

**Carmel M Martin**

MBBS, MSc, PhD, MRCGP, FRACGP, is Associate Professor of Family Medicine, Northern Ontario School of Medicine, Ottawa, Canada. cmartin@cmartin.ca

Chris Peterson

PhD, Honorary Research Fellow, School of Social Sciences, La Trobe University, Victoria.

Improving chronic illness care

Revisiting the role of care planning

Background

Chronic illness is increasingly being recognised as a widespread, debilitating and costly burden. Most models of care used in the acute care setting are inappropriate for chronic illness and are costly.

Objective

This article examines the goals of chronic illness care in the Australian general practice context and related issues from a conceptual perspective. It describes developments in care planning in Australia, particularly Medicare payments for care planning, and discusses how such developments can assist general practitioners in patient care. A case study of an Aboriginal patient with chronic illness is described to illustrate the issues discussed.

Discussion

Care planning/management based on a partnership model can bring about some success in management, even with the most difficult cases. Illness support, management of rest of life conditions and treatment and self management of disease are required. Care planning/management items, as part of the Enhanced Primary Care program provide incentive payments to address key models of improving complex chronic care. This can result in improved system organisation and self management of chronic illness.

■ **The number of deaths worldwide from chronic, noncommunicable disease is estimated to rise from 60 to 73% or higher by 2020, creating an increasing demand for care. Chronic disease affects about 25% of the Australian population; the majority over 65 years of age. This prevalence is likely to increase as the population ages. The top 10 diseases in Australia are chronic, and these are responsible for 43% of the total burden of disease.¹ Chronic illness – a broader term than disease – encompasses patients' lived experience of chronic disease and its morbidity burden.**

Chronic disease management requires a care plan devised by a health care provider. In the Australian primary care setting much chronic care is provided by the general practitioner. However, the two major models of chronic disease management – the Wagner model, emphasising service integration – and the model based on Lorig, emphasising the patient journey, have emerged from USA hospital based experience with minimal development of the family doctor's role.^{2,3}

In the past decade, the Australian Government introduced payments in the Medicare system – based upon the Department of Veterans' Affairs initial model⁴ – for service items that reflect both the goals and complexity of chronic illness care and the time required by GPs to provide such care – the Enhanced Primary Care (EPC) items.⁵

These items encompass care planning, case conferencing for patients of all ages, and health assessments for the elderly. They recognise the different needs of Aboriginal people. In some cases, these items are part of much larger pilot schemes of system redesign such the coordinated care trials.⁶ Central to the incentives for improved chronic illness care are the Medicare funded General Practice Care Plans for those with chronic disease with complex care needs, based on previous work conducted by the Department of Veterans' Affairs.⁷ The number of Medicare funded care plans conducted by GPs has increased from 5408 early in their introduction in 2000, to 406 172.⁵ These items were revised and adapted to remove considerable 'red tape'. Statistics indicate that, in the final

quarter of 2006, almost 1 million Australians have been involved in care plans for complex chronic illness care.⁵

The following case study shows the complexities that can be involved with chronic illness management.

Case study

Josie, an Aboriginal woman in her mid 50s, provides a good example of how chronic illness takes place within the context of a person's emotional and social life. She describes many worries and severe hardship, both physical and emotional, over the years. Josie has a nervousness about her; she fidgets a lot and moves around constantly as she talks with you. She is trying to give up smoking. She claims she has 'tried everything' and seems unhelpful about her chances of ever giving up. She says that her illness [emphysema] had killed her mother and her sister 18 months after they were diagnosed. She expected a similar fate and that it would be 18 months since her diagnosis a little later in the year.

For Josie, smoking with already damaged lungs is a major problem. However the disease model can only offer help in diagnosis and perhaps the best drugs to use. Josie's GP, Dr Mark, finds the chronic disease management and risk factor reduction extremely challenging, within an evidence based disease management and self management guidelines framework. Dr Mark describes their interaction: Josie comes to see me before she goes for her appointments to the chest clinic. She is always very anxious because they will lecture her about her smoking. She says: 'The smokes are the only thing that keep me going. You tell them doc'. I really feel that all I can do is support her. We have tried a lot of strategies. She does give up for a while, but as soon as life pressures build up, she relapses. We try to work out strategies to deal with the crises in her life.

