Lower Hume Primary Care Partnership (LHPCP) Integrated Chronic Care Report 2019-2020

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

2. What agencies have you worked with on continuous improvement in integrated chronic care activity?
    - Alexandra District Health (ADH)
    - Kilmore & District Hospital (K&DH)
    - Nexus Primary Health (NPH)
    - Seymour Health (SH)
    - Yea and District Memorial Hospital (Y&DMH)
    - Lower Hume Aboriginal Health and Wellbeing (LHAH&W) Program
    - Murray Primary Health Network (PHN)
    - National Association of Diabetes Centres (NADC)
    - Healthily
    - University of Melbourne Rural Health (UMRH)
    - Local pharmacies (15)
    - Local GP's (21)

3. What method did you utilise?
    - This work supports the implementation of the Transforming Chronic Care Strategy 2018-2022. The Lower Hume Diabetes Collaborative and Service Development Collaborative continue to implement their sub-regional plans to meet the objectives of improving local diabetes care and embedding health literacy practices within their organisations.
    - This work links with and supports the Victorian Korin Korin Balit-Djak 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?

- Lower Hume agencies last undertook the ACIC in October 2014.
- It was decided not to complete the ACIC in 2019-2020 as there were numerous quality improvement actions that were still being collaboratively implemented and we now had a new regional strategy to incorporate new actions.
- Organisations also continued to progress collaborative NADC pre-audit informed quality improvement actions to work on before applying for accreditation which was incorporated into this work.

5. Do you have a current Improvement Plan based on the ACIC in place?

- The 2018-2019 plans were reviewed and updated in May 2019 (until December 2019) and then again in December 2019 (until June 2020), this was undertaken in 6 month cycles due to uncertainty of PCP funding beyond both 6 month extensions received.
- Strategies and actions were further simplified/changed and timeframes extended to enable better understanding and effective implementation across the entire agency and in line with COVID-19 impacts on partner organisations and consumers.

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 previously completed our own consumer research into local diabetes care through a consumer diabetes survey and focus group. We refer to these results to reinforce positive aspects of local care and areas for improvement to consider as we develop a local model of care.

7. If continuing with any chronic disease activity. What do you plan to focus on, in the area of chronic illness care in 2020-2021?

- Continue a focus on diabetes quality improvements, using the expanded chronic care model and National Association of Diabetes Centres (NADC) audit reviews. Possibly looking at doing another audit as NADC accreditation criteria will be updated in December 2020.
- Review structures to report back and share improvements and learning's between agencies.
- Collaboratively implement quality improvements within diabetes care and health literacy across all agencies.
- Incorporate COVID-19 information, resources and consider impacts when progressing/revising all chronic care work.

Note: These plans were reviewed again in May 2020 and will be implemented until December 2020 again due to uncertainty of PCP funding and COVID-19 impacting on partner organisations having the time, capacity and resources to implement this collaborative work effectively. This has in turn required the System Integration Coordinator to undertake continuous and increased engagement strategies to ensure not only partner organisations continue to progress this work where possible, but also that they continue to work collaboratively with the PCP. The partner organisation feedback has been that they value the collaborative work undertaken and the support provided by PCP to implement this work, but can't see this continuing as collaboratively and effectively if PCP's are not funded for an adequate period of time. This has made embedding chronic care quality improvements across partner organisations within the Lower Hume catchment very difficult as this process takes long term commitment, time, resources and support. There's also been a lot of involvement in building capacity and informing partner organisations of the best practice and appropriate information regarding COVID-19 and it's impacts on the chronic care space and people with chronic conditions, which will be discussed further in our PCP COVID-19 annual report.

