Chronic Care and Education

Judith L. Bowen, MD, FACP¹, Edward H. Wagner, MD, MPH, MACP², and David P. Stevens, MD³

¹Oregon Health & Science University, Portland, OR, USA; ²MacColl Institute for Healthcare Innovation, Group Health Research Institute, Seattle, WA, USA; ³The Dartmouth Institute for Health Policy and Clinical Practice, West Lebanon, NH, USA.

J Gen Intern Med 25(Suppl 4):569
DOI: 10.1007/s11606-010-1449-z
© Society of General Internal Medicine 2010

INTRODUCTION

Primary care is hard work. In the chaotic ambulatory environment where health care professionals strive to provide the highest quality care possible while dealing with practices that are overflowing with patients needing care and documentation needing attention, it is little wonder that residents say “not for me, thanks.” The work of the teams that participated in the Academic Chronic Care Collaboratives reported in this Supplement to the *Journal of General Internal Medicine* may be changing that sentiment. Transforming chaos to productive interactions between prepared practice teams and activated patients is hard work, yes, but also extremely rewarding. The work published here gives us a glimpse into what is possible for future primary care practices.

How could one not be inspired as the initial skepticism of health care team members across the country gave way to cautious optimism as they began to see improved chronic care results? Some discovered new meaning in their work. Many teams overcame, to some extent, the entrenched model of “doctor-in-charge” to embrace team care, with each member given autonomy and earning respect for assuming unique roles and responsibilities for providing quality chronic care...together. Residents training in pediatrics, internal medicine, and family medicine were members of these teams, witnessing and participating in the transformation of care delivery and their education programs.

All team members embraced the power of patient registries. Reactions grew from initial skepticism (“Those can’t be my results, I’m a better doctor than that”) to reliance on reports of their results that informed their improvement work (“What can we change that will result in improvement for our population?”). Once having used registry data to inform practice decisions and improve care,

most professionals learned there was no turning back. Residents began to ask questions: “Why don’t we manage chronic renal failure patients using registries?” “What about preventive health registries?” “Do the endocrinologists in my institution know how well they are doing with their diabetes care?”

All team members witnessed the power of patient engagement as a transforming force for change. How can one not be inspired when a passive, discouraged individual with diabetes becomes an engaged person—empowered by knowledge and support—who is able to better control his or her blood sugars? Residents learned to grant patients the responsibility for making the daily decisions required to live well with diabetes. Just enough patients achieved this transformation to encourage teachers and residents to develop innovative curricula to improve skills in communication, motivational interviewing, and self-management action planning. Residents across the country are having new kinds of conversations with patients living with chronic illnesses. These outcomes suggest that while the work of primary care education is hard, it can be rewarding work and well worth the effort.

In the pages that follow, you will read about the Chronic Care Model, the national and California Academic Chronic Care Collaboratives, new tools for evaluating clinical and educational change, and newly discovered joy in work. You will read about the work of teams changing the way care and education are delivered in residency training programs. We report here only a fraction of the work currently underway to improve chronic care and education. We wish to thank the Robert Wood Johnson Foundation, the MacColl Institute for Healthcare Innovation, and the Association of American Medical Colleges for financial and organizational support of these efforts. We also thank the California Healthcare Foundation for generous financial support of the California Collaborative and this supplement to the *Journal*. Without the support of these organizations, most residents might still be saying, “not for me, thanks.” Instead, many of the residents we worked with during these Collaboratives are re-committing to their careers in primary care.

Corresponding Author: Judith L. Bowen, MD, FACP, Oregon Health Science University, 3181 SW Sam Jackson Park Road, Portland, OR 97239-3098, USA (e-mail: bowenj@ohsu.edu).