

**NORTHERN MALLEE PCP CHRONIC DISEASE PARTNERSHIP WORKING PARTY  
INTEGRATED CHRONIC DISEASE MANAGEMENT/SERVICE CO-ORDINATION  
MINUTES/ACTION PLAN 2010-2012**

**Wednesday 7th July 2010 at 1.00pm, Meeting Room 1, SCHS Ramsay Court**

**Present:** Jackie Reddick, Nicole Shaw, Rob McGlashan, Susanne Johnston, Chris Hermans, Sharen Digby, Peta Weber, Jenny Stringer, Barb Griffiths, Troy Bailey, Cheryl Lacey, Tara Williams, Ruth Fox, Jenny Lloyd, Lindal Munroe, Michelle Gray, Dallas Kirby

**Apologies:** Jaq Dhaliwal, Linda Henderson, Lana Hura, Stephan Parr

**Guest Speaker: Troy Bailey – ARGUS** Troy gave a presentation on where ARGUS is up to within our region. This system is working well for the GP's. A copy of the presentation has been circulated with these minutes for your perusal. Troy also has a CD available which explains the ARGUS system for people to have a look at.

Activity	Outputs	Activity finalised	Responsible	Impacts	Progress
<b>1. Care Planning</b>					
1.1. Gather data and explore local problems with regards to care planning – conduct local audits and share results	<ul style="list-style-type: none"> <li>• Items to audit determined by each agency</li> <li>• Audits conducted at each agency</li> <li>• Audit results shared and explored at a meeting between all participating agencies</li> <li>• Content of local education workshops determined and informed by audit results</li> </ul>	2010	S J	Increase number of care plans in Northern Mallee that meet the VHA criteria (see attached)  Care planning processes documented*  Improved consistency in	<b>5.5.10</b> Research existing care plan tools used by service providers and the problems associated with these tools. Survey to be sent out. <b>2.6.10</b> <ul style="list-style-type: none"> <li>• Results of the survey are still coming in and will be reviewed next meeting.</li> <li>• It was decided that as a group we need to establish a common understanding of what “Care Planning” is for this project, and to all be using the same terminology.</li> <li>• An example of each</li> </ul>

				care planning*	<p>agencies “Care Plan” will be presented at the next meeting for all to look at and discuss.</p> <p><b>7.7.10</b> NMPCP will follow up with ARGUS and Connecting care to see where these two programs are sitting and whether there is a chance that the 2 could merge into one?</p>
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	<ul style="list-style-type: none"> <li>• Three workshops – Mildura (SCHS, Hospital, MAHS), Robinvale (RDHS, MVAC) and Mallee Track (MTHCS) – attended by 80% of staff in chronic disease or allied health teams</li> </ul>	June 2010	All		<p><b>7.7.10</b> 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.</p>
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	<ul style="list-style-type: none"> <li>• Experienced facilitator engaged</li> <li>• Three facilitated learning workshops attended by 2-3 reps of each agency</li> <li>• All participating agencies complete Plan Do Study Act cycles about care planning between workshops</li> </ul>	July – Nov 2010	All		<p><b>2.6.10</b> \$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 utilised across the PCP catchment.</p>
1.4. Issues and opportunities for future work beyond the 2010 Care Planning Collaborative identified	<ul style="list-style-type: none"> <li>• Issues for future work identified during the Collaborative process, documented and report to PCP Executive</li> </ul>	Dec 2010	PCP EO		
* These three elements of care planning were identified as highest priority at the second strategic planning workshop.					

<b>2. Diabetes Pathways</b>					
<p>2.1. Finalise pathway and protocol for people with diabetes accessing the visiting endocrinologists (paed &amp; adult)</p>	<ul style="list-style-type: none"> <li>• Pathway for visiting endocrinologists documented and endorsed by endocrinologists, diabetes educators and health service leaders via PCP Executive</li> <li>• Pathway used by all Northern Mallee Health services and use confirmed</li> </ul>	<p>June 2010 Dec 2010</p>	<p>All</p>	<p>Diabetes service gaps in Northern Mallee identified and regional planning to fill them underway</p> <p>Shared understanding of best practice diabetes care</p>	<p><b>5.5.10</b> Joint submission being put in with CHERC as lead agency to DHA.</p> <p><b>2.6.10</b> This document is currently being reviewed.</p> <p><b>7.7.10</b> CHERC have successfully been appointed to provide the Loddon Mallee Region with workshops for the implementation of diabetes pathways. (Copy attached to minutes)</p>
<p>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</p>	<ul style="list-style-type: none"> <li>• Workshop with all providing services to people with diabetes represented</li> <li>• Outcomes of workshop documented</li> <li>• Report to PCP Executive the service gaps or improvements required to meet best practice</li> <li>• PCP Executive's resulting actions shared with workshop participants</li> <li>• People living with diabetes in Northern Mallee consulted on service gaps, and informed of PCP Executive's actions</li> </ul>	<p>June 2010 July 2010 Dec 2010 Dec 2010</p>	<p>All</p>		
<b>3. Strengthening Primary Health Care for Aboriginal People</b>					

