Upper Hume PCP
Integrated Chronic Disease Management Plan
2009-2012

Operational Plan 2009-2012

(incorporating the Evaluation Plan)

Compiled by:
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Acknowledgements

This plan has been developed form the input of many individuals. The input from staff at the following organisations at planning sessions and other forums is gratefully acknowledged.

- Advance Your Business
- Albury Wodonga Health – Wodonga Campus (formerly Wodonga Regional Health Service)
- Albury Wodonga Regional General Practice Network
- Alpine Health
- Beechworth Health Service
- City of Wodonga
- Department of Health (formerly Department of Human Services) ICDM Industry Advisors
- Gateway Community Health
- Indigo North Health
- Indigo Shire
- North East Victoria Division of General Practice
- Tallangatta Health Service
- Upper Hume Primary Care Partnership
- Upper Murray Health and Community Service

Background

It is well known that the burden of chronic disease is increasing at a rapid rate, and putting huge pressure on our health care system. In Victoria, approximately 70% of the total burden of disease is attributable to six groups: cardiovascular disease, cancers, injuries, mental health conditions, diabetes and asthma (DHS 2008). Our primary health care system must be able to respond in an appropriate and cost effective way to this challenge. This includes prevention, early detection and proactive management of chronic disease. Funding has been provided to Primary Care Partnerships (PCPs) and primary health care services, to support them to develop planned, managed and proactive care for people with chronic disease. PCPs will play a key role in bringing together health service providers and other key stakeholders to work towards a coordinated, integrated health care service for people with chronic disease. The service will be underpinned by the Expanded Chronic Care Model (see Appendix One) and utilise the service coordination elements as described in the Victorian Service Coordination Manual to ensure that clients receive the right service, in the right place, at the right time.

The Planning Process

The ICDM Plan 2009-2012 has grown out of the achievements and lessons learnt from the 2006-2009 Plan. It is informed by key documents from the Department of Human Services (DHS) and other Victorian agencies who are leading chronic disease service re-design.

Expected outcomes for PCPs to achieve in ICDM are set out in the Primary Care Partnerships Revised Program Logic July 2009 (see http://www.health.vic.gov.au/pcps/downloads/programlogic.pdf). This document details outcomes, objectives, processes, DHS expectations and DHS inputs and has formed the basis for the development of our ICDM priorities. One of the deliverables for 2009-2012 is the completion of the ICDM Questions in the Service Coordination Survey. So ensure agencies continue to progress the areas targeted in the survey, the ICDM components of the survey has also been embedded into the plan.
The survey is available at
http://www.health.vic.gov.au/pcps/downloads/icdm_survey_questions.pdf.

An ICDM Planning day was held on the 20 April 2009. Twenty one (21) participants from 13 key agencies within Upper Hume PCP (UHPCP) attended. The day was independently facilitated to ensure that an independent, non-biased facilitation process occurred. A DHS Industry Advisor attended to ensure consistency with Departmental expectations, while the PCP Service Coordination Project Officer ensured that planning incorporated a strong service coordination component (see acknowledgements at the beginning of this plan).

The aim of the planning day was for the participants to:

1. develop clear priorities to work on for the next three years; and
2. to examine the governance and change management structure in which to progress the ICDM priorities across the PCP.

Planning Day Outcomes

1. UHPCP ICDM Priorities

From the planning day the following vision and priorities were developed:

1. Achieve a shift in thinking in chronic disease from acute service models to the expanded chronic care model in:
    - Clients
    - Staff
    - Community
    - GPs
    - Management

2. Establish clear, integrated, flexible, well resourced, evidence based client (self management) pathways
3. Establish clear assessment and care planning with one aim being to reduce assessment duplication
4. Establish Outcome Measures that demonstrate quality chronic disease management and client outcomes

