Overview and request for information from divisions

Early Intervention in Chronic Disease in CHSs (EIiCD) Initiative 06-07 & 05-06

November 2006

This overview is for divisions whose catchment includes one or more of the CHSs and PCPs funded for EIiCD commencing in 06-06, or that commenced in 05-06. We want to highlight the opportunities for divisions to have input to the funding in your catchment, for effective GP participation in planning and implementation. This includes the possibility of negotiating to be funded directly. At the end I have asked for some information to help GPDV collate updated descriptions of the models and funding allocations around the state to share with you, and identify issues with which you'd like GPDV to assist.

In September DHS regional offices started to communicate with stakeholders about the 06-07 rollout. DHS regions ran briefing sessions in Sept/Oct (to which relevant divisions would have been invited). New guidelines have been prepared: *Chronic Disease Management Program Guidelines for Primary Care Partnerships and Community Health Services, DHS, October 2006.* These guidelines were mailed in late October and can also be downloaded from the DHS website: http://www.health.vic.gov.au/communityhealth/publications/cdm_guidelines.htm

This is the second year of the EIiCD initiative – nine CHSs were funded in 05-06, and is now extended to a further nine CHSs in 06-07. Each of the 18 CHSs will receive recurrent funding of $400,000 per annum – mainly for additional service delivery.

REGION	LGA	2006-07 CHSs	2005-06 CHSs
NORTH-WEST METRO	Darebin	Darebin CHS	
	Moreland	Moreland CHS	
	Brimbank		ISIS Primary Care
	Banyule		Banyule CHS
	Maribyrnong		Western Region Health Centre
EASTERN METRO	Knox	Knox CHS	
	Monash	Monash Link CHS	
	Whitehorse		Whitehorse CHS
SOUTHERN METRO	Casey & Cardinia	Casey - Cardinia CHS	
	Kingston	Central Bayside CHS	
	Frankston		Frankston CH
	Greater Dandenong		Dandenong CHS
GIPPSLAND	Latrobe	Latrobe CHS	
GRAMPIANS	Ballarat	Ballarat CHS	
LODDON MALLEE	Greater Bendigo	Bendigo CHS	
	Mildura		Sunraysia CH
HUME	Greater Shepparton		Goulburn Valley CHS
BARWON-SOUTH WESTERN	Greater Geelong		Barwon Health

Corresponding PCPs will receive recurrent funding as follows (called Integrated Chronic Disease Management (ICDM) initiative):

- $50,000 per annum if one EIiCD funded CHS is in their catchment
- $70,000 if there are two EIiCD funded CHSs
- Those PCPs without an EIiCD funded CHS in their catchment will receive $30,000 to work on integrated chronic disease management across services

> "The ICDM and EIiCD initiatives are funded under Australian Better Health Initiative (ABHI) and will seek to improve integration between State-funded primary health care services and Commonwealth-funded GPs, consistent with the objectives of the ABHI." (p.5 of Guidelines)

What is the funding for exactly?

Overall - to better coordinate chronic disease care across service providers/agencies in each catchment, for the population whose care needs are not yet highly complex (highly complex are HARP-CDM clients) and to increase service delivery capacity within CHSs.

The detail is described in the Guidelines that were made available at the end of October http://www.health.vic.gov.au/communityhealth/publications/cdm_guidelines.htm

In summary, the roles for the PCPs and CHSs are:

PCPs - improve communication, referral and care planning between agencies.

CHSs: - deliver a range of additional services (such as allied health, nursing, self mgt programs)
- organisational change and partnership development with key agencies in chronic disease prevention and management.

Roles for other agencies, particularly GPs, are to refer appropriate clients to CHS, and coordinate and collaborate on care plans for patients with chronic disease.

Each CHS and PCP with new EIiCD program funds are to provide an implementation plan and budget - due on Dec 1st 2006 – to regional DHS office. The implementation plans require sign off from the CHS, PCP and division. Feedback will be provided before Christmas and alterations made in Jan 07. Each CHS has $167,000 available in the first year for planning and development.

GPDV advised DHS to strengthen the message that divisions need to be involved in both designing and implementing these initiatives so that they includes realistic roles for general practice. We asked DHS to make clear that CHSs and PCPs can provide funding to divisions, who are best placed to work on achieving the participation of general practice.

