

BRIEF (9) July, 2008

Role of the Practice Nurse, Care Coordination for Chronic Disease Management

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

Background

This briefing explores the role of the practice nurse in the coordination of care for people with chronic conditions. Focus groups were conducted with general practitioners and practice nurses to gain an understanding of the specific tasks that might be conducted by practice nurses. Five themes emerged that indicated the need for a developmental and well supported implementation process. This research was conducted at the Gold Coast Division of General Practice. The full article (in journal publication review) can be found at www.gpql.com.au/Programs/Collaborative_Research_Hub

The Role of the Nurse in Care Coordination

Both information provided by the consumer and documented information related to the medical condition and treatment are equally important to continuous service provision, providing the link from one service episode to another.¹ The role of the team in the practice setting has been shown to provide consistent and coordinated service integration.

Clarity around the role of practice nurses is required to improve chronic care expertise and to respond to workforce pressures.² A system wide change must incorporate a change in skill-mix with the creation of new roles and new workers.³ To improve the effectiveness, efficiency and responsiveness of the health system, the competencies within and across teams of health professionals needs to change, and will require considerable education and attitude change. The Australian Coordinated Care Demonstration Trials⁴ and similar trials in the United Kingdom⁵ identified the need for structures and strategies to support their practice in the area of chronic disease management.

The Task of Coordinated Care

To improve outcomes for people with chronic disease, interventions must simultaneously implement strategies to change GP behaviour, re-organize general practice, improve information systems and deliver high quality patient education/support. A systematic review⁶ of coordination strategies identified two major categories which fell across the continuum from the service practitioner and individual with the chronic condition (micro-level) to the system level (macro-level). These categories are focussed on the process to facilitate coordination (e.g., communication strategies, supports for service providers and supports for individual consumers) and those focussed on structures for coordinating activities (e.g., shared information systems, referral proformas, care plans, decision support systems and so forth). The most successful strategies in terms of outcomes for consumers were those that involved a re-organisation of structures to strengthen relationships between organisations and the provision of tools to actively support coordination (e.g., a shared care plan and records).

In reality, however, few models of care have been found to address all these components or activities. Indeed, some evidence has suggested that they may not need to contain all these activities, as long as they contain a set of key elements. For instance, Wagner⁷ and his colleagues concluded that successful comprehensive coordination programs typically contained four essential elements, namely,

1. Collaborative problem definition;

2. Targeting, goal setting and planning;
3. A continuum of information, self-management training and support services; and
4. Active and sustained follow-up.

In most studies, the actual tasks of a care coordinator mirrored these components⁸, namely assessing and planning, implementing plans and delivering services, re-assessing and adjusting plans (see Table 1 for detailed description of these activities). Similarly, Woolf, Glasgow et al. (2005)⁹ found that across 17 practice-based coordination interventions, five common elements could be identified. They categorised these elements according to a model of health psychology used extensively in counselling (the 5As model). The five components included:

- (1) *Assess*: Identify chronic conditions and unhealthy behaviours;
- (2) *Advise*: Offer brief advice;
- (3) *Agree*: Set collaborative goals and action plans (e.g., behaviour “prescriptions”),
- (4) *Assist*: Provide more extensive education (e.g., training), counselling (e.g., coaching, case management), and self-help tools (e.g., pedometers, activity logs, food diaries); and
- (5) *Arrange*: Organise services, follow-up and reinforcement (e.g., e-mail or telephone follow-up, patient-held health diaries)

Research Project

The aim of this research was to:

- Identify the activities that nurses could engage in to support care coordination in general practice;
- Understand and address the barriers experienced (or likely to be experienced) by general practices and nurses in general practice in delivering care coordination for patients with chronic conditions;
- Identify the types of supports that are considered necessary to assist nurses in general practice to deliver extended care.

Thirteen participants engaged in three stakeholder focus groups. The participants consisted of 4 male GPs, 5 female Nurses, 2 female Practice Facilitators and 2 male Division Representatives (i.e., a coordinating body for general practice). Across these participants, seven practices were represented (i.e., the sample included 3 GP/Nurse pairs) and one Nurse was employed at an Indigenous Health Service. The data collection and analysis is explained in detail in the full article review. Overall the aim of the analysis identified the key themes that emerged in relation to activities that were currently (or could be) undertaken by practices nurses, barriers and issues faced (or expected to face) and possible solutions.

