UNDER THE SAME ROOF: CO-LOCATION OF PRACTITIONERS WITHIN PRIMARY CARE IS ASSOCIATED WITH SPECIALIZED CHRONIC CARE MANAGEMENT (PUBLICATION)

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CONTEXT

Chronic diseases are the leading cause of death worldwide, and their burden is predicted to increase. Canada and New Zealand are similarly affected by the growing burden of chronic disease, which has had substantial impact on the primary care system – 80% of adult visits to General Practitioners in Canada are due to chronic condition management. Patient care teams may be an efficient means of providing systematic, safe and best practice care for complex patients. Shared premises are thought to be a critical factor to enable effective interdisciplinary care, and co-location also reflects the growing interest in redesigning traditional primary care into 'patient-centred medical homes', such that there is one point of access to an array of services and professionals.

OBJECTIVES

This study aims to determine whether primary care practices with co-located non-physician members may offer broader services and specialized care for patients with chronic conditions.

METHODS

Survey data from 330 General Practices in Ontario, Canada, and New Zealand, of the Quality and Costs of Primary Care in Europe (QUALICOPC) surveys was used for this study. Four sets of outcome variables were explored: Disease management programs, Special sessions, Extent of nurse service provision, and Equipment in practice. Logistic and linear multivariable regression models were employed to examine the association between the number of disciplines working within the practice, and the capacity of the practice to offer specialized and preventive care for patients with chronic conditions.

FINDINGS

The distribution of responses to the availability of disease management programs was similar in Ontario and New Zealand. Slightly more New Zealand practices offered special sessions or clinics for all three groups of patients (16% compared to 13% of Ontario practices). Most New Zealand practices indicated a high level of nurse service provision, 90% selected 'yes' to all relevant questions, while only 45% of Ontario practices reported the same level of provision. The amount of equipment available also differed, on average Ontario practices had 12 of the 30 items while New Zealand practices had a mean equipment score of 17.5. The multivariable analyses revealed consistently positive associations between the number of co-located disciplines and the provision of special sessions for people with diabetes, people with hypertension, and for the elderly; participation in disease management programs for diabetes, COPD, and asthma; the amount of equipment used within the practice; and the extent of nurse service.

CONCLUSIONS

The co-location of multiple disciplines may be a means to facilitate the delivery of specialized and preventive care services for people with chronic conditions. However, organizational and funding constraints suggest the housing of multiple disciplines is beyond the capacity of many primary care practices. In Canada, nearly 50% of GPs operate from fee-for-service models, an approach that may disincentivize the delegation of tasks to non-physicians. The New Zealand National Health Committee also suggested funding was an administrative barrier to collaborative health care, in particular for those with multiple conditions, which may not individually satisfy criteria for targeted funding. We suggest policy-makers and health care providers review how funding and organizational arrangements may enable this primary care structure, and researchers consider the optimal size and composition of patient care teams.

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