

Fresh eyes for chronic care management

Anna Poutu Fay BHSc, medical student, The University of Auckland

In November 2008 I completed my BHSc at Auckland University. One week later I began working for Counties Manukau on a service project designed to engage as many patients as possible in the diabetes 'Get Checked' (DGC) programme. Patients who are engaged in treatment, who are motivated and actively collaborate with their clinicians, tend to have much better clinical outcomes. However, engaging patients with chronic conditions can be demanding and difficult work. To improve the uptake and effectiveness of the DGC programme, I was asked to review 3500 Counties Manukau known diabetic patient profiles in order to ascertain which

ing to get them in for a check-up. I am also following up to determine whether these patients are or should be enrolled in the Chronic Care Management (CCM) programme. After follow-up, I will collate a report to send to Counties Manukau to document how well this intervention strategy has worked and what else might help to improve patients' ability to successfully self-manage their diabetes.

Working with ProCare Network Manukau, I have experienced the plunge from theory into practice. Real health care as it is delivered on the ground is very different from health care studied in overview. All the appalling statis-

disheartening, but scandalous. The status quo is simply not good enough.

Many people older and wiser than myself have attempted to improve the coordination and delivery of health care services. Still, I marvel at the obvious and severe shortcomings of the CCM service delivery system. This is clearly not the fault of individuals. I have observed many health care practitioners and support workers in both DHBs and PHOs working hard, doing the best they can with what they have. Nevertheless, with the increasing prevalence of chronic conditions across Aotearoa New Zealand, the need for better deployment of resources to treat and

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GP practices had significant numbers of high risk Maori and Pasifika patients with diabetes. Excluding patients who had already had a DGC in 2008, I was able to identify 15 GP practices that included 600 known diabetic patients who were either overdue for their DGC or else had never had a DGC at all. Fourteen of my 15 target practices were supportive of the programme, but six practices declined to participate, citing logistical and resource problems. With support from the remaining nine practices, I am in the process of contacting large numbers of high-risk patients and help-

tics we learn about at university are no longer abstractions, but real people in need of urgent attention on a daily basis. But what is most immediately and overwhelmingly evident to the newcomer is the extreme fragmentation of our health care system. Continuity of care is a phrase often heard but apparently seldom found in the real world of South Auckland. Lack of communication between health care stakeholders is both chronic and severe. Amidst chaos and confusion, our health care system is really struggling, achieving only a fraction of its potential. This is not only

manage these patients is crucial. My observations lead me to several conclusions:

1. Many primary care providers are woefully under-resourced for the management of chronic conditions

Some of the GP practices in this project have neither a practice nurse or practice manager. To effectively and efficiently

CORRESPONDENCE TO:
Anna Poutu Fay
annapfay@gmail.com

follow-up patients, systematic attention is needed. Giving busy GPs bottom-line responsibility for following up DNAs (Did Not Attend) is highly impractical. They have neither the time nor the inclination to try to contact and persuade reluctant patients to come in for their appointments. Practice nurses and practice managers can improve the organisational effectiveness of a GP practice by extending both the range of medical services available and improving the ability to deliver these services to a greater number or greater percentage of patients. Community Health Coordinators (CHCs) can also play a very important role in facilitating the liaison between practice and patient. CHCs are specifically trained to manage issues of

assurance that this information will be made fully available throughout their health care network. As a result, they don't get adequate monitoring and follow-up.

3. There is a marked absence of incentives for successful chronic health care management

Most GP practices are run as fee-for-service businesses. While doctors are paid to provide preventative care, they are paid equally well or better when prevention fails and further treatment becomes necessary. Being paid for sickness instead of health does not prevent doctors from sincerely wanting the best outcomes for their patients. However,

hybrid payment structure would reward physicians for after-hours access, for communicating with patients via phone or e-mail, for attention to detail and doing disease management at the point of care.'

4. Fragmented services have resulted in 'silo' health care

Health audits are conducted infrequently and without sufficient authority to make positive changes. Appropriately organised information flows between stakeholders that could allow the same information to be used for multiple tasks are discouraged. Often, the need to respect patient privacy and confidentiality has led to protocols that impair the ability to share important information. To cite just one example, the Diabetes Projects Trust conducts in-depth audits of GP practices, but their findings are neither widely available nor well-used.

5. Disempowerment and lack of clear accountability for health care delivery is the norm

Who is actually in charge of our health-care system? Who regards themselves as having the authority to make changes to the delivery of health care? In conducting my research, I have yet to meet anyone who regards themselves as in-charge or capable of making structural changes. Everyone seems to regard themselves as 'just following orders'. Accountability is needed both at the level of clinical process and at the level of clinical outcome. Health care practitioners need to be able to take responsibility not only for the quality of care they provide, but for the actual clinical outcomes which result.

6. There is an urgent need to develop effective multidisciplinary working relationships across systems

Effective chronic care management requires a multidisciplinary team of health professionals across several

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non-compliance. Where CHCs are able to develop good working relationships with a GP practice and its patients, they can make community outreach a reality.

