AUSTRALIAN PRIMARY HEALTH CARE RESEARCH INSTITUTE

THE AUSTRALIAN NATIONAL UNIVERSITY

APHCRI DIALOGUE

THE BULLETIN OF THE AUSTRALIAN PRIMARY HEALTH CARE RESEARCH INSTITUTE

ISSUE 1, 2010

EFFECTIVE MANAGEMENT OF CHRONIC DISEASE IN PRIMARY HEALTH CARE

By Professor Mark Harris and Professor Nicholas Zwar

Health reform and chronic disease care

As part of the National Primary Health Care Strategy, the Commonwealth Government announced a new program to support coordinated care for people with diabetes. This involves patients enrolling with a practice which is then block funded to provide multidisciplinary care - the model which is likely to be extended to other chronic conditions in the future [8]. The recent budget also announced block funding for practices to employ nurses and the introduction of some Medicare items to support practice nurse involvement in chronic disease management [9].

The health reform agenda has been in part based on the rising prevalence of chronic diseases such as diabetes in Australia and the burden that this places on the community and the health system [1-3]. Primary health care has an important role in the early and effective management of these conditions to prevent complications and the need for hospitalisation [4, 5]. However, available evidence suggests a gap between current practice and that which is required to achieve these outcomes[6, 7].

What is needed for effective chronic disease management in primary health care?

Effective chronic disease management requires a shift away from episodic to more structured approaches to care. The Chronic Care Model provides a framework for the organisation of care for patients with chronic disease [10]. A systematic review conducted in 2006 identified the importance of some key elements of the model in improving quality of care and health outcomes, especially the combination of support for patient self management and multidisciplinary team care[11].

Multidisciplinary care planning has been supported by the Enhanced Primary Care (EPC) program introduced in 1999 and subsequently modified in 2005 to provide patients with chronic complex conditions with access to Medicare funding for a limited number of allied providers visits as part of a multidisciplinary care plan [12]. There have also been incentive payments through the Practice Incentive Program (PIP) for completion of an annual cycle of care (including assessment of physiological and behavioural risk factors and complication screening) [13]. Both these have had positive impacts. Structured care planning is associated with improved intermediate outcomes (such as HbA1c) especially for patients with initially poor control [14]. Shared care systems and the introduction of the diabetes incentives were associated with improved quality of care and intermediate outcomes [15, 16].

A major cause of the remaining gap between evidence and current practice in the management of chronic disease in general practice is the limited organisation capacity for regular monitoring, patient recall, education to support self management and referral to other providers [17, 18]. Cross sectional studies have found associations between multidisciplinary teamwork within practices and access to and quality of care as perceived by patients [19]. Patients with chronic disease recognise the constraints and are receptive to more structured approaches and the involvement of other providers, including practice nurses and other non GP staff as long as this does not erode their continuity of care with their GP [20].

Future directions

Creating the right conditions for structured multidisciplinary care in general practice is challenging. The National Primary Care Collaboratives have demonstrated that improvements are possible with the right incentives and supports. General practice networks have a key role to play in the facilitating these improvements. Facilitation of team roles for practice nurses and administrative staff has been found to be associated with improved patient assessed quality of care for diabetes and

AUSTRALIAN PRIMARY HEALTH CARE RESEARCH INSTITUTE

THE AUSTRALIAN NATIONAL UNIVERSITY

APHCRI DIALOGUE

THE BULLETIN OF THE AUSTRALIAN PRIMARY HEALTH CARE RESEARCH INSTITUTE

ISSUE 1, 2010

cardiovascular disease [21]. However, creating teams across organisational or cultural boundaries (especially between private and public services) is more difficult [22]. Super clinics and other models of integrated primary health care are also envisaged to provide a model for co-located multidisciplinary teams to provide better care for patients with chronic disease [8]. The impact of these models on quality care for chronic disease should be evaluated and, if successful, they could be extended to other general practices.

In summary, there is evidence to support a systematic and planned approach to multidisciplinary care for patients with chronic disease in primary care. Despite some positive programs in recent years, significant barriers have remained. The initiatives announced as part of the current reforms go some way towards addressing these barriers, especially in providing more flexible arrangements to fund team care and encouraging continuity of chronic disease care. However, some questions remain about their suitability for patients with multiple co-morbid conditions rather than single diseases and whether the funding provided is sufficient for the complex needs of some patients. There are also concerns about the impact of pay for performance on the doctor-patient relationship. These need to be monitored and explored in further research.

The Australian Primary Health Care Research Institute commissioned a systematic review of chronic disease management, which was conducted by: Professor Nicholas Zwar, Professor Mark Harris, Professor Rhonda Griffiths, Professor Martin Roland, Dr Sarah Dennis, Mr Gawaine Powell Davies and Mr Iqbal Hasan.