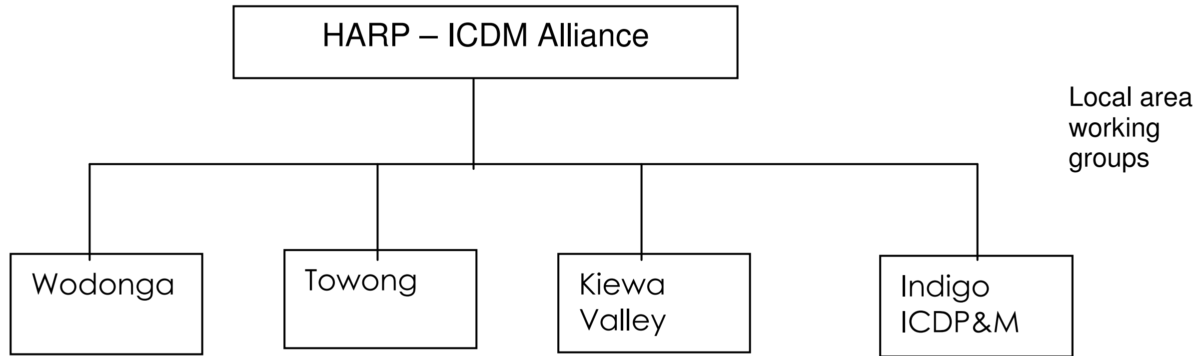
2. UHPCP Governance and Change Management Structure

To date ICDM Work in the Upper Hume PCP has been overseen by the HARP ICDM Alliance. The Alliance was set up, and remains a requirement under HARP funding. The Alliance membership comprises Senior Managers of Health Services, HARP, DHS, GP Divisions, the PCP EO and ICDM Project Officer. Mungabareena Aboriginal Corporation and Local Government are also represented.

An UHPCP ICDM Working Party was established in 2008, to action PCP deliverables from the 2006-2009 ICDM Plan. The working party comprised clinicians and program managers from key stakeholder organisations across the PCP and was chaired by the UHPCP ICDM Project Officer. The working party functioned well for networking and resource sharing, but was unable to move beyond this role due to the geographical, resource and service differences across the PCP.

A decision was also made to trial working parties in each Local Government Area (LGA). The new working parties will be formed in Indigo, Wodonga, the Kiewa Valley of Alpine and Towong. The HARP ICDM Alliance will continue to meet bi-monthly and retain its functions of:

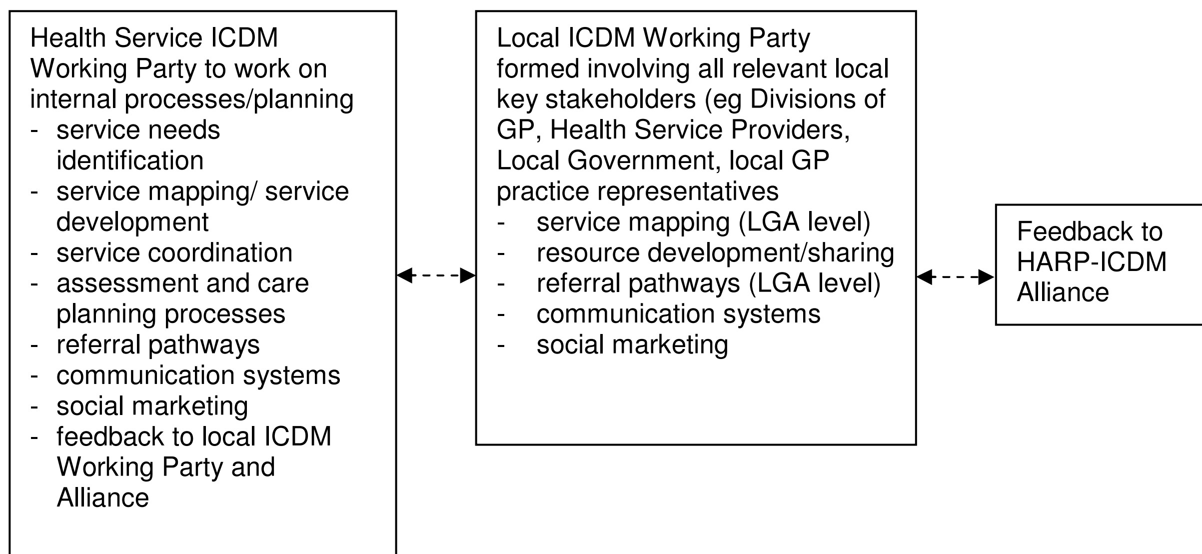
- Lead agency Albury Wodonga Health- Wodonga Campus;
- Overseeing the ICDM plan;
- Supporting Working Group activities;
- Education - ↑ knowledge re ICDM;
- Governance of HARP-ICDM.



