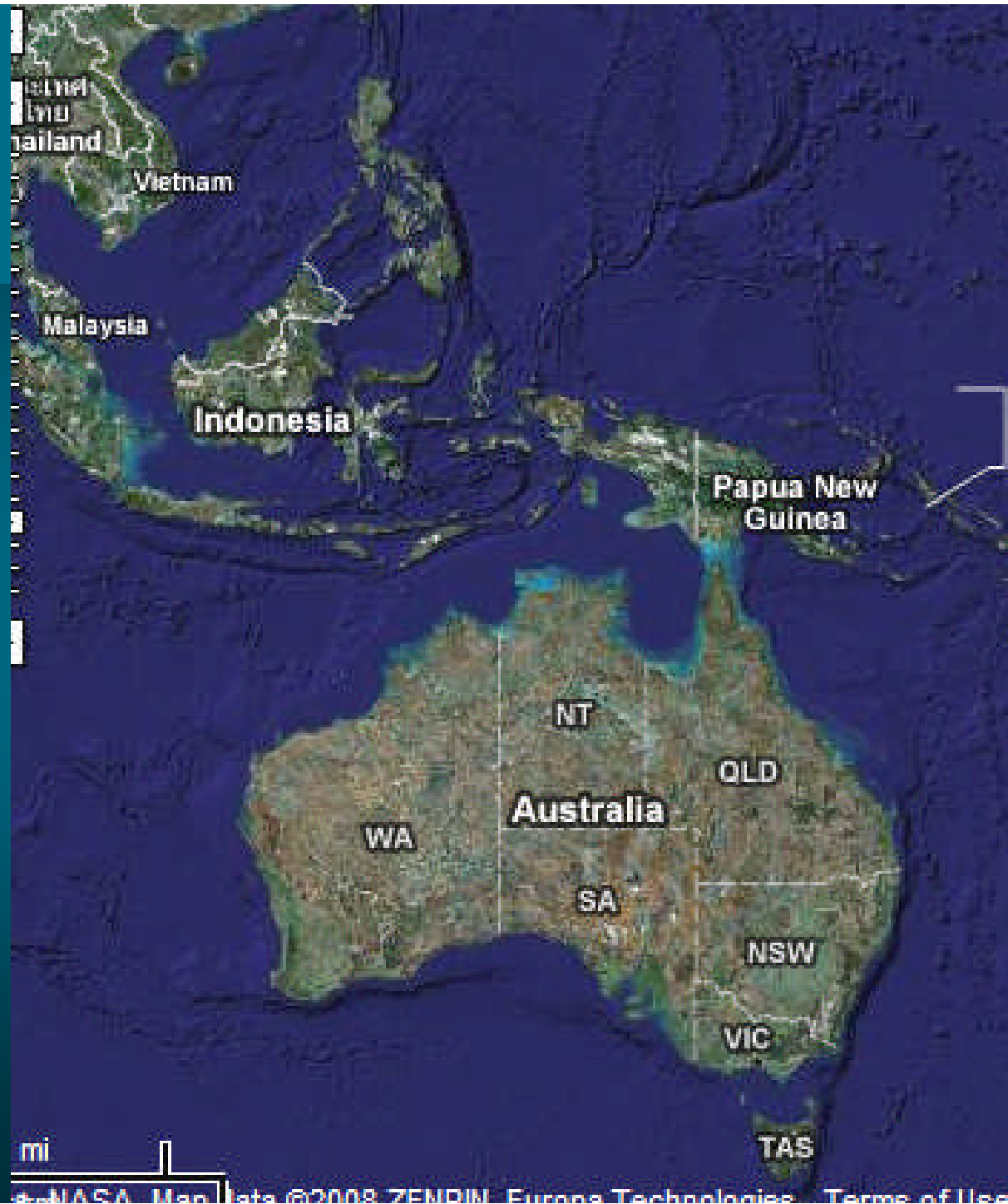


Integrating Chronic Disease Management in Victoria: A Partnership Approach

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Department Human Service,
State Government of Victoria

