ORIGINAL ARTICLE

Involvement of practice nurses and allied health professionals in the development and management of care planning processes for patients with chronic disease – A pilot study

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Abstract

Introduction: Medicare items were introduced in 2005 to encourage general practitioners (GPs) to involve other healthcare providers in the management of patients with chronic disease. However, there appears to be barriers to converting financial incentives and the use of information technology as a communication tool to better patient outcomes. The aim of this study was to explore these barriers from the perspectives of practice nurses and allied health practitioners.

Methods: Three focus groups were held, comprising a convenience sample of 10 practice nurses and 17 allied health professionals from south-east Melbourne.

Findings: Findings were reported under five themes: (1) attitudes and beliefs, (2) communication using care planning documents, (3) electronic communication, (4) care planning and collaboration between healthcare professionals and (5) ongoing challenges.

Conclusion: While allied professionals use care planning tools, there is confusion about the extent to which these tools are for the GPs to provide structured care to assist with communication or funding mechanisms for allied health services. Further research is needed on the contributions of these groups to the care planning process and how communication and collaboration between healthcare professionals can be strengthened.

Introduction

The healthcare system in Australia is complex with a mix of Commonwealth and State Government funded services and services supported by private health insurance. Medicare is the Commonwealth Government's universal health insurance scheme, which was introduced in 1984 and is partially funded by an income tax levy. Despite providing substantial funding for public hospitals, it also gives subsidies to doctors working outside the public hospital system. In certain circumstances, allied health practitioners, dentists and psychologists can have the rebates for their fees paid by Medicare. One of the circumstances when patients can obtain rebates for attending allied health practitioners occurs when they have a chronic medical condition with complex needs and they are referred by their GPs. The referral must include the creation of a care plan.[1,2] A care plan is a written, comprehensive and longitudinal plan of action that sets out the health care needs of a patient and the type of services and support required to meet these needs.[3]

Since the early 2000s, general practice in Australia has undergone a transformation due to the Commonwealth Government establishing funding streams for health professionals other than medical practitioners. Funding is now provided for the employment of nurses in general practices ('practice nurses')[4,5] and allied health professionals[6,7] who provide specialist services relevant to managing chronic illness, for example, podiatrists, physiotherapists, occupational therapists, social workers, dieticians, diabetes educators, exercise physiologists and psychologists.[8] In 2005, the Australian Government introduced three new Medicare items: general practice management plans (GPMPs), team care arrangements (TCAs) and their associated reviews.[8-10] GPMPs are written plans developed by GPs for patients with chronic disease(s) to coordinate patients' treatment, and can be undertaken by GPs alone. TCAs are

also written plans and cover cases where the GP needs to involve multiple healthcare providers; they are designed to make allied health services more affordable by providing Medicare funding for five allied health treatment sessions per patient per year. Together, GPMPs and TCAs are intended to improve access to services for patients with chronic illness.[8-11]

Patients struggling with chronic disease(s) require planned, regular interactions with caregivers who are linked by clinically relevant information systems and continuing follow-up.[12] While a coordinated approach provides optimal management of chronic disease(s),[13] it has also been suggested that it rarely results in genuine collaboration.[9] This may be due to a number of reasons including requirements making coordination unwieldy,[8] poor understanding and use of the Medicare items,[14] shortage of appropriately trained practice nurses (PNs) and uncertainty about their roles,[14-16] additional paperwork required,[15] complex and inconsistent care planning templates,[3] challenges with using computers in general practice,[17] lack of patient access to and limited use of technology,[18-20] time constraints and difficulty communicating with other health providers[21] and GPs rarely discussing care planning with other providers.[9]

It is clear that as technology use increases and healthcare delivery processes change,[22] communication between GPs and service providers is important[23] because the quality of information exchange has an impact on patient outcomes.[24] In addition, efficient practice systems are important to assist GPs to make clinical decisions and to make links with community resources and services.[20] Along with effective communication, the use of information technology (IT) through secure websites[25-27] for health information exchange may assist in addressing some of the barriers to effective management of patients with chronic disease(s).[26]

While there is literature published about the introduction and merits of GPMPs and TCAs[8-11, 13,14] and clinicians[22] and patients about web-based care planning,[18-20] limited literature was found describing PNs' views and experiences,[22] and no literature was found describing allied health professionals' (AHPs) perspectives.

The aim of this study was to investigate PNs' and APHs' views and experiences of their involvement in the development and management GPMPs and TCAs.

Methods:

Study methodology: qualitative vs. quantitative

A qualitative methodology was chosen to gain in-depth insight[28,29] into the various health professionals' experiences of their involvement in the development and management of GPMPs and TCAs.

