Integrated Chronic Disease Management Case Study

PCP Member Agency Engagement in Integrated Chronic Disease Management - Wimmera PCP

The Wimmera Primary Care Partnership (WPCP) facilitated and maintained the active engagement of their member agencies in a working group that identified priorities and developed a plan for Integrated Chronic Disease Management (ICDM) in the Wimmera region. Participating member agencies have collaboratively developed the strategies to address their priorities, and taken an active role in actioning the strategies.

PCP staff have utilised case studies in the working group to maintain a holistic client-focussed approach in ICDM, and have also developed a strategy for communicating key messages back to management of member agencies.

The Drivers

- The ICDM guidelines for PCPs, and the PCP ICDM deliverables
- Recognition by PCP staff that ICDM requires partnership and collaboration of member agencies
- Awareness by member agencies that better integration of services was required for optimal client service and outcomes

The Players

- All health services throughout the Wimmera
- WestVic Division of General Practice
- Wimmera Primary Care Partnership
- LGAs
- HACC
- Goolum Goolum Aboriginal Cooperative
- DHS
- Private Allied Health Practitioners

Member agencies receiving minutes and information;

- DVA
- Women's Health Grampians
- Disability Services

Practices Promoting Successful Outcomes

- An initial member agency forum was facilitated (June 07) to ascertain the level of interest and commitment to a regional approach to ICDM. From this forum, type 2 diabetes was identified as a common unifying focus of member agencies, the Reference Group was formed, and the PCP staff drafted Terms of Reference to be approved by the group.
- The ICDM approach built on the established relationships of Wimmera PCP where member agencies were already engaged in HP and SC. Partnership is an established way of operating in WPCP and member agencies could see the value of this approach to ICDM.
- A planning forum was held (October 07) to collaboratively identify regional shared priorities for diabetes management and an action plan to address the priority issues.
- Identifying immediate wins (identifying capacity to fill a diabetes educator vacancy through the available time of a staff member in another organisation) and an achievable short-term plan with a clear outcome (developing and implementing a client held record) reinforced the value of partnership
- Case studies are used at all reference group meetings to maintain a whole of system awareness and a client-focus for ICDM. The Consumer Pathway through Service Coordination flowchart keeps the case studies focused and reinforces the inter-relationship of Service co-ordination and ICDM.
- 'Position statements' are developed from each ICDM working group meeting and used to communicate key messages to higher management levels within member agencies

The Challenges

- Varying expectations from member agencies
- Some Reference Group members encountered resistance within their organisations to sharing work practice and information of services with other agencies
- Some Reference Group members encountered resistance within their organisations to working with and communicating with General Practice – 'why do we need to let them know what we are doing?'

The Results

- Improved intersectoral respect and awareness of each others services by member agencies as evidenced by a Diabetes Nurse Educator vacancy filled at Goolum Goolum Aboriginal Health Service via the Chronic Disease Reference Group meeting. Regional Diabetes Care Pathways are in development which detail who does what, where and how.
- Development and broad acceptance of a client-held record for people with diabetes and subsequent improved information sharing. The client held record does not replace health service medical records but empowers clients to be actively involved in sharing of their own information.
- Awareness of misconceptions or barriers between GPs and health services leading to monthly 'café' meetings between Wimmera PCP and West Vic Division of GP staff to address issues. This has resulted in development of GP engagement tools for Diabetes Self Management & HARP chronic disease programs.

Key Learnings

Active involvement and collaboration between member agencies at all levels of planning and implementation of local ICDM strategies is essential

Case studies assist to maintain a client-focussed and whole-of-system approach and illustrate the continuum between service co-ordination and integrated chronic disease management

The PCP's strong established partnerships provide a solid platform on which to build improvements in chronic disease practices. Members have ownership of the ICDM reference group and process which reinforces practice, and identifies gaps and priorities for ICDM in the Wimmera Region

Multiple communication strategies support ongoing problem solving and member agency engagement at management and practitioner level in ICDM

CD Reference Group
July 2007 to July 2008

Self Management Capacity Building

- Flinders Model of Chronic Care management delivered at Halls Gap.
- Health Coaching Horsham May 2008

DHS Self Management Mapping – Wimmera
PCP Completed Feb 2008

To Reference developed.

Meetings held regularly.

July – What are our issues in CD Management in the Wimmera?

Mapping of Diabetes Services – October 2007 and Strategy Day

Diabetes Working Group formed – January 2008

Patient hand held record development.

Meetings of podiatry optometry, DEA, GPs for input

Diabetes Directory of Services development.

August
DHS levels of Chronic Care.
Risk Factors in the Wimmera.
Westvic Active Script Program early intervention.

October – Mapping of Diabetes Services & Strategy.
Day patient:

- Hand held record.
- Focus on prevention.
- Directory of services in Wimmera.

November – Finding CD early care pathways, recall behaviour change.

January – Coordinated care:

- Case study of service coordination in action with HARP.

Position statements to be developed to inform senior health management and DHS of critical issues in CD Management.

- Service Coordination
- Working with GP

February – DSM program case study connecting Care SCTT Tool.

March - Westvic GP Management & Plans Case Study