Long-term condition management: health professionals' perspectives

Natasha Ashworth RN; **Shona Thompson** PhD

School of Nursing, Eastern Institute of Technology, Taradale, New Zealand

ABSTRACT

INTRODUCTION: Long-term conditions (LTCs) are the leading cause of morbidity and mortality in New Zealand. The burden upon patients and health care services to manage these conditions has prompted calls for primary care to lead the way in early diagnosis and coordination of LTC care. The purpose of this study was to investigate the perspectives of health professionals in a geographically-isolated region of New Zealand regarding current levels of LTC management to provide direction for future service development.

METHODS: Semi-structured, face-to-face interviews conducted in 2009 with 10 purposively sampled health professionals in the primary care field, including four general practitioners, four nurses and two management team personnel, all practising in a regional District Health Board. The resultant data were analysed using a general inductive thematic approach.

FINDINGS: Three main themes were identified by the health professionals as being key issues pertaining to the management of LTCs. These are discussed as issues pertaining to management, information and communication and leadership.

CONCLUSION: The results showed that LTC management is rated as highly important by health care professionals who are aware of the need to change current delivery methods to improve client outcomes. All those interviewed highlighted issues related to funding as being a significant barrier to implementing innovations in LTC management, including nurse-led services. Plans to develop integrated family health centres, information technology systems and increased collaboration between clinicians were hailed as potential solutions to improving LTC management.

KEYWORDS: Chronic disease; family nursing; family practice; nurse led clinics; nurse's practice patterns

Introduction

This research was conducted in a region of New Zealand with a high prevalence of long-term conditions (LTCs) with the associated need for good quality management. That this need is not adequately met by existing health care services is highlighted by the continuing rise in ambulatory sensitive presentations to secondary care, many of which relate to complications of chronic illnesses.[1] This is despite some excellent health care initiatives shared between the Primary Health Organisations (PHOs) and general practices. The PHO featured in this research is a mainly urban area with 35% of the population living in deciles* 9 and 10 on the deprivation scale. Maori make up 35% of its total population, 58% of whom live in deciles 9 and 10. These figures indicate that large numbers of both Maori and non-Maori live with high levels of deprivation associated with poor health outcomes.[2,3,4]

The landscape of primary care in New Zealand has changed frequently over the preceding decades resulting from a series of governmental

* Decile is a statistical term meaning the division into 10 parts. In New Zealand the term refers to socioeconomic division of the population in bands associated with material deprivation, where 1 is least deprived and 10 is most deprived.

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CORRESPONDENCE TO:
Natasha Ashworth
Turanganui PHO,
Lowe Street, Gisborne,
New Zealand
ashworth.tash.rob@xtra.co.nz

funding changes and initiatives. The fee-for-service system was officially replaced by capitation funding in 2001 but, in reality, access to funding is a complicated process and is often task- or fee-for-service–based.[5] In 2004 Care Plus was rolled out which provided funding to primary care, via PHOs, for clients with LTCs with the aims of improving care, improving primary health team work and reducing inequalities.[6,7] Care Plus was designed to include nurses as deliverers of LTC care, acknowledging that the structure of Care Plus, and in some PHOs the nomenclature, would vary between PHOs and practices within PHOs.[8]

Further changes for primary care lie ahead, arising from the health discussion paper *Better, Sooner, More Convenient*, which proposes changes to primary care to deliver better management of LTC services by increasing the multidisciplinary nature of primary health.[9] An integral part of the proposed changes is the development of integrated family health centres housing a wider range of health professionals. Nurse-led services for LTC management have been successfully developed in many countries,[10,11,12,13] but in New Zealand such services are less well-established which has been ascribed to the structure and funding of primary care.[14] However, a recent statement regarding primary care nursing cited successful New Zealand models of nurse-led LTC services within primary care and predicted an increased role for nurses within integrated family health teams.[15]

Models of LTC management have been developed internationally over the last 20 years, of which the most widely used is the Chronic Care Model (CCM).[16] The CCM consists of six primary areas that are held to lead to improvements in patient outcomes. These are:

- patient self-management;
- delivery system redesign;
- provider decision support;
- clinical information systems;
- effective health system leadership, and
- linkages to community resources.

