

## Editorial

# Use of chronic disease management plans in rural practice

The traditional model of general practice in Australia is one of episodic visits to the doctor initiated by the patient. Within these consults, GPs struggle to deal with presenting problems, ongoing chronic disease needs and a myriad of administrative tasks. As the population ages, more and more patients will be living with a chronic disease.<sup>1</sup> Guidelines for 'best practice' management of these chronic diseases become more detailed with each evidence-based update requiring ever more monitoring and the initiation of additional medication. With the dual pressures of increasing numbers and increasing complexity, the gap between achievable care and best-practice care will widen unless the work can be shared. The introduction of enhanced primary care Medicare item numbers provides a financial incentive to change the delivery of primary care to one in which care can be effectively shared. Patients are given a management plan detailing their needs, personalised goals and the tasks of each health care provider.

Initial uptake of care planning Medicare item numbers was hampered by their complexity. In this report, the authors describe an initiative to identify the barriers to wider use of care planning in rural practice.<sup>2</sup> An educational intervention was attended by practice nurses, managers and doctors. Following this intervention, there was an expected increase in confidence and knowledge about the process of using Medicare item numbers, but we are not told whether it was these participants who were responsible for increased numbers of items claimed.

In rural areas, workforce shortage often demands innovative solutions to problems, such as dealing with

increasing chronic disease burden. It is feasible for practice administrative staff to take a significant role in organising patient recall visits, pathology testing and completion of waiting room checklists. Practice nurses can successfully take on new roles to lead the assessment of patients and coordination of referrals to allied health. Nurses can work with patients to define personalised goals, screen for comorbid depression and collect biophysical and pathology measures. Practice nurses are also well placed to provide self-management advice and resources for patients, thus freeing up the GP to concentrate on diagnosis and clinical management.<sup>3</sup> Medicare item numbers are a potential financial engine to fund this enhanced service for our patients. Research in Australia is currently under way to compare the clinical outcomes of nurse-led collaborative care using GP management plans with usual care.

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## References

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- 2 Pierce D. Identifying and addressing barriers to the use of enhanced primary care plans for chronic disease in rural practices. *Australian Journal of Rural Health* 2009; 17: 220–221.
- 3 Dunbar J, Reddy P. Integration and coordination of care. *Australian Journal of Rural Health* 2009; 17: 27–33.