General Practice Engagement in Integrated Chronic Disease Management

A Resource for Primary Care Partnerships

This fact sheet describes how general practice engagement in Integrated Chronic Disease Management can be enhanced, and provides case studies of successful work around Victoria.

This fact sheet can be read in conjunction with the Department of Human Services position statement and resource guide, Working with General Practice, January 2008, available at www.health.vic.gov.au/communityhealth/gps/.

> **General practice is the provision of primary continuing comprehensive whole-patient medical care to individuals, families and their communities.**
> *Working with general practice: Department of Human Services position statement*

General practice plays a critical role in integrated chronic disease management. General practice is spending an increasing amount of time supporting people with long-term or chronic medical conditions. The Bettering the Evaluation and Care of Health (BEACH) survey states that just over one-third of all problems managed in general practice are now of a chronic nature.[1]

General practice engagement is the logical function of Divisions of General Practice. Divisions' long-standing relationships and established trust with practices creates a firm foundation for effective engagement. Primary Care Partnerships across Victoria are developing local systems and agreements to enhance integrated chronic disease management. All Divisions of General Practice in Victoria are members of Primary Care Partnerships.

Understanding the general practice system is an essential first step to partnership. The *DHS Working with General Practice* position statement and resource guide provides background information about general practice, and the MBS flipchart includes an overview of MBS items involved in chronic disease management.

Integrated Chronic Disease Management is dependent upon general practice being engaged on a number of levels. When discussing general practice engagement, the strategies and the barriers, it is important to be clear about which of these levels of engagement is being addressed: General practice engagement in individual care; chronic disease programs; and/or service and policy development.

[1] Britt H, Miller GC, Knox S, et al 2004. General practice activity in Australia 2003–04. Canberra: Australian Institute of Health and Welfare (General Practice Series No. 16).

These three levels of general practice engagement in ICDM are further explained:

1. **Individual care** – each person with a chronic disease having a relationship with a General Practitioner (GP) and their general practice (which may include a practice nurse, practice manager and other clinicians) and the general practice being involved, in a coordinated way, in the care of the person with a chronic disease;
2. **Chronic disease programs** – local chronic disease management programs need to be developed in a way that reflects the role of general practice in chronic disease management and involves them appropriately;
3. **Service and policy development** – the perspective of general practice needs to be sought and incorporated into chronic disease service and policy development.

This resource provides a range of strategies and case studies in each of these areas.

1. General practice engagement in individual care

General practice engagement in an individual's chronic disease care generally serves two purposes: nursing and allied health practitioners sharing information with a general practice and requesting the GP's involvement in a care planning process.

Sharing information between agencies and GPs can be enhanced by health care organisations having systems and policies for:

- Acknowledging and accepting referrals from GPs;
- Informing GPs of treatment plans and treatment outcomes; and
- Requesting clinical results and medical history to assist with treatment plans or measuring effectiveness of interventions.

Requesting involvement in a care planning process includes:

- Involving GPs in the care planning process, particularly where there is complexity;
- Understanding the Medicare Benefits Schedule items which general practice use for care planning, including establishing and/or reviewing GP-led GP Management Plans (MBS #721) and Team Care Arrangements (#723) plans, or involving GPs in care plans led by other health practitioners (#729); and
- Understanding the responsibilities inherent in accepting a referral through a Team Care Arrangement.

Establishing care plans and access to MBS-funded allied health

When community health practitioners believe that a person with chronic disease could benefit from a GP-led care plan and/or MBS-subsidised access to allied health, they should first identify the person's usual general practice and then work with them to ascertain whether or not the person already has a care plan. If not, the person's usual GP should be contacted regarding likely benefits of a care plan and access to MBS allied health. When coordinating services in this way, it is important that everyone involved:

- Understand the requirements of the relevant MBS item numbers and understand which people are eligible for these services;
- Ensure that the person with chronic disease's usual GP is aware of the services being provided or offered by community health; and
- Recognise that the ultimate decision about whether to offer and deliver a GP-led care plan (GP Management plan and/or Team Care Arrangements) is that of the GP in consultation with the person with chronic disease.

More information about MBS item numbers is available at:
http://www.health.vic.gov.au/communityhealth/gps/mbs.htm

REFERRAL FEEDBACK FORMS (BETTER HEALTHCARE IN GIPPSLAND)

Through this regional initiative, GPs in Gippsland were consulted on their preferred methods for receiving feedback after making a referral. 'Referral Outcome' templates were developed for a range of nursing and allied health professionals.

