



GP Plus Health Care Strategy

August 2007



Government
of South Australia
Department of Health

The National Library of Australia Cataloguing-in-Publication entry:

South Australia. Dept. of Health.
GP plus: health care strategy.

ISBN 9780730899006 (pbk.).

1. Family medicine — South Australia.
2. Managed care plans (Medical care) — South Australia.

I. Title.

362.104258099423

This publication may be reproduced in whole or in part subject to the inclusion of acknowledgement of the source.

Department of Health
11–13 Hindmarsh Square
Adelaide SA 5000

www.health.sa.gov.au

Contents

Minister's Message	1
Introduction	2
GP Plus Health Care Centres	5
Purpose of the Centres	5
Anticipated outcomes from the Centres	6
Structure	6
Service provision	7
Integrated services	9
Enablers	10
Research and teaching	11
Business model	11
Operational matters	12
GP Plus Health Networks	13
Other GP Plus Health Care Programs	14
GP Plus Practice Nurse Initiative	14
Health Call Centre	14
Risk Factor and Lifestyle Programs	15
Self-Management Programs	15
Chronic Disease Community Program	15
Transition Care Program	16
Metro Home Link Service	16
Next Steps	17





Minister's message

The GP Plus Health Care Strategy provides a clearer understanding of the role of GP Plus Health Care Centres and other primary health care initiatives as well as outlining how they will operate within South Australia's health system.

The Strategy addresses key recommendations arising from the Generational Health Review to provide a fully integrated and accessible health care system and to increase prevention and early intervention services to promote good health.

The Government of South Australia recognises that it is difficult to meet rising demand and the increasing community expectations of the health care system. An ageing population and increasing levels of chronic disease presents us with significant challenges.

The statistics are sobering. Currently, about 40% of the Australian population has a chronic health condition and disease rates rise rapidly with age. This accounts for more than two thirds of all health expenditure.

To meet these challenges we must turn our efforts to early intervention, illness prevention and health promotion while making it easier for people to obtain a range of allied health services within their local community.

The Strategy identifies opportunities for health care professionals to work in a more collaborative way to strengthen primary health care services in South Australia.

GP Plus Health Care Centres and GP Plus Health Networks will be supported by other initiatives such as the GP Plus Practice Nurse Initiative, Metro Home Link Service and the Health Call Centre.



The first GP Plus Health Care Centres have opened at Aldinga and Woodville and two further Centres are being developed at Marion and Elizabeth. Over the next few years, six centres will be opened in the metropolitan area and two are planned for Port Pirie and Ceduna.

These Centres and the implementation of initiatives outlined in this Strategy will relieve the demands on our public hospitals and complement services provided by local general practitioners.

As we embark on a new era of integrated health care, I look forward to the next stage of these reform initiatives and to developing collaborations across the sector for a healthier South Australia.

A handwritten signature in black ink, which appears to read "John Hill". The signature is fluid and cursive.

JOHN HILL MP
MINISTER FOR HEALTH



Introduction

In general, the health of South Australians is good and we have access to excellent health care services. However, demand for health services is growing at unsustainable rates while community expectations of our health system are increasing.

Many factors are contributing to this including:

- ▶ Ageing of our population.
- ▶ Increasing prevalence of chronic disease.
- ▶ Increasing community expectations about access to health care.
- ▶ Known and forecast workforce and skill shortages across all clinical specialities.
- ▶ Emerging technological improvements with a resultant increase in demand for health services.
- ▶ Requirement to upgrade the physical infrastructure of hospitals and primary health centres.
- ▶ Continued rising cost of health care that is increasing at a rate faster than the state's revenue base.

In order to address these factors, the Government recognised the need for change and accordingly made a strong commitment in the commissioning of the Generational Health Review (GHR) in 2003. The GHR identified a range of challenges for the Government to consider in reorientating the health system from an illness to a wellness system. To achieve this, we need to shift our focus towards health promotion, illness prevention and early intervention, rather than just providing more resources into the acute care sector. There also needs to be a significant reconfiguration of our health services to better balance the organisation and delivery of services between a population and patient centred approach and an individual

treatment and service provider approach.

