

BRIEF (10) July, 2008

Five Components of Practice Based Care Coordination, Nurse-led Model

This briefing was prepared as part of a primary health care research collaboration between Griffith University and General Practice Queensland.

Background

This briefing presents the findings of the five themes/components which emerged through focus group discussions with general practitioners and practice nurses to determine the role of the practice nurse in care coordination. Briefing number 9 provides the background information which led to the development of the five components which emerged from the study. A proposed model of care is presented to support an implementation process for a practice-based model of care. This study was conducted at the Gold Coast Division of General Practice. The full article (in journal publication review) can be found at www.gpqld.com.au/Programs/Collaborative_Research_Hub

Results and Challenges of Practice-Based Care Coordination

Five major themes emerged that would require attention prior to the implementation of coordinated care interventions in the general practice setting. The five themes include: conceptual confusion; internal and external partnerships; culture change; financial models for a business context and; professional definition, development and recognition. The results suggest that any model of care coordination would need to be supported by a developmental process which supports the themes. This includes developing an understanding and clarity around the definition of coordinated care, developing a whole of practice approach to address cultural change, developing the capacity to support internal and external partnerships, development and recognition of the role of the nurse and a full understanding of the financial models that could support care coordination.

Theme One: Conceptual Confusion

Coordinated care was a “fuzzy” term that meant different things to everyone and raised considerable confusion in discussions. There was no single model or understanding of coordinated care or an approach that would suit everyone. The data clearly indicated that practices all worked in different ways, even in relation to the same activity, concept or process. Further, within-practice variability was evident across individual patients and populations (i.e., Indigenous, Nursing Homes). The nature and extent of care coordination undertaken at the practice level varied considerably, along with the views about the possibility of an extended nurse role. Even within practices, views varied considerably, suggesting the need for extensive cultural change and communication prior to the development of new models of care.

Practice Enablers (to support implementation and future engagement) included:

- The capability of the practice (including internal and external communication systems);
- Workforce capacity, and;
- Knowledge of primary and allied health processes.

Practices that had implemented some form of coordinated care for patients with chronic conditions had generally used one of four approaches:

(1) an internal model (i.e., extending the role of an existing nurse);

(2) an external model (i.e., employing an external service coordinator to work with practice clients);

(3) a practice cluster model, where several practices shared staffing or resources or;

(4) an unspecified model, which involved the inclusion of some aspects of coordination and planned follow-up but was not labelled as a specific approach.

Each model had significant advantages and disadvantages.

Practice Implications

Without a clear definition and a shared model of coordinated care, there was confusion about how to evaluate its outcomes in comparison to 'usual care'. This confusion had obvious implications for:

- Quality improvement
- Workload allocation
- Workforce autonomy
- What skills and resources would be needed for it to work.

Theme Two: Internal and External Partnerships

Nurses relied heavily on personal relationships with their peers, GP's, service providers and patients. So much so that it was believed that the success of any model was thought to hinge on the GP-Nurse relationship. The knowledge around how the practices operated varied between the GPs and nurses and indicated the need for more formal communication strategies to create a stronger sense of understanding about coordinated care. Trust from both the GP and the nurse was an important element and interaction within the practice.

Relationships with external providers presented many challenges for nurses. An example of this was the difficulty nurses faced in trying to liaise with external providers (e.g. specialist, allied health practitioners) who did not respond and report in a timely manner. It was identified that a systematic approach to locating local health service providers and the patient attendance and experience would provide continuity and value add to current practice. Currently approaches are ad hoc, there is a lack of awareness of services and it is a time consuming process.

Information sharing and providing continuity of care between practices and hospitals was problematic, adding to the intensive process of tracking patients. Strong partnerships between practices and external providers and effective communication protocols were considered important to ensure referrals preceded smoothly.

Theme Three: Cultural Change

The need for cultural change and the gradual shift to extended roles and practice-based care coordination were highlighted repeatedly. Within practices this would require the role of the nurse to be fully understood and for attitudinal change that would enable the GP to trust nurses to engage in extended activities. Patients also needed to be educated to understand the value of extended care, although it was identified that this was a choice and that patients could decide whether to engage or not.