The outcome is that the Guidelines do stress that work with GPs is to be coordinated through divisions, and exhort PCPs and CHSs to allocate resources to divisions accordingly.

See on page 17 the statement related to the ICDM funds to PCPs:

> "PCPs should consider allocating resources to the DGP, to engage GP representatives (through the DGP) in activities such as developing local agreements for the identification of clients requiring interagency care planning."

And again, in relation to CHSs with EIiCD funds and their corresponding PCPs, on page 20:

> "The PCP and CHS should work with GP representatives and key DGP staff to design a service model at the CHS that ensures:
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> - Strategies for informing GPs and their staff about the initiative are appropriate and effective;

- Strategies for developing general practice capacity needed to participate eg to identify eligible patients, share information such as GP management plans or information arising from a relevant SIP service, liaise effectively with CHS service providers and so on;
- Targets for reach to GPs (i.e. how many GPs/GP practices to work with) are agreed and realistic;
- Processes for GP referral and participation in care planning are realistic and aligned with MBS guidelines;

To engage GPD and GPs, PCPs and CHSs should consider allocating resources to the GPD, to support strategies for engaging and working with local GPs. In order for a model to include GPs as referrers, providers of medical perspectives in care plans, and key members of primary care and multidisciplinary teams, there must be strong DGP leadership in the model design and implementation. This will require the PCPs and CHS to negotiate an arrangement (including provision of funding) with the local DGP to increase their capacity to liaise with general practice around CDM. This could include:

- Providing funding to the DGP to enable reimbursement for GP reps to provide clinical input to the service model design;
- Developing a funded position within the DGP to conduct practice visits to targeted GPs to 'recruit' general practice engagement and provide systems development to enable GPs to participate; and
- Providing funding to the DGP to enable work around targeted GP liaison which includes establishing:
    - Referral pathways from GPs (to maximise the proportion of general practices in the catchment areas that participate in the program) and
    - Communication mechanisms that will improve coordination of care.

DGPs, PCPs and CHSs, in conjunction with other PCP member agencies, should develop an agreed plan for building on existing capacity for liaison with general practice. Expanding or building on existing DGP programs and services such as GP representation, practice support/visiting and continuing professional development should be considered.

The outcomes being sought include:

- GP representation and participation in planning and development,
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- DGP-based coordination of GP engagement,
- Support for systematic approaches to identification of eligible patients in general practice (for example using agreed clinical and/or service usage eligibility criteria supported by information management systems in the practice),
- Referral, feedback, and care planning processes for general practice,
- Sustainable GP participation,
- Flexible arrangements (for example delivery of services within general practice clinics, incorporating roles for nurses in general practice)" (p.20)

While the imperative for divisions to be involved, and the opportunity to be funded to do so, is clear, it is a challenge that there is no pre-determined allocation for divisions. Nor is there a one-size fits all 'model' as to how the increased capacity for GP liaison that is required to develop and implement a sensible plan, is to be achieved. However, (as we understand) some examples of arrangements negotiated by divisions in the first year of funding are as follows:

- Mornington Peninsula – a GP liaison position based 2 days per week in the division and 3 days per week in the CHS "Staying Well" program. This position is jointly funded from PCP and CHS funds
- Western Melbourne – a Practice Development position (part time) based at the division to facilitate GP liaison activity across two funded CHSs. This position is funded from CHS funds

- North East Valley – a GP liaison position based at the CHS with whom division staff are working. This position is funded from the PCP funds.

There are also allocations for GP focus groups, meetings etc in most of the models.

These examples might be helpful for those divisions engaged in current negotiations on 06-07 arrangements, and also for those involved in ongoing implementation in the existing EIiCD sites.

I have attached the table showing descriptions from the EIiCD sites funded in 05-06 that we collated last year FYI. We intend to do the same for the new sites, and will collate information from the implementation plans (due Dec 1st) and disseminate it to you all.

Request for information:

- For divisions with pre-existing EIiCD programs in your area - Could you please provide updated details on the information that appears in the attached table? I will collate and provide an updated version ASAP. Also, please let us know if there are any particular issues with which GPDV might be of assistance.

- For divisions with new EIiCD programs - Could you please let us know how the discussion on the model for GP participation/liaison etc and associated funding is progressing in your catchment, and how GPDV might be of assistance.

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