

What is the Australian Better Health Initiative?

The Australian Better Health Initiative is part of the Council of Australian Government's 4 year plan – '\$1.1 Billion injected to health' announced in 2006. ABHI is directly funded by the Department of Health and Ageing until June 2010. There are five focus areas:

1. Promoting Healthy Lifestyles
2. Signposting early detection of risk factors and chronic disease
3. Supporting lifestyle and risk modification
4. Encouraging active patient self management of chronic conditions
5. Improving the communication and coordination between services

The main focus for ABHI in the Mid North Coast DGP is Primary Care Integration – Focus area 5 – in the areas of Diabetes and CHD. However this work will also have an impact in the other focus areas, for example Focus Areas 2, 3 & 4. The main aim is to improve the patient journey and patient outcomes through better collaboration with existing and newly developed primary care networks. Improving communication between providers will underpin this work.

What Do We Hope To Achieve?

The ABHI Primary Care Integration Program aims to promote solutions to primary care integration between general practice and other local health care providers that will assist in the delivery of seamless patient care. The Regional Coordinators will liaise and negotiate with Primary Care Providers, GPs, Allied Health, Specialists, Area Health Service representatives and other stakeholders to map existing services, determine the level of existing integration of service, opportunities for collaboration and develop collaborative models of care.

An ABHI Working Groups are being set up with representatives from NCAHS, GPs, Specialists, Allied Health & a patient representative. These groups will track progress and give guidance to the program. The first meeting took place in July 2008. Project Key Performance Indicators include increased uptake of Care Plans and developing shared care protocols.

Program Components

Chronic Disease Collaborative

The MNCDGP is facilitating a Chronic Disease Collaborative program that targets patients with Type 2 diabetes and prediabetes. 15 local practices are taking part from right across the Division area. This has a direct linkage to our Australian Primary Care Collaborative practices and is part of the Australian Better Health Initiative Program. The Collaborative is managed by the ABHI Regional Coordinator based in Coffs Harbour.

What is it?

A quality improvement program that targets populations of patients with Diabetes issues by:

- Establishing and maintaining disease registers for Diabetes
- Cleanse patient database & improve quality of diabetes registers
- Regularly monitoring the blood pressure and HbA1c & Cholesterol measures of patients with Diabetes
- Developing strategies to improve these measures
- Develop recall/reminder systems for diabetic patients
- Sharing ideas & experience with other local practices
- Activities overseen by local Diabetes Working Group which includes GPs, PNs, local Endocrinologist & Allied Health

What have practices been doing?

- Setting up chronic disease registers on diabetes
- Monitoring their diabetes populations' blood pressure and HbA1c measures on a monthly basis and implementing strategies to improve these measures from month to month
- Producing monthly measures on diabetes and sharing the data:
 - For diabetic patients:
 1. No of patients on the Diabetes Register
 2. % diabetic patients HbA1c < or = 7,
 3. % diabetic patients with blood pressure < or = 130/80
 4. % diabetic patients with cholesterol < or = 4 mmol
- Recalling patients who have had no pathology results within the last 12 months
- Measuring practice prevalence percentage rates for diabetes.
- Trying to improve practice diabetes prevalence rates - prevalence tends to be too low.
- Some practices have been setting up a nurse led service for diabetic patients where most or all diabetic patients receive GPMP care plans & Team Care Arrangements where appropriate

Practice Networking

Practices attend local bi-monthly informal breakfast/lunch meetings to discuss progress & share ideas between practices

- Networking opportunities taking place at the Learning Workshops

Workshops

- Practices have attended 2 Division-run Learning Workshops in 2008/9. Topics covered:
 - Learn about the improvement model & process
 - How to set up disease registers and recall/reminder systems
 - How Chronic Disease Self Management can improve patient outcomes

- Admin staff - training on following areas: reception, telephone skills, medico legal issues, privacy & CDM MBS items

- Practices will attend the 3rd Learning Workshop in early 2010. Topics to be covered:
 - Updates by local specialists on best practice in Diabetes & CHD
 - NSW Health Get Healthy Program
 - Nurse led clinics

Prevention

- At all organised events prevention & health checks have been promoted including the local LMP - Why Weight
- Used MAHS underspend to fund 250 free places on the Why Weight program. Any patient deemed suitable by their GP could be referred including patients with a chronic condition. Outcomes will be evaluated. We are also hoping that this will improve the local profile of the Why Weight program

What have practices got out of it?

- Improved outcomes for patients
- Learning a systematic approach to chronic disease management
- Increased linkage to specialists & allied health
- Regular networking with local practices
- Hands on, regular support from the Division

Results

- 15 practices have set up & are maintaining diabetes registers for the first time
- 2850 diabetic patients involved with the program
- 4 practices setting up Nurse Led Clinics
- Improvement in measured % HbA1c < 7 in last 12 months: 200%
- Improvement in measured Cholesterol < 4 mmol in last 12 months: 260%
- Improvement in measured BP < 130/80 in last 12 months: 56%

Future?

- Setting up CHD registers & improving patient outcomes using the new APCC CHD measures
- £rd Learning Workshop

Other ABHI areas the Division will be working on:

ABHI Focus Area 2 – supporting use of the new MBS item number 713 – Diabetes Risk Assessment and support the use of the existing item numbers for health checks.

ABHI Focus Area 3 – supporting lifestyle risk modification, e.g. Lifestyle Modification Program as part of COAG Diabetes Prevention Program and supporting MBS item number 713.

Troughout this program your local Regional Coordinator, dedicated to ABHI work, will support you.

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