



Chronic conditions

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Definition

Chronic illness is the irreversible presence, accumulation or latency of disease states or impairments that involve the total human environment for supportive care, maintenance of function and prevention of further disability.¹

Chronic conditions are defined by the World Health Organization as having one or more of the following characteristics: they are permanent, leave residual disability, are caused by nonreversible pathological alteration, require special training of the patient for rehabilitation, or may be expected to require a long period of supervision and care.²

A chronic condition is defined as including any form of chronic illness, disease or symptom complex or disability, and is often of long duration and generally slow progression.²

A distinction needs to be made between chronic illness, which impacts on the wellbeing and the holistic functioning of the patient, and chronic disease, which may have little affect the day-to-day life of the patient other than the medical management required to prevent future mortality and morbidity. For instance, hypertension and hypercholesterolaemia are chronic diseases that require effective management and monitoring to prevent future cardiovascular events, but these diseases are unlikely to have as significant affect the daily wellbeing of the patient as for example, the chronic illness caused by, for example, rheumatoid arthritis.

Curriculum in practice

Typical presentations that illustrate how the chronic conditions curriculum applies to general practice include:

- Ted, 78 years of age, has ischaemic heart disease. who had a percutaneous stent inserted into his left anterior descending coronary artery in June 2004. Three years ago he suffered a myocardial infarct which resulted in congestive cardiac failure and a left ventricular ejection fraction of 42%. He has a past history of smoking and a long history of type 2 diabetes with hypercholesterolaemia and moderate hypertension. He was recently found to have albuminuria. He has atrial fibrillation for which he is taking warfarin but he has erratic INRs because, as a keen fisherman, he does not keep regular hours or meals.
- Emily, 58 years of age, is still working to support her youngest child who currently attends university. She presents for a 'check up' as she is feeling tired all the time and becomes short of breath when climbing stairs. At the time of menopause about 4 years ago, she had heavy periods and became mildly anaemic. This was treated with iron supplements for 3 months. You suspect that Emily may be anaemic again as she appears quite pale and you wonder if this might be due to the nonsteroidal anti-inflammatory drug that she takes intermittently for arthritis of the knees and wrists. Emily had a mammogram and Pap test about 18 months ago and is not taking any other medication, however you notice that she has lost about 5 kg since her last visit. The only other symptom she reports is long term constipation and haemorrhoids. Emily's haemoglobin returns as 8.5 g/dL and a subsequent colonoscopy finds a 6 cm poorly-differentiated adenocarcinoma of her ascending colon.

Rationale and general practice context

Chronic disease represents a substantial and increasing portion of healthcare expenditure and practitioner workloads.³ The burden of chronic diseases is rapidly increasing worldwide, with chronic diseases contributing to approximately 60% all deaths globally.² The proportion of the burden of noncommunicable disease is rising with 80% of these deaths having associated modifiable risk factors.⁴

The rate of chronic problems managed by general practitioners has increased significantly between 2000–2001 and 2009–2010 from 48.2 to 54.1 chronic problems per 100 encounters,⁴ resulting in an estimated additional 16 million chronic problems managed in general practice nationally in 2009–2010 compared with 2000–2001. Two chronic conditions, cardiovascular disease and cancer, constitute the two major causes of death in the Australian community.

Most working age Australians consider their health to be good, but results from the 2007–2008 Australian Bureau of Statistics National Health Survey reported that the commonest problems were eyesight (52% of the population), arthritis (15%), asthma (10%), hayfever and allergic rhinitis (15%) and hypertensive disease (9%). Other commonly reported conditions were back pain and disc disorders (14%) and deafness (10%).⁵ The prevalence of these diseases increases with age and nearly all people in Australia aged 65 years and over report at least one long term condition.⁵

The National Public Health Partnership (NPHP) identifies the following chronic conditions as having the largest affect the burden of disease in Australia:⁶

- ischaemic heart disease (also known as coronary heart disease)
- stroke
- lung cancer
- colorectal cancer
- depression
- type 2 diabetes
- arthritis
- osteoporosis
- asthma
- chronic obstructive pulmonary disease (COPD)
- chronic kidney disease
- oral disease.

The role of the GP

Both in Australia and internationally, the traditional medical and social care based on the disease centred acute hospital model has not met the needs of people with chronic illness, particularly with respect to psychological and long term care management.

General practice care models have been shifting in recent times from professional and service centred management to care that emphasises the individual managing and living with chronic disease, illness and disability. This has been identified as helping health outcomes.⁷ In addition, the primary aim of chronic disease management shifts from cure to reducing the progression of symptoms and further complications.

Patients with chronic disease will have varying needs for medical management and support, depending on the disease type, the disability associated with that disease, and the stage of disease. Health system responses, including general practice, will need to match the appropriate level of healthcare needed.⁷ In addition, the primary aim of chronic disease management shifts from cure to reducing the progression of symptoms and further complications.

