



CHRONIC DISEASE MANAGEMENT FORUM OUTCOMES REPORT

PREPARED BY:

THE REGIONAL DEVELOPMENT COMPANY



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Contents

| | |
|--|-----------|
| INTRODUCTION..... | 3 |
| REFLECTION | 4 |
| What is currently working?..... | 4 |
| What is not working? | 5 |
| What could be done better?..... | 6 |
| Any new ideas? | 8 |
| VISION..... | 9 |
| INTEGRATION APPROACH | 10 |
| Partnership | 10 |
| Partnership (continued) | 11 |
| Understanding Consumer Needs..... | 11 |
| Understanding Consumer Needs (continued)..... | 12 |
| Partnering With Consumers..... | 12 |
| Partnering With Consumers (continued)..... | 13 |
| Coordinated and Planned Care | 13 |
| Coordinated and Planned Care (continued) | 14 |
| Self-Management Support..... | 14 |
| Self-Management Support (continued) | 15 |
| Health Promotion | 15 |
| Health Promotion (continued) | 16 |
| Targeting Subgroups | 17 |
| Targeting Subgroups (continued) | 18 |
| Planning for Success | 18 |
| Planning for Success (continued) | 19 |

The Regional Development Company Pty Ltd
PO Box 25
Wangaratta VIC 3676

Ph: 03 5722 2207
Fax: 03 5722 2507
Email: rdc.office@regionaldevelopment.com.au
Web: www.regionaldevelopment.com.au



INTRODUCTION

On 29 May 2008, member agencies representatives from across the Goulburn Valley Primary Care Partnership met to consider the integrated management of chronic disease in the Goulburn Valley. Representatives from the Department of Human Services Integrated Chronic Disease Management Primary Health Branch were active participants in the workshop.

The workshop purpose was to:

- Reflect on what is currently working, not working and what could be done better;
- Gain an understanding of what integrating chronic disease management across Goulburn Valley will require;
- Develop a short term vision for Goulburn Valley Primary Care Partnership for tackling an integrated approach to chronic disease management;
- Identify an approach for integrating chronic disease management across Goulburn Valley.

This report summarises the information generated by the workshop participants.



REFLECTION

Forum participants considered what is working, what is not working and what could be done better for the way in which chronic disease management occurs across Goulburn Valley currently as well as identifying some new ideas.

What is currently working?

Programs / services

- Individual home visits for clients with COPD and / or CHF – these provide education to clients and carers
- Exercise group reaches out to small communities e.g. Tatura and Rushworth
- HARP – DMT
- Organisations in Goulburn Valley delivering high standard services
- Excellent intake processes
- Diabetes education and support group
- Diabetes self management program
- Central intake
 - Better idea of clients walking in the door
 - Early identification of clients with chronic diseases
 - Optimising opportunities to integrate care of people with chronic diseases
- Services providing good programs
- May excellent programs
- Individual client services, the implementation model
- Cardiac rehabilitation program – service model works
- SACS / HARP programs
- Individual hospital discharge planning

Communication

- Open, asking approach of the PCP
- We do talk about how to do it better
- Shared allied health between Cobram and Yarrawonga
- PCP newsletter was working
- Collaboration across agencies and sharing of client care
- Alliance conversations
- Partnerships / networking

Commitment to process and commitment of staff

- High quality expertise diabetes services at Goulburn Valley Diabetes Service
- Good attendance today = commitment to move forward
- Dedication of staff to change in regard to chronic disease management
- Personal care



- That agencies sent representatives to today's forum
- Commitment of staff

Training

- Health coaching
 - As capacity building of allied health
 - As a method of working with people with disease
- Well trained and skilled HACC assessment staff
- Training for chronic disease management e.g. Flinders Model

Other

- I have no idea what is working

What is not working?