The South Australian Government's first response to the GHR, *First Steps Forward 2003–2006*, outlined the first stages of a 20 year plan to reform the state's health system. The most visible achievements from *First Steps Forward* have been in progressive service reforms in areas such as early childhood services, new governance arrangements, hospital substitution programs and investment in community-based health services. The Government's *South Australia's Health Care Plan 2007–2016*, published in June 2007, provides a 10 year plan to further the aims set out in the GHR. Some of these strategies will include working with general practitioners and other community-based health care providers to make health services more accessible to people in their local communities. In particular, the strategies will focus on people with chronic diseases, people at risk of developing a chronic disease, and people most in need of assistance to achieve good health.

Building on the foundations set out in *First Steps Forward*, the next phase also includes a revitalised commitment to mental health and early childhood services, two of the Government's key priorities for service improvement.

In pursuing the Government's agenda of increased health promotion, illness prevention and early intervention services, the Department of Health seeks to work closely with general practice and other services, including greater collaboration between State and Australian Government funded agencies to better respond to the health needs of local populations. One of the key concepts developed in response to the Government's commitment to increased health promotion, illness prevention and early intervention is the GP Plus Health Care Strategy.



This strategy comprises:

- ▶ Development of GP Plus Health Care Centres within metropolitan and country areas, beginning in localities that have been identified as having the highest need.
- ▶ Further enhancement of GP Plus Health Networks (previously known as Primary Health Care Networks) in metropolitan and country areas.
- ▶ Continuing the development of population-based health promotion activities that enable individuals, families and communities to take responsibility for their own health and wellbeing.
- ▶ The collaborative implementation of initiatives such as the GP Plus Practice Nurse Initiative with the Divisions of General Practice.
- ▶ Continuing the development and implementation of programs that support risk factor identification, self-management support, chronic disease management and out of hospital care.
- ▶ Continuing the enhancement of hospital substitution programs to support patients within their home environment.
- ▶ Implementation of a Health Call Centre to improve access to the most appropriate health information and services; to provide individuals with greater capacity to manage their own health; and to assist in the integration of health services.

South Australia's Strategic Plan (2007) clearly articulates key objectives for the next decade including improving the health of the community. The development of the GP Plus Health Care Strategy particularly supports these objectives as one part of the broader state health system.

Planning principles

The following planning principles have assisted in defining the next phase of the health reform:

- ▶ Taking a population health approach in planning the level and location of services to ensure services meet the needs of local populations where they can be provided safely, effectively and efficiently.
- ▶ Providing a consistent approach to service delivery with a focus on the needs of the individual and communities, rather than the needs of the provider.
- ▶ Achieving an appropriate balance of 'in hospital' and 'out of hospital' health services.
- ▶ Improving the coordination and integration of services to present a complete system of health care to the consumer.
- ▶ Improving the level of early intervention and illness prevention services.
- ▶ Optimising opportunities for partnerships across State and Australian Government, with non-government organisation and with the private sector.
- ▶ Achieving health productivity benchmarks based on national best practice.
- ▶ Consolidating clinical expertise to enhance safety, quality and sustainability, and the provision of safe and effective clinical teaching and research.
- ▶ Optimising access to elective and emergency services.
- ▶ Ensuring affordability and long-term financial sustainability.



GP Plus Health Care Centres

GP Plus Health Care Centres will help to advance and support the reconfiguration of the health system as outlined in the SA Health Care Plan. The Centres will provide a focal point within the community where a range of primary health care service providers work together to enable improved coordination and delivery of care. Each Centre will be developed based on the outcomes of a Health Improvement Plan and will include collaboration with local service providers and local communities to ensure the specific needs of the local community are addressed. For this reason it is expected that there will be a variety of different service delivery models, although the underpinning philosophy will remain consistent.

The underpinning philosophy of the GP Plus Health Care Strategy is one of collaboration with local general practitioners to complement the services provided by general practice and to make it easier for the local community to access a broader range of allied health, mental health, drug and alcohol, nurse practitioner, counselling and other support services closer to home. This also means collaboration with local government, other local health service providers (eg. pharmacists) and the non-government sector.

In addition, to further improve access to clinical services, a number of services currently provided from acute hospital facilities will also be offered through GP Plus Health Care Centres. These services may include a number of specialist outpatient clinics and non-complex diagnostic and screening services.