Quality improvement activities in chronic illness care

Improvement area	Planned actions to achieve improvements	Agencies involved	Results of actions	Measures used
Health care delivery system	Communicate organisational commitment to chronic illness care.	SH	SH Chronic Illness Care meetings (3) continued to work on and embed diabetes and health literacy quality improvements within and across their organisation up until February 2020 when they were postponed due to COVID-19 impacts.	Bi-monthly meetings and minutes track progress against their plan.
	Murray PHN Goulburn Valley Community Advisory Council (GVCAC) representation to enable Lower Hume community voices are heard regarding health care system improvements.	LHPCP	System Integration Coordinator is a member of the Murray PHN GVCAC. Reviewed and fed back on 2 briefing packs for rounds 3 and 4. Completed 2 briefing rounds engaging with 16 Lower Hume community members regarding: 2 town wellbeing audits; 10 community place interviews; 3 photo descriptions of happy place interviews; and 2 My Health Record expanded community consultations to inform health care system improvements and feedback to Murray PHN board. Also distributed 2 briefing round summary papers to all community members involved. COVID-19 restrictions impacted on the second briefing round as face to face meetings weren't an option. Developed Facebooks posts for the Murray PHN Health Voices, obstetrics referral pathways survey and both briefing round surveys to extend this to the wider community to have their voice heard on local health system delivery matters. Attended Murray PHN GVCAC mental health telehealth consultation to feedback on Lower Hume consumer and clinician experiences regarding barriers and enablers during COVID-19. Supported promotion of and hosted the Seymour live streamed site of the Murray PHN GVCAC's Smiling Minds community event, held in Shepparton. The Seymour site had 8 out of the 12 registered people attend, with very positive feedback. Followed up the event with a Smiling Minds Facebook post with links to their website to promote their mindfulness resources and app.	Number of briefing rounds completed and number of Lower Hume community members engaged/consulted. Community event promoted and hosted.

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	Regional OM-G PCP Coordinators and Statewide System Integration CoP and secretariat groups representation to enable sharing work, support and capacity building opportunities for PCP coordinators to add further benefit to partner organisations.	LHPCP GVPCP CHPCP Other statewide PCP's	System Integration Coordinator is a member of and supports convening the OM-G PCP Coordinators (4), System Integration CoP (3) and System Integration CoP secretariat (6) meetings. System Integration Coordinator organised for Andrew Brown from Deakin University to deliver a 3 hr Systems Thinking training session at the October 2019 System Integration CoP meeting. Also involved in the development and review of the systems thinking presentation, as well as presented on LHPCP systems thinking work.	Quarterly OM-G PCP Coordinator, System Integration CoP and secretariat meetings attended. Basecamp used to share presentations, resources and information from these meetings. An annual evaluation report is submitted to Vic PCP EO'S to show the effectiveness of the CoP.
Self-management support	Self-management support colleague support group and training.	ADH NPH SH Y&DMH LHAH&W Program Murray PHN NADC	Quarterly Lower Hume Diabetes Collaborative (LHDC) meetings (only 3 as the 1 was cancelled due to low numbers) have presentations to aid self-management support and inform quality improvements, including: GoShare Healthcare presented by Healthily and Going Rural Health initiative presented by UMRH.	LHDC quarterly meetings discuss presentation topics and what members will do or have done relating to presentations, to further progress collaborative quality improvements.
	LIFE program local service brochures reviewed and updated annually.	ADH Nexus	Commenced updating the Life Program brochures in February 2020, but then postponed it due to COVID-19 restrictions impacting normal service delivery, resulting in the program not running in 2020.	Life program local service brochures updated and distributed to local pharmacies and within local health services.
	LIFE program to be delivered within Lower Hume.	ADH Nexus	Currently 2 organisations are registered to run the Life program, with 1 running 1 group of 11 workers and partners participants and a community group which was postponed due to no registrations until March 2020 and then again due to COVID-19 restrictions. Currently promoting the Diabetes Victoria Life program telehealth sessions.	Number of agencies registered to deliver Life Program and number of groups run.

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	Pilot the Diabetes Australia SMART program to run in Lower Hume.	Nexus	Nexus staff have completed training for the SMART programs in late 2019. However, the SMART programs were meant to commence in April 2020, but again with COVID-19 restrictions impacting normal service delivery these have not commenced as yet.	Number of SMART sessions run and number of consumers participating in these sessions.
	Review tools for diabetes care planning including Healthily, RACGP one pager, MedWise app and My Health Record.	ADH K&DH NPH SH Y&DMH LHAH&W Program NADC	After evaluation of the Important Diabetes Check Booklet it was decided that it would not be pursued as a regional tool, so the collaborative recommenced reviewing 5 other tools to use. Currently comparing the Healthily GoShare Healthcare and NADC PERL platforms to inform if organisations can implement this patient self-management education platform across the Lower Hume region.	Tools reviewed and agreement on which tools to utilise within agencies and to promote across Lower Hume.
	Implementation of Lower Hume Health Literacy Toolkit.	ADH K&DH NPH SH Y&DM	5 agencies planned and implemented collaborative quality improvements in regards to *Attribute 6: Uses health literacy strategies in interpersonal communication and confirms understanding at all points of contact.* This included running a health literacy campaign during October 2019.	Health literate self-assessment traffic light matrix used to select next attribute to implement collaboratively quality improvement.
			The LHPCP Coordinator sourced and distributed best practice health literacy resources, information and training for organisations to utilise during the campaign. Also developed 6 Facebook posts around the 5 key health literacy promotional messages the collaborative agreed on.	Health Literacy campaign planned, run and evaluated.
			During the health literacy campaign partner organisations: sent emails to staff informing them of what health literacy month would entail; ran a what is health literacy media release in 4 local papers at the start of the month; created service displays regarding the 5 key messages; promoted the Vic PCP online health literacy training to staff; and 3 out of 4 organisations shared the 6 LHPCP Facebook posts to their Facebook pages. This campaign approach was then reviewed and has now become an annual campaign delivered collaboratively by the	