Integration and communication

- Lack of shared skills, knowledge and expertise
- Ownership at service worker level
- Individual service approach
- Many programs with "same themed" objectives and required outcomes - ? ability to join – politics / funding areas
- Not utilising demographics in planning

Referral and communication

- GP's not responding well with referrals to exercise groups for Tatura and Rushworth
- GP referrals to healthy living course low
- Referral process
- Streamlining
- Appropriateness of referrals

Symptoms of impaired service delivery

- Not able to recruit dietetics services for home visiting
- Respite
- "Early" management of chronic disease
 - Who is identifying it?
 - Are they referring on?
- Waiting lists for various services
- Identification of needs / service gaps for individual clients
- No central system / register of clients in Moira Shire with chronic disease
- Multi session diabetes programs / courses
- GP engagement
 - Some using MBS item numbers
 - Some not



- Some using total care plans
- Others not
- At times decreased referrals to services not linked to MBS item number
- 50% communication breakdown which causes referral and impaired service delivery

Other

- Discharge planning at hospital not adequately dealing with chronic disease clients (frequent flyers)
- Lack of local sharing of knowledge / skills
- Cross communication between services to offer complete and total services
- GP engagement on self-management of diseases
- PCP working parties have limited value
- Silos of health care
- Failure to integrate all players e.g. GP's, HACC, client
- Lack of planning and coordination
- Collaboration between agencies needs improvement
- Poor history of partnership between some key agencies
- Members need to get engaged

What could be done better?

Consumer engagement

- Viewing the health care continuum from the consumer perspective

PCP involvement

- PCP leadership in chronic disease (great start today)
- Members need to participate
- Need clear direction / strategy for the PCP's to work

Resources to deliver

- Resources / programs have to reach rural communities (Moirra / Strathbogie)
- Rural health team access to services in small rural communities
- Need resources and planning to cope with an ageing population

Funding

- Funding at CHC level by DHS
- Funding for planning by DHS
- Specific funding to small rural health services to support chronic disease management
- Resources for prevention and health promotion

Health promotion

- Health promotion and community education at local level – GP versus community versus CHCs versus HS



GP engagement

- GP referral to exercise groups
- GP input to home action plans for CHF and / or COPD
- GP understanding of self-management (state-wide and national issues etc)

Identifying service gaps

- Need a good understanding of region-wide service gaps and issues

Integration

- Structure of communication where resources, ideas and training can be shared
- Planning integration
- Always communication

Better linkages

- Linkages between services
 - HACC
 - Discharge planning
 - CHC
 - "Specialist" services such as HARP
- Pathways
- Communication of programs
- Linking
- MHA communication mechanism with local health promotion / treatment services
 - Cobram
 - Yarrawonga
 - Numurkah
 - Nathalia
- Adopting a whole of catchment approach to ICDM
- Better communication with specialist sources e.g. knowing when they are visiting
- Working with other agencies on the same projects

Assessment tools / identification

- Assessment – particularly initially and referral pathways

Better use of expertise available

- Sharing of expertise staff

Care planning and care sharing

- Inter-agency care planning and referrals
- Cross referrals between services
- Coordination between health discipline specific services and non-specific self-management supports



Any new ideas?

Access to services

- Better access to community transport for specialist appointments
- Transport is going to be an issue in the future
 - Lack of community transport
 - Cost of petrol
- Stay connected through integrated education opportunities
- Regional / catchment based training, networking

Keeping it local

- LGA based chronic disease specialised units
- Need for local referral pathways to be identified
- DHS funding for central intake
- Identifying a way of nominating “local care planner” agency for those clients not yet eligible for HARP
- More proactive approach to deliver services where people live (more an association than an idea)

Service development

- Rehabilitation style services in an outpatient setting to foster effective and sustainable self-management
- More in-home support for physical activity
- Funded case managers for people with chronic diseases
- Employ PCP workers to run programs over a number of agencies to support smaller agencies

Capacity building

- Training of staff in CDM to meet service gaps e.g. self-management group programs, CHC, local support
- Motivational interviewing and / or health coaching for all allied health staff – a new way of working with clients
- Training
- Projects supported by universities
- Leverage combined expertise of rural health school (Melbourne University?)
- Numurkah showing a better way to a healthy life, healthy communities project
- New 2008-2011 project

IT support

- A database of available services including
 - Target population
 - Goals of intervening
- Shortly computerisation must be at a level that allows better health outcome pathways
- Implement GRANITE or other web-based medical information sharing system



VISION

Our Vision

By 2010, Integrated Chronic Disease Management across the Goulburn Valley will mean we have a partnership between the consumer and service providers to deliver the right care in the right place at the right time.

