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MANAGING TRANSITIONS IN AND BETWEEN PRIMARY AND ACUTE SERVICES - A GP PERSPECTIVE

or

'Zen and the Art of Chronic Disease Management'

You, who work in primary care, don't need an early warning tsunami detection system to know that we are about to get hit by a wave of chronic disease - it has already reached our shores. Like Richard Matthews in this picture, we need to learn to enjoy the ride - relax and be calm. Coming from the North Coast, we would say that we need to create a world of 'zen'.

Our practice was one of one thousand that has participated in the Australian Primary Care Collaboratives program. We know what the evidence tells us we should be achieving for our patients with Diabetes, Coronary Artery Disease, and COPD. How can we achieve these targets in our practices, given the resources we have available and the communities we work in? In the Collaboratives program, practices tried out new systems for delivering care, measured the outcomes, and shared their stories. Therfore, any good ideas that I raise in this paper, you can be sure I have stolen shamelessly from someone else. Any boofhead ideas are undoubtably my very own.

Chronic Disease and Primary Care

Primary care is emboldened to take responsibility for chronic disease management by the work of Barbara Starfield, whose work will be well known to most of you. Her research comparing health systems from all over the world found that chronic disease outcomes **are not** improved by more specialists, new diagnostic tools, new medications. Outcomes **are** improved by better delivery of primary care.

Some reasons for this are -

1) management of chronic disease is about managing co-morbidities. This benefits from a generalist approach

2) outcomes in chronic disease are improved by a long-term partnership with a primary care provider

3) the 'real work' in chronic disease is done by the patient (Carol, one of our patients, told an audience at a workshop that "its a partnership in which I have to do all the bloody work!")

Change Principles

There are 5 key change principles for improved chronic disease management that arose from the collaborative process. They are

1) Engage the Practice Team - successful practices developed a core practice team committed to improved patient care, with the patient at the centre

2) Practice Herd Health - you need to know who your patients are and what they've got, and be able to measure their collated outcomes so that you can know whether any change you make is an improvement.

3) Deliver systematic and proactive care - most collaborative practices found that a practice nurse in the role of chronic disease manager was of enormous benefit in developing systems to deliver reliable care. GPs may be many things, but being systematic is generally not one of them.

4) Promote patient self-management. The Real Work in Chronic Disease Management is done by the patient and their families. This is 'the greatest untaped resource in health care.'

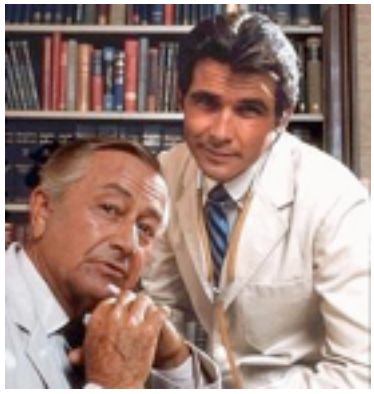
5) Integrate your care with other services - Integrated care is dependent on relationships, informational consistency and timely communication.

Model of Care

Best outcomes in chronic disease are achieved in the Medical Home model.

Patients partner with a particular general practitioner, supported by an interdisciplinary practice team, delivering comprehensive care. Other services are wrapped around this team. The Medical Home thus acts as a gateway to all the care a patient needs (rather than a gatekeeper)

General Practice and new models of Chronic Disease Management



Chronic Disease Management is now the major activity in general practice. The BEACH study shows that more than 50% of consultations are regarding a chronic condition. In patients aged 75-85, this figure is 80%.

Many general practices have now developed accurate registers of their patients with chronic disease and have proactive systems for their management. Practice nurses are working in the new role of chronic disease managers.

Some of the features of Chronic Disease Management systems in these practices are:

-accurate registers of patients with chronic disease
-three monthly nurse-led chronic disease 'clinics'
-an annual cycle of care including preventative health activities
-an interdisciplinary approach using diabetes educators, dietitians, exercise physiologists etc
-a focus on patient self management and behaviour change
-a consultation approach based around teams, conditions, goals, measures and actions
-monthly aggregation of clinical measures to make sure changes are leading to improvement (eg % of patients with diabetes with HbA1C < 7%, % of patients with CAD who have LDL < 2.0, % of patients with COPD who have had spirometry)
-patient held health summaries and/or online shared EHR including relevant goals and results.

