Helen Bolger-Harris
RN, RM, GDipChild&FamHealthNurs, MPH, is a PhD candidate, School of Psychology, Deakin University, and Health Promotion Coordinator, Kingston-Bayside Primary Care Partnership, Victoria. ehpl@deakin.edu.au

Peter Schattner
MD, MMed, FRACGP, is Clinical Associate Professor, Department of General Practice, Monash University, Victoria.

Mary Saunders
BA(Hons), DipEd, DipHealthPromotion, is Program Manager, Monash Division of General Practice, Melbourne, Victoria.

Using computer based templates for chronic disease management

Background
General Practice Management Plans (GPMPs) and Team Care Arrangements (TCAs) were introduced in 2005 to promote better chronic disease management and to provide funding to support general practitioner involvement in care planning. To develop these plans, GPs complete forms documenting goals and strategies using computer based templates.

Objective
This article evaluates GP use of computer based templates for GPMPs and TCAs, their views about using them, and community health service (CHS) staff attitudes to the role of TCAs in coordination of care.

Method
A qualitative interview based study of 31 GPs from solo and group practices and 15 service providers from community health centres (n=46).

Discussion
Most GPs interviewed used templates in claiming the GPMP and TCA items. Reasons GPs chose not to use the items included time constraints and uncertainty about the process. Community health service staff identified difficulties with TCAs and care coordination. This study suggests that templates assist GPs in claiming for GPMP and TCA Medicare Benefits Schedule item numbers but do not in themselves facilitate care coordination. To improve care coordination between general practice and other agencies, communication regarding TCAs must be improved.

The chronic disease management (CDM) Medicare Benefits Schedule (MBS) items were introduced into the MBS schedule on 1 July 2005.[1] These items included General Practice Management Plans (GPMPs) and Team Care Arrangements (TCAs) which replaced the original care planning items. Previously, formal care planning had not been widely adopted by GPs,[2] so the rationale for the change was to facilitate care planning within the general practice setting (via GPMPs) and to improve the multidisciplinary care coordination process (via TCAs).[1]

There is limited evidence on the effectiveness of care plans in improving CDM.[3] In addition, there is little research on TCAs due to their recent introduction. However, use of previous care planning Medicare items and views on barriers to coordination of care were evaluated in one study.[4] From interviews with 30 GPs, this study concluded that although implementation of items facilitated collaboration between GPs and other health care professionals, other strategies were also required for integration to succeed.[4]

There are now several templates available for use with GPMPs and TCAs that are downloadable into general practice clinical software. The Monash Division of General Practice (MDGP) developed a range of generic and disease specific templates for GPMPs and TCAs based on best practice guidelines.[5] These were developed in response to requests from the division's member practices. Other divisions have also produced templates, as has the Australian Government Department of Health and Ageing.

Method

Aims

The aims of this study were to ascertain whether GPs use the available GPMP and TCA computer templates and their views on the utility of the templates. In addition, CHS staff attitudes were sought, regarding templates and the role of TCAs in coordination of care.

Setting

The study was conducted in the southern metropolitan Melbourne (Victoria) region comprising MDGP, Southcity GP Services (SGPS) and three community health centres (CHSs) within the Inner South East Partnership In Community Health (ISEPICH) Primary Care Partnership.

Participants

Two groups of participants were interviewed: GPs and CHS service providers.

Group one

The first group of participants were GPs within the MDGP and SGPS boundaries. Recruitment of these GPs was performed via a computer generated randomisation process of the respective membership databases in which GPs were randomly telephoned and invited to participate. Thirty-one GPs participated in the interviews representing a mix of solo and group practices and full and part time GPs (*Table 1*). Approximately four GPs in the MDGP and six GPs in SGPS declined to participate.

Group two

Participants in the second group were service providers from the three CHSs within the ISEPICH catchment. Providers interviewed were from a range of disciplines including duty/intake workers, allied health professionals, a program manager and a hospital admissions risk program (HARP) case manager. Recruitment involved directly targeting personnel within CHSs who had experience with TCAs.

Measures

GP interviews

General practitioners were interviewed using one of two interview schedules developed for the project based on whether the participants were users or nonusers of the CDM MBS items (*Table 1*). The interview schedules were piloted with two GPs outside the catchment. The principal themes of the interview schedules were the use of the templates and GPs' attitudes to using them. The schedules were developed via preliminary discussions with division staff. They comprised 13 questions for users of the Medicare items and nine for nonusers.

