

## **Improving Chronic Disease Care:**

**Learnings from the Integrated Disease  
Management Projects**

**October 2005**

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## Executive Summary

Integrated Disease Management (IDM) is an important component of Victoria's Primary Care Partnership (PCP) Strategy, the pioneering primary care service system reform.

For over four years Primary Care Partnerships have been working at the local level, achieving system wide change. It is through these partnership arrangements that improved care coordination has been achieved, especially for people with chronic disease.

The creation of partnerships across the service sector was identified as crucial to the success of Integrated Disease Management.

IDM is a comprehensive and multidisciplinary approach to the care of people with, or at risk of, a particular disease or condition, aiming to reduce the burden of disease through a holistic approach. It encompasses the continuum of care from prevention through to treatment, management and maintenance.

Studies strongly suggest that people with chronic disease have a better quality of life, experience fewer complications and reduce their overall use of health care resources if they participate in an IDM program tailored to their needs.

Following an evidence based review, five IDM pilot projects were funded for three years in 2001 under the Department of Human Services (Victoria) IDM Initiative.

Rural and metropolitan PCPs auspiced the projects which encompassed heart failure, hypertension, diabetes and asthma. The projects dovetailed the implementation of statewide service coordination tool templates providing a platform for consistent referral, assessment and care planning in primary care.

The IDM projects aimed to inform future planning for chronic disease care by developing models of care that sought to:

- Increase quality of life and health outcomes for consumers
- Reduce preventable hospital admissions and emergency presentations
- Prevent or delay the development of disease
- Reduce health inequalities between population subgroups.

The projects trialled different processes and components of IDM to accommodate local priorities, resources and existing care practices through strategies addressing:

- Consumer orientation and engagement
- Consumer self management
- Coordinated and planned care based on evidence of best practice and care pathways
- Engagement of stakeholders including General Practitioners
- Early intervention and prevention of chronic disease.

More than 1000 consumers collectively were involved in the intensive coordinated chronic disease programs

Key outcomes included the development of models of care that supported:

- Consumer participation in the planning, implementation and evaluation of projects.
- Improved coordinated and planned care with greater consumer access to multidisciplinary teams and self management support.
- Consumers experiencing increased confidence in managing their disease and implementing lifestyle changes, improvements in quality of life and high levels of satisfaction with their care.
- Establishment of evidence based and consumer centred disease management frameworks.
- Skill development of service providers and implementation of information systems to promote best practice and coordination of care.
- Integrated community health promotion programs.

The experience of building community programs targeting consumers with chronic disease resulted in key learnings about IDM and effecting change. Enablers and barriers were identified and the relationship between best practice and key learnings explored to further understand the best approaches to improve care for people with chronic disease. These learnings are applicable for health care agencies, programs and providers, including General Practitioners, alike.

*In Maribyrnong Ivan was amazed when a specialist heart failure nurse visited him and his family in his home. They provided “excellent” support and information and worked with him to help him navigate the health system and take control of managing his heart failure.*

*For Joan in Casterton it seemed too difficult to coordinate everything she needed to do for her diabetes. Her general practitioner suggested she join the new coordinated diabetes service. All she needed to do was make an appointment to speak with the diabetes educator at the clinic. The diabetes nurse educator also arranged appointments with the dietitian and podiatrist. Joan now feels confident in managing her diabetes and her HbA1c has come down. The reminder letters for her diabetes check ups certainly help too.*

## 1. Integrated Disease Management: An Overview

Chronic disease poses different problems for different people. Appropriate and timely delivery of consumer focused chronic disease care can deliver better health outcomes for consumers.

### Improving chronic disease care

This document provides an overview of the learnings from the Integrated Disease Management (IDM) pilot projects implemented by Primary Care Partnerships (PCP) in Victoria during the period 2001 to 2004. Strategies for chronic disease care that were successfully implemented with community health agencies are identified. Enablers and barriers are discussed to further understand the best approaches to improve care for people with chronic disease. These are applicable for health care agencies, programs and providers, including General Practitioners (GPs), alike.

### The context

Victoria’s Primary Care Partnerships (PCP) Strategy aims to develop a more integrated health care system. The objectives for PCP’s include health care providers and consumers working together to plan and coordinate services across their catchment and a systematic and coordinated approach to early identification of consumer needs, planned care and communication across services.<sup>1</sup>

### Integrated Disease Management

Integrated Disease Management (IDM) is an important component of Victoria’s PCP Strategy. IDM is a comprehensive and multidisciplinary approach to the care of people with, or at risk of, a particular disease or condition, aiming to reduce the burden of disease through a holistic approach. It encompasses the continuum of care from prevention through to treatment, management and maintenance.<sup>2</sup>

Studies strongly suggest that people with chronic disease have a better quality of life, experience fewer complications and reduce their overall use of health care resources if they participate in an IDM program tailored to their needs.<sup>3</sup>

### The IDM projects

In 2001 five IDM pilot projects were funded for a period of three years, at three metropolitan and two rural PCP locations.

The pilot projects targeted:

- Hypertension (Banyule Nillumbik Primary Care Alliance)
- Type 2 diabetes (South East Primary Care Partnership)
- Type 2 diabetes and heart failure (WestBay Alliance)
- Asthma (Southern Grampians Glenelg Primary Care Partnership)
- Type 2 diabetes (South West Primary Care Partnership)

A summary of each of the projects is provided on the following pages.

<sup>1</sup> Primary Care Partnerships. *Primary Care Partnerships Strategic directions 2004-2006; Better Health – stronger communities.* Victorian Government Publishing Service; 2004.

<sup>2</sup> Primary Care Partnerships. *Integrated Disease Management: Interim Policy Directions and Guidelines.* Victorian Government Publishing Service; 2001.

<sup>3</sup> Institute for Public and Health Services Research, Monash Medical Centre, and Centre for Community Child Health, Royal Children’s Hospital. *Literature Review of Effective Models and Interventions for Chronic Disease Management in the Primary Care Sector.* Victorian Government Publishing Service; 2000.

## Key components of Integrated Disease Management

- *Augmentation of practice systems with **coordinated and planned care based on evidence of best practice** and care pathways*
- *Systematic attention to the **information and behaviour change needs of consumers** and support for **self management***
- ***Appropriate targeting** of population subgroups of greatest need*
- ***Intervention strategies across care continuum** promoting early intervention and secondary intervention strategies*
- ***Consumer participation***
- ***Sustainable partnerships** between consumers, health care providers and health care initiatives.*

## Key aims

The IDM projects aimed to inform future planning for chronic disease care by developing models of care that sought to:

- Increase quality of life and health outcomes for consumers
- Reduce preventable hospital admissions and emergency presentations
- Prevent or delay the development of disease
- Reduce health inequalities between population subgroups.

An evidence based review elicited the key components IDM attributed to achieving these goals.<sup>4</sup>

## Evaluation

The Australian Institute of Primary Care undertook common evaluation across the projects.<sup>5</sup>

In addition, each project conducted an internal evaluation to provide a qualitative analysis of the processes involved in the planning, implementation and evaluation of projects. This information was to be used to inform programs and services targeting people with chronic disease. The final internal evaluation reports and related documents from each of the projects form the basis of this document.<sup>6,7,8,9,10</sup>

The internal evaluation reports for each project may be accessed on the Victorian Government Health Information Site.<sup>11</sup>

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4 Adapted from the Institute for Public and Health Services Research, Monash Medical Centre, and Centre for Community Child Health, Royal Children's Hospital. *Literature Review of Effective Models and Interventions for Chronic Disease Management in the Primary Care Sector*. Victorian Government Publishing Service; 2000.

5 Australian Institute of Primary Care. *Integrated Disease Management Pilot Projects: External Evaluation Summary Report*. LaTrobe University; 2004.

6 Gill M, Willcox J. *Take the Pressure Down: Implementing a Self Management and Hypertension Program in the Community*. Banyule Nillumbik Primary Care Alliance; 2004.

7 Thomacos N. *Integrated Disease Management Project: Evaluation*. South East Primary Care Partnership; 2004.

8 Cancian U, White E, Adamson S. *Asthma Integrated Disease Management for South West Victoria: Final Report*. Southern Grampians and Glenelg Primary Care Partnership; 2003.

9 Adamson S, Wakely J, Nichols J. *Models of Coordinated Care for People with Diabetes: Final Report*. South West Primary Care Partnership; 2004.

10 WestBay Alliance. *Integrated Disease Management Project: Final report – heart failure, type 2 diabetes*. WestBay Alliance; 2004.

11 Primary Care Partnerships Publications, Victorian Government Health Information. <http://www.health.vic.gov.au/pcps/publications/index.htm>

## Key outcomes from the IDM projects

More than 1000 consumers collectively were involved in the intensive coordinated chronic disease programs. The evaluations findings indicated:

### Improvements for consumers

- Consumers reported increased knowledge and ability to self manage their chronic disease and better health outcomes with improvements in clinical health indicators, lifestyle changes and quality of life.<sup>12</sup>
- Positive consumer service outcomes with improved access to, and high levels of satisfaction with, services.<sup>13</sup>
- Increased coordinated and planned care with greater consumer access to multidisciplinary teams and self management support.
- Consumer participation models with consumer involvement in the planning, implementation and evaluation of projects.

