Lower Hume PCP Integrated Chronic Care Report 2015/16

1. What population group/condition(s) have you targeted?
   - People with diabetes
   - Aboriginal community

2. What agencies have you worked with on continuous improvement in integrated chronic care activity?
   - Seymour Health (SH)
   - Alexandra District Health (ADH)
   - Yea and District Memorial Hospital (Y&DMH)
   - Nexus Primary Health (NPH)
   - The Kilmore and District Hospital (K&DH)
   - Lower Hume Aboriginal Health and Wellbeing Program Officer
   - Mitchell Shire Council
   - Murrindindi Shire Council
   - Murray Primary Health Network (PHN)
   - Local pharmacies
   - Pharmacy Guild

3. What method did you utilise?
   - This piece of work supports the implementation of the Hume Region Chronic Care Strategy and throughout implementation has been advised by the Hume Region Chronic Care Steering Committee and Diabetes Collaborative. The Lower Hume Diabetes Working Group reports to the Hume Diabetes Collaborative and have developed their own sub plan to meet the objective of improving local diabetes care.
   - The Lower Hume Chronic Care Improvement Plan 2014-2016 was developed based on Assessment of Chronic Illness Care (ACIC) results in 2014 and operationalises the Expanded Chronic Care Model, testing improvements on diabetes care.
   - This work also links with and supports the Victorian Koolin Balit Strategy and involves the Lower Hume Aboriginal Health and Wellbeing Program Officer.

4. When did you last undertake the ACIC with agencies in your area?

   October 2014.

   It was decided not to complete the ACIC again as it provided limited value for the time commitments required from agencies. Additionally, it appears that the theoretical nature of the model is not well understood by the practical workforce, and LH PCP plays a lead role in bridging the gap to implement the theory into

practice. Annual review of the Lower Hume Chronic Illness Care Plan allows for reflection and identification on future areas for improvement.

5. Do you have a current Improvement Plan based on the ACIC in place?
   - Yes. The initial plan was developed for 2014-2016 with annual review and updating.
   - As a result of working with agencies to implement the plan for the past 2 years it has been identified that strategies and actions need to be simplified to enable understanding and implementation.

6. Have you ever undertaken the Patient Assessment of Chronic Illness Care (PACIC)? If so, when did you do it and with which agencies?
   - No. We have completed our own consumer research into local diabetes care through a consumer diabetes survey and focus group (discussed below in community linkages). The results reinforced positive aspects of local care and areas for improvement to consider when developing a local model of care.

7. What do you plan to focus on, in the area of chronic illness care in 2016-17?
   - Review and refine Lower Hume Chronic Care Plan into 2016-17 action plan
   - Continue a focus on diabetes and consider how to replicate improvements for other conditions
   - Re-engage member agencies who have not been actively implementing the improvement plan
   - Review structures to report back and share improvements and learnings between agencies

Quality improvement activities in chronic illness care

Improvement area	Planned actions to achieve improvements	Agencies involved	Results of actions	Measures used
Organisation of the health care delivery system	Assemble organisational lead team. Communicate organisational commitment to chronic illness care.	Seymour Health	Seymour Health have a Chronic Illness Care working group that meet monthly, they have reviewed and refined the chronic illness care plan into an action plan. Communicating organisational commitment commenced with consumers talking to staff about their experiences living with multiple chronic illnesses.	Monthly meetings track progress against the plan. Evaluation survey found that the consumer talk increased: - staff awareness of people having multiple conditions with individual needs, and -the importance of listening.
Community linkages	Adopt or create a referral pathway for diabetes.	Alexandra District Health Nexus Primary Health Seymour Health Yea & District Memorial Hospital The Kilmore & District Hospital Murrindindi Shire Council Mitchell Shire Council	Conducted consumer research (survey and focus group) to inform local model of care. Analysing the data to identify areas for local improvement. Partnering with Murray PHN on the	77 consumer surveys completed and 6 consumers participated in focus group facilitated by La Trobe University. Results being analysed and summarised into a report. Process and initial findings presented at GV Health Research Fair, Public Health