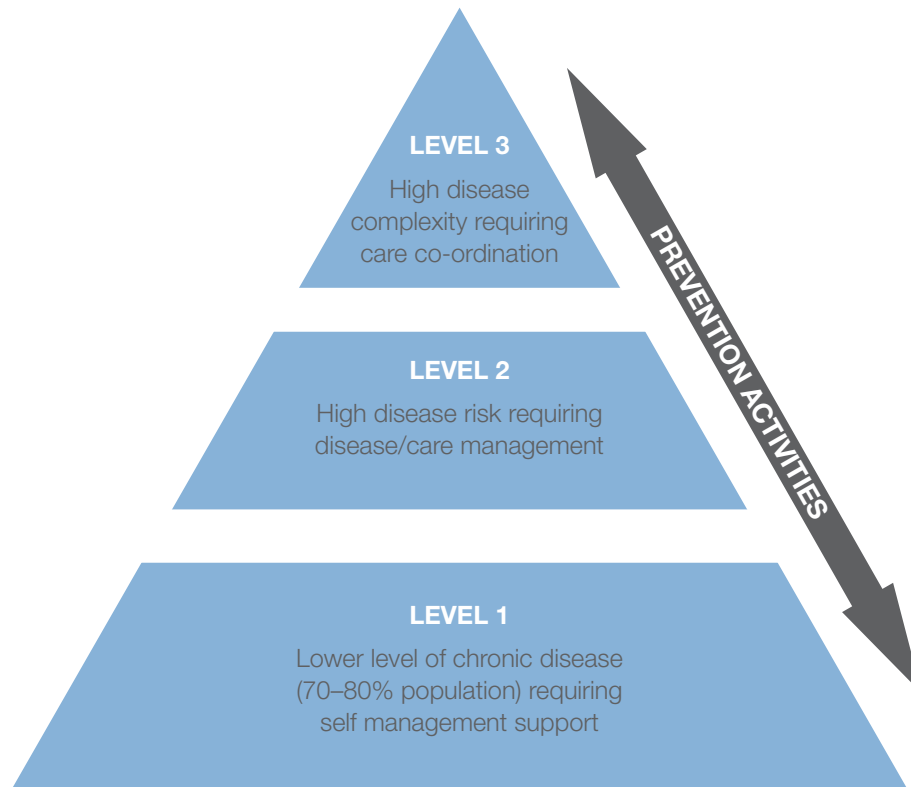


Figure 1. Levels of healthcare need to be matched to the care needs of chronic disease

Lifestyle modification, general practice and chronic disease

There are many complex determinants of chronic disease, including social, economic and cultural factors. While some strategies are needed to attenuate the effects of these factors such as income support or governmental population health initiatives, modification of lifestyle factors is particularly important in managing chronic disease in general practice.

Important common lifestyle factors in the development of chronic disease identified for change in general practice are the SNAP risk factors: smoking, nutrition, alcohol and physical activity.⁸ Lessening exposure to the risk factors of smoking and alcohol and promoting the benefits of good nutrition and physical activity, helps prevent and control chronic disease.

A multidisciplinary approach to general practice chronic disease management

Care for patients with chronic illness is complex and needs to be supported by a systematic approach to self management, information management and multidisciplinary teamwork.⁷

The increasing prevalence of chronic disease has led to major changes in the methods of healthcare delivery and the role of different health professionals in delivering such care.

The role of the GP in chronic disease management varies over time but is central for most patients. General practitioners have ongoing relationships with their patients, which provides a central point of co-ordination for long term chronic disease management. Continuity of care, which is a key feature of general practice, has been shown to improve the quality of care and health outcomes for patients with chronic diseases.⁹

This continuity of care is particularly important in the significant proportion of patients who have more than one chronic disease, resulting in relatively complex disease management. General practitioners can co-ordinate care and are able to provide more holistic care for patients than the primarily disease focused care of the secondary and tertiary healthcare sector.

The healthcare team includes the general practice team (GPs and practice nurses), other primary healthcare professionals (eg. pharmacists, physiotherapists, psychologists) and healthcare professionals from the secondary sector.

In particular, practice nurses have an increasingly important role in the delivery of systematic care for chronic diseases in the general practice setting, and are similarly becoming better placed to participate in holistic rather than just disease-specific care.

In some locations and practices, for example in rural and remote settings, the boundaries between primary and secondary care may be less distinct, and the GP may be responsible for a greater proportion of in hospital patient care.

Patients and their carers have an extremely important role in the management of chronic diseases. Therefore supporting and educating patients in their self management is a critical role for GPs and general practice staff involved in the care of patients with chronic disease.

