

## PCP Integrated Chronic Disease Management - Case study

### Details of PCP contact

<b>Name of PCP</b>	Bendigo Loddon
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<b>Position/Title</b>	Programs Coordinator
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### Identified Partners

<b>Partner Organisation</b>	<b>Roles and responsibilities with regard to the project</b>	<b>Contact person details (name, position)</b>
Dingee Bush Nursing Centre	<p>Provision of clinician and peer support volunteer for Better Health Self Management (BHSM) training.</p> <p>Marketing and registrations.</p> <p>Liaison with participants.</p> <p>Provision of venue and catering.</p> <p>Conduct of the BHSM sessions.</p> <p>Evaluation of the Dingee course.</p>	Viv Fazulla – Nurse Manager
Inglewood and Districts Health Service	<p>Provision of clinician and peer support volunteer for BHSM training.</p> <p>Marketing and registrations.</p> <p>Liaison with participants.</p> <p>Provision of venue and catering.</p> <p>Conduct of the BHSM sessions.</p> <p>Evaluation of the Korong Vale course.</p>	Jenny Boromeo – Diabetes Nurse Educator
Boort District Health	<p>Work in partnership with Northern Districts Community Health Service to provide a BHSM course in Boort.</p> <p>Marketing and registrations.</p> <p>Liaison with participants.</p> <p>Provision of venue and catering.</p> <p>Conduct of the BHSM sessions.</p> <p>Evaluation of the Boort course.</p>	Judy Keath – Director of Nursing and Client Care

Northern Districts Community Health Service	Work in partnership with Boort District Health to provide a BHSM course in Boort.  Marketing and registrations. Liaison with participants. Provision of venue and catering. Conduct of the BHSM sessions. Evaluation of the Boort course.	Angela Roney – Diabetes Nurse Educator
Murray Plains Division of General Practice	Promotion of BHSM Course through Medical Practices in Loddon Shire.	Judith Murray – Chronic Disease Project Worker
Loddon Shire Council	Promotion of BHSM Course through HACC Services in Loddon Shire.	Wendy Gladman – Manager Community Services
Bendigo Community Health Services	Meet with the Diabetes in Loddon Action Group regularly.  Arrange training in BHSM for 2 clinicians and 2 peer volunteers.  Provide marketing materials. Evaluation of the project.	Jan Moore – Diabetes Nurse Educator
Bendigo Loddon PCP Secretariat.	Provision of funding. Resourcing and advice.  Licence from Stanford University.  Annual Reports to Stanford University.	Leah Wilson – Programs Coordinator

Case Study Title	Development of Self Management Groups for People Living with Type 2 Diabetes in the Loddon Shire.
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### Summary/Abstract (200 words)

The Diabetes in Loddon Action Group is auspiced by the Bendigo Loddon Primary Care Partnership and was formed in 2007 as a result of a Loddon Shire Council request for the PCP to assist in supporting the growing numbers of people in the Shire who were living with diabetes, and assist the community to prevent diabetes. One of the strategies included in the 2009-2012 Work Plan of the Group is to develop the capacity of the agencies in the Loddon Shire to conduct Better Health Self Management Groups across the Shire.

This project was chosen for a case study as 10.3% of the population in the Loddon Shire has diabetes and this is the highest percentage of all local government areas in Victoria. No agencies received funds to address diabetes in the Shire although a small rural health service and a community health service provided part time diabetes nurse educators in the area. No Better Health Self Management courses had been delivered previously in the Loddon Shire. The project trained four people to conduct the BHSM courses, obtained a licence for the courses from Stanford University, enabled 5 BHSM courses to be promoted, and conducted across the Shire and continues to provide support and advice to the graduates of the BHSM courses.

## Background

<b>Name of Project</b>	<p>Development of Self Management Groups for people living with Type 2 Diabetes in the Loddon Shire.</p> <p>This is a project of the Diabetes in Loddon Action Group which aims to focus on the prevention and support of Type 2 diabetes in the Loddon Shire.</p>
<b>Target client group</b>	<p>People living with Diabetes Type 2 in the Loddon Shire.</p>
<b>DHS ICDM expectations 2009-12</b>	<p>Develop implementation plans to enhance the capacity of the local workforce to provide coordinated best practice support for self management.</p> <p>Develop local service systems that provide support for self management in the Loddon Shire.</p> <p>The ICDM funded agency (BCHS) had active participation in PCP processes with relevant stakeholders.</p>
<b>Background</b>	<p>“Chronic diseases currently make up more than 70% of Australia’s overall disease burden due to death, disability and diminished quality of life. This is expected to increase to 80% by 2020” (Australian Institute of Health and Welfare 2002). It is estimated that there are over 833 people who have been diagnosed with Diabetes in the Loddon Shire and 1.1 new cases are being diagnosed each week (<a href="http://www.diabetesepidemic.com.au">www.diabetesepidemic.com.au</a>).</p> <p>Following an invitation by the Loddon Shire Council to address the concerns held by the Council about the high and rising prevalence of Type 2 Diabetes in the Shire in August 2007, and subsequent consultation with health services located in the Loddon Shire, the Bendigo Loddon Primary Care Partnership facilitated the establishment of the Loddon Chronic Disease Group (now the Diabetes in Loddon Action Group). The Group agreed to focus on the prevention of, and support for people with, diabetes in the Shire. Boort District Health has accepted the Lead Agency role for this working group and the member organisations have agreed to work together to focus on improving planned, managed and proactive care for those with diabetes and prevention of diabetes, particularly with vulnerable groups, in the Shire.</p> <p>The member organisations are:</p> <ul style="list-style-type: none"> <li>• Boort District Health</li> <li>• Inglewood and Districts Health Service</li> <li>• Dingee Bush Nursing Centre</li> <li>• Northern District Community Health Services</li> <li>• Murray Plains Division of General Practice</li> <li>• Loddon