

**MINUTES OF INTEGRATED CHRONIC DISEASE MANAGEMENT
AND SERVICE COORDINATION MEETING
HELD SCHS RAMSAY COURT MEETING ROOM 1**

4TH AUGUST 2010

Present: Jaq Dahliwal, Mandie Hayes, Ruth Fox, Barb Griffiths, Jackie Reddick, Linda Henderson, Rob McGlashan, Susanne Johnston

Apologies: Nicole Shaw, Lydia Senior, Chris Hermans, Peta Weber, Amanda Jones, Cheryl Lacey

Meeting Commenced: 1.00pm

UPDATES FROM ACTION PLAN:

INTEGRATED CHRONIC DISEASE MANAGEMENT

1. Care Planning

1.1 *Gather data and explore local problems with regards to care planning – conduct local audits and share results*

A survey was prepared and distributed to all members of the Integrated Chronic Disease Management and Service Coordination group. The survey was to gather data and explore local problems with regards to care planning – conduct local audits and share results. This survey has been completed and results compiled as they were received in an attachment to these minutes. A presentation on the results will be presented at a later meeting.

All agencies were asked to bring along a copy of their care plans which they use in their organization, we had a few agencies bring theirs along but ran out of time at that particular meeting to discuss the differences. Will look at this at a later date.

It was decided as a group that we need to establish a common understanding of what “Care Planning” is for this project and have all services utilizing a common care planning system to be used across the Northern Mallee region, and also to have everyone using the same language. Jackie Reddick will be presenting the different types of care plans currently being utilized being: individual plans, intra agency plans and inter agency plans. For the purpose of this project we are looking at inter agency plans across the Northern Mallee region.

A presentation on ARGUS was given by Troy Bailey of Mallee Health Care Network, Troy gave an informative update on who uses ARGUS and how the system works between GP’s and service providers. A copy of this presentation can be obtained by contacting the Northern Mallee Primary Care Partnership.

ARGUS and Connecting Care have now both been taken over by DCA. Rob McGlashan is now the regional representative for this meeting and will be reporting back to this group with updates on the progress and any changes to be made with regard to ARGUS or Connecting Care.

1.2 *Local education re care planning – its current status locally (from audits) and best practice/direction, to achieve a common understanding of care planning and build the rationale for improvement*

NMPCP will look into education around “What is Care Planning” for practitioners so that everyone in the Northern Mallee region have the same understanding of what care planning is for this particular project. \$10,000 has been allocated from PCP funding to run “Care Planning Workshops” once the working party have decided on a single care planning tool to be utilized across the PCP catchment.

1.3 *Care Planning Collaborative: Use a quality improvement process to improve care planning across Northern Mallee, which involves facilitated workshops, Plan-Do-Study-Act cycles and facilitator support for participants between workshops*

Plans are underway to provide Plan-Do-Study-Act cycles to our Northern Mallee region. Awaiting further information from the Department of Health.

1.4 *Issues and opportunities for future work beyond the 2010 Care Planning Collaborative identified*

Nothing to report at this stage.

2. Diabetes Pathways

2.1 *Finalise pathway and protocol for people with diabetes accessing the visiting endocrinologists (paed & adult)*

This document is currently being reviewed.

2.2 *Review all available services for people with diabetes (Type 1, Type 2 and Gestational) in the Northern Mallee against the Loddon Mallee Regional Diabetes Pathways published in 2009*

The Collaborative Health Education and Research Centre (CHERC) Bendigo Health have successfully been appointed to provide the Loddon Mallee Region with workshops for the implementation of diabetes pathways.

CHERC are holding a Regional Diabetes Pathways workshop on September 1st 2010 at Mildura Private Hospital from 12.00 – 2.30pm. This workshop is to discuss “Where are they leading?” Information sharing and gathering for diabetes service providers.

A new project officer has been employed with Mallee Health Care Network to implement the “Reset Your Life” project. She is working with Sunraysia Community Health Services, GP’s, Mallee Track Health Services, and Robinvale Health Services to increase the awareness of 40-49 year olds as to the risk of pre-diabetes. This program is similar to the “LIFE” program. The project is to run from June to November 2010, there has already been an increase in referrals since the start of the project.

3. Strengthening Primary Health Care for Aboriginal People

This project has been put on hold for now.

