

Frankston Mornington Peninsula Primary Care Partnership

Community Health Plan 2006 - 2009

Deliverable 4: Integrated Chronic Disease Management

December 2006

Endorsed by PCP Chair:

Name: Christine Morka

Signature:



Date: 17/1/07

All PCPs

GOAL	OBJECTIVE	STRATEGY	PLANNED IMPACT
<p>1. To develop an up-to-date electronic database on self-management interventions provided by PCP member agencies.</p> <p>Facilitate planning processes to develop self-management interventions within member agencies that respond to gaps identified in the mapping process.</p>	<ul style="list-style-type: none"> To have all PCP member agencies complete the DHS self-management survey. To facilitate integration of self-management planning across the health promotion continuum in PCP member agencies 	<ul style="list-style-type: none"> Employ Community Advocacy Project (CAP) Officer one day per week to visit PCP member agencies, to assist them to complete the self-management survey – educating them on ICDM while at the same time promoting the CAP Project. Include ICDM in the Health Promotion Alliance planning continuum 	<p>A full range of self-management strategies reflected across the whole of the health promotion continuum available to chronic disease patients/clients in the sub-region</p>
<p>2. Facilitation of a process for agencies to define their roles and responsibilities, especially acute and community health services, in relation to providing self-management interventions for people with chronic disease.</p>	<p>To develop common understandings of care planning between General Practice and Frankston Mornington Peninsula Primary Care Partnership (FMPPCP) member agencies</p>	<p>Use GP Small Grant (20,000) to contribute to Care Liaison position shared between Mornington Peninsula Division of General Practice (MPDGP) & Frankston Community Health Service (FCHS) to explore and articulate care planning perspectives and practices within general practice and in community health.</p>	<p>Common understanding and approach to care planning between General Practice and Community Health.</p>
<p>3. Successful implementation of the Better Access to Services (BATS) framework by progressing common practices, processes, protocols and systems for initial contact, initial needs identification, referral, assessment and care planning by member agencies, particularly as it relates to people with chronic disease.</p>	<p>Support FCHS) Stay Health Program (SHP) to participate in the FMPPCP E-Referral and Service Coordination System.</p>	<ul style="list-style-type: none"> Support FCHS to review service coordination processes within their agency, using '<i>Service Access Models: a way forward</i>' as a guide. Encourage FMPPCP member agencies dealing with chronic disease to nominate a staff member to attend FMPPCP Service Coordination meetings and assist programs to implement decisions taken there. GP Liaison Nurse to educate GPs and GP Practice Nurses in Service Coordination practices and processes. 	<ul style="list-style-type: none"> Peninsula Health's Complex Care Program and Stay Healthy Program are full participants in the FMPPCP E-Referral and Service Coordination System. General Practitioners referring into these programs participate in the FMPPCP E-Referral and Service Coordination System.
<p>4. Developed and defined local agreements and systems to identify clients with chronic disease who require comprehensive assessment, by working with PCP member agencies, particularly GPs.</p>	<p>To develop pathways for people who have a chronic disease into PH Complex Care and Stay Healthy Programs through (Mornington Division of) General Practice and other PCP member agencies.</p>	<p>To contribute with a proportion of PCP EIICD & GP Small Grant funding – for a GP Liaison Nurse jointly employed by MPDGP and FCHS – to assist GPs to identify patients and participate in comprehensive assessment with FCHS and other PCP member agencies.</p>	<ul style="list-style-type: none"> Enhanced early intervention for people with chronic disease. Embedded comprehensive assessment for people with chronic disease
<p>5. Developed and defined local agreements and systems to identify clients with chronic disease, who require cross-disciplinary /multi-agency (including GP) care planning, by working with PCP member agencies, particularly GPs.</p>	<p>To develop links and pathways for people who have a chronic disease into PH Complex Care and Stay Healthy Programs through (Mornington Division of) General Practice and other PCP member agencies.</p>	<p>To contribute with a proportion of PCP EIICD & GP Small Grant funding – for a GP Liaison Nurse jointly employed by MPDGP and FCHS – to assist GPs to identify patients and participate in shared care planning with FCHS and other PCP member agencies.</p>	<p>Enhanced early intervention for people with chronic disease Embedded shared care planning for people with chronic disease</p>

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6. Developed and defined local agreements and systems around initiating and co-ordinating care planning for people with chronic disease by working with PCP member agencies, particularly GPs.	To develop links and pathways for people who have a chronic disease into PH Complex Care and Stay Healthy Programs through (Mornington Division of) General Practice and other PCP member agencies.	To contribute with a proportion of PCP EIiCD & GP SMasII Grant funding – for a GP Liaison Nurse jointly employed by MPDGP and FCHS – to assist GPs to initiate and coordinate shared care planning with FCHS and other PCP member agencies.	Enhanced early intervention for people with chronic disease Embedded shared care planning for people with chronic disease
7. Strengthened approaches to address disadvantage and health equality in Integrated Health Promotion initiatives, including barriers to participation such as chronic disease.	To respond to local needs in relation to the burden of disease for people with chronic disease, in, for example, local Afgan/ Sudanese communities.	<ul style="list-style-type: none"> • To encourage/support FCHS CC and SHP programs to participate in the FMPPCP Health Promotion Alliance • Utilise FMPPCP Community Advocates to visit local CALD groups (with GP Liaison Nurse) providing information and access to CC & SH programs. 	Health access equality for people with chronic disease in the sub-region.

