

2006-2007 Report – Integrated Chronic Disease Management

Across the Shires of Indigo and Towong, the City of Wodonga & the Kiewa Valley of Alpine



Community Health Plan Implementation Agreement
2006 - 2009

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Deliverable 4: Integrated Chronic Disease Management

Hospital Admission Risk Program – Chronic Disease Management (HARP-CDM) for management of people with acute chronic illness. Extensive local data collection has been undertaken and supports a focus on those people who are at risk of hospitalisation due to chronic respiratory conditions, chronic heart conditions and diabetes.

We consider that chronic disease management across the continuum is a catchment wide issue and intend to ensure a streamlined approach by establishing a governance structure that supports the program objectives of both the HARP – CDM and the Integrated Chronic Disease Management goals of the PCP. Our Upper Hume HARP-CDM/ ICDM Alliance has been formed.

Our Participating organisations include:

Wodonga Regional Health Service, Glenview Community Care (Rutherglen), Tallangatta Health Service, Chiltern & District Health Service, Walwa Bush Nursing Centre, Upper Murray Health and Community Services, Beechworth Health Service, Mungabareena Aboriginal Corporation, AWAHS, Upper Hume Community Health Service, Border Division of General Practice, North East Division of General Practice, Alpine Health (Mt Beauty), Indigo Shire and the City of Wodonga.

Goal 4.1 – Map and develop self –management interventions for chronic disease

Complete a mapping of self-management interventions (provided by agencies within the catchment). Facilitate planning processes to develop self-management interventions within member agencies that respond to gaps identified in the mapping process.

Objective	Strategy/Action	Planned Impact	Who	By when	Current Progress – Aug07
4.1.1 To determine the number, type and geographic distribution of self management interventions across Upper Hume.	a) Undertake annually the DHS self management mapping tool in accordance with Community Health Plan reporting guidelines.	Number of completed surveys highlighting numbers, types and geographic distribution of self management interventions.	Each agency PCP follow up	Sept07	Stayed informed of state progress in developing the tool still to be released.
	b) Collate and analyse results of mapping exercise with particular reference to highlighting gaps / duplications	Clarify the location (availability), numbers & types of programs	DHS - collation Analysis PCP	Jan- April 08	Wodonga Regional Health Service has collected some of this with HARP.

Objective	Strategy/Action	Planned Impact	Who	By when	Current Progress – Aug07
4.1.2 Address gaps/ duplications in self management of chronic disease across Upper Hume	c) Undertake consultative process with key stakeholders to identify a response to gaps / duplication in self management interventions.	Appropriate self management interventions are delivered by key stakeholders	Discuss at Alliance PCP - Organiser Facilitator	May08	Discussion at meetings – no work started
	d) Agree on processes to address gaps/duplications in self management interventions	Gaps / Duplications addressed through improved targeting of self management interventions.	As above	May08	Discussion at meetings – no work started
	e) Identify organisation/workforce capacity, opportunities for resource sharing and potential reorientation.	Changes in service delivery options Staff training/ capacity building undertaken	As above Alliance/Agencies	May- June08	Discussion at meetings – ideas provided to Hume Region for consideration in joint workforce development.

Goal 4.2 – Define roles and responsibilities of member organisations in ICDM

Facilitate a process for agencies to define their roles and responsibilities, especially acute and CHS in relation to providing self-management interventions for people with chronic disease.

Objective	Strategy/ Actions	Planned Impact	Who	By When	Current Progress
4.2.1 Support member agencies to clearly define and articulate their roles and responsibilities regarding self management interventions	a. Establish a Chronic Disease Management working group of key stakeholders – clear terms of reference, participation required and commitment to action.	We have partnerships and integration in the delivery of self management interventions across a continuum of care for people with chronic disease.	Alliance with broad membership of agencies	Done	Working group established with Terms of reference.
	b. Encourage and facilitate all programs and services	Accessible and up to date web based information is	PCP – Connecting Care	07 – 08	Consideration given to each sector - search topics in CC

Objective	Strategy/ Actions	Planned Impact	Who	By When	Current Progress
	impacting on CDM to use Connecting Care and register their information on connecting care.	available about local service provision. Agencies info in CC.	Agencies		to support CDM
	c. Build capacity of member organisations and others identified to deliver chronic disease self management interventions. This will include a regular forum and shared professional development.	Our organisations work in best practice models and have staff confident in contemporary self management interventions.	Alliance and PCP Refer 4.1.2e And 4.3	May 08	Planning session rescheduled from May 07 to August 07 – waiting for mapping survey

Goal 4.3 – Implement the Better Access to Services framework

Successful implementation of the Better Access To Services (BATS) framework by progressing common practices, processes, protocols and systems for initial contact, initial needs identification, referral, assessment and care planning by member agencies, particularly as it relates to people with chronic disease.