The templates can be found at the following link:
http://www.health.vic.gov.au/communityhealth/cdm/res_bhig.htm

POLICIES AND TEMPLATES FOR GP COMMUNICATION (WHITEHORSE COMMUNITY HEALTH SERVICE)

The Whitehorse Community Health Service dedicated funds within their Early Intervention in Chronic Disease Program, known as the Whitehorse Good Life Club, to employ a GP Liaison Officer at the local division of general practice. With the assistance of this role, discussions were held with the local division's Chronic Disease Reference Group to agree upon points in the continuum of care when communication with the GP was required.

Consultation also occurred to guide content and format of the communication, resulting in communication letter templates and timelines which community health staff were oriented to and encouraged to utilise. Staff compliance with the GP communication guidelines and formats was reviewed through a file audit.

This led to policies at the community health service to guide communication with general practice. Some of the principles of these policies include the following:

Whitehorse Community Health Service (WCHS) has implemented policies for communication with GPs, which include communicating:

- Acknowledgement of referral received from a GP promptly
- Planned interventions for a client
- Changes to a treatment plan or new referrals planned during intervention
- Outcomes of intervention and planned follow-up or discharge arrangements
- If intervention is ongoing, progress reports at regular intervals (essential if the intervention is part of a Team Care Arrangement)

WCHS also ensure that GP feedback letters are:

- One page (single side) in total
- Name, address, date of birth and Medicare number of person with chronic disease
- What the outcomes of the service provided are
- What the clinician is needing the GP to do is clearly outlined – bold and in a box; providing space for a short written response within the letter, if appropriate, rather than requesting a full response letter.
- If the GP is not required to do anything, letters clearly state that the feedback is for information only.

A sample GP letter is published in the report *Navigating Self-Management,* visit:
http://www.goodlifeclub.info/pdf/6_Self-management_in_gp_V2.pdf

2. General practice engagement in chronic disease programs

A second common objective of general practice engagement is to increase referrals from general practice to chronic disease management programs or services run by primary health services.

Some strategies for promoting new programs which community and regional health service in Victoria have found to be successful in increasing referrals from general practice to new programs are further explored in case studies below:

- Providing feedback to GPs about specific clients who have benefited from the new program;
- Dedicated GP liaison positions
- Practice nurse tours; and
- GP education events.

GP LIASION OFFICER (BANYULE COMMUNITY HEALTH SERVICE)

A GP Liaison role at Banyule Community Health was initially developed to encourage referrals from GPs to the Early Intervention in Chronic Disease initiative (Health for Life Program). The success of the role has been credited to the advice and direction provided by the North East Valley Division of General Practice (NEVDGP). Establishment funding for the role was provided through the Primary Care Partnership and it was developed collaboratively.

Practice visits

All General Practices located across Banyule and some GPs bordering the Banyule LGA (52 practices) were visited by the GP Liaison Officer within three months. A key contact (Practice Manager or Practice Nurse) was nominated by each GP at the first interview, and contact maintained with this person, which has been a vital strategy to developing a collaborative relationship between General Practices and BCH. The GP Liaison officer does follow-up visits to the practices 2-3 monthly.

"There were some important things we discovered for establishing and maintaining cooperative and congenial working relationships with GPs," says Kay Milner, GP Liaison Officer. "Be sensitive to the time constraints of GPs; patients will always come first. Ten minutes is usually an acceptable request for a GP's time if you wish to meet. Commitment to follow up on requests, prompt response to telephone messages and punctuality for appointments are essential for developing a trusting relationship."

Focusing discussions on individual clients

Contact with GPs was focused on individual patients, not just the new program. Before contacting a GP, at least one patient was identified from the community health database and contact was made with the GPs by phone, to discuss whether this patient could benefit from a referral to the new program. This strategy provided an excellent opportunity to briefly explain how the new program may benefit their patient and to request a brief visit to explain the Program in more detail.

"Some people say that it is difficult to get through to GPs on the phone but I have always found our GPs to be very responsive," says Kay Milner, GP Liaison Officer. "I always phone about a specific client or patient, not just a general query or request, and have all the client's details, date of birth etc, in front of me when I call."

