appropriate care, family physicians can build a trusting relationship with patients that allows for continuity of care and comprehensiveness, which can counter the complexities of chronic comorbidities.²⁰

Combining these elements of care, the PMH model is ideally suited for managing chronic care. The patient-centred approach is the most appropriate for providing chronic care management for patients with chronic comorbidities, by managing diseases simultaneously.

Chronic care management should be led by family physicians and the PMH team, involving the communities in which their patients reside. If properly organized and supported, the interprofessional PMH teams can help prevent and delay many chronic diseases as well as significantly mitigate their effects.¹

MODELS FOR CHRONIC CARE MANAGEMENT

Many models have been developed for managing chronic care. Although they include different elements or strategies, they often have common recommendations² for tackling chronic care management, such as:

- Promoting proactive care
- Identifying needed services based on risk stratification
- Acknowledging primary care as the hub for management supports
- Using health information systems
- Building community partnerships
- Promoting self-management
- Using best practice guidelines

Some chronic care management models use a disease-specific approach, which may not be helpful in managing complex patients with comorbidities.¹¹ When adapting a chronic care model to family practice, the following strategies¹¹ may help with developing an integrated approach:

- Streamline approaches for related conditions, such as a common program for metabolic-syndrome conditions like diabetes and hypertension
- Promote self-management tools that apply to many chronic conditions and can help patients with comorbidities manage their overall care
- Foster a family-centred approach; research has shown that family members often play a significant role in managing chronic conditions

A helpful resource for family physicians using best practice guidelines is the Canadian Task Force on Preventive Health Care, established by the Public Health Agency of Canada to develop clinical practice guidelines that support primary health care providers delivering preventive health care. For example, the task force recently developed guidelines for **Obesity in Children**.[†]

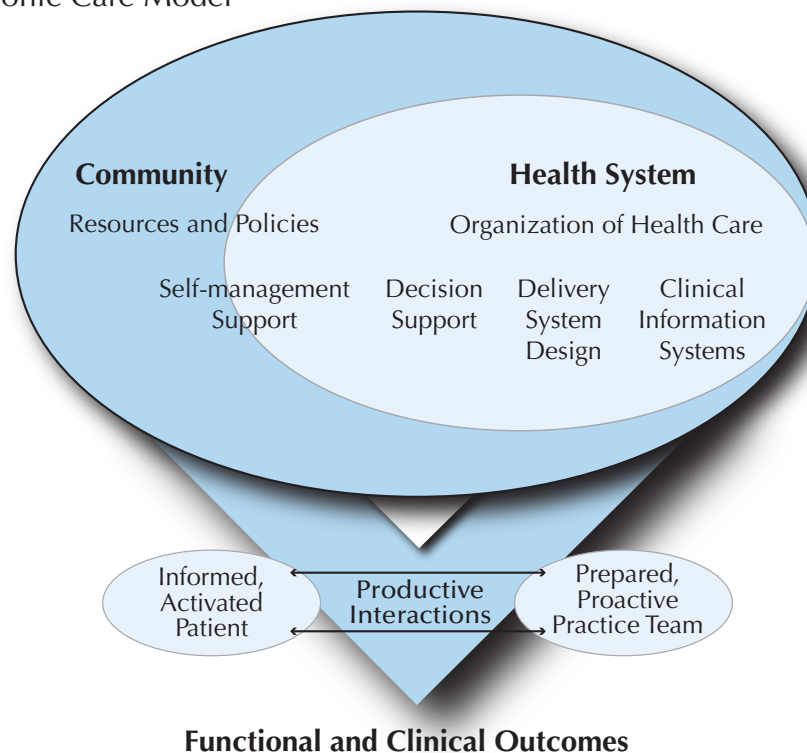
Prevention in Hand[‡] (PiH), a CFPC initiative, provides access to a user-friendly website and a mobile application that are valuable health care resources for health professionals and the public to easily access current and accurate information about preventing chronic diseases. Family physicians can access resources for professional guidelines as well as tools that support behaviour change.

[†]Canadian Task Force on Preventive Health Care – Obesity in Children: <http://canadiantaskforce.ca/ctfphc-guidelines/2015-obesity-children>.

[‡]Prevention in Hand (PiH): www.preventioninhand.com.

