WPCP Integrated Chronic Disease Management - Case Study

Details of PCP contact

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<th>Name of PCP</th>
<th>Wellington Primary Care Partnership</th>
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<tbody>
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Identified Partners

<table>
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<tr>
<th>Partner Organisation</th>
<th>Roles and responsibilities with regard to the project</th>
<th>Contact person details (name, position)</th>
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<tbody>
<tr>
<td>East Gippsland PCP</td>
<td>Collaborated to produce and promote training calendar, organise training, provide ongoing post training support</td>
<td>Emily Durbridge. CDM Project Worker</td>
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<td>Wellington PCP</td>
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<td>Lorrie Read/Mel Hibbins, CDM Project Worker SCPCP</td>
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<td>South Coast PCP</td>
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<td>Rosemary Harbridge, Manager ICDM CWGPCP</td>
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<td>Central West Gippsland PCP</td>
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Case Study Title

Self Management: The way forward in Gippsland

Summary/Abstract (200 words)

Before the Better Health Care In Gippsland Project (2004/06), the Gippsland PCPs implemented an agreed regional approach to ICDM and Service Coordination.

In 2007, a statewide self-management mapping exercise occurred. In early 2008 the mapping report was distributed, which highlighted a skills shortage in self-management, and a lack of organisational support for self-management.

Gippsland PCPs collaborated to design, implement and evaluate a self-management training plan. The plan included post training support and a follow-up survey.

The models delivered were:
- Motivational Interviewing
- Stanford University Better Health Self Management
- Health Coaching

Key evaluation findings:
- Need for ongoing mentoring and support
- Key challenges include time, funding and organisational support
- The need for ongoing system redesign work and quality improvement as per the Chronic Care Model

The results of the training evaluation will inform future work of the PCPs and determine how to provide ongoing post training support across the region and locally.

Post training support encouraged the transference of knowledge into practice and behaviour change. In Wellington, this has included peer support and professional development at CDM Network meetings, and monitoring through the CDM worker. Post training support is ongoing and a component of the WPCP Strategic Plan.
### Background

#### Name of Project
Gippsland Integrated Chronic Disease Management Training Program 2007-2010

#### Target client group
- Health practitioners and managers
- Clients will benefit as a result of training program

#### DHS ICDM expectations 2009-12
The *Gippsland Integrated Chronic Disease Management Training Plan* addressed earlier issues raised by the 2006-2009 CHIPIA, and continues to enhance the capacity of the local workforce to provide coordinated, best practice clinical care and support for self-management (*PCP Revised Program Logic, 2009, p.5*).  

### Background

This project was designed in response to the findings of the Department of Health’s 2007 Self Management (SM) Mapping, which highlighted a shortage in skills and organisational support for chronic disease self management (Appendix 1).

The decision to focus upon Better Health Self Management (BHSM), Health Coaching (HC) and Motivational Interviewing (MI) was endorsed in early 2008 by Gippsland Health Services Partnership (GHSP, regional body).

During June 2008, the Gippsland PCP ICDM Workers developed a training plan to address the issues identified by the SM Mapping, which were:
- The need for training; and
- Organisational support for SM practice.

Each worker researched, organised training and provided post-training support. A follow-up survey conducted in July 2010 evaluated the training program.

In Wellington, partner agencies have trained in and implemented the Stanford BHSM program and health coaching. Wellington CDM Network has provided post training support and professional development activities.

The project delivered on building the capacity of the Gippsland health practitioners to provide SM support for clients with chronic disease. This was a component of the 2006-2009 CHIPIA and WPCP Strategic Plan 2009-2012 (Appendix 2).

The objectives for the project were to:
- Deliver a regional self management training calendar
- Provide post training support
- Evaluate the calendar by surveying participants
- Inform future training and post training support activities from evaluation report
- Ensure Wellington needs are included

### Objectives
The overall aim of the project was to build workforce capacity to improve client outcomes in the management of chronic disease.
Specific objectives were to:
- Provide self-management training for health practitioners
- Provide localised post training support and networking opportunities for practitioners
- Review and report on training outcomes including post training support

**Project participants**

- Training participants: practice nurses, community and allied health workers, bush nurses, management staff, volunteers
- PCP ICDM staff

**Methodology and approach**

The training models delivered to over 160 participants were:
- Motivational interviewing (MI)
- Stanford University Better Health Self Management (BHSM)
- Health Coaching (HC)

The key project activities were:
- Collaboration between the PCP ICDM workers: regular contact via email, phone and meetings to design the training program
- Training workshops were organised in different locations across the region to meet the geographical differences in the region
- Launch and promotion of calendar
- Targeting specific people to ensure correct audience
- Requesting management support for attendance at training and participation in post training support activities
- Followup survey to investigate whether there has been an improvement in practice and behaviour
- PCP ICDM staff facilitated post training and peer support locally
- Workshop learnings shared across the region
- Implementation of the BHSM program in Wellington, and some aspects of health coaching