The roles of the LGA groups will be to:

- Plan and deliver on ICDM priorities (as appropriate for local needs and resources);
- Use of tools to track and report back to the Alliance;
- Each local area will decides on membership - suggest key membership;
- Nominate local champion/s that will attend the Alliance.

In order for ICDM to progress at an LGA level, agencies who have a key role in delivering services to clients, who have chronic conditions, will need to review and ensure their own internal processes align with best practice ICDM and statewide expectations, as outlined in relevant Department of Health policy and guidelines, and the PCP ICDM Program Logic. It is recommended that this be done via agency ICDM working groups. Effective chronic disease management needs to be supported by sound service coordination. It is important that staff who play a key role in service coordination are involved in chronic disease service development.



Capacity Building and Resources.

To assist the LGA groups in remaining on track with the PCP priority areas, the ICDM project Officer will attend the LGA meetings. The Project Officer will also be available as a resource to each group to link them with external resources and projects as required.

The Project Officer will also be responsible for organizing three PCP wide events each year, to bring together members of each working party to network, share resources and stories, look for opportunities to work together and to enhance each others capacity to undertake ICDM. Where appropriate these will involve other relevant deliverable areas, in particular service coordination.

A number of tools are available to support agencies in re-orientating their services towards best practice chronic disease management. The Upper Hume PCP would like to acknowledge and thank the authors of these documents for their generosity in sharing them for our use.

- The Whitehorse Division of General Practice's "Navigating Self Management", cited on 20 August 2009 at http://som.flinders.edu.au/FUSA/CCTU/pdf/Navigating_self_management%20March%202008.pdf - gives a practical approach to implementing self management into chronic disease services.
- "Organisational Skills Analysis Tool - Chronic Disease Care" by Gill + Wilcox is an excellent audit tool to assist agencies in chronic disease service planning.
- The "Self Management Assessment Tool for Community Organisations" also developed by Gill + Wilcox is another organization self assessment tool, which focuses more specifically on embedding self management principles across the health service.

The above tools, along with the ICDM project logic and ICDM questions from the Service Coordination Survey have been used to develop each of the indicators outlined in the tables below.

Evaluation and Dissemination Planning

ICDM Priority Goal 1	Achieve a shift in thinking in chronic disease from acute service models to chronic disease self management service model			
Population target group/s	**Health Service Management**			
Objective	**Strategy**	**Indicators**	**By when?**	**Resources**
1.1 The agency supports best practice chronic disease management/self management services	The agency: ▪ has a vision for chronic disease management/self management services which is supported by agency policies and plans; ▪ allocates appropriate resources and time to the development and provision of chronic disease management/self management services; ▪ has identified and sourced available data about health needs/status of individuals/communities and at risk populations; ▪ collated a profile of the existing services to identify needs and set priorities; ▪ has used interdisciplinary collaboration to develop work plans with clear objectives, agreed timeframes and specified team member roles. (Note this may include disease specific work plans); ▪ supports team members involved in chronic disease/self management services to participate in chronic disease related committees, working parties and professional activities; ▪ Provides opportunities for team members to access relevant professional development activities/resources and expand their individual skills.	Agency policies/plans Minutes of meetings/planning sessions, budget reports, staff diaries, professional development records Collated data/reports Community profiles/reports Minutes of meetings/agency work plans Minutes of meetings, staff diaries Professional development records	Dec 2009	Staff and management time $ for resources & professional development
1.2 The agency provides a welcoming, culturally appropriate and non judgemental environment tailored to meet the needs of the individual (see Wagner Model with Equity Lens).	▪ Team members are sensitive to cultural beliefs and the social and economic circumstances of individuals; ▪ Information/education is provided in a variety of formats and structured to suit different learning styles, literacy levels; ▪ Information is provided in appropriate languages and interpreters are used as per organizational policies; ▪ Individuals are provided with consumer friendly versions of best practice guidelines. ▪ Client and family/others are listened to, respected and treated as partners in care. ▪ Tools are available to clients to record and monitor their condition and self management	Cultural awareness training Making Two Worlds Work Audit Audit of client resources Organisational policy Evidence of resources in appropriate languages, use of interpreters Audit of client resources Evidenced in assessment documentation Client monitoring	Dec 2010	Staff and management hours $ for resources & professional development