Indicators of success in achieving this vision will be:

- All stakeholders including general practitioners are engaged;
- All stakeholders have an agreed common approach to consumer assessment and care planning;
- Appropriate direct client care is occurring in the right place at the right time;
- Information, resources and knowledge are being shared;
- There is equity in access and outcomes for consumers.



INTEGRATION APPROACH

| Partnership | |
|--|--|
| <p>Are we organised for success? How far are we prepared to go?</p> | <ul style="list-style-type: none"> ● Organised for success: <ul style="list-style-type: none"> ○ Better prepared than 5 years ago but communication still needs to be improved ○ Have a framework for success but it needs to be a bit better coordinated ○ Organisations and partners have acknowledged that chronic disease management is required and that they need to look at themselves and what support they need to become better service providers ○ Have the motivation, willingness to work in partnerships, networks and are taking the first steps ● Not organised for success as: <ul style="list-style-type: none"> ○ Aging population will continue to place demands on current services ○ There is not enough collaboration ○ Services are working in silos ○ Health and clinical services not clear in regard to change management ○ Not all stakeholders engaged ● Prepared to go as far as: <ul style="list-style-type: none"> ○ Key players are willing to participate in change ○ Organisations are prepared to network and collaborate and share information but need to take next step with a strategic focus ○ Funding a new assessment approach ○ Changing funding to support new models and collaborations ○ Develop a common goal, plans, have objectives, timelines, pooled resources, strong network, continued support and sustainability ○ Undertaking major changes ○ Synchronising activities ○ Increasing level of shared resources ○ Analyse what capacity needs to be built and how to build it ○ Establishing a workable working plan then expand over time and improve after evaluation ○ Delivering right care, right place at right time that is client centred and client driven and equitable |



| Partnership (continued) | |
|--------------------------------|---|
| | <ul style="list-style-type: none"> ○ Agreement to use processes and tools across all services ie SCOT tool ○ Creating dialogue between providers at a local level and then between local providers and regional services to determine what needs to be done to ensure success |
| Critical components/issues | <ul style="list-style-type: none"> ● Need helicopter overview – strategic direction not just service mapping again ● Need to move pieces closer together |
| Benefits | <ul style="list-style-type: none"> ● Move from 'what's in it for us' to what can we do together for the benefit of the consumer |
| Barriers | <ul style="list-style-type: none"> ● Too much, too many approaches, different messages at different levels – what is really out there? |
| Opportunities | <ul style="list-style-type: none"> ● Committed and prepared to go further at this level but need to get commitment throughout each organisation and between services |
| Solutions/Ideas/Actions | <ul style="list-style-type: none"> ● Constantly check what is out there and what is being delivered ● Ensure referrers know what is out there ● Encourage service coordination |

| Understanding Consumer Needs | |
|--------------------------------------|--|
| Where is the greatest consumer need? | <ul style="list-style-type: none"> ● Aged ● With the greatest population – which will lead to rationalisation of services ● The provision of a one stop shop ● Disadvantaged groups such as <ul style="list-style-type: none"> ○ CALD ○ Aboriginal ○ People with disabilities ○ Lower SES ○ Isolated ○ People with no transportation ● Provision of a range of flexible and responsive services within their local community ● Need to ask the consumer in order to determine as they don't know what they don't know ● Consumers need access to services that includes more allied health and effective care coordination |



| Understanding Consumer Needs (continued) | |
|---|---|
| Critical components/issues | <ul style="list-style-type: none"> • Need to identify what we need to do • Need to target quiet people as they are often the ones with the most need • Need to get right service to right person |
| Benefits | <ul style="list-style-type: none"> • Involvement of consumer – education and or promotion of services to consumers |
| Barriers | <ul style="list-style-type: none"> • Danger of creating service ghettos |
| Opportunities | <ul style="list-style-type: none"> • Not just targeting where largest population is • Target CALD, aboriginal, low socio economic, disadvantaged • Provide access to isolated communities |
| Solutions/Ideas/Actions | <ul style="list-style-type: none"> • Undertake interpretation of population • Use consumer participation information • Map services for different stages |