### Improvements for health care providers and organisations

- Establishment of consumer centred and sound disease management frameworks based on evidence of best practice.
- Development of information systems that record, transfer and feedback consumer information across the service system.
- Intensive training and education for more than 550 health care providers including health professionals and General Practitioners (GPs) in management of chronic disease, self management, lifestyle change and coordinated care.
- Integrated health promotion programs around primary and secondary prevention.

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<sup>12</sup> Australian Institute of Primary Care. *Integrated Disease Management Pilot Projects: External Evaluation Summary Report*. LaTrobe University; 2004.

<sup>13</sup> *Ibid*





*“The course was very beneficial to me, and I learned a lot of ways to improve my health. It gave me confidence to manage my blood pressure better. Towards the end of the course my blood pressure improved, my medication was reduced and I felt relaxed and positive.”*

**Consumer, BNPCA**

## 2. Profiling the Projects

### Take the Pressure Down: Banyule Nillumbik Primary Care Alliance (BNPCA)

Building a consumer orientation in the Take the Pressure Down project showed how important hypertension and self management were to consumers and allowed consumer needs to drive the program strategies. The centrally coordinated self management programs demonstrated better health consumer outcomes including improvements in confidence, knowledge, ability to manage health, self efficacy, lifestyle changes and quality of life indicators.

#### Key features

- **Consumer participation model** with consumer centred strategies, consumer reference group and qualitative consumer research that informed planning, implementation and evaluation of the project.
- **Accessible catchment-wide self management programs** delivered by community and acute health agencies.
- **Central coordination** supporting implementation of a coordinated and planned care model based on evidence of best practice for hypertension and self management. This included a central intake point and protocols to support providers with integration of systematic referral and feedback mechanisms.
- **Sustained self management professional development** with leader training programs for consumers and health care providers and support for individual agencies to explore applicability of self management models for all chronic diseases for their agencies.
- **Primary prevention** through physical activity with a comprehensive web-based Physical Activity Directory integrated with BNPCA health promotion initiatives.
- **Transferable model for social marketing of health issues** at a local level utilising hypertension in the first instance.



#### Lois' Story

*“Joining the Consumer Reference Group for Take the Pressure Down changed my life. I was scared but determined.*

*What followed with the Group and Project took me onto a new journey. It restored my hope and my decision to help others. I felt part of the community and I discovered that if I tried, I could recover, following my strokes.”*

**Lois Mentieth, Consumer Reference Group member and Peer Self Management Group leader, BNPCA**



*“The action planning exercises were useful because it made things achievable and practical. This built my confidence that I could self manage.”*  
**Consumer, SEPCP**

## IDM Diabetes Project: South East Primary Care Partnership (SEPCP)

This project successfully engaged the participation of the majority of General Practitioners (GPs) in a coordinated type 2 diabetes service model. Basing the project in the Dandenong District Division of General Practice (DDDGP) and building on pre-existing diabetes education services and trusted relationships with division staff facilitated the engagement of GPs. Consumers demonstrated improved health and wellbeing including clinical indicators, such as HbA1c,<sup>14</sup> by moving through the coordinated system via the Diabetes Coordination and Assessment Service (DCAS) to receive self management education that was timely and convenient.

### Key features

- **DCAS located at the DDDGP.** This service provided a link between consumers, GPs and health care agencies. GPs referred to the central intake point and project staff assessed, triaged, tracked and monitored consumers' progress through the integrated service system. Initial information was provided to consumers to address their immediate needs and they were referred to the most appropriate health care agency, providing consumers with a seamless supported pathway to integrated multidisciplinary care.
- **Capacity building.** Training for health professionals and resource support increased the availability of diabetes self management and strength training programs provided by multidisciplinary teams in the two community health centres.
- **Integration of services with tools and systems** that supported and promoted service coordination beyond the life of the project by a number of health care providers.
- **Health promotion project** with GPs and consumers to raise consumer awareness of their risk for developing diabetes, including directives to ask GPs for testing.
- **Diabetes self management programs (DSMP).** Greater access to DSMP for consumers was a result of training and service reorientation.
- **Consumer Advisory Group** allowed for consumer input into project planning.

### A GPs Story

*It's reassuring to know that patients are able to access a quality diabetes self management service within a desirable timeframe. I also like the streamlined but comprehensive service package that is offered to newly diagnosed patients and appreciate the prompt feedback that I receive.*

**Dr Graeme Downe, GP, SEPCP**

<sup>14</sup> Southeast Primary Care Partnership. Evaluation Group HbA1c Paired T Test. SEPCP IDM Diabetes Project. 22/12/2003



## Asthma Integrated Disease Management Project for the South West: Southern Grampians Glenelg Primary Care Partnership (SGGPCP)

High levels of morbidity from asthma and poor levels of asthma management within rural areas in South West Victoria prompted the Asthma Integrated Disease Management Project for the South West. A two pronged approach utilised a coordinated model for asthma education services within GP practices and health promotion activities focusing on primary school children, travellers and maternal and child health nurses. Following asthma education consumers reported significant lifestyle changes and an improved ability to manage their asthma. This project shared funding with the SWPCP project.

### Key features

*“I knew nothing about asthma when we first started. I now feel far more confident and know how to manage it.”*  
**Consumer, SGGPCP**

- **Asthma education service model** within a GP practice featuring integrated coordination, promotion of best practice, a multidisciplinary approach and consumer and health care provider resources. This model aimed to support GPs implement the *Asthma 3 Plus Plan*.<sup>15</sup>
- **Promotion of best practice guidelines and professional development** with health care providers including GPs.
- **A primary school based asthma education project** *Asthma Share It With Others* using resources developed by Grade 5 and 6 children. This material is now available statewide through Asthma Victoria.
- **Health promotion** focusing on travellers producing the resource *Take It Easy, Not Wheezy* with Asthma Victoria.
- **Professional development** for maternal and child health nurses and community nurses to encourage smoking cessation for parents.

*“As a health professional I can really see huge potential for how we manage asthma in this region - people do respond to education and information and it is important we approach it as a team.”*  
**Health Professional, SGGPCP**



**Traveller's Asthma resource  
 from SGGPCP**

<sup>15</sup> See details and resources at the National Asthma Council Australia's web site at [http://www.nationalasthma.org.au/publications/3plusplan/3plus\\_rev.html](http://www.nationalasthma.org.au/publications/3plusplan/3plus_rev.html)



*“A Diabetes Support Group was formed as a result of this project. It is still going strong, with 20 attendees at most meetings.”*

**Barbie Sawyer, SWPCP**

## South West IDM Diabetes Project: South West Primary Care Partnership (SWPCP)

Making coordinated specialist diabetes services accessible to people in rural areas was a key feature of the South West IDM Diabetes Project. Co-locating specialist diabetes education at a GP practice level, combined with education of GPs and practice staff facilitated the identification of consumers, the use of multidisciplinary referral and coordinated care plans and improved consumer knowledge and health behaviours.

An example of a continuing partnership with the local indigenous communities of Gunditjmara, Framlingham and Winda Mara has been the Indigenous Vascular Disease Strategy including the early detection of type 2 diabetes.

This project shared funding with the SGGPCP project.

### Key features

- **A GP practice focused model of coordinated care** for consumers with diabetes.
- **Co-locating and resourcing specialist diabetes education in GP practices** to undertake a care coordination role. This involved coordinating allied health referrals, capacity building and engaging consumers in the self management of their condition.
- **Protocols and processes with professional development** for GPs, practice staff and practice nurses, including local computerised consumer registration and recall and reminder systems.
- **Promotion of best practice guidelines** for diabetes across the South West region.
- **Health promotion partnership** with local indigenous communities of Gunditjmara, Framlingham and Winda Mara to investigate culturally sensitive ways to improve outcomes for people with diabetes.

### Brian's Story

*“I have found [the program] very informative and it has made a big difference to my outlook.*

*Having an understanding of how diabetes affects the body has changed my ability to cope with the day to day conditions of the disease. The comprehensive information about diet, managing weight loss and all the other possible complications I have found to be very reassuring that I can manage what comes.*

*Not having any knowledge of diabetes before being diagnosed, my sessions with Barbie [diabetes nurse educator] are very important steps on the way to being able to cope with the disease and improve my general health and fitness.”*

**Brian J. Hunter, Consumer, SWPCP**



## WestBay Integrated Disease Management Project: WestBay Alliance (WBA)

Tailoring self management education for consumers with type 2 diabetes and heart failure from Culturally and Linguistically Diverse (CALD) communities was a focus of the WestBay IDM project. Project officers visited consumers in their homes to support them to access health care professionals and to encourage self management with individual, culturally specific education resources. Consumers reported improvements in health and well being, marked changes to lifestyle and diet and improved self confidence and quality of life.

### Key features

- **Project officers visited consumers in their homes**, working one to one with consumers to answer questions about their condition, help them access local health services and encourage self management and life style changes through goal setting.
- **Partnering with statewide specialists and local community groups** to develop disease specific information, patient hand held records, action plans and disease service directories for both type 2 diabetes and heart failure in eight community languages (Italian, Greek, Vietnamese, Croatian, Serbian, Macedonian, Maltese and Portuguese).
- **Tracking the consumer experience** through the health care system to better understand the complexity and utilisation of the health care system.
- **Supporting GPs** by linking in with relevant GP Division Initiatives including Enhanced Primary Care (EPC) plans.
- **Resourcing and training** of health care providers to support promotion of self management.