	activities. • Clients have full and easy access to their paper/ electronic record.	tools/resources Organisational policy and procedure		
1.3 The agency has well developed communication systems for sharing client information across the organisation	▪ Client organisation has system/s for sharing client information across the organisation ▪ Clients have systems in place for self monitoring and self managing their chronic health condition	Single client file Integrated e-database Client hand held records Individually tailored client monitoring systems.	Dec 2010	Staff/ Management hours $ for resources
ICDM Priority Goal 1	**Achieve a shift in thinking in chronic disease from acute service models to chronic disease self management service model**			
Population target group/s	**Health Service Staff**			
Objective	**Strategy**	**Indicators**	**By when?**	**Resources**
1.4 Cultivate desirable expertise in the coordinator/manager role.	Chronic disease services have a project coordinator/manager with academic and/or experiential preparation in program management.	Position description/s	Dec 2009	Staff/ Management hours Position descriptions
1.5 Ensure staff have a clear focus on the self management model.	Team member job roles are defined and performance expectations clearly articulated (for example in work plans/position descriptions) and in line with vision and mission statement (see 1.1)	Work plans/position descriptions	June 2010	
1.6 Ensure core chronic disease care is provided by a multidisciplinary team with members who have appropriate qualifications, recent experience and knowledge in chronic disease conditions.	Team members are competent in: ▪ Describing the factors involved in the development of chronic disease, the disease process and treatment options (within the boundaries of evidence base) to clients ▪ Educating clients on the interrelationship between nutrition, exercise, stress, smoking, medications, and encouraging healthy living in clients with a chronic disease. ▪ Discussing the client's role in managing their condition along with health risk and benefits of change. ▪ Assessing and providing information appropriate to the client readiness to change ▪ Providing information to clients on how to prevent (through risk reduction behaviour), recognize and treat short and long term complications ▪ Educating clients to set their own goals to promote health, and problem solving for daily living ▪ Empowering clients to develop strategies for dealing with the emotional and social impact of a chronic disease ▪ Providing information to clients in a format they can identify with. ▪ Utilsing group facilitation strategies to enhance skill development, self management skills and peer support.	Staff position descriptions Staff professional development record Evidence of staff qualifications/ registration Self management Audits Client resources Chronic disease management program outlines. Health coaching mentoring group (support for applying training to practice)	Dec 2010	Staff hours $ for resources professional development & professional support

	▪ Providing information about other disease specific services such as Diabetes Australia, Asthma Victoria, Arthritis Victoria, and National Stroke Foundation and local support services (eg Support Groups, walking groups, community service groups, Men's Shed)			
ICDM Priority Goal 1	Achieve a shift in thinking in chronic disease from acute service models to chronic disease self management service model			
Population target group/s	General Practice			
Objective	**Strategy**	**Indicators**	**By when?**	**Resources**
1.7 GPs/GP staff & other community based services/organizations are aware of chronic disease management services across the LGA and refer clients to services on a regular basis	▪ Collate data on available chronic disease management services, and out into a user friendly format (may need to consult with target audience on what the best format is) ▪ Audit general practice referrals (and other key referral agencies if appropriate) to determine which GPs/agencies do not refer clients and where appropriate strategies to market services and promote communication can be implemented ▪ Audit feedback from health services back to referring agencies to determine - Level of feedback - Content of feedback - Frequency/timeliness of feedback ▪ Implement quality improvement measures as required (e.g. policies, procedures, communication/feedback templates)	Resources to inform GPs of services, evidence of GP engagement Referral Audits Audits of feedback from health services to general practice Policies, procedures, communication/feedback templates	June 2011	Staff hours Division of General Practice Staff Hours Administration Support
ICDM Priority Goal 1	Achieve a shift in thinking in chronic disease from acute service models to chronic disease self management service model			
Population target group/s	Community/Clients			
Objective	**Strategy**	**Indicators**	**By when?**	**Resources**
1.8 Self management is promoted to clients 1.9 Programs and interventions offered by the service actively support consumer/ peer involvement	Information provided to clients is consistent with and provides support for self management ▪ Programs are offered in community settings. ▪ Mechanism and systems are in place to ensure community participation and input into chronic disease program needs identification, planning, monitoring, evaluation and resource development. ▪ The needs of specific cultural and other minority groups, particularly those defined as "at	Client resources/program outlines Program information Minutes of meetings/planning sessions/focus groups Community consultation reports, evaluation reports	June 2011	Staff hours Self management training Consumer reps/consumer groups