Related curriculum areas

Refer also to the curriculum statements:

- *E-health*
- *Population health and public health*
- *Multidisciplinary care.*

Training outcomes of the five domains of general practice

1. Communication skills and the patient-doctor relationship

- CHRT1.1 Use appropriate verbal and nonverbal communication techniques (eg. open and closed questions, reflection, summarising) to gather additional history from patients and, when appropriate, family members, carers and/or other members of the multidisciplinary team, especially relating to lifestyle factors and chronic disease.
- CHRT1.2 Assess adherence to medication regimens and the ability to sympathetically ascertain from the patient or, where appropriate, family members, carers and/or other members of the multidisciplinary team, factors contributing to adherence.
- CHRT1.3 Explain the need for specific physical examinations to be made in the context of a specific consultation at one point of time and obtain patient consent to perform these examinations or, when appropriate, the consent of a family member or carer.
- CHRT1.4 Effectively communicate diagnoses of chronic diseases including comorbidities, acute exacerbations, complications to patients and, when appropriate, family members, carers and other members of the multidisciplinary team.
- CHRT1.5 Explain the role of tests and investigations (including pre- and post-test counselling) at different disease stages for prevalent chronic diseases, including at times of potential acute exacerbation or acute complication, and obtain patient consent to perform those tests/investigations or, when appropriate, that of a family member or carer. This should include explanations when tests and investigations are not required.
- CHRT1.6 Communicate test and investigation results in the context of particular chronic disease(s) to patients and, when appropriate, family members, carers and/or other members of the multidisciplinary team.
- CHRT1.7 Use a patient centred, supportive disease management approach and develop long term relationships that help patients with chronic conditions to take as much responsibility as possible for their own health outcomes.
- CHRT1.8 Understand the patient's knowledge, attitudes and meaning of their illness.
- CHRT1.9 Understand the importance of patient centred communication in improving health outcomes.
- CHRT1.10 Be responsive and empathetic to fluctuations in the physical and mental state of patients with chronic diseases.
- CHRT1.11 Negotiate and document appropriate management plans to optimise patient wellbeing, autonomy and personal control of their chronic disease health outcomes, emphasising a shared approach to decisions regarding management.
- CHRT1.12 Appropriately refer to specialist physicians where necessary.
- CHRT1.13 Effectively communicate negotiated management plans for chronic diseases including comorbidities, acute exacerbations and/or complications of the diseases, when appropriate, to family members, carers and/or other members of the multidisciplinary team including specialist physicians.
- CHRT1.14 Maintain long term, supportive relationships with patients who do not respond to, or co-operate with, medical management.

- CHRT1.15 Use patient reminders (electronic or paper based) to facilitate appropriate proactive care.
- CHRT1.16 Use, when appropriate, tools to assess readiness to change and techniques that motivate, educate and facilitate behavioural change.
- CHRT1.17 Negotiate secondary and tertiary prevention strategies for patients with chronic diseases, taking into account the presence of risk factors, the stage of the disease and the potential for a changing risk/benefit ratio of medications or other treatments used for the disease over time.
- CHRT1.18 Assess the patient's understanding of their condition and educate them on how their condition may affect their quality of life.
- CHRT1.19 Assist patients to contact others with similar conditions and/or relevant support organisations.

2. Applied professional knowledge and skills

- CHRT2.1 Understand the principles of diagnosis, management and monitoring of chronic diseases and comorbidities and how these may relate to the disease course over time.
- CHRT2.2 Understand the natural history, prognosis, treatment and management of chronic conditions commonly encountered in general practice, including the ways in which some treatments may affect patients.
- CHRT2.3 Understand how the presence of comorbidities can affect disease prognosis and management.
- CHRT2.4 Understand the relevant anatomy, physiology, pathology and psychology appropriate to the management of common chronic conditions, the current best evidence for their management and the potential harms of pharmacological and nonpharmacological forms of treatment.
- CHRT2.5 Identify relevant risk factors for future health events in the context of chronic disease, including adverse effects of medications and other medical interventions used to manage chronic disease.
- CHRT2.6 Identify medical, nursing, allied health, pharmacy and other health professionals involved in the care of patients with chronic diseases.
- CHRT2.7 Understand the importance, benefits and limitations of medical generalists in the provision of care for chronic conditions.
- CHRT2.8 Be able to take a history and examine patients for internal medicine and chronic conditions that are relevant to high quality general practice.
- CHRT2.9 Evaluate the physical, psychological and social levels of function and disability.
- CHRT2.10 Identify barriers that affect patients accessing optimal care for their chronic conditions and formulate practical strategies that they can adopt to help overcome these barriers.
- CHRT2.11 Use appropriately written records (eg. patient records including referral letters and correspondence, prescriptions, previous results of investigations) to gather relevant patient history.
- CHRT2.12 Identify and implement practical and pragmatic approaches to managing chronic diseases and comorbidity in the context of general practice that take into account the inherent uncertainty and complexity in biopsychosocial domains.
- CHRT2.13 Utilise techniques that support and maintain healthy lifestyle changes (eg. motivational interviewing, appropriate referral to other healthcare and specialist providers).