The Chronic Care Model (CCM; Figure 2), also known as the Wagner Model, is one of the most comprehensive chronic care management models and has been adapted to a variety of settings and diseases. The CCM acts a basis for PMH-like models focused on delivering proactive, planned, and evidence-based chronic care to patients.²² The model advocates a multi-faceted approach for primary care teams and focuses on productive interactions between informed, empowered patients and prepared, proactive practice teams.²³

Figure 2: The Chronic Care Model



Reproduced with permission of the American College of Physicians²³

The following are explanations of the model's key components:³

- Self-management support: providing self-management tools to help patients and their families acquire the skills to manage their illnesses
- Delivery system design: creating practice teams with a vision of creating various roles for practitioners to implement preventive and management services for those who face chronic illnesses
- Decision support: integrating evidence-based clinical practice guidelines into daily practice
- Clinical information systems: using reminder systems to comply with practice guidelines, and registries for planning individual and community-based care
- Community resources: establishing community partnerships to enhance supports for patients and communities

- Health care organization: organizing the service and delivery of the health care system to support chronic care management

In Canada, various provincial health authorities use different chronic care models to develop comprehensive chronic care management strategies. Alberta, British Columbia, and Newfoundland and Labrador use the Expanded CCM. It goes beyond a clinical focus to include elements of the population health promotion field, which encompasses prevention efforts, recognition of the social determinants of health, and enhanced community participation.²⁴ The Ontario Chronic Disease Prevention and Management Framework was developed using the CCM and the Expanded CCM to create an approach that is evidence-based, population-based, and client-centred.²⁵ While the specific model used in each province or territory may not be the same, they share similar features and aim to introduce strategies to prevent chronic diseases and manage chronic care.

STRATEGIES FOR INCORPORATING CHRONIC DISEASE MANAGEMENT

The family practice plays a central role in preventing chronic diseases and managing chronic care. Chronic care management should take place throughout the progression of chronic diseases—from experiencing the risk factors, to developing the intermediate conditions, to arriving at the disease endpoints. Patients at each stage require various prevention and management interventions to ensure their optimal health. Family physicians should be aware of different factors and conditions to address these effectively.¹²

While many solutions are rooted in complex system-level changes, this guide focuses on practical strategies that individual family physicians can adopt by reorganizing aspects of their practices and using available resources. This guide offers recommendations for effectively approaching chronic care management on three levels—in the practice, in the community, and in broader advocacy.

IN THE PRACTICE

Promoting self-care

The goal of self-managed care should be building confidence in patients and their personal caregivers to help them deal more effectively with their illnesses and improve their health outcomes. Physical activity, nutrition, adherence to medications, and self-monitoring are components of effective self-care for many chronic conditions. Many patients may face challenges when following recommended guidelines, adding complexity to the support role of their care team. To promote self-care successfully, practices need appropriate human resources (primary care teams), adequate training, and ongoing implementation support for the patients.²⁶

In order for chronic care programs to be effective, patients must be involved as partners in their care and supports must be consistently available.¹² Key features of self-management include:

- Working with patients to identify self-management tools to help them track and monitor healthy behaviours, as well as building confidence²
- Providing patients and their caregivers with information about community and social services that may improve their health²
- Addressing patient distress related to a chronic disease^{27,28}
- Improving patient self-efficacy by discussing real-life situations and challenges that patients may face and using problem-solving skills to address them²⁹
- Fostering positive patient-physician interactions by asking questions and listening to patient responses to ensure that problems are identified from the patient's perspective²⁶
- Including goal-setting, planning, and problem-solving strategies during an appointment to help patients develop a realistic action plan and to address any immediate concerns²⁶
- Addressing health literacy issues and medical obstacles to self-management by ensuring that patients understand goals, expectations, medical terminology, and metrics.²⁶ For example, one proposed health literate care model³⁰ suggests that health care providers should assume that patients may not understand health information relevant to their care, and asserts that health literacy interventions will improve the outcomes for patients in managing their chronic diseases. For more information about addressing health literacy in the practice, refer to the Best Advice guide *Health Literacy*.[§]



Various tools have been developed to help care providers enable self-management support. Appendix A contains practical resources when engaging in conversations with patients about self-care practices. The 7 As of Behaviour Change, in Appendix B, is a useful tool in prevention counselling. Considering a family physician's time constraints, have other team members responsible for using these tools and working with patients on self-management strategies.

