



The below information is provided as a guide to the plan and reporting templates for the ABHI Primary Care Integration Program 2009/10 Annual Plan, 6mth and 12mth reports.

### ABHI PCIP 1- Workplan

Your approved ABHI PCIP workplan will be pre-loaded onto PHCRIS. If any changes or modifications are required to the approved strategies and activities, please download the attached document and highlight your changes (using track changes formatting) in the table itself. Once complete use the link to re-upload your workplan for assessment. Note that your 09/10 plan should be formatted to allow for reporting in an adjacent column.

For **VIC, NSW, QLD and WA SBOs ONLY**, it is expected that your indicators will reflect the categories (Leadership, Representation, Communication, Collaboration, Administration and Coordination) as outlined in your PCIP Schedule. You may have additional indicators if you wish.

### ABHI PCIP 2 (not applicable to VIC, NSW, QLD and WA SBOs)

The number and proportion of general practices using **integrated shared care pathways or business rules** to support chronic disease prevention and management [Jul 09-Jun 10]

Please note that this data is **required** to be collected in each 6 monthly period.

### Explanation of indicator

#### ***Integrated Shared Care Pathways***

The number and proportion of general practices using **integrated shared care pathways** or business rules to support chronic disease prevention and management:

- Integrated shared care pathways are about agreed communication and coordination processes (eg. referral and feedback, care planning, case conferencing); and
- Such pathways may involve private and/or public providers.

What are integrated shared care pathways (ISCP)? They can also be known as coordinated care pathways, care maps, or anticipated recovery pathway. ISCPs are task orientated care plans which detail essential steps in the care of patients with a specific clinical problem and describe the patient's expected clinical course. They offer a structured means of developing and implementing local protocols of care based on evidence based clinical guidelines.

#### ***Business rules***

The number and proportion of general practices using integrated shared care pathways or **business rules** to support chronic disease prevention and management:

- Business rules are not the same thing as integrated shared care pathways;
- Business rules support the use of integrated shared care pathways; and
- Examples include: GPs receiving timely feedback or the practice systematically identifies eligible patients for an ISC pathway.

Business rules enable the integrated shared care pathway to operate well. They are an agreed process between primary care providers for dealing with common clients, from initial contact, needs identification, assessment and care planning

### **ABHI - PCIP 3 (PCIP (SBO) 2 for VIC, NSW, QLD and WA SBOs)**

Divisional involvement in the work being progressed locally through **state government funded** programs (eg the *HealthOne NSW* initiative, clinical redesign etc) to support chronic disease prevention and management [Jul 09-Jun 10]

*Please note that this data is **required** to be collected in each 6 monthly period.*

### **ABHI - PCIP 4 (PCIP (SBO) 3 for VIC, NSW, QLD and WA SBOs)**

The extent to which general practices use a communications application, or an electronic system between primary care providers and hospitals where relevant, that supports the **timely and appropriate exchange of patient information** (eg clinical software tools, secure messaging.) [Jul 09-Jun 10]

*Please note that this data is **required** to be collected in each 6 monthly period.*

### **Explanation of indicator**

Only those SBOs and Divisions who are using ABHI PCIP funding for the purposes of employing staff to extend this focus area in general practices are required to report against this Performance Indicator. Qualitative data including evidence of the benefits and results (outcomes) achieved.

### **All Divisions of General Practice and the TAS, ACT, NT and SA SBOs ONLY**

### **ABHI PCIP Indicators 5 – 7**

MBS data for relevant items under these Indicators will be provided by the Department to Divisions and the WA, ACT, NT and SA SBOs as per the provisions outlined in the MPA.

### **ABHI - PCIP 5**

The number and proportion of general practitioners claiming **MBS GP Management Plans, Team Care Arrangements and Multidisciplinary Care Plans.** [Jul 09-Jun 10]

*This indicator is only required to be reported against in the 12 Month Report. It is not required at the 6 Month Report however you can enter reporting details if you wish.*

### **ABHI - PCIP 6**

The number and proportion of general practitioners claiming **case conferencing items.** [Jul 09-Jun 10]

*This indicator is only required to be reported against in the 12 Month Report. It is not required at the 6 Month Report however you can enter reporting details if you wish.*

### **ABHI - PCIP 7**

The number and proportion of general practitioners claiming **Medication Management Review items.** [Jul 09-Jun 10]

*This indicator is only required to be reported against in the 12 Month Report. It is not required at the 6 Month Report however you can enter reporting details if you wish.*

### **ABHI PCIP Indicators 8 – 10**

Information reported in these indicators can be ‘copied and pasted’ from your approved work-plan (if relevant). These indicators are only required to be reported against in the 12 Month Report. They are not required at the 6 Month Report however you can enter reporting details if you wish.