4. Osteoporosis

4.1 *Investigate the high prevalence of osteoporosis in the Northern Mallee*

4.2 *Identify appropriate opportunities for intervention of improvement around osteoporosis*

Arthritis

Arthritis Victoria Inc. Osteoporosis Victoria are conducting a “Get Active With Arthritis Workshop” on Tuesday 17th August from 6.30pm – 8.15pm at the Alfred Deakin Centre.

Arthritis Victoria has recently begun planning an exciting new project – the Arthritis Map of Victoria. The project, co funded by the Ian Potter Foundation, will develop a dynamic and interactive online map that will display the latest information on the prevalence of arthritis and osteoporosis across Victoria. It will also display information on relevant local services such as rheumatologist, physical activity classes and self-help groups. The map will help improve understanding of the impact of arthritis and osteoporosis on the population of Victoria and improve future planning and service delivery. They are inviting input into the development of the map at a planning workshop. NMPCP will follow up and report back to the group.

4.3 Other

Physical Activity for Older Adults Directory has been completed and distributed across the Northern Mallee PCP catchment area.

A consultant has been employed to develop a Community Health & Wellbeing Profile for the Northern Mallee PCP catchment area. Members of the working group are encouraged to provide input into this profile.

5. Partnership Development

5.1 Confirm structure of Northern Mallee PCP's ICDM work

Completed and ongoing

5.2 Merge PCP's Service Coordination and Chronic Disease activity

Completed

5.3 Ensure that all service providers involved in chronic disease management are engaged in the care planning collaborative

Completed and ongoing

5.4 Recruit project officer to lead ICDM work

Completed. Susanne Johnston & Rebecca Koren

5.5 Ensure that key stakeholders in the SPHCAP project are engaged in PCP ICDM work

Completed and ongoing

SERVICE COORDINATION

1. Increase awareness and use of e-communication capabilities within agencies

1.1 Support agencies new to e-communication to implement e-communication capabilities

Ongoing

1.2 Provide ongoing support to existing e-communication enabled agencies

Ongoing

1.3 Encourage agencies to utilize the electronic acknowledgement and feedback capabilities of connectingcare.com

Ongoing

1.4 Support agencies to adopt e-communication process and imbed into processes and procedures

- Mildura Rural City Council - Completed and working well
- Mildura Base Hospital Midwider – Completed and working well
- Robinvale District Health Services – completed, but need to check on Robinvale Maternal and & Child Health Services
- Mildura Aboriginal Corporation – need to check

- Mallee Health Care Network – work going on
 - Support other agencies – ongoing
2. Improve access to services for consumers in Northern Mallee
- 2.1 Agencies develop and implement a streamlined, consistent approach to initial needs identification, referral, assessment and care planning**
- 2.2 Agencies improve the quality and accuracy of information provided for e-communication**
- 2.3 Support development of interagency protocols and agreements to streamline interagency processes**
- Work with local Diabetes Service providers to develop interagency protocols for referral and management of consumers accessing visiting endocrinologist clinics – in progress
 - Work with local HACC Meals on Wheels and Assessment providers to develop local protocols for assessment and referral of HACC eligible consumers for Meals on Wheels services – Completed
 - Work with Mildura Base Hospital Midwifery Services and providers of Maternal & Child Health Services to improve the delivery, accuracy and feedback of information related to birth notifications and discharge plans for new births – in progress
3. Improve agencies and the community's awareness of services provided by other agencies in the Northern Mallee
- 3.1 Support opportunities for information sharing and collaborative promotional activities**
Ongoing
- 3.2 Support opportunities for print and electronic information sharing**
Ongoing
- 3.3 Create opportunities for interagency information sharing**
Ongoing
4. Continue to implement the Victorian Service Coordination Practice manual and Service Coordination Tool Templates (SCTT) / Victorian Statewide Referral Form (VSRF) to a broader range of services and programs
- 4.1 Support services and programs new to service coordination to implement Service Coordination processes and tools**
- 4.2 Work with Division of GP's to encourage use of the Victorian Statewide Referral Form**
- 4.3 Increase awareness of VSRF to non GP agencies**
5. Other Business
- 5.1** No meeting in September due to Diabetes Workshop
- 5.2** New look agenda and minutes

Meeting closed: 2.15pm

Next meeting: Wednesday 6th October 2010 at 1.00pm, Meeting Room 1, SCHS Ramsay Court.