References:

[1] Begg S VT, Barker B, Stevenson C, Stanley L, Lopez A. The burden of disease and injury in Australia 2003. Canberra: Australian Institute of Health and Welfare; 2007.
[2] Australian Institute of Health and Welfare. Chronic diseases and associated risk factors in Australia, 2006. Canberra; 2006.
[3] Strong K, Mathers C, Leeder S, Beaglehole R. Preventing chronic disease: How many lives can we save? Lancet. 2005.
[4] Gulliford MC. Availability of primary care doctors and population health in England: is there an association? J of Public Health Medicine. 2002;24(4):253-4.
[5] Mitchell GK, Brown RM, Erikssen L, Tieman JJ. Multidisciplinary care planning in the primary care management of completed stroke: a systematic review. BMC Family Practice. 2008;9:44.
[6] Briganti EM, Shaw JE, Chadban SJ, Zimmet PZ, Welborn TA, McNeil JJ, Atkins RC. Australian Diabetes, Obesity and Lifestyle Study (AusDiab). Untreated hypertension among Australian adults: the 1999-2000 Australian Diabetes, Obesity and Lifestyle Study (AusDiab). Medical J of Australia. 2003;173:135-9.
[7] Wan Q, Harris MF, Jayasinghe UW, Flack J, Georgiou A, Penn DL, Burns JR. Quality of diabetes care and coronary heart disease absolute risk in patients with type 2 diabetes mellitus in Australian general practice. Quality and Safety in Health Care. 2006;15(2):131-5.
[8] Department of Health and Ageing. Building a 21st Century Primary Health Care System: Australia's First National Primary Health Care Strategy. Canberra: Commonwealth of Australia; 2010.
[9] Australian Government. Portfolio Budget Statements 2010-11 Budget Related Paper No 1.11; Health and Aeing Porfolio. Canberra; 2010.
[10] Wagner E, Austin B, Von Korff M. Organising care for patients with chronic illness. Milbank Q. 1996;74:511-44.
[11] Zwar N, Harris M, Griffiths R, Roland M, Dennis S, Powell Davies G, Hassan I. A systematic review of chronic disease management. Canberra: Australian Primary Health Care Research Institute; 2006.
[12] Department of Health and Ageing. Chronic Disease Management (CDM) Medicare Items. 2010 [cited; Available from: www.health.gov.au/internet/main/publishing.nsf/Content/mbsprimarycare-chronicdiseasemanagement
[13] Department of Health and Ageing. Supplement to Medical Benecits Schudel: Subgroup 2 - Completion of an annual cycle of care for patients with diabetes mellius. . Canberra: Commonwealth of Australia; 2005.
[14] Zwar NA, Hermiz O, Comino EJ, Shortus T, Burns J, Harris MF, . Do multidisciplinary care plans result in better care for type 2 diabetes? . Australian Family Physician. 2007;26:85-9.
[15] Harris MF, Priddin D, Ruscoe W, Infante FA, O'Tool BI, . Quality of care provided by general practitioners using or not using division based registers. . Medical J of Australia. 2002;177:250-2.
[16] Georgiou A, Burns J, McKenzie S, Penn D, Flack J, Harris MF,. Monitoring change in diabetes care using diabetes registers: experience from Divisions of General Practice. . Australian Family Physician. 2006;35:77-80.
[17] Oldroyd J, Proudfoot JG, Infante FA, Powell Davies G, Bubner T, Holton C, Beilby JJ, Harris MF. The views of Australian GPs about providing healthcare for people with chronic illness: a qualitative study. Medical J of Australia. 2003;179(1):30-3.
[18] Proudfoot J, Infante F, Holton C, Powell-Davies G, Bubner T, Beilby J, Harris MF. Organisational capacity and chronic disease care - An Australian general practice perspective. Australian Family Physician. 2007;36(4):286-8.
[19] Jayasinghe UJ PJ, Holton C, Powell Davies G, Amoroso, Bubner T, Beilby J, Harris MF. Chronically ill Australians' satisfaction with accessibility and patient-centredness. International Journal for Quality in Health Care 2008;20:105-14.
[20] Infante FA, Proudfoot JG, Powell Davies G, Bubner TK, Holton CH, Beilby JJ and Harris MF. How people with chronic illnesses view their care in general practice: a qualitative study. Medical J of Australia. 2004;181(2):70-3.
[21] Taggart J, Schwartz A, Harris MF, Perkins D, Powell Davies G, Proudfoot J, Fanaian M, Crookes P. Facilitating teamwork in general practice: moving from theory to practice. . Australian J of Primary Health. 2009;15:24-9.
[22] Harris MF, Chan BC, Daniel C, Wan Q, Zwar N, Powell-Davies G. Development and early experience from an intervention to facilitate teamwork between general practices and allied health providers: the Team-link study. BMC Health Services Research. 2010;10:104.

Editor: Will Wright / E: will.wright@anu.edu.au / T: +61 2 6125 2026 / W: www.anu.edu/aphcri