- Victoria's health sector reforms responding to the issue of chronic disease
- Primary Care Partnerships - voluntary alliances
- The difference we have seen from Integrated Chronic Disease Management



Victoria - Australia

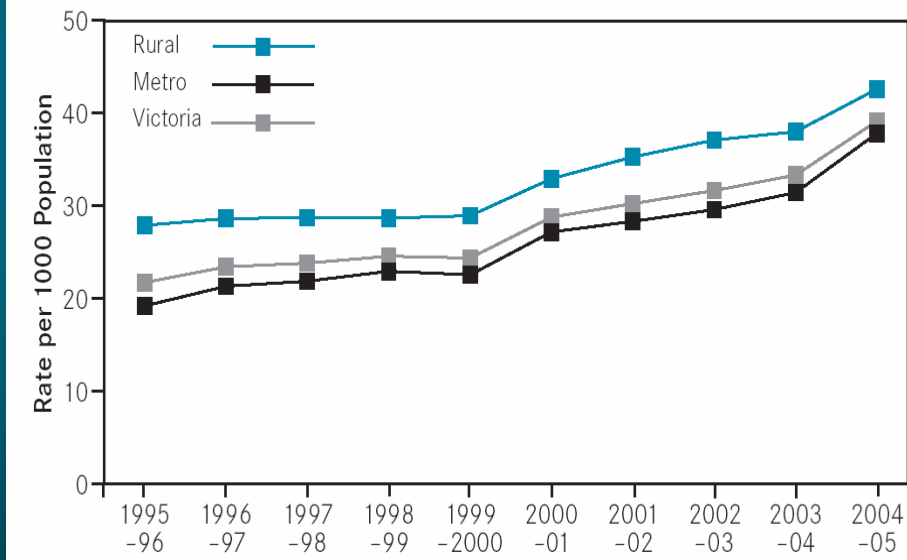


The good news ...

- \$85 billion annually - 9.5% of GDP
- Relatively good health care system
- Good health
- Ranked equal second -lowest mortality attributable to health care
- Life expectancy ranks seventh in the world

The issues – the impact of chronic disease

Figure 1: ACSCs admission rates, Victoria, 1995-96 to 2004-05



- Changing profile of the population
 - ageing, longevity
- Shifting burden of disease
 - 80% growth in hospital admissions for ambulatory care sensitive conditions