- CHRT2.14 Understand how to refer patients with chronic diseases to other members of the multidisciplinary team and liaise with team members regarding patient care.
- CHRT2.15 Use systematic approaches to case management, care co-ordination and advocacy (demonstrating an understanding of the need for continuity of care and remedial action as appropriate), including effective follow up and review processes for chronically ill patients.
- CHRT2.16 Critically reflect on emergent evidence based patient management information and implement appropriate modifications to existing management plans.
- CHRT2.17 Implement established methods to assure quality control such as periodic clinical audits to assure quality of care in patients with chronic disease.
- CHRT2.18 Embrace new technologies that have been demonstrated to improve health outcomes.

3. Population health and the context of general practice

- CHRT3.1 Understand the meaning of chronic illness and disease and the variable impact it has on the quality of life of an affected person, their family and the community.
- CHRT3.2 Understand the environmental, social, cultural and economic factors which contribute to the development and persistence of chronic conditions.
- CHRT3.3 Utilise the various health and community resources available for the support, prevention, diagnosis and management of chronic conditions.
- CHRT3.4 Understand government policies and administrative requirements which relate to assisting people with chronic conditions, including chronic care Medicare item numbers.
- CHRT3.5 Help and support patients to overcome barriers related to their chronic condition (including stigmatisation, stoicism, social stereotyping and cultural norms).
- CHRT3.6 Understand the problems faced by patients (and their families and carers) in fulfilling underlying needs for better social support, coping skills and sense of patient autonomy and control.
- CHRT3.7 Understand the chronic health problems of specific community groups (eg. Aboriginal and Torres Strait Islander people, people from culturally and linguistically diverse backgrounds and people with developmental disabilities).
- CHRT3.8 Use screening procedures to identify asymptomatic individuals at risk for common chronic diseases, and for those with existing chronic conditions (secondary prevention).
- CHRT3.9 Advocate for people with chronic conditions to support their access to services, benefits and entitlements.
- CHRT3.10 Understand the need to balance decisions that affect populations and the individual (eg. allocation of funding).
- CHRT3.11 Work effectively in a team, and where appropriate, as team leader to provide optimal care to people with chronic disease.
- CHRT3.12 Identify opportunities for prevention of chronic disease, especially within high risk groups.

4. Professional and ethical role

- CHRT4.1 Actively participate in multidisciplinary primary care teams.
- CHRT4.2 Understand the GP's role in shared and continuing care with hospital specialist teams.
- CHRT4.3 Provide support to patients and their families throughout the illness, and especially at times of crisis and change in the disease or treatment.
- CHRT4.4 Provide support at times of transition through the healthcare system (eg. on discharge from hospital).
- CHRT4.5 Implement methods for monitoring and evaluating quality long term care, and changing in response to feedback.
- CHRT4.6 Implement the ethical principles underlying the care of patients with chronic conditions in general practice (eg. concerning informed consent, privacy, autonomy, legitimacy and issues associated with end-of-life).
- CHRT4.7 Undertake home and nursing home visits and discuss the importance of these services in the management of chronic conditions.
- CHRT4.8 Actively develop team leadership skills.
- CHRT4.9 Effectively engage other members of the multidisciplinary team or wider health service networks in appropriate educative activities, including reinforcement of key messages.

5. Organisational and legal dimensions

- CHRT5.1 Develop, maintain, co-ordinate and evaluate disease management programs, including recall and prompted care systems, both within general practice and with multidisciplinary teams.
- CHRT5.2 Use and have readily accessible current evidence based guidelines for chronic disease management.
- CHRT5.3 Be aware of currently funded programs to assist in the management of chronic conditions (eg. National Chronic Disease Strategy).
- CHRT5.4 Provide timely, accurate and evidence based information to patients and carers on relevant chronic diseases.
- CHRT5.5 Use medical record systems appropriate to the care of patients with chronic conditions (eg. effective long term follow up, tracking and prompted systematic periodic review).
- CHRT5.6 Have strategies for time management, taking into consideration heavy demands on time and effort when managing complex medical problems and chronically ill patients.
- CHRT5.7 Use modern medical information systems effectively to assist in the prevention, diagnosis and management of chronic conditions.
- CHRT5.8 Be aware of ethical considerations in team approaches to healthcare (eg. sharing of health records).
- CHRT5.9 Be able to discuss the legal and advocacy aspects of chronic conditions (eg. certification, confidentiality, legal report writing, legal requirements of prescribing and refusal, withholding and withdrawal of treatment).
- CHRT5.10 Understand the full potential of computer records and e-health measures in disease management and prevention, including the use of electronic communication between other healthcare providers.
- CHRT5.11 Understand the importance of involving practice staff in the care of people with chronic disease, and their carers.

