Chronic disease self-management: implementation with and within Australian general practice

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ABSTRACT

- Although there is evidence for the effectiveness of self-management support, there has been limited engagement of Australian general practice staff with self-management support provided by other services.
- Efforts to integrate self-management support into general practice have also been challenging, largely because of capacity constraints and the difficulties of incorporating it into existing work practices.
- A broader systemic approach is needed, including a collaborative approach between providers, a range of self-management support options, training of general practice staff, and changes to the organisation of services and the way in which they relate to each other.
- The expanding role of practice nurses, new models of integrated primary health care and changes to the role of the Divisions of General Practice present an opportunity for this to be incorporated "from the ground up".

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Chronic illness contributes the major burden of disease in Australia.[1] About 55% of people aged 65–84 years have five or more long-term conditions.[2] The prevalence of chronic illness is increasing, driven largely by population ageing and an increase in lifestyle risk factors.[3,4] General practice reaches 87% of the population each year and provides most care to patients with chronic illness, especially those with mild to moderately severe disease. It also plays an increasing role in managing lifestyle risk factors.[5,6]

The National Chronic Disease Strategy defines self-management as "active participation by people in their own health care".[7] This is increasingly seen as important, given the rising burden of chronic illness and the resulting effects on the health system. People with chronic illnesses need to develop the skills to manage their risk factors, monitor their diseases, make effective use of services and medications, and cope with the impact of disease on their lives.[8] This requires patients to be empowered to self-manage their health and to attain the knowledge and skills to make the most effective use of the health care system.[9]

Self-management support is defined as collaboratively helping patients and their families to acquire the knowledge, confidence and skills to manage their condition;[9] there is a wide range of approaches to achieve this. It may be achieved through self-management support programs, which aim to develop the knowledge, skills and confidence necessary to enable patients with chronic illnesses to manage their health in partnership with health care providers.[10] Health care providers can help patients to engage with their own care, and provide them with information and support to self-manage their condition. Self-management support programs can also be provided by self-help organisations and be led by peers with chronic diseases.

This review aims to examine the implementation of self-management support with and within general practice. It is based on a qualitative review and a synthesis of international literature and some of the limited research that has been conducted in Australia.

Evidence of the effectiveness of chronic illness self-management support

In a recent systematic review of evidence for strategies to achieve better outcomes for patients with long-term conditions in primary health care, we found that self-management support was effective across most outcome measures recorded and for a range of chronic illnesses.[11,12] It was particularly effective in improving patient-level outcomes for diabetes, heart disease and hypertension. The components of self-management support found to be effective included patient education, distribution of educational material and motivational counselling. It was more likely to be effective when delivered in a group setting and when combined with other strategies, such as developing multidisciplinary teams comprising medical, nursing and allied health professionals, which created opportunities for further self-management support.[11,12]

Lay-led generic group self-management education programs are effective in improving the self-efficacy and quality of life of patients with chronic long-term conditions.[13] Participants receive social support from their peers, which may also lead to the development of local social networks. They are well suited to the needs of older patients with a number of comorbid conditions, as a focus on one condition would be inappropriate for such patients. One of the most comprehensively evaluated generic self-management programs is the Expert Patients Programme (EPP) in the United Kingdom. It focuses on developing self-care and self-management skills in people with a wide range of long-term conditions. The EPP was formerly conducted within primary care by Primary Care Trusts; it is now managed as a community interest company. The program is group based and is delivered by a network of trainers, including some with long-term conditions. It has been demonstrated to be cost-effective, improving quality of life of people with long-term conditions, and is sustained over a long period.[14] However, it has not been successful at targeting people from ethnic minority groups or those who are socioeconomically disadvantaged and most in need.[15]

Disease-specific models of self-management support have been commonly delivered by health providers in group settings or individually, especially for asthma,[16] diabetes[17,18] and arthritis.[19] These are often well suited to younger patients with a single chronic illness and have been shown to be effective, especially in improving disease-specific intermediate measures of health outcome, such as glucose control in diabetes or blood pressure in hypertension.[20,21]