The resources used during the project include:
- Statewide SM mapping results
- The BHCiG Resource Kit
- Other tools provided during the training program:
  - BHSM tools located on the Stanford University website
  - Partners in Health Scale
  - Assessment of Chronic Illness Care Audit tool
  - Wagner Chronic Care Model
- Training facilitators

Participants of BHSM and HC were required to obtain management support and sponsorship to attend the training (Appendices 3 & 4). This was to ensure that suitable people were attending training and would implement the programs back in the workplace.

External trainers from Melbourne were engaged to deliver BHSM and HC therefore, it was essential that participants would actually implement their training after completion. A financial commitment was required for health coaching training in WPCP and EGPCP, along with management support and commitment to participate in post training support activities and implementation of skills.

In Wellington, the Stanford leaders have been meeting and communicating through the CDM network to support each other. The CDM worker has also provided followup and
Providing training and networking opportunities around care coordination and self-management, builds the capacity of agencies to deliver best practice chronic illness care, as described in the WPCP Strategic Plan (Appendix 1).

Service coordination is a tool for ICDM, and is more than just e-referral. The SM Mapping and followup survey identified gaps in care coordination, organisational support and referrals.

The Expanded Chronic Care Model emphasises the importance of SM support, delivery system design, decision support and the interaction between health promotion principles and ICDM (Expanded Chronic Care Model, 2003).

Building supportive environments, empowering individuals to self manage and building a supportive community will be a result of upskilling health professionals. The BHSM program is an example of developing skills of individuals and creating supportive environments. Sending the message out to the community and developing personal skills, will help to achieve an activated community and activated clients (Expanded Chronic Care Model, 2003).

Email, phone and face-to-face discussions occurred between PCP ICDM workers, training participants and management figures within agencies. Local PCP updates, newsletters and meetings were the mechanisms used to promote the training program.

The PCP Managers kept GHSP informed during the project and will forward the evaluation report when completed.

Post training support occurred via phone, email and meetings with the ICDM workers and local networks. Some agencies have chosen to provide their own support through discussion at team meetings and senior management discussion.

Gippsland Divisions of General Practice assisted in the development of the calendar, to ensure scheduling to maximise participation rates across sectors. The Divisions were an important vehicle for supporting and promoting the calendar into general practices, as practice staff attended MI and HC training in Wellington.

### Results

| Service improvement and innovation | In Wellington, of the 8 people trained in BHSM, only 3 have successfully implemented the 6-week workshop. Two participants moved away (including the Master Trainer) and the other participants were unable to run a course due to time constraints and the program not relating to their position. Of the 16 people trained in HC in Wellington, 11 people were health practitioners with the potential to implement the model. Two practitioners from CGHS attended the regional MI in Warragul in 2009. Unfortunately, both have since moved on from CGHS. WPCP are training more people in motivational interviewing in September 2010 and February 2011. In Wellington:  • CGHS has run 3 BHSM groups to date, with a total of 18 people completing the course  • One of these groups was run in outlying areas which was very successful  • The only issue CGHS have experienced is getting the initial figures to form a group. It has been featured in |

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Wellington PCP Integrated Chronic Disease Management Case Study
the local newspaper but it needs more publicity and positive feedback (see Appendices 7 & 8)

- CGHS staff have the full backing of the organisation to address CDM but need the community to recognise they have a chronic disease and there are systems that can be put in place to help them live with it
- Partnerships built with stakeholders included outlying facilities and multidisciplinary team. CGHS need to focus on GP referral into SM programs in future.

### Outcomes

Under the training program, approximately 26 participants were from Wellington including people who attended multiple courses.

Of those trained under the regional training plan, 32 people completed the follow up survey (Appendix 5).

The survey identified these main themes:

- Time and funding are a problem
- Lack of organisational support
- Ongoing mentoring and support is required

Difficulties identified:

- Six-week BHSM commitment from clients and staff is difficult.
- Some clients are not accustomed to SM and have a different expectation from health professionals.
- Some elements of HC are practiced but not to the full extent due to time constraints and complex clients.
- Understanding of SM is varied
- Managers were provided with adequate information about the trainings offered, however inappropriate staff members attended training
- In Wellington and East Gippsland, two people were trained as Stanford Master Trainers to address sustainability needs. Unfortunately, the Wellington Master Trainer has moved away.

Recommendations for ongoing work include:

- Further post training support in Wellington
- Further Community of Practice forums
- Further training including updates
- Organisation wide Chronic Care Model implementation as part of the WPCP Strategic Plan.