Flexibility of arrangements with private providers including general practitioners who may choose to operate from these facilities will be essential and will reflect the best outcome achievable for the community to be served by the Centre.

GP Plus Health Care Centres are intended to build on the strengths of general practice by working in partnership with other providers, including Aboriginal Community Controlled Services, other agencies, local government and the non-government sector. The Centres provide a way to deliver primary health care services to people as close to their home as possible. This means a shift from a service-centric model to a patient-centric model.

General practitioner involvement at each Centre will be determined by a combination of local health needs, GP workforce availability, and consultation with local general practices and the local Division of General Practice.

Purpose of the Centres

The purpose of the Centres is to:

- ▶ Assist in the early identification of risk factors affecting the immediate and long-term health of an individual.
- ▶ Assist in the management of patients with chronic and complex conditions through the provision of care coordination.
- ▶ Assist as a navigator linking the acute and primary health care providers to provide a more balanced health system and services to individuals.
- ▶ Provide health promotion and illness prevention strategies in the local community.
- ▶ Respond to specific health needs affecting the local population, particularly those who are most in need.
- ▶ Provide a community resource for self-management groups and other health and wellbeing activities.

- ▶ Increase the opportunities for extended hours access to primary health care and general practice services.
- ▶ Increase teaching, training and education opportunities for health professionals.
- ▶ Make it easier for general practitioners to provide enhanced services for their patients.

Anticipated outcomes from the Centres

The key outcomes anticipated from GP Plus Health Care Centres are:

- ▶ Increased equity of access to health services.
- ▶ Decreased number of patients requiring referral to hospital.
- ▶ Increased availability of minor injury services at a community level.
- ▶ Delivery of services closer to home.
- ▶ Integration of all primary health care services and existing community health services.
- ▶ Increased use of self-management programs.
- ▶ Increased early detection of health status risk factors.
- ▶ Early intervention in the management of risk factors affecting the health of an individual.
- ▶ Improved management of chronic conditions.
- ▶ Increased evidence of clear pathways and an easy process for patients to follow.

Structure

Conceptually, GP Plus Health Care Centres are 'hubs' which, in conjunction with other private, government, local government and non-government services, form a comprehensive network to ensure that services are delivered as close as possible to where people live, that care is coordinated, and that opportunities to promote health and prevent illness are maximised.

GP Plus Health Care Centres will build on the existing infrastructure of community health centres. Historically, community health centres have provided a range of primary health care services to local communities quite independently from local general practitioners and other private primary health care providers. However, the GP Plus Health Care Centre model underpins the new direction of existing community health services that is already underway, and is based on greater integration with all other services.

This new focus will improve collaboration and coordination between providers and reduce duplication of services. This will enable improved targeting of effort and result in a broader range of services being available to the community. GP Plus Health Care Centres will, over time, develop into state-of-the-art primary health care services, complementing general practice and assisting as a navigator that links the acute and primary health care systems to provide a more balanced health system.

GP Plus Health Care Centres will be established on the basis of approximately one Centre per 100 000 population. This means that there will be about ten Centres in the Adelaide metropolitan area.

In country regions, cooperation between general practitioners, the local community hospital and the community health centre has been well developed

for many years. It is anticipated that the implementation of the GP Plus Health Care service model will further enhance primary health care service provision to rural communities. A number of facility redevelopments in key areas have been identified as priorities for implementing this reform approach in country South Australia.

Within the metropolitan area, the ten Centres will form the main group of GP Plus Health Care Centres. Centres are currently being planned for Elizabeth and Marion, with Centres already operating at Aldinga and Woodville.

The Woodville Centre has a specific role in providing for the needs of young people. It is the main base for SHine SA, as well as providing drug and alcohol, mental health, and other healthy lifestyle services.

In some areas of significant general practice shortages, such as Elizabeth, there will be an opportunity for general practitioners to occupy space and work within the GP Plus Health Care Centre.

GP Plus Health Care Centres will vary in size depending on their proximity to hospital facilities, on population needs, and on other allied health services available.

The hours of operation will vary depending on need and service type but it is expected that services will be available for extended hours seven days per week.