Study design: in-depth FGS

Focus groups were chosen because the researcher can explore a small group of participants' in-depth knowledge, and compare experiences and views.[28,29]

Setting

All three focus groups were held in the Monash Division of General Practice (a local organisation funded by the Commonwealth Government to provide educational support to general practice staff) located in south-east Melbourne. This organisation was selected because of the professional relationship with the research team from Monash University and its central location for participants to travel to.

Participants – inclusion and exclusion criteria

Participants self-selected involvement by (a) responding to the invitation and (b) by attending a focus group. There were no other inclusion or exclusion criteria.

Sampling and recruitment

A convenience sample[28,29] was recruited via the Monash Division of General Practice who circulated invitations to all practice nurses and allied health professionals on their database. Interested personnel responded back to the research team, providing an email address and/or a telephone number for the purpose of contact to advise time, date and venue of the focus.

Research instrument

Following a review of the literature on the involvement of PNs and AHPs, and the development and management of GPMPs and TCAs,[3,5,8-11,13,14,17-27,30-33] a semi-structured interview schedule was developed comprising five themes (Table 1).

Data collection

Three focus groups were held in July 2009. All were of 2 hours' duration and included a brief demonstration of a web-based care planning tool as an example of an option to using paper-based tools. The first comprised seven PNs. The second comprised 11 APHs (five podiatrists, four dieticians and two diabetes

educators). The third comprised three PNs and six AHPs (a physiotherapist, dietician, podiatrist, diabetes educator, occupational therapist and an exercise physiologist). This mix of groups provided a unique opportunity to identify similarities and differences in the experiences of these two groups. Only one participant in each of the three groups was employed by a publicly funded health service (a community health service), the remaining were employed in private practices. Twenty-three participants were females and all had been in practice for several years.

The focus groups were facilitated by the research team, tape recorded and transcribed verbatim by an external organisation.

Table 1. Themes developed to elicit participants' perspectives and a sample of the questions asked

Theme	Illustrative sample of questions
1. Attitudes and beliefs on care planning, GPMPs and TCAs	What is a GPMP? What is their purpose (GPMPs. TCAs)? What is the difference between a GPMP and referral? What are TCAs? What are your experiences in developing GPMPs? Why might you receive 'paperwork' from GPs? What do you think about the quality of GPMPs and TCAs that you receive?
2. Communication using care planning documents	Does care planning lead to better communication between members of the healthcare team? What do you think of the GPMP templates that are currently used in your practice? Would you prefer to simply receive a referral letter rather than a formalised GPMP? What do you do with a GPMP when it arrives by fax but you are not with the patient? Do you provide feedback for TCAs or simply 'tick the box' to accept the GPMP/TCA? Is there a risk of too much information being shared?
3. Electronic communication	Does electronic communication make a difference to the functioning of a healthcare team? What is your experience? What are the problems with electronic communication? Is email useful? Would a web-based GPMP/TCA template be useful?
4. Care planning and collaboration between healthcare professionals	Does care planning make the healthcare team more of a team than simple referrals and letters would? Do all members of the team need to see all the information within a care plan? Do AHPs ask patients to go to their GP to 'get a plan', and if so, do the AHPs explain what it is about? What is the difference between care coordination and care planning? Does the former really occur? What happens when patients have more than one GP or cannot remember the name of their GP? What does that mean for 'collaboration'? How can allied health professionals provide input into a care plan when they have not yet seen the patient?
5. Ongoing challenges	What is a 'perfect' care planning process? If we move forward electronically, will we leave patients behind?

Data analysis

Data were manually and systematically analysed according to the Framework Method[34], which involves a five-stage inductive and deductive process of becoming familiar with the data by reading the transcripts to recognise recurring words and themes, and interpreting the themes to understand participants' perspectives.[28,34] Two team members (KJ and PS) independently coded the transcript, guided by the five themes used in the focus groups. When there was a difference in opinion, the issues were discussed until agreement was reached. No data management software was used.

The findings[28,29,34] are reported under the five focus group themes. In this study, the term 'care planning' refers to the Medicare items known as GPMPs and TCAs. During the focus groups, the terms 'care planning' and 'GPMPs' or 'TCAs' were used interchangeably. Comments made by participants are identified by notating the focus group (FG1-3) and whether the comment was made by a PN or APH.

Medical ethics approval

This research was approved by the Monash University Human Research and Ethics Committee (MUHREC) CF09/0897:2009000418.

Results

Attitudes and beliefs on care planning, general practice management plans (GPMPs) and team care arrangements (TCAs)

Most participants agreed that the concept of care planning was good and should improve patient care. However, several indicated that there appeared to be a lot of unsatisfactory 'paperwork', resulting in either too much information being provided or that clinical goals and strategies were not sufficiently individualised for specific patients.

"There is so much paper that comes out of my fax machine of which only the top sheet and the bottom are relevant. Everything in between is a requirement" (FG2 AHP).

