Do Team Care Arrangements address the real issues in the management of chronic disease?

Paul A Hartigan, Tuck Meng Soo and Marjan Kljakovic

ABSTRACT

- Care plans are a decade-old program for coordinating care of patients with chronic illness.
- The program currently involves Team Care Arrangements (TCAs), which require all providers to agree on all management decisions contained in the plan. By contrast, conventional referral processes leave it to providers to exercise their judgement about the other providers to be involved.
- TCA requirements make coordination unwieldy and lack an evidentiary basis.
- More importantly, although care plans were introduced to encourage general practitioners to shift from an episodic to a global approach, they do not necessarily do this.
- The care plan objective would be better served by the development of comprehensive patient summaries.

MJA 2009; 191: 99–100

For editorial comment, see page 85

Modern strategies for dealing with chronic illness call for better planned and coordinated approaches that look beyond individual episodes of illness in favour of a broader view.[1,2] To address this change in focus, care plans were introduced in Australia in 1999. They were established with the aim of changing general practitioners' management of chronic illness at the micro or patient level, and were intended to "enable GPs to shift from short-term, episodic fragmented care to whole person care that is integrated with other health care providers".[3]

They sought to

- encourage a more systematic approach by requiring GPs to explicitly identify treatment objectives and the means to their attainment;
- encourage patient involvement; and
- improve coordination by requiring GPs and other health care providers to agree on a diagnosis and treatment package for the patient.

In July 2005, in response to GPs' concerns, the Australian Government split the care plan program in two. GP Management Plans (GPMPs) could be undertaken by GPs alone, and Team Care Arrangements (TCAs) were instituted to cover cases where the GP needed to involve other health care providers.[4]

Reduced-fee allied health services (eg, dentistry, podiatry, psychological counselling, physiotherapy) are available to patients for whom both a GPMP and a TCA have been written.[5,6] Reduced-fee allied health services are broadly consistent with TCAs, as both are intended to improve access to services for patients with chronic illness. However, their specific objectives differ from those of TCAs in the sense that they are designed to make allied health services more affordable, whereas TCAs are intended to change GPs' management of chronic illness. There is much anecdotal and some research evidence[7] indicating that they have become an important stimulus to GPs to write TCAs.

Coordination of treatment of patients with chronic illness already takes place as part of the existing referral process — GPs send a patient to specialists or other health care providers with a referral letter outlining the problem and the assistance sought, and await the specialist's reply.

However, TCAs are markedly different from the conventional referral process. They have a two-phase structure, comprising the initial development of the plan and its review, with the latter becoming available after a minimum of 3 months has elapsed. The key stipulations of the developmental phase are that the GP's roles include

> contacting the proposed providers and obtaining their agreement to participate, realising that they may wish to see the patient before they provide input but that they may decide to proceed after considering relevant documentation, including any current GPMP [and] collaborating with the participating providers to discuss potential treatment/services they will provide to achieve management goals for the patient . . .[8]

Thus, in the initial phase of TCA development, the GP must discuss the plan with all the other providers and obtain their agreement to it; be ready to suspend further work on the plan should any of them wish to see the patient; and, by implication, negotiate any change proposed by one of the providers with the others. Only then can the TCA be implemented and the rebate claimed. The same requirement applies to the review stage of TCAs. The GP is required to coordinate TCA review; this role includes

> collaborating with the participating providers to establish the patient's progress against the previously nominated treatment/service goals, and agreeing on any necessary changes and on the specific treatment/services to be provided by each member of the team . . .[8]

In effect, TCAs freeze diagnosis and treatment for at least 3 months until a review is permissible, as any GP who tries to observe the guidelines (by obtaining clearance for any change from all the identified providers) will simply find it too onerous and time consuming to do so until the review fee is accessible.

By contrast, the existing referral process provides for a continuous flow of treatment decisions and actions, with no a-priori requirement about which providers are to be involved. Decisions about other provider involvement in any specific management decision are a matter for the professional judgement of the provider concerned, with the GP normally exercising a general coordination role. To take a limiting case, under TCA rules, a change of medication proposed by an endocrinologist for a patient with diabetes would have to be cleared with all other providers (eg, the dietitian and the podiatrist). Under conventional referral practice, neither the endocrinologist nor the GP would consider it necessary to check a change in medication with allied health providers.

Can Team Care Arrangements serve their purpose?

TCAs fail on two grounds. Firstly, the assumption behind TCAs appears to be that patient outcomes will improve if all management decisions are agreed upon by all the providers involved; or, conversely, other provider involvement, which is left to the judgement of the initiating provider, produces less desirable outcomes. This is an extremely rigid and cumbersome model for the coordination of care to patients with chronic illness, and, as far as we are aware, there is no research evidence justifying the assumption behind it — that it improves patient outcomes.