Service provision

GP Plus Health Care Centres will provide a range of core services that are based in the community and are ambulatory in nature. In metropolitan areas, they will not have overnight beds for elective or emergency admissions, although some country Centres will provide these services.

The model of service delivery will support a flexible and responsive approach to local priorities as well as enabling the development of new or expanded roles such as GP specialists, nurse practitioners, lifestyle advisors and care coordinators.

This requires a population planning approach that includes:

- ▶ Epidemiological evidence of the local community's burden of disease.
- ▶ Community consultation and engagement processes, especially to determine the health needs of vulnerable populations.
- ▶ The alignment of services and strategic partnerships and links with existing diagnostic and primary health care services (such as general practice, non-government organisation, local government and private sector) in the community.

Underpinning the service profile will be strong links to the local general practice, which will help determine the services required.

In some services, links will be created with the acute care sector by establishing Clinical Networks. For example, a cardiac network will enable a patient with cardiac disease to be followed through from an acute episode requiring hospital admission back to the patient's general practitioner with referral to lifestyle management programs such as exercise and dietary advice. Operating within a cardiac network, a general practitioner will be able to seek timely specialist information to better manage the cardiac patient at home.

An indication of services that could be provided by GP Plus Health Care Centres

- ▶ GP Specialists - expansion of existing GP specialist roles where general practitioners can refer to other general practitioners to reduce waiting times for access to specialist advice.
- ▶ Ambulatory care services reconfigured from existing hospital-based outpatient clinics and supported by visiting specialists.
- ▶ Minor procedural facilities for general practitioners or visiting specialists wishing to provide this service.
- ▶ Minor injuries services to reduce the need for attendance at a hospital emergency department for non life-threatening events.
- ▶ Community nursing and nurse practitioner services for early risk assessment clinics, patient education and advice.
- ▶ Chronic disease management programs.
- ▶ Lifestyle and risk factor management programs.
- ▶ Self-management education and support programs.
- ▶ Care coordinators for the day-to-day coordination of patients with complex health needs, providing consistent support at home to maintain health and independence.
- ▶ Special services for children including those linked to the Children's Centres. Examples of these services may include speech therapy, developmental clinics and parenting skills development.
- ▶ Pharmaceutical advice (some Centres may include a commercial pharmacy).
- ▶ Cancer support services.
- ▶ Sexual health services.
- ▶ Antenatal and post-natal clinics.
- ▶ Aged, adult, adolescent and child mental health services.
- ▶ Dental clinics.
- ▶ Drug and alcohol services.
- ▶ Counselling services.
- ▶ Health promotion activities.
- ▶ Diagnostic services such as:
 - Pathology including 'point of care testing'
 - Radiology: upper/lower limb, chest x-ray
 - Ultrasound: general
 - Respiratory function tests
 - Electrocardiograms.
- ▶ Allied health and nursing services for assessment, treatment and rehabilitation:
 - Physiotherapy
 - Occupational therapy
 - Speech therapy
 - Diabetes educators
 - Asthma educators
 - Podiatrists
 - Dietitians.

Integrated services

GP Plus Health Care Centres provide a pathway for creating effective integration with other services. This will occur with a broad range of service provision. In some specific cases services will be integrated with, for example, children's services, pharmacy, and mental health services.

Children's Centres for early childhood development and parenting

Children's Centres (previously known as Early Childhood Development Centres) are an across Government initiative, led by the Department of Education and Children's Services. The centres build on the integrated early childhood service delivery model.

The new Children's Centres include childcare, education, health and family services for children aged 0 - 8 years and their families. The centre accommodates education, long day care, clinic/visiting professionals' rooms, group rooms and community space.

A team of early childhood educators, child health professionals, community development workers and family support staff will work with the community to deliver a broad range of programs either on site or through links to other services.

20 Children's Centres are being developed. Most centres will be based in school sites. Five of these centres have already been open and are located at Enfield, Elizabeth Grove, Hackham West, Wynn Vale and Angle Park.

It is anticipated that some health services provided from the Children's Centres will be provided through or in conjunction with GP Plus Health Care Centres. This will occur where a more comprehensive assessment and response to the needs of children

and families are required, or where specialised resources are shared rather than duplicated between services. These linkages will also enable effective transition from early childhood into adolescence and adulthood.