*"I exercise up to an hour each day. I feel much better and my blood sugar levels have come down – my HbA1c is less too."*  
**Consumer, WBA**

### Roman's Story

*After joining the WestBay project Roman received culturally relevant diabetes and lifestyle information and self management support encompassing his Filipino culture.*

*Roman believes he would have approached his diabetes management differently at diagnosis if he had been given the right advice and support. He says "This project gave me a new life".*

**Roman, Consumer WBA**



### 3. Key Learnings

The experience of building community programs targeting consumers with chronic disease resulted in key learnings about IDM and about effecting change.

These key learnings can be grouped as follows:

- Understanding needs in chronic disease
- Coordinated and planned care based on evidence of best practice
- Self management for consumers
- Health promotion
- Targeting subgroups of greatest need
- Consumers as partners in chronic disease
- Sustainable partnerships, including partnerships with GPs
- Managing sustainable change.

#### Understanding needs in chronic disease

The consultative phase of the IDM projects elicited consistent messages from both consumers and health care providers on the issues faced in accessing and delivering chronic disease care.

Many of the barriers to managing chronic conditions perceived by both consumers and health care providers related to the ability to access services and developing a consistent approach to the delivery of care.

Understanding consumer and health care provider barriers provides valuable insight into where to commence when planning service delivery changes and a common and objective platform for inter-agency planning.

#### Consumer barriers to managing chronic disease

*“They spoke another language, I didn’t really understand what he meant when he started to tell me about what my heart is doing when the pain happened or when the weight went up and I drank too much: I couldn’t put it all together.”*

**Consumer, WBA**

- **Psychosocial impact:** Managing the financial burden, impact upon quality of life and that of the family, denial of the impact of living with a chronic illness.
- **Lack of understanding:** Unable to access information about their disease, unclear about their role in self management.
- **Knowledge of services:** Poor understanding of the services available and the role of the different health professionals.
- **Consistency of information:** Receiving different (sometimes contradictory) information from different health professionals or being unable to understand the language used.
- **Access to services:** Inability to access services for a number of reasons including distance, lack of transport and language.

*It's just so hard to get people in...You book people in but in 4-6 weeks the patient has forgotten what you've told them. There's an urgency when you give a diagnosis...There's an acute period after diagnosis where you need to get someone on to them...the longer it takes between diagnosis and treatment - it loses its impact.*

**GP, SEPCP**

*It makes it very difficult seeing a patient when the only information I have is the GP's referral which says something like "Sister please see this person...Sugar"*

**Diabetes nurse educator, SWPCP**

## Health care provider barriers to managing chronic disease

- **Knowledge and skills:** Lack of knowledge or recognition of chronic diseases and disease-specific best practice guidelines. Lack of skills to support consumers with lifestyle change and self management strategies.
- **Consistency:** Lack of consistency in consumer information, use of clinical guidelines, assessment and care planning information.
- **Coordination:** Poor communication between care providers and lack of coordination of services across catchment areas.
- **Access to services:** Poor knowledge of other services with referral pathways and referral requirements unclear.
- **Resources:** Insufficient time and specialised staff.

## Coordinated and planned care based on evidence of best practice

### Coordinated Care Strategies

Strategies developed by health care agencies involved in the IDM projects included the development and implementation of:

- Common practices, processes, protocols and systems for the sharing of consumer and service information incorporating service coordination tools, recall and reminder systems and feedback mechanisms.
- Consumer consent and privacy processes consistent with legislated standards.
- Best practice clinical guidelines including multidisciplinary pathways for better service, consumer care plans and care coordination between health care providers.
- Service directories.
- Training for health care providers, including GPs, in best practice guidelines and coordinated care.

### Positive consumer outcomes

The IDM project evaluations reflected improved service outcomes for consumers with improved access, and higher levels of satisfaction with services. Improvements in clinical outcomes, positive lifestyle changes and quality of life were also demonstrated across all projects.<sup>16</sup>

### Success factors for coordinated care practice change

Critical success factors for achieving these practice changes included:

- A cooperative approach to planning
- Centrally coordinated care pathway
- Use of systems and protocols based on evidence of best practice
- Building on existing resources and infrastructure
- Building local capacity and supporting dissemination.

*"A coordinated, multidisciplinary approach is less of that stuff for GPs to do, so it's time saving - I reckon it saves half an hour at diagnosis"*

**GP, SEPCP**

*"I joined the Cardiac Rehabilitation Program. My nurse put me onto it through the resource directory. It is great I have met other people with heart failure. It is a terrific support for me."*

**Consumer, WBA**

<sup>16</sup> Australian Institute of Primary Care. *Integrated Disease Management Pilot Projects: External Evaluation Summary Report*. LaTrobe University; 2004.

## A catchment-wide review of services

*A catchment wide review of services rather than an agency focussed approach to planning facilitated the implementation of a Diabetes Care and Assessment Service and agencies' agreement to use common service coordination tools in the SEPCP.*

*These changes were reported to result in:*

- *Significant numbers of referrals from GPs*
- *Client data and information moving well across the service system*
- *Reduced waiting times for access to services*
- *Centralised client referral, assessment and tracking*
- *Uptake of the tools and practice beyond the life of the project by a number of community health centres and GPs.*

*"The centralised coordination of the self management programs facilitated recruitment of participants and provided leaders with support in organising and conducting the programs contributing to their successful delivery".*

**Kim Gray, Austin Health, BNPCA**

## A cooperative approach to planning

Improvements in service delivery were achieved when agencies planned together with a focus on:

- The consumer experience and needs
- A catchment wide review of services rather than agency focused
- Inclusive consultation and planning.

All the projects identified that the cooperative approach to planning resulted in more clearly identified gaps in services, with agencies working cooperatively on strategies to address the gaps. This included resource sharing, realignment of resources and collaboratively seeking other funding sources.

Acknowledgment of the confusion for consumers receiving different information from agencies resulted in all projects gaining agreement for agencies to provide the same information to consumers. For most projects, agencies reached agreement on utilising or adapting information from peak organisations rather than attempting to develop new information.

## Centrally coordinated care pathway

Centrally coordinated care with agreed entry points for consumers was trialled in all projects with many benefits demonstrated for both consumers and health care providers. Factors that facilitated this process included:

- Documented and agreed referral pathways across agencies that were valued by stakeholders
- Clear point of entry for consumers
- Dedicated resources allocated to the coordination role
- Shared and agreed expectations across services
- Building on existing referral pathways and relationships
- Building capacity of providers to provide services
- Organisational support
- Promotion of the central coordination role across agencies
- Resource sharing.

Identifying a clear entry point and a dedicated coordination role supported referrals to both the SWPCP and SEPCP diabetes projects and the SGGPCP asthma project where a clinical educator worked closely with a general practice. This resulted in greater access to services and improvements in care coordination.

Focusing on the consumer experience provided the impetus for agencies in the BNPCA and SEPCP to agree on a central intake point for coordination and enrolment in self management programs. This process had clear benefits for the consumer with greater choice of venues and times for programs without the barrier of numerous phone calls to find the right program.

The importance of these facilitating factors is further highlighted by the WBA experience where the service coordinators had difficulty engaging with GPs and local agencies. This was reported to be related to the fact that the coordinators (who were employed by the project) were not known to local health care providers or aligned to an agency recognised by local providers.



## A health care provider's story

*The coordination of care for people with diabetes allowed me to ensure that the cycle of care was completed for each person by my association with the GPs.*

*I was able to do this because clients agreed for me to access their medical history allowing me to ensure all complications screenings were complete. The project also raised the profile of diabetes within the GPs practice, and the community.*

*I believe that the diagnosis of diabetes is now occurring earlier than it was prior to the project, and that the people with diabetes involved in the project have more chance of self-managing their disease.*

*Access to a qualified diabetes educator only occurred for our community because of this project. Prior to this people had to travel 60kms to access an accredited diabetes educator.*

*The GPs are very keen to continue having me work from their clinic, and they actively seek my input.*

**Barbie Sawyer, Diabetes Nurse Educator, SWPCP**

## Use of systems and protocols based on evidence of best practice

### Service coordination initiatives

Changes to information sharing, privacy, referral and feedback practices were more readily adopted when they were linked to the PCP service coordination strategy. Learnings were gleaned from the IDM models that furthered the service coordination initiatives and agencies could see more readily that the work could support and complement changes they were required to implement in these areas.

Providers identified that these processes facilitated increased information sharing and the quality of the information reduced assessment time, facilitated more timely delivery of services and supported care planning. Consumers also identified clear benefits with not having to repeat their story with each consultation and greater access to services.

Development of catchment-wide service directories was readily adopted by all projects with agencies identifying clear benefits for agencies, providers and consumers.

### Best practice clinical guidelines

The promotion of best practice clinical guidelines is fundamental for chronic disease models to help consumers and health care providers identify the best methods of health care and make informed choices. Multifaceted approaches and building on existing resources and strategies proved to be most successful with strategies including:

- Dissemination of peak body guidelines
- Working with local health care providers to adapt guidelines for local conditions and available services
- Integration of guidelines into care and action plans
- Translating guidelines into consumer friendly formats
- Supporting clinical audits
- Consumer hand held records
- Professional development activities
- Increased access to allied health professionals and multidisciplinary teams.

