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THE UNIVERSITY OF NEW SOUTH WALES
SCHOOL OF PUBLIC HEALTH AND COMMUNITY MEDICINE

A SYSTEMATIC REVIEW OF CHRONIC DISEASE MANAGEMENT

Zwar N, Harris M, Griffiths R, Roland M,
Dennis S, Powell Davies G, Hasan I

POLICY CONTEXT

Worldwide, the prevalence of chronic diseases and their risk factors are increasing and placing more demands on health care systems and carers. Australia is grappling with how it might respond to this at a policy level.
The Chronic Care Model (CCM) provided the framework for this systematic review of the evidence of interventions for chronic disease management in primary health care. The review used the CCM as a framework for the analysis.

KEY FINDINGS

Self-management support

Self-management support, in particular patient education and motivational counselling are beneficial. Self-management support interventions are associated with improvements in disease measures, such as HbA1c in diabetes and other patient outcomes like: quality of life, health and functional status, patient satisfaction and health service use. There is most evidence for self-management support for diabetes and hypertension, with some evidence for arthritis, and the evidence is less clear for asthma and Chronic Obstructive Pulmonary Disease.

Delivery system design

Multidisciplinary teams are effective in improving disease measures and adherence to guidelines, particularly for diabetes, hypertension and lipid disorders. The combination of self-management support and delivery system design is particularly effective, for example, nurses acting as case managers for diabetes, combined with self-management education. The development of multidisciplinary team care, especially the role of practice nurses, reminders and proactive follow up are important in the management of chronic conditions. Many of the delivery system design interventions are designed to support self management.

Decision support and clinical information systems

Evidence-based guidelines and educational meetings for health professionals improve health professional adherence to guidelines and some patient outcomes. Health professional education alone does not improve patient health outcomes. Clinical information systems that provide audit and feedback encourage the use of decision support.
Health care organisations and/or community resources play significant roles in chronic disease management. There is no evidence about the role of these organisations in the literature.

POLICY OPTIONS

Self-management support

- Engage primary health care through the development of programs to support the training of GPs, practice nurses, community health, multicultural and Aboriginal health workers in chronic disease self-management
- Encourage or mandate the inclusion of patient self-management education into chronic disease care plans
- Link the referral to allied health providers under Medicare arrangements to self-management support in general practice
- Explore the role of Divisions of General Practice in providing self-management support to general practices
- Support self management by linking general practice with community health, multicultural health and Aboriginal health services to provide group self-management support targeted for specific ethnic groups
- Explore how the home medicines review could be used to enable pharmacists to support self management

Delivery system design policy options

- Extend the financial support for practice nurses to become more involved in self-management especially group programs for patients in general practice, including self-management education
- Extend the financial support for practice nurses to provide group clinics and outreach visits for patients with chronic disease, including self-management support
- Support training of primary care staff in a multidisciplinary team approach to management of chronic disease. Training should focus on clear roles and responsibilities of the team members
- Link the referral to allied health providers under Medicare arrangements to facilitate multidisciplinary self-management support in general practice

Decision support and clinical information systems policy options

- Further develop practice incentive payment (PIP) and service incentive payment (SIP) programs to encourage guideline-based chronic disease management
- Integrate chronic disease SIP and PIP incentives so that patients are not considered as a series of separate chronic diseases
- Encourage greater use of streamlined SIP and PIP incentives to improve quality of care
- Encourage the use of chronic disease registers; only diabetes is supported by PIP at present. Encourage the use of registers in the provision of audit data for practices to use in quality improvement process

- Support the use of data extraction tools and Collaboratives methodology to improve the quality and use of practice data
- Continue to support the development and revision of disease specific guidelines
- Develop programs to support the training of GPs and practice nurses in guideline-based chronic disease management in general practice
- Provide support to GPs and practice staff so that they can make more effective use of clinical information systems for patients with chronic illness

METHOD

A systematic review of the published literature, including a review of published systematic reviews was undertaken with a focus on chronic disease management in primary care. The Chronic Care Model (CCM) was used as the conceptual framework for the synthesis of the evidence. The interventions in the included studies are described and mapped to the elements of the CCM. The elements are analysed to determine their effectiveness on outcomes such as physiological measures of disease, health professional adherence to guidelines, health status and quality of life. In addition to the systematic review there is an in depth exploration of the management of chronic disease in countries comparable to Australia, many of which based their policy on aspects of the Chronic Care Model.

For more details, go to the full report

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