Malaysian Family Physician 2010; Volume 5, Number 1
ISSN: 1985-207X (print), 1985-2274 (electronic)
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Online version: http://www.e-mfp.org/

Conference Proceedings

Panel Discussion: Chronic Disease Management in Private General Practice: What is the Future? Annual Scientific Meeting, Academy of Family Physicians of Malaysia. 4th April 2010, Kuala Lumpur

THE CORFIS EXPERIENCE

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Low Wilson. The CORFIS experience. Malaysian Family Physician. 2010;5(1):57-58

The CORFIS Programme was conceived by the Clinical Research Centre, HKL in 2007 in the hope of piloting a chronic disease management strategy among the Malaysian private general practitioners to tackle the current epidemic of cardiovascular chronic diseases.[1-5] The programme was implementing as a clinical research study i.e. a community trial in June 2007. The study recruited a total of 70 GPs within the Klang Valley region with an enrolment of 705 patients diagnosed with hypertension, diabetes mellitus (DM) and/or hyperlipidaemia. The GPs were clustered randomised centrally in a 2:1 ratio to provide either chronic disease care (CORFIS) or usual care. Patients were followed up for a period of 6 months from date of enrolment.

The CORFIS intervention consists of elements from the chronic disease care model based on both the Wagner's and WHO's Innovative Care for Chronic Condition (ICCC) framework[6-9] i.e. multidisciplinary care, evidence-based guidelines (based on Malaysia's CPG for hypertension, DM and hyperlipidaemia), patient empowerment and self-management, custom designed medical information technology & web-based application to facilitate chronic disease care among health professionals, as well as incentive support for both the healthcare providers and patients. GPs who were allocated into the CORFIS arm will receive a team of nurse educator, pharmacist and dietician who will help manage their patients in their respective discipline. Disease counselling and monitoring of compliance were provided with great emphasis on empowering patient to self-monitor. Each primary care team worked together to provide optimal individualised care for the patients and information were captured and disseminated via the custom-designed web application (www.corfis.gov.my). Target organ screening services (such as diabetic retinopathy, nephropathy and cardiovascular changes) were provided to patients during community road shows and reports were reviewed online by a group of specialists. Both the healthcare providers and patients were provided with the necessary equipments and training to facilitate chronic disease management.

The CORFIS study ended on the 31st December 2008. Data were cleaned and analysed in 3 separate subgroups i.e. hypertension, diabetes and hyperlipidaemia. The main data[10-11] are as follow:

Hypertension Group (320 intervention versus 177 control)
There was significant reduction in systolic blood pressure (BP) in the intervention group (median -9.0mmHg; -60 to 50) versus control (median -2mmHg; ranged from -50 to 48) (p=0.0029) as well as diastolic BP (Intervention arm: median -6.0mmHg; ranged from -53 to 30 versus control arm: median 0.0mmHg; ranged from -42 to 30) (p<0.001). 68% of the hypertensive patients in the intervention group achieved BP control compared to 58% in control (p<0.0281). More hypertensive patients with uncontrolled BP (achieved target control in the intervention arm (57%) compared to control (34%)(p<0.001). There was no difference in target BP achievement among patients who has achieved BP control at baseline.

Diabetes Group (268 intervention versus 106 control)
Significantly higher reduction was detected in the intervention arm than in the control arm for HbA_{1C} (median of -0.7% versus -0.2%) and fasting blood glucose (median of -0.4mmol/l versus 0.1mmol/l) after 6 months. More diabetic patients in the intervention arm than control arm (58% versus 42%; p<0.01) achieved glycaemic target and significantly higher number of diabetic patients with uncontrolled HbA_{1C} at baseline achieved target control in the intervention arm than control arm (43% versus 23%; p<0.01).

Hyperlipidaemia Group (299 intervention versus 128 control)
The median change on LDL is -0.3 mmol/l in the intervention arm compared to -0.1 in the control arm with p=0.001. 50% uncontrolled hyperlipidaemic in the CORFIS arm achieve LDL control compared to its counterpart in the control arm (32%) with p=0.027. Significant number of hyperlipidaemic patients with 2 or more cardiovascular risk factor with poor LDL control at baseline achieve target after 6 months in the intervention (71%) compared to control group (29%) with p=0.003.

Other Findings:
Approximately 20% more patients who underwent CORFIS Care achieve treatment target within 6 months compared to usual care. Patients with hypertension are 4.32 times more likely to achieve BP target with CORFIS Care; Patients with DM are 11.19 times more likely to achieve glycaemic target with CORFIS Care; Patients with Hyperlipidaemia are 6 times more likely to achieve LDL target with CORFIS Care.

