Best advice on chronic disease management

Francine Lemire MD CM CCFP FCFP CAE, EXECUTIVE DIRECTOR AND CHIEF EXECUTIVE OFFICER

Dear Colleagues,

I met a former patient in the supermarket recently. While catching up, he updated me on his personal and familial life. I was pleased he had followed my suggestion of seeing the dietitian in our unit and had lost 10 kg. I remembered that when he had come to see me with his most pressing symptoms, I had not only tried to address his immediate concerns, but also worried that he continued to have "a life worth living": When was his blood pressure last checked? He is taking long-term medication for an inflammatory joint condition. How is this going? When was his bloodwork last done? Our pharmacist monitors his international normalized ratio and I am in the loop. What is the status of his valvular heart disease?

There have been considerable changes in the practice profiles of family physicians in the past 30 years. We are seeing fewer patients with communicable diseases and more with multiple chronic conditions. By far most (83%) Canadians 65 and older report at least 1 chronic condition, and nearly one-quarter report living with 3 or more chronic diseases, with high estimated prevalence among adults for chronic conditions like diabetes (9.3%), hypertension (22.7%), and arthritis (15.3%).[1] Although clinical practice guidelines abound, they typically do not address the implications of comorbidities. There might be relationships and interactions between conditions, and the social determinants of health, such as poverty, the environment, and health disparity, can influence all of them.[2]

Family doctors are involved in looking after complex patients before, during, and after more specialized interventions. They have a "unique task profile" to accompany their patients on their journeys.[3] As such, CFPC's most recently released *Best Advice. Chronic Disease Management in a Patient's Medical Home* (PMH) guide[1] is timely and relevant. This guide provides best-to-date evidence regarding the magnitude of this issue, describes chronic disease models of care, and, most important, suggests proactive strategies that can be implemented in family practice. Up to 80% of premature heart disease, stroke, and type 2 diabetes, and 40% of cancers could be prevented with active management interventions.[1] These are powerful statistics. How can we achieve these outcomes?

Promote self-management and maintain ongoing physician-patient interaction. An important element of self-management is goal setting. This can be a potent element of family physician–patient interaction. Shared decision making can allow patients to own decisions, affirm their health priorities, and be true participants in their care. A unique way to facilitate this is through use of secure messaging, texting, and Web-based communications, connecting while reducing the need for travel by patients. Privacy and security concerns need to be considered.

Promote timely access and employ patient rostering. This requires paying attention to regularly scheduled appointments, in which proactive management can take place, and same-day access for more urgent care. Patient rostering can allow the practice team to better identify patients with chronic diseases or complex situations and proactively plan preventive measures and management strategies.

Use group visits and work in teams. Family physicians who use group visits report greater patient and provider satisfaction, increased self-management, and lower prevalence of chronic disease.[1] Team composition, guided by the needs of the practice population, is important—so is how we work in teams, connect and communicate, and manage overlapping and complementary scopes of practice. Coordinated, integrated care for each patient is the primary goal.

Adopt electronic medical records and evaluate practice strategies. This is an important element of the evolution of family practice that is essential for quality improvement and patient safety initiatives. Data are important; ultimately, patient records should "serve patient care, respect patients' preferences, and ideally also enhance their self-management."[3] Physicians can be agents of change in communities. Developing community partnerships, advocating to address social determinants of health, and promoting healthy environments (eg, urban design to facilitate walking or cycling; smoke-free public places) are important ways, at a community or regional level, to exert influence.

Have you developed or found ways of integrating strategies in your practice to better look after your complex patients—and, hopefully, make your life a little easier? If so, please share these at PMH Talk (**http://patientsmedicalhome.ca/talk**), a new forum we have established to discuss ideas about and experiences with the PMH.

Cet article se trouve aussi en français à la **page 687.**

Acknowledgment

I thank **Cheri Nickel** and **Eric Mang** for their assistance with this article.

References

1. *Best advice. Chronic disease management in a Patient's Medical Home.* Mississauga, ON: College of Family Physicians of Canada; 2016. Available from: **http://patientsmedicalhome.ca/resources/best-advice-guides/best-advice-guide-chronic-care-management-patients-medical-home/**. Accessed 2016 Jul 7.
2. Green B. Caring for patients with multiple chronic conditions: balancing evidenced-based and patient-centered care. *J Am Board Fam Med* 2013;26(5):484-5.
3. Wensing M, Kersnik J. Improving the quality of care for patients with chronic diseases: what research and education in family medicine can contribute. *Eur J Gen Pract* 2012;18(4):238-41.