Learning objectives across the GP professional life

Medical student

1. Communication skills and the patient-doctor relationship

- CHRLM1.1 Describe the use of appropriate verbal and nonverbal communication techniques (eg. open and closed questioning, reflection, summarising) to gather additional history from patients and, when appropriate, family members, carers and/or other members of the multidisciplinary team, especially relating to lifestyle factors and chronic disease.
- CHRLM1.2 Outline the assessment of adherence to medication regimens and sympathetically ascertain from the patient or, where appropriate, family members, carers and/or other members of the multidisciplinary team factors contributing to adherence.
- CHRLM1.3 Explain the need for specific physical examinations to be made in the context of a specific consultation at one point of time and obtain the patient's consent or, where appropriate, the consent of family members or carers to perform those examinations.
- CHRLM1.4 Outline effective communication of diagnoses of chronic diseases including comorbidities, acute exacerbations and/or acute complications of the disease to patients and, when appropriate, family members, carers and/or other members of the multidisciplinary team.
- CHRLM1.5 Outline the role of indicated tests and investigations (including pre- and post-test counselling) at different time points in the disease journey for prevalent chronic diseases (including at times of potential acute exacerbation or acute complication) and obtain the patient's consent or, where appropriate, the consent of family members or carers to perform those tests or investigations. Outline the same for tests and investigations that are not indicated.
- CHRLM1.6 Outline principles for communicating test and investigation results in the context of particular chronic diseases to patients and, when appropriate, family members, carers and/or other members of the multidisciplinary team.
- CHRLM1.7 Describe the use of a patient centred, supportive approach and develop ongoing relationships that help patients with chronic conditions to take as much responsibility as possible for their own health outcomes.
- CHRLM1.8 Describe the role of gaining an understanding of the patient's knowledge, attitudes and meaning of their illness.
- CHRLM1.9 Describe the use of patient centred communication in improving chronic disease health outcomes.
- CHRLM1.10 Describe the principles in negotiating and documenting appropriate management plans to maximise patients' wellbeing, autonomy and personal control of their chronic disease outcomes, emphasising a shared approach to decision making.
- CHRLM1.11 Describe attitudes and behaviours related to chronic conditions that may be barriers to positive health outcomes, including stigmatisation, stoicism, social stereotyping and cultural norms.

2. Applied professional knowledge and skills

- CHRLM2.1 Describe relevant history and examination skills for high quality management of internal medicine and chronic conditions.
- CHRLM2.2 Describe the principles of diagnosis, management and monitoring of chronic diseases and comorbidities and how these may relate to the disease course over time.
- CHRLM2.3 Outline the natural history, prognosis, treatment and management of the chronic conditions commonly encountered in general practice, including the differing ways in which treatments may affect some people.
- CHRLM2.4 Describe how the presence of comorbidities can affect disease prognosis and management.
- CHRLM2.5 Describe various physical, psychological and social levels of function and disability.
- CHRLM2.6 Outline the relevant anatomy, physiology, pathology and psychology appropriate to the management of common chronic conditions, the current best evidence for their management and the potential harms of pharmacological and nonpharmacological forms of treatment.
- CHRLM2.7 Describe the relevant risk factors for the future development of chronic disease, including adverse effects of medications and other medical interventions used to manage chronic disease.
- CHRLM2.8 Describe systematic approaches to case management, care coordination and advocacy, including effective follow up and review processes for chronically ill patients.
- CHRLM2.9 Describe the physical and mental status of patients with chronic conditions.
- CHRLM2.10 Describe the appropriate use of tools to assess readiness to change and techniques that motivate, educate and facilitate behavioural change for chronic disease control.

3. Population health and the context of general practice

- CHRLM3.1 Outline the meaning of chronic illness and disease, and the variable impact it has on the quality of life of the patient, their family, and the community.
- CHRLM3.2 Describe appropriate screening procedures required to identify asymptomatic individuals, individuals at risk of common chronic diseases, and those who already have chronic conditions (secondary prevention).
- CHRLM3.3 Describe the use of evidence based guidelines for chronic disease management.
- CHRLM3.4 Describe barriers that affect patients accessing optimal care for chronic conditions and practical strategies that can be adopted to overcome these barriers.
- CHRLM3.5 Describe the environmental, social, cultural and economic factors which contribute to the development and persistence of chronic conditions.
- CHRLM3.6 Describe the problems faced by patients (and their families and carers) in fulfilling underlying needs for better social support, coping skills and sense of patient autonomy and control.
- CHRLM3.7 Outline the chronic health problems of specific community groups (eg. Aboriginal and Torres Strait Islander people, people from culturally and linguistically diverse backgrounds and people with developmental disabilities).
- CHRLM3.8 Outline the balancing of policy decisions that affect populations and the individual (eg. allocation of funding).