Users of the CDM MBS items were asked about their frequency of claiming the items, the chronic diseases with which they used the items, the types of templates they used, their views about them, and suggestions for improving the templates. Nonusers of the CDM MBS items were asked their reasons for not using them, their awareness of the templates, and if the availability of a suitable template would assist them in using the items in the future.

CHS service provider interviews

Community health service providers were interviewed using a third interview schedule developed for use during this project. It contained questions about how often they received TCAs, the formats used by GPs with TCAs, whether the TCAs aligned with their agency's intake processes and whether the information supplied in a typical TCA facilitated coordination of care.

Procedure

Semi-structured face-to-face interviews were conducted with 14 GPs in the MDGP and 17 in SGPS, representing approximately 10% and 8% of the total number of eligible GPs in each division respectively. Only one GP was interviewed from each practice to ensure a range of practices were represented. The average length of interviews was 20 minutes for users of the items and 10 minutes for nonusers. For convenience, one focus group interview of 1 hour duration was held with 15 providers from one of the CHS. Most service providers from the other CHS had no previous experience with TCAs. Six semi-structured interviews were conducted with the minority who had experience with TCAs.

Results

General practitioners who were users of the CDM MBS items made Medicare claims for them on average 1–5 times per month. Templates were used for a range of chronic conditions including diabetes, ischaemic heart disease, depression and osteoarthritis. The majority of respondents nominated 'private' health care providers as part of the TCAs, rather than 'publicly' funded providers.

The source of templates used varied greatly and included those supplied in the GPs' medical software, those developed by MDGP, and those developed by GPs themselves and/or others from their practice.

The advantages the GPs offered for using templates with these items were that they were quick to use, provided prompts, provided a checklist, were comprehensive, ensured guidelines were adhered

Table 1. Demographic profile of GPs interviewed

Division	No. of GPs interviewed	Gender	Solo/group practice	Full or part time in the practice	User/nonuser of CDM MBS items
Monash Division of General Practice	14	10 men 4 women	3 solo 11 group practice	2 part time 12 full time	11 users 3 nonusers
Southcity GP Services	17	12 men 5 women	1 solo 16 group practice	8 part time 9 full time	15 users 2 nonusers
Total	31	22 men 9 women	4 solo 27 group practice	10 part time 21 full time	26 users 5 nonusers

to and that their use meant the GP was less likely to have his or her claims for payment rejected by Medicare. The fact that the templates could be modified to meet the GPs' own perceived needs seemed to contribute to their usefulness.

Disadvantages identified regarding the templates were that there was too much duplication of information between GPMPs and TCAs, and they were too 'public service-like'. However, all GPs interviewed stated they would be less likely to complete the plans and claim the Medicare item numbers if they had no template.

The templates developed by MDGP were regarded favourably by GPs, especially the disease specific templates. General practitioners who used the MDGP templates were asked for suggestions to improve them. These included availability of templates that cater for patients with multiple chronic diseases and improved compatibility with all available GP software. Another suggestion was to lessen perceived duplication between GPMPs and TCAs, especially regarding past history and current medications.

Nonusers of the CDM MBS items were asked why they did not use them. Four out of the five GPs interviewed who were nonusers of the items were not aware that templates were available. Other reasons for nonuse included that they were too busy, they were unsure of the process involved or they believed the items were too 'business focused' and took away from 'real doctoring'.

Representatives from two of the three CHS consulted reported their agency rarely received TCAs, while one reported they regularly received them. Some providers reported they received TCAs via fax or mail but several usually only received a brief referral letter. Often the medical history and medication list were not included.

Community health service respondents stated that communication between the GP and the CHS staff member usually occurred at the initiation of a TCA and then again at the completion of service delivery. They felt this was inadequate. The CHS interviewees stated there was some confusion about their role and the GP's role regarding the TCA, eg. the expected frequency of communication and who should initiate this. Several CHS staff suggested that having access to a practice nurse could facilitate better communication between the practice and the CHS.

The templates therefore did not appear to provide all the information required by CHS as part of the referral process. The Victorian Statewide Referral Form (VSRF) is recommended, and in some instances, required for referral by GPs to primary care agencies in Victoria. However, there was apparent confusion about the purposes of TCAs and the VSRF, with the former being used for referrals by some of the GPs (for which it was not designed) rather than the VSRF. Several CHS staff stated, however, that they were supportive of GPs using both the TCA and VSRF together.