| Partnering With Consumers | |
|---|---|
| We can support consumers to be more proactive in their care by: | <ul style="list-style-type: none"> • Undertaking health promotion • Providing education at all levels – community and service provision • Introducing training to assist staff to educate consumers ie coaching, mentoring and understanding their role in a client centred system • Preparing care plans in consultation with consumers - consumer directed • Empowering them by asking them what they need and or want • Rewarding self management • Encouraging consumers to be active partners in order to build positive experiences • Introducing client held records • Utilising simple language • Providing easily understood options, pathways with strong clinician support for selecting best option/pathway |
| Critical components/issues | <ul style="list-style-type: none"> • Staff culture • Client expectations • System does not support a self management/coaching model |
| Benefits | <ul style="list-style-type: none"> • Better consumer outcomes • Less acute presentations |



| Partnering With Consumers (continued) | |
|--|---|
| Barriers | <ul style="list-style-type: none"> • Workload and time • Consumers and staff attitudes • Service management – complex change management required in organisations |
| Opportunities | <ul style="list-style-type: none"> • To create a bottom up/top down approach with organisations – board, ceo, executive to clinicians • Better use existing resources (experienced/skilled staff) |
| Solutions/Ideas/Actions | <ul style="list-style-type: none"> • Build on existing HACC Active Service Model and CCSM • Review medical training • Educate at all levels • Ensure consumer empowerment is reflected all documentation ie service plans, job descriptions • Develop a geographic model where all services in a town have a philosophy of self management and client empowerment • All staff trained in evidenced based self management and ensure integrated into 'usual' practice ie tools, policies, pathways, job descriptions |

| Coordinated and Planned Care | |
|--|--|
| We can enhance the coordination and planning of chronic disease care by: | <ul style="list-style-type: none"> • Generating greater cooperation and communication within health promotion • PCP taking the lead – becoming the local champions • PCP facilitating dialogue, forums and training • Developing an agreed best practice approach • Lobbying DHS to fund new approaches and reward collaboration <ul style="list-style-type: none"> ○ health coaching; ○ Better Health Self Management; ○ Flinders model • Building strong trusting partnerships across the catchment • Understanding what works for the consumer • Conducting team meetings for those involved in chronic disease • Creating universal documentation approaches • Developing a Goulburn Valley wide plan • Establishing or building on existing staff networks • Creating an informative Hume Service directory • Improving use of E-Referral • Developing a structure around who manages an individual's |



| Coordinated and Planned Care (continued) | |
|---|---|
| | <ul style="list-style-type: none"> • needs • Creating linkages between services • Ensuring there is organisational commitment and resources to enable the delivery of chronic disease care |
| Critical components/issues | <ul style="list-style-type: none"> • None identified |
| Benefits | <ul style="list-style-type: none"> • None identified |
| Barriers | <ul style="list-style-type: none"> • None identified |
| Opportunities | <ul style="list-style-type: none"> • None identified |
| Solutions/Ideas/Actions | <ul style="list-style-type: none"> • Create a communication strategy that underpins how inform, communicate, partner and collaborate • Develop and implement an effective governance structure • Service coordination group to support members to increase consumer participation • PCP Executive to set the direction and act as the governing body to ensure that the members are meeting the vision created • Strategic alliances with ABHI funding • Integrated chronic disease management needs to be part of the way we do business |

| Self-Management Support | |
|--|--|
| Is the adoption of a self management approach happening with our clinicians, managers and consumers: | <ul style="list-style-type: none"> • Need to encourage general practitioners as they have an important role in supporting self management principles • Need to increase and improve education and training for all clinicians in a top down way • Need to improve the awareness and understanding of a self management approach to consumers • Need to change consumers expectations • All participants need to understand the self management model, concept and practices in the same way as some understand better than others • Need to clearly identify what self management services are available • Need to enhance health promotion • Need to be able to target hard to reach consumers ie middle aged men • Need to demonstrate to service providers good examples of self management clinical practices • Need to find ways to integrate self management practice into |