<p>3.1. Link Care Planning Collaborative detailed in Section 1 of this work plan to SPHAC project, with MAHS and MVAC as key stakeholders– develop appropriate strategies</p>	<ul style="list-style-type: none"> <li>• MAHS, MVAC and other stakeholders in SPHAC project participate in quality improvement activities focused on care planning</li> <li>• SPHCAP project objectives around care planning are met</li> </ul>	<p>Jun 2010</p>	<p>All</p>	<p>Increase number of care plans for aboriginal people in Northern Mallee that meet the VHA criteria</p> <p>Improve health of aboriginal people in Northern Mallee</p>	<p><b>5.5.10</b> NMPCP met with Graeme Fletcher from VACCHO and waiting for copy of their SPHAC implementation plan and Barbara Griffiths from MDGP reported recruiting for SPHAC Project Officer currently in progress this will sit with MDGP.</p> <p><b>2.6.10</b> Nothing to report this month.</p>
<p>3.2. Coordinate the recruitment, orientation and support of staff to be appointed by the SPHAC project, the Regional Closing the Gap strategy, the DGP Closing the Gap position/s and PCP ICDM projects</p>	<ul style="list-style-type: none"> <li>• Project staff for PCP ICDM work, SPHCAP, Regional Closing the Gap strategy, DGP Closing the Gap are recruited, orientated and supported in a manner that demonstrably shares resources and experience between the PCP and MAHS</li> </ul>	<p>Apr 2010</p>	<p>All</p>		
<p>3.3. Ensure there is not duplication between activities pursued by the SPHCAP project, Regional Closing the Gap strategy, DGP Closing the Gap work and PCP work</p>	<ul style="list-style-type: none"> <li>• Work plans for SPHCAP, Regional Closing the Gap, DGP Closing the Gap and PCP ICDM do not duplicate activities</li> </ul>	<p>Apr 2010</p>	<p>All</p>		
<p><b>4. Osteoporosis &amp; Arthritis</b></p>					
<p>4.1. Investigate the high prevalence of osteoporosis in the Northern Mallee</p>	<ul style="list-style-type: none"> <li>• Report to PCP ICDM Working Group which details age breakdown, service utilisation, comparison populations and other key features of osteoporosis in Northern Mallee</li> </ul>	<p>Dec 2010</p>	<p>PCP EO</p>	<p>Effective strategies developed to address osteoporosis in Northern Mallee</p>	<p><b>5.5.10</b> Physical Activity for Older Adults Directory has been completed and distributed.</p> <p><b>2.6.10</b> A consultant has been employed to develop a Health &amp; Wellbeing Profile. Members of the working group are encouraged to have input into this profile.</p>

4.2. Identify appropriate opportunities for intervention or improvement around osteoporosis	<ul style="list-style-type: none"> <li>PCP ICDM Working Group work plan details a plan of action around osteoporosis</li> </ul>	Jun 2011	All		
<b>5. Partnership Development</b>					
5.1. Confirm structure of Northern Mallee PCP's ICDM work	<ul style="list-style-type: none"> <li>Structure of PCP ICDM work (including members of all groups and roles of each group) documented and confirmed by all groups</li> </ul>	Mar 2010	PCP EO	Strong and effective partnership between all Northern Mallee agencies supporting people living with chronic disease	5.5.10 Collate interested parties to be added to partnership group. Formed network members list for distribution. 7.7.10 Completed and ongoing
5.2. Merge PCP's Service Coordination and Chronic Disease activity	<ul style="list-style-type: none"> <li>SC work plan 2009-12 developed that is merged with or complementary to ICDM work plan 2009-12</li> <li>Governance structure for SC work of PCP does not supplantation ICDM structure</li> </ul>	June 2010	PCP EO		5.5.10 <b>Completed.</b>
5.3. Ensure that all service providers involved in chronic disease management are engaged in the care planning collaborative	<ul style="list-style-type: none"> <li>SCHS, MTHS, RDHS, Division of General Practice, MAHS, MVAC, Mildura Hospital acute services and outpatient services all participate in Care Planning Collaborative</li> </ul>	April 2010	PCP EO		5.5.10 In progress 7.7.10 Completed and ongoing
5.4. Recruit project officer to lead ICDM work	<ul style="list-style-type: none"> <li>Appropriately qualified project officer appointed, using statewide PCP Project Officer recruitment checklist</li> </ul>	April 2010	PCP EO		5.5.10 <b>Completed. Susanne Johnston &amp; Rebecca Koren.</b>
5.5. Ensure that key stakeholders in the SPHCAP project are engaged in PCP ICDM work	<ul style="list-style-type: none"> <li>MAHS, MVAC and other stakeholders in SPHAC project participate in quality improvement activities focused on care planning</li> </ul>	June 2010	All		5.5.10 In progress. 7.7.10 Completed and ongoing

## 6. Other Business:

6.1 **Terms of Reference** – Any one with any comments, send through to Rob prior to next meeting. **2.6.10** It was decided that we need clear guidelines from NMPCP executive as to which agencies should be represented on this working party from both the Service Co-ordination and Integrated Chronic Disease Management groups. **7.7.10** The terms of reference stand as they are currently.

6.2 **Name Change** – If any one has any ideas for a new name for this meeting as current one way to long winded, please bring your suggestions along to the next meeting or email Rob. **2.6.10** No feedback at this stage. **7.7.10** The name will stand as it is until further notice.

**Meeting Closed:** 2.05pm

**Next meeting:** Wednesday 4th August 2010 at 1.00pm, meeting Room 1, SCHS Ramsay Court.

**Notes:** PCP EO – Primary Care Partnership Executive Officer; MTHCS - Mallee Track Health & Community Service; RDHS - Robinvale District Health Services  
SCHS – Sunraysia Community Health Service; MVAC - Murray Valley Aboriginal Co-operative; MAHS – Mildura Aboriginal Health Service; Hospital – Mildura Base Hospital; SPHCAP  
- Strengthening Primary Health Care for Aboriginal People project at SCHS & MAHS 2009-12; DGP - Division of General Practice