POLICY OPTIONS

Information sharing for the management of chronic conditions in primary health care: How does it work and what are the outcomes?

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Policy context

Chronic conditions are recognised as being among some of the most common and costly to the Australian health care system. Expenditure on chronic conditions already accounts for the majority of all health care spending. The prevalence of chronic conditions is also increasing nationally. This highlights the importance of developing policy that will encourage effective management and treatment to optimise the benefits of future resource input and Government expenditure.

Prior research indicates that chronic health problems are most effectively managed, treated and prevented through a collaborative approach where clients and health workers from various disciplines work together to achieve defined goals. The use of care plans can assist in facilitating collaboration; however, it is unknown how or whether information is being shared within multidisciplinary teams to provide the necessary basis for this. In addition, few studies have explored the experiences of clients and health workers, even though these people are most centrally involved in managing chronic health problems through collaborative approaches. To address these gaps our research examined if and how information is being shared through the care planning process. It also explored the enablers and barriers to effective multidisciplinary information sharing. We investigated these issues through seeking the views and experiences of clients and health workers, while also observing care planning practice.

Policy options

The following strategies were identified through the research as being conducive to improving the effectiveness of collaborative approaches to chronic condition management.

> As part of primary health care reform, assessment of care plan use and effectiveness should be built into the accreditation and performance review process.

  o It is particularly important to assess whether care plans are being used and whether they are being used effectively rather than only identifying if they exist.

  o It is also important to identify whether multiple care plans are operating for the same client within and across health services and, if so, whether these care plans are being coordinated.

> Those claiming funding for care plans should be required to produce plans for ensuring their effective implementation and sharing before funding is provided.

> Medicare Locals should identify areas of possible service overlap in their regions and, in doing so; optimise the benefits that may be achieved through current funding.

> Medicare Locals should be involved in the development and management of systems which facilitate the coordination of services within a local network and enhance information transfer between these services.

> Consistent guidelines are required to clarify what information health workers can share if they have full consent. The option for selective client consent should be mandatory.

> Practice nurse positions should be dedicated to the management of client care plans. This would allow practice nurses to take on a dedicated role, similar to that of a case manager to ensure greater continuity for clients and facilitate collaboration within multidisciplinary teams.

   o Freeing up practice nurses to dedicate their time to managing care plans may relieve some of the burden on general practitioners whose workloads often preclude them from spending the time necessary to establish effective lines of communication with other members of multidisciplinary care teams.

   o However, for the full potential of this arrangement to be realised funding arrangements would need to be modified to ensure that the work of practice nurses could be recognised and that health services using this system could be renumerated accordingly.

> In order to ensure the most effective approach to enhancing integration, cooperation and consistency must be present at a policy level. This is imperative given the range of new initiatives that are being implemented, such as Medicare Locals and the GP Super Clinics. These initiatives are currently managed by several Government braches which makes coordination across these braches necessary to avoid further service overlap and to optimise the benefits of future resource input.

> Adequate time for information sharing needs to be provided to health care providers at the service level.

   o This may require the modification of existing funding systems to allow health services to be renumerated for the time staff spend engaging with other members of multidisciplinary care teams.

Key findings

The findings indicate that information sharing occurs through various methods in the management of chronic conditions. These methods are identified and explained in the full report.

In general, care planning was found to facilitate the sharing of information within multidisciplinary teams across primary health care services and sectors. Analysis of the various sources of data that were collected during the study suggested that, *when working effectively*, care planning tools enhanced information sharing by:

> establishing the expectation that information will be shared with all members of the health care team, including with the client;

> providing a structured framework through which a team approach to chronic condition management could be established;

> providing a set of documents for use by each member of the team which could be distributed easily and effectively through multiple means such as email, mail and the sharing of client files;

> creating scope for multidisciplinary review of a clients' care plan; and

> allowing health workers access to all information obtained through holistic assessment of client needs, such as financial situation and family relationships.

Although it was evident that care planning tools did facilitate information sharing, the current situation is more complex and some of that complexity has been explored throughout the full report. In addition, it must be acknowledged that the current tools and processes did not always work as effectively as possible. This means that while information sharing may be occurring to some extent, information is not shared effectively in all cases and sometimes the processes do not achieve the intended results. The policy options identified in this report are intended to target areas where current processes can be optimised to produce improved results.

The research also identified several specific enablers and barriers to information sharing. These are listed in Figure 1.

Figure 1 Overview of the main factors that influence the effectiveness of information sharing

Enablers	Barriers	Both enablers and barriers
Valuing of communication	Different perception of purpose of care	Consent
Clients informed about extent of help available	Closed communication	Free visits linked to GP management Plan
Client knowledge about health worker communication	Fragmented communication	Suspicion
Care continuity	Overlapping care plans	Health worker & client relationship
Involvement of clients in decisions	Belittling, sabotage, put downs, snide comments	Knowledge of care plan
Negotiation	Railroading	Role definition within the team
Emphasis used in conversation	Varied understandings of terminology	Team definition
Openness and accessibility of care plans	Time	Client ownership

These factors impact on the effectiveness of chronic condition management by influencing the extent of client involvement and the opportunities available for multidisciplinary collaboration. Detailed explanations about these enablers and barriers, as well as the effects they produce, is included throughout the full report.