	risk" are identified and participation by these groups in service development is actively promoted. ▪ Consumers are involved in program delivery/support programs.	Program plans, support program information. Chronic disease volunteer/s		
ICDM Priority Goal 1: Impact evaluation • Chronic disease health service provision is modelled on (and can be mapped to) the expanded chronic care model				
ICDM Priority Goal 2	Establish clear, integrated, flexible, well resourced, evidence based client (self management) pathways			
Population target group/s				
Objective	**Strategy**	**Indicators**	**By when?**	**Budget**
2.1 Self management pathways are established at an Agency level	Intake staff and staff working with clients who have chronic conditions have a good knowledge of chronic disease management services, both internally and available outside their organization. Chronic disease management services and their referral criteria are documented in a clear, easy to follow format The agency has clear protocols for Initial Contact/ Initial Needs Identification and can: • determine eligibility for the service • identify individuals at high risk • ensure those at high risk are referred and care prioritized appropriately within the service • refer individuals not eligible for the service to appropriate resources • ensure referrals from other agencies are acknowledged (receipt of referral) and informed of outcome of referral. Clinical care protocols, pathways and decision support tools are documented in line with evidence based guidelines and demonstrate; • systems for routine monitoring of progress and review of goals • systems for proactive re-call of consumers not currently receiving care • simple systems for consumer re-entry and crisis support Services to support health behavior change are available (within /or across agencies) in a range of formats (individual and group) to meet individual needs, circumstances and capabilities of individual clients.	Care pathways (internal and external Documented information on services Documented intake (IC/INI) procedures Documented prioritisation (demand management) tools Intake/Single Point Entry data Audit of client medical records Systems/procedures for client review, recall, re-entry and crisis support Benchmarking of systems with evidence based guidelines. Self management services available in group and 1:1 formats.	Dec 2011	Staff hours Information on internal/external services Staff hours (clinical & intake) Service coordination expertise Staff hours Patient information systems Best Practice Guidelines Staff time Self management training
2.2 Self management pathways are established	The agency seeks to work cooperatively with other organisations to • Problem solve in gaps/duplications in chronic disease management programs	Participation in Harp ICDM Alliance	Dec 2011	Staff hours Admin

at an Inter agency level	• develop interagency agreements on structured referral pathways to services available outside the organization, including programs which support the maintenance of lifestyle changes • broaden availability of self management programs. • Develop systems to ensure effective communication (e.g. Connectingcare) of client information/record within the organisation and between external providers • ensure key partners are involved in the development of new services and/ or products. • undertake social marketing of chronic disease services/ self management programs	Participation in LGA working groups Documented client referral pathways for clients with chronic disease (condition specific and generic), which include internal and external services as appropriate. Documented demand management tools and processes Evidence of marketing of services, media relationships		resources Connecting care Marketing skills

ICDM Priority Goal 2: Impact evaluation

- **The agency will have documented referral criteria for chronic disease services**
- **The agency will have documented client referral pathways for clients with chronic disease (condition specific and generic if appropriate) which include internal and external services as appropriate.**
- **The agency will have demand management tools and processes.**

ICDM Priority Goal 3	Establish clear assessment and care planning with one aim being to reduce assessment duplication			
Population target group/s				
Objective	**Strategy**	**Indicator**	**By when?**	**Resources**
3.1 Clear assessment processes are established which reduce assessment duplication within the agency.	The agency has examined assessment items for particular chronic condition/s, and has clearly documented processes which minimise assessment duplication. Assessment is based on the participation of the individuals with chronic disease, their support systems(s) and interdisciplinary team members. Assessment items are documented in a standardised form, based on best practice standards, and identify • Needs beyond the presenting issue • Key medical, functional, lifestyle (including lifestyle risk factors), social and psychological information to reflect a comprehensive picture of consumer/family/carer strengths, resources and problems. • Client self management needs and activities including: beliefs, behaviours, knowledge, skills, confidence, strengths and barriers	Minutes of meetings, assessment processes, assessment-related documents. Assessment documents	Dec 2011	Staff time Evidence Based Practice Guidelines Examples of assessment items

