RACGP

Position Statement: General practice plays the lead role in the management of patients with multimorbidity

June 2014

Background

Multimorbidity, the presence of multiple chronic conditions in a single individual*, is both common and increasingly the norm in general practice patients.[1,2] It is estimated that approximately 50% of patients visiting general practice have two or more chronic conditions.[3,4] The prevalence of multimorbidity increases with age and as Australia's population ages, this figure is expected to grow.[1,5] However, multimorbidity is not restricted to the older population, with many younger patients requiring long-term management of multiple conditions.[2,6] It is a significant problem across all age groups, placing strain across the healthcare system, and its prevalence is increasing at a faster rate in socially disadvantaged populations.[7]

Individuals with multimorbidity face substantial challenges relating to the affordability of and access to ongoing care, as well as fragmentation of care, medication adherence and conflicting management advice.[1,8,9] In patients with a number of chronic conditions, treatment and management of one disease can often contribute to poorer outcomes of a co-existing disease.[10] Multimorbidity is associated with reduced quality of life, problems related to polypharmacy and increased risk of hospitalisation. These issues add to the burden of illness for patients with multimorbidity.[7, 11]

Health systems underpinned by strong primary care lead to better outcomes, lower costs and improved population health.[12] General practice is the cornerstone of the Australian health system, and is best placed to manage these patients, providing a central point of care as well as integrating care between multiple health and social practitioners, caregivers and the wider system.[5,9,13]

The RACGP is committed to supporting general practitioners (GPs) and their teams in taking a lead role in managing patients with multimorbidity by advocating for changes to the health system and by supporting them in their clinical practice.

1. General practice as the main coordinators of care

Patients with multimorbidity frequently transition between healthcare providers in the primary, secondary and tertiary care settings, leading to fragmented and poorly coordinated care.[8,14] General practice is best placed to provide person-centred, continuous and coordinated care to patients with multimorbidity.[15-17] Government support of this 'medical home' model is needed if the benefits of improved integration and communication between service providers, caregivers, individuals and the wider health system are to be achieved.[13]

GPs and their teams need adequate time to provide comprehensive, holistic and coordinated care for patients with multimorbidity.[16,18-19] Determining treatment priorities and providing care that optimises function and quality of life requires longer consultations and additional time coordinating care outside the regular consultation. This is a major issue not currently acknowledged and supported through the present health funding models.[13,15,18]

RACGP position

1.1. To best manage multimorbidity, the RACGP believes government recognition and support for GP-led person-centred models of care that integrate and coordinate care to improve patient outcomes and quality of life, is needed.

1.2. This should be supported by a government-funded model of care that improves access to multidisciplinary care and reflects the level of service complexity and comprehensiveness required for patients with multimorbidity.

*Multimorbidity is generally accepted as the presence of two or more diseases with some level of complexity or disability; however, the definition varies widely throughout the literature. In consultation with members and key stakeholders, the RACGP will develop a definition that is relevant and appropriate for Australian general practice.

2. Priority setting and clinical competence

A shift away from the single disease paradigm that dominates much of clinical care is urgently required. The complexity of multimorbidity means that a single disease approach to management, perpetuated by disease specific guidelines, is inadequate and may be harmful.[8,14] Clinicians need to be increasingly aware of complex interactions between diseases and conditions, address treatment burden and make decisions based on patient preference, available evidence, clinical expertise and experience.[10,20,21]

GPs need to become adept at working with patients to assess disease burden and impact, as well as prioritising treatment and management options.[18,22] GPs will need more relevant training and skills to be able to support decision making for these complex patients.[13]

RACGP position

2.1 The RACGP believes that educational and training organisations must work to equip GPs with the relevant skills to better assess and manage patients with multimorbidity.

3. Guidelines and information to support decision making

To support decision making, GPs need access to evidence-based clinical information at the point of care that is tailored to the needs of patients with multimorbidity. GPs need guidelines, tools and patient resources to assist them to better assess and manage patients with multimorbidity.[15,20] Specifically, GPs need information to assist in the development of comprehensive care plans that consider the impact of treatment burden, reduce adverse outcomes related to polypharmacy and disease/treatment interactions and promote medication adherence.[8,22,23] Additionally, GPs need patient information resources to facilitate shared decision making, navigate local service networks and encourage better self-management.[17,19,21,22]

RACGP position

3.1 Guideline developers must recognise that single disease guidelines need to better address the assessment and management of patients with multimorbidity.

3.2 To support the provision of information, we believe government investment in the development of tools, processes, information and services relevant to care of patients with multimorbidity is required.

3.3 This includes government support for the development of consumer information for the management and support of patients with multimorbidity.

3.4 The RACGP believes Medicare Locals (Primary Health Networks[†]) have an important role to play in facilitating GP access to information about appropriate local services.