4. Professional and ethical role

- CHRLM4.1 Outline how to provide support at times of crisis and transition (eg. at time of diagnosis).
- CHRLM4.2 Describe the GP's role as part of a multidisciplinary team in providing optimal care to people with a chronic disease in the primary care setting.
- CHRLM4.3 Outline the ethical principles underlying the care of patients with chronic conditions in general practice (eg. consent, privacy, autonomy, legitimacy and issues associated with end-of-life) within the hospital setting.

5. Organisational and legal dimensions

- CHRLM5.1 Identify and describe the medical, nursing, allied health, pharmacy and other health professionals involved in the care of patients with chronic diseases.
- CHRLM5.2 Describe methods of managing patients with chronic disease.
- CHRLM5.3 Describe the full potential of computer records in disease management and prevention, including the use of electronic communication between other healthcare providers and patient recall systems.
- CHRLM5.4 Describe the various health and community resources available for the support, prevention, diagnosis and management of chronic conditions.
- CHRLM5.5 Describe the role of assisting patients to contact others with similar conditions and relevant support organisations, such as self help groups.

Learning objectives across the GP professional life

Prevocational doctor

Assumed level of knowledge – medical student

1. Communication skills and the patient-doctor relationship

- CHRLP1.1 Demonstrate the use of appropriate verbal and nonverbal communication techniques (eg. open and closed questions, reflection, summarising) in the hospital setting to gather additional history from patients and, when appropriate, from family members, carers, and other members of the multidisciplinary team, especially relating to lifestyle factors and chronic disease.
- CHRLP1.2 Demonstrate the nonjudgmental assessment of adherence to medication regimens and sympathetically ascertain from the patient, or where appropriate, family members, carers, and/or other members of the multidisciplinary team, factors contributing to adherence in the hospital setting.
- CHRLP1.3 Demonstrate the ability to effectively communicate diagnoses of chronic disease(s) including comorbidities, acute exacerbations and/or acute complications of the diseases to patients and, when appropriate, family members, carers, and/or other members of the multidisciplinary team.
- CHRLP1.4 Demonstrate the ability to explain the role of indicated tests and investigations (including pre- and post-test counselling) at different time-points in the disease course for prevalent chronic diseases (including at times of potential acute exacerbation or acute complication) and obtain patient consent (or the consent of a family member or carer where appropriate) to perform those tests/investigations. Demonstrate the same for tests and investigations that are not indicated.
- CHRLP1.5 Demonstrate the ability for communicating test and investigation results in the context of particular chronic diseases to patients and, when appropriate, family members, carers, and/or other members of the multidisciplinary team in the hospital setting.
- CHRLP1.6 Demonstrate use of a patient centred, supportive approach and develop ongoing relationships that help patients with chronic conditions to take as much responsibility as possible for their own chronic disease outcomes.
- CHRLP1.7 Demonstrate an ability to gain an understanding of the patient's knowledge, attitudes and meaning of their illness in the hospital setting.
- CHRLP1.8 Demonstrate the use of patient centred communication in improving chronic disease health outcomes in the hospital setting.
- CHRLP1.9 Demonstrate the negotiation and documentation of appropriate management plans to maximise patients' wellbeing, autonomy and personal control of their chronic disease health outcomes, emphasising a shared approach to management decisions in the hospital setting.
- CHRLP1.10 Outline approaches for the long term management of patients who do not respond to, or co-operate with, medical management.

2. Applied professional knowledge and skills

- CHRLP2.1 Demonstrate history and examination skills for internal medicine and chronic conditions that are relevant to high quality hospital based medicine.
- CHRLP2.2 Demonstrate the ability to assess physical, psychological and social levels of function and disability in the hospital setting.
- CHRLP2.3 Demonstrate the appropriate use of tools to assess readiness to change and techniques that motivate, educate and facilitate behavioural change for chronic disease control in the hospital setting.
- CHRLP2.4 Demonstrate the ability to be responsive and empathetic to fluctuations in the physical and mental state of patients with chronic conditions in the hospital setting.
- CHRLP2.5 Demonstrate support for overcoming barriers to positive health outcomes for people with chronic attitudes and behaviours including stigmatisation, stoicism, social stereotyping and cultural norms.
- CHRLP2.6 Demonstrate the ability to identify the relevant risk factors for the future development of chronic disease, including adverse effects of medications and other medical interventions used to manage chronic disease in the hospital setting.
- CHRLP2.7 Demonstrate use of all information sources (eg. patient records, including referral letters, prescriptions, previous results of tests and investigations to gather relevant patient history) when formulating management plans.
- CHRLP2.8 Demonstrate systematic approaches to case management, care co-ordination and advocacy, including effective follow up and review processes for chronically ill patients in the hospital setting.