[§] Best Advice guide *Health Literacy*:

<http://patientsmedicalhome.ca/resources/best-advice-guides/best-advice-guide-health-literacy-patients-medical-home>.

Case study: Integrated Health Network, British Columbia

In Port Alberni, British Columbia, patients whose family physicians are part of the Port Alberni Integrated Health Network are offered various chronic care management and wellness programs, including the Chronic Disease Self Management Program, a 6-week workshop that helps patients with chronic diseases better manage their symptoms. The program goal of promoting self-confidence and motivation is accomplished through the workshop's information and practical skills. The workshops cover a variety of topics, including healthy eating, starting and maintaining exercise, pain and fatigue management, communicating with health care providers, managing medications, and so on.³¹

Maintaining ongoing physician-patient interaction

Closely related to self-management is the idea of building patient-physician partnerships. Strong relationships between patients and members of their care team, including nurses, pharmacists and dietitians, make family practice settings an appropriate avenue for effective chronic care management. Provider-patient conversations around chronic care management can cover:

- Education
- Community supports
- Care modifications
- Patient goals
- Negotiation
- Evaluation of treatment plans

These ongoing conversations, which empower patients to be active participants in their own care, have the potential to increase chances of adherence to care plans and of improved health outcomes.^{32,33}

A unique way to facilitate ongoing interaction is secure messaging as well as telephone- and Internet-based communication. These interactions have been shown to improve health outcomes and they do not require patients to incur additional time or cost travelling, allowing for easier communication more often.³⁴ It is important for family physicians to understand the complexities associated with Web-based communications because of concerns over privacy, safety, and timeliness. For suggestions about managing Web-based interactions with patients, refer to the Canadian Medical Protective Association's [Using email communication with your patients: legal risks](#).[†]

[†] The Canadian Medical Protective Association – Using email communication with your patients: legal risks: www.cmpa-acpm.ca/-/using-email-communication-with-your-patients-legal-ris-1.

Promoting timely access

Offering timely services is an essential component of chronic care management, which promotes continuity of care between patients and their primary provider. Many practices, particularly larger practices with chronically ill patients, prefer scheduling models that offer both scheduled appointments and same-day scheduling when dealing with complex conditions.³⁵

- Scheduled appointments allow physicians and patients to plan care appointments, where chronic care issues are proactively managed. They focus on aspects of care that typically are not delivered during an acute care visit. Regularly scheduled visits allow family physicians to deliver evidence-based clinical management as well as patient self-management.³⁶ Planned care visits are also avenues that support preventive care that is not part of chronic diseases, to ensure that preventive tests are completed.
- Same-day visits give patients the opportunity to see their physician promptly when care is needed. Same-day visits can be reserved for routine (ie, non-chronic health concerns) or urgent visits to allow patients to see their care provider as soon as possible.^{33,37}

The number of same-day appointments reserved in each practice can vary and should be in proportion to need, depending on the average number of work days the practice has. It is important to note that scheduling follow-up visits can be critical in assisting both the patient and physician with managing chronic care.³⁶ Extending office hours to operate beyond typical business hours also provides prompt access to care for patients who otherwise would not see their family physicians.

Refer to the Best Advice guide [Timely Access](#)[†] for more information on effective strategies to promote timely access in a primary care setting.

Employing patient rostering

Patient rostering is a process by which patients register with a family practice, family physician, or team. Rosterer can promote developing and strengthening the continuing relationship between patients and their family physician, nurses, and other team members. This long-term relationship is critical for effective chronic disease management.

Patient rostering also facilitates effective preventive care and supports continuous quality improvement activities in the practice. Rosterer helps family physicians and teams identify patients with chronic diseases, enabling them to provide important preventive and management services.³⁹

Accessing summary information about their practice population can enable physicians to ensure their practices are staffed with the appropriate team members. For instance, if many

[†] Best Advice guide *Timely Access to Appointments in Family Practice*:
<http://patientsmedicalhome.ca/resources/best-advice-guides/best-advice-guide-timely-access>.

patients have diabetes, the lead physician may consider employing a diabetes educator as a part of the team.