Josie has many health problems including cervical cancer. The diagnosis of a chronic illness such as cancer and the treatment, including surgery, may completely disrupt already vulnerable families with the result that the ill person is left bereft, for example: Josie: 'I got [the operation] done on the 1 August and me husband chucked me out on the 23 August. My husband wouldn't let me see the kids. That nearly destroyed me. So I had to go and see a shrink... I thought well I wouldn't fight him, you know. So I didn't. I ended up with naught anyway'.

Josie's breathing has become steadily worse over the past 2 years and she appears to have lost the battle to keep her family together and her son out of trouble with the police.

Disease, illness and chronicity – what are they?

The discipline of general practice has long recognised that the features of chronic illness take its care beyond a disease based model into a biopsychosocial model.⁸ In the biological focus of this model the notion of disease predominates, with chronic illness, the quality of life or disability is a result not only of the disease but also of psychological and social aspects. There are many issues for the person and their family to come to terms with including dependence upon medical practitioners and health professionals, and the social, psychological and economic burden of chronic illness. Having a chronic illness is also expensive and for many people their lifestyle will be affected by additional costs.⁹

The burden of chronic disease is not spread evenly across the population. People from certain population groups (eg. lower socioeconomic or those with mental health issues) tend to experience more chronic disease.¹⁰

Goals of chronic illness care

Since 2000, there has been more emphasis on the role of self management for chronic illness care. This is where a plan is drawn up encompassing learning and other activities and skills.¹¹ This growth of self management programs has helped make patients more involved with their treatment regimens and provides a range of health and life skills that can support them through their illness.² However, it appears that the potential role of the GP may be underdeveloped in relation to both self management and social support in illness care in care plans.¹²

The role of general practice

Australian GPs have had little support or recognition of the care required for patients with chronic illness, and a lack of financial remuneration or appropriate resources to make such time consuming, emotionally draining and long term care viable. In addition, compared to some international colleagues, Australian GPs have had less access to nursing care in their practices. The relatively generous payments for EPC chronic illness care provide, at least for larger practices, the opportunity to buy in nursing care to support implementation of chronic illness strategies.¹³

Medical training for general practice endorses both disease and illness care based upon the biopsychosocial model. However, while the biopsychosocial model of care is highly appropriate for chronic illness care, it is poorly utilised in clinical practice. Chronic illness is managed by a significant proportion of GPs in a chronic physical disease or biomedical framework because that is the dominant model.

Constructing new models of care for chronic disease

In November 1999, the Australian Federal Government introduced a range of Medicare items under the EPC initiative. These items were in response to the demand for better opportunities to provide chronic illness care from GPs, and the need to develop financial structures which reflected the time and effort required by GPs in implementing chronic illness care. The items intended to provide more preventive care for older Australians and improve care coordination between GPs and other health professionals providing care for people of any age with chronic conditions and complex care needs.^{5,14}

In our case study, the items allowed Josie's GP to be funded to undertake the development of a multidisciplinary care plan to manage her care and to have case conferences with members of her multidisciplinary team if required. As Josie is an Indigenous Australian and over 55 years of age, her GP is also able to undertake a preventive health assessment with Josie.

Central to the EPC initiative is a shift from reactive, episodic care to longitudinal structured and comprehensive care. This integrates medical care with care from allied health professionals and other

disciplines such as teachers and probation officers whose role is inextricably linked to health outcomes in chronic illness.

What is care planning/management?

Increasingly, evidence indicates that chronic illness care is required to be structured, integrated and multidisciplinary. Care planning provides a model and a tool with which to provide this care.¹⁵ It also addresses the increasing desirability of consumer involvement in their own care by being a patient centred tool that focuses on their needs and goals.

Recent evaluations of care planning have demonstrated that the conduct of care plans can be associated with improved processes and outcomes of care.^{16–18} However, the same literature indicates some ambivalence and ambiguity about the actual tasks of care planning,¹⁸ how best to implement care planning,¹⁹ which patients would benefit, the benefits of a shared approach to planning²⁰ and the role of care planning in the changing roles of both the GP and the patient.^{6,21}

Care planning has traditionally been part of nursing, allied health professional and other care. Care planning/management assists the GP to monitor and review care over a set period of time. It involves:

- assessment of patient goals, their disease and illness impact and service profile
- participatory development of a management strategy for biopsychosocial care
- implementation of the care plan signed off by both patient and doctor
- monitoring and periodic review, and
- feedback and reassessment.

Care planning and approaches to management vary according to the individual patient, their phase of illness and context, and to the clinical context and style of the practice (*Table 1*).