The implementation of guidelines comes up against logistical problems which affect how the evidence is applied.<sup>17</sup> For example, most projects identified that implementation of evidence based care pathways and plans resulted in increased health care provider time. The use of group education programs was a successful strategy used by projects to meet this increased demand.

<sup>17</sup> Freeman AC Sweeney K. Why general practitioners do not implement evidence: qualitative study. *BMJ* 2001;323:1-5.

*“I have patients use their action plans and use them competently. Patients are using the asthma devices better. Therefore there are better outcomes with the use of medication.”*

**GP, SGGPCP**

### Care plans

Consumer supported care plans were used to promote consistency of planning and delivery of care, act as a communication tool and raise awareness of best practice. When care plans or action plans were a feature of the intervention consumers reported receiving one or creating one. Commonly the uptake of care plans from GPs was limited. A number of factors may have contributed to the limited uptake including:

- Medical Benefits Scheme (MBS) rules for eligibility for a care plan made it difficult for GPs to identify appropriate patients to refer
- Changes to the Enhanced Primary Care (EPC) item eligibility criteria early in the life of the projects reducing the number of patients eligible for a EPC Care Plan.

### Building on existing resources and infrastructure

Implementing and sustaining changes that supported improvements in care coordination were most successful when:

- Changes were consistent with the agencies objectives and/or linked to existing services and partnerships
- A multifaceted approach was adopted
- Existing resources and strategies were adapted locally and integrated into agency practice.

### Building local capacity

All projects undertook significant professional development activities with local health providers to support the delivery of best practice care. A common finding was that, along with building knowledge and skills, capacity building must focus on implementation issues for practitioners and support organisational change. Practitioners attending training programs identified significant barriers to practice change from within their organisations.

### Essential elements of self management interventions<sup>19</sup>

- Information on disease, health management and best practice guidelines
- Recognition and support to cope with changes in role
- Recognition and support to cope with emotional changes
- Problem solving training
- Support enhancement of self efficacy
- Regular systematic follow up
- Collaborative implementation and tracking of care plans with consumers.

*“When I saw the dietitian (it) was really helpful. I understand what to eat now, I was overeating. Now I am losing weight and I feel much better.”*

**Consumer, WBA**

*“Taking control is daunting. The reality is as a result of attending a course I am doing things now that I thought I couldn’t do.”*

**Consumer, BNPCA**

## Self management for consumers

A key mandate of IDM projects was to look at models of care that promoted self management for consumers. The IDM policy guidelines identified:

*“Effective self management is based on partnership between consumers, their families and health professionals, in which the consumer is encouraged to play an active role in monitoring and managing the symptoms of the disease.”<sup>18</sup>*

All projects implemented strategies to promote self management for consumers. An increased ability to self manage chronic disease was identified by consumers collectively, with reported improvements in knowledge and increased confidence in managing their condition. In most cases these changes were maintained at six months after completion of the program. Some projects were able to demonstrate significant lifestyle changes and improvements in health indicators.

### Strategies to promote self management

#### Integrating self management into consumer programs

Focusing on incorporating the essential elements of self management interventions into program development ensured projects and participating agencies were able to make significant changes to previous practices to improve support for consumer empowerment and self efficacy.

Projects were successful in integrating aspects of self management, such as facilitating access to information and best practice, into program delivery or augmenting existing programs. This was achieved by adding problem solving, action planning and enhancement of self efficacy strategies. Some agencies took the initiative to review programs from an agency wide perspective aiming to integrate self management strategies into all programs.

#### Utilising validated self management programs

The BNPCA introduced a validated self management program and added a hypertension and local resource overlay. The Better Health Self Management Program (Stanford University)<sup>20</sup> is a standardised and validated six week self management group program that is supported by a training manual and leader training. The established, evidence based framework assisted with developing a common understanding among consumer and health care providers. At a management level it was seen as having clear advantages. Working with Nillumbik Community Health Service to coordinate programs and training for self management

for the catchment, the BNPCA established a self management centre of excellence.

<sup>18</sup> Primary Care Partnerships. *Integrated Disease Management: Interim Policy Directions and Guidelines*. Victorian Government Publishing Service; 2001.

<sup>19</sup> Adapted from Robert Wood Johnson Foundation. *Seven Essential Elements of Self Management Interventions*. The Center for Advancement of Health; 2002. <http://www.cfah.org> Accessed 25/6/2002.

<sup>20</sup> Stanford Patient Education Research Center. <http://patienteducation.stanford.edu/> Accessed 10/8/04.

*“It made a pleasant change to be asked as a consumer what I needed to do to control my health problems and not to be told what I needed to do by health professionals.”*

**Consumer, BNPCA**

*“Having the record has reminded me about my diabetes and makes me more motivated.”*

**Consumer, WBA**

*“The blood pressure cards have been a huge hit...they are a way of getting people to see their GP and take care of themselves.”*

**Program leader**

### Awareness raising and capacity building

Projects reflected that a poor understanding of self management among health care providers, particularly GPs, was a barrier to intervention. Health care providers felt they lacked the skills and processes to promote self management. Widespread education and promotion, as well as avoiding labelling programs “self management”, were seen to improve uptake for consumers and health care providers.

Three of the projects implemented self management training for health care providers and consumer peer leaders. This was organised either through the Flinders University Human Behaviour and Health Research Unit’s *Chronic Disease Management Training*<sup>21</sup> program, the Arthritis Victoria *Self Management Program – Leadership training*<sup>22</sup> or self management experts. Internal evaluations showed that this training was well attended and highly valued. Projects identified that ongoing support, with implementation at an agency level, was required to maximise training benefits. Practitioner networks established by both SGGPCP and BNPCA provided an ongoing opportunity to share information and skills.

### Service coordination to support self management

Key elements of service coordination provided valuable support for self management including:

- Increasing access to self management services
- Consumer care and action plans
- Support for recruitment
- Consumer resources including hand held records
- Service directories.

## Emerging Issue

### Hand held record: a useful self management tool

A consumer hand held record (HHR) is an inexpensive and practical intervention to help build consumer involvement. Three of the projects utilised HHRs and key learnings included:

- HHRs present information in a meaningful and timely fashion in an otherwise fragmented information system with multiple health records.
- HHRs can build value and a sense of team work for consumers and health professionals and improve continuity of care.
- Ethnicity may impact on HHR with WBA demonstrating people from a non English speaking background were less likely to have a HHR.
- Uptake can be more successful for different disease states. WBA found 42% of consumers with heart failure reported taking their HHR to every appointment compared to 7% of diabetes participants.
- For HHRs to be successful they need to be supported by an active health care provider and well integrated into the practice and clinical pathway. The majority of consumers in the WBA project indicated that their doctor do not promote the use a HHR, suggesting doctor opinion could be seen as a determinant of consumer acceptance and faith.

<sup>21</sup> Human Behaviour and Health Research Unit, Flinders University. *Chronic Conditions Self Management Workshops*. <http://som.flinders.edu.au/FUSA/CCTU/home.html> Accessed 24/7/04

<sup>22</sup> Arthritis Victoria. *Self Management Leader Training Courses*. <http://www.arthritisvic.org.au/About/selfmanage.htm#Self%20Management%20Leader%20Training%20Courses> Accessed 24/7/04

## Asthma: Share It With Others

By the children for the children



*The students of Warnambool Primary School (Years 5 & 6, 2003), were the project team for Asthma: Share It With Others Primary Schools Project in the SGGPCP.*

*The children actively developed an education framework with a CD-ROM PowerPoint presentation title Asthma: Share it with others. It will be incorporated into the Australia wide Asthma Friendly Schools Program.*

## Health Promotion

Varying approaches to health promotion were adopted by the IDM projects including interventions focusing on behavioural risk factors, identifying “high risk” undiagnosed individuals and secondary interventions such as regular screening for complications.

### Factors contributing to success

Factors that contributed to the success of health promotion activities included:

- Activities that were consistent with the wider PCP health promotion strategy and involved dedicated health promotion planning groups
- Building on programs already established
- Consultation with consumers and involvement of consumers in planning
- Developing partnerships particularly with organisations outside the health field
- Focusing on capacity building to broaden the activity beyond specific diseases. For example BNPCA worked with agencies to develop a local social marketing model and SGGPCP provided QUIT training for maternal and child health and community nurses.

### Health promotion examples

SGGPCP made a conscious decision to concentrate their efforts on health promotion, thereby freeing up resources to develop partnerships and work intensively with local schools. This resulted in the development of resources that are now being promoted statewide through Asthma Victoria.

A dedicated health promotion planning group brought together the skills of clinical practice and providers focusing on health promotion. This was important in the successful development of a local physical activity directory by the BNPCA project, in partnership with the local council.

Projects indicated difficulties in planning and implementing a comprehensive health promotion strategy. They reported struggling with developing strategies that encompassed the breadth of the care continuum from primary prevention through to comprehensive chronic disease management with the physical resources available.

The pressure to demonstrate tangible consumer outcomes may have influenced projects to expend greater time and resources at the provision of care end of the continuum. Current system wide changes including policy changes to support greater emphasis on health promotion and the introduction of common planning tools for integrated health promotion will help to address these issues.

