

# Practice Integration Coordinator

Denise McKenzie



## New Role at the AWGPN to Help Better Service General Practices in the West

Denise McKenzie has recently been promoted to a newly created position within the Adelaide Western General Practice Network as our Practice Integration Coordinator. This is an exciting / evolving role which will not only integrate our programs internally at AWGPN, but also working on how best we can streamline / Integrate our practice services; therefore ensuring we can respond more appropriately and efficiently to our customers - YOU!

Denise will continue with the overseeing of our GP+ Practice Nurse Initiative and Nursing in General Practice (NiGP) Program. She is happy to continue in this role as practice nursing as it is dear to her heart, and she is proud to be part of the evolution of the expanding role of Practices Nurses in South Australia, especially here in the AWGPN region.

Denise is looking forward to working more closely with ALL our practices in the region; and also hearing from you our stakeholders; on how to promote our various available services and programs.

## The Australian Better Health Initiative (ABHI)

As of July 1st 2006, the Australian Government in collaboration with state and territory governments have begun implementing a five-year, \$500 million national Australian Better Health Initiative package to reduce the impact of chronic disease.

The five priority areas for action are:

### 1. Promoting Healthy Lifestyles

through consistent public messages on health and well-being, through implementing national and state consistent local programs to facilitate and support lifestyle changes.

### 2. Supporting Early Detection of Lifestyles & Chronic Disease

Through a new Well Person's Health Check, available nationally to people 45-49 years old with one or more identifiable risks that lead to chronic disease. The health check will;

- ▶ Recognize patients at risk of developing chronic conditions
- ▶ Provide an opportunity to promote lifestyle changes, for example through Lifestyle Prescriptions (Lifescrpts), or referrals to local community programs.

### 3. Supporting Lifestyle & Risk Modification

through development of seamless pathways to services that assist people wanting to make changes to their lifestyle.

### 4. Encouraging Active Self-management of Chronic Disease

Through liaison and encouragement of general practitioner initiatives and referral to services ranging from group based courses to different forms of counseling.

### 5. Improving Integration & Coordination of Care

This measure will enhance and improve the coordination and continuity of care for people with chronic diseases to promote a more flexible, innovative and tailored support to people with chronic conditions.

continued page 9 ▶

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◀ continued from page 8

## Primary Care Integration Program (PCIP)

The national overarching aim of the ABHI Primary Care Integration Program is to encourage and endorse solutions to primary care collaboration between general practice and other local health providers that will support the delivery of more cohesive and 'seamless' patient care.

Adelaide Western General Practice Network through its Practice Integration Coordinator and CDM team encourages general practice to:

- ▶ **Incorporate integrated primary health care into their core business**
- ▶ **Work at multidisciplinary partnerships and the use of General Practice Management Plans (GPMPs), Team Care Arrangements (TCAs), condition specific action plans and seamless referral pathways.**
- ▶ **Strengthen and consolidate communication channels, information sharing and collaboration between community health, allied health, acute and primary care sectors so that patients receive more streamlined timely care with better health outcomes.**

## Chronic Disease Management Program

'Encouraging active patient management practices and self-management' is an identified target area within ABHI.

Adelaide Western General Practice Network has received funding to strengthen the capacity of the existing and future primary care workforce to support chronic disease management (CDM) and self management (CDSM). The networks Chronic Disease Management focus is to:

- ▶ **Encourage and support GP and practices to facilitate holistic approaches to health care provision through the use of Practice Incentive Payments (PIPs) for chronic disease prevention and management, case conferencing, management and action plans.**
- ▶ **Provide opportunities for discussion and promotion of chronic disease prevention and management support**
- ▶ **Facilitate dissemination of new and existing CDM support training, resources and information**
- ▶ **Increase systematic adoption and promotion of self management programs**
- ▶ **Support integration and linkages of GPs and practices with community health initiatives, allied health and acute care services for chronic disease prevention and management.**

Implementation of local chronic disease prevention programs for patients found at high risk of diabetes and coronary heart disease after appropriate assessment that focus on lifestyle and behavioural modification.

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