Focus

Why would clinicians want to participate in disease management?

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KEY POINTS

- Disease management offers opportunities to change a number of the difficulties facing New Zealand general practice
- New Zealand GPs are naturally conservative and currently demoralised, and will need to see advantages before adopting disease management
- A shift in attitude to seeing teamwork as an opportunity not a threat is essential
- Disease management projects need to provide appropriate incentives, both financial and better patient outcomes
- Appropriate support and education for patients, doctors and other health professionals in disease management is essential to success

New Zealand general practice is currently characterised by relatively short 10- to 15-minute consultations, mainly initiated by patients for the treatment of their acute symptoms. The management of chronic disease is often fitted around this acute care ("while I am here can I have my diabetes script") and it remains largely unsystematic. This episodic care may be of a high standard, but has rarely been systematically planned to meet the longer term needs of patients with chronic illnesses. These needs include preventive as well as maintenance treatments. Patient care is rarely audited to assess whether it is effectively meeting the needs of patients. Patients, providers and funders have not agreed on suitable meaningful and measurable outcomes for even the most common chronic diseases. There is enthusiasm to change the style of consultation to one which stresses quality and is more patient-centred. One way to achieve both a quality- and patient-focused system of care for people with chronic illnesses is to adopt a disease management approach to patient care.

Disease management offers a systematic new approach which emphasises the central role of the primary care team in partnership with secondary care colleagues, and aims to improve the quality of care and health outcomes for patients.1 It has been defined as a systematic, population-based approach to identify persons at risk of a disease or its complications, intervene with specific programmes of care, and measure clinical and other outcomes.2 Of course, many of these interventions are already being undertaken by a number of GPs, some with the assistance of their Independent Practitioner Associations (IPAs).3 The difference is that disease management offers a comprehensive system of care, record-keeping and audit that can be applied across a number of conditions. It is the practice population which is seen as the focus of care, record-keeping and audit as well as the individual in each consultation.4

Disease management programmes in both New Zealand and the UK are still in their

infancy and have received relatively little published evaluation. However, in the US there is a longer history of care and disease management.5 Although it is difficult to extrapolate experience based on a different system of health care, there are some lessons to be learned from the US literature. It appears that to be successful, disease management projects need to be flexible and able to adapt to local conditions. Ample support and appropriate incentives need to be available for both patients and practitioners. In New Zealand it is likely that a successful disease management programme will be dependent on:

- supportive national and local political environment
- the practice environment and its ability to deliver a team approach6
- adequate systems including information management
- appropriate incentives
- access to education
- defined agreed outcomes
- realistic time frames and flexibility in the method of delivery.

Environment

1. Political

Encouraging clinicians to see both the opportunities and costs of participating in disease management programmes is a challenge for its champions. Threats include the low morale in general practice in New Zealand. Many GPs feel undervalued and threatened by the seemingly inexorable fragmentation of primary health care. Some chronic disease care could be provided outside general practice by commercial firms or others.5 Fear of the erosion of general practice, coupled with the belief that chronic disease care is core general practice business, should be a potent incentive for GPs to become involved in disease management. The opportunities presented by the political enthusiasm for disease management could be seen as an opportunity to improve care for our patients. However, this political "flavour of the month" also engenders suspicion that disease management will be another stick with which to beat the medical profession.

2. Local

Experience with guideline implementation indicates that local involvement and buy-in is essential for success. Disease management is likely to be no different. General practice must therefore be sufficiently organised at a local level to manage a disease management project. Few IPAs have sufficient resources of staff, clinical teams and systems to facilitate local development and implementation of such programmes even if funding were available. National implementation without local involvement is likely to be largely ignored. Unfortunately, one national organisation is cheaper and may be seen as more easily controlled. Relationships between GPs and secondary care have to be nurtured so that projects become mutually owned and accepted by all concerned in an individual person's care.

3. Practice

Practices currently vary greatly in their level of sophistication of information management and computerisation. Similarly, there is large variation in the degree of teamwork between nurses, doctors, administrative staff and pharmacists. The challenge for project managers is to design systems which service the spectrum from totally paper-based to fully electronic. Projects need to be permissive enough to allow both well-developed multidiscipli-nary teams and the solo doctor with no nurse to participate within their limitations. Practices need to be allowed to evolve, not be forced to join a revolution. Demand-led general practice is often said to be too busy for a systematic approach and to have insufficient space to expand resources. However, a systematic approach allows routine checks to be scheduled away from peak times, reducing the pressure on appointments and rooms. General practice will need confidence in its future funding streams before greater investment in practices and staff will occur.