Whilst the value of elements of this model have been demonstrated, it has not been applied in its entirety often enough to provide firm evidence for its direct implementation.[17,18,19,20] A central tenet of the CCM is the role of planned care, which identifies all those with an existing LTC and recalls them for regular review and education as well as implementing a system for screening the practice population for undiagnosed conditions.[14] Health care is evolving from a system based around acute presentations to a more proactive planned care environment.[21] In each District Health Board (DHB) the use of a CCM, increased multidisciplinary teamwork, and the development of a strategic plan for LTCs, is part of the recommendations from the National Health Committee (NHC) of New Zealand in the 2007 report, *Meeting the Needs of People with Chronic Conditions*.[22]

In light of recent and forthcoming changes to the structure of primary care, this study sought to determine the views of those involved in planning, funding and delivering LTC management in primary care. This study asks the question: What are health professionals' perspectives on the management of long-term conditions?

WHAT GAP THIS FILLS

What we already know: Long-term condition management is a growing concern in primary care and many in general practice are looking for ways to evolve the delivery of care to meet increasingly complex client needs. Nurses are at the forefront, delivering primary care long-term condition services in many countries, but less so in New Zealand.

What this study adds: This work presents the views of some health care managers, general practitioners and nurses on the current management of long-term conditions, the barriers experienced in affecting change of service delivery, and suggestions for future directions in long-term condition management. A focus on a geographically-isolated region of New Zealand provides insights into the delivery of primary care outside the main centres.

Methods

The research is a qualitative study.[23] Ten health care professionals were purposively sampled as key informants for the research and were interviewed once, face-to-face, during 2009. These were identified by the lead researcher who works as a clinical nurse specialist in the region of the PHO on which the research focussed. Two were from DHB and PHO management teams, four

were nurses and four were general practitioners (GPs). They represented a variety of practice sizes. The semi-structured interviews averaged one hour in length, were audiotaped and later transcribed. Questions were guided by themes from the literature.†

The project gained approval from the Northern Regional Ethics Committee and the Eastern Institute of Technology Research Approvals Committee.

This research was designed as a descriptive inquiry with the goal of providing a 'comprehensive summary' of the participants' perceptions resulting from the identification of themes prevalent in the data.[24] A general inductive approach to data analysis was used following Thomas's recommendations for extending the analysis from simple identification of themes to the formation of categories linked to underpinning literature and theory.[25] Key themes are discussed below, identified under three categories.

Findings

The qualitative data derived from interviews with purposively sampled health professionals found that, from their perspectives, the key issues arising in the care of LTCs can be categorised as concerning management, information and communication and leadership.

1. Management issues

Management issues relate strongly to operational elements of general practice. These elements are key determinants of who delivers LTC management and how it is delivered. Amongst those interviewed, funding was a recurrent theme in discussion of the management of LTCs, alongside issues related to general practice operations under the current financial structure. In most cases the GPs interviewed were very concerned about health care funding. As one explained:

> Family medicine is so complicated in its structure of funding and it annoys me when you have specific targets which are only then attached to money, and I just find them irksome really. (GP 1)

Despite changes in funding structures over the last 10 years, the current model was described generally as being 'fee-for-service'. One of the major problems with this model, as highlighted by those interviewed, was that it inhibited the development of nurse-led clinics and the use of multidisciplinary approaches to care.

The health professionals expressed frustration that funding was often linked to a specific disease or a moment in time, not to the individual with the disease. Lack of continuity in revenue streams was also cause for frustration, such as when changes are made to the types of services funded. As one nurse explained:

> We've tried different thing(s), or the PHO have tried different things, and then a year later that funding's gone and suddenly nobody's interested in it anymore. (Nurse 3)

Those interviewed from management teams made it clear that funding for primary care was unlikely to increase beyond its current level and could in fact be reduced in future. This situation requires new ways of delivering services and the interviewed health professionals offered several suggestions, including lump sum funding to general practice, integrated family health centres, salaried GPs, increased use of nurse-led clinics and incentivised population health goals. One GP, when discussing nurse-led services, gave an insightful caution to those planning such services:

> I think sometimes there's a perception that it might be cheaper but in fact it's not cheaper. We should do this because it's better, but it's not cheaper. It's like all good chronic care or preventative care, we don't save money we spend money in order to do it better. (GP 4)

† Main questions included:
'Tell me about long-term condition services available in primary care in this Primary Health Organisation.'
'Tell me about whether you think these programmes meet the needs of all of your clients with regard to long-term conditions.'
'What do you think about evidence-based guidelines for long-term condition management in theory and in practice? What barriers do you see to improving long-term condition services in this Primary Health Organisation?'

