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Has any good come of it?

The casual observer might look at Vancouver's Downtown Eastside (DTES) and wonder if things are better since the opening of the SIS. They *are* better—not a lot, but better than they were 5 years ago. It is not entirely because of the SIS, but that may have played a small part. Police crackdown on street level dealers and a focus on addicts who use or fix in or near parks and schools are prosecuted, and this has made a huge difference. Enforcement works.

What is lost in many of the discussions about supervised injection sites are the uniformed officers who patrol the areas around the sites. I am very proud of their efforts in the DTES and their continued professionalism in the face of such heated debate and criticism from both sides. The officers continue to do their job. There is a huge untold story here.

People have become used to thinking of the DTES as a centre for public urination and defecation, prostitution, open sex, panhandling, drug trafficking, assaults, and violent crime. It is not fair. This is a great neighborhood, a unique community made up of many fine, law-abiding citizens. It was never more obvious when 40 additional officers patrolled the DTES in 2003. People walked the street in safety, baby strollers were commonplace, and officers were stopped on the street and thanked for their dedication to make things better. BCMJ

gpsc

Chronic Disease Management Module supports GPs to deliver better care

A recent international survey[1] showed that within the year under study, only 38% of Canadians with diabetes received all four basic tests included in the recommended care guidelines.

The sizable gap between recommended care for chronic disease patients and the care they actually receive—as well as the fact that such patients now account for the majority of all primary care visits—underlines the urgency of efforts by the General Practice Services Committee (GPSC) to support BC's family physicians.

"In modern family practice, the monitoring of chronic ailments is more difficult than ever," says GPSC co-chair Dr Bill Cavers, a Victoria physician. "Walk-in clinics are taking patients with the more easily and immediately treatable conditions, so family physicians are left to deal with ongoing and very complex care."

Recognizing that support for family physicians has not kept pace with the changing nature of their work, the GPSC's Practice Support Program has developed a chronic disease management (CDM) module designed to help physicians, medical office assistants, and other care providers develop a more structured approach to providing evidence-based care.

Response to the module, which is offered by practice support teams in all health authorities, has been extremely positive, with 642 physicians currently enrolled and 128 registered for future sessions.

"It's not surprising that the CDM module is well received," says Dr Cavers. "It provides a number of effective tools and planning elements to help GPs be proactive in terms of managing care for patients with chronic ailments."

According to Dr Cavers, without such initiatives, care tends to be reactive and far less efficient because physicians are busy managing patients on a visit-to-visit basis. "You see a patient and order some lab work, but there's nothing to prompt you to find

The CDM Toolkit—Frequently asked questions

What is the CDM Toolkit?
The CDM toolkit is a clinical information system that helps doctors manage their patients who have chronic conditions.

Why was it developed?
It was developed in 2003 at the request of family practitioners involved in the South Vancouver Island Health Authority's Chronic Disease Collaborative and the province-wide CHF Collaborative.

What does the toolkit do?
It helps physicians develop a patient registry and informs a physician which patients may require intervention and follow-up.

Who funded its development?
The Ministry of Health.

Who has access to the data?
The toolkit is an extension of the physician's medical record. No one other than the physician can authorize access to an individual patient's information entered into the toolkit.

out whether the lab work was done in a timely way, or to follow up with the patient about the results. It is also difficult to keep track of patients who don't readily come in for an appointment."

While the CDM tools and strategies facilitate such follow-up, Dr Cavers is quick to point out they do not mandate or restrict how care is provided. "There is always clinical judgment required—CDM strategies do not remove that need."

The CDM module has three main components:

- Developing patient registries
- Using the CDM toolkit
- Implementing planned recall

A series of up to eight learning sessions, with "action" phases between them, supports the significant practice changes physicians are being asked to make in their chronic disease care. Physicians and their MOAs attend the learning sessions in their local community to learn how to develop patient registries, determine which patients require testing, manage group visits, help patients use self-management tools, and other CDM-enabling techniques.

After an initial learning session, physicians are assisted in implementing the CDM toolkit. Using the secure, web-based toolkit, doctors and MOAs fill out patient flowsheets based on clinical guidelines. They can share their de-identified results with other participants in the project and, with the patient's permission, can share personalized information with other health care providers for better coordination of care.

"I also provide a copy of the flowsheet to patients so they are aware of their blood pressure and clinical findings, which encourages their involvement in their care," says Dr Cavers.

The CDM toolkit also provides recall reports listing patients who are due for an office visit, or who require scheduled tests or procedures. Currently there are more than 1000 toolkit users in BC. Physicians in Saskatchewan, Manitoba, and Yukon are also using the toolkit.

CDM practices offer significant benefits for physicians and medical staff, from better management of complex patients, to increased job satisfaction and more accurate billing.

In addition to the obvious patient benefits of more rigorous, evidence-based care and improved outcomes, CDM practices offer significant benefits for physicians and medical staff, from better management of complex patients, to increased job satisfaction and more accurate billing.

Other Practice Support Program modules—all based on extensive input from GPs—include advanced access (a scheduling system), group visits, and patient self-management.

The Practice Support Program is an initiative of the BCMA and the Ministry of Health via the joint GPSC. Its purpose is to provide change management strategies and support to improve physicians' working lives and patient care. In addition, it helps physicians learn about and implement the 2006 Agreement's financial incentives. For more information, see www.bcma.org.

—Liza Kallstrom
Lead, Change Management and Practice Support

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