## Targeting subgroups of greatest need

A key mandate for IDM is working towards the goal of “reducing health inequalities between population subgroups”.

### Successful strategies

Strategies that were successful in identifying and engaging with subgroups within the population were:

*“My nurse gave me information in my own language (Italian). It was very useful. I can follow it very well. My family read it too.”*

**Consumer, WBA**

#### Consultation during the early planning phase

Through a process of consultation with local service providers and a review of catchment demographics in the planning phase of their project, WBA identified the need to focus on information for culturally and linguistically diverse (CALD) communities.

Recognition of this issue in the early planning phase resulted in strategies being identified and articulated in work plans and appropriate resource allocation. Early planning allowed the project time to develop and build on existing relationships with local community groups which provided valuable support with engagement strategies and translation of project information. Involvement of local groups also supported ownership of the services and resources.

#### Partnership

Aware that the local indigenous community were not accessing mainstream diabetes services, they were approached by the SWPCP to work in partnership on key diabetes strategies. This approach involved identifying a project worker to plan and implement programs collaboratively with community health workers.

#### Identifying target groups and recruitment strategies

*“I have learned how to relax when finding it hard to breathe, what my lungs look like, how to use my puffer properly, how to cope with asthma ..and how to use my medication.”*

**Young Consumer, SGGPCP**

The BNPCA hypertension project identified that middle aged men and consumers in subrural areas were underrepresented in their programs. This evidence allowed practitioners to gain support from within their agencies to develop programs targeted to these groups.

The SGGPCP *Asthma: Share It With Others By the children for the children* was developed following consultation with local service providers who identified that 10-13 year old children were not managing asthma well but were keen to learn and were beginning to self manage.

#### Dedicated resources

The need to plan early and document strategies within a work plan was highlighted by the SEPCP experience where lack of time and resources hindered their efforts to engage with local CALD communities.

## Making consumer participation meaningful

*Projects reflected that consumer participation required planning and commitment but was worth the effort. They identified that meaningful consumer participation required:*

- *Early involvement of consumers*
- *Commitment to achieving shared goals and genuine collaboration*
- *Support across agencies and all management levels*
- *Sharing of power and decision making and an understanding of roles, rights and responsibilities*
- *Effective dissemination and implementation*
- *Mechanisms to recognise and acknowledge consumer involvement*
- *Clear protocols and processes around consumer representation, consultation, remuneration and conflict resolution*
- *Persistence, patience and flexibility on all sides to build relationships*
- *Multiple strategies using a combination of traditional (e.g. Consumer Reference Group) and non-traditional (e.g. community activity) initiatives*
- *Allowance of time and financial resources.*

*“The consumer reference group gives a voice to consumers and is a force for change”*

**Consumer Reference Group Member, BNPCA**

*“The Consumer Reference Group provided a framework to work within and often resulted in the project taking a direction that could not have been anticipated or identified without access to consumer views.”*

**Project Coordinators, BNPCA**

## Consumers as partners in chronic disease

### Consumer Participation

There is growing interest in and evidence around the links between consumer and carer participation, improved quality of care and health outcomes for consumers. Consumer participation is a core element of the Social Model of Health and is a central vision for PCPs.<sup>23</sup>

It is argued that there are four motivations for consumer participation. These are that participation is an ethical and democratic right, improves service quality and safety, improves health outcomes and makes services more responsive to the needs of consumers.<sup>24</sup>

### How consumers participated

Consumer participation varied between projects. Strategies included:

- **Consumers as active decision makers** in their own care and treatment.
- **Participation in program organisation** including planning, implementation, evaluation and dissemination through program specific or PCP Consumer Reference Groups (CRGs).

Both the SEPCP and BNPCA, through the establishment of a program specific CRG, and the SWPCP, through consultation with the PCP CRG, were able to clearly identify that consumer input had significantly influenced their programs.

Internal evaluations also demonstrated that the establishment of a CRG requires a significant commitment of time and resources but, if well supported, can contribute immeasurably to positive experiences and longer term benefits for participating consumers, the project and the community.

- **Participation in planning and delivery of education and training** as peer leaders or consultants.
- **Consumer oriented and focused project strategies.**
- **Consumer priorities and needs identified** through qualitative research with interviews and focus groups.

### Positive outcomes for all

Projects reported a range of benefits from consumer participation, ranging from positive health and connectivity benefits for consumers to programs and services being more responsive to the needs of consumers.

<sup>23</sup> *Primary Care Partnerships. Primary Care Partnerships Strategic directions 2004-2006; Better Health – stronger communities. Victorian Government Publishing Service; 2004.*

<sup>24</sup> *Consumer Focus Collaboration. The evidence supporting consumer participation in health. National Resource Centre for Consumer Participation in Health; <http://www.participateinhealth.org.au/clearinghouse/Docs/evidence.pdf> Accessed 14 July 2004.*

## Consumer recruitment and access

The projects learnt valuable lessons about the importance of focusing on consumer access and recruitment to fully operationalise and capitalise on the system changes.

Broadening entry points and recruitment into a program increased access for consumers, reduced selection bias and reduced the risk of reliance on one source for recruitment. Developing services where consumers can enter via a range of entry points and move through using pathways to support their individual needs are ideal.

All projects were able to achieve a range of entry points for consumers. This was by working with agencies to act as intake points, through service coordination protocols and through practices supporting appropriate referrals into centrally coordinated programs.

*“It’s good it’s at the Division, because I probably wouldn’t remember the referral process if it was somewhere else. I can just ring up. I only have to remember the Division. There are so many referral processes for different things.”*

**GP, SEPCP**

### Recruitment via health providers

Building on local referral patterns and professional relationships and utilising local champions and project staff with knowledge of the local area were seen as clear advantages to successful recruitment.

Recruitment through GPs was most successful in the projects that were either located in GP practices or at the Division of General Practice and built on processes known to GPs. The GPs in SEPCP already had a commitment to using a successful service. GPs highly valued the timely access provided for their patients and the feedback they received. This probably facilitated their adoption of modified processes and procedures, something which other projects were unable to achieve.

Projects showed that health care providers “struggle” with selling self management and recruiting to programs. This is consistent with national and international self management and coordinated care program experiences.<sup>25,26</sup> Self management education for health providers and longer term programs with extensive promotion were seen as possible solutions.

Selling of early results to stakeholders was a useful strategy to promote greater engagement of services in the project. If clear benefits can be articulated, selling early results supports health care providers in promoting their participation to management and can facilitate greater interest from other stakeholders.

25 Gardner K, Sibthorpe B. Impediments to change in an Australian trial of coordinated care. *J Health Serv Res Policy* 2002;7 S1:S2-7.

26 Banyule Nillumbik Primary Care Alliance. *Informal survey of local self management programs and personal discussion with Professor Kate Lorig, Stanford University. Banyule Nillumbik Primary Care Alliance; 2003.*

### Recruitment indirectly via health providers

WBA found success with consumer recruitment via an agency structure. A local GP agreed to use his database to identify and contact consumers with diabetes, inviting them to attend the program. This contact recruited 100 consumers.

### Direct consumer recruitment

Direct consumer recruitment was successful with those who tried it either through community organisations, mass media or direct targeting. Encouraging word of mouth promotion by consumers helped hasten this process.

Eighty percent of BNPCA's consumers were recruited through communication via mail drop. Direct targeting helped recruit people who were not usually engaged with health agencies, particularly younger age groups and men. Direct targeting of consumers bypasses gatekeeper barriers and is reasonable in cost.

**Do you have?**

- high blood pressure • diabetes
- heart problems • depression • asthma

**...or any other long term health problem?**  
Then this is the program for you.

**This is a program with a difference!**  
Learn the skills to manage your health

- Stress management and relaxation techniques
- Healthy eating and exercise
- Manage your medications
- Communicate well with your doctor
- Set goals and solve problems

Gain support and encouragement from others facing the same challenges.  
A family member or friend is welcome to attend with you.

**Research has shown this program really works!**  
The program has been completed by thousands of people in Australia and worldwide and has proven to be effective in helping people manage health problems.

*"The course was very beneficial to me, and I learned a lot of ways to improve my health. I felt relaxed and positive by the end of the course."*  
Jan, Montmorency

**There is a program near you**  
The course is run by health professionals at different locations across Banyule and Nillumbik including:

- Austin and Repatriation Medical Centre
- RDNS - Diamond Creek
- Eitham Community Health Centre
- Banyule Community Health Service
- Judge Book Village

**How do I book into the program?**  
Speak to Shaunagh or Janine to find out more about the program including times and dates of programs scheduled near you.  
Tel: 9340 9157 or 9430 9142

**OMRON**  
BLOOD PRESSURE MONITORS

**Eitham Community Health Centre**

An example of direct mail flyer to targeted consumers

## Sustainable Partnerships

### Partnering stakeholders: Crucial for success

Partnering key stakeholders and creating partnerships across the service sector were identified as crucial to the implementation and success of IDM. Projects employed considerable effort and resources in engaging and working with stakeholders. This was to ensure that representation extended to groups such as consumers, community and acute health services, local government, General Practitioners, community support services, non government specialist organisations, Royal District Nursing Service, universities and DHS.<sup>27</sup>

### Facilitating partnerships

Factors that influenced partnering and full engagement of health care providers and agencies were:

- Agency leadership and high level management commitment
- Shared power and decision making and an understanding of roles, rights and responsibilities
- Shared goals with participation in planning and implementing change early in the project to foster ownership
- Clearly identified benefits and incentives for providers and agencies
- Individual targeting of health care providers to gain buy in
- Value added training and education of health care providers followed up with support infrastructure and reinforcement
- Identifying key opinion leaders and change agents
- Utilising consumers as allies to provide benefits feedback to health care providers
- Resourced and stable workforce within agencies and programs.