Several other reasons for using nurses to lead LTC services were mentioned. These included providing rural health service cover, helping to address the issue of the diminishing GP workforce, and reducing costs to the practice and the client. Comments indicated that careful consideration needed to be paid to the type of roles devolved to nurses so that each clinician works to their skill set and strengths, and within their scope of practice. One GP said:

> The conclusion we came to was that it may be better, safer all round, for more of the chronic care to be nurse-led and so that leaves us to focus on the acute triage. (GP 2)

When asked why nurse-led services were not more common in primary care, those interviewed cited a variety of reasons including lack of nurse motivation, lack of representation at a DHB level, training and role protection. Both of the managers considered role protection to be a significant barrier to changes in LTC management. One of the managers described 'a little bit of letting go' being needed by primary care clinicians.

General practitioners and nurses all commented on the time pressures they faced in primary care with increasing numbers of presentations for increasingly complex conditions. When managing LTCs the nurse participants felt that 10-minute GP consultations were not long enough. GPs described LTC care as 'chipping away' in 'an accumulation of small increments of time'. All the participants commented on time pressures impacting on the ability to become involved with planning and funding discussions at the DHB or PHO level, on their ability to keep up with advances in technology such as decision support tools, and managing complex, hard-to-reach clients.

Some positive solutions were advanced, however. One nurse suggested adopting a model in which technology is utilised to free-up clinician time by using email or phone contact with clients. One GP described adding LTC management to a normal consultation:

> You know it doesn't take very long, just a tape measure and a set of scales and it takes a minute to do their bloods and so treating cardiovascular risk like measuring blood pressure, it's just part of day-to-day life. (GP 3)

Many in primary care, however, still view acute presentations as being an effective way of managing LTCs. The interviewed GPs described having seen planned care clinics fail in other areas due to high numbers of 'did not arrive' patients, or cited their practice demographic as being unsuitable for planned services. Practices with successful planned care described increased teamwork between nurses and administrators to achieve clinics suited to client needs, and providing a system of reminders to enhance attendance. Interviewees described how, in some practices, a combined approach of planned LTC clinics and opportunistic screening worked well to catch hard-to-reach clients, particularly with groups described as being harder to reach than others. For example:

> We opportunistically have to do diabetic checks on some patients who just don't come in with the recall, so when they come in to see the GP about something, for prescriptions, we try and work with them before they actually see the GP. (Nurse 3)

Management issues were the most prevalent of those raised by the health professionals interviewed. Interestingly, it was evident that many had already given thought to how these issues could be overcome, and were ready with suggestions for change or international examples of models of service delivery. Suggestions included the development of nurse specialists in chronic care to help mitigate the effects of the diminishing GP workforce, increased client self-management and integrated family health centres.

2. Information and communication

Information technology (IT) developments designed to improve client care and provide greater access to information have been presented in health care debates as ways to improve LTC management, but all participants spoke about their frustrations with unintegrated IT systems. One GP explained:

> We should be operating from the same database in primary care but we don't, so people communicate

> with phone calls, with bits of paper that are faxed and the bits of information that are unwieldy and are only part of that patient's record. (GP 4)

Whilst it may seem relatively simple to integrate IT systems, especially in primary care where the general practices and community health organisations are using the same software, issues arise when a wider set of health workers have access to client information. One GP commented, 'There's a real issue around confidentiality', but a manager pointed out:

> If you were a person with a long-term condition it would seem to me that there would be a set of precursors that should follow you around that aren't sensitive. (Manager 2)

While the participants all acknowledged the need for increased communication between clinicians delivering care to clients with LTCs, communication problems were reported across the sector. One nurse explained:

> We're all so busy doing things and people think they've told people things (but they haven't). (Nurse 3)

And a GP commented:

> No, we (primary and secondary care) don't talk about a particular patient in terms of planning care and that sort of thing. (GP 3)

The health professionals spoke about relationship building as being a vital component of LTC care. They recognised that a good relationship was necessary between clinicians in primary and secondary care in order to deliver effective LTC management.

Many of the health professionals pointed out that poor communication often resulted in lost information, mixed messages to clients and 'duplication and triplication of service delivery', unacceptable in a cost-sensitive health environment. From this perspective, the newly-proposed integrated family health centres were presented as a solution to increase interpractice and intersectorial communication as well as reduce service duplication for clients with LTCs.