Community Mental Health Care Services

Existing Community Mental Health Care Services are being further developed to provide for the expansion of existing community-based mental health services, including the development of Community Mental Health Centres as outlined in the Government's response to the Social Inclusion Board's report "Stepping Up: A Social Inclusion Action Plan for Mental Health Reform 2007-2012". These services include prevention, early intervention, treatment services, and rehabilitation for people with mental illness.

In some instances it is anticipated that Community Mental Health Centres could be co-located with or adjacent to GP Plus Health Care Centres. Irrespective of their actual physical location there will be service integration between Community Mental Health Centres and GP Plus Health Care Centres to enable people with co-existing mental health and chronic illness to receive comprehensive care.

Services will be provided in partnership with the patients' general practitioner so that both the general health and mental health requirements for people are catered for as close to home as possible.

It is expected that people with less complex, short-term mental illnesses or drug and alcohol problems will be managed through routine services provided by general practitioners in conjunction with counselling and support services provided through the GP Plus Health Care Centres. Community mental health can provide specialist services for those with more complex needs.

Pharmacy services

It is proposed that pharmacists will be members of the primary health care team in GP Plus Health Care Centres. Pharmacists will perform a range of clinical activities and participate and contribute their knowledge and skills to care planning and the ongoing care of patients with chronic conditions.

A model, which includes pharmacists, would provide the following functions:

- ▶ Medication reviews in the home or nursing home during normal business hours.
- ▶ Increased scope to provide advice and counselling.
- ▶ Potential participation in case-conferencing.
- ▶ Student placements (medical and pharmacy).
- ▶ Training opportunities (medical and pharmacy).
- ▶ Research opportunities in medication management.
- ▶ Additional roles for pharmacists.
- ▶ Cost-neutral participation.
- ▶ Enhanced after hours access to medicines.
- ▶ Collaboration with local commercial pharmacies.

Enablers

The development of GP Plus Health Care Centres requires two distinct enablers: information management systems, and workforce development and redesign.

Information management systems

A key component of the GP Plus Health Care Centre

will be information management systems that will enable full connectivity across all health service providers.

Over time the information management systems will enable:

- ▶ The creation of common patient identifiers and common patient records. With the patient's consent, all service providers involved in the patient's care will have access to the health information they need and patients will only have to provide their details once.
- ▶ Access to booking systems that will enable one service to make an appointment for a patient with another service. For example a young person attending for family planning advice will also be able to have an appointment made with a drug and alcohol counsellor if required.
- ▶ Remote reading of diagnostic imaging. For example, x-rays taken at the Centres may be remotely read by radiologists located at a tertiary or general hospital, or in another privately managed imaging service. All reports would be sent back to the requesting clinician electronically.
- ▶ The use of an internet based care planning and decision support system for the management of chronic care: including care planning, referral to other providers, monitoring of pathology tests and biomedical readings, and recalls and reminders.
- ▶ The collection of information to determine future service planning.

Workforce development and redesign

South Australia has the oldest health workforce, along with the oldest population in Australia (15.2%

of South Australia's estimated resident population was aged 65 years or more in June 2005). The age profile indicates that 40% of the existing health workforce will exit the workforce in the next 15 years, with replacement numbers much lower. Consequently, workforce shortages as a result of retirement and reduced participation rates are likely to be felt more quickly in South Australia.

Apart from the ageing of the population, health workforce shortages are exacerbated by many factors, including the unnecessary duplication of clinical services that lead to inefficiencies of scale and inability to provide 24-hour service coverage where needed. The health workforce also has very small numbers of particular specialist workers, which leaves services vulnerable when only one or two staff retire or are absent for any reason. Additionally, there is a mal-distribution of staff, with outer metropolitan as well as rural and remote services often experiencing difficulties in attracting staff including visiting specialist staff.

GP Plus Health Care Centres will require the workforce to be reorganised through:

- ▶ Health system business re-engineering.
- ▶ Job redesign and innovation that enhance the patient journey.
- ▶ The development of multi-skilled teams through standardised training and skill-based competencies.
- ▶ A workforce that is trained and deployed to support new services.