Refer to the Best Advice guide [Patient Rostering](#)[§] for further information about the benefits of patient rostering, and advice for family physicians who have implemented rostering or are considering it.

Using group visits

Group visits (appointments, sessions) can help patients with chronic diseases.¹ Patients should be involved in setting the agenda and discussing care management during these visits.⁴⁰ This allows for productive conversations about strategies to manage care in an empowering manner. Family practices that have used group visits report:

- Increased patient and provider satisfaction
- Increased patient self-management
- Decreased prevalence of chronic diseases

Leading successful group visits requires careful planning as well as health care team collaboration to ensure the efficient delivery of the services. Examine provincial or territorial billing guidelines for group medical visits for information about how they can be financially supported in a family practice. For more details about setting up group visits in a family practice, refer to the General Practice Services Committee (BC) [Group Medical Visits Tools & Resources](#).[‡]

Case study: Group visits, Alberta

A family practice in Taber, Alberta, includes a significant percentage of elderly patients with complex needs. Using panel information from electronic medical records, 14 patients (age 65 and older) were identified as appropriate for group visits based on their cognitive function, mobility, and interest in participation. These patients had an average of 5.7 diagnoses, and required an average of 18.7 visits per year.

Group visits were provided monthly and run by the core family practice team, including the family physician, medical office assistant, and registered nurse. Other presenters often attended, as well as the local pharmacist, community nurse, medical students, and residents. The visits included time for individual reviews of physical conditions and medications, a presentation on a topic of the patients' choosing, as well as group interaction and questions to the presenter and/or physician. A nutritional break was important for social interaction.

Typically, 6–8 individual appointments were provided in an average 2.5 hour period. By offering group visits, all 14 patients could be seen during that same time frame. Results included improved clinical outcomes, patient and provider satisfaction, patient self-management, and a reduced requirement for appointments.

[§] Best Advice guide *Patient Rostering in Family Practice*:
<http://patientsmedicalhome.ca/resources/best-advice-guides/best-advice-guide-rostering>.

[‡] General Practice Services Committee (BC) – Group Medical Visits Tools & Resources:
www.gpsc.bc.ca/what-we-do/professional-development/psp/modules/group-medical-visits/tools-resources.

Working in teams

Interprofessional primary care teams can improve clinical health outcomes for patients with chronic diseases, including type 2 diabetes and depression.⁴¹ A key component of providing effective chronic care management services is ensuring that primary care practices have the appropriate mix of trained staff.² Primary care practices with multidisciplinary teams excel at recommending preventive services and community-based programs.

Practices may find it useful to create a human resources plan to ensure an adequate mix and numbers of providers to offer the proper support for patients with multiple chronic conditions. Members of the health care team can assist with planning, counselling, and follow-up services that typically fall on the physician but can be managed by other team members.¹⁴

Patient care benefits from the expertise of various professionals including nurses, pharmacists, social workers, and nutrition and exercise coaches.²⁰ In addition to having the right composition that responds to community needs, it is important for teams to communicate efficiently by meeting to discuss patient challenges and develop a coordinated plan.

Overall, patients benefit from health care teams as they allow the care to focus on wellness, prevention, and patient education.²⁰ The PMH model strongly emphasizes collaborative interprofessional teams and highlights the importance of communication between team members.

Case study: Primary care network, Alberta

In Alberta, health care teams work together in primary care networks (PCNs)—a network of doctors and other health care providers, such as nurses, dietitians, and pharmacists, working together to provide primary care services. A PCN can be composed of one clinic with many physicians and support staff, or several doctors in various clinics in a specific geographic area. Each PCN has the flexibility to develop programs and provide services in a way that meets the needs of its local patient population.⁴² This model of care delivered by a multidisciplinary team has proven to be successful, reporting increased patient satisfaction with wait times, better use of screening tools as part of health promotion and disease prevention, increased access to chronic disease management, and a decreased use of emergency room services.⁴³

The interaction between family physicians and other specialists is also essential in integrating care plans that result in improved care management and health outcomes. Family physicians can coordinate care with other specialists and referral services, working in partnership with the patient and other health care professionals to deliver the most appropriate care.