3. Leadership

During the interviews the health professionals often referred, directly or indirectly, to components of clinical leadership. The comments applied to leadership within practice teams and at wider PHO or DHB level. GPs and nurses both commented on the need for clinical leadership to enhance client care. One GP opined:

> I think there is a lack of leadership... both clinical and management leadership... Nobody seems to have the overview of what kind of population we're dealing with, what works, what doesn't. (GP 2)

From a nurse's perspective:

> I've always thought it would be really nice to have somebody mentoring... just, like, an overall mentor if you're not sure about something, just somebody else you can go to. (Nurse 4)

One of the concepts of PHOs was to increase clinician involvement in planning and funding decisions and therefore increase clinical leadership. However, several participants made comments reflecting their perception of a lack of meaningful involvement, for example:

> I think it's clear that we're not involved in the critical political and funding decisions and that, when there is an attempt made at discussion, generally the decisions have already been made. (GP 4)

The management participants also spoke about their attempts to increase clinical leadership opportunities and highlighted the difficulties they faced due to such a disparate workforce:

> You could talk to the 24 GPs that are in the PHO [and they will each] show you something you haven't even thought of. Because their practice, and that's not their scope of practice, the way they practice, whether it's from a business perspective or a professional perspective, is so completely different. (Manager 2)

Clinical leadership for nurses was reported to have been recently implemented, but the application of this had not yet resulted in a standardised workforce, as one of the management team explained:

> I understand some of the nurses actually have portfolios in terms of long-term conditions whereas in other (practices) nurses seem to be handmaidens. (Manager 1)

Professional development was acknowledged as important for GPs and nurses in primary care, contributing to effective clinical leadership, but this was described as a challenge in the primary care environment as one doctor pointed out:

> It's an issue for primary care GPs because they fund themselves and because the breadth of their required expertise is so wide it's hard to know which part (to focus on). (GP 4)

The nurses interviewed felt that opportunities for their professional development had recently increased, and the relevance of professional development to primary care nurses had also improved. However, access to it does not exist equally across all practices and nurses reported that barriers still exist in some smaller practices where cover absence is hard to arrange. One participant suggested that increased use of online learning, such as interactive 'webinars', would enable broader access to education.

Discussion

The strongest issue raised by the participants of this research concerning LTCs related to funding. For the GPs, funding structures appeared to be a significant barrier to delivery of LTC services. The nurses acknowledged funding as a barrier, but were less connected to it as they were not usually involved in the processes of generating income or the decisions as to how the funds were used. Several GPs suggested that lump sum funding would be a welcome alternative as it would give them increased autonomy in the management of service delivery for their client group. They recognised, however, that increased autonomy would also mean increased accountability and subsequent workloads.

The research highlighted the duplication of services that exists across this relatively small PHO, with iwi organisations, the PHO and secondary cares all delivering LTC services similar to primary care. By increasing the cooperation and communication across these groups it would be possible to develop a meaningful framework for delivery of services, as recommended by the NHC, where each group is clear about their core business and, as a collective, they fulfil the recognised needs of the area.

GPs and nurses identified access to professional development and education as an issue. The PHO would be well placed to offer a coordinated approach to primary care education including nursing cover for time out of general practice and inclusion of nurses in GP education sessions. These suggestions lead naturally to improved teamwork, as hoped for with the introduction of Care Plus,[6] and increased opportunities for clinical leadership[14].

General practitioners interviewed also identified the need for a 'voice' at service development level. Whilst measures have been taken to improve clinical leadership, the research participants raised doubts as to whether these measures were fulfilling current needs. Due to the different structures of general practices, this is a hard group to represent. GPs also doubted the value of their involvement in higher level planning and funding activities as they believed that often the significant decisions had already been made prior to their attendance. The GPs need to feel as though any commitment of time and effort into planning and funding strategies will be rewarded with real power and involvement in decision-making. Management teams, on the other hand, look to GPs working more collectively rather than as individuals.

Other practical considerations were raised in delivery of LTC services. The development of integrated family health centres was suggested by those interviewed, which would be designed to house a range of health professionals, therefore providing the multidisciplinary working environment described by the NHC.[22] Increased cooperation across primary and secondary care has been highly recommended[9,22] and some of the health professionals highlighted this as a local issue. Clinicians spoke about their desire for increased collegial support in the management of clients with complex LTCs. One way this has been addressed locally is through virtual clinics

with secondary care clinicians visiting primary care clinics.

Oncoming directives from the MoH could serve to provide the changes in structure desired by many of those interviewed, but to deliver improved LTC care to an ever-growing number of clients requires changes in thinking. For nurses to evolve into leaders of LTC services, further changes are needed. The practice team has to increase their collaborative working with each team member being trusted to fulfil the role to which their skills are best suited. Nurses have to grow in skills and confidence to encompass these new roles. The PHO and DHB management teams play a large part in the potential success or failure of upcoming changes and need to be responsible for continuing to encourage the development of meaningful clinical leadership structures and improved communication between secondary and primary care.

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COMPETING INTERESTS
None declared.