Workforce capacity will be maximised to ensure supply, requiring:

- ▶ Reconfiguring and developing new roles for health professionals and support staff.

- ▶ Task transfer and task substitution.
- ▶ Professional and support staff.

Research and teaching

GP Plus Health Care Centres provide an infrastructure to increase the status of primary health care research and clinical placement opportunities. For example, the preventive services provided by general practitioners and allied health practitioners create opportunities for graduate and undergraduate students to become involved in the solution to the growing illness burden.

GP Plus Health Care Centres will participate in vocational training and education and in undergraduate and postgraduate medical, nursing, allied health and clinical support education programs. This will mean providing clinical placements and other opportunities for appropriate experience.

It is also expected that research programs based within the GP Plus Health Care Centres will provide evidence for further program development based on appropriate patient and population health outcomes.

Business model

The new service model will be developed by the reorientation of existing services and resources plus additional new investment - both capital and recurrent. It is not the intention of GP Plus Health Care Centres to be set up in competition with general practice, private allied health services or local pharmacies. It is also recognised that some large corporate general practices may already be providing extended services to their patients. In this

instance, GP Plus Health Care services may further enhance these practices through the provision of 'in reach' services to the general practice.

GP Plus Health Care Centres will work with general practice to provide priority services to those most in need. This means that those patients with complex co-morbidities or chronic illness will have priority status.

Given the varying nature of each GP Plus Health Care Centre, individual business models will need to be developed and negotiated with local stakeholders.

Continued investment in primary health care will demonstrate the benefits of an early intervention model. Over time, as the benefits of primary health care are realised, increased levels of investment will be possible.

Operational matters

Operational policies and procedures need to be established for the GP Plus Health Care Centres. These will be developed through discussions between Regional Health Services, the Divisions of General Practice and other key partners who may refer to and utilise the GP Plus Health Care Centres.

Population data planning, evaluation and refinement of existing programs will also need to be undertaken. A medium-term timetable showing the activities and schedules will be a useful planning tool.

It is expected that GP Plus Health Care Centres will be owned and managed by the appropriate Regional Health Service. However, each Centre will have a local governance arrangement which ensures that all partners operating within that Centre are able to contribute to the day-to-day running of the Centre.



▲ Aldinga GP Plus Health Care Centre

GP Plus Health Networks

GP Plus Health Networks are being implemented to improve primary health care services, to integrate services between general practice, community health, other local service providers and hospitals, to improve continuity of care for people with complex diseases and conditions, and to contribute towards improvements in the health of local populations. The initial focus of the Networks was to improve the integration of care for people with type 2 diabetes, cardiovascular disease and respiratory disease, and work with people with risk factors to reduce long-term risk of developing the disease. This initial work has provided the platform for the implementation of other services to support chronic disease.

Partnerships between Health Service Regions, general practice and other non-government providers were created through Memoranda of Understanding, which were signed in June 2006. The Network partners have been working towards the development of new care pathways that will provide opportunities to redefine clinician and service roles and responsibilities for target chronic diseases as part of the SA Health Care Plan. Networks will become a focal point of regional population health care planning.

A key task for each Network is to produce a Health Improvement Plan for its geographic population over the next 12 months. This plan will be based on a range of population and practice level data, and will identify the health needs of the population and the service requirements to meet those needs. This will include identifying the range of services that need to be provided in a GP Plus Health Care Centre and the location of these Centres in the future. In identifying health needs, the Health Improvement Plan will also consider issues of equity, ensuring that the health needs of the most disadvantaged communities, such

as Aboriginal and Torres Strait Islander communities and some newly arrived migrant groups, are addressed as a priority.

The Networks will facilitate communication between providers, which will include the use of information management systems. These systems will contribute to coordinated care planning and care pathways, improve continuity of care, and enable patient referral and recall at defined intervals.

Networks will facilitate services along both the 'life course' (conception to death) and 'disease continuum' (risk factor identification to complicated disease), respond to primary health care needs, improve the management of chronic disease, and undertake health promotion and primary prevention activities. Networks actively contribute to planning at a local population health level, allowing effective consideration of the social and other determinants of health.

Networks place an emphasis on reaching the most disadvantaged populations, including low socio-economic status, Aboriginal and Torres Strait Islander populations, and outer urban, rural and remote communities.