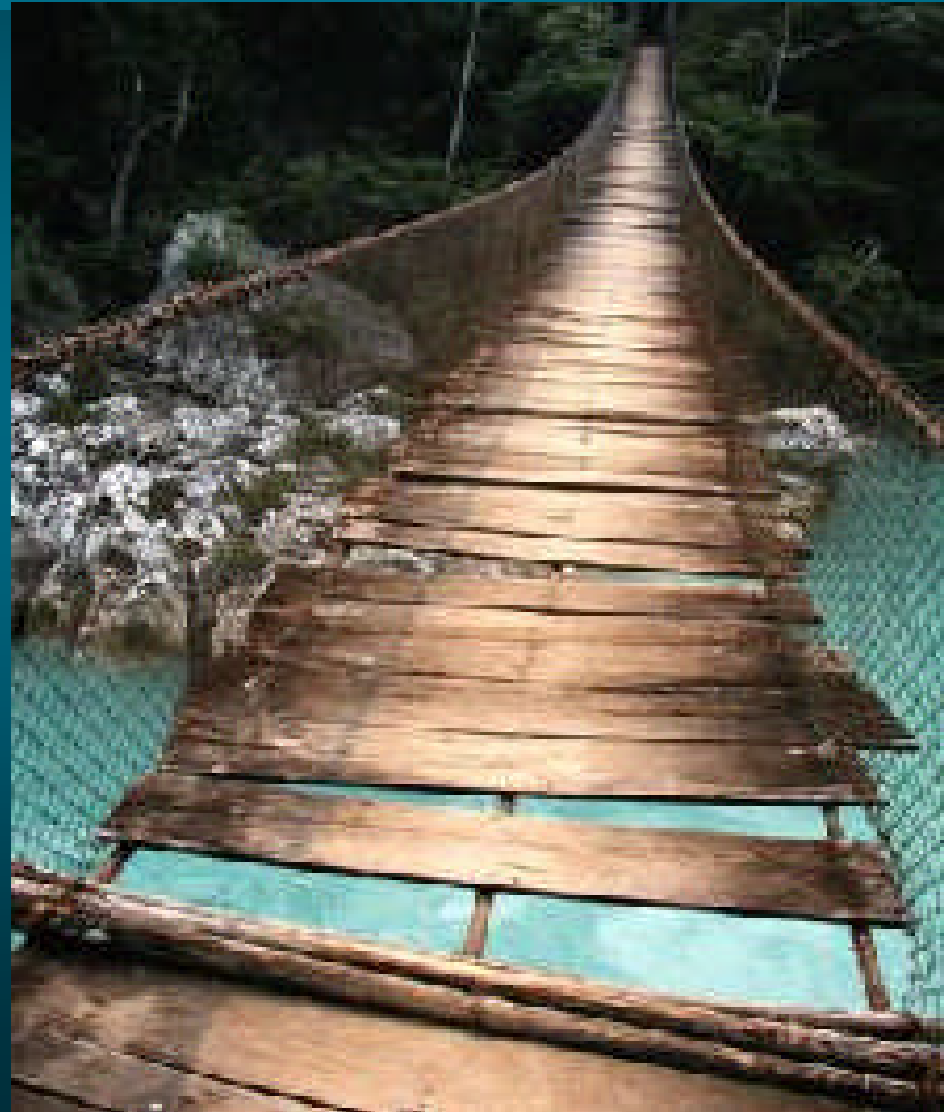
The issues for the system

Fragmentation:

- Working with 3 tiers of government
- Multiple funding streams and programs
- Public and private funded services

The issues for the system

- Service delivery favours acute focus
- Traditional funding approaches inadequate
- Uncoordinated, inefficient and ad hoc approaches
- Level of management of chronic disease in line with recommended care continues is low
- Few inter agency protocols



The issues for the consumers:

- Inaccurate information about what help is available
- Inconsistent practice
 - identifying needs, assessment, privacy
- Lack of coordination between health service providers
- Inconsistent responses to problems

Responding to the challenges:

- Make system wide change
- Reduce fragmentation, duplication and improve coordination and integration
- A proactive focus on patients, carers and their families
- Achieve 'smarter, efficient' services
- Better joined up services

