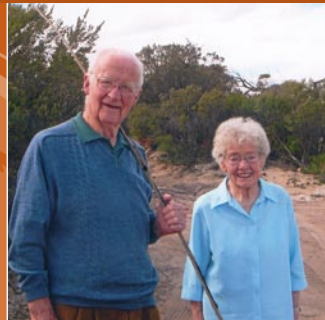
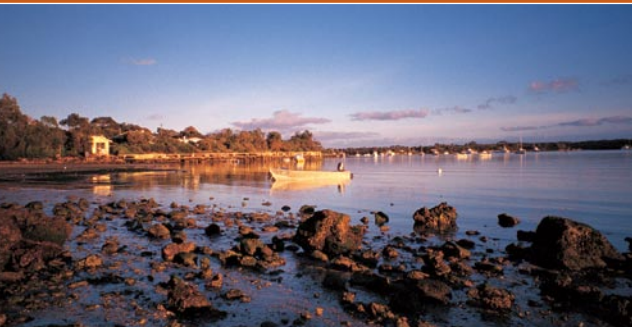


# Incorporating self-management support into General Practice



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# Incorporating self-management support into General Practice

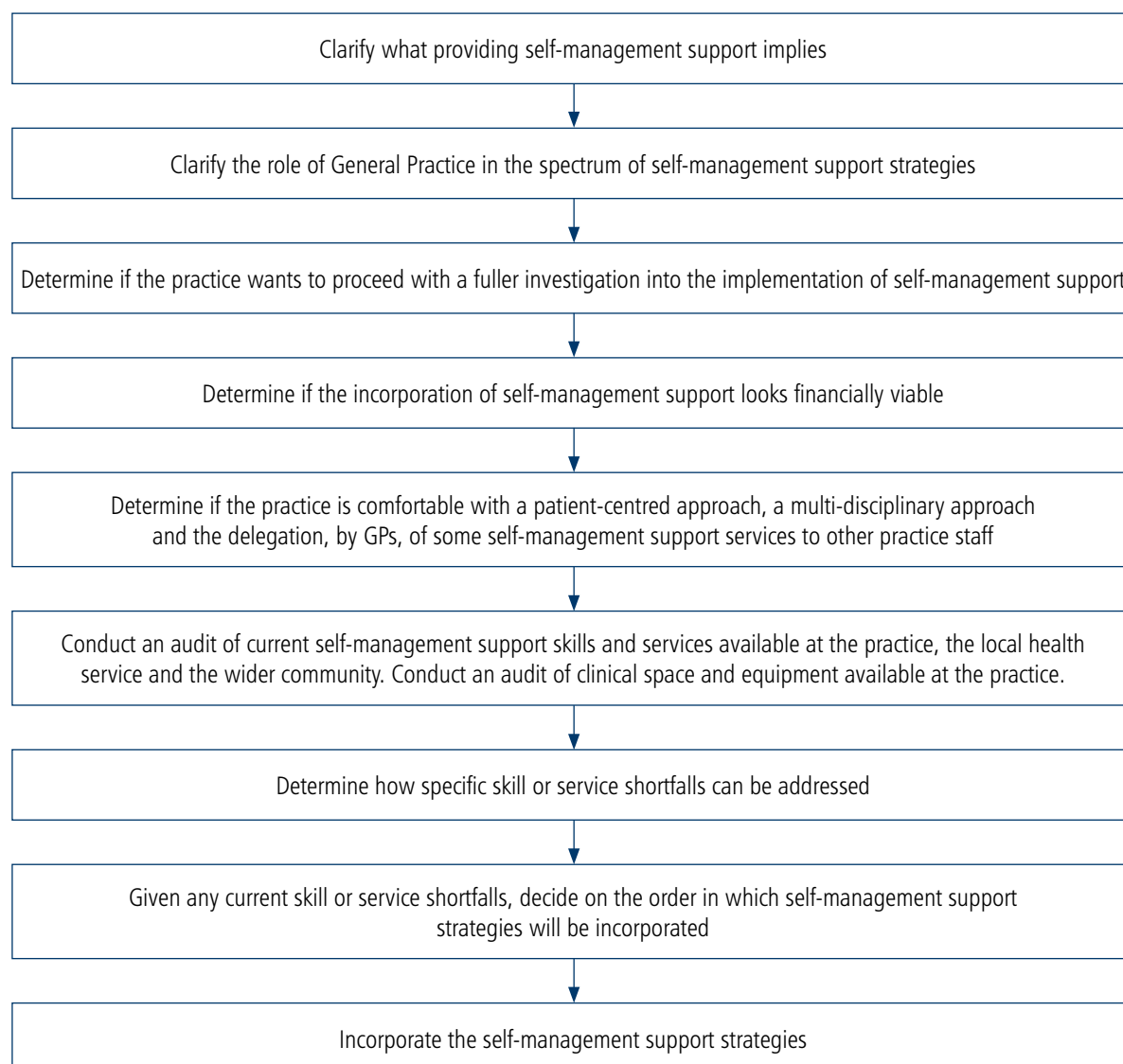


## Introduction

The decision to move from acute care provision to a more preventative, client-centred approach incorporating self-management support should not be made without considering a number of issues, including the financial implications. Like all change, it will involve alterations in work habits, relationships, power structures and skill requirements.

The diagram below represents a possible sequence of the decisions and changes involved. While the issues involved are dealt with more fully in the rest of this booklet, it is highly recommended that practices approach their local Division of General Practice for assistance in exploring the issues involved and the practicalities of implementing any prospective changes.

## Steps in incorporating self-management support into General Practice



## Step 1: Clarify what providing self-management support implies.

Self-management is the active participation by people in their own health care.

Assisting a client to self-manage involves providing education, support and services to improve their knowledge, attitude, skills, and confidence to be involved in:

- preventing or delaying the onset of a chronic disease
- planning and adhering to their care plan
- monitoring and responding to their symptoms
- managing the impact of their condition on their life
- making healthy lifestyle decisions

### For more information

Read Sections One, Two, and Four of this guide.

Contact your local Division of General Practice. They may be able to provide information or suggest another practice to contact for more information.

## Step 2: Clarify the role of General Practice in the spectrum of self-management support strategies.

Support for self-management can come from the medical, behavioural, or socio-economic models of health promotion and ranges from direct clinical service provision to advocating for more allied health services in a particular area.

In self-management support, General Practice is often seen as having the role of:

- providing the client with a portal to the health service
- providing a client-centred approach
- screening for risk factors in 'well' people
- providing or referring clients to preventative education providers
- involving chronically ill clients and their other health care providers in the development and review of client-centred care plans
- coordinating the periodic monitoring of people with chronic disease and, in partnership with the client, making any required changes to their care plan