A paradigm shift in thinking

The current model of health care focuses on disease, provider and institutional centred care. Locus of control is with practitioners – medical practitioners, nurses and other health professionals – and institutional requirements. Self management is seen as a mechanism for cost shifting. Its major focus is on individual disease prevention

and control through medical and surgical intervention. There are evidence based guidelines and disease management protocols, and economic interventions are based on controlling costs.

In our case study, Josie's psychosocial needs dominate her disease needs. The disease model centred in institutional care is failing her, except when she becomes very ill and needs rescuing. A humane system sees Josie at the centre of her care. Her journey through health, disease and illness is personal and the system needs to be flexible and adaptive to support her to optimise the quality of her life.

Policy, appropriate remuneration, ongoing evaluation, consumer advocacy, and provider leadership are required to shift from acute institutional centred care to person centred chronic disease and illness care.

Features for effective GP care planning/management

Four domains impact on the effectiveness of GP care planning: the patient, the GP, the practice, and the broader health system.

The patient

Patient interest and motivation to be involved in care planning and resources to participate in the interventions are central to successful outcomes. Our case study demonstrates that it is often less advantaged patients whose lives and illnesses are complex who most require a care plan and care management support. Considerable extra effort is often required in these situations, which can involve additional support work (often unfunded) beyond care planning. It is essential to involve family or other community support people in the care planning process. Additional local case management support is sometimes needed.

The GP

There is often resistance to care planning/management from GPs when faced with complex patients. Problems with red tape are still of concern, yet as practices have computerised and developed other solutions, there has been a demonstrable increase in care planning. International chronic disease models²² place the role of the GP and care planning as central to the future of chronic care, however, time and ongoing motivation is needed to support

Table 1. Care plan requirements according to patient characteristics^{7,8,11}

| Patient characteristics | Care plan requirements |
|--|--|
| Complex patient (multimorbidity) with a difficult medical problem requiring frequent investigations and hospital admissions | Plan centers on diagnosis and managing complications, comorbidities, multiple tests and medications. Also needs medical, illness and therapeutic care planning |
| 'Well' chronic disease patient | Plan involves secondary and tertiary prevention and ongoing rehabilitation (eg. lifestyle, psychosocial, physical interventions to slow down the disease, complications and comorbidities) |
| Frail older patient with complex aging impairments with some medical needs | Plan requires some disease prevention needs but mainly involves strategies to promote independence, improve quality of life and reduce the risk of institutionalisation |
| Aboriginal patients, within their community and value systems, or others, experiencing social exclusion through ethnicity, poverty, geography and life chances | May fit in any of the above groups Plan must also address social, financial or cultural issues |

GPs as they move from episodic care models to incorporate more structured chronic care.

General practice

Care planning, implementation and review are a time consuming process. A balancing act is required to balance within the practice, the number of patients with care plans that each doctor has as part of the case load to 'share the care'. Practice reorganisation and infrastructure support is needed. Certain systems can assist, for example, a practice list/database of patients with chronic illness with recall and reminder systems. Care plan reviews can be facilitated by the use of either a paper or computer based recall system.

Health system issues

Financial structures that recognise the time and effort involved for GPs in developing the care plan and providing new models for chronic illness care are needed. Currently, only GPs are directly funded through Medicare for their involvement in the development and review of care plans. This often means that non-GP contributions to care plans may be inadequately financed. In addition, there are difficulties in doctors and health professionals having the time and opportunity to liaise over care. Yet the funding of allied health professionals is enabled with care planning, so it genuinely provides access to services. The introduction of MBS item numbers is not sufficient to ensure the success of care planning. In rural and outer suburban city areas there are increasing reports of GP shortages. Regardless of remuneration, some doctors find that taking the time to do care plans for patients with complex health issues is at the cost of time with their other patients.²³ This relates in part back to workforce issues of recruitment and retention and workforce planning.

Care planning needs to be introduced slowly and with sufficient support to allow for a cultural shift among GPs and other health care providers, patients and policy makers. Feedback to Medicare and state and private health funding systems needs to continually adjust the 'carrots and sticks' around care planning in response to feedback from the stakeholders to gradually improve this activity. This knowledge translation into clinical (biopsychosocial) actions by the GP, and the wider health system, remains an international challenge.

