Banyule Nillumbik Primary Care Alliance

STRATEGIC PARTNERSHIP GROUP

Appendix 1

CHRONIC DISEASE MANAGEMENT

Stakeholder consultations

Purpose of consultations

Consultations with key stakeholders were conducted to identify clinical, practical and service issues in relation to current chronic disease programs that could inform considerations for improving integration of chronic disease care across the catchment.

Semi structured interviews were conducted with staff involved in chronic disease care. The participating organisations identified appropriate staff to be involved in the consultations. Organisations represented and individual interviewed are outlined in Table 1.

Key areas explored in the interviews were:
- What Chronic Disease programs were being offered?
- What model of care was used?
- Referral pathways
- Barriers to integrated chronic disease care across the region
- What would be the priorities for change to improve integration of chronic disease care in the region?

Programs offered, models of care and referral pathways for each organisation are summarised in Table 2.

Table 1: Organsiations consulted

Person	Organisation	Position
Kay Milner	Banyule Community Health	Team Leader / GP Liaison Health for Life (EliCD)
Carol Phillips	Banyule Community Health	Service Coordinator Health for Life Program
Janine Scott	Nillumbik Community Health Service	Senior manger
Sally Western	Nillumbik Community Health Service	Program Manager - Allied Health
Maggie Scott	Royal District Nursing Service	Diamond Valley Centre Manager
Penny Murphy	Royal District Nursing Service	Heidelberg Centre Manager
John Fletcher	North East Valley Division of General Practice	
Noel Stewart	North East Valley Division of General Practice	
Louise Shanahan-Mckenna	Northern Health – BECC	
Debbie Wilkinson	Northern Health – BECC	
Alison Kernke	Melbourne City Mission – Eltham Retirement Village	Team Leader – Allied Health
Taya Shevchenko	Austin Health	Director Hospital Primary Care Liaison Unit
Fiona McCormack	Austin Health	HARP Co-ordinator

Table 2: Summary of programs and care models across catchment

Organisation	CDM programs	Care Models	Referral pathways
RDNS	No specific CDM program Number of disease specific programs e.g Diabetes Palliative care Cystic fibrosis Continence Wound care Haemophilia HIV/AIDS Stomal therapy Post acute care Breast Cancer	All clients have standardised assessment. Disease specific care plans. Management goals documented. Key worker allocated to client. Care delivered by primary care nurses supported by disease specific specialist consultant. RDNS Institute responsible for ongoing training and staff and program development. Supporting independence and self care underlying ethos of all programs.	Formalised protocols with number of agencies. Clear referral pathway between acute and RDNS - RDNS liaison person. Using Service coordination templates to refer out.
Banyule	Health for Life program (Early Intervention funding) for people with Type 2 diabetes, respiratory and cardiovascular disease and osteoporosis. Austin HARP programs A number of other disease specific programs/ services such as diabetes, respiratory and depression and generic programs	6 month program active coaching program with 12 month review. Standardised assessment, care plans (not standardised) incorporating client's goals and wellness plan. Key worker allocated to client. Strong focus in lifestyle issues. Combinations of treatment, information, education, social support, preventative exercise programs. Plan to extend coaching program to other services.	GP and practice nurse referrals supported by GP liaison work by program. COPD entry criteria linked to HARP criteria to allow for internal cross referral into most appropriate program. Referral to relevant allied health within services and other community programs. Self referral, internal and GP and external health professionals.
BECC	No specific CDM program but number of programs providing services for	Case management. Coordination/Referral.	Central intake system. Referrals form Acute GPs and community

	people with chronic disease: Aged Care Assessment Service - Transition Care Linkages - Community Aged Care Packages EACH packages - Post Acute Care Information and Advisory Centre Activities of Daily Living Display Centre Northern Health HARP programs Diabetes Heart Respiratory	Education/prevention/support/secondary consultations. No formalised self management approach. Self Management (Better Health Self Management program). Disease specific programs combinations of education/self management /care coordination. Standardised assessment and care planning within services but not across services both groups. HACC assessment process used within aged care services. InterRAI Tool being trialled by HARP programs HARP looking at common care plan tool.	agencies, some self referrals. BECC using SCCT templates for referral and privacy and consent. Most referrals form Acute some GP referrals. HARP some using SCCT referral and consent. Considering using universal (version) referral tool.
NCHS	CDM Model – Better Living program Austin HARP programs A number of other disease specific programs/ services such as diabetes, cardiac and generic programs	Standardised individual approach. Generic screening tool, clients elect to be in program, Flinders assessment, and discipline specific care plan client goals. Ongoing review and follow up yet to be defined. Key worker allocated to client. Combinations of treatment, information, education, social support, preventative exercise programs.	Self referral and other allied health referrals some GP referrals Central intake system

NEVDGP	Chronic Disease Advisory Group Support Banyule Health for Life GP liaison officer IT support for CDM	Division Staff and GPs consider how Division programs are meeting needs of CDM Education of GPs and practice staff Working with GPs to improve information management systems so that practices can accurately: Identify CD patients and practice population Develop systems to capitalise on funding for CDM Develop systems to systematically deliver and evaluate CD care	
Austin Health	HARP CDM programs Diabetes CD programs Community Link Programs	Range of models: Case management. Coordination/Referral. Education/prevention/support/secondary consultations/ specialist care. Outreach/ rehabilitation Coach program used in cardiac Some consistency of in assessment and care planning within programs but not across programs	Referral pathways dependant on program Mostly inpatient and GPs some emergency department and community health Some of programs have entry criteria based on clinical indicators

Issues identified from the consultations

Barriers

- Waiting lists
- Cant' discharge chronic care clients
- Appropriate referral pathways for ongoing support/ Knowing what is there, accessing it and joining it up
- GPs don't have resources to mange complex clients so refer to hospital as they don't have any where else to refer.
- Lack of clarity around who is suitable for HARP and community programs
- Engaging with men
- Funding model
- Geographical barriers
- Lack of care coordination- not clear who will take responsibility for coordinating care
- Hard to prioritise self management when dealing with acute problems
- Practice change for staff – to more person centred model/ Changing clinicians thinking/way of practicing
- Systemising chronic disease care
- GPs don't refer in/engaging with GPs
- Lack of out of hrs services and centralised delivery of services – need to get out into community
- Lack of programs for skeletal and neurological problems
- For GPs the quality of their patient/practice data and lack of systems
- SCCT tool barrier for GPs
- HARP internal barriers: partnerships with community health need to improve /funding model/acute doesn't understand impact of CD on individual or health system/ lack of coordination across HARP programs

Wish list

- Consolidating paper work across the catchment /Common assessment processes
- Strategies for recruiting and retaining staff
- Engaging with GPs/ Improved relationships with GPs – link more with division
- More home based services esp. dental, podiatry Physiotherapy
- Pooling of funds to support greater access for aids and equipment
- Build more cooperative relationships with other agencies and general practice / collaborative planning model development /More information on local demographics e.g. Disease prevalence at LGA level.
- More options for ongoing support in the community for people with chronic disease e.g programs that support physical activity social engagement something that will give individuals a sense of purpose
- Greater support for smoking cessations and health eating programs
- Out of hrs care
- Consider obesity as a chronic disease
- Area based planning – plan around client needs not service needs
- Catchment wide service coordination models
- Resources/ coordinator role
- Ongoing training e.g. Health coaching, motivational interviewing, person centred assessments
- Greater utilisation of Northern Self Management Network for sharing of information
- More collaboration with GPs around care plans
- Consider catchment wide approach to evaluating services
- BNPCA – Self Management mapping - resource obvious gaps
- Improved coordination between HARP and community
- Education and training for GPs on IM analysis (PEN tool) and developing ongoing systems
- Look at how GPs and community health can work better together – keep GPs in the loop rapid response to referral