- referring clients to medical specialists
- referring clients to allied and community health for services, support, or education
- referring clients to community groups for services, support, or education
- providing or referring clients for self-management training (generic or disease specific)
- maintaining a disease register and recall systems to actively follow and support self-management

### For more information

Case Studies 1, 3, 6, and 10 in Section Three of this guide report on CDSM support models that directly involve GPs. Section Five presents 'A model of self-management support for General Practice'

### Step 3: Determine if the practice wants to proceed with a fuller investigation into the implementation of self-management support.

This needs to be an informed and considered decision because the change will require time, energy, resources, and change management skills. Real benefits to the practice and to clients will become increasingly evident over a timeframe of years rather than months, and initially, there may even be an increased workload as both acute and preventative care is provided.

Staff and client perceptions of General Practice need to change.

- Client perceptions of what service and support a General Practice provides will need to be altered so that, over time, the clients appreciate the benefits of going to the doctor even when they are well.
- Staff perceptions of what General Practice is about also need to change. There needs to be a general understanding and consensus among staff that the preventative and CDSM support functions are just as important as acute care.

The practice also needs to consider:

- whether the change fits with the practice's philosophy of health care and promotion
- who in the practice will perform the function of "CDSM support champion", i.e., who is going to drive the change process
- whether the owners and managers of the practice are supportive of the change
- whether the changes are going to suit, or be adopted by all GPs at the practice, and whether this matters

### Step 4: Determine if the incorporation of self-management support appears financially viable.

Your local Division of General Practice may be able to:

- provide information about the various Enhanced Primary Care items, Practice Incentive Payments and Service Incentive Payments. A list of EPC items is included in this booklet.
- provide assistance with an initial search of the practice's clinical database to estimate the number of clients that would qualify for the various EPC services per year
- provide estimates of staff requirements
- provide an initial overview of various self-management support models

If necessary, adapting an optimal care model to one that is financially and physically feasible should be considered.