	• Client stated issues/problems			
3.2 Clear Care Planning processes are established which reduce assessment duplication within the agency.	The agency has clear and documented processes for care planning of all individuals with a chronic disease attending the agency. Service specific or intra-agency care plans: ▪ are documented in a standardized format for all clients with a chronic condition ▪ are developed collaboratively with individuals(s) with chronic disease, their support systems(s) and interdisciplinary team members ▪ documents who is participating in the plan and their assigned responsibilities ▪ use collaborative goal setting based on the client's confidence in their ability to make change. ▪ allow for management options to be discussed with the client and the agreed issues/problems/risk profile, client concerns smart goals, strategies and actions to be documented ▪ identify appropriate resources/programs that will support self management ▪ document specific follow up plans, including referral to other providers, information supplied and review dates ▪ documented consumer acknowledgement A copy of care plan and follow up plan is: ▪ provided to the client. ▪ effectively communicated to others involved in the clients care ▪ documented in the client's medical record	Care planning procedures Client medicals records Client care plans Medical record/care plan audits	Dec 2011	Staff hours SCCT tool Information on locally available resources/supports
ICDM Priority Goal 3: Impact evaluation ▪ **The agency has documented, streamlined processes which indicate key assessment and care planning points.** ▪ **Clients presenting for care with particular chronic diseases which require a multidisciplinary approach have streamlined assessment process to minimise assessment duplication.** ▪ **Assessment and care planning items can be easily identified in the client medical record.**				
ICDM Priority Goal 4	**Establish Outcome Measures that demonstrate quality chronic disease management and client outcomes**			
Population target group/s				
Objective	**Strategy**	**Indicators**	**By when?**	**Resources**
4.1 The agency (with partner agencies where	**Process evaluation** Outcome measures may include data which demonstrates that:	Documented outcome	June	Staff hours

appropriate) will decide upon client data to measure outcomes of chronic disease interventions.	• early detection of risk factors for chronic disease complications occurs • Individuals with chronic disease attending the service report or demonstrate increased ability to accomplish goals for healthy living with chronic disease that are important or meaningful to them and consistent with their desired quality of life. • Individuals with chronic disease report or demonstrate increased confidence in managing their chronic disease, including using resources to prevent complications. • There is improved physiological control of their chronic disease as demonstrated by relevant biochemical markers and appropriate behaviour change. • emergency and other hospital admissions related to preventable complications are minimized • length of hospital stays related to chronic disease complications is minimised.	measures data is determined by the agency. Methods for data collection are embedded into client assessment, monitoring and review processes	2011	Clinical indicator information Best practice Guidelines
4.2 The agency will set up systems that ensure continuous quality improvement.	Systems are put in place to routinely collect and analyse outcome measure data for clients with chronic conditions Quality management systems are established to ensure continuous quality improvement.	Systems for routinely retrieving and analyzing data are established Data is regularly reviewed for quality improvement/reporting purposes.	Jun 2012	Input from Quality Staff.

ICDM Priority Goal 3: Impact evaluation

- The agency will have clearly defined outcome measures
- The agency will have systems in place for routine collection, monitoring and evaluating chosen outcome measures.

Preparation of evaluation report	Key contacts within UHPCP agencies are responsible for collection and provision of relevant data to the ICDM Project Officer. The ICDM Project Officer for the Upper Hume PCP is responsible for collating evaluation findings and developing evaluation report
Dissemination	Annual evaluation reports will be disseminated to all relevant stakeholders and the Victorian Health Department Hume Region Office

References

- DHS Primary Health Branch, "Primary Care Partnerships Revised Program Logic July 2009" cited on 21 September 2009 at http://www.health.vic.gov.au/pcps/downloads/programlogic.pdf

- DHS Primary Health Branch, "Revised Chronic Disease Management Program Guidelines for Primary Care Partnerships and Primary Health Care Services", October 2008 cited on 20 August 2009 at http://www.health.vic.gov.au/communityhealth/downloads/cdm_program_guidelines.pdf