GP LIASION OFFICER (BANYULE COMMUNITY HEALTH SERVICE) - CONTINUED

Successfully generating referrals and trust
More than 50% of Banyule (and surrounding) General Practices have referred patients to the EIiCD Program since implementation in October 2005. Currently 135 patients have been referred to the Program with 80% referrals from general practices. 28 Case Conferences have been conducted involving GPs.

The GP Liaison role has supported a gradual but significant improvement in communication between GPs and BCH demonstrated by continuing patient referrals and feedback from GPs.

"I have referred a number of patients with Chronic Disease to the 'Health for Life' Program. I have found the Program to be very useful and supportive for these patients. It has been a valuable adjunct to my medical care."
- Dr. Janelle Francis, West Heidelberg Medical Centre

As a consequence of these achievements, the NEVDGP have established a GP Liaison role in the neighbouring local government area of Nillumbik.

For more information, see '10 Steps for GP Engagement' at www.health.vic.gov.au/communityhealth/cdm/cop.htm

Practice nurses and practice managers

Practice nurses and practice managers can be critical in building a relationship that enhances referrals between a new program or service and a GP or a whole practice. Many Divisions of General Practice facilitate practice nurse and practice manager networks and it may be worthwhile finding out from your local Division whether they have such networks and tapping into these resources for disseminating information about the local services available.

A practice nurse is a registered nurse employed in a general practice whose duties can range from administrative to undertaking clinical procedures or running nurse-led clinics, including chronic disease or disease-specific clinics. Medicare is encouraging nurse involvement in GP Management Plans and Team Care Arrangements, and funding nurses to monitor and support patients on GP-led care plans (MBS item #10997 for practice nurses).

Practice managers can in some cases be a GP but many practices, particularly larger ones, employ a dedicated practice manager to oversee the business and administrative sides of a general practice.

PRACTICE NURSE TOURS (WHITEHORSE COMMUNITY HEALTH SERVICE)
Tours of Whitehorse Community Health Service for local practice nurses were arranged with support from the Whitehorse GP Liaison Officer based at the local division of general practice. The tours were held for one hour over a lunch hour with lunch provided.

The initial intention of the Practice Nurse tours was to specifically promote a new program, the Whitehorse Good Life Club. However, on evaluating what the Practice Nurses found most beneficial, it was evident that an overall orientation to the community health service was required. The tours resulted in a small increase in

referrals to the Whitehorse Good Life Club but significant increases in referrals to other programs at the community health service including dental and podiatry.

GPs and practice nurses reported that they found it easier to discuss with their patients referrals to specific clinical services such as dietetics and podiatry than they did proposing referral to a self-management program such as the Whitehorse Good Life Club. The practice nurse tours did enhance referrals to the self-management program as GPs became more receptive to the organisation arranging internal referrals for self-management support after the initial clinical need for which the patient was referred had been addressed.

For more information about the Whitehorse Good Life Club, visit: www.wchs.org.au/content/programs/good-life-club/

Referrals to chronic disease self-management support

There may be particular issues to address when engaging general practice specifically around chronic disease self-management programs – these programs are a different way of working and require some practice change from clinicians delivering them as well as those referring and working with patients who are involved with them.

Jordan and Osborne describe barriers to GP engagement with chronic disease self-management programs as including:

- Uncertainty of the benefits of self-management programs (resulting from failure to effectively communicate the potential benefits);
- Limited local evidence on the impact of programs on patients' self-care abilities; and
- Scope and purpose of programs not well understood.[2]

Fact sheets about Chronic Disease Self-Management may assist in clarifying the benefits of self management support. Visit www.health.vic.gov.au/communityhealth/cdm/resources.htm.

GP EDUCATION NIGHT (KNOX COMMUNITY HEALTH SERVICE & KNOX DIVISION OF GENERAL PRACTICE)

Knox Community Health Service (KCHS) launched an intensive smoking cessation service in 2007 as part of its Early Intervention in Chronic Disease initiative.

"Simply sending a brochure to GPs about this new service was not going to work, it would just get lost in the avalanche of brochures that GPs receive," says Anne Parkes, Active Health Program Manager. "We sought feedback from the Knox Division of General Practice as we were developing the service and together designed a more strategic approach to promoting it to GPs."