3. Population health and the context of general practice

- CHRLP3.1 Demonstrate the ability to identify barriers impacting on patients' accessing optimal care for their chronic conditions in the hospital setting and practical strategies patients can adopt to overcome these barriers.
- CHRLP3.2 Demonstrate appropriate screening procedures required to identify asymptomatic individuals at risk of common chronic diseases, and those who already have chronic conditions (secondary prevention).
- CHRLP3.3 Review opportunities for the prevention of chronic disease, especially among high risk groups.

4. Professional and ethical role

- CHRLP4.1 Demonstrate the capacity to work effectively in a team and as a team leader to provide optimal care to people with a chronic disease.
- CHRLP4.2 Provide support at times of transition through the healthcare system (eg. on discharge from hospital).
- CHRLP4.3 Describe the ethical principles underlying the care of patients with chronic conditions in general practice (eg. consent, privacy, autonomy, legitimacy, and issues associated with end-of-life) within the hospital setting.
- CHRLP4.4 Be aware of ethical considerations of team approaches to healthcare (eg. sharing of health records).
- CHRLP4.5 Describe the legal and advocacy aspects of chronic conditions (eg. certification, confidentiality, legal report writing, legal requirements of prescribing and refusal, withholding and withdrawal of treatment).

5. Organisational and legal dimensions

- CHRLP5.1 Demonstrate the use of evidence based guidelines for chronic disease management.
- CHRLP5.2 Identify and describe the relevant medical, nursing, allied health, pharmacy and other health professionals involved in the care of patients with chronic diseases in the hospital setting.
- CHRLP5.3 Demonstrate the use of the various health and community resources available for the support, prevention, diagnosis and management of chronic conditions.
- CHRLP5.4 Describe how hospital links to general practice in methods of managing patients with chronic disease.
- CHRLP5.5 Demonstrate appropriate and effective referral and liaison of patients with chronic diseases to other members of the multidisciplinary team in the hospital setting.
- CHRLP5.6 Demonstrate the appropriate referral of assisting patients to contact others with similar conditions and relevant support organisations, such as self help groups, in the hospital setting.
- CHRLP5.7 Discuss strategies for time management, taking into consideration demands on time and effort when managing complex medical problems and chronically ill patients.

Learning objectives across the GP professional life

Vocational registrar

Assumed level of knowledge – prevocational doctor

1. Communication skills and the patient-doctor relationship

- CHRLV1.1 Demonstrate the use of appropriate verbal and nonverbal communication techniques (eg. open and closed questions, reflection, summarising) in the general practice setting to gather additional history from patients, and, when appropriate, from family members, carers, and other members of the multidisciplinary team, especially relating to lifestyle factors and chronic disease.
- CHRLV1.2 Demonstrate the nonjudgmental assessment of adherence to medication regimens and sympathetically ascertain from the patient or, where appropriate, family members, carers, and/or other members of the multidisciplinary team, factors contributing to adherence in the general practice setting.
- CHRLV1.3 Demonstrate the ability for communicating test and investigation results in the context of particular chronic disease(s) to patients and, when appropriate, family members, carers, and/or other members of the multidisciplinary team in the general practice setting.
- CHRLV1.4 Demonstrate use of a patient centred, supportive approach and discuss how to develop long term relationships to help patients with chronic conditions take as much responsibility as possible for their own chronic disease health outcomes in the general practice setting.
- CHRLV1.5 Demonstrate the ability to gain an understanding of the patient's knowledge, attitudes and meaning of their illness in the general practice setting.
- CHRLV1.6 Demonstrate use of patient centred communication in improving chronic disease health outcomes in the general practice setting.
- CHRLV1.7 Demonstrate the negotiation and documentation of appropriate management plans to maximise patients' wellbeing, autonomy and personal control of their chronic disease health outcomes, emphasising a shared approach to management decisions in the general practice setting.
- CHRLV1.8 Demonstrate systematic approaches to case management, care co-ordination and advocacy, including effective follow up and review processes for chronically ill patients in the general practice setting.
- CHRLV1.9 Demonstrate the ability to perform appropriate medical procedures for chronic disease management in the general practice setting.
- CHRLV1.10 Demonstrate skills to support patients who do not respond to, or co-operate with, medical management in the general practice setting.

2. Applied professional knowledge and skills

- CHRLV2.1 Demonstrate history and examination skills for internal medicine and chronic conditions appropriate to high quality general practice.
- CHRLV2.2 Demonstrate the ability to identify the relevant risk factors for the future development of chronic disease, including adverse effects of medications and other medical interventions used to manage chronic disease in the general practice setting.
- CHRLV2.3 Demonstrate negotiation of secondary and tertiary prevention strategies for patients with chronic disease, taking into account the presence of risk factors, disease stage and potential for changing risk/benefit ratio of medications or other treatments used over time in the general practice setting.
- CHRLV2.4 Demonstrate the appropriate use of tools to assess a patient's readiness to change and techniques that motivate, educate and facilitate behavioural change for chronic disease control in the general practice setting.
- CHRLV2.5 Demonstrate the ability to assess various physical, psychological and social levels of function and disability in the general practice setting.
- CHRLV2.6 Demonstrate the ability to identify and implement practical and pragmatic approaches to managing chronic diseases and comorbidities that take explicit account of the uncertainties and complexities across biopsychosocial domains in the general practice setting.
- CHRLV2.7 Demonstrate the use of techniques to support and maintain healthy lifestyle changes (eg. motivational interviewing, appropriate referral to other primary healthcare providers and/or specialist providers).
- CHRLV2.8 Demonstrate the ability to be responsive and empathetic to fluctuations in the physical and mental state of patients with chronic conditions in the general practice setting.