### Engaging acute care services

Effectively engaging with acute care services to facilitate referral pathways to community services or implement shared practices for improved service coordination proved challenging for all projects. WBA identified that recruitment to the project from acute care providers worked best when a staff member was able to navigate the different professional and administration cultures of the hospital system.

SEPCP and WBA were able to build onto their diabetes and heart failure projects by successfully applying for HARP funding.<sup>28</sup> The SEPCP is working with acute and primary care services to enhance the care of individuals with both type 2 diabetes and significant cardiovascular risk and to support GPs in their role as care coordinators. One of the strategies used is to facilitate pathways from acute to community services.

<sup>27</sup> *Primary Care Partnerships. Integrated Disease Management: Interim Policy Directions and Guidelines. Victorian Government Publishing Service; 2001.*

<sup>28</sup> *Information about the Hospital Admission Risk Program (HARP) may be found at the Victorian Government Health Information web site at <http://www.health.vic.gov.au/hdms/harp/>. Accessed 26/6/04.*



**Kay Morey, Accredited Home Medication Review Pharmacist, with Jean Mace**

## Emerging Issue

### Pharmacists: an untapped resource

78.2 million consultations around medications and health occur annually in community pharmacies around the country.<sup>29</sup>

Two projects (SGGPCP and BNPCA) undertook qualitative research with pharmacists and found that they are core, untapped stakeholders in primary care who could be partnered with to improve care for people with chronic conditions.

- Pharmacists are accessible and often the trusted first point of contact for consumers. They play a large role in chronic disease education and care. For example, SGGPCP found pharmacists provided education about inhalers and written resources to 40-100% consumers purchasing inhalers. Moreover, the percentage of asthma medication purchased without a script can be as high as 30%, indicating individuals may not be visiting their GP for regular review.
- Pharmacists were seeking better communication with other providers; education and protocols around chronic diseases and self management; and validated tools and resources for consumers.
- Barriers to involvement are similar to those for GPs, with pharmacists running a commercial business with time and resource constraints.

### Ways to engage pharmacists

- Representation on agency, program and PCP steering committees.
- Capacity building for pharmacists and pharmacy staff around availability of local programs and services, self management, primary care best practice, service coordination and primary care partnerships. BNPCA employed a self management qualified pharmacist in a mentoring program to work with pharmacies to build knowledge around self management, develop tools and systems to ensure systematic referral to self management programs and support links between the pharmacists and local health care providers.
- In the service coordination loop pharmacists offer an excellent opportunity as a referral source. For example, pharmacists involved with the Home Medication Review Initiative comprehensively review an individual consumer's medication regimen on a home visit following referral from a GP.<sup>30</sup>

<sup>29</sup> *Berbatis CG, Sunderland VB, Mills CR, Bulsara M. National Pharmacy Database Project. School of Pharmacy, Curtin University of Technology of Western Australia; 2003.*

<sup>30</sup> *Home Medication Review Initiative. Health Insurance Commission. [http://www.hic.gov.au/providers/incentives\\_allowances/pharmacy\\_agreement/about\\_hmr.htm](http://www.hic.gov.au/providers/incentives_allowances/pharmacy_agreement/about_hmr.htm) Accessed 6/8/04*

## Practical strategies for engaging General Practitioners (GPs)

*The lessons learnt from the projects would suggest that engaging GPs may be effective and less time consuming if an agency wide approach was adopted with the following practical strategies:*

- **Building relationships.** GPs used programs where there was a relationship between the service coordinator and the GP. Consider creating GP liaison roles for practitioners in agencies.
- **Local Divisions of General Practice.** Approach the local division of general practice (DGP) for consultation and inclusion within the program.<sup>32</sup> **DGPs strategic plans** can indicate current and future foci and where the program may add value.
- **GP representatives.** Include GPs and DGP representatives on planning and steering committees. GPs are usually paid for their time in these instances.
- **Reaching GPs.** Investigate communication strategies to reach GPs such as continuing education sessions, weekly faxes and DGP newsletters. DGPs can help identify appropriate GPs to target and clinical peer leaders may be useful. As an example the Otway DGP accompanied SWPCP project workers to meet GPs to facilitate discussion and implementation.
- **Examine local programs** and their strategies and experiences in engaging GPs. Linking to or building on these can increase familiarity for GPs.
- **Qualitative research,** such as interviews and focus groups with GPs may provide insight into program targeting.
- **Linking to other funded programs** such as Enhanced Primary Care Planning Initiatives, Practice Incentive Programs and the Mental Health Initiative may increase attractiveness. Audits for GPs that contribute to continuing education points may facilitate buy in. SWPCP utilised a diabetes management audit and BNPCA trialled the Heart Foundation's Multiple Cardiovascular Disease (CVD) Risk Factor Clinical Management Audit.
- **Be clear about the offer** for GPs. It needs to be well packaged and easy to access with clear benefits and incentives for both the patients and GP practice.
- **Initial targeting.** Consider starting with a few targeted GP practices that agree to work with you and where you are likely to have most success. Broaden out once a model is established and successful.
- **Practice staff.** Consider the role of practice nurses and practice staff in the engagement of GPs and in the program process.

## General Practitioners

General Practitioner (GP) engagement is seen to be integral to successful integrated disease management and proved to be one of the most challenging aspects for the projects. Consideration of factors that can support successful GP engagement and the barriers can help focus effort and resources. It should be noted that while some elements were successful for some projects they were not successful for others.

### Encouraging GP engagement

Factors that contributed to successful GP engagement included the following:

- Provision of immediate and tangible patient benefits such as timely access to services
- Programs delivered through a Division of General Practice or individual GP practices with personnel already familiar to GPs
- Systematic representation of GPs in planning
- Building on local achievements and systems already in place
- Linking to GP initiatives such as the Practice Incentives Programs and Enhanced Primary Care (EPC) MBS incentives and providing incentives for GPs such as facilitated care plans<sup>31</sup>
- Resources and education around service coordination and best practice guidelines
- Building feedback from health professionals to GPs into the service coordination models
- Programs targeted towards a "priority" disease such as diabetes
- Involving GP practice staff where appropriate in education and systems development, due to their ability to influence referrals
- Developing a agency wide GP engagement Strategy which could include a key liaison person that GPs can contact and who coordinates all communications with GPs and divisions.

### Barriers to GP engagement

Barriers inhibiting engagement appeared to include:

- Many local, state and federal initiatives competing for GPs time and attention
- Lack of GP numbers in some regions and large workloads
- Reluctance of GPs and GP Divisions to fully engage with untried short term initiatives
- GPs lack of understanding about the benefits of self management and multidisciplinary care in chronic disease
- GPs not feeling that specific diseases, such as hypertension, require the same complexity of care or intensity of interventions as other chronic diseases.

<sup>31</sup> Department of Health and Ageing, Australian Government. *Enhanced Primary Care – Medicare Benefits Items.* <http://www.health.gov.au/epc/>. Accessed 6/8/04

<sup>32</sup> *Links to local DGPs can be found at the National Divisions of General Practice site at* <http://www.gp.org.au/>. Accessed 6/8/04

*“Diabetes lends itself to it very nicely – it’s the best model. We can deal with other conditions – asthma, hypertension, ourselves, but diabetes, because it involves so many facets.”*

**GP, SEPCP**

### Further consideration

Whilst some projects experienced success with these strategies, the same strategies were not successful for others. For example:

- Linking into Commonwealth EPC MBS packages as the incentive for GPs to engage with programs met with varied success. GPs identified that the reorientation of practice systems required to systematically implement care planning is difficult to achieve and the barriers often outweigh the financial incentives. This suggests that if GPs have already established practice systems using EPC items then linking into this can be worthwhile, but aiming to initiate GP use of EPC items may be unrealistic.
- Ensuring the enablers to GP engagement are in place did not translate into GP referrals for a number of projects, suggesting that attention to barriers to referral is crucial to success. Barriers to referral are consistent with barriers outlined under GP engagement.
- Further factors influencing GP referral included:
  - GPs not knowing individuals providing service
  - previous experiences of referrals to organisations such as not receiving feedback, patient unable to be seen
  - complex eligibility criteria
  - complex referral processes
  - patients reluctance to attend new services

## Considering evaluation

*The projects found that when considering evaluation, the following strategies aided success:*

- *Incorporating evaluation as part of the education pathway process and not as a separate entity.*
- *Building transparent evaluation pathways with considered data sources including qualitative and quantitative data.*
- *Formal review process of data periodically through the process.*
- *Short, validated questions for consumers with low number of variables that are easily analysed.*
- *Simple and straightforward consent processes containing only the necessary information.*
- *Collecting information on practices and processes as well as consumer change.*
- *Utilising data as a feedback driver for practice change.*
- *Incentives for consumers and stakeholders to complete evaluation.*
- *A single contact for evaluation that is separate from the education team.*

## Managing sustainable change

Managing change of any kind in the health system is always a challenge. The projects identified the following key change agents influencing the level of successful change and creating sustainability.