Current CDM efforts in the private sector

Efforts in chronic disease management within the private sector remain fragmented.[12] Limited chronic disease management services are often conducted by private hospitals (e.g. Gleneagles, SJMC, Sunway Medical Centre), NGO / Charity Organisation (e.g. PDM, NKF, MSO, 7th Day Adventist Church, Sau Seng Lum Dialysis & Rehabilitation Centre), some private clinics / wellness centres and chronic disease care programme organised by the pharmaceutical companies (e.g. COACH Programme by Pfizer). Many of the services provided includes target organ screening, dietetic counselling, coaching on self-management, disease counselling and short-term follow-up.

Although each set-up has its own merits and functionality, it is often limited to a single disease group (most often DM or obesity). Other chronic diseases are often not covered in their services and continuity of care between these organisations and the patient's primary healthcare providers remains questionable. On the other hand, programmes such as COACH or CORFIS that aimed to provide complementary chronic diseases services to the local private primary healthcare providers, face their own set of challenges and much research will need to be done to answer the questions on their sustainability and cost-effectiveness. There is an urgent need to increase awareness of chronic disease management among the local healthcare professionals and patients in order to bring about significant improvement in the primary healthcare sector.

REFERENCES

1. Yusoff AF, Kaur G, Omar MA, et al. Malaysian burden of disease and injury study 2005. Kuala Lumpur: Institute of Public Health, National Institute of Health Malaysia; 2005
2. National Institute of Diabetes, Digestive & Kidney Disease, NIDDK. United States Renal Data System (USRDS) Annual Data Report; 2008.
3. Malaysia Ministry of Health. National Health Morbidity Survey III. Kuala Lumpur: Institute of Public Health Malaysia; 2006.
4. Wild S, Roglic G, Green A, *et al.* Global prevalence of diabetes: estimate for the year 2000 and projection for 2030. *Diabetes Care*. 2004;27(5):1047-53.
5. Hossain P, Kawar B, El Nahas M. Obesity and diabetes in the developing world-a growing challenge. *N Engl J Med*. 2007;356(3):213-5.
6. World Health Organization (WHO). Innovative care for chronic conditions: building blocks for action: global report. Geneva: WHO; 2002.
7. World Health Organisation (WHO). WHO CVD-Risk Management Package for Low and Medium Resource Settings. Geneva; WHO; 2002.
8. Wagner EH, Austin BT, Davis C, *et al.* Improving chronic illness care: translating evidence into action. *Health Aff (Millwood).* 2001;20(6):64-78.
9. Wagner EH, Austin BT, Von Korff M. Improving outcomes in chronic illness. *Manag Care Q.* 1996;4(2):12-25.
10. A Randomized Controlled Trial to evaluate the efficacy of a Community-based Cardiovascular Risk Factors Intervention Strategies (CORFIS Trial) in managing hypertension, diabetes mellitus & hyperlipidaemia in primary care setting. Asia-Pacific Primary Care Research Conference 2009 - Making primary care research relevent; Dec 5 - 6 2009; City Bayview Hotel, Melaka, Malaysia.
11. A Randomized Controlled Trial to evaluate the efficacy of a Community-based Cardiovascular Risk Factors Intervention Strategies (CORFIS Trial) in managing hypertension, diabetes mellitus & hyperlipidaemia in primary care setting. The Singapore Disease Management & Primary Care Forum 2009; Oct 16 - 17 2009; Suntec Convention Centre, Singapore.
12. Ramli AS, Taher SW. Managing chronic diseases in the Malaysian primary health care – a need for change. *Malaysian Family Physician.* 2008;3(1):7-13.

Statin therapy should be offered to older patients at high risk of atherosclerotic disease events

Roberts CGP, Guallar E, Rodriguez A. Efficacy and safety of statin monotherapy in older adults: a meta-analysis. *J Gerontol A Biol Sci Med Sci.* 2007;62(8):879-87.

This is a meta-analysis of randomized controlled trials enrolling persons aged 60 years and older (n=49,210 participants). The statin group showed a significant 15% reduction in all-cause mortality in older adult (RR 0.85, 95% CI, 0.78-0.93; p<0 .001). The relative risk of cancer comparing statins to placebo was 1.06 (95%CI 0.95-1.18). Adverse event data were not consistently reported.

Statins have a neutral effect on cancer and cancer death risk

Dale KM, Coleman CI, Henyan NN, *et al.* Statins and cancer risk: a meta-analysis. *JAMA*. 2006;295(1):74-80.

This is a meta-analysis of 22 randomised controlled trials. Statins did not reduce the incidence of cancer (OR, 1.02; 95% CI, 0.97-1.07) or cancer deaths (OR, 1.01; 95% CI, 0.93-1.09).