

Inner East Primary Care Partnership – Integrated Chronic Disease Management June 2011 – June 2012

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V1	25.7.2011	Document Created
V2	8.9.2011	Word Changes
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Section One – Background Information

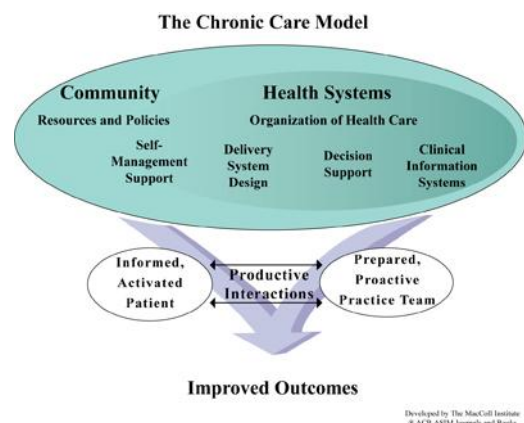
Introduction

This Inner East Primary Care Partnership (IEPCP) Integrated Chronic Disease Management (ICDM) Plan 2011-2012 outlines initiatives and activities which will be collaboratively developed and implemented by PCP member agencies across the catchment over the next year (2011-2012).

Plan Development

The ICDM 2011-2012 plan was formed after the June ICDM Reference Group where the PCP asked key questions “Where are we now and what have we achieved?”, “Where do we want to be?”, “How do we get there?” and importantly, “How do we measure our progress?”. This information, and the achievements and lessons learnt from the 2010-2011 Plan was used to guide the ICDM Plan of 2011-2012.

A subsequent meeting of the ICDM Reference Group in October 2011 reviewed and supported the plan.



The plan is also informed by key documents from the Department of Human Services (DHS) including the Primary Care Partnerships Revised Program Logic July 2009 (see <http://www.health.vic.gov.au/pcps/downloads/programlogic.pdf>) and the Wagner Chronic Care Model. The Program Logic document details outcomes, objectives, processes, DHS expectations and DHS inputs and has formed the basis for the development of our ICDM priorities. The Wagner Chronic Care Model “identifies the essential elements of a health care system that encourage high-quality chronic disease care. These elements are the community, the health system, self-management support, delivery system design, decision support and clinical information systems.”¹

IEPCP Strategic Directions

IEPCP Vision

The IEPCP has articulated a vision for Melbourne’s inner east community to experience high levels of wellbeing, with excellent health and social outcomes:

- For an individual and the community this means a larger variety of health and social needs are being met, with

¹ Improving Chronic Illness Care. (2011). The Chronic Care Model. Retrieved 8 September, 2011, from http://www.improvingchroniccare.org/index.php?p=The_Chronic_Care_Model&s=2.

greater ease in accessing and navigating the service system;

- For the service system, it means greater seamlessness; and,
- For the IEPCP member organisations, it means greater opportunity, efficiency and better outcomes along with community and staff satisfaction

The IEPCP proposes achieving this through system-level change, with a clearly defined role as partnership facilitator or orchestrator.

IEPCP Strategic Directions

The ICDM activities in this plan are informed by an overarching IEPCP Strategic Directions Plan covering the period 2009-12. Current IEPCP strategic directions articulate three priorities, these are working with populations that:

- have complex and chronic conditions;
- are ageing; and/or,
- are experiencing poor mental health.

These areas have been identified as the points of greatest leverage for a regionalised, collaborative inter agency service response. The areas chosen are based on evidence suggesting:

- The top six causes of death in Victoria are ischaemic heart disease, stroke, lung cancer, chronic obstructive pulmonary disease (COPD); colon/rectum cancer and diabetes mellitus;
- The top two causes of disability in Victoria are mental disorders and chronic respiratory disease;
- All IEPCP members already provide services in one or more of these areas.

Plan Content

This plan outlines the broad ICDM goals related to the earlier discussed priority areas, with measurable objectives aligned to each goal. Strategies and ICDM interventions are listed under each objective. Reporting measures are included under each strategy.