### Making sustainability a clear outcome

When constructing chronic care models making sustainability a clear outcome from the outset fostered lasting outcomes. Planning a clear integration and sustainability handover phase to other agencies was seen to be useful.

In addition sustainability was seen to be promoted by:

- Developing clear models with defined outcomes and demonstrated incentives and benefits for consumer and health care providers
- Integrating with established programs, structures and initiatives within the community
- Building connectivity between consumers and health professionals to programs
- Building systems around programs including health information technology systems
- Identifying the key elements with the major impact and the level of integration to other services which is required
- Working with stakeholders to identify further funding opportunities and the elements that are attractive to health agencies.

### Formalising the change

A formal documented project management methodology with clear strategies, documented operational work plans and planned outcomes was seen to be critical to bringing about change.

Setting a clear planning and consultation phase before active implementation to allow engagement of stakeholders and collection of data to plan and formalise program strategies was identified by projects as crucial to facilitating successful implementation.

### High level stakeholder support and engagement

Top down health care agency leadership and commitment, with Chief Executive Officer involvement, was a major key to bringing about change. Shared values, strategies, ownership and responsibilities around practice change are an extension of this commitment. Identifying champion agencies and key personnel with best fit were seen to facilitate uptake.

### **Adequate resourcing**

Health care providers who were able to readily relate to a program's focus and build working relationships with key workers and agencies were seen to be effective change agents. Mentoring and training of local health care providers in project management and change management was seen to build change management understanding in the community.

### **Streamlined evaluation**

Streamlined evaluation pathways and robust data management with clear outcomes is important within the initial planning and consultation phase. Evaluation involves all the dimensions of a program – inputs, processes, costs, outputs/outcomes and externalities. How data can be used as a driver to promote practice change and health care provider engagement should be considered.

A systematic review and evaluation (such as Plan-Do-Study-Act cycles) is suggested to monitor progress as well as sustain interest and commitment by participating stakeholders.

### **Spreading the word with dissemination**

Dissemination of outcomes and learnings in a relevant and timely fashion is essential to build the credibility of the change sought. Social marketing concepts can be used as workable guiding principles. Early selling of the change “wins” can facilitate further change and acceptance.

# How to promote integrated disease management within and across organisations: “A Quick Guide”

| Key Strategies          | Understanding Consumer Needs & Partnering with Consumers  | Coordinated and Planned Care  | Self Management  | Health Promotion   | Targeting Subgroups   |
|-------------------------|---|---|--|--|---|
| <b>Organisations</b>    | <ul style="list-style-type: none"> <li>Collate population data to identify priority chronic health conditions and at risk groups.</li> <li>Consult consumer representatives.</li> <li>Raise awareness of importance of consumer consultation.</li> <li>Support/resource consumer groups.</li> <li>Involve consumers in planning and implementation of programs.</li> <li>Community engagement</li> </ul>  | <ul style="list-style-type: none"> <li>Support implementation of service coordination tools.</li> <li>Support development of local recall and reminders systems for individuals with chronic conditions.</li> <li>Promote sharing of best practice guidelines, tools, processes.</li> <li>Building capacity through training and resource development to support uptake of best practice guidelines.</li> <li>Local care pathway development</li> <li>Partnership arrangements for coordinated care</li> <li>GP engagement/integration</li> <li>Systems development</li> <li>Change management</li> </ul> | <ul style="list-style-type: none"> <li>Raise awareness of the role and importance of self management.</li> <li>Capacity building to upskill and resource service providers to promote self management.</li> <li>Support collaborative approach across catchment e.g. central intake for self management programs, support with promotion/recruitment, practitioner special interest groups.</li> </ul> | <ul style="list-style-type: none"> <li>Collate population data and information from local agencies to identify priority chronic health conditions, risk factors and at risk groups.</li> <li>Consult consumer representatives.</li> <li>Support coordination of health promotion activities across catchment.</li> <li>Raise awareness of chronic disease risk factors.</li> </ul>                             | <ul style="list-style-type: none"> <li>Collate population data and information from local agencies to identify at risk groups.</li> <li>Raise awareness and support collaborative planning to reach sub groups of special need.</li> <li>Consult consumer representatives.</li> </ul> |
| <b>Community Health</b> | <ul style="list-style-type: none"> <li>Develop an understanding of the personal impact of health problems and what consumers desire from services.</li> <li>Involve consumers in planning and implementation of programs, utilise consumer reference groups, inclusion of consumers on advisory groups, consultation with special interest groups and peak bodies and use consumer surveys/focus groups.</li> <li>Support consumers to be actively involved in their own care.</li> </ul> | <ul style="list-style-type: none"> <li>Develop practices and processes to ensure care for people with chronic health conditions includes:                             <ol style="list-style-type: none"> <li>systematic assessment</li> <li>care plan developed in accordance with best practice guidelines</li> <li>systematic follow up and reviewed</li> <li>care involves multidisciplinary team.</li> </ol> </li> </ul>  | <ul style="list-style-type: none"> <li>Raise awareness of the role and importance of self management and build capacity of practitioners to promote self management.</li> <li>Adopt an organisational wide approach to integration of self management into all consumer services.</li> <li>Promote the use of validated self management models.</li> </ul>   | <ul style="list-style-type: none"> <li>Include early intervention and prevention strategies for chronic conditions in local health promotion plans.</li> <li>Link to and build on peak body health promotion activities e.g. Heart Foundation, Diabetes Australia.</li> <li>Collaborate with local organisations, General Practitioners to support risk factor screening for high risk individuals.</li> </ul> | <ul style="list-style-type: none"> <li>Systematically review services and utilise knowledge and expertise of chronic conditions to identify high risk or sub groups of special need.</li> <li>Plan appropriate interventions to target high risk groups.</li> </ul>                   |

| Key Strategies                     | Understanding Consumer Needs & Partnering with Consumers   | Coordinated and Planned Care   | Self Management  | Health Promotion  | Targeting Subgroups  |
|------------------------------------|--|--|--|---|--|
| <b>Organisations</b>               |  |  |  |   |  |
| <b>Acute Care</b>                  | <ul style="list-style-type: none"> <li>Develop an understanding of the personal impact of health problems and what consumers desire from services prior to program planning and development.</li> <li>Involve consumers in planning and implementation of programs (see comm.health section).</li> <li>Support consumers to be actively involved in their own care.</li> </ul> | <ul style="list-style-type: none"> <li>Develop practices and processes to ensure care for people with chronic health conditions is provided in accordance with best practice guidelines (see comm.health section).</li> <li>Link consumers through appropriate referral pathways to community organisations.</li> </ul>  | <ul style="list-style-type: none"> <li>Raise awareness and build capacity of practitioners to promote self management.</li> <li>Adopt an organisational wide approach to integration of self management into all consumer services.</li> <li>Promote the use of validated self management models.</li> </ul>                                 | <ul style="list-style-type: none"> <li>Raise awareness of chronic disease risk factors.</li> <li>Support coordination of health promotion activities across catchment.</li> </ul>   | <ul style="list-style-type: none"> <li>Systematically review services and utilise knowledge and expertise of chronic conditions to identify high risk or sub groups of special need.</li> <li>Work collaboratively with community organisations to plan appropriate interventions to target high risk groups.</li> </ul> |
| <b>Allied Health Practitioners</b> | <ul style="list-style-type: none"> <li>Assess how chronic health problems impact on the individual.</li> <li>Support active involvement in own care.</li> </ul>  | <ul style="list-style-type: none"> <li>Develop practices and processes to ensure care for people with chronic health conditions is provided in accordance with best practice guidelines (see comm.health section).</li> </ul>  | <ul style="list-style-type: none"> <li>Develop protocols to ensure systematic attention to self care behaviours of individuals at all visits including strategies to support implementation of lifestyle change and self care.</li> </ul>  | <ul style="list-style-type: none"> <li>Develop protocols for early identification and intervention for high risk individuals.</li> <li>Link to and build on peak body health promotion activities e.g. Heart Foundation, Diabetes Australia.</li> </ul>   | <ul style="list-style-type: none"> <li>Utilise knowledge and expertise of chronic conditions to identify high risk or sub groups of special need.</li> <li>Work collaboratively with community organisations plan appropriate interventions to target these groups.</li> </ul>   |
| <b>Local Government</b>            | <ul style="list-style-type: none"> <li>Collate population data.</li> <li>Draw together information from local agencies.</li> <li>Consult consumer representatives.</li> <li>Support/resource consumer groups.</li> </ul>   | <ul style="list-style-type: none"> <li>Develop practices and processes to ensure care for people with chronic health includes:                             <ol style="list-style-type: none"> <li>a broad needs assessment or a comprehensive assessment                                     <ul style="list-style-type: none"> <li>care plan developed in accordance with best practice guidelines</li> <li>systematic follow up and review</li> <li>care coordination.</li> </ul> </li> <li>appropriate referrals to health professionals and community care organisations.</li> </ol> </li> </ul> | <ul style="list-style-type: none"> <li>Identify opportunities to support behaviour change/self care practices across local government services/programs.</li> <li>Raise awareness of the role and importance of self management.</li> <li>Capacity building to upskill and resource service providers to promote self management.</li> </ul> | <ul style="list-style-type: none"> <li>Collate population data and information from local agencies to identify at risk groups.</li> <li>Consult consumer representatives.</li> <li>Support coordination of health promotion activities across catchment.</li> <li>Raise awareness of chronic disease risk factors.</li> </ul> | <ul style="list-style-type: none"> <li>Collate population data and information from local agencies to identify at risk groups.</li> <li>Raise awareness and support collaborative planning to reach high risk/sub groups of special need.</li> <li>Consult consumer representatives.</li> </ul>                          |