2. There is a severe lack of service integration

Currently, the communication between national services such as CarePlus and DGC, and locally-based initiatives such as CCM is extremely inadequate. Although they are on the same patient profile, these services are completely out of synch with each other, responsive to different care plans, each with its own targets and timelines. Many patients with diabetes are identified only upon their hospital admission for some other complaint. Their diabetes becomes part of their NHI record, but there is little

it can and does prevent them from being able to deliver optimal outcomes. If a doctor's self-interest were directly and pragmatically aligned with their patient's self-interest, quality of care would improve. Being paid to keep people healthy would ideally become the cornerstone of medicine. However, where this agenda has been applied in capitated systems such as health maintenance organisations, narrowly-defined economic self-interest has led to a fragmented system in which neglect is too often the norm. As Dr Paul Grundy¹ summarises:

'If you pay strictly fee-for-service you get too many services. With just capitation you get too few services. With pay-for-performance, you get only a focus on the measure they are being paid for. [This]

health sectors. The doctor–patient relationship is widely acknowledged as critical to the successful delivery and use of health care; however, strong and effective relationships need to be cultivated and sustained, not just between patients and providers, but between providers themselves. Real continuity of care depends upon strong working partnerships between all relevant stakeholders.

Based on my recent observations and conclusions, I would like to suggest four steps that I believe could significantly improve our management of patients with chronic conditions.

STEP 1: Develop practitioner role changes that support integrated, continuous care

Many issues associated with low levels of patient compliance can be attributed to a lack of fit between the protocols of centralised care and the practical realities of patients suffering from chronic conditions. A patient-centred approach to health care delivery is critical to addressing these issues. *Community health workers* can play a fundamental role in assisting and supporting patients to access, use and navigate a health system that is not yet oriented towards patient-centred care. Community health workers can advocate for a patient-centred approach, and assist patients to make informed decisions about their own care. By systematically following up patients, *practice managers* can ensure continuity of care and help shape positive patient attitudes towards health and illness. More consistent and frequent patient contact will contribute to improving overall health outcomes. Regular contact encourages patients to become and remain proactive, and not simply reactive, about their care. *Practice nurses* and *GPs* should avoid assuming burdensome administrative tasks and responsibilities. In a well-managed practice, clinical staff

are free to focus on delivering quality, timely clinical care.

STEP 2: Re-allocate resources towards primary care

The old adage that an ounce of prevention is worth a pound of cure still holds true. We need better support for primary prevention and early intervention. For the same health dollars we could treat many more patients, much more effectively, with much less human misery, by focussing on primary care. More successful treatment of chronic conditions at a primary level means less tertiary care and fewer expensive hospital stays. It would be difficult to overstate the benefits of prevention and early intervention.

STEP 3: Increase systemic accountability for clinical process and outcomes

The prevalent assumption that economic self-interest and the ‘free market’ will work to ensure widely available quality health care is fatally flawed. Medical patients, particularly those with chronic conditions, are not informed consumers who can freely select from among competing health care products and services. Our health care system needs to target incentives that reward good practice, not only at the level of service delivery, but also at the level of clinical outcome. In order to ensure best practice, health practitioners need to be given bonuses for good performance as well as disincentives for inadequate performance.

STEP 4: Strongly held positive beliefs and values can contribute to the provision of quality health care services

Medicine is fundamentally about reducing human suffering and restoring human dignity. Everyone deserves good health. If they cannot have

good health, they deserve good care. Medicine thrives on a sense of mission... Almost everyone who chose to work in the health sector entered the field believing that they were going to make a difference to the quality of others’ lives, that quality health care was possible and that anything less was unacceptable. It seems to become harder to hold onto these ideals as time passes, but that does not make these principles less important. Most health care practitioners claim that nobody should be disadvantaged because they are ill, because they are culturally different, or because they are ignorant of the requirements for becoming an ideal patient. Yet the reality in South Auckland is that people are disadvantaged each and every day. We can do something about this.

Think back to what you were like at my age and stage of life. Can you remember feeling idealistic, uncompromising, enthusiastic and passionate about the promise of medicine? Can you recall your intolerance of seeing it practised badly? You may well remember making similar observations and reaching similar conclusions to mine. You may recall that the proposals made here are not novel ideas. A patient-centred approach to medicine with active outreach, emphasis on primary care and early intervention, good follow-up and feedback systems, information sharing, with built-in rewards for excellent performance underpinned by a strong commitment to a set of positive beliefs and values is both possible and necessary. Such an approach to community care has always been needed and indeed, is needed now more than ever.

Reference

1. National Committee for Quality Assurance. Coming home to better care: 2007 NCQA Annual Report. p 11. Available from: http://www.ncqa.org/Portals/0/Publications/Resource%20Library/Annual%20Report/NCQA_Annual_2007.pdf Accessed 27 December 2008.