Both generic and disease-specific programs are often developed in parallel with general practice, whose staff members may lack knowledge of the effectiveness of these programs and the skills to appropriately reinforce them. Although some studies have reported changes in patient health-seeking behaviour,[22] reduced demand on health service utilisation[23] and reduced health care

Enablers of engagement of self-management support with and in general practice

- Collaboration between Divisions of General Practice, state health services and non-government organisations to provide and coordinate provision of self-management and self-management support education programs.
- Education of general practice staff on the evidence of the effectiveness of self-management programs, and the skills required for sharing decision making with patients, and to provide effective self-management support.
- Identification of patients who may benefit from self-management support from practice records.
- Development of the role of practice nurses in self-management support for patients with chronic illness.
- Inclusion of negotiation of self-management support as part of patient care plans.
- Inclusion of self-management support in allied health services that are provided on referral of a patient with chronic disease under a Team Care Arrangement.
- Referral pathways that are sustained over time and facilitate direct communication and a continuing role for general practice staff in supporting self-management. ◆

costs,[24] there is still a lack of conclusive evidence of reduced demand on health services owing to self-management programs. Interestingly, the strongest evidence for the impact of self-management education on hospital admissions and use of emergency departments comes from studies from the United States and China,[25-27] which have relatively less developed primary care gatekeeping, and therefore greater scope for self-management to affect hospitalisation.

Implementation with general practice

As chronic illness management is increasingly provided by general practice, self-management support needs to be well integrated with the general practice team.[15] The World Health Organization describes a triad of care between the patient and family, community and health care provider.[28] Appropriate use of or attendance at a primary health care provider is seen as an important potential outcome of self-management education, but is often not achieved.[29] Therefore, general practice has an important potential role in providing and identifying suitable patients for referral for self-management support.

Despite this potential, self-management support programs are often established in parallel with general practice, with limited engagement between the two. For example, a process evaluation of the Expert Patients Programme suggested that awareness and engagement of health professionals, particularly general practitioners, was low.[30] This lack of engagement has resulted in low rates of referral to group programs, especially for patients from ethnic minority groups.[31] Poor integration with general practice may lead to missed opportunities for follow-up and behaviour reinforcement, and to inconsistent advice.

In Australia, the evaluation of the initial round of Sharing Health Care Initiative projects found that although GPs were generally very receptive, there were barriers to their active involvement.[32] Two of these projects aimed to integrate self-management support with general practice. One rural project was able to recruit participants by encouraging direct referral and reviewing lists of patients in the GPs' records. The other, which focused on formal partnerships and referral mechanisms, failed to effectively recruit GPs.[33] To further the Australian Better Health Initiative, the 2006–07 federal budget made an investment to provide training for health professionals to assist people with chronic conditions to better manage their own health. Integration of self-management activities into primary care will be important to the success of this initiative.[34]

In 2006, we conducted a qualitative follow-up study in south-west Sydney to explore the sustainability of the implementation of one of the Sharing Health Care demonstration projects.[35] We identified language and cultural barriers to the implementation in culturally and linguistically diverse communities, and that older people tended to accept their role as passive recipients of health care. The projects' sustainability was adversely affected by other work pressures on staff involved in delivering it, and its poor engagement with general practice.[35]

The short-term nature of the program was a disincentive for GPs to commit to the program, and, despite Divisions of General Practice involvement, the level of effective engagement of GPs was disappointing. Some engagement did occur, centred around the use of Team Care Arrangements ("team care plans"), and this tended to have a positive effect on the long-term relationship between the GP and community health staff:

> I did finally increase my contact with the GP when the programme was running and I'm still in touch and they still do plans and I do plans for the patient.[35]

Some enablers of engagement of general practice with self-management support programs identified from this and other studies are listed in the Box.