| Self-Management Support (continued) | |
|--|--|
| | current usual care |
| Critical components/issues | <ul style="list-style-type: none"> • Need all clinicians/services to follow a consistent approach so that consumers get a consistency of messages • Need management support |
| Barriers | <ul style="list-style-type: none"> • Clinicians need to not impose their own values or goals on the consumer • Model must be supported by management to enable service providers to adopt self management support • Difficult for consumers to carry through their self management goals in the real context |
| Opportunities | <ul style="list-style-type: none"> • Approach will be able to be matched to the consumer's changing needs |
| Solutions/Ideas/Actions | <ul style="list-style-type: none"> • Top down – bottom up approach – managers and staff with consumers • Create community awareness to support healthy lifestyle changes • Undertake a media campaign around self management • Establish peer support groups • Educate generic services ie personal care however don't disempower • Increase understanding between services of what each other does – what is the right services, right place, right time? • Take current learnings and integrate them into existing services and practices • Conduct training using expertise, skills and knowledge of staff already in Goulburn Valley to integrate self management concepts into usual care |

| Health Promotion | |
|---|---|
| What risk factors are being considered and addressed? | <ul style="list-style-type: none"> • There is risk that focus will be on acute end of integrated chronic disease management rather than on upstream - needs energy at both ends of the spectrum • Some risks are being missed: <ul style="list-style-type: none"> ○ smoking, ○ drug and alcohol use, ○ excessive weight, ○ homelessness, ○ mental health • Some risks not be adequately addressed: <ul style="list-style-type: none"> ○ obesity, |



| Health Promotion (continued) | |
|-------------------------------------|---|
| | <ul style="list-style-type: none"> ○ nutrition/diet ○ lack of physical activity ○ motivation ● Not covering all chronic conditions mostly just the specifics ● Covering chronic illness but not necessarily covering consumers in level 3 or 4 of hierarchy ● System not coping with level of volume resulting in risk of poor service to consumer ● Services reactive rather than proactive in following areas: <ul style="list-style-type: none"> ○ Rural men and their stress, hypertension ○ Lifestyle ● Living in Moira/Strathbogie |
| Critical components/issues | <ul style="list-style-type: none"> ● Addressing the risk factors ● Maintaining healthy behaviour change ● Providing consistent messages ● Reducing the demand on the more medical end of the care continuum |
| Benefits | <ul style="list-style-type: none"> ● Getting in early helps to increase quality of life and delays need for specialist or more intensive medical services ● Getting consumers used to being empowered and becoming in control of one's health – building self advocacy |
| Barriers | <ul style="list-style-type: none"> ● Hard to measure level of impact or outcomes – longitudinal impact studies |
| Opportunities | <ul style="list-style-type: none"> ● Agencies working together (collaborating) to provide health promotion ● IHP working groups addressing risk factors – CDM services need to link into these |
| Solutions/Ideas/Actions | <ul style="list-style-type: none"> ● Need to get involved in local council planning and policy development ● Partner with University of Melbourne to <ul style="list-style-type: none"> ○ Study perceptions of what is healthy behaviour – risk factors ○ Study impact of health promotion interventions ● Ensure service staff have ongoing support and training – updated knowledge of what is out there to support health promotion ● Links between health promotion services and chronic disease management services – S.C. need to consider health promotion referrals/links as well as intervention referrals ● Raise community awareness |