## **Step 5: Determine if practice staff are comfortable with a client-centred approach, a multi-disciplinary approach and the delegation, by GPs, of some self-management support services to other practice staff.**

### **A client-centred approach**

Implementing a client-centred approach implies that:

- over time, the health care provider will come to understand the client and the context of their life. They will measure or be attuned to the client's willingness, ability, and confidence to accept greater responsibility for their health.
- the health care provider and the client will negotiate and agree about the nature of the client's problem, the client's priorities, the goals of their treatment and the roles of the client and health care providers in that treatment.
- the treatment regime and goals set are realistic and take into account the context of the client's life.
- enhancement of the relationship between the health care provider and the client is given a high priority.

If it is not suitable for a client at a particular point in time, the client-centred approach might not, for example, involve the automatic application of the evidenced-based schedules of care. Both the practice staff, and the GP involved, need to be comfortable with such diversions from recommended care.

The practice needs to be comfortable dealing with the non-clinical issues that might arise as client care evolves towards client-centred approaches.

### **Multi-disciplinary care**

Clients with chronic diseases often need multi-disciplinary care. This need increases with the complexity of the chronic illness and the number of co-morbidities.

The efficient provision of multi-disciplinary care requires that there is recognition and mutual respect for all members of the health care team. The various health care providers bring the specialist skills and knowledge of their disciplines to self-management support. Appropriate allocation of tasks and responsibilities, coupled with clear communication of goals and objectives between members of the team, should lessen the workload of the GP, improve support for the client, ensure more efficient use of time and resources, and improve patient outcomes.

### **Delegation of duties**

The self-management model of care enables GPs to delegate to practice staff some of the workload associated with routine patient management processes. Rather than treating all patients in a direct hands-on approach, GPs are only required to coordinate the care of clients. This should liberate them so that they can work more intensively with those clients who require their direct care.

To implement such an approach, GPs must be confident that employees have the qualification, training, skills, and understanding of self-management support to undertake the tasks they are delegated. Staff must also understand both the responsibilities and limitations of their role.

The owner of the practice also needs to be comfortable that the time staff are allocated for self-management support (e.g., a one hour appointment to coordinate a TCA) falls within the financial constraints of the practice. Also required is a realisation and understanding that additional time will sometimes be needed if optimal outcomes are to be achieved.

## Step 6: Conduct an audit of current self-management support skills and services available at the practice, the local health service and the wider community.

If the practice is planning to incorporate CDSM support services, then an audit of the currently available skills and services is advisable.

Among the issues to be considered are:

- whether there are disease-specific CDSM educators available; e.g., diabetes or asthma educators
- whether there are generic or disease-specific CDSM courses available
- what allied, community, and mental health service providers are available
- whether there is a qualified pharmacist available to assist with medication reviews
- whether there is a service directory available from the Division of General Practice, the local health service, or council
- whether those currently working at the practice have the skills to manage the clinical database and software to support CDSM? (e.g., searching the database, managing the recall system and disease registers, producing documents and templates, data entry and data cleansing)
- whether staff have the communication skills and attitudes to implement a client-centred approach
- where these skills are available; e.g., at the practice, at the local health service, at private providers, at volunteer organisations, or at support groups
- what skills and services will the practice need to provide
- what organisations and groups will the practice need to collaborate with to provide a wider range of self-management support? Divisions of General Practice manage the More Allied Health Service (MAHS) program and could be contacted for information.
- whether the practice has enough clinical space to provide self-management support staff with an effective work environment? If physical space is an issue, then consideration could be given to allowing self-management support staff to work from home and to provide some services in clients' homes.

## Step 7: Determine how specific skill or service shortfalls can be addressed.

### Employ the required staff

People with the requisite skills may be available and could be employed. Practice Incentive Payments support the employment of a practice nurse or Aboriginal Health Worker. Multi-skilled staff can provide a range of services; e.g., a CDSM nurse may also be a qualified diabetes or asthma educator.

