GPDV Comments on Draft Guidelines for DHS Chronic Disease Programs June 2005

1. GPs are not just sources of referral for such programs. Such programs should actively engage GPs as part of a multidisciplinary coordinated approach. GPs are the key providers of medical case management and so are an integral component of integrated disease management.

   GPs have a central role in providing well-coordinated care for people with chronic disease and/or complex needs and have primary responsibility for the medical management of people with chronic diseases. For many people with chronic disease multi-disciplinary interventions are required to complement medical management.

2. Implementation plans must include strategies for engaging and working with local GPs to provide an integrated service system response to people with chronic disease and/or complex needs. The Commonwealth have encouraged GPs to take a multidisciplinary proactive approach to chronic disease through the provision of reimbursement arrangements within the Medicare Benefits Schedule(MBS) and the Practice Incentives Program. A footnote could provide the following detail:
   The MBS currently includes provision for Enhanced Primary Care (EPC) assessments and care plans, and mental health items. The PIP includes incentives for mental health, diabetes, and asthma planned approaches.

3. GP Liaison:

The program must include active liaison with general practice. Targeted GP liaison will be required to maximise the proportion of general practices in the catchment areas that participate in the program. Divisions and the fundholders for complex care programs should develop an agreed plan for building on existing capacity for liaison with general practice. Building on existing Division 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 & development
- Division-based coordination of GP engagement
- Support for systematic approach to identification of eligible patients in general practice eg using agreed clinical and/or service usage eligibility criteria supported by information management systems in the practice
- Referral, feedback, and care planning processes are realistic for general practice
- GP incentives incorporated to support sustainable GP participation
- Flexible arrangements eg deliver services within general practice clinics, incorporate roles for nurses in general practice

4. Recruitment criteria should be clear and negotiated with other like local programs to avoid competition for clients. A one –stop referral point for a number of similar programs would be a major advantage for GPs and their patients.

5. The complex care programs should require a nominated GP for all participants as you can't have good care without continuity of medical care.

6. Complex care programs should be encouraged to consider brokerage arrangements to address service gaps in a flexible manner.

7. If self management is considered as part of a complex care program group self management is not the only option. The Good Life Club and the division based heart coaching programs both have individualised coaching approaches that are very effective and cost efficient.

   Evidence from 5 trials around Australia suggests that recruitment to self management is very difficult and that it works best where GPs are engaged and convinced of the value of self management

   There does need to be some consideration to the fact that not all clients can benefit from self management eg dementia, intellectual disability, brain damaged, alcohol related, etc.

8. It needs to be clear whether residents of residential aged care facilities are eligible. Programs should certainly include residents of SRSs who are high need and bouncing around the service system currently because of poor supports.

9. Re evaluation it would be useful to include service utilisation data inc use of hospital services, and client and carer satisfaction, and GP feedback. It would also be advisable to move to a common minimum data set for baseline and yearly collection eg quality of life and use of hospital services.