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			Lower Hume Service Development Collaborative. They have commenced planning for the 2020 health literacy campaign and will aim to add more media releases and local radio spot promotion this year. 2 organisations have started to deliver their own face to face health literacy training during induction of new staff.	
Decision support	Agencies sustain primary National Association of Diabetes Centres (NADC) membership and collaboratively support each other to complete accreditation process.	ADH NPH SH Y&DMH NADC	4 agencies have maintained their NADC primary care membership, with 0 agencies currently working through the accreditation process due to limited capacity at the moment. NADC have informed the group that the accreditation workbook and process will be updated by December 2020.	All agencies are primary NADC members and working towards accreditation.
	OM-G Diabetes Clinical Network has Lower Hume representation to enable Lower Hume area understanding.	ADH NEXUS	OM-G Diabetes Clinical Network still has 2 Lower Hume representatives on the governance group, as well as the health literacy, high risk foot and oral health working groups. These groups at the moment don't seem to be progressing due to competing priorities with COVID-19.	Number of collaborative member representatives on the OM-G Diabetes Clinical Network governance and number of working groups involved in.
	Agencies have a commitment to multidisciplinary care for consumers with high risk foot complications	ADH SH Nexus Y&DMH NADC	Commenced updating the high-risk foot brochures in February 2020, but then postponed it due to COVID-19 restrictions impacting normal service delivery, resulting in some services not running in 2020. Also awaiting the NADC foot health accreditation link to go live so we can add it to the brochures.	High risk foot service local brochures updated and distributed to local health services.
Client information system system design	Agencies review processes for following up missed appointments with consumers	ADH NPH SH Y&DMH	Most organisations have informal processes of telephoning or sending a letter out to consumers who miss appointments. 2 organisations have policies/guidelines for following up missed appointments and 3 use a reminder SMS service.	Agencies have processes in place to follow-up missed appointments.
	Agencies work with Murray and Eastern Melbourne PHN's	LHPCP	System Integration Coordinator distributed information, system requirements and resources regarding the importance of using	Number of agencies

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	to register their service for My Health Record.	ADH NPH SH Y&DMH	My Health Record, especially during COVID-19. Still no agencies have registered for My Health Record as ongoing discussion of low use within Lower Hume. Discussion had around first building understanding of the importance of MyHealth Records in the community to advocate for G.P clinics to use within Lower Hume.	registered for My Health Record.
Knowledge of services / Partnering with pharmacies.	Diabetes local service brochures are reviewed annually and updated	ADH K&DH NPH SH Y&DMH	Commenced updating the Diabetes local service brochures in February 2020, but then postponed it due to COVID-19 restrictions impacting normal service delivery, resulting in some services not running in 2020.	Diabetes local service brochures are current and distributed to all pharmacies.
	Agencies work with Murray PHN and Eastern Melbourne PHN to register their service for Health Pathways.	ADH Y&DMH	3 agencies are currently registered, but minimally utilising Murray PHN Health Pathways.	Number of agencies registered and utilising Health Pathways.
	Agencies sustain communication and partnerships with local pharmacies to promote the use of NDSS factsheet resources and local service brochures.	ADH K&DH NPH SH Y&DMH Local pharmacies	All agencies have maintained contact with local pharmacies to sustain partnerships and develop partnership approaches to diabetes care in 2019. System Integration Coordinator developed a NADC Pharmacy Project Case Study relating to the DHHS funded project that finished in June 2019.	All pharmacies contacted at least twice a year (no contact in 2020 due to COVID-19 restrictions). Collaborative pharmacy work is promoted and shared where ever possible.

Further information visit http://lhpcp.org.au/chronic-care/ .