### Train existing staff

The local Division of General Practice may be able to provide assistance with:

- clinical software training
- providing details of EPC, PIP, and SIP payments and requirements
- providing examples of how other practices have implemented self-management support
- providing a directory of local services

Consider training at least two practice staff members in the construction and modification of clinical software templates. This is a relatively simple but valuable skill and will provide the practice with the capability to edit templates as required. No matter how carefully forms are designed, they generally need alterations once they are actually used. There will be frustrating delays if the practice does not have the in-house skills to carry out these alterations.

Training in self-management and client-centred care is available from Flinders University.

- The Flinders Human Behaviour & Health Research Unit provides training courses on their chronic care model. Details of these are available at <http://som/flinders.edu.au/FUSA/CCTU>. The Spencer Gulf Rural Health School (SGRHS), based in Whyalla, also offers training in the Flinders Model. For more information contact [kate.warren@unisa.edu.au](mailto:kate.warren@unisa.edu.au) or SGRHS at <http://sgrhs.unisa.edu.au>
- Flinders University offers a Graduate Certificate in Health (Chronic Condition Self Management) and a Graduate Diploma in Chronic Condition Management. Details of these are available at [www.flinders.edu.au](http://www.flinders.edu.au) or by emailing [Sharon.Lawn@fmc.sa.gov.au](mailto:Sharon.Lawn@fmc.sa.gov.au).

### **Advocate for improved or increased service provision**

Practice staff can advocate for improved or increased allied, community, and mental health services in the local area. See Case Study 1 & 13.

Practice staff can advocate for the provision of CDSM education courses by the local health service or a community group.

### **Integrate service delivery and establish referral pathways**

So that clients have a fuller range of self-management support, the practice can integrate and coordinate their services with other providers in the area. Protocols concerning referral pathways and information flows need to be agreed upon and understood by all service contributors.

## **Step 8: Given any current skill or service shortfalls, decide on the order in which self-management support strategies will be implemented.**

### **What model?**

Decide on a model of self-management support - See case studies 1, 2, 3, 6, and 10 for ideas.

Discuss your model with your local Division of General Practice or with a practice that is experienced in self-management support.

Get copies of a range of health assessment and care plan pro formas and checklists. These are available at [www.health.gov.au/epc](http://www.health.gov.au/epc). Divisions of General Practice often have a range of example pro formas and templates on their website. Clinical software packages often include a range of templates to support CDSM.

### **What clients?**

Interrogate your clinical database to identify clients needing self-management support.

Initially it may be more successful to search for prescription patterns rather than medical histories; e.g., to identify clients with angina, it may be more accurate to search for clients prescribed angina puffers rather than search for clients with angina listed as a condition in their medical history.

It is likely that the existing clinical database will require maintenance to improve its accuracy and usefulness. Initially, this may consume a large amount of staff time, but is a worthwhile investment.

Consider starting with 'cooperative' clients with simpler health needs before moving onto more complex or difficult clients. This will allow basic systems to be established before they require adjustments to cope with more complex cases.

Consider starting with clients from just one disease grouping; e.g., clients with diabetes.

## What services?

Consider the following order of implementation:

- EPC Health Assessments
- EPC GP Management Plans
- EPC Domiciliary Medication Management Reviews
- EPC Team Care Arrangements
- Non-EPC funded screening of 'well' clients - at first opportunistically and ultimately becoming a more planned approach
- Non-EPC funded coordination and integration of services and self-management support with local health services, aged care facilities, etc.
- Advocating to cover shortfalls in self-management support in the area

This order moves:

- from simpler to more complex service provision
- in the direction of service delivery that enables previously collected information to be used in the subsequent service; e.g., information gathered at a health assessment may be useful if a GP management plan is later constructed
- from those services directly funded by EPC items, to those that require self-management support practices and philosophy to be incorporated into normal practice operation
- from those services that the practice can provide on their own, to those that require integration and cooperation with other health providers and institutions, and finally to advocating to alleviate shortfalls in local service provision.

## When?

Consider initially quarantining a session or two a week for EPC activities while systems are established.

Allow longer appointments early in the implementation to allow time for the refinement of systems, processes, and staff roles.

## A rationale for the suggested order of implementation

### Health Assessments

Health Assessments will generate EPC income.

Both the practice nurse and the GP can be involved, allowing a working relationship to develop. Some health assessments can be partially completed at the client's home, freeing clinical space and providing a higher financial return. Anecdotally, home-based health assessments provide higher quality data and fuller input from the client.