3. Population health and the context of general practice

- CHRLV3.1 Outline current government chronic disease program policies which relate to assisting people with chronic conditions in the general practice setting.
- CHRLV3.2 Demonstrate the ability to identify barriers impacting on patients' access to optimal care for their chronic conditions in the general practice setting and practical strategies patients can adopt to overcome these barriers.
- CHRLV3.3 Describe appropriate screening procedures required to identify asymptomatic individuals, individuals at risk for common chronic diseases, and those who already have chronic conditions (secondary prevention) in the primary care setting.

4. Professional and ethical role

- CHRLV4.1 Demonstrate the provision of support at times of crisis and transition (eg. at time of diagnosis).
- CHRLV4.2 Demonstrate the capacity to work effectively, either within a team or as a team leader to provide optimal care to people with chronic disease in the primary care setting.
- CHRLV4.3 Demonstrate application of ethical principles underlying the care of patients with chronic conditions in general practice (eg. consent, privacy, autonomy, legitimacy, and issues associated with end-of-life).
- CHRLV4.4 Demonstrate the review of new technologies that have been shown to improve health outcomes for people with chronic conditions.

5. Organisational and legal dimensions

- CHRLV5.1 Demonstrate methods of managing patients with chronic disease.
- CHRLV5.2 Demonstrate ready access to and use of evidence based guidelines for chronic disease management.
- CHRLV5.3 Identify and describe the roles of relevant medical, nursing, allied health, pharmacy and other health professionals involved in the care of patients with chronic diseases in the general practice setting.
- CHRLV5.4 Demonstrate the use of the various health and community resources available for the support, prevention, diagnosis, and management of chronic conditions available to your general practice population.
- CHRLV5.5 Demonstrate appropriate and effective referral and liaison of patients with chronic diseases to other members of the multidisciplinary team in the general practice setting.
- CHRLV5.6 Incorporate new technologies that have been demonstrated to improve health outcomes for people with chronic conditions.
- CHRLV5.7 Demonstrate advocacy for people with chronic conditions to support their access to services, benefits and entitlements in the primary care setting.
- CHRLV5.8 Outline the management of chronic conditions as they apply to house and nursing home visits.
- CHRLV5.9 Demonstrate how to appropriately assist patients to contact others with similar conditions and relevant support organisations, such as self help groups, in the general practice setting.
- CHRLV5.10 Demonstrate use of government policies and administrative requirements that relate to assisting people with chronic conditions.

Learning objectives across the GP professional life

Continuing professional development

Assumed level of knowledge – vocational registrar

1. Communication skills and the patient-doctor relationship

- CHRLC1.1 Outline the general practice systems relating to the maintenance, coordination and evaluation of disease management programs, including recall and prompted care systems and involvement of multidisciplinary teams.
- CHRLC1.2 Demonstrate the ongoing negotiation and documentation of appropriate management plans to maximise patients' wellbeing, autonomy and personal control of their chronic disease health outcomes, emphasising a shared approach to management decisions in the general practice setting.
- CHRLC1.3 Review processes for supporting patients who do not respond to, or co-operate with, medical management in the general practice setting.

2. Applied professional knowledge and skills

- CHRLC2.1 Demonstrate critical reflection and implement modifications to approaches for general practice chronic disease management as new evidence based patient management approaches emerge.

3. Population health and the context of general practice

- CHRLC3.1 Demonstrate review of government chronic disease programs and policies that relate to assisting people with chronic conditions in the general practice setting.

4. Professional and ethical role

- CHRLC4.1 Consider ongoing review of leadership skills with respect to multidisciplinary team management and chronic conditions.
- CHRLC4.2 Demonstrate the role in shared care and ongoing care with hospital specialist teams.

5. Organisational and legal dimensions

- CHRLC5.1 Demonstrate ongoing review of the relevant medical, nursing, allied health, pharmacy and other health professionals involved in the care of patients with chronic diseases, within your general practice and local community setting.
- CHRLC5.2 Demonstrate regular review of health and community resources available for the support, prevention, diagnosis and management of chronic conditions available to your general practice population.
- CHRLC5.3 Demonstrate the implementation of methods for monitoring and evaluating quality long term care and responsiveness to feedback.

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