Objective	Strategy / Actions	Planned Impact	Who	By when	Current Progress
4.3.1 Support member agencies to fully implement the BATS Framework	a) Establish clear and agreed referral pathways for people with chronic disease and complex care issues – COPD, Diabetes, Chronic Heart Failure.	Pathways for COPD, Diabetes and Chronic Heart Failure are clear in each element of service coordination.	Alliance & Divisions of General Practice PCP Service Coordination	Aug08	Implementation of e-referral – key CDM health providers engaged. Supporting Connecting care to work on solution with e-pit which our GPs use.
	b) Implement the new service co-ordination PPPS framework across those working with people who have a chronic disease. Refer to our service coordination (Deliverable 3)	100% of organisations utilising the elements of the Service Coordination tools. Formal agreement is established	PCP Service Coordination	June 08 (check region Eref.plan)	Refer to service coordination goals.
	c) Build capacity to implement	Member agencies can	Alliance	June09	Listed needs for professional

Objective	Strategy / Actions	Planned Impact	Who	By when	Current Progress
	and support the required change management practices. This will include communication, workforce development, mentoring.	demonstrate their participation in BATS.			development – to be scheduled at region and also locally.

Goal 4.4 – Identify and assess people with a chronic condition

Developed and defined local agreements and systems to identify clients with chronic disease who require comprehensive assessment, by working with PCP member agencies, particularly GPs.

Objective	Strategy / Actions	Planned Impact	Who	By When	Current Progress
4.4.1 Increase access to and reduce duplication of comprehensive assessments for people with a chronic condition.	a) Support implementation of the DHS chosen statewide comprehensive assessment tool - InteRAI	Common assessment tool is used by agencies.	Alliance	Following release of DHS tool.	WRHS through HARP have started this process.
	b) Increase use of comprehensive assessment at time of diagnosis.	Early intervention aimed at reducing complications	GP divisions PCP resource	June 08	

Goal 4.5: Identification of people requiring care planning

Developed and defined local agreements and systems to identify clients with chronic disease who require cross disciplinary /multi agency (including GP) care planning, by working with PCP member agencies, particularly GPs.

Objective	Strategy/ Actions	Planned Impact	Who	By when	Current Progress
4.5.1 Improve access to an optimal level of care	a) CDM Alliance Working group will utilise learnings from the Better Links project, Lead Agency project and other relevant sources to identify appropriate and effective levels of care planning. Research level and matrix	Care planning methods are identified	Alliance PCP + Research	Feb08	Better links project completed. <i>Recommendations informing work with Diabetes type II pathways.</i>

Objective	Strategy/ Actions	Planned Impact	Who	By when	Current Progress
planning for people with chronic disease.	of care planning requirements.				
	b) Develop and implement local agreements for best practice service coordination (BATS framework) for care planning arrangements across all settings. c) Increase use of written care plans.	People have timely access to relevant levels of care coordination.	Alliance	Dec 08	Commencement of HARP 2006-2007. Border Division has supported forums and education to Practices to implement Enhanced Primary Care items.

Goal 4.6: Initiating and co-ordinating care planning

Developed and defined local agreements and systems around initiating and coordinating care planning for people with chronic disease by working with PCP member agencies, particularly GPs.

Objective	Strategy/ Actions	Planned Impact	Who	By when	Current Progress
4.6.1 To implement an integrated system of care planning (see 4.5.1) for people with chronic disease and complex conditions.	a) Develop knowledge and skill of care planning in a client centred approach across our organisations/stakeholders.	Increased consistency of care planning using evidence based best practice	PCP to organise with Alliance	June08	Border division continuing education and support in using GP team care arrangements. Better Links project informing next steps.
	b) Implement care planning arrangements with all key stakeholders including private providers, GPs and allied health providers.	Increase use of care plans Increased uptake of MBS Team Care Arrangements	PCP Divisions of General Practice	June08	In planning phase with Border Division to support GPs, practice nurses and diabetes educators in this work.
4.6.2 Care plans are client/person centred	a) Establish policy and practice to ensure people with chronic and/or complex care needs are involved and empowered in all aspects of their care planning (self-management approach).	Provision of responsive person- centred care. Evidence of client involvement in care planning	Agencies PCP	March 08	Identified learning needs for professionals.

Goal 4.7 An equity approach to addressing health inequality

Strengthened approaches to address disadvantage and health equality in IHP, including barriers to participation such as chronic disease.

Objective	Strategy/ Actions	Planned Impact	Who	By When	Current progress
4.7.1 Build the capacity of our organisations to include an equity approach across planning, implementation and evaluation of programs for people with chronic and complex conditions.	a) Train and support organisations to implement an equity lens to the planning and delivery of self-management interventions to reduce barriers to participation across ICDM service models.	Number of organisations and staff trained and using an equity lens	WHGNE PCP	Dec 07	Women's Health Goulburn North East working with UHPCP agencies on equity approaches in practice
	b) Identify disadvantaged people who are not accessing services	Increased understanding of groups not being reached and barriers	Alliance PCP	Dec 07	Women's Health Goulburn North East working with UHPCP agencies on equity approaches in practice
	c) Include in our models of care strategies to address the barriers	Increased reach	Agencies	Dec 07	Women's Health Goulburn North East are developing a package of tools to support organisations to incorporate culturally specific needs into policy and planning. Aboriginal Impact Policy and Practice Reference group being established. Health Promotion working group is working on this also.
4.7.2 Qualitative evaluation from service users.	a) Develop and deliver an evaluation of a clients journey through our system of care	Clients/consumers report clear pathways and feel empowered in their management of their disease.	Student Agency PCP	07 08 09	HARP utilised one volunteer client to 'test' the model of care and provide feedback. Some changes were made to processes as a result of this close consultation/case study.