The introduction of health assessments also requires or provides an opportunity to:

- update medical data about the client
- establish or modify recall systems
- develop and apply skills relevant to client-centred care as management goals are negotiated with the client
- identify clients who need care planning or medication reviews

### GP Management Plans (GPMP)

GP Management Plans (GPMP) are slightly more complex than Health Assessments. They may necessitate, even though it is not mandated, the collection of information from other providers. It is common for the GP to construct a GP Management Plan with the client.

A client-centred approach is required to negotiate the plan of care. Decisions about the care plan need to be negotiated with the client and take into consideration their opinions, priorities, needs and problems. This process of negotiation can be informal or use structured tools. See patient-centred care planning in Section Two of this guide. The plan also needs to consider accepted care guidelines.

Decisions about the frequency of care plan reviews and renewals need to be made, and the coordination of service provision and education is necessary to avoid clients becoming appointment-weary. The clients will appreciate care plan renewals and reviews being coordinated with other service delivery; e.g., Fluvax injections.

A series of referrals for self-management education or clinical service provision may be necessary. This requires an awareness of what clinical and educational support is available in the area.

## **Team Care Arrangements (TCA)**

The development of a Team Care Arrangement (TCA) is more complex than developing a GPMP.

The coordination of Team Care Arrangements can be quite time consuming. It is usual for the practice nurse, in conjunction with the client, to play a key role in the development of the arrangements. Further efficiencies are achieved if one staff member develops expertise in the development of TCAs and cultivates working relationships with other health care providers in the area. See Case Study 6.

Efficiencies will also be gained by targeting those clients who are most likely to benefit from the effort involved in setting up a TCA. Clients that are unlikely to adhere to a plan may need to be referred for more intensive self-management support, or may be considered unsuitable for self-management support at that point in time.

Only clients with complex needs requiring care from a multi-disciplinary team qualify for a TCA. The GP must review and confirm all assessments and elements of the arrangement. See the client journey diagram in Case Study 1.

The approach is client-centred.

Team Care Arrangements require collaboration with at least two other health care providers who are providing on-going treatment to the client. The communication between the providers and the practice must always be two-way and is best done verbally. A record of the conversations should be recorded in the client's clinical record.

Referrals to service providers eligible for Medicare rebates may be provided. Depending on the client, referral to self-management education may be advisable.

## **Non-EPC funded prevention and early detection**

Once a practice has developed expertise, information systems and successful work practices in EPC-funded service provisions, they have the skill base and systems to provide planned preventative screening programs for 'well' community members.

General Practice is well placed to provide this chronic disease prevention strategy (screening and referral for education) as part of their normal service to clients. Client knowledge of their risk factor values; e.g., BSL, BP, cholesterol, and BMI is important in raising the awareness of the need to address the contributing lifestyle factors.

While screenings can be carried out opportunistically, they can be planned and then followed by appropriate client education programs. Case Study 1 briefly describes a 'Men's Health Assessment' that Cummins Medical Practice has developed. The program will be funded through normal MBS item income and run at a time of the year when the rural community is not busy (e.g., not during seeding). It will be promoted through suitable print media; e.g., the 'footy budget' and through presentations to local community groups.

## Integration and coordination of CDSM support and advocating for increased CDSM support

After several years of direct involvement in self-management support a practice will have:

- expertise in effectively supporting self-management in the region the practice services
- established relationships with a network of health care providers
- established referral pathways

The practice will be well placed to help integrate and coordinate service delivery in the practice region. The gaps in service provision will have become obvious, and again the practice is well placed to support applications for increased services. See Case Study 1 and 13.

## Step 9: Evaluating the effectiveness of the self-management support provided by the practice.

See 'Evaluation' in Section Six of this guide. Contact your local Division of General Practice for more assistance.

Evidence suggests that the preventative care and self-management support will, over a number of years, reduce the acute and emergency care requirements of clients. Eyre Peninsula GPs can look forward to less call outs, a more acceptable lifestyle, and a few more fishing trips.