This plan has three goals:

- 1: Support a catchment wide approach to ICDM according to priority areas common to, and agreed by, active partner agencies.
- 2: Support Organisational Practice Change and Service System Reform consistent with current best practice standards and the Wagner model.
- 3: Increase and Support Sector and Workforce Capacity to deliver evidence based EliCD/ICDM Services for clients with complex, chronic disease.

Partner Agencies

The success of any partnership depends on sustaining the process, particularly as leadership, administrations, and policy makers change. Initial commitment and energy of partners commences the partnership, however IEPCP believes the following components are the key to sustaining partnerships over a long period or until they conclude naturally through meeting their goal (time limited):

- creating a sense of interdependence between ICDM partners

- recognising and rewarding members for their contributions in the partnership work
- combining planning with action (whilst balancing 'who' undertakes the various tasks related to each initiative with each partner's financial/non-financial resource capacity), and
- creating a learning partnership through IEPCP's capacity building (organisational, workforce and partnership development, resourcing and leadership).

The extensive scope and reach of partnerships (both internal and external) who provide resources to undertake the full range of tasks required for successful governance, planning, implementation, monitoring and evaluation of the initiatives contained within the plan are evident in the ICDM Reference Group ToR. Additional member agencies are identified through stakeholder analyses in each project plan.

Section Two – IEPCP Integrated Chronic Disease Management Plan 2011-2012

Goal 1 Support a catchment wide approach to ICDM according to priority areas common to, and agreed by, active partner agencies

Objectives	Key Strategies	Estimated Impacts	Evaluation	Time Lines
To improve the local systems for people with type 2 diabetes	Continue the previous work of the IEPCP of the Improving the Diabetes Journey (ItDJ) Project using a collaborative using PDSA Framework. Provide 1:1 support to agencies to implement the PDSA framework within their agencies.	ItDJ tools (Type 2 Diabetes Care Pathway, Type 2 Diabetes Priority Pathway Tool, The Client Information Pack and the Recall and Reminder Map) are implemented within agencies.	Case studies of diabetes system change will be conducted through utilising monthly agency PDSA's submitted to IEPCP. These will be utilised to assess uptake of ItDJ tools. Additional evaluation will be conducted if necessary.	June 2011-June 2012
	Implement an online navigation tool navigation of diabetes services in the EMR.	Improved navigation of diabetes services in the EMR	Pilot (testing the website), online survey, Google analytics.	June 2011-June 2012
To participate in the development, implementation and evaluation of regional ICDM related strategies to address common issues.	Regional ICDM workers meet to participate in a working group for networking, planning, implementation, monitoring and evaluation purposes of ICDM work identified from the ItDJ project, and other ICDM networks. Promote regional ICDM improvements through IEPCP communication plan (email, website, e-bulletin). Promote sector ICDM projects at ICDM	Outcomes are enhanced by a collaborative approach. Improved sector knowledge of ICDM improvements in the EMR.	Evaluation will be conducted through the yearly partnership survey additional evaluation as identified as needed such as the meeting evaluation survey.	June 2011-June 2012

	<p>Reference Group.</p> <p>Support dissemination of improvements through poster presentation preparation workshop.</p>			
<p>To enhance the effectiveness of the ICDM program plan across the IEPCP catchment.</p>	<p>Evaluate the current quality of the IEPCP ICDM partnership.</p> <p>Utilise results of the partnership tool to improve partnerships with agencies to enable an effective working environment.</p> <p>Revise the ICDM Reference Group to accurately reflect roles and functions.</p>	<p>The effectiveness of the ICDM program plan across the IEPCP catchment will be enhanced. This will facilitate and enable the embedding of ICDM in position descriptions, strategic plans, organizational policies and processes.</p>	<p>Evaluation via the <i>New York Partnership Assessment Tool.</i></p>	<p>June 2011-June 2012</p>

Goal 2 Support Organisational Practice Change and Service System Reform consistent with current best practice standards and the Wagner model.