Conclusion

Care planning is a significant paradigm shift in the provision of care for those with chronic illness. Perhaps this has not been sufficiently marketed; and knowledge translation only slowly results in a shift in practice. However, with increasing pressures on the health care dollar, an aging population, and increasing consumer expectations for care and technology, there will be a need to streamline care. Care planning/management, with ongoing adjustment to feedback, provides an incentive and a mechanism to assist GPs and their health professional colleagues to partner with those with chronic illnesses and complex conditions to improve their outcomes.

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References

1. Australian Institute of Health and Welfare. Australia's health. Canberra: AGPS, 2006.
2. Lorig K, Sobel D, Stewart A, et al. Evidence suggesting that a chronic disease self management program can improve health status while reducing utilization and costs: A randomized trial. *Med Care* 1999;37:5–14.
3. Wagner E. Chronic disease management: what will it take to improve care for chronic illness? *Eff Clin Pract* 1998;1:2.
4. Oswald J, Martin CM, McKay D. Health care plans for local medical officers – an educational resource. The Repatriation Comprehensive Care Scheme. May edn. Canberra: Commonwealth Department of Veterans' Affairs, 1999.
5. Enhanced Primary Care. Available at www.health.gov.au/internet/wcms/publishing.nsf/Content/Enhanced+Primary+Care+Program-1. [Accessed 21 July 2007].
6. Battersby M, Harvey P, Mills PD, et al. SA HealthPlus: a controlled trial of a statewide application of a generic model of chronic illness care. *Milbank Q* 2007;85:37–67.
7. Martin CM, Parbury L, McKay D, Hossian A. Effectiveness of Health Care Planning Evaluation Trial. Final report. Canberra: Department of Veterans Affairs, 1999. Available at www.dva.gov.au [Accessed July, 2001].
8. McWhinney I. A textbook of family medicine. 2nd edn. New York: Oxford University Press, 1997.
9. Lynn J, Adamson DM. Living well at the end of life: adapting health care to serious chronic illness in old age. USA: Rand Corporation, 2003.
10. World Health Organization. Innovative care for chronic conditions: building blocks for action. Available at www.who.int/diabetesactiononline/about/iccreport/en/index.html [Accessed 15 July 2007].
11. Swerisen H, Weeks A, Belfrage J, et al. A randomized control trial of a self-management program for people with a chronic illness from Vietnamese, Chinese, Italian and Greek backgrounds. *Patient Educ Couns* 2006;64:360–8.
12. Martin CM. Chronic disease and illness care: additional principles of family medicine are needed to address ongoing health system redesign. *Can Fam Physician* 2007; in press.
13. Oldroyd J, Proudfoot J, Infante F, et al. The views of Australian GPs about providing healthcare for people with chronic illness: a qualitative study. *Med J Aust* 2003;179:30–3.
14. The Royal Australian College of General Practitioners. Enhanced Primary Care Guidelines 2000. 2001. Available at www.racgp.org.au/.
15. Weingarten S, Henning J, E Badamgarav, et al. Interventions used in disease management programmes for patients with chronic illness: which ones work? Meta-analysis of published reports. *BMJ* 2002;325:925.
16. Preen DB, Bailey BE, Wright A, et al. Effects of a multidisciplinary, post-discharge continuance of care intervention on quality of life, discharge satisfaction, and hospital length of stay: a randomized controlled trial. *Int J Qual Health Care* 2005;17:43–51.
17. Zwar NA, Hermiz O, Comino EJ, Shortus T, Burns J, Harris M. Do multidisciplinary care plans result in better care for patients with type 2 diabetes? *Aust Fam Physician* 2007;36:85–9.
18. Shortus TD, McKenzie SH, Kemp LA, Proudfoot JG, Harris MF. Multidisciplinary care plans for diabetes: how are they used? *Med J Aust* 2007;187:78–81.
19. Fuller J, Harvey P, Misan G. Is client-centred care planning for chronic disease sustainable? Experience from rural South Australia. *Health Soc Care Community* 2004;12:318–26.
20. Jackson CL, Marley JE. A tale of two cities: academic service, research, teaching and community practice partnerships delivering for disadvantaged Australian communities. *Med J Aust* 2007;187:84–7.
21. Beilby JJ. Primary care reform using a layered approach to the Medicare Benefits Scheme: unpredictable and unmeasured. *Med J Aust* 2007;187:69–71.
22. Wagner EH, Austin BT, Von Korff M. Improving outcomes in chronic illness. *Manag Care Q* 1996;4:12–25.
23. Martin C, Rohan B. Chronic illness care as a balancing act. A qualitative study. *Aust Fam Physician* 2002;31:55–9.