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		Murray PHN La Trobe University	development and implementation of Murray Health Pathways.	Association of Australia (PHAA) and Australian Disease Management Association (ADMA) conferences. Murray Health Pathways includes local diabetes and Hospital Admission Risk Program (HARP) pathway.
Self-management support	Self-management support colleague support group. Implementation of Lower Hume Health Literacy Toolkit.	Seymour Health The Kilmore & District Hospital Goulburn Valley (GV) PCP Baptcare Vision Australia Seymour Health Alexandra District Health	LH and GV PCPs convene quarterly West Hume Chronic Care Collaborative meetings. The purpose is to encourage discussion, networking and learnings around self-management support and chronic illness care. The group has also supported the ongoing implementation of Asking Better Questions. An example of an outcome of the WHCCC is that Seymour Health has incorporated Teach Back training into their team meetings and education calendar. Seymour Health has completed a Health Literacy Organisational Assessment across 3 departments to inform an organisational plan. ADH implemented a policy for the development of information and utilise their consumer advisory committee for input and feedback into information and service design.	Evaluation of 2015 meetings confirmed that 89% agreed that the support group environment increased their confidence to provide self-management support. Health Literacy Organisational Assessment completed to inform action plan. Information policy implemented. At least 3 consumers' feedback on material before publication.
Decision support	Agencies become affiliate members of the National Association of Diabetes Centres (NADC).	Alexandra District Health Nexus Primary Health Seymour Health Yea & District Memorial Hospital	3 organisations have registered as affiliate members of NADC to commit to implementing best practice diabetes care. Consumer research findings will guide Lower Hume Diabetes Care Centre model. 3 organisations participated in the	NADC membership. LH PCP attending the NADC Best Practice in Diabetes Centres Symposium to showcase our work.

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	Increase communication with specialists utilising telehealth.		Australian National Diabetes Audit (ANDA) with a Hume region report providing clinical indicators to evaluate care. Hume region clinical network being established to analyse findings and identify areas for improvement. Telehealth consultations are being provided by the Diabetes Educator at Yea & District Memorial Hospital at Nexus Primary Health's Kinglake site for local clients. Y&DMH have completed 5 telehealth consultations with 2 clients since April 2016. As a result there have been significant improvements in clinical indicators including HbA1c levels, reduced hypoglycaemic episodes and less insulin required.	Hume region ANDA report. Number of consultations. Clinical indicators.
Delivery system design	Consumers with diabetes receive recommended reviews.	Seymour Health	Seymour Health is piloting a diabetes specific inpatient assessment form to collect information on ongoing care and prompt referrals.	Piloting diabetes specific admission form.
Clinical information systems	Diabetes related results recorded in client files. Agencies work with Aboriginal health workers to implement supportive practices.	Seymour Health Nexus Primary Health Seymour Health Lower Hume Aboriginal Health and Wellbeing Project Officer	Engaging with general practices to identify information that could be provided with referrals or on admission to support continuity of diabetes care. Seymour Health is commencing a pilot of the Road to Good Health program for Aboriginal people with and/or at risk of developing diabetes and their families.	Scoping existing tools and resources including Hume Whittlesea Catchment Diabetes Referral Form. Road to Good Health Community Information Session 11/07/2016. Screening and referral forms distributed to GPs.
Partnering with pharmacies	Agencies increase communication with local pharmacies to support continuity of care.	Alexandra District Health Nexus Primary Health Seymour Health Yea & District Memorial Hospital Kilmore and District Hospital	Local health services contacted pharmacies in their area to identify their current role in diabetes care and how they would like to work together with health services. As a result: -Local diabetes services posters have been develop and distributed for each	88% (n=14) of local pharmacies were initially contacted and completed engagement survey. 93% (n=13) responded that they would value resources to support customer diabetes questions and increased communication with local

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		Local pharmacies Pharmacy Guild	town. -Diabetes training delivered by local allied health clinicians was provided to staff working in local pharmacies and general practices and recorded for increased reach. LH PCP is communicating with the Pharmacy Guild to support ongoing collaboration with pharmacies. DHHS has funded an evaluation of this work engaging pharmacies which will inform a toolkit for others to replicate.	health services. 35 people representing 12 organisations attended training. Post training evaluation survey confirmed that: -92% found the sessions useful -74% increased their knowledge of local health services -70% increased their knowledge of how to refer to local health services - 61% increased their confidence in screening for type 2 diabetes. Training videos uploaded onto website http://lhpcp.org.au/chronic-care/ Consultant engaged to complete evaluation and toolkit. Presenting on this work at PHAA and ADMA conferences.

Further information

http://lhpcp.org.au/chronic-care/