Rules for CDM in Secondary Care

My Latin teacher, Fr Fraser, had three rules for Latin translation.

1. Make up your mind that you can't do it.

2. Misread the text

3. Where there are no difficulties, invent them.

We would inevitably follow these rules when confronted with a Latin text.

I think these would be Fr Fraser's rules for managing chronic disease in secondary care -

1. Start hospital avoidance at the hospital door, (not some years beforehand and some kilometres distant).

All patients require proactive and systematic management, those with chronic disease more so.

If you wait till they have presented to hospital the third time, you've missed the boat.

2. Keep the drawbridge up.

General Practice has a great deal of clinical information about patients, including recent results and specialist consultations.

It is worrying that this data is not routinely obtained when patients are admitted to hospital.

As well as making care safer, it would make it easier for the treating doctors.

As Fr Fraser used to say "Why go to hell when you can go to heaven for half the trouble?"

3. Train your patients to use the hospital as their medical home

If specialist outpatient clinics regularly review patients with stable chronic disease, it is not surprising that these patients present to the hospital when they have a concern or an exacerbation. Where else can they go?

Specialists are a scare resource that have particular important skills. As Prof Des Gorman says, "we should not be using 747s to deliver the milk". Especially when a milk truck would do a better job. The evidence is that using specialist clinics that focus on one part of the body for routine chronic disease management produces worse outcomes than a generalist 'medical home'.

4. Build new things, don't leverage the old.

General Practices are each managing about 200 patients with diabetes and 200 with coronary artery disease, most of these systematically.

When designing new systems, we need to be careful not to replace existing resources and relationships.

It makes sense to increase resources as disease progresses, but not to introduce a new care coordinator and a different centre to be the medical home.

5. Its more fun to buy running shoes than it is to go running.

It is usually not more care coordination that is needed to prevent an unplanned admission. What is usually needed is more care.

We need an agile response to a change in patients needs, with clinical and non-clinical services available in a timely way. This would contrast with the prevailing culture in some services currently, where there is an 'intake system' which aims to ration supply and reduce demand.

So, rather than increased investment in coordination, it may be more appropriate to increase investment in actual care delivery - especially as there appears to have been reduced funding for community care despite increasing demand. Any extra funding provided to a region is often not discretionary but directed to reducing elective surgery waiting lists.

Some suggested principles for a SCDM program

- the role of general practice in long term management of chronic disease should be recognised. Where practices have a capacity to provide care planning and care coordination services for patients in a SCDM program, this should be supported and not replaced. Where practices do not have this capacity, new services should partner with the practices to build these skills. In South Australia, State Health provides funding for nurses to work as chronic disease managers in general practices so that these skills can be developed.

- the aim should be to deliver services as close to the patient as possible. In the home, or the 'medical home', should be the preferred site.

- hospitals should have a 'GP inreach' program rather than a 'hospital outreach' program. Patients in the SCDM program could have a dual admission to hospital, with the GP acting as a virtual VMO, consulted at admission and at key points during the admission, as well as having direct involvement in discharge planning.

- partnership between community health and general practice should become 'business as usual'; we need to get rid of 'our patient' and 'your patient' thinking. We should immediately improve the effectiveness of primary care delivery by developing greatly increased collaboration between our community nurses, practice nurses and GPs. There should be a well defined process whereby a community nurse partners with a specific general practice as part of the core patient care team. In HealthOne Mt Druit this process has been greatly facilitated through the leadership of an experienced community RN in the role of GP Liaison Nurse.

- our program should have a 'triple aim' : to improve patient outcomes, to make care more satisfying for patients and care providers, and to use resources more effectively to control the 'bottom line'. We need to put more Zen in our Chronic Disease Management.

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