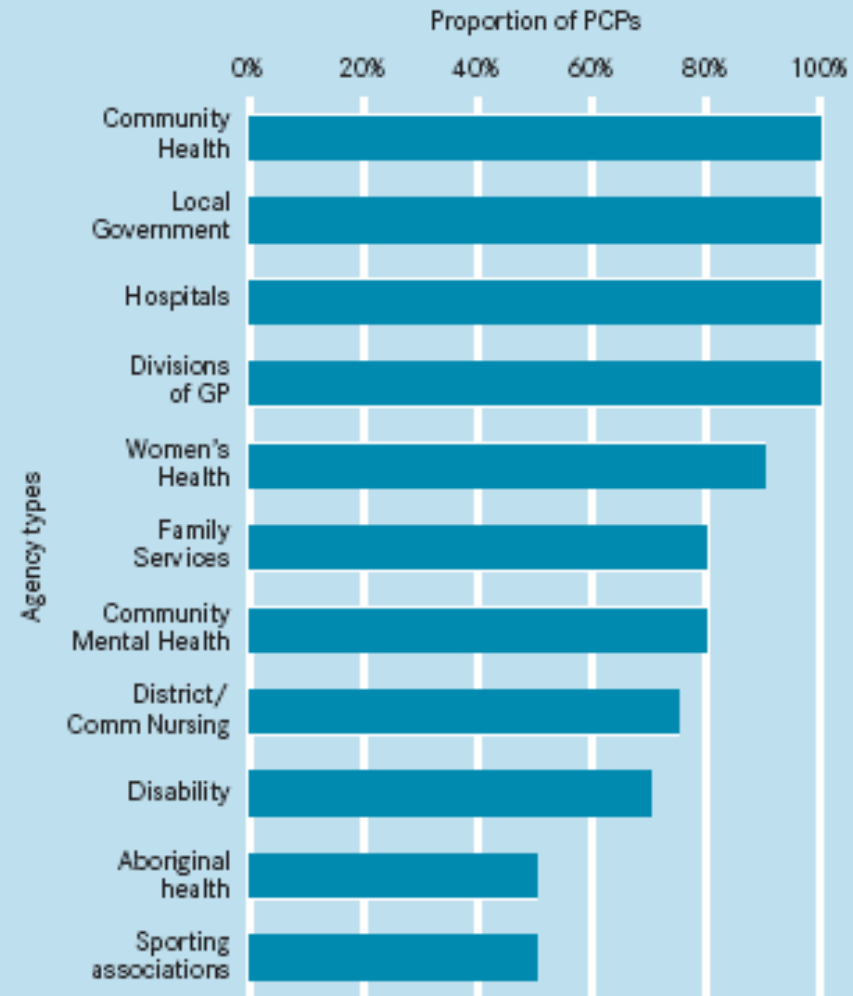
Partnerships of agencies across Victoria



Primary Care Partnerships –improving the overall health and wellbeing of Victorians

- Improving the consumer experience and outcomes
- Reducing the preventable use of tertiary services

Membership of PCPs



Building partnerships – get the foundations right



Foundation work

- ✓ Partnership development
- ✓ Planning

Planning and Implementation

- ✓ Service Coordination
- ✓ Integrated Health Promotion
- ✓ Partnership development

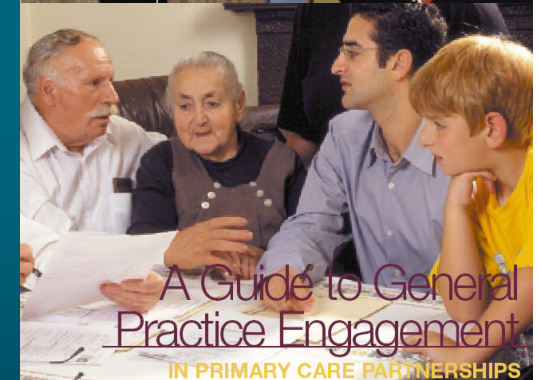
*Symptom of the
early stages of
partnership*



Primary Care Partnerships –making a difference

All PCPs offer:

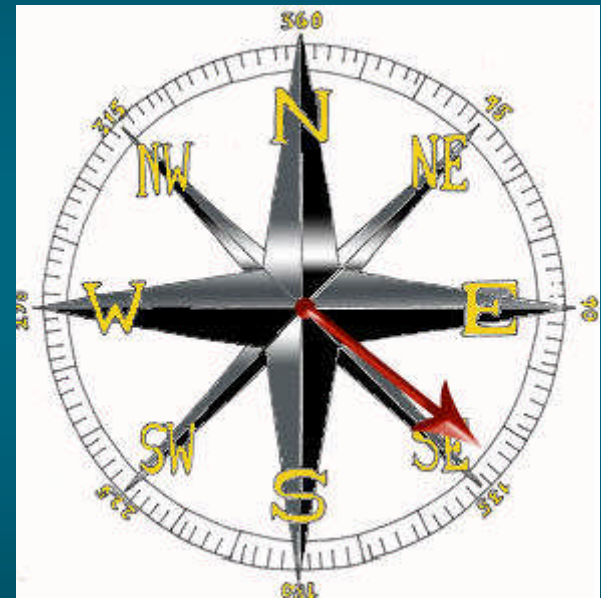
- seven years of experience in partnerships
- established governance structures
- systematic engagement of a broad range of providers
- focus on people with multiple and complex needs
- improving access to services
- working to increase the use of statewide enablers such as consistent practice standards
- a focus that includes prevention and early intervention.