Adopting electronic medical records

An electronic medical record (EMR) is a digital medical record that clinicians maintain for each patient. Physicians can set up EMRs to collect patient information about demographics, medical and drug histories, and diagnostic information such as laboratory results and findings from diagnostic imaging.⁴⁴ EMRs can support chronic care management by helping:^{45,46}



- Identify patients/populations who are at-risk or need follow-up
- Target services to patients based on their level of risk
- Improve screening services
- Improve case management for patients with chronic diseases
- Maintain communication with patients through patient portals
- Enhance adherence to changes in clinical guidelines
- Monitor health conditions on a regular basis

EMRs are widely recognized as an essential tool to coordinate care, particularly for patients with comorbidities who may be seeing various health care providers for different concerns.²⁰ EMRs often help manage patients by providing readily available access to patient data before and during a visit. Positive changes can result from preventive care reminders being sent to the physician, with alerts for any outstanding screening tests.^{47,48}

Practices using EMRs are also able to access patient files in less time than paper-based clinics.^{41,49} EMRs are a useful data collection tool that allows physicians to track patient information and measure progress. They can sort through patient files by medication use or by diagnosis. As a result, they can quickly and confidently make changes in care, such as medication recalls and treatment guidelines.⁴¹ This translates not only to significant time savings, but also to high-quality patient care.

The Best Advice guide *Adopting EMRs in a Patient's Medical Home*[‡] provides practical advice about what to consider when implementing an EMR system.

[‡]Best Advice guide *Adopting EMRs in a Patient's Medical Home*:
<http://patientsmedicalhome.ca/resources/best-advice-guides/best-advice-guide-adopting-emrs>.

Evaluating practice strategies

To ensure that the strategies provided throughout this guide are used successfully, it is important that practices implement evaluation measures that are suitable for their patients and practice population. To promote continuous quality improvement, metrics can be used to evaluate chronic care management interventions to assess their efficiency. Metrics will vary depending on the services being offered; some useful metrics to consider include:⁵⁰

- Program outputs (eg, access, continuity, program allocations and expenditures)
- Panel size
- Screening rates
- Patient and provider satisfaction
- Individual and community-level health outcomes (eg, prevalence of risk factors and chronic disease, social determinants)
- Intermediate program outcomes (eg, community engagement, coalition-building, policy development)
- Qualitative indicators (eg, information from specific client and community groups)

This guide focuses primarily on what physicians can do within the four walls of their practices, the micro level. However, community-level activity and broader advocacy can also be very effective in chronic care management.

IN COMMUNITIES

Developing community partnerships

Practices that link clinical services and community supports can help ensure that patients with, or at high risk of, chronic diseases have access to needed resources to prevent or manage their conditions. Referring patients to accessible and effective community programs can improve their quality of life, helping them avoid complications and reduce their need for more health care services. Developing community partnerships can include:⁵¹

- Learning about existing health promotion services offered in the community (eg, tobacco cessation lines, support groups, etc.) and linking patients to them when needed
- Collaborating with other local health care professionals who may be providing care to the practice's patients
- Establishing partnerships with other health services (eg, hospitals, other care providers, etc.) to improve community and population health, using community benefit investments and advocacy

Case study: Family health team, Ontario

The South East Toronto Family Health Team (FHT) formed a partnership with Toronto Parks, Recreation and Forestry in the FHT's Healthy Weights Program. A therapist from Parks and Recreation worked one-on-one with patients to develop a personalized action plan for physical activity based on the patient's needs. The goal was to get overweight patients more physically active, based on their personal interests.

The therapist collaborated with the FHT dietitian and social worker. The social worker's role was to complete a series of cognitive behavioural therapy classes with patients enrolled in the program and monitor behaviour changes. At the end of each class, 30–45 minutes of exercise was incorporated. This partnership worked effectively, as it built on the team members available in the FHT and connected patients with community supports to improve their health.⁴

Case study: Family practice partners, Prince Edward Island

Family practices in Prince Edward Island, such as Sherwood Medical Centre in Charlottetown, partnered with the diabetes education centre to provide diabetes care. Nurses from the centre visited the family practice offices once a month to provide care for complex patients chosen by the family physicians, which improved diabetic control for the patients. The opportunity for face-to-face communication was informative for both the patients and their family physicians.