There is evidence to suggest that TCA coordination requirements are widely ignored — GPs prepare their TCA care plans, send them to the identified service providers, take on board any comments that may come back (they rarely do), and regard their consultation obligations as having been satisfied.[7,9]

Secondly, and more importantly, TCAs do not address the kind of behavioural change in GPs at which care plans are aimed. The care plan program aims to enable GPs to take a global view of the patient's condition and treatment. It can be argued that the existing referral system is inconsistent with, or at least does not promote, this objective. There is nothing in the incremental approach of the conventional referral process that calls for the GP to pause and develop an overall view of the patient's condition and treatment that goes beyond episodic care. TCAs, which capture the patient's condition and treatment at a point in time, might be thought to supply just such a view. However, although the guidelines for TCAs ask GPs to identify treatment objectives and services, there is no requirement, or even a suggestion, that these be based on a global view, either of the patient's condition or of treatment options. The guidelines are consistent with a care plan that addresses a particular episode only.

Patient summaries

There are many elements in the solution to this problem, but one of primary importance is the development of a comprehensive patient summary. Unlike acute care patients, patients with chronic illness often have comorbidities and a lengthy history, and therefore generate an information base that is larger and more complex. They are also usually cared for by multiple providers, and this opens the possibility of communication breakdown.

It is therefore especially important that providers have a shared overview of the patient's condition that includes all the key data in readily accessible form — the kind of patient health summary stipulated in criterion 1.7.2 of the Royal Australian College of General Practitioners' *Standards for general practices*.[10]

Care plans in their present form do not require this kind of health summary, but it ought to be the bedrock on which they are built. A comprehensive health summary would enable the GP to draw up well considered treatment objectives and priorities, provide clinical information of real value to other health professionals, identify and resolve problems of coordination, and eliminate oversights. In its absence, the attainment of these essential elements of an effective care plan will be difficult, if not impossible.

Competing interests

This article was funded by a researcher development scholarship, under the aegis of the Australian National University Medical School.

Author details

Paul A Hartigan, BA, Manager, Special Projects[1]
Tuck Meng Soo, MA, MB BS(Hons), FRACGP, Principal[1]
Marjan Kljakovic, MB ChB, FRNZCGP, PhD, Professor of General Practice and Director, Academic Unit of General Practice and Community Health[2]
1 Interchange General Practice, Canberra, ACT.
2 Australian National University, Canberra, ACT.
Correspondence: paulhartigan@actewagl.net.au

References

1 Australian Health Ministers Conference. National Chronic Disease Strategy. Canberra: Australian Government Department of Health and Ageing, 2005. http://www.health.gov.au/internet/main/publishing.nsf/Content/pq-ncds-strat (accessed May 2009).
2 World Health Organization. Innovative care for chronic conditions. Building blocks for action. Global report. Geneva: WHO, 2002.
3 Wilkinson D, Mott K, Morey S, et al. Evaluation of the Enhanced Primary Care (EPC) Medicare Benefits Schedule (MBS) items and the General Practice Education, Support and Community Linkage Program (GPESCL). Final report. Canberra: Australian Government Department of Health and Ageing, 2003.
4 Eastern Sydney Division of General Practice. New Medicare Chronic Disease Management items replace Enhanced Primary Care (EPC) care planning items from 1 July 2005. http://www.esdgp.org.au/PDF/EPC_Factsheet.pdf (accessed May 2009).
5 Australian Government Department of Health and Ageing. Medicare Benefits Schedule Allied Health and Dental Care Services. Medicare benefits for allied health and dental care services provided to people with chronic conditions and complex care needs. Canberra: DoHA, 2005. http://www.health.gov.au/internet/mbsonline/publishing.nsf/Content/804912723A0CF127CA2574F900213580/$File/2005-11-Allied.pdf (accessed May 2009).
6 Australian Government Department of Health and Ageing. Allied Health Services Under Medicare — fact sheet. http://www.health.gov.au/internet/main/publishing.nsf/Content/health-medicare-health_pro-gp-pdf-allied-cnt.htm (accessed May 2009).
7 Kirby SE, Chong JL, Frances M, et al. Sharing or shuffling — realities of chronic disease care in general practice [letter]. *Med J Aust* 2008; 189: 77.
8 Australian Government Department of Health and Ageing. Chronic Disease Management item explanatory notes. Canberra: DoHA, 2008. http://www.health.gov.au/internet/main/publishing.nsf/Content/90B4B11AA217041FCA2573D4001A50F8/$File/CDMItemExplanatoryNotes.pdf (accessed May 2009).
9 Shortus TD, McKenzie SH, Kemp LA, et al. Multidisciplinary care plans for diabetes: how are they used? *Med J Aust* 2007; 187: 78-81.
10 Royal Australian College of General Practitioners. Standards for general practices. 3rd ed. Melbourne: RACGP, 2005: 37.

(Received 7 Nov 2008, accepted 26 Feb 2009) ❑