Integrated chronic disease management

Guiding Principles:

- Integrate the system around peoples needs
- Shift the balance from responding to illness to keeping people as well as possible
- Focus efforts on the most disadvantaged people and places
- Work across the lifespan
- Get the best value from state, commonwealth and private investments



A comprehensive approach to chronic disease management

Level 1

People with chronic diseases and complex needs who frequently use hospitals

Level 2

People with chronic diseases and complex needs who use hospital or are at risk of hospitalisation

Level 3

People with chronic diseases and/or complex needs

Level 4

Whole population

HARP-
Chronic
Disease
Mangm't

Early
Intervention in
Chronic Disease

Health Promotion/
Public Health

Intensity

Intensive Care Coordination

- Care across the continuum
- Tertiary and secondary prevention
- Enrolled patient population
- Comprehensive assessment and care planning
- Specialist medical and GP management
- Additional services as appropriate
- Self-management approach
- Comprehensive hospital discharge planning

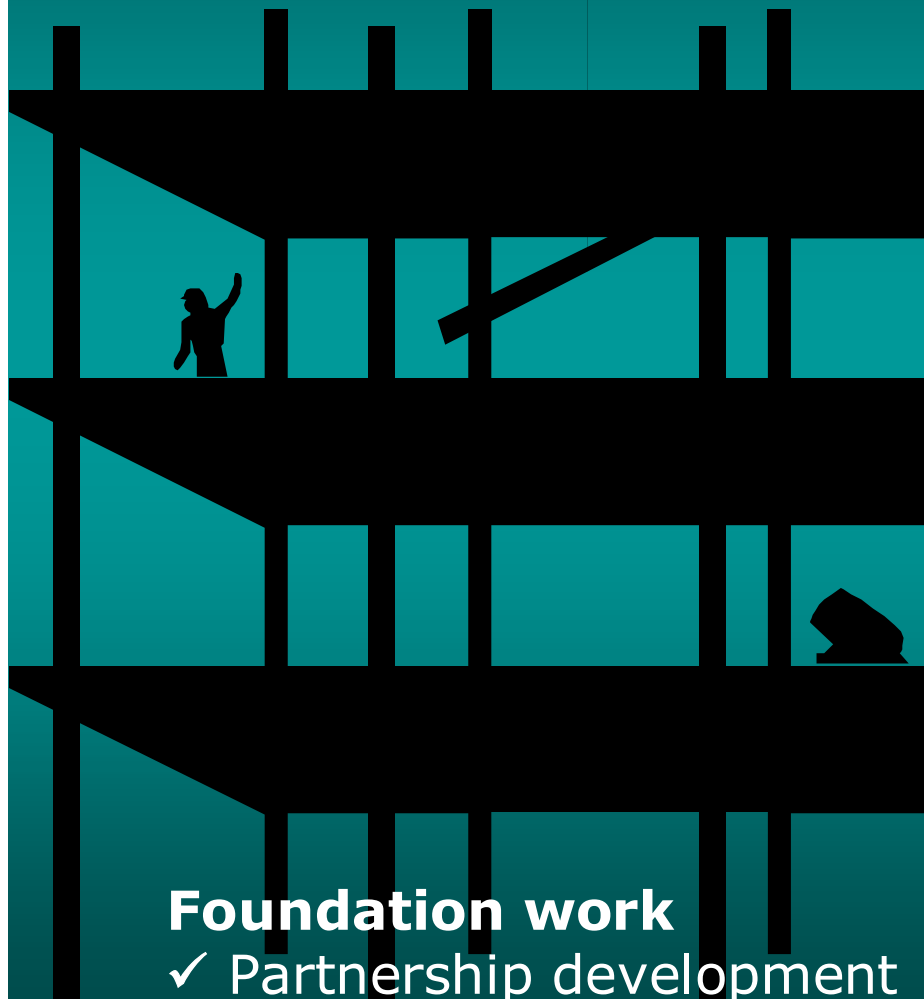
Proactive Management

- Planned, Managed Care
Community Health Services, GPs
Multi disciplinary Care
Self management programs

Primary Prevention

For example: Risk identification
Obesity reduction / smoking cessation

Primary Care Partnerships – the foundation for the Early Intervention in Chronic Disease initiative



Foundation work

- ✓ Partnership development
- ✓ Planning

Integrated Chronic Disease Management

- ✓ Early Intervention in Chronic Disease
- ✓ Partnership development

Planning and Implementation

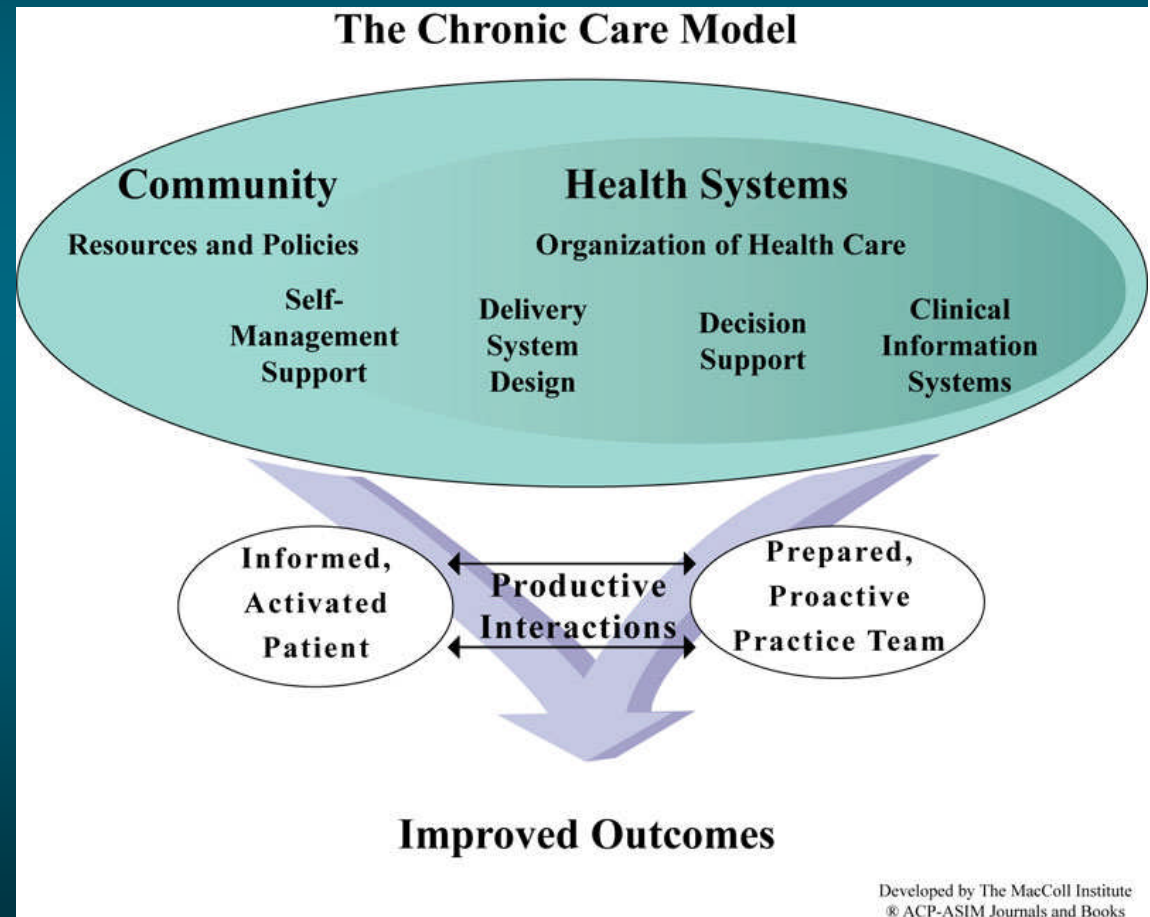
- ✓ Service Coordination
- ✓ Integrated Health Promotion
- ✓ Partnership development