Over the next 12 months a GP Plus Health Networks framework will be developed to provide direction and guidance to the existing Networks.



Other GP Plus Health Care Programs

There are a number of other programs to help to deliver the GP Plus Health Care Strategy. The SA Health Care Plan will lead to many of these programs being expanded over time. In addition, new programs will be initiated as a result of the Health Improvement Plans produced by GP Plus Health Networks.

GP Plus Practice Nurse Initiative

The GP Plus Practice Nurse Initiative aims to increase the capacity of general practice and so reduce workforce pressure on general practitioners in areas of high demand or areas with significantly high rates of chronic disease in metropolitan Adelaide. Up to 50 practice nurses have been recruited on a time-limited basis to support general practice in order to enhance long-term care planning in place of episodic care. Practice nurses will provide support to general practitioners to improve the management of chronic diseases, and they will be integral to the services provided by GP Plus Health Care Centres and general practice.

The GP Plus Practice Nurse Initiative, which was introduced in January 2007, is working towards supporting general practitioners in the development of GP Management Plans and Team Care Arrangements. These are services that aim to improve integrated care arrangements for people with chronic complex conditions and include the use of patient information systems to track and follow up patients, the use of multidisciplinary care teams in the provision of care, and support for patient self-management programs.

Practice nurses are also being used to assist general practices to promote good health and preventive health care by increasing the focus on chronic disease management, conducting screening, and

providing education for individuals and the community.

Health Call Centre

The Health Call Centre will be accessible 24 hours a day, seven days a week, enabling anyone, anywhere, to obtain health triage, information and advice. This will include advice on where health and medical assistance might be obtained. Advice will be provided by trained nurses and based on guidelines developed in collaboration with health professionals.

In conjunction with the Australian Government, the Health Call Centre will be established to:

- ▶ Enable health care services to work together better.
- ▶ Reduce pressure on hospital emergency departments for telephone advice.
- ▶ Potentially relieve pressure on acute health services such as emergency departments, ambulance services and urgent GP services.
- ▶ Assist people to attend health services more appropriately (for example, someone may go to a GP clinic instead of a hospital emergency department following advice from the Health Call Centre).
- ▶ Provide better access to information and advice without increasing demand on other health services.
- ▶ Provide safer and more consistent health care advice over the phone.

- ▶ Provide another way to improve the long-term health of our community through health promotion, prevention and early intervention, and by having communities more informed about their health.
- ▶ Reduce the effect of GP shortages, particularly after-hours, by enabling people to access medical advice at any time - especially on minor ailments.
- ▶ Provide better access to health information and advice for disadvantaged groups such as Aboriginal and Torres Strait Islander communities, rural and remote users, people with disabilities and the elderly.
- ▶ Improve access to health information and advice for people with a speech or hearing impairment and for people with language difficulties.
- ▶ Provide a platform for the development of additional services such as chronic disease management programs including remote monitoring of conditions.

Risk Factor and Lifestyle Programs

A statewide approach to Lifestyle and Risk Factor Programs will focus principally on behavioural SNAPS risk factors (i.e. Smoking, Nutrition, Alcohol, Physical Inactivity and Stress). Lifestyle and Risk Factor Programs aim to prevent or delay the onset of disease and illness by targeting adults and groups with the highest risk of developing preventable chronic diseases. Lifestyle and Risk Factor Programs are being developed for groups as well as for individuals through one-to-one appointments with appropriate lifestyle advisors/coordinators operating within accredited programs. The program will be supported by the recruitment of at least 12 lifestyle advisors/coordinators by the end of 2007, and planning is underway to expand the program to 50 lifestyle advisors/coordinators within four years.

A statewide approach will ensure the quality and safety, access and equity, and accreditation and training for Risk Factor and Lifestyle Programs. The programs will be accessed primarily through referrals from general practice and GP Plus Health Care Centres. GP Plus Health Networks will have a key role in influencing the implementation of the programs.