In Wellington, post-training support has been key to systems change. WPCP has set up organisational capacity for change by ensuring more than one person from an organisation attends training. This enhances learning, increases organisational support and likelihood of implementation of new skills.

WPCP has engaged the CDM Network in mentoring, professional development and peer support activities. Practitioners experience the benefits of regular discussion with their peers and the members benefit from learning from each other’s experiences.

The Wellington CDM Network has consistent numbers and representation across sectors and agencies, providing added benefit and sustainability to post training support.
### Status and sustainability

The evaluation report will be distributed when available, and the learnings shared locally, regionally and potentially statewide (Draft Evaluation Report: Appendix 6).

Through an agreed regional approach to collaboration, the ICDM project workers are continuing to focus on:

- Networking and support
- SM training across the region; and
- Developing and supporting local training expertise

CGHS BHSM plans:

- Local interest from Arthritis Support Group and Maffra Senior Citizens
- Four groups planned next year; one is planned for Rosedale and an evening group in Sale
- BHSM has had positive impacts on some participants and will use this to promote courses (Appendices 7 & 8)
- CGHS are trialling a care coordination model. This will enhance the skills of those trained in SM through implementation, mentoring and support across the organisation
- WPCP are investigating training a BHSM Master Trainer to meet future training needs and sustainability issues

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YDHS have been running BHSM programs regularly for years and average 3 programs a year.

In Wellington, two volunteers and a health professional have recently trained in BHSM (YDHS & CGHS). There is an update organised for November for BHSM leaders to maintain accreditation.

The Wellington CDM Worker will continue to provide peer support and professional development opportunities through the CDM Network.

WPCP are committed to ongoing referral pathways work as part of improving the client journey and coordinating care.

WPCP are creating a document detailing self-management programs across the catchment to aid in referrals.

### Conclusions

In response to the statewide mapping exercise in 2007, the 4 Gippsland PCPs agreed to work together to address the ICDM needs of the region. A regional training plan was created, implemented and has been evaluated with a follow up survey of participants.

Key success factors across the region

- Peer support/mentoring in the workplace and through PCP
- Changes in client health behaviours
- Systems change in organisations
- Increase in practitioners trained in SM
- Increase in SM programs offered
- Peer support

Key challenges from the survey include:

- Inadequate time to practice SM techniques with clients
- Inadequate computer system for monitoring and following up clients
- Lack of coordinated approach to CDM
Limitations of the project include:
- Small number completed the survey
- Funding and time constraints
- Lack of organisational and systems support
- Staff turnover in organisations
- Understanding of SM is varied

There is ongoing regional commitment to collaboration, capacity building and workforce development. There are regular meetings with PCP ICDM workers including discussion around ongoing support for past, present and future training participants.

Through the Early Intervention Project, CGHS are trialling a care coordination model, which is a new direction for the organisation. This will include looking at referrals into self-management programs for clients with chronic conditions.

WPCP is committed to providing practitioners with professional development opportunities, training and post training support to ensure agencies are providing best practice chronic disease care for their clients. The CDM Network will continue to prioritise this activity.

References (optional)

Department of Human Services 2009, Primary Care Partnerships Revised Program Logic July 2009, Department of Human Services, Government of Victoria, Melbourne.  

Improving Chronic Illness Care 1999, The Chronic Care Model, MacColl Institute for Healthcare Innovation, Seattle, Washington USA  
http://www.improvingchroniccare.org/index.php?p=The_Chronic_Care_Model&s=2

Improving Chronic Illness Care 2003, The Expanded Chronic Care Model, The MacColl Institute for Healthcare Innovation, Seattle, Washington USA  

List of Appendices

1. Statewide Mapping Report

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   sm_mapping_report_0607.pdf

2. WPCP Strategic Plan

   [PDF]

   1_WPCP_Strategic_Plan_24_Nov_09.doc


   [PDF]

   BHSM_Flyer_FINAL_Page_1.pdf

5. Evaluation Survey


7. BHSM Participant Letter #1

8. BHSM Participant Letter #2

List of Acronyms

- **BHSW**: Better Health Self Management (Stanford University)
- **CDM**: Chronic Disease Management
- **CGHS**: Central Gippsland Health Service
- **CWGPCP**: Central West Gippsland Primary Care Partnership
- **GHSP**: Gippsland Health Services Partnership
- **HC**: Health Coaching
- **ICDM**: Integrated Chronic Disease Management
- **MI**: Motivational Interviewing
- **PCP**: Primary Care Partnership
- **SCPCP**: South Coast Primary Care Partnership
- **SM**: Self Management
- **WPCP**: Wellington Primary Care Partnership
- **YDHS**: Yarram & District Health Service