KCHS and the Knox Division of General Practice jointly hosted an education night for GPs which was eligible for QA&CPD (continuing education) points. Guest speakers included a local respiratory physician and a representative of the Alfred Hospital's Lung Health Promotion Unit explaining the evidence behind the intensive smoking cessation model which was to be launched locally. The education night was combined with a meal.

[2] Jordan, J. E., Osborne, R. H., 2007. Chronic disease self-management education programs: challenges ahead, MJA 186.2:84-87.

Community health staff members that were to deliver the new service attended the evening so that they could be introduced to the GPs directly and also contribute to a panel discussion about the new service.

Articles and photos were published in the Division's newsletter to extend the awareness to those GPs who were not able to attend. The event successfully brought this new service to the attention of GPs and generated referrals.

For more information about the Knox Smoking Cessation Service visit www.kchs.org.au/cdm.shtml

3. General practice engagement in service and policy development

Primary health care services need to seek and incorporate general practice's perspective into service and policy development. Divisions of General Practice are an invaluable resource for this work, and Primary Care Partnerships (PCPs) are an important platform through which to engage.

Examples of General Practice representation on PCP committees may include:
- Local GP on PCP ICDM Reference Group, usually sourced by the Division
- Staff from Division on PCP ICDM Reference Group
- Division CEO on PCP Executive/Board
- GP Liaison Officers from major hospitals on PCP Executive

In addition to representation of general practice on relevant PCP governance groups, there may be the need to specifically seek GPs' input to service and policy development, and examples of how this has been done include the following, which are further explored in case studies below:
- GP telephone surveys, developed with and co-ordinated through the local division of general practice
- Leveraging off a win – begin with a small but successful projects
- Identify and partner with GP champions
- Use existing networks and gatherings of GPs

GP TELEPHONE SURVEY (KNOX COMMUNITY HEALTH SERVICE)
As part of its consultation for the development of the Early Intervention in Chronic Disease initiative, Knox Community Health Service partnered with the Knox Division of GPs and the Chronic Illness Alliance to interview local GPs by telephone.

The community health service proposed a range of consultation mechanisms to the Knox Division who provided invaluable advice that a recent drug and alcohol project had undertaken consultation by telephone which had been successful and well-received by the GPs. Building on this success, KCHS worked with the Division to jointly develop some interview questions. It was identified at this early stage that some of the issues that the community health services was interested to learn about were able to be answered through existing data collection sources which the Division shared with KCHS rather than having to ask the GPs again.

The Chronic Illness Alliance (CIA) were contracted to undertake the phone interviews. The Division, however, made the initial contact with GPs and arranged the interview times.

A report was prepared and endorsed jointly by CIA, KCHS and the Division.

The report is available at the following link: www.kchs.org.au/library/list.chtml?folder=Early%20Intervention%20in%20Chronic%20Disease%20Initiative

Leverage off a win. Some PCPs have found it beneficial to run a small, effective project with local GPs, usually in conjunction with the Division, engaging in partnerships and coordinated care. Once effective working relationships have been established and common goals identified, increased engagement in more strategic service and policy development work develops. Many of the examples highlighted in this document demonstrate this.

PRACTICE NURSE PILOT PROJECT (SOUTHERN GRAMPIANS GLENELG PCP)

In Hamilton, a rural town of 9,400 people in western Victoria, key members of the Primary Care Partnership (PCP) including the Division of General Practice, Health Service and General Practitioners worked together to develop a part-time (0.1EFT) practice nurse role to enhance care coordination for Type 2 Diabetes. The position was funded for 8 months by the PCP, supported in its development by the Division of GPs and based within a rural General Practice. It was established to be sustainable and although the project has now concluded, the role has proved both financially viable and delivering benefits to the community such that it is continuing indefinitely.

General practice engagement within the Southern Grampians Glenelg PCP was greatly enhanced by this small but successful project. This project was presented to the Australian Diabetes Educators Association national conference in 2008.

For more information, visit: www.sggpcp.com

GP champions. There may be a particular GP in your area who has an interest in strategic service and policy development work and has done so in the past. Some PCPs refer to such people as 'GP champions', engaging their services in a range of ways, leveraging from their enthusiasm and learning from experiences of working with them to encourage other GPs to get involved. Community Health Services with GPs on staff may find it ideal to start with these internal GPs.