As we are approaching the final year of the ABHI PCIP program, we need to look at methods to evaluate the program from a national perspective (ie. to draw out common themes and challenges). Indicators 8, 9, and 10 directly reflect the aims and objectives in your funding Schedule and therefore it is anticipated that the information reported against them will feed into a

national evaluation which will inform future policy in CDSM identified as a key principle of the National Primary Care Strategy.

#### **ABHI - PCIP 8**

The objective of the Integration Program is to encourage more integrated patient centred care by supporting general practice to:

- Engage with the work of local Primary Care Partnership Councils, and other state funded primary care initiatives that seek to improve service co-ordination and integrated chronic disease prevention and management;
- Communicate and link better with other primary care providers;
- Make better use of existing primary and community care services including commonwealth, state and non-government organisation funded services with a focus on patients with chronic disease;
- Utilise tools/strategies that will assist in better managing patients with chronic disease (e.g. disease registers, referral, recall & reminder systems, care planning); and
- Contribute to work around developing local chronic disease care pathways (generic or specific) or other priority activities with a chronic disease management focus.

#### **ABHI - PCIP 9**

The Participant has been funded to support and encourage general practice to incorporate integrated primary health care into their core business and to work more collaboratively with other primary care providers in the prevention and management of chronic disease.

#### **ABHI - PCIP 10**

The Participant has been funded to adopt a range of strategies that include (but not exclusively):

- Working collaboratively with the ABHI Primary Care Incentive Program State-wide Coordinator, ensuring that where relevant, activities are implemented consistently across the State (or Territory);
- Promoting to general practice the importance and benefits of integrated primary care service delivery in the prevention and management of chronic disease;
- Building a knowledge-base on the factors that act as barriers against, or act to increase, the engagement of general practice in integrated primary care service delivery to prevent and manage chronic disease;
- Promoting and identifying examples of best practice and facilitate transfer across general practices;
- Providing resources, and where relevant, training (or organising training) to general practice staff in the use of information tools and services, in the context of integrated primary care services delivery; and
- Sharing with the Divisions of General Practice Network best practice knowledge and resources around integrated primary care service delivery models relevant to the prevention and management of chronic disease. In this respect, any materials produced in the course of this Project (e.g. communication strategy, business rules etc) by the Participant are to be shared with the Divisions Network via the AGPN clearinghouse.

## **VIC, NSW, QLD and WA SBOs ONLY**

### **ABHI PCIP (SBO) Indicators 4 – 6**

Information reported in these indicators can be ‘copied and pasted’ from your approved work-plan (if relevant). These indicators are only required to be reported against in the 12 Month Report. They are not required at the 6 Month Report however you can enter reporting details if you wish.

As we are approaching the final year of the ABHI PCIP program, we need to look at methods to evaluate the program from a national perspective (ie. to draw out common themes and challenges). Indicators 8, 9, and 10 directly reflect the aims and objectives in your funding Schedule and therefore it is anticipated that the information reported against them will feed into a national evaluation which will inform future policy in CDSM identified as a key principle of the National Primary Care Strategy.

### **ABHI - PCIP (SBO) 4**

The objective of the Integration Program is to encourage more integrated patient centred care by supporting general practice to:

- Engage with the work of local Primary Care Partnership Councils, and other state funded primary care initiatives that seek to improve service co-ordination and integrated chronic disease prevention and management;
- Communicate and link better with other primary care providers;
- Make better use of existing primary and community care services including commonwealth, state and non-government organisation funded services with a focus on patients with chronic disease;
- Utilise tools/strategies that will assist in better managing patients with chronic disease (e.g. disease registers, referral, recall & reminder systems, care planning); and
- Contribute to work around developing local chronic disease care pathways (generic or specific) or other priority activities with a chronic disease management focus.

### **ABHI - PCIP (SBO) 5**

The Participant will support and encourage Divisions of General Practice (Divisions) in their respective State to incorporate integrated primary health care into their core business so that Divisions have the expertise to act as change agents, effective in encouraging and supporting general practices to work more collaboratively with other primary care providers in the prevention and management of chronic disease.

### **ABHI - PCIP (SBO) 6**

The Participant has been funded to adopt a range of strategies that include (but not exclusively):

- Working collaboratively with the Australian General Practice Network (AGPN) to promote to Divisions the need to encourage and facilitate the promotion to general practice of integrated primary care;
- Assisting Divisions, as required, to promote the uptake of business rules, shared care pathways, electronic systems or communications applications etc. that support integrated primary care; and
- Sharing with the Divisions of General Practice Network best practice knowledge and resources around integrated primary care service delivery models relevant to the prevention and management of chronic disease. In this respect, any materials produced in the course of this Project (e.g. communication strategy, business rules etc) by the Participant are to be shared with the Divisions Network via the AGPN clearinghouse.