| Key Strategies   | Understanding Consumer Needs & Partnering with Consumers  | Coordinated and Planned Care   | Self Management  | Health Promotion  | Targeting Subgroups |
|--|---|--|--|---|---------------------|
| <p><b>Organisations</b></p> <p><b>Pharmacies</b></p> <ul style="list-style-type: none"> <li>Assess how chronic health problem impacts on the individual.</li> <li>Support active involvement in own care.</li> </ul>   | <ul style="list-style-type: none"> <li>Develop practices and processes to ensure people with chronic health conditions:                             <ol style="list-style-type: none"> <li>have their initial needs identified</li> <li>are linked through appropriate referral pathways to community organisations.</li> </ol> </li> </ul>   | <ul style="list-style-type: none"> <li>Develop protocols to ensure systematic attention to self care behaviours of individuals at all visits including strategies to support implementation of lifestyle change and self care.</li> </ul>  | <ul style="list-style-type: none"> <li>Develop protocols for early identification of high risk individuals and appropriate referral.</li> <li>Link to and build on peak body health promotion activities e.g. Heart Foundation, Diabetes Australia.</li> </ul> | <ul style="list-style-type: none"> <li>Work collaboratively with community organisations to plan appropriate interventions to target high risk/ special need groups.</li> </ul>                     |                     |
| <p><b>Divisions of General Practice</b></p> <ul style="list-style-type: none"> <li>Collate population health data to identify priority chronic health conditions and at risk groups in the catchment.</li> <li>Consult with consumers and community representatives as part of population health needs assessment and strategic planning.</li> <li>Involve consumers and community agency reps in planning &amp; implementation of programs.</li> <li>Assist general practices to consult with their patient population e.g. systems for encouraging patient feedback, satisfaction surveys, newsletters etc.</li> </ul> | <ul style="list-style-type: none"> <li>Implement national general practice programs to ensure best practice management of chronic conditions eg. Diabetes SIP, Asthma 3+visit program.</li> <li>Support the development of agreed local referral pathways and protocols that assist general practice to access allied health providers with whom to undertake multidisciplinary care.</li> <li>Intensive and systematic support for implementation of registers, recalls &amp; reminder systems in general practices for individuals with chronic conditions.</li> <li>Promote sharing of best practice guidelines, tools and processes in a general practice setting.</li> <li>Build capacity in general practice through training, practice visits and resource development to support uptake of best practice guidelines.</li> </ul> | <ul style="list-style-type: none"> <li>Raise awareness in general practice of the role and importance of self management.</li> <li>Provide general practice with information about self management programs in the local area.</li> <li>Participate in service system developments to implement systematic referral to self management programs as part of general practice care.</li> </ul> | <ul style="list-style-type: none"> <li>Assist general practice to comprehensively identify patients with risk factors and implement systematic intervention.</li> </ul>  | <ul style="list-style-type: none"> <li>Work collaboratively with community organisations to plan appropriate interventions, including a general practice role, to target at risk groups.</li> </ul> |                     |

| Key Strategies   | Understanding Consumer Needs & Partnering with Consumers  | Coordinated and Planned Care   | Self Management  | Health Promotion   | Targeting Subgroups   |
|--|---|--|--|--|---|
| <p><b>Organisations</b></p> <p><b>General Practice including Practice nurse &amp; Practice manager</b></p> | <ul style="list-style-type: none"> <li>Assess how chronic health problems impact on the individual.</li> <li>Support active involvement in own care.</li> <li>Develop an understanding of what/how patients want services delivered from the practice through consultation processes such as patient feedback, surveys etc.</li> </ul>                                  | <ul style="list-style-type: none"> <li>Develop practices and processes to ensure care for people with chronic health conditions includes:                             <ol style="list-style-type: none"> <li>systematic assessment</li> <li>Care plan developed in accordance with best practice guidelines</li> <li>Systematic follow-up and review</li> </ol> </li> <li>Implement a practice population approach to ensure that best practice care is provided systematically to all those who attend the practice.</li> <li>Refer patients through appropriate referral pathways, to allied health providers in the public and private systems, and to self management support in the community.</li> </ul> | <ul style="list-style-type: none"> <li>Develop protocols to ensure systematic attention to self care behaviours of individuals at all visits, including strategies to support implementation of lifestyle change and self care.                             <ul style="list-style-type: none"> <li>Where possible, refer eligible patients to self management programs.</li> </ul> </li> </ul> | <ul style="list-style-type: none"> <li>Comprehensively identify patients with risk factors and implement systematic, best practice intervention.</li> <li>Monitor practice population health outcomes data eg HbA1c, smoking cessation.</li> <li>Implement RACGP guidelines for addressing risk factors (SNAP).</li> </ul> | <ul style="list-style-type: none"> <li>Utilise knowledge and expertise in chronic conditions (clinical and practice population data) to identify high risk or sub-groups of special need.</li> <li>Work collaboratively with division and other agencies to plan appropriate interventions to target these groups.</li> </ul> |
| <p><b>Aged Care Assessment Services (ACAS)</b></p>   | <ul style="list-style-type: none"> <li>Assess how chronic health problems impact on the individual's functional abilities and their capacity to remain living in their own home.</li> <li>Joint or coordinated assessment process with existing providers to ensure a comprehensive understanding of care needs and assessment processes are not repetitive.</li> </ul> | <ul style="list-style-type: none"> <li>Implement a practice population approach to ensure:                             <ol style="list-style-type: none"> <li>comprehensive multidisciplinary assessment covers the restorative, physical, medical, psychological, cultural and social dimensions of client needs</li> <li>care planning process is planned and coordinated with other service providers involved in care management</li> <li>information sharing with other service providers is comprehensive and reflects a coordinated approach</li> </ol> </li> </ul>   | <ul style="list-style-type: none"> <li>Utilise multidisciplinary assessment and care planning to identify opportunities to support behaviour change and self care practices.</li> <li>Appropriate referrals to support self-management.</li> </ul>   | <ul style="list-style-type: none"> <li>Utilise multidisciplinary assessment and care planning processes to identify opportunities for health promotion, early intervention and preventative care.</li> </ul>   | <ul style="list-style-type: none"> <li>Utilise ACAS Minimal Data Set to identify sub-groups with chronic health problems and their need for assistance.</li> </ul>  |

## For further information

### Primary Care Partnerships



#### Banyule Nillumbik Primary Care Alliance (BNPCA)

C/O Banyule City Council  
 PO Box 51, Ivanhoe Vic 3079  
 T 03 9457 9845  
 E [bnpcaadmin@infoxchange.net.au](mailto:bnpcaadmin@infoxchange.net.au)  
 W [www.bnPCA.org.au](http://www.bnPCA.org.au)



#### Southeast Primary Care Partnership (SEPCP)

C/O Dandenong Community Health Centre  
 Level 3, 329 Thomas St, Dandenong Vic 3175  
 T 03 8792 2266  
 E [wendy.mason@southernhealth.org.au](mailto:wendy.mason@southernhealth.org.au)



#### Southern Grampians and Glenelg Primary Care Partnership (SGGPCP)

C/O Frances Hewett Community Centre  
 PO Box 283, Hamilton Vic 3300  
 T 03 5551 8452  
 E [rosie.rowe@wdhs.net](mailto:rosie.rowe@wdhs.net)  
 W [www.sggpcp.com](http://www.sggpcp.com)



#### South West Primary Care Partnership (SWPCP)

C/O South West Health Care  
 Ryot St, Warrnambool Vic 3280  
 T 03 5563 1242  
 E [pcpadmin@swarh.vic.gov.au](mailto:pcpadmin@swarh.vic.gov.au)  
 W [www.swarh.com.au/pcp-southwest](http://www.swarh.com.au/pcp-southwest)

#### WestBay Alliance (WBA)

13-15 Mason St, Newport Vic 3015  
 T 03 93980718  
 E [administration.westbaypcp@isis.com.au](mailto:administration.westbaypcp@isis.com.au)  
 W [www.wmrpcp.org.au](http://www.wmrpcp.org.au)



### Department of Human Services

#### Primary Care Partnership Publications, Victorian Government Health Information

<http://www.health.vic.gov.au/pcps/publications/index.htm>

#### For further information

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 Rural & Regional Health & Aged Care Services  
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### **Consolidation of IDM learnings**

The Primary and Community Health Branch of the Rural & Regional Health & Aged Care Service Division commissioned this IDM learnings document. Its purpose is to provide action learnings about implementing chronic disease programs to help inform programs and services targeting people with chronic disease.

Acknowledgments to the project workers and Primary Care Partnerships on whose dedicated work this document is based.

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