Objectives	Key Strategies	Estimated Impacts	Evaluation	Time Lines
To support agencies in improving communication with GPs (particularly referrals).	<p>Through the DH PDSA model for improvement project facilitate agreed agency and interagency QI activities, develop, strengthen and maintain linkages between member agencies undertaking QI work.</p> <p>IEPCP participation at DH PDSA model for improvement project Steering Committee.</p> <p>IEPCP participation at agency quality improvement committees.</p>	Improved processes and systems for communication with GP's and care planning.	DH is collecting and evaluating the project through the PDSA templates, indicator data and a post project evaluation. The subsequent report will be used for evaluation.	June 2011-Novemeber 2012
To enhance the capacity of IEPCP agencies to deliver chronic disease (Ie diabetes) services that are culturally appropriate to CALD and indigenous groups in the LGAs of Manningham, Whitehorse, Boroondara, Manningham, Monash.	<ul style="list-style-type: none"> • Ensure ItDJ information package is culturally appropriate and available in main language groups • Implement workforce development strategies (2 workshops- Building cultural competence in your organisation, and Managing chronic disease with CALD clients) to support improvements in cultural competency within and across agencies- including workforce development for CALD communities. 	Improved delivery of chronic disease (diabetes services etc) services that are culturally appropriate to CALD/ATSI community in the LGAs of Manningham, Whitehorse, Boroondara, Manningham, Monash.	Conduct workshop evaluations for the workshops	June 2011-September 2012 Feb 2012-June 2012
Identify current standards of Chronic Illness Care in partner	To plan, implement and evaluate the PACIC, ACIC, SC and ICDM Survey, and ICDM Checklist in member agencies.	Current standards of Chronic Illness Care in partner agencies are identified (future work may include	Evaluation of data will occur through analysis of the collected data.	October 2011-June 2012

agencies.	Collaborate with member agencies to offer chronic illness care audits (PACIC, ACIC, ICDM Checklist).	planning and implementing improvements).		
To build the capacity of partners to implement the Wagner Chronic Illness Care Model	Facilitate the embedding of ICDM in position descriptions, strategic plans, organizational policies and processes (through the recommendations generated from the PACIC and ACIC).	Improved capacity of partners to implement the Wagner Chronic Illness Care Model	Through a project evaluation (TBA).	December 2011- June 2012

Goal 3 Increase and Support Sector and Workforce Capacity to deliver evidence based ElicD/ICDM Services for clients with complex, chronic disease.

Objectives	Key Strategies	Estimated Impacts	Evaluation	Timelines
To strengthen the capacity of clinicians in the IEPCP catchment that work with chronic and complex clients to provide best practise care.	Implement recommendations of the Client Centred Care Survey through: <ul style="list-style-type: none"> • Implementing an EMR ICDM Education and Events Calendar to support clinicians aiding clients to cope with long term conditions and behaviour change strategies. • Support agencies in developing systems and processes to support care delivery. This includes delivering project Management Training for clinicians and staff conducting ICDM projects in the IEPCP catchment. • Support ongoing clinician skill development and practice change 	Improved capacity of clinicians in the IEPCP that work with chronic and complex clients to provide best practise care.	Individual workshop evaluations (pre and post) and final project evaluation and report.	June 2011-June 2012
	Support and improve clinicians' knowledge and practice in the area of intellectual and physical disabilities, with specific relation to Disability Accommodation Services clients through developing and delivering workshops.	Improved CHS clinician competence in working with DAS clients.	Individual workshop evaluations (pre and post) and final project evaluation and report.	June 2011-June 2012

<p>To support evidence-based and competency-based workforce development initiatives throughout Victoria for PCPs and those agencies who work with clients with chronic and complex needs through the Workforce Innovations Project.</p>	<p>Identify core competencies for working with clients with chronic and complex conditions.</p> <p>Develop strategies to standardise a TNA for chronic and complex conditions that incorporates identified core competencies.</p> <p>Identify current training needs in Victoria</p> <p>Identify current training options and utilisation patterns</p>	<p>Improved implementation and standardisation of Training Needs Analyses within PCPs.</p>	<p>Evaluation of the project will focus primarily on the pilot of the TNA.</p> <p>Overall pilot objectives will be evaluated through data collected within the surveys.</p> <p>A survey will disseminated to participating pilot PCP's and agencies to review the Toolkit, associated resources and the effectiveness of the pilot.</p> <p>Subjective data will be collected through the state-wide ICDM PCP group to assess the effectiveness of described impact of the project.</p>	<p>October 2011-June 2012</p>
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