NSW HEALTH

EXECUTIVE SUMMARY

NSW Chronic Care Program

Strengthening general practitioner involvement in chronic care

Review and recommendations

Background

Chronic illness presents a growing challenge to health care services in Australia. This growing challenge results not only from the increasing burden of chronic illness generally but also from the health system's traditional focus on acute episodic care, rather than on provision of integrated care systems for chronic conditions across the care continuum. Integrated care is particularly important for patients with chronic conditions who require ongoing access to a range of services by multiple providers in settings including the home, community, general practice and hospital. In Australia it is estimated that as many as half of patients with chronic diseases do not receive best practice management.

General practitioners have a key role to play in providing well-coordinated chronic care as part of a multi-disciplinary team. They are generally the initial point of contact for people with chronic illnesses and play a key role in prevention, diagnosis and management of chronic disease in the community. Their role and workload are being increasingly impacted upon by the growing focus on supporting people with chronic illnesses in their home and community environment.

Phase one of the NSW Chronic Care Program saw the successful engagement of local general practitioners and Divisions of General Practice in a number of priority health care programs across NSW, to improve the continuity of care of patients with chronic conditions in their region. An important initiative in phase two of the NSW Chronic Care Program is to identify and implement critical factors for success in engaging general practitioners and NSW Divisions of General Practice.

This report seeks to inform Area Health Services of innovative initiatives across NSW and elsewhere and to inform future NSW Health policy, including models for chronic care management. It does so by reviewing information obtained from:

- literature (peer reviewed and 'grey' literature) on:
  - chronic disease management
  - integration and general practitioner (GP) engagement
  - current policy (national and international)
- semi-structured interviews with:
  - general practitioners
  - representatives of Divisions, including executive officers, program managers and Division Board members
  - Area Health Service staff, in particular staff linked with the local priority health care programs.

Current initiatives for integration of chronic care services

In NSW, integration of chronic care service provision is currently being promoted by:

- Commonwealth initiatives provided through the Medicare Benefits Schedule to encourage and reward GPs for undertaking multi-disciplinary and continuing care, such as Enhanced Primary Care (EPC), the Practice Incentive Program, Service Incentive Payments, More Allied Health Services and Medicare*Plus*
- NSW Health initiatives including:
  - NSW General Practice Council which reports to the Minister for Health and is considering integrated and coordinated models of care involving general practice
  - NSW Chronic Care Program which has been responsible for several key initiatives that support integration and best practice care, such as Clinical Service Frameworks for heart failure, respiratory disease and cancer, *My Health Record*, the NSW Chronic Care Collaborative and *NSW Aboriginal Chronic Conditions Area Health Service Standards*
  - Primary Health Care Networks
  - *NSW General Practice Information Management and Technology Strategy* and Health elink
  - NSW Health Effective Discharge Planning Framework
  - *Framework for integrated support and management of older people in the NSW health care system 2004–2006*
  - Transition care for young people with chronic illnesses

- Other models of integration, including multi-purpose services, coordinated care trials, Divisions and Hospitals Integration Program, After Hours Primary Medical Care Program, National Demonstration Hospitals Program, Hospital in the Home, and co-location or close location of primary care facilities.

Barriers and challenges to integration

The literature and stakeholder interviews identify a range of barriers to effective integration of chronic care services. These relate to:

- the complex nature of many chronic illnesses and the systems of care required for their optimal management
- the different and sometimes conflicting drivers and incentives under which the various stakeholders, including Commonwealth, States, Area Health Services, GPs and people with chronic illnesses operate
- inadequate communication between care providers
- the complex mix of Commonwealth and State funds that together provide the various aspects of care for people with chronic diseases across the continuum of care also leads to difficulty in operating integrated systems of care.

Successful strategies for facilitating integration

Effective working partnerships between the various providers of chronic care services are essential to successful integration of care. Divisions of General Practice have been a driving force in facilitating GP/hospital integration over recent years. At a local level, clinical champions or executive sponsors in Area Health Services and Divisions are another key driver for integration, providing leadership for effective change management.