BROADER ADVOCACY

Addressing social determinants of health

Chronic diseases cannot be addressed with medical care alone. The best way to deal with chronic diseases is to avoid getting them in the first place. To prevent chronic diseases from becoming more prevalent, root causes—which are often based in social determinants of health—must be addressed.

Many family physicians recognize that it is difficult to treat the immediate health concerns of their patients without addressing the underlying social conditions that lead to poor health. The social conditions in which patients live contribute significantly to their health status and their likelihood to develop chronic diseases. Family physicians have an important and powerful voice to use in advocacy for social and health policies that will have a significant positive impact on their patients' health.

Fostering family practices that respond to community needs are key features of the PMH model. The Best Advice guide *Social Determinants of Health*[§] provides practical advice for health professionals about improving their patients' social determinants of health.

Supporting environmental approaches

An environmental approach refers to an initiative to change policies and physical surroundings that influence health behaviours. When implemented in community settings, such as schools and workplaces, environmental approaches can promote positive health behaviours and help prevent and manage chronic diseases.⁴⁵ Examples of environmental approaches include:⁴⁶

- Urban design that encourages walking and cycling
- Smoke-free regulation in public settings
- More access to healthy foods; for example, supporting food banks or community gardens

CONCLUSION

These practical guidelines, which align directly with the PMH framework, can assist a practice with implementing supports that prevent and manage chronic diseases. This can lead to improved patient outcomes, fewer health complications, and increased preventive services and community supports.

Due to their unique relationship with patients and the broad range of services they offer, family physicians have a key role to play in chronic care management. The strategies provided in this paper can help family physicians promote change with individual patients and society at large. By collaborating with health care teams and patients, family physicians can deliver patient-centred care that mitigates the effects of chronic diseases.



[§]Best Advice guide *Social Determinants of Health*:
<http://patientsmedicalhome.ca/resources/best-advice-guides/best-advice-guide-social-determinants-health>.



Appendix A: Self-management support tools

TARGET PRACTICE

A model for patient-physician interaction for self-management

Target Practice

Options for self-management of your chronic conditions

Circle all conditions that you manage: diabetes, asthma, hypertension, arthritis, heart disease, others: _____

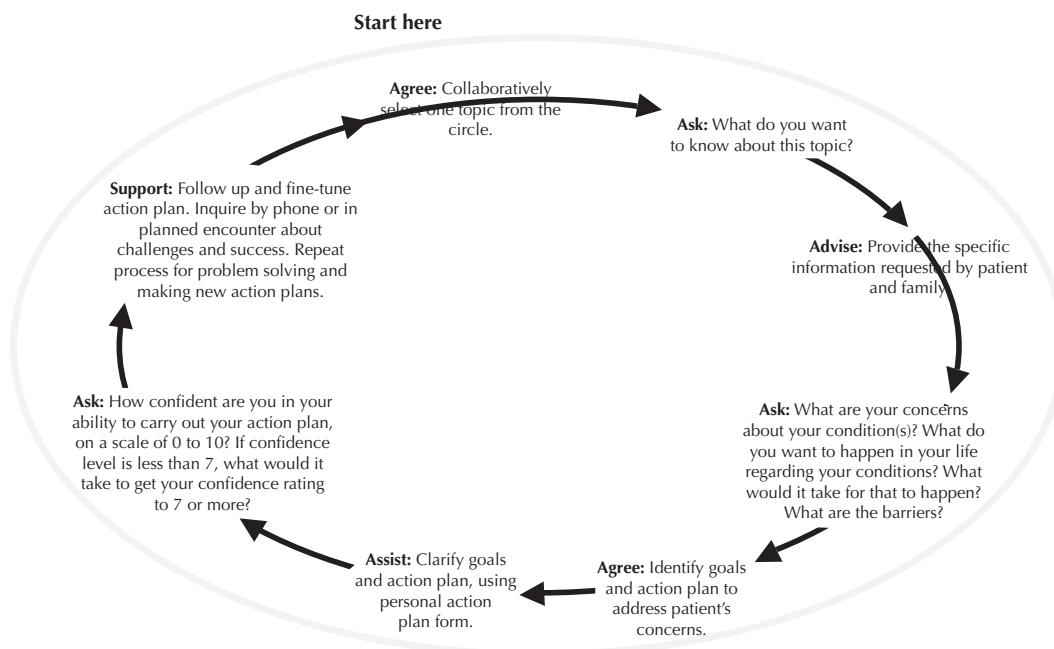
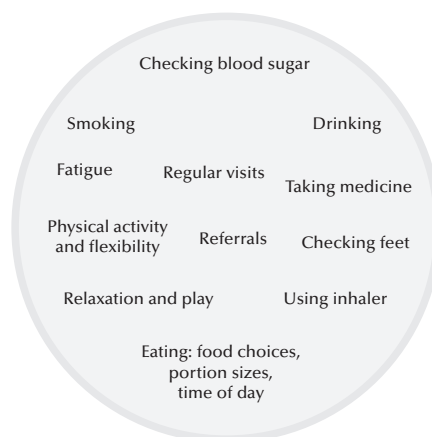
Name: _____