In view of the often long waiting lists at CHS, the providers were generally supportive of patients being referred to them following initial referral to private providers under the Allied Health Initiative,[6] provided the GP ensured that there was adequate communication about this. However, one CHS respondent stated that having patients attend another service before attending the CHS fragments the care given, and often that private providers tend to provide care for acute conditions, which may not be appropriate for chronic conditions. It was felt that TCAs did not clarify these matters.

Discussion

In their study on care plans for diabetic patients, Vagholkar et al[7] found that care plans contained limited documentation of clinical information. They suggested that care plan templates need to be more consistent and simpler to use in order to ensure minimum standards of documentation.[7]

Our study suggests that the use of templates appears to only assist GPs in their claiming of GPMP and TCA item numbers and does not necessarily facilitate care coordination. Care coordination is described as an important objective of TCAs.[1]

Several communication issues exist between general practice and CHS providers in terms of TCAs. The TCA appears to have been used more for administrative purposes than as a real tool for collaboratively planning and managing patient care. Providers from two of the three CHS stated they rarely received TCAs, despite a high uptake of the TCA MBS items in the local area. This apparent discrepancy is likely to be due to GPs referring to private providers and/or providers other than the CHS in those areas. In order to improve coordination of care between general practice and other agencies, communication regarding TCAs needs to be improved. Developing the role of practice nurses in the TCA process might be one avenue to achieve this. In addition, the role of TCAs in the referral process needs to be examined further to determine how the TCA is best used with other resources such as the VSRF.

While this study was undertaken in one region of a large city, some of the main factors identified, such as the value of templates in assisting GPs to fulfil Medicare requirements for CDM, are likely to apply to other regions. However, the small sample size in this study is a limitation and caution is needed in generalising these results to all GPs and CHS staff. There was also a risk of self selection bias as the health professionals who declined an interview may have held views different to those who agreed to be interviewed. Finally, using different data collection methods for the CHS staff interviews (one-on-one versus a focus group 'interview') may have resulted in a degree of bias because of possible 'group consensus' in the latter.

Implications for general practice

- Most GPs reported they would be less likely to claim the CDM MBS items without having access to a template/s. Therefore GPs can benefit from using computer based templates to assist in claiming these MBS item numbers.
- GPs might find it easier to use these MBS item numbers if they are able to overcome their perceived lack of time (eg. by obtaining the assistance of practice staff or a practice nurse).
- If GPs remain uncertain about how to develop GPMPs and TCAs, they should enlist guidance from sources such as their local division

of general practice, to assist their use of these MBS item numbers.
- CHS staff identified that TCAs do not necessarily facilitate care coordination.

Conflict of interest: none declared.

References

1. Department of Health and Ageing. New Medicare chronic disease management items replace Enhanced Primary Care (EPC) care planning items from 1 July 2005 Fact Sheet. Available at www.health.gov.au/internet/wcms/publishing.nsf/Content/648DE4B114E3370BCA257019007DB5C3/$File/factsheet.pdf [Accessed June 2007].
2. Blakeman T, Harris MF, Comino EJ, Zwar NA. Implementation of the enhanced primary care items requires ongoing education and evaluation. Aust Fam Physician 2001;30:75–7.
3. Zwar NA, Hermiz O, Comino EJ, Shortus T, Burns J, Harris MF. Do multidisciplinary care plans result in better care for patients with type 2 diabetes? Aust Fam Physician 2007;36:85–9.
4. Blakeman TM, Harris MF, Comino EJ, Zwar NA. Evaluating general practitioners' views about the implementation of the Enhanced Primary Care Medicare items. Med J Aust 2001;175:95–8.
5. Monash Division of General Practice. Templates for GP Management Plans and Team Care Arrangements. Available at www.monashdivision.com.au/resources/templates.htm#gp_management_plans_tca [Accessed June 2007].
6. Department of Health and Ageing. Medicare items for allied health services for people with chronic conditions and complex care needs Fact Sheet. Available at www.health.gov.au/internet/wcms/publishing.nsf/content/79299CE412BC11F4CA256F19003CB46A/$File/Allied%20Health%20%20fact%20sheet%201%20Jan%2006.pdf [Accessed February 2007].
7. Vagholkar S, Hermiz O, Zwar NA, Shortus T, Comino EJ, Harris M. Multidisciplinary care plans for diabetic patients: what do they contain? Aust Fam Physician 2007;36:279–82.

AFP CORRESPONDENCE afp@racgp.org.au