Theme Four: Financial Models for a Business Context

There was a clear need for the financial viability of the model to identify the economic returns for general practice. A summary of key areas identified included:

- The need for education around the financial viability;
- Summaries of MBS item numbers and how to use them effectively;
- Need to demonstrate the affordability (and income earning potential);
- Need to address the barriers associated with the financial viability including:
 - consistency in applying for standard MBS items due to excess paperwork;

- Unnecessary complicated process (through enhanced primary care MBS item numbers);

For clients, clear guidelines about funding opportunities were considered to be an incentive for participating in coordinated care. Nurses carried a sense of responsibility to ensure that patients maximised the benefit of their private health insurance or had access to a small pot of funds to purchase essential services. For patients with complex chronic diseases, it was difficult to meet their health-related needs without additional funding or by relying on the non-government sector. Funded services were also seen as an incentive for patients to engage in their health care needs and increasing the capacity of nurses to work collaboratively with patients.

Theme Five: Professional Definition, Development and Recognition

Barriers for nurses in the practice setting included:

- Time as the greatest challenge;
- The coordination of the care required a dedicated role;
- The level of commitment was not possible in all types of practices;
- Workforce included many part-time nurses;
- Other non-work responsibilities (such as parenting);
- Highly dedicated to extra-curricular professional skill development such as education sessions, networks and conferences;
- Administrative demands (both existing and those bought on by the extended level of care) – particularly those nurses without access to a receptionist;

Despite these barriers raised, nurse-led coordination activity was viewed positively and was overwhelming welcomed. It was stressed however, that to achieve the desired outcomes and any extension to their role, could only be achieved through a whole-of-practice commitment. The potential positive outcomes included:

- Team based approach including significant change and education;
- More time to build relationships and consult with patients;
- Greater role in patient education;
- Time allocated to the preparation of documents, assessments and reviews and organising time for review with the GP;
- Allocated office space for meeting with patients privately;
- Skills required include – time management, business planning, organisation and a 'natural aptitude'

It was identified that not all nurses would want to take on this extended role of care coordination and to take a greater responsibility in 'treatment only', 'coordination only' or a 'mix' of the two.

Support at the organisational level from networks and Divisions of General Practice were seen to be important to the role. Examples include:

- A network of "Primary Health Nurses" (similar to the GP collaborative networks)
- Divisions role in:
 - providing facilitator/mentor (e.g. Care Coordination Practice Facilitator);
 - Developing and distributing resources;
 - Potentially – funding for services or for support at the practice level;
 - Guidance and advocacy

The follow up briefing (11) highlights the potential implementation of a system framework to support processes that incorporate a range of structures to assist practices to engage in the delivery of coordinated care.

Acknowledgments

This briefing is a summary of a research paper (in journal publication review)

Paper Title: **A Practice-Based Model of Care Coordination for Chronic Disease Management: The Role of Nurses in General Practice**

Available at: www.gpqld.com.au/Collaborative_Research_Hub

Authors: Elizabeth Kendall¹, Heidi Muenchberger^{1,3}, Carolyn Ehrlich¹, Ronita Neal¹, Kim McFarlane^{1,3}, Kylie Armstrong^{1,2}

1. Centre of National Research on Disability and Rehabilitation, Griffith Institute of Health & Medical Research, Griffith University, Meadowbrook Q 4131
2. General Practice Queensland
3. Queensland Health Southside District Place-Based Initiative

The work was made possible by funding from the Gold Coast Division of General Practice, Queensland Health and the Motor Accident Insurance Commission

Gold Coast Division of General Practice Website: www.gcdgp.com.au

For further information contact:

Dr Kylie Armstrong
Senior Research Fellow (Primary Health Care)
Griffith University & General Practice Queensland
Griffith Institute for Health and Medical Research
karmstrong@gpqld.com.au
07 47258868

Professor Elizabeth Kendall
Centre of National Research on Disability and
Rehabilitation Medicine
Griffith Institute for Health and Medical Research
Griffith University
e.kendall@griffith.edu.au