Findings of Focus Groups

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:

1. conceptual confusion;
2. internal and external partnerships;
3. culture change;
4. financial models for a business context and;
5. professional definition, development and recognition.

Briefing number 10 outlines the findings in more detail. 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.

Recommendations and Implementation of a Trail

Using the activities identified in the themes as a framework, the Gold Coast Division of General Practice has begun a trial with a group of participating practices. This includes creating a localised practice-based model that represents each of the five themes/components of care coordination. To support implementation of the model, support structures have been developed which includes: Care Coordination Practice Facilitator, a Primary Health Nurse Network, a Developmental Implementation System (focusing on cultural change, readiness, protocol development and process design) and a Care Coordination Resource Kit.

This study has highlighted the need for a supportive developmental process that incorporates a range of broad structures to assist practices to engage in the delivery of coordinated care, ensuring “practice readiness” and maximizing both capacity and sustainability of the model. This includes providing ongoing mentorship to negotiate roles and requirements within the practice, provide administrative assistance with financial, procedural and other aspects of care coordination, and guidance/advocacy for practices as needed.

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

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Table 1: Activities of a Care Coordinator identified by Chen et al. (2000)⁸

<p>Assess and Plan: Identify all important problems and goals, produce a clear, practical plan that addresses these problems and list specific goals.</p> <ol style="list-style-type: none">1. <i>Identify people with chronic conditions who require assistance and uncover all important problems.</i> These are the problems that can keep the person from better health and lead to unplanned hospitalizations. These problems vary for each patient.3. <i>Address all important problems and goals.</i> Every important problem and goal should have a plan and an intervention or interventions to address it.4. <i>Draw from a comprehensive arsenal of proven interventions.</i> A care coordinator must have a broad array of appropriate, proven interventions available in order to choose the best ones to meet a patient's needs.5. <i>Produce a clear, practical plan of care, with specific goals.</i> The first step concludes with a written, individualized plan of care. It is important that all concerned—patient, care coordinator, GP - have a common, agreed-upon set of goals for the patient, and when and how the patient is going to achieve them.
<p>Implement and Deliver. In the second step, Implement and Deliver, the care coordinator must implement the plan and deliver the services outlined in the plan of care. Care coordinators provide services of care coordination and communication, patient education, oversight of the care plan and assurance that interventions happen as planned.</p> <ol style="list-style-type: none">1. <i>Build ongoing relationships with the GPs and with other providers.</i> This task enables care coordinators to coordinate care and facilitate communication among providers.2. <i>Build ongoing relationships with patients and families.</i> The foundation for this relationship is often laid during the initial assessment in the first step.3. <i>Provide patient education.</i> This intervention must be part of every plan of care. Programs must teach patients crucial self-care skills, such as proper diet for their condition, medical compliance, self-monitoring, emergency action plans, and skills to cope with the stresses of chronic illnesses.4. <i>Make certain that planned interventions get done.</i> This task involves monitoring to make sure each intervention gets done.
<p>Reassess and Adjust. Determine whether the interventions are working and, if they are not, adjust the plan. This step has five tasks:</p> <ol style="list-style-type: none">1. <i>Perform periodic reassessments.</i> Contact patients on a regular basis to make sure they continue to progress and have not encountered new problems.2. <i>Be accessible.</i> Patients must have an easy way to reach a care coordinator.3. <i>Nurture the relationship with GPs and providers.</i>4. <i>Nurture the relationship with patient and family.</i>5. <i>Make prompt adjustments to the plan of care as needed.</i> If the reassessment in the first task reveals a lack of progress, the plan of care may need to be changed. Several interventions may have to be tried and discarded before a successful solution is discovered. Changes in the plan of care also need to be made promptly, sometimes even urgently. Patients' level of risk for complications may change, necessitating a change in follow-up frequency.