- DHS Primary Health Branch, "Service Coordination and Integrated Chronic Disease Management (ICDM) Survey 2009" cited on 21 September 2009 at http://www.health.vic.gov.au/pcps/downloads/icdm_survey_questions.pdf

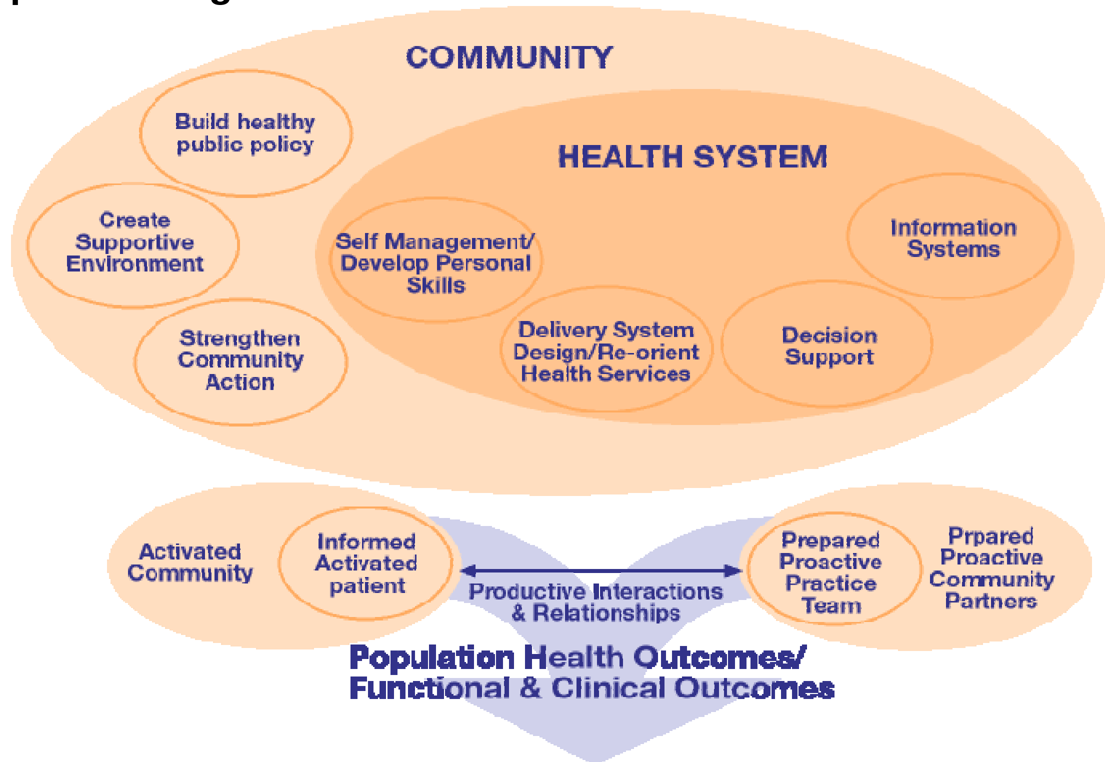
- Gill + Willcox, "Organisational Skills Analysis Tool - Chronic Disease Care" available by contacting Marie Gill : marie@gillandwillcox.com.au

- Gill + Willcox, North Central Metro Primary Care Partnership, "Self Management Assessment Tool for Community Organisations", available by contacting Marie Gill : marie@gillandwillcox.com.au

- The Whitehorse Division of General Practice's "Navigating Self Management", cited on 20 August 2009 at http://som.flinders.edu.au/FUSA/CCTU/pdf/Navigating_self_management%20March%202008.pdf gives a practical approach to implementing self management into chronic disease services.

Appendix One

Expanded Wagner Model of Chronic Care



Created by: Victoria Barr, Sylvia Robinson, brenda Marin-Link, Lisa Underhill, Anita Dotts & Darlene Ravensdale (2002)
Adapted from Glasgow, R., Orleans, C., Wagner, E., Curry, S., Solberg, L. (2001). Does the Chronic Care Model also serve as a template for improving prevention? The Milbank Quarterly. 79(4), *and* World Health Organization, Helath and Welfare Canada and Canadian Public Health Association. (1986). Ottawa Charter of Health Promotion.