Looking forward

The RACGP is committed to supporting all GPs and will work towards a sustainable and effective approach to managing multimorbidity, as outlined in this position statement. For queries or more information, contact the RACGP Quality Care team at qualitycare@racgp.org.au

[†] In May 2014, the Government announced the replacement of Medicare Locals with Primary Health Networks from 1 July 2015 www.budget.gov.au/2014-15/content/bp2/html/bp2_expense-14.htm

References

1. Fortin M, Soubhi H, Hudon C, Bayliss EA, van den Akker M. Multimorbidity's many challenges. BMJ 2007;334(7602):1016–7.
2. Mercer SW, Smith SM, Wyke S, O'Dowd T, Watt GC. Multimorbidity in primary care: developing the research agenda. Family Practice 2009;26(2):79–80.
3. Brett T, Arnold-Reed DE, Popescu A, Soliman B, Bulsara MK, Fine H, et al. Multimorbidity in patients attending 2 Australian primary care practices. Ann Fam Med 2013;11(6):535–42.
4. Britt H, Harrison C, Miller G, Knox S. Prevalence and patterns of multimorbidity in Australia. Med J Aust 2008;189:72-7.
5. Harrison C, Britt H, Miller G, Henderson J. Multimorbidity. Aust Fam Physician 2013;42(12):845.
6. Taylor A, Price K, Gill T, Adams R, Pilkington R, Carrangis N, et al. Multimorbidity – not just an older person's issue. Results from an Australian biomedical study. BMC Public Health 2010;10(1):718.
7. Uijen AA, van de Lisdonk EH. Multimorbidity in primary care: prevalence and trend over the last 20 years. Eur J Gen Pract 2008;14(Supp1):28–32.
8. Sinnott C, Mc Hugh S, Browne J, Bradley C. GPs' perspectives on the management of patients with multimorbidity: systematic review and synthesis of qualitative research. BMJ Open 2013;3:e003610.
9. Smith SM. Chronic diseases: what happens when they come in multiples? Br J Gen Pract 2007;57(537):268–70.
10. Campbell-Scherer D. Multimorbidity: a challenge for evidence-based medicine. Evid Based Med 2010;15(6):165–66.
11. Fortin M, Dubois M-F, Hudon C, Soubhi H, Almirall J. Multimorbidity and quality of life: a closer look. Health and Quality of Life Outcomes 2007;5:52.
12. Starfield B, Shi L, Grover A, Macinko J. The effects of specialist supply on populations' health: assessing the evidence. Health Aff (Millwood). 2005;Suppl Web Exclusives:W5-97-W5-107.
13. Salisbury C. Multimorbidity: redesigning health care for people who use it. Lancet 2012;380(9836):7–9.
14. Gilbert AL, Caughey GE, Vitry AI, Clark A, Ryan P, McDermott RA, et al. Ageing well: improving the management of patients with multiple chronic health problems. Australas J Ageing 2011;30(Suppl 2):32–7.
15. Guiding principles for the care of older adults with multimorbidity: an approach for clinicians: American Geriatrics Society Expert Panel on the Care of Older Adults with Multimorbidity. J Am Geriatr Soc 2012;60(10):E1-E25.
16. Mercer SW, Fitzpatrick B, Gourlay G, Vojt G, McConnachie A, Watt GC. More time for complex consultations in a high-deprivation practice is associated with increased patient enablement. Br J Gen Pract 2007;57(545):960–66.
17. Thiem U, Theile G, Junius-Walker U, Holt S, Thurmann P, Hinrichs T, et al. Prerequisites for a new health care model for elderly people with multimorbidity: the PRISCUS research consortium. Z Gerontol Geriatr 2011;44(2):115–20.
18. Kadam U. Redesigning the general practice consultation to improve care for patients with multimorbidity. BMJ 2012;345:e6202.
19. Smith SM, Soubhi H, Fortin M, Hudon C, O'Dowd T. Interventions for improving outcomes in patients with multimorbidity in primary care and community settings. Cochrane Database Syst Rev 2012;4:CD006560.
20. Guthrie B, Payne K, Alderson P, McMurdo ME, Mercer SW. Adapting clinical guidelines to take account of multimorbidity. BMJ 2012;345:e6341.
21. Tinetti ME, Fried TR, Boyd CM. Designing health care for the most common chronic condition – multimorbidity. JAMA 2012;307(23):2493–94.
22. Morris RL, Sanders C, Kennedy AP, Rogers A. Shifting priorities in multimorbidity: a longitudinal qualitative study of patient's prioritization of multiple conditions. Chronic Illn 2011;7(2):147–61.
23. Roland M, Paddison C. Better management of patients with multimorbidity. BMJ 2013;346:f2510.