Date: _____

Agreements:

- The circle includes a variety of self-management skills ... they ALL may be highly important to your health, but you don't need to do ALL of them ALL the time
- If there is a topic that is more important to you, add it to the circle
- Nobody does all of these perfectly
- It is best to work on one or two at a time
- This is a partnership, you will not be pushed
- You choose which one(s) you want to discuss today

The steps outlined below give an interactive feedback loop between physician and patient.



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PERSONAL ACTION PLAN

Helping patients develop a plan for healthy behaviours

Action Plan (Example)

1. Goals: *Something you WANT to do:*

Begin exercising

2. Describe

How: Walking

Where: Around the block

What: 2 times **Frequency:**

When: after dinner

3. Barriers: have to clean up; bad weather

4. Plans to overcome barriers: ask kids to help; get rain gear

5. Conviction 8 **& Confidence** 7 **ratings**
(0 - 10)

6. Follow-Up: next visit – 2 months

Action Plan

1. Goals: *Something you WANT to do:*

2. Describe

How:

Where:

What: **Frequency:**

When:

3. Barriers:

4. Plans to overcome barriers:

5. Conviction **& Confidence** **ratings**
(0 - 10)

6. Follow-Up:



Appendix B: *Model of self-management support*

SEVEN As MODEL OF SELF-MANAGEMENT SUPPORT[‡]

- **Ask** permission to discuss, explore readiness for change, and use motivational interviewing to move patients along the stages of change. Ask about preferred ways to learn.
- **Assess** readiness for change as well as lifestyle issues, health-related risk factors and behaviours; understanding of disease and ask for any questions; assess nutrition, physical activity, psycho-social, economic, occupational and environmental factors. Assess for any literacy issues.
- **Advise** with clear, specific, and personalized advice to promote behaviour change and knowledge; use effective change approach. Use plain language and appropriate learning materials matched to patient's learning style.
- **Agree** on common ground/shared decision making about the nature of the problem, the treatment goals, and the physician and patient roles in the plan. Agree on realistic, modest, and achievable goals to help reduce negative lifestyle behaviours and promote positive behaviours. Focus on motivation and ability.
- **Assist** the patient in achieving agreed-upon goals with a variety of techniques including teach back, behaviour change, self-help, or counselling. Provide tools, information, and supports as needed. Help patients overcome barriers, identify strategies to improve adherence, and reward specific behaviour to increase motivation.
- **Arrange** follow-ups to help and support the patient. Adjust the plan and/or refer as needed. Involve other health care providers/team members when necessary, including community support groups and programs that support chronic disease self-management that are tailored to the patient, and that consider culture and literacy, etc.
- **Advocate** at a community level to promote systems change that help patients live in an environment that supports and encourages healthy lifestyle choices and options. Promote healthy behaviours in the practice population as a whole, in the clinic environment and at the community level. This can include advocacy for specific programs to improve literacy and address other social determinants of health.

[‡]Adapted from Plourde G. 6 As Model of Counselling in Obesity [Letters], and Vallis M, Piccinini-Vallis H, Sharma A, Freedhoff Y. Re:6 As Model of Counselling in Obesity [Reply]. *Can Fam Physician*. 2013 Feb 7. Available from: www.cfp.ca/content/59/1/27.abstract. Accessed 2016 April.



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