PNs and AHPs working in private and public organisations had different experiences. Those working in community health services reported that they could not access Medicare funding available for TCAs, even though GPs asked them to be a part of a care team. This meant they provided feedback to GPs even though they were not specifically funded to do so, and did not gain any direct benefit from it.

"There's an expectation for AHPs to provide feedback, but often we feel there's no reason to write long reports that justifies the time spent on follow ups just to complete the care planning cycle because our agency doesn't get anything for it, yet it's a lot of time we could be spending looking after another client potentially" (FG3 AHP).

Some felt they were contacted simply to make up the required numbers for a TCA 'sign-off' according to Medicare rules. There was confusion between accepting a referral and accepting the information presented in the GPMPs and TCAs. There was also uncertainty about the difference between feedback about the patient and feedback about the GPMP and/or TCA, and the differences between the GPMP and the TCA. The confusion arose particularly for those employed in community health services when they were not a part of the Medicare funding process.

"It's a glorified referral system … I don't see any difference in just getting a referral from the doctor with a letter. I don't feel connected" (FG 2 AHP).

Restrictions on the number and timing of visits to AHPs (five visits that must be taken in a calendar year) were a challenge, particularly when it was not possible to know in advance how many visits should be allocated to particular AHPs. Others queried why they were expected to provide feedback when the patient was not present or before the patient had been reviewed.

"*It is probably only relevant when the patient is in front of you. Unless the patient is in front of me, I can't remember the details. So, just getting emails about all different patients, it would be just in the abstract really" (FG 3 AHP).*

Communication using care planning documents (GPMPs and TCAs)

Many doubted whether the GPMP and TCA documents were good communication instruments when compared to letters written by GPs after patients were seen.

"The majority of care plans are fairly generic looking" (FG 1 PN).

Participants suggested that healthcare professionals still do not really talk to each other. Most doubted whether patients understood the purpose of care planning and the content of the documents, particularly as the document format was not patient-friendly. They thought that there were too many boxes and they looked too technical.

I think they [care plans] are not in patient language (FG 2 PN).

Electronic communication

Opinion was divided about whether electronic communication was a specific enhancer of inter-professional communication. Some thought email is a useful tool although it risked an excessive flow of information.

"In terms of preparing the care plan, if you can do it all online and send it to each different provider, it saves a huge amount of time in general practice" (FG3 AHP).

Of importance, not all had regular access to email and most felt that patients would be quite unlikely to want to contribute to their personal GPMPs or TCAs via computers, in part, because people with chronic diseases are generally older and therefore often less comfortable with electronic communication.

"*I'm not always accessibly on the web, I'm not always in a place where the computer is online and I think it becomes very unwieldy. I think it's fine if you are in a location, so if you are here all the time, then it's easy, but I am not, I move around, so I don't think it's practical" (FG3 AHP).*

Other frustrations about email included the need to encrypt patient information in an environment with incompatible programmes. Lack of hardware was an issue; not all AHPs had access to computers, and not all had online access at all of their practice locations. After a web-based tool was demonstrated, most commented that while this tool might have some advantages and was clearly the 'way of the future', participants were skeptical about the likelihood of many GPs and health professionals wanting to learn yet another computer program. Concern was also expressed on whether this or any other web-based tools are compatible with the various clinical software programs available, with most expressing reluctance on having to use different systems in parallel.

It's a problem if the internet is down (FG2 AHP).

That's what lets us down and it's not just the frustration, it actually impacts on patient care if you don't communicate. Things get repeated and unnecessary conversations occur (FG1 PN).

4. Care planning and collaboration between healthcare professionals

Most accepted the concept of a healthcare 'team', which includes the AHPs involved in patients' care, and many thought TCAs brought AHPs and GPs a little closer, resulting in more communication and coordination than was previously the case.

It definitely would improve communication, so people would know who they players are (FG2 PN)

Participants were surprised that GPs might be annoyed or frustrated when patients asked them 'for a referral' to access AHP services that are subsidised by Medicare funds. Participants thought GPs were in the best position to know about Medicare eligibility, and therefore felt it was reasonable to refer patients to the GP to seek advice in this regard. At the same time, many participants felt that patients often did not seem to understand why they were referred to allied health professionals as many patients did not return for follow-up. PNs felt the process worked best if they personally reviewed the patients rather than trying to develop the GPMP or TCA from the existing medical record. Having the patient present was particularly useful in developing individualised, realistic goals and strategies. The nurse's ability to develop a GPMP was further enhanced by conducting a formal 'health assessment' for older patients when relevant, and using the appropriate Medicare item number for that assessment.

"I think that it's great if I can access all that [information] - that would be good" (FG3 AHP).