| Targeting Subgroups | |
|---|--|
| What population group needs to be targeted? | <ul style="list-style-type: none"> • Whole of population including indigenous and CALD • HACC client group – easy group to target • Dependant on need • 50 + with chronic disease • Youth group for health promotion • Should the focus for demographics be on economic circumstances or some other measure rather than age – need better analysis of data so not just a population based approach • Who are the sub groups? What are their demographics? • Across the board but target over 50's as they have been identified as having higher needs • Young people with chronic disease • Hard to reach groups • Those with risk factors but no disease • Those in early stages of disease • Those requiring increase in disease management • Those with diabetes, heart disease, respiratory disease, obesity |
| Critical components/issues | <ul style="list-style-type: none"> • Target the most vulnerable disadvantages based on research in catchment • Subgroups could be based on economic or social issues versus health status eg sicker • Small rural towns geographic approach • Population groups need to be clearly defined • Services need to be provided at appropriate times in appropriate ways • Need to identify initial case manager • If do not establish the client group maybe missing the target |
| Benefits | <ul style="list-style-type: none"> • Decrease in hospital admissions • General practitioners having more time • Healthier population • Integrated approach to client care • Client taking responsibility for own health |
| Barriers | <ul style="list-style-type: none"> • Acute medical and general practitioners not consistently using SCOT tools for referrals and case planning • Open and honest communication • Geographic distance – critical mass |



| Targeting Subgroups (continued) | |
|--|--|
| Opportunities | <ul style="list-style-type: none"> • Creating a better service system • Building better relationships between agencies • Avoiding duplication • Client will only have to tell story once • Development of a seamless system |
| Solutions/Ideas/Actions | <ul style="list-style-type: none"> • Appoint a case manager on entry to service • Catchment wide adoption of PPP5 |

| Planning for Success | |
|--|--|
| Where shall we begin? How will we know we are being successful? | <ul style="list-style-type: none"> • Shall begin by: <ul style="list-style-type: none"> ○ Conducting more planning with managers and staff ○ Inviting consumer participation in planning ○ Monitoring and evaluating processes ○ Developing a plan for the planning stage ○ Reviewing what each team is doing to determine that there is no duplication ○ Tracking numbers of GP Managed Care Plans and Team Care Arrangements ○ Tracking care coordination across the catchment or organisation ○ Mapping central intake progress and impacts ○ Obtaining agreed priorities ○ Focusing on client outcomes – reduced chronic disease ○ Creating mechanisms to engage all required stakeholders to make commitment ○ Establishing agreed benchmarks for measuring success that can be applied to HARP, Diabetes Centre, GVCHS/GVHealth/CDM and other local initiatives ○ Training specialist nurses in pulmonary coronary and contract out to smaller organisations as ‘train the trainer’. Oversee the staff. ○ Encouraging GP practices to employ suitably qualified staff ie credentialed diabetes educators to oversee care plans and make recommendations such as referrals • Know successful when: <ul style="list-style-type: none"> ○ CDM network is providing right service in the right place at the right time for every person who needs it ○ Coordinated and integrated assessment occurring |



| Planning for Success (continued) | |
|---|--|
| | <ul style="list-style-type: none"> ○ Have increased funding from DHS ○ Funding CD case management positions ○ Establishing chronic disease intake and assessment units for each LGA ○ Federal and state directions complement each other ○ Stakeholders are committing and collaborating ● Consumers are able to enter at any point in the system and have their say in what they need |
| Critical components/issues | <ul style="list-style-type: none"> ● Need discussion with all service providers – ensure everyone who needs to be at the table is involved ● Need to develop agreed outcomes and priorities ● Need to conduct research, needs' analysis and evaluation ● Need to undertake planning with clear networks and pathways ● Determine what to do with chronic/complex non HARP ● Need to conduct education and training – profession parody |
| Benefits | <ul style="list-style-type: none"> ● Gain an understanding of actual numbers ● Brings all stakeholders together – building on platform of partnerships |
| Barriers | <ul style="list-style-type: none"> ● Ownership, competitive nature of agencies/organisations ● Lack of understanding in change management processes ● Current culture of working in isolation/silos – lack of vision |
| Opportunities | <ul style="list-style-type: none"> ● Financial business approach to funding and business practice |
| Solutions/Ideas/Actions | <ul style="list-style-type: none"> ● Conduct marketing and education within the community ● Involve consumers in planning ● Cost benefit/neutral analysis to promote benefits of this approach ● PCP facilitation/leadership/networking/groups across community, operational and strategic planning and implementation ● Allow PCP to gain collegial support ● PCP to analyse and communicate federal and state policy direction ● Get each member agency to understand their role within PCP ● Encourage all providers to accept that they are part of a total system – health provider ● Keep promoting and educating all stakeholders about the social model of health |