There is now significant evidence supporting a coordinated team approach to the delivery of effective clinical care for chronic illness. In the Australian healthcare system, GPs are key members of this team, given their role as providers of the key elements of chronic care across the care continuum. The active engagement of GPs in the development and joint implementation of chronic care initiatives is crucial to their success.

Establishing integrated care generally requires a change in individual and institutional attitudes, management structures and inter-relationships and approaches to care.

Recommendations

The following key principles are the basis of successful integration of chronic care:

- Well-being of the person with chronic illness should be the common objective of all providers of chronic care services and the primary focus of integrated care.
- Commitment of all key stakeholders is required to effect meaningful change. Clinical and executive champions as well as Divisions of General Practice can play an important role in fostering this commitment.
- Successful integrated care is reliant on service providers being able to communicate in a timely and effective way, either directly or in terms of access to appropriate services.
- No single strategy or approach alone will ensure integration and effective partnerships, rather an approach incorporating several strategies has been found to be the most effective.
- Achievement of integrated care between Area Health Service providers and GPs may only be possible among clusters of GPs or in limited settings, but closer collaboration or better-coordinated care which falls short of integration is a preferable alternative to autonomous operation of care providers.

Within the context of these underlying principles, and on the basis of evidence from the literature review and information from stakeholder consultation, the following strategies are recommended to Area Health Services to strengthen GP involvement in chronic care initiatives:

Formal integration strategies

- Develop formal collaboration mechanisms, such as Memoranda of Understanding with Divisions of General Practice. These should declare mutual expectations and goals with identified performance indicators.
- Agree terms of engagement and processes for Division and/or GP representation. These should include appropriate remuneration for GPs involved in Area Health Service meetings and service planning activities.

- Where multiple Divisions correspond to Area Health Service boundaries, agreements should, if appropriate and feasible, be with a consortium of Divisions.
- Where possible, Memoranda of Understanding should be linked to a joint budget, comprising funds for integration projects, to be accountable to the joint executive. The existence of joint funding, with a delegated authority or executive committee, ensures that programs are action and outcome focused.
- Area Health Services develop local systems and agreements, under the auspices of the local MOU, which reflect the contribution of general practice in Area Health Service integrated care and service planning. For specific programs or in large (metropolitan) Area Health Services, where service relationships are between the local health service and Division, service level agreements (SLAs) are recommended. The SLA should detail the individual roles, responsibilities and performance indicators.
- Service planning and development of programs should actively involve appropriate general practice representation and be cognisant of general practice initiatives.

Common or agreed systems for organising care

- Establish GP Liaison Officer positions to provide an advisory role to Area Health Services with respect to general practice, and act as a conduit between Area Health Services, Divisions and general practice to ensure access to a consistent general practice perspective for Area Health Service staff. These positions can also act as facilitators for further consultation with local GPs.
- Develop job descriptions of positions with intersectoral responsibilities to include a requirement to liaise with Divisions and GPs.
- Co-locate appropriate liaison positions in Divisions of General Practice to build capacity and knowledge about general practice clinical and business agendas. This strategy can facilitate the education of staff from both organisations about the corporate agenda, and the cultural and business issues for their counterpart.
- Explore local options for improving (and streamlining) methods for accessing both service information and services themselves by way of Area-wide call centres, computer-based directories or nominated contacts.

Shared methods for enhancing quality

- Encourage and facilitate opportunities for joint education sessions between Area Health Services and Divisions.
- Support innovative approaches to the development of strong working relationships, support structures, patterns of referral and education and peer-support opportunities between general practice and hospital based professionals. This may include capacity building programs for special interest GPs to benefit from specialist input and be better equipped to support their peer group in general practice.
- Facilitate evidence-based changes to GP/clinical practice through use of GP liaison officers, practice nurses and joint education sessions.
- Raise the profile of local integrated care projects and programs through clinical leaders.

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