The best care plan comes just following a health assessment I agree with you. You know absolutely everything; you know their family support …it's a very comprehensive care plan you have to write after you've done a health assessment (FG1 PN)

Most agreed that a barrier to collaboration was that patients do not always remain with the same GP, or, they may consult more than one GP. Some patients endeavour to 'play the system' and obtain separate TCAs from different GPs so that they can have additional visits to AHPs. When Medicare rejects payment for these extra visits, AHPs are left out of pocket or with 'bad debts'.

"The trouble is now lots of patients have different GPs; they'll go to a variety of doctors and it does make it really hard when you're doing the care" (FG3 PN).

"Community health, for example, doesn't get any funding for the Medicare so there's only certain visits that can be used for clients" (FG2 AHP).

The majority agreed that a bureaucratic process that involved paper shuffling could not possibly improve care management to such an extent that it would lead to health benefits. It was felt that the focus on increasing access to AHPs via Medicare funding has led to distortions in the care planning process.

"I think what has changed is that a lot of patients are accessing allied health services which they probably didn't before care plans" (FG1 PN).

Ongoing challenges

While most agreed that increased electronic communication in the health sector was inevitable, there were many problems still needed to be overcome.

Communication between AHPs and GPs remains difficult with or without the care planning process. Participants found it challenging to know when to provide feedback to a GP, particularly when they were uncertain whether the patient would return to the referring GP for follow up. If feedback should be provided at the end of a series of visits, as per the TCA guidelines, then a report might slip through if the patient does not attend an appointment.

There is too much communication. There's a danger of that, I can see (FG 2 PN).

It was felt that difficulties such as these are not solved by the current care planning process or by electronic communication.

Discussion

This study focused on experiences with care planning in Australia. It is difficult to compare these with other countries because of differences in healthcare systems, including funding models. There are also differences in training and education, and the roles of allied health professions[4,7] as well as practice nurses' qualification requirements and roles.[4,16] Nonetheless, many of the issues and concerns raised in the findings of this study may provide lessons for the international community.

Most of the practitioners were from private practice[8-10] and as Medicare funding is for GPs working in this capacity, these participants are likely to represent a cross-section of the views of PNs and AHPs from metropolitan practices. Publicly funded practitioners also use care planning as a part of good clinical practice within their organisations.[13]

One barrier is the lack of understanding of how the process works from the perspective of Medicare item requirements.[14,15] While these health professionals understood the value of good communication,[23,24,35] there was only guarded confidence that the current system contributed to this; participants frequently reverted back to the conceptual and practical problems experienced when using GPMPs and TCAs.

There was a clear message from the three focus groups that neither a web-based format[3, 21, 26, 27] nor alternative forms of electronic communication can be separated from other aspects of care planning because all aspects need to be considered together, including the understanding that patients do, or do not have knowledge about, or interest in GPMPs and TCAs.[18-20,22] While a discussion about the potential benefits of electronic communication elicited considerable interest, participants raised a range of issues that went well beyond communication difficulties.[3,9,14,15,17-19,22,30] The concept of a GPMP and TCA, the nature of inter-professional engagement, the time and financial pressures in clinical practice, and most importantly, the need to have the patient at the centre of the process, all add layers of complexity to chronic disease management.

Limitations of this pilot study must be noted. While the participant number is relatively small (27 participants), this work provides insight into the views and experiences of PNs and APH, which were rarely reported before. In addition, there were no participants from rural areas where a lack of services may be the major challenge.[14] Publicly funded practitioners were also under-represented, thus, it was not possible to explore whether there were differences between those employed in private and/or public practice.

Conclusion

This study confirmed that not all health professionals have the same requirements for information from GPs, and that PNs will tend to see things from their own particular domain. Communication systems vary between different clinics and organisations, and technical factors can influence those who are being asked to reflect on the broader issues involved in team-based care planning.[3,8]

This study suggests that while PNS and AHPs acknowledge that the use of GPMPs and TCAs has some merit, there is confusion about the extent to which GPMPs and TCAs are tools for the GP to provide more structured care, to assist communication with a broader care team, or are funding mechanisms for allied health services. It appears that effective communication and the use of information technology (IT) for health information exchange may assist in addressing some of the barriers to effective management of patients with chronic diseases,[26] provided that efficiency is not lost.

Further research is needed to gain additional insight to the contributions of these two important groups to the care planning process and patient care, and to how communication between healthcare professionals can be strengthened.

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Conflict of interest

There was no conflict of interest for all authors.

How does this paper make a difference to general practice?

- Communication continues to be a problem between general practitioners (GPs) and allied health professionals, particularly if patients do not remain with the same GP.
- Opinion was divided about whether electronic communication enhanced inter-professional communication or not.
- The majority agreed that the concept of a healthcare team includes allied health professionals.
- Although most agreed that increased electronic communication in the health sector was inevitable, there were many problems that still needed to be overcome.

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