START LOCALLY (DAREBIN COMMUNITY HEALTH)

In developing their new chronic disease self-management service at Darebin Community Health, the staff decided to start locally – piloting all initiatives, from referral forms to recruitment of people with chronic disease with the GPs employed within their community health service. They worked especially closely with a practice nurse who worked with these GPs and received a lot of practical feedback about how to develop their service. The team chose as their next focus for general practice engagement a group of local practices who had already been working together on quality improvement through the Australian Primary Care Collaboratives program.

This targeted approach in the early stages of a new program allowed for staged trialling and feedback on new systems and processes at the community health service.

For more information about Darebin Community Health's chronic disease self-management program, visit: www.dch.org.au/services/list.chtml?category=Chronic%20Disease%20Management

Using existing networks. General practitioners and representatives of general practice will have a range of different forums in which they meet. Many Divisions of General Practice have GP reference groups where a community organisation can request an agenda item for discussion (see example of Whitehorse case study, page 3). In some areas, appropriate forums may involve networks which are broader than general practice but which may still be relevant. To inform service and policy development, using existing networks can be a valuable mechanism, and save time and resources.

MARYBOROUGH VISITING MEDICAL OFFICER (VMO) NETWORK

The doctors who serve the region surrounding Maryborough, a rural town of 12,736 in northern Victoria are supported by the WestVic Division of General Practice. In addition they meet monthly at the hospital. Known as Visiting Medical Officers (VMOs) they form a strong network and their meetings are a forum to discuss all number of new initiatives and ongoing issues arising.

In establishing the Early Intervention in Chronic Disease (EIiCD) initiative in partnership with WestVic Division of General Practice, it was identified that this VMOs group would be an invaluable network to involve in the decisions which had to be made about service development. Considerable resource has been invested by the hospital's senior management, such as the Director of Nursing, in building and maintaining this group's regular meetings to be very well-attended and productive. It has been decided that this group would be one means for general practice consultation, rather than developing any new structures specifically for the EIiCD funding.

4. Divisions of General Practice

There are 29 divisions of general practice in Victoria. Divisions are predominantly funded by the Commonwealth Government to provide services and support to general practice at the local level to achieve health outcomes for the community. A division is a local organisation of general practices with a membership comprised of GPs and others. They are overseen by an elected Board of Directors and they vary in size and budget.

All 29 Victorian divisions of general practice are members of PCPs and have been working with other PCP member agencies and some individual GPs to develop and implement shared care pathways to support client referral and communication pathways, including the sharing of client information.

Australian Better Health Initiative – Primary Care Integration Program (ABHI-PCIP)

The Australian Better Health Initiative (ABHI) is a package of programs aimed at promoting good health and reducing the burden of chronic disease for all Australians. One of five elements in the ABHI initiative is the Primary Care Integration Program (PCIP). The Commonwealth Department of Health and Aging (DOHA) has approved 15 submissions for around $6 million in funding for the Primary Care Integration Program in Victoria. These 15 submissions include all 29 Victorian general practice divisions.

General Practice Victoria is supporting divisions to meet the following objectives:

- to engage with the work of local PCPs, and other state funded primary care initiatives
- to communicate and link better with the range of primary care providers
- to facilitate general practice use of existing primary and community care services including Commonwealth, state and non-government organisation funded services with a focus on patients with chronic disease
- to facilitate general practice 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)
- to contribute to work around developing local chronic disease care pathways (generic or specific) or other priority activities with a chronic disease management focus.

The ABHI PCI program provides additional opportunity to enhance and strengthen the work of the PCPs in ICDM and provides another opportunity for engagement with divisions of general practice.

General Practice Victoria (GPV)
As the peak body for Divisions of General Practice in Victoria, GPV supports divisions in their endeavours to ensure a skilled, viable and effective general practice workforce, to improve the health and wellbeing of the people of Victoria.
www.gpv.org.au

Information about other important organisations and initiatives for general practice can be found in Working with General Practice: Department of Human Services position statement and resource guide.

Conclusion

Key learnings for enhancing general practice engagement in integrated chronic disease management include:

- Understand general practice, using resources available from DHS and GPV
- Work in partnership with your local Division of general practice
- Seek input from general practice about how you work together
- Focus on outcomes for individual clients more than theoretical outcomes for new programs and services
- Build relationships and consider the best contact within a general practice may be a practice nurse or a practice manager

For further information about General Practice Engagement in Integrated Chronic Disease Management, please contact:

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December 2008