Gone fishing

## The Enhanced Primary Care (EPC) items

While a range of EPC items is listed below, it is important to appreciate that the range and requirements of the items vary over time. **It is, therefore, highly recommended that practices periodically check the full current details and requirements of the items at <http://www9.health.gov.au/mbs>.**

**Details, sample pro formas, and checklists associated with the EPC items are available at [www.health.gov.au/epc](http://www.health.gov.au/epc)**

Apart from the list below, no further details of the EPC items are provided in this resource kit because it is preferable for practices to check current details online.

### Health Assessments:

Depending on the Health Assessment, the service can be completed at the practice, or part of the assessment can be completed at the client's home or aged care facility.

ATSI 0 to 14	Item 708
ATSI 15 to 54	Item 710
45-49 at risk of C/Disease	Item 717
Aged Care residents	Item 712
ATSI Aged 55 or over	Item 704 or 706 depending on location
Aged 75 and over	Item 700 or 702 depending on location
Refugees & H/Entrants	Item 714 or 716 depending on location

### Care and Management Planning:

GP Management Plan	Item 721
GPMP Review	Item 725
Team Care Arrangement	Item 723
TCA Review	Item 727
Contribution to TCA	Item 729
Contribute to CP in RACF	Item 731 (RACF is a Registered Aged Care Facility)
Mental Health	Item 2710
MH Care Plan review	Item 2712
Medication Review	Item 900 (DMMR), 903 (RMMR)

### Case Conferences:

Payment depends on whether conference is 15-30min, 30-45min, or over 45min

#### To organise:

In community	Item 740, 742, or 744 depending on length
On discharge	Item 746, 749, or 757 depending on length
At Aged Care Facility	Item 734, 736, or 738 depending on length

#### To attend:

In community	Item 759, 762, or 765 depending on length
On discharge	Item 768, 771, or 773 depending on length
At Aged Care Facility	Item 775, 778, or 779 depending on length

### Service and education:

Payment depends whether service provision was completed at or out of the surgery and on the length of the consultation

Diabetes Cycle of Care	Item 2517-2526, 2620-2635
Asthma Annual Cycle	Item 2546-2559, 2664-2667

Check details at <http://www9.health.gov.au/mbs>.

## Checklist for incorporating self-management support into General Practice

### Decide whether to shift from an acute care model to a model that incorporates support for self-management.

Determine if all staff members are in favour of the change.

Discuss the implications of only some staff agreeing with the change and decide if the implications are acceptable.

Decide which individuals will be responsible for driving the change process.

Conduct a survey of clients' current opinions and knowledge of self-management.

Discuss the implications of the survey results and possible promotional strategies.

### Determine possible sources of information and help.

Contact the local Division of General Practice and determine the level of their support and involvement.

Investigate other sources of support, including other practices.

### Reach agreement about the practice's level of involvement in self-management support.

Which components of CDSM support will the practice offer? - Prevention activities and education, early detection, patient-centred care planning, self-management education, referrals, on-going support and mentoring, recall systems, advocacy, community development.

### Investigate the requirements and range of EPC items.

What is the complete range? What items are applicable to the practice clientele? What are the mandatory requirements of those items? What additional/optional services could also be offered? Collect samples of pro formas and templates.

### Establish the financial viability of the change.

How many clients will qualify for EPC services? How many clients will need other self-management support that is not covered by EPC items? What is the potential annual income? What are the annual costs of providing self-management support?

### Reach consensus on the acceptability of anticipated changes in work patterns and staff roles.

Reach a consensus on the acceptability of a patient-centred approach.

Reach a consensus on the acceptability of a multi-disciplinary team approach.

Reach a consensus on the range of tasks that GPs will delegate to practice nurses.

