

Integrated Chronic Disease Management Case Study

General practice - PCP partnership delivers system-wide reform and benefits for people with chronic disease

Resource for Primary Care Partnerships

Consumers, healthcare providers and health services in Melbourne's north-eastern suburbs are enjoying increased service coordination and integrated chronic disease management resulting from a strong partnership between the North East Valley Division of General Practice (the Division) and the Banyule Nillumbik Primary Care Alliance (BNPCA), a Primary Care Partnership (PCP).

International evaluations identify collaboration as a crucial predictor of success in improving the quality of healthcare across a region, specifically that partners in this work need to be willing to do each of the following, both individually and collectively: exchange information, harmonise activities, share resources and enhance their partner's capacity.¹ This case study describes a partnership which is delivering this thorough definition of collaboration.

The players

- North East Valley Division of General Practice, a member of the Banyule Nillumbik Primary Care Alliance
- Banyule Nillumbik Primary Care Alliance whose member agencies include community health, local government, hospitals, RDNS, the Division, other community organisations and consumers.

The drivers

The BNPCA vision is to work together to promote improved health and community services leading to better health outcomes for the communities of Banyule and Nillumbik. The BNPCA understood that most people access primary care services via a GP and therefore relationships with general practice, which could be accessed through their partner Division of General Practice, were crucial to the Alliance's activity.

Key learnings

Many opportunities can be grasped when there is a strong basis of collaboration. PCPs are an ideal platform to build this collaboration with general practice. Regular, ongoing sharing of information is a crucial first step towards collaboration.

A purposeful approach is required. The BNPCA's GP Integration Strategy provided invaluable direction to the building of this partnership to a level of collaboration which is delivering improvements for clients.

Collaboration between all partners in the primary health care system can improve and streamline support and care for people living with chronic disease. The changes required both within and between agencies call for an investment of time and energy in building up partnerships and collaboration. The pay off is important and sustainable improvements for our communities.

¹ Wagner, E., Austin, B., Coleman, C., 2006, It Takes a Region: Creating a Framework to Improve Chronic Disease Care, California HealthCare Foundation, p.25, available at <http://improvingchroniccare.org/>.

Practices promoting successful outcomes

Examples of how the Division and BNPCA have worked together through this partnership are presented for this case study against each of Wagner et al's four levels of collaboration described earlier and pictured (right).

Exchange information

> Division as an active PCP member

The Division is an active, ongoing member of BNPCA. The Division CEO is a member of the BNPCA Executive and the Deputy CEO is a member of both the Service Coordination Working Group and the Chronic Disease Collaborative. This ensured that all parties were aware of each others' activities. The BNPCA staff also receive the weekly eNews distributed by the Division and have shared information with local general practices about BNPCA members' programs through this avenue.

Harmonise Activities

> GP Integration Strategy

The BNPCA Executive, which includes representation of 11 member agencies including the Division, endorsed a 'GP Integration Strategy' in June 2006 which brought together all of BNPCA's activities relating to general practice into a coherent strategy. A work plan with actions, timelines and performance measures accompanied the strategy.

Share Resources

> Joint professional development sessions

Training sessions in motivational interviewing were funded and run jointly by BNPCA and the Division, fulfilling a need of both of their members. The sessions being run jointly also promoted interdisciplinary learning which is increasingly understood to be an effective and important approach to training in primary care and beyond.

> **A GP Liaison position** was created jointly by BNPCA and the Division to support the Early Intervention in Chronic Disease initiative at Banyule Community Health. BNPCA contributed funds and the Division provided invaluable advice, direction and mentoring in the development and undertaking of the role. The success of this role, and improvements it delivered for general practice, the community health service and clients was an 'early win' for the partnership and built confidence that future partnership activities could be successful. (For further information about the GP Liaison role, see the case study in 'General Practice Engagement in ICDM' available at www.health.vic.gov.au/communityhealth/cdm/resources.htm)

Enhance partner's capacity

> **The GP Liaison position**, originally funded by BNPCA, was able to be extended and expanded when the Division identified a funding opportunity. The Division's subsequent contribution of additional funds allowed the role to be expanded to include another part of BNPCA's catchment, specifically working with Nillumbik Community Health, and forming the basis for a consistent approach to general practice integration and engagement across BNPCA's catchment.

> **'Living with a Chronic Condition: Getting the right help, in the right place, at the right time'** is a major initiative undertaken by all key partners of BNPCA so that they can provide a 'no wrong door' approach to chronic disease care across Banyule and Nillumbik. The Division's commitment to this initiative has ensured that it accurately represents and meets the needs of general practice and therefore increased service coordination and quality of care for people with chronic disease.

The Collaboration Primer Model

Exchange Information — *Network*

+

Harmonize Activities — *Coordinate*

+

Share Resources — *Cooperate*

+

Enhance Partner's Capacity — *Collaborate*

From: Wagner, E., Austin, B., Coleman, C., 2006, It Takes a Region: Creating a Framework to Improve Chronic Disease Care, California HealthCare Foundation, p.25, available at www.improvingchroniccare.org

The results

Outcomes of the partnership between the Division and BNPCA have included:

- A successful GP Liaison program at both Banyule and Nillumbik Community Health Services which has been featured at state-wide forums and delivered increased service coordination and service access for people living with chronic disease;
- Streamlined referral process to chronic disease programs across the BNPCA catchment launched in 2009, based on the principle of 'getting the right help, in the right place at the right time', accompanied by agreements to provide consistent and quality feedback to GPs;
- Interdisciplinary training opportunities for clinicians including GPs; and
- Increased funding for community health services' chronic disease initiatives.

For more information, visit www.bnPCA.org.au or www.nevdgp.org.au.

For more information about Integrated Chronic Disease Management and Primary Care Partnerships, including further case studies and resources, visit:
<http://www.health.vic.gov.au/communityhealth/cdm/resources.htm>