



Chronic disease management in primary health care: from evidence to policy

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Outline for Today

- § Introduction
- § Findings
- § Policy Implications
- § Further research
- § Questions
- § Appendix

Introduction

- § The Australian Primary Health Care Research Institute (APHCRI) funded this research into chronic disease management in primary care.
- § The research was conducted by a team of researchers from University of New South Wales, University of Western Sydney and University of Manchester
- § Aim of research: To determine the effectiveness of chronic disease management interventions in the primary care setting.

Introduction

- Shift from **reactive** to **proactive** system of healthcare to support the management of chronic disease
- The person with chronic disease should be **activated** and well **informed** about their condition
- Increasing role of **primary care** professionals in the management of chronic disease

World Health Organization. Innovative care for chronic conditions: Building blocks for action: Global report. Geneva: World Health Organization; 2002. Report No: ISBN 92 4 159 017 3.

Expanded Chronic Care Model

permission



Key findings – delivery system design

§ Beneficial effects

- Improvements in disease outcomes (e.g. HbA1c) and adherence to guidelines, health service use

§ Types of delivery system design intervention

- Multidisciplinary team care, making full use of the practice nurse, nurses acting as case managers and providing self management support
- Making use of patient reminders and encouraging proactive follow-up of the patient
- Many of the interventions are design to support and increase opportunity for self management support

§ Chronic diseases

- Improved patient outcomes with diabetes, hypertension, lipid disorders
- Evidence less clear for arthritis, COPD and asthma

§ Beneficial effects

- Most improvements in health professional adherence to guidelines with improvements in some patient outcomes

§ Types of delivery system design intervention

- Use of evidence based guidelines
- Educational meetings and support of primary health care professionals
- Distribution of educational materials to health professionals

§ Chronic diseases

- Improved process and some patient outcomes for diabetes
- Some evidence for improved adherence to guidelines for asthma

§ Beneficial effects

- Improvements in disease outcomes (e.g. HbA1c), quality of life, health and functional status, satisfaction and health service use

§ Types of self-management intervention

- Patient education, motivational counseling, intensive, specific, group or community based to one, empowerment
- Difficult to sustain, increased knowledge does not always translate into improved health outcomes

§ Chronic diseases

- Improved patient outcomes with diabetes, hypertension, lipid disorders and to lesser extent arthritis
- Evidence less clear for COPD and asthma

§ Beneficial effects

- Most improvements in health professional adherence to guidelines with improvements in some patient outcomes

§ Types of delivery system design intervention

- Use of evidence based guidelines in clinical computer systems
- Systems to encourage audit and feedback
- CIS most often supported decision support

§ Chronic diseases

- Most evidence to support use of CIS in the management of diabetes

Findings - Summary

- § Chronic Care Model provided useful framework for analysis
- § Patient outcomes improved
 - Self management support, delivery system design, decision support
- § Process outcomes improved
 - Delivery system design, decision support and clinical information systems
- § Little evidence for the most effective interventions to support the role of community resources and health care organisations in chronic disease management

§ Self Management Support

- Education for GPs and practice nurses in self management support
- Encourage incorporating Self Management education into care plans
- Increase role of allied health in providing self management support
- Help link general practice with self management support for specific groups such as Indigenous Australians and people from CALD backgrounds
- Explore role of pharmacists in self management support using Home Medicine Reviews

§ Delivery System Design

- Support extension of role of practice nurse to provide self management support groups
- Support training of practice staff in multidisciplinary team approach. Training needs to focus on clear roles and responsibilities of the team members
- Support role of allied health providers

§ Decision support and clinical information systems

- Encourage use of chronic disease registers, recall and reminder systems
- Encourage and support use of registers in the provision of audit data for practices to use in quality improvement processes
- Support the use of data extraction tools and Collaborative methodology to improve the quality and use of practice data
- Support training of GPs and practice nurses in guideline-based chronic disease management
- Provide support to GPs and practice staff so they can make more effective use of clinical information systems in care of patients with chronic illness

- § Sweden – nurse led chronic disease clinics at primary health centres and in hospital polyclinics. Most commonly focus on diabetes and hypertension
- § England – considerable local diversity but nurse led clinics are common and nurses as case managers for patients with complex needs. Also P4P system which rewards GPs for chronic disease care for 10 conditions
- § Canada – de-centralised health system – province based models of shared governance and increased collaboration
- § Incentives for providers and/or purchasers/payers in a number of countries

- § Lack of studies on Chronic Care Model elements of community resources and health care organisation
- § Research of interventions in the Australian context is lacking
- § Evaluation of impact of current initiatives such as EPC chronic disease items, Practice and Service Incentive Payments

§ APHCRI Stream 12 Extension Funding - Optimising Skill-Mix in the Primary Health Care workforce for Care of Older Australians

§ Key findings

- Evidence of successful task substitution from doctors to nurses in case management using guidelines, proactive patient follow-up, care planning and goal setting, self management education
- Evidence of task substitution between doctors and pharmacists in medication review and management using therapeutic algorithms, medication compliance checking, monitoring and goal setting, screening and referral, self management education

Questions?

- § How is the policy environment developing in regard to taking forward these options?
- § What are the implications of policy processes such as the Health and Hospitals Reform Commission, National Primary Health Care Strategy and Preventative Health Taskforce?

Appendix

The full report on CDM is available from:

<http://www.anu.edu.au/aphcri/Domain/ChronicDiseaseManagement/index.php>

Paper

Dennis S, Zwar N, Griffiths R, Roland M, Hasan I, Powell Davies G, et al.
Chronic disease management in primary care: from evidence to policy. MJA.
2008;188 (8 Suppl):S53-S6.

Chronic Care Model: www.improvingchroniccare.org

Workforce report available from:

www.anu.edu.au/aphcri/Domain/Workforce/index.php

International Comparisons

Managing chronic conditions: experience in eight
Countries. www.euro.who.int/Document/E92058.pdf