Self-Management Programs

A statewide approach to Self-Management Programs will be developed to improve partnerships with health providers and to empower individuals to take an active role in the ongoing management of their chronic condition. The strategy for South Australia is based on three pillars:

- ▶ Increasing health literacy.
- ▶ Increasing the availability and use of evaluated self-management support programs for people with chronic disease.
- ▶ Increasing the development and use of self-management skills and tools by health providers so that clients can be appropriately assessed, managed or referred.

Chronic Disease Community Program

The Chronic Disease Community Program aims to improve the quality of life for people living with chronic diseases and provide them with a tailored Chronic Disease Management Care Plan. Providing health care in community settings will reduce acute episodes of chronic disease and reduce episodes of unplanned hospitalisations.

The program provides targeted and tailored care packages to assist people with better management of their health and wellbeing.

An integrated Chronic Disease Management Care Plan will be developed by general practitioners for all people identified in this program. The plan assists in the reduction of acute exacerbations and deterioration that often results in hospitalisation. Proactive care planning will improve disease management and reduce the symptoms and co-morbidities associated with chronic disease. The Chronic Disease Management Care Plan includes early detection of decline, management of complications, multidisciplinary teamwork, phone coaching, and opportunities for people to self-manage their symptoms.

A multidisciplinary team, including general practice, medical specialists, private allied health, primary health care services and non-government organisations, community pharmacists, dental services and domiciliary services work in partnership with people with chronic conditions to develop care plans.

Self-management is a key focus of this approach to enable the client to better understand and manage their disease.

Professional care as determined by the Chronic Disease Management Care Plan will generally take place in primary health care settings, for example GP Plus Health Care Centres or in general practice.

Transition Care Program

The Transition Care Program provides short-term and goal-oriented support services for older people at the conclusion of a hospital episode.

The Program provides older people who are eligible with a package of services that aims to improve their health and independence. Services provided in the Transition Care Program may include low intensity

therapy (such as physiotherapy, occupational therapy and/or social work), nursing support and/or personal care.

Metro Home Link Service

The Metro Home Link Service assists in allowing people in public hospitals who no longer need acute care to return home earlier with a package of support services. This support package is tailored to an individual's particular needs. The support package may comprise; clinical monitoring; nursing and physiotherapy; an overnight care worker; respite; assistance with personal care; domestic assistance; and support to attend medical appointments.

For these patients, it is not advisable that they spend extended periods in an acute care setting as their care needs are outside the scope and purpose of an acute hospital setting.

The Metro Home Link Service also provides a service response for people who can avoid a hospital admission through the provision of a targeted support package arranged by a general practitioner. A significant proportion of those persons assisted are living with chronic disease conditions.

Next Steps

The next 12 months and beyond will see an expansion of existing programs and the introduction of some new initiatives to further grow the GP Plus Health Care Strategy and will clearly demonstrate the Government's commitment to increased health promotion, illness prevention and early intervention.

These next steps will include:

- ▶ Development of a GP Plus Health Networks framework to provide direction and guidance to the existing Networks. Metropolitan regional health services will continue to support and resource the ongoing operation of the existing Networks. During 2007–08 the Department of Health will also work with Country Health SA to consider the role GP Plus Health Networks can play in country areas.
- ▶ South Australia's involvement in the National Health Call Centre Network. This service commenced in the southern metropolitan area in July 2007 and is progressively being rolled out across the state. It will be operating statewide by June 2008.
- ▶ Expansion of existing hospital avoidance and discharge programs, including services within country areas, and a focus on palliative care and hospital avoidance and prevention.
- ▶ Increasing the scale of the existing chronic disease management programs, such as diabetes, chronic obstructive pulmonary disease and chronic heart failure programs. Other models or approaches will also be developed to target conditions that are responsive to management in primary health care settings rather than in hospitals. Home tele-monitoring is an example of such a model.
- ▶ Production of Health Improvement Plans by GP Plus Health Networks for their respective geographic populations over the next 12 months.

These plans will be based on a range of population and practice level data and will identify the health needs of the population and the services requirements to meet these needs.

- ▶ Development of the Country Health Care Plan within the 12 months to provide a blueprint of the future health service system in country South Australia. This will cover planning for specific services and population groups, including planning for GP Plus Health Care Centres.

Concurrently, other investigations will be undertaken to identify further innovative programs and initiatives that align with and complement the GP Plus Health Care Strategy.