Early Intervention in Chronic Disease Initiative

- Involves collaboration between Community Health Services, Primary Care Partnerships and Divisions of General Practice
- A recurrent investment funded with 18 sites across the State
- Informed by the Wagner Chronic Care Model – planned, managed, proactive care -
- Target group – clients with chronic disease and/or complex needs prior to significant complications or decline
- Focus on coordinated care and care planning

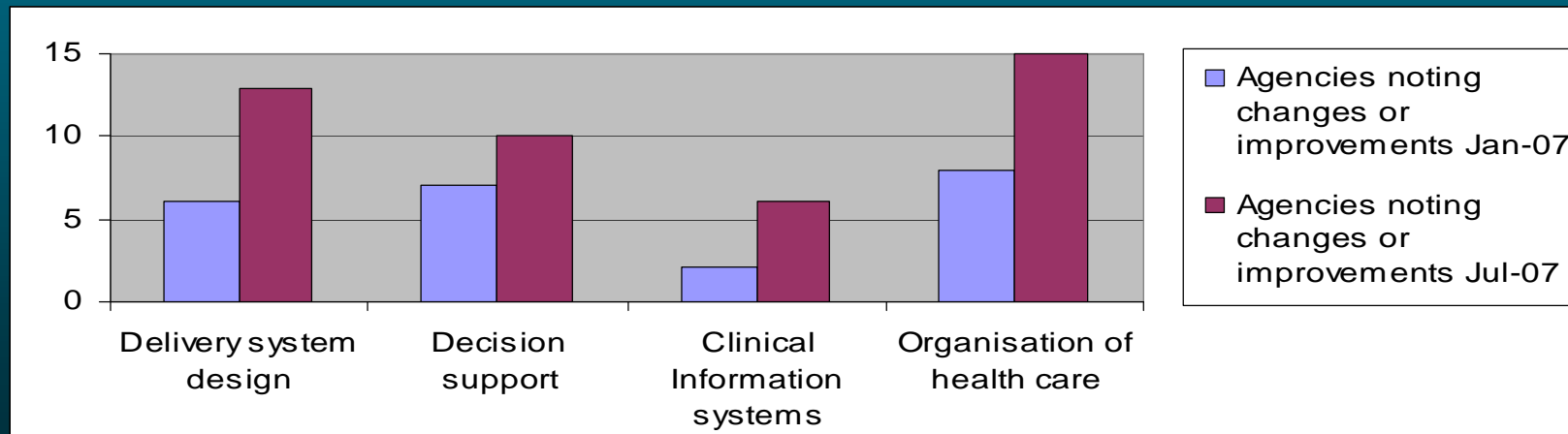
Post 2005 - Integrated Chronic Disease Management: A whole of system change required

- A proactive model of care
- Aim: An informed, activated client interacting with a prepared, proactive practice team, resulting in quality and improved outcomes
- Wagner's Chronic Care Model:
6 Interdependent elements for high quality chronic care



Early Intervention in Chronic Disease – Early Wins

- More than 2,300 active clients across Victoria
- Programs are appropriately targeted at high need clients
- Agencies are noting improvements against the Wagner Chronic Care Model
- Local evaluations are positive



What have we found?

Working in
Partnership
can be hard
work





But well worth the effort when you get there



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