

Banyule Nillumbik Primary Care Alliance

FINAL REPORT

CHRONIC DISEASE COLLABORATIVE PROFESSIONAL SUPPORT

JULY - DEC 2008

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Background

In February 2008 the BNPCA facilitated the initiation of the BNPCA Chronic Disease Collaborative. The purpose of the collaborative is to provide an opportunity for member agencies involved in chronic disease care to meet regularly and consider strategies to implement the vision outlined in the BNPCA Strategic Statement of Intent for Integrated Chronic Disease Management.

The collaborative has regular representation from a number of organisations (See appendix 1) and has met monthly since April 2008. Over this time the group has been focussed on three key areas:

- Sharing and collating population health data to identify the chronic disease population, service gaps, consider at risk groups and opportunities to jointly plan programs to address gaps.
- Mapping of programs across the catchment and developing a consistent approach to classification and communication in relation to programs using the Kaiser Permanente levels of chronic and complex care prevention and management as a framework.
- Exploring consumers' expectations and experience of chronic disease services in the catchment.

The key areas were identified as being consistent with strategic directions for member agencies and policy initiatives of funding bodies. Consistent themes in the General Practice Primary Care Integration Program, HARP, Community Health and PCP Chronic Disease program guidelines include:

- Improving Integration of Chronic Disease Care
 - better communication and linking across the range of primary care providers
 - developing local chronic disease care pathways that support ease of access to programs for clients
 - Supporting self management
 - Embedding self management support into care delivery processes in particular assessment and care planning
 - Ensuring health professionals have the skills to help clients with essential self management skills such as goal setting and action planning
 - Providing more systematic, consistent care for people with chronic conditions
 - utilisation of tools/strategies that will assist in better managing patients with chronic disease (e.g. disease registers, referral, recall and reminder systems, care planning).
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Outcomes of the Collaborative

Improving Integration of Chronic Disease Care

Streamlined referral process

The group have focussed over the past 6 months on improving access to care for people with chronic conditions by agreeing on a common referral framework for chronic disease across the region.

As most people with a chronic condition see a GP it was decided to focus on strategies to promote GP referrals to community programs. The aim of having a common referral framework is to simplify the process for general practice to refer people with chronic disease to community programs.

The process will help General Practitioners match patient needs with appropriate services and eliminate the need to know and have contact details or eligibility criteria for each program and organisation involved.

To support this process agencies have:

- Mapped their programs according to level of care needed. Level of care need is determined by severity of disease and intensity and complexity of care needs as described in the Community Health and HARP chronic disease management guidelines (see appendix 2).
- Agreed on which programs /services align with each of the levels of care (see appendix 3).
- Agreed that when a GP referral is received, service access where possible will identify the most appropriate program and service for the client and internally organise inter agency referrals if needed.

A consistent approach to referral has been agreed upon which includes:

Level 1, 2 +3 patients will have care plans developed and agencies will provide GPs with:

- Receipt of referral and indication of when assessment has been arranged
- Notification if patient does not attend for the assessment appointment
- Outcome of assessment process, details of care plan and other referrals
- Ongoing progress reports
- Notification if patient is discharged from the service.

Level 4 Patients will be provided with support for lifestyle change through individual or group sessions and agencies will provide GPs with:

- Receipt of referral and indication of the program patient is being provided

- Notification if patient does not attend for session
- Progress reports, information on other referrals
- Notification when client has completed the program/sessions.

A draft brochure that will be used to promote the process to GPs has been developed along with a supporting client version.

The PCP is consulting with service access workers across agencies to work through implementation issues.

Collaborative members are working internally within their agencies to ensure processes are in place to meet the feedback criteria and processes agreed upon.

The collaborative is working towards launching the streamlined referral process to GPs and the sector in April.

The work undertaken on a streamlined referral process has raised interest both within DHS and other PCPs, are encouraging their agencies to consider the approach. The DHS ICDM industry advisor has included the model in presentations to other PCPs on good practice examples for ICDM.

Catchment demographic report

A report outlining prevalence of chronic disease and risk factors for chronic disease in the region has been prepared under the direction of the Collaborative. The report has also provided detailed profiling of a number of key chronic diseases that are of high prevalence and or impact significantly on emergency presentations for the region. The detailed profiling outlines best practice guidelines for intervention and service provision for each of the chronic diseases. The disease profiles will support individual agencies align program delivery/planning with catchment demographics and assess current practice within their organisation against the evidence and best practice guidelines.