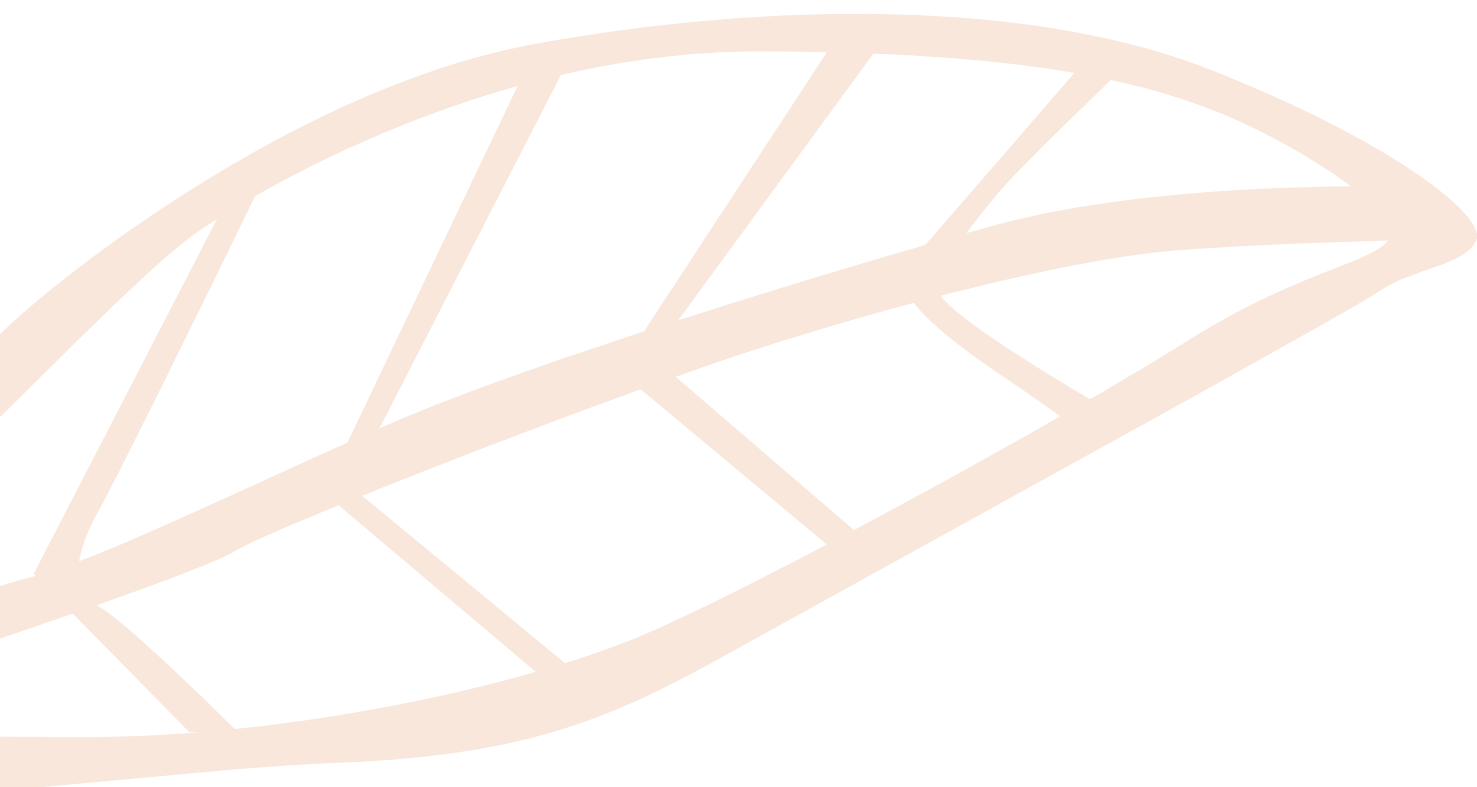
### Complete the initial audit.

Conduct an audit of skills, services, equipment, and space currently available at the practice.

Conduct an audit of current information systems and data management skills.

Conduct an audit of services available from other providers in the local area.

- Make decisions about the model of self-management support to be implemented.**  
What services? What processes, procedures, and staff will be required? What referral pathways are possible? What level of integration with other providers is possible? What pro formas or templates will be used? What recall methods and protocols suit the practice staff and clientele? What is the optimal model of self-management support? What is realistic?
- Make decisions about human resource recruitment and training.**  
Which existing staff members require training? What training do they require? Where and when is such training available and at what cost? How much time is involved? What skill set is required of any additional staff recruited?
- Make decisions about the order of implementation.**  
Which services? Which clients? Which illness groups? When?
- Make decisions about the method of evaluating the self-management support program.**  
Is the purpose of the evaluation to judge or to improve the program? Are qualitative, quantitative or mixed methods most appropriate?
- Establish linkages with other health providers and reach an agreement about the protocols for referral pathways and processes.**
- Recruit and provide self-management support to the first few clients and adjust systems as required.**



# Notes





# Notes