PCPs working with CHSs funded under the EIiCD initiative

GOAL	OBJECTIVE	STRATEGIES/INTERVENTIONS	ESTIMATED IMPACT
8. Successful implementation of workforce development strategies for self-management, particularly for community health services and GPs.	To work with MDGP and PH Stay Healthy Program (SHP), providing information about workforce training in better health self-management.	<ul style="list-style-type: none"> • FMPPCP EIiCD Self-Management Database described above, including • Information about availability of Better Health Self Management Courses, and the • SNAP Guide for General Practitioners 	A trained work force in better health self management, including GPs
9. Successful implementation of communication and marketing strategies (developed in conjunction with the MDGP) that promote the benefits and availability of local self-management interventions to GPs.	To work with PH SHP to develop a 'program promotion strategy' for use in promoting the Program to both General Practice and other PCP member agencies.	<ul style="list-style-type: none"> • Work with SHP to develop a (DVD) Information Kit for promotion to GPs and other member agencies • GP Liaison Nurse to use kit to promote SHP to GPs. Liaison Nurse to visit 2 GP Practices per week. • FMPPCP CAP Worker to use kit to promote program when visiting PCP member agencies to complete self-management mapping activity. • Community Advocates and GP Liaison Nurse to visit CALD groups, providing information/ access to SHP 	All GPs and staff in FMPPCP member agencies to be aware of SHP.
10. Improved communication and collaborative care planning (by working closely with the Divisions of General Practice) between GPs and community health services.	To embed collaborative care planning between GPs and SHP	Use \$30,000 of PCP EIiCD funding to MDGP to contribute to a GP Liaison position shared jointly b/w MDGP and FCHS SHP. GP Liaison Nurse to develop care plans for chronic illness for use b/w GPs and FCHS SHP.	Consistent, collaborative care planning b/w GPs and Stay Health Program.
11. To ensure that clients get the right care in the right place, regardless of where they enter the service system .	Development and adoption of disease-specific care pathways	<ul style="list-style-type: none"> • GPs and SHP to participate in FMPPCP E-Referral and Service Coordination System • SHP to develop, implement and evaluate Comprehensive Care Plans for use by SHP Key Workers • SHP to develop, implement and evaluate Mini-Screening & Functional Assessment for use by SHP Allied Health Workers • Promote use of relevant SCTTs for initial screening of chronic disease in other PCP member agencies 	Clients get the right care in the right place, regardless of where they enter the service system.
12. Support for change management provided to agencies, particularly community health services, which are implementing new systems/strengthening existing systems to provide proactive care rather than reactive care for clients with chronic disease.	GPs and PH SHP to participate in FMPPCP E-Referral and Service Coordination System.. SHP to participate in FMPPCP Health Promotion Alliance	<ul style="list-style-type: none"> • Support FCHS to review service coordination systems, particularly in relation to ICDM programs, • Provide technical assistance in sending and receiving encrypted e-referrals through PCPs e-referral system • Encourage SHP to nominate a 'health promotion portfolio holder' in the SHP staff two attends HPA meetings and assists Program to implement decisions taken there. 	Clients get the right care in the right place, regardless of where they enter the service system.

GOAL	OBJECTIVE	STRATEGIES/INTERVENTIONS	ESTIMATED IMPACT
13. Facilitation of a process for agencies to develop and implement consistent approaches to the use of decision support tools to support ICDM.	GP Liaison Nurse and SHP key workers to assist clients to receive 'whole of health care' through facilitating care management across PCP member agencies participating in a given client's health care.	Support continuity of care initiatives aimed at providing efficient and effective transfer of health information across the care continuum to improve health outcomes for people with, or at risk of developing, chronic disease.	Effective and efficient system in place supporting whole of health care for clients with chronic disease
14. To contribute to the knowledge base in relation to lessons in relation to ICDM	Dissemination of transferable change management lessons in relation to ICDM.	<ul style="list-style-type: none"> • Through FMPPCP member agency forums • Through FMPPCP newsletters • Through participating in statewide evaluation 	Shared learnings arising from FMPPCPs participation in EIiCD
15. Completion of the statewide evaluation tools for EIiCD.	To meet reporting deadlines as required	To complete the PCP related sections of the statewide evaluation tools for EIiCD	Establishment of best practice in relation to EIiCD across the state.