Implementation in general practice

In the UK, there are increasing calls for general practice to take on the role of providing self-management support.[36] However, while GPs value increased patient self-management, this support role may clash with what they perceive to be their professional responsibilities and accountabilities, and they find it difficult to fit self-management support into their normal work patterns.[37] Although there has been hope that practice nurses may take a greater role in educating and providing self-management support for patients with chronic illness, many practice nurses lack the skills and time to take this on.[38] There are also doubts about the efficacy of interventions provided as part of the existing work of primary care providers.[39,40] Researchers in the US have found that integrating self-management support into family practice requires both an organisational commitment and a personal commitment by health care providers to self-management.[41]

In an exploratory study of diabetes self-management support in a disadvantaged area of south-west Sydney, a complex link was demonstrated between patient diabetes self-efficacy and perceived quality of GP care.[42] The results suggested that good GP care is not a substitute for self-management education, but may work synergistically to enhance the effect of self-management support.[42]

The Flinders Model was developed to provide a structured process for assessment, collaborative identification of problems and goal setting, leading to the development of individualised care plans, which aim to enhance patient self-management. Most evidence for the impact of this model on health outcomes has been in the context of the SA HealthPlus coordinated care trial, which included other strategies to manage care.[22,43]

This and other models of self-management support have been adopted by many Divisions of General Practice. In 2005–2006, over three-quarters of Divisions reported that they engaged with health professionals and practice staff by providing training to support lifestyle risk modification or encourage patient self-management.[44] However, uptake by practices has remained very limited. Although Team Care Arrangements are designed to facilitate self-management support, many GPs are unaware of self-management education programs, so self-management education and support is frequently missing from care plans.[45]

Implications

It has been challenging to engage GPs with self-management support programs in Australia and overseas. Although there is evidence of the effectiveness of such self-management support programs, many GPs are still uncertain of the benefits when considering whether to refer their patients to group programs or to provide support themselves. Many GPs prefer their patients to receive individual and disease-specific education rather than group and generic programs. This divide is exacerbated by limited direct communication between GPs and self-management education providers, except sometimes via the exchange of care plans. Ideally, there should be a range of options available for general practice to use (generic or disease-specific, group or individual, facilitation by lay leaders or health professionals, or a combination of these), with strategies to facilitate increased communication.

Incorporating self-management support into general practice is also challenging. There is an uneasy fit between the approach required to develop self-management skills and the traditional, more directive approach of clinical practice. This is changing, with the increasing adoption of techniques such as motivational interviewing into general practice. However, this remains difficult in the context of the work pressures operating on general practice clinicians and their practical difficulty of finding the time to incorporate self-management support into daily work schedules.

Kennedy and colleagues have called for a "whole systems perspective" to facilitating self-management support in general practice.[46] They acknowledge the need for strategies to operate at patient, professional and health service levels to sustain effective self-management.[46] Thus, self-management support of patients may need to be complemented by training of providers in patient-centred care and changes to service organisation to allow patients better access to help. Self-management support needs to be seen as part of an overall shared or team approach to decision making about health care between patient and provider, not a replacement for it.

All this suggests that we still have some way to go in developing the range of models for self-management support that are effective and translatable to the whole health system. New models of integrated primary health care services are currently being developed by state and federal governments. These have an explicit focus on providing a more integrated approach to the team management of patients with chronic long-term conditions, including through the use of care plans. Self-management support has also been increasingly recognised in the role of practice nurses in chronic disease management.[47] However, the capacity of general practice to take these up has been constrained by funding and workforce availability.

Divisions are also developing their role as providers or "purchasers" of local health services, especially allied health services. These present an opportunity to build self-management support into the fabric of primary health care rather than it being an "add-on" that has to be accommodated. Self-management support needs to be seen as a key aspect of overall chronic disease management and an opportunity for GPs and other practice staff to engage in and promote better quality of care and health outcomes for their patients.

Competing interests

None identified.

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