4. Clinician

Clinicians (both doctors and nurses) respond in many ways to requests to change. Their current state of change has to be acknowledged, and they may need to be assisted to move beyond their chosen pace. Education and discussion are vitally important. These can solve practical issues for the practice teams such as disease coding, how to organise practice nurses doing home visits or patient education, and scheduling 30-minute appointments. These discussions allow identification of the enthusiasts to become the advisers in the planning of future projects. They will then pilot a project. Further education sessions for the remaining doctors and nurses can then be held using the original GPs and nurses as opinion leaders.

Phased implementation allows problems with the programme to be addressed. The initial education programme can be used to design the project using ideas generated by group discussions with practice teams. The project will then be more likely to fit the needs of the practices and encourage a sense of ownership. This ideal process can be contrasted with the current situation with diabetes annual checks.

While funding and support for disease management are to be applauded, early public promotion by HFA and pharmaceutical interests are forcing hasty responses which are likely to alienate GPs and slow down the acceptance of disease management. It does not allow time for recruitment of volunteers and the diffusion effect to occur.

Systems and information management

The diversity of general practices adds complexity to the systematic collection of information to be shared between all providers of care. Many disease management projects in New Zealand have needed to make a paper-based system available although an electronic solution is clearly preferable. Most IPAs do not have a single practice management software (PMS) used by all members. The wide variety of PMS means that IPA disease management systems have to interface with each one. Some IPAs are trying to influence the software used by developing their own or having a preferred system, a response to the very poor software support that New Zealand GPs have suffered for many years. Thirty-two-bit practice management software systems will allow greater sharing of disease management templates and extraction of anonymous data for transfer to central agencies. Other solutions include entering disease management assessments on to a secure website accessible by authorised health-care providers.

The project needs to be flexible to the current information technology of the

practice. Attempts to change preferred systems within the practice would meet with resistance. One of the major difficulties to introducing new projects can be form design. Possible solutions include on-line completion of forms, and telephone referral with the form completed by the person receiving the referral. Different members of practice teams may be more reliable at completing systematic tasks than some doctors, and practices may be encouraged to participate by finding a nurse or practice manager to lead the change.

Incentives

Clinicians can be encouraged to make changes more easily when they can see the advantages for their patients, such as evidence of better outcomes or improved services. If GPs see disease management as enhancing the doctor/patient relationship rather than detracting from it, then they will buy into it. If it is seen as a way of limiting what patients receive, or turning general practice into a form-filling, box-ticking computerised activity instead of a patient-focused activity, then it won't happen. The real buy-in will occur when doctors sit down with their patient for a prolonged time, review pre-arranged test and examination results, and start making a jointly agreed plan of care. Surely this is more patient-centred and likely to produce better outcomes than spending most consultations on acute issues and writing scripts and laboratory forms? Somehow disease management has to provide tools to do what we currently do better, rather than something superimposed on what we currently do. GPs will also change if they can see a professional enhancement of their role, such as improved access to diagnostics or better acute care services for patients in a disease management project.

Most general practices are small businesses with significant fixed expenses, which cannot afford to take on new work without adequate financial recompense. Funding may be a combination of three types: payment for patient education or for consultation time; payment for data collection and provision; and payment for continuous quality improvement. The source of this funding and the mix of each type may have a considerable influence over the success of any scheme.

Flexibility in the rate of change

Many GPs feel cynical about the motives behind the enthusiasm of government agencies for guidelines and disease management. They can remember that health maintenance organisations and pharmaceutical companies were the first to espouse disease management, and they may be suspicious of both types of organisation. A phased introduction of the concepts may assist doctors to appreciate the advantages of a systematic and integrated approach to patient care. This will only occur if the introduction is gradual. Practices will adopt change at differing rates, and are starting from different levels of care and organisation. Disease management projects need to be flexible enough to cope with this variation.

References available on request.

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