The collaborative will also be able to use the information to; identify service gaps, at risk groups, consider jointly planning programs to address gaps and look at consistency of care across services to support evidence based practice.

Supporting self management

The finding of the statewide self management mapping undertaken in 2007 identified that for all organisations across the state less than half the people who have undertaken self management training are implementing the training. Key barriers reported highlighted the need for organisational support and system changes. The need for organisational support

and system changes to effectively implement systematic self management support strategies is also a consistent theme in recent literature and a key learning stressed by national and international programs that presented at the recent National Chronic Disease Conference. In considering strategies for supporting self management across the region the Collaborative has identified the need to broaden practitioner skills to support clients and to consider strategies for gaining organisational support and identifying system changes needed.

Workshop for health service managers

In November a the PCP facilitated a practical workshop for health service mangers in Banyule and Nillumbik focusing on changes needed at an organisational level to support practitioners embed self management into their practice. The workshop was attended by 16 managers/practitioners from a range of service providers including community health, local government, acute health and rehabilitation services. Evaluation of the workshop indicated most participants felt the workshop was relevant to their work, increased their understanding of self management and reported that they would be able to use the information to implement changes in their organisation to promote self management.

Health Coaching

To address improving practitioner skills the collaborative has also identified a training model for health coaching. Practitioners who have attended other 1-2 day health coaching programs consistently report that they lack confidence in their skills to implement the training. The training program that will be offered involves a one day health coaching workshop followed up with one triad training session and three individual training sessions. Triad sessions will involve an opportunity to practice coaching with a colleague and to give and receive constructive feedback to each other and from the trainer. Individual training sessions are conducted by the trainer and focus on practicing skills and tailoring training and coaching to the individual's needs. The program will commence March 4th and be jointly funded by BNPCA and participating agencies.

The Collaborative has submitted for a workforce innovation grant which if successful would help to provide ongoing support to those trained, to address implementation issues. Implementation issues will also remain a focus of the work undertaken by the Collaborative over the next 6 months.

Consulting with consumers

Understanding how clients perceive services and their experience of accessing and using services was seen as important by the Collaborative when considering how to improve chronic disease care in the catchment.

In October the BNPCA took on a third year Latrobe social work student (Pam Halstead) for a 3 month placement to research with consumers their experiences of chronic disease services. RDNS, BCHS, NCHS and Austin HARP nominated 3 clients each to be interviewed by Pam.

The interviews explored; client experiences of accessing services, perceptions of care they received, how involved in decision making they felt and what they thought could be done to improve the service. Pam will complete the final report of the project by mid February and the Collaborative will use the findings to consider strategies for adopting a more "client centred" approach to care delivery.

Plans for 2009

The Collaborative plans to continue to meet in 2009 to follow through with the work undertaken in 2008 and continue to identify new opportunities for improving chronic disease care within and across services. Plans for the first half of 2009 and key tasks are outlined below.

Improving Integration of Chronic Disease Care

- Implementation of the streamlined referral process
 - Finalise and produce GP and Client brochure
 - Secure sponsorship
 - Finalise and implement dissemination strategy
 - Sector forum March/April
 - April launch to GPs
- Review catchment demographic report; consider jointly planning programs to address gaps and look at consistency of care across services to support evidence based practice.

Promoting Self Management

- Facilitate implementation of health coaching in individual services
- Work together to problem solve and identify strategies for promoting implementation of coaching and other care delivery changes needed to promote self management

- Review the findings of the client journey project and identify strategies for developing a more “client centred” approach to planning and delivery of care.

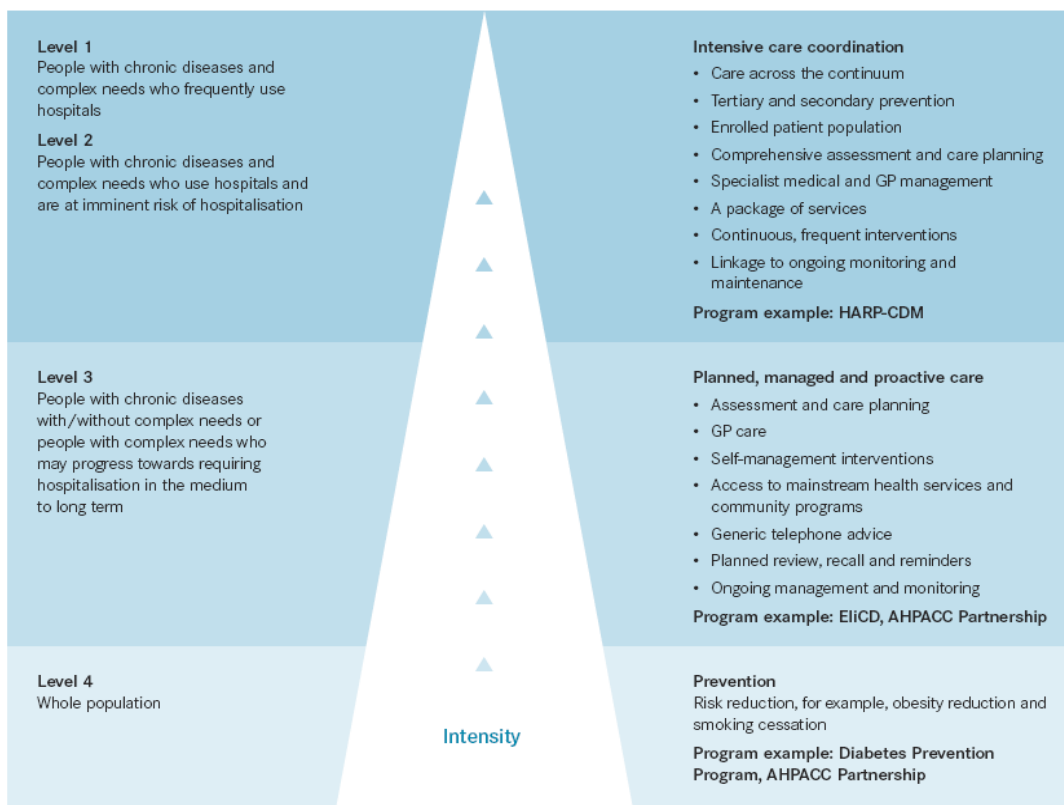
Providing More Systematic, Consistent Care for People with Chronic Conditions

- Review assessment and care planning practices for chronic disease in member agencies and consider strategies for developing consistent approaches across the catchment.

Appendix 1: BNPCA Chronic Disease Collaborative Members

Representative	Organisation
Julie Watson	BNPCA
Sally Western	Nillumbik Community Health
Kay Milner	Banyule Community Health
Carol Phillips	Banyule Community Health
John Fletcher	North East Valley Division of General Practice
Fiona McCormack	Austin Health - HARP
Riekie Sloggett	Austin Health - HARP
Louise Shanahan- McKenna	Northern Health - HARP
Penny Murphy	Royal District Nursing Service
Izabela Andersen	(DHS Regional office)

Appendix 2: Levels of chronic and complex care prevention and management



Appendix 3 – Levels of service for people with chronic disease

Type of service	Description	Organisations providing service
<p>Patient uses hospitals frequently or are at imminent risk of hospitalisation.</p> <p>E.G Heart Failure, diabetes COPD and lack social supports or condition is unstable. Not all medical conditions are accommodated in these programs</p> <p>Level 1+2</p>	<p>For patients with complex problems requiring:</p> <ul style="list-style-type: none"> • intensive care coordination • Comprehensive assessment and care planning • Specialist medical and GP management • A package of services • Continuous, frequent interventions • Linkage to ongoing monitoring and maintenance • Support with Self-management interventions lifestyle change 	<p>Austin Health HARP programs</p> <p>Royal District Nursing Service</p> <p>Northern Health HARP Programs</p>
<p>Patient requires education about their condition, support with lifestyle changes and or psychosocial</p> <p>Level 3</p>	<p>For patients with a chronic condition requiring:</p> <ul style="list-style-type: none"> • Assessment and care planning • Information about their condition • Support with Self-management interventions lifestyle change 	<p>Royal District Nursing Service</p> <p>Banyule Community Health</p> <p>Nillumbik Community Health</p>
<p>Patient requires support with adopting healthy lifestyle behaviours</p> <p>Level 4</p>	<p>For people at risk of or with a chronic disease who are not requiring level three type intervention but seeking support with adopting healthy lifestyle behaviours Ideal referral pathway to support lifecscript interventions Access smoking cessation, healthy eating or physical activity programs</p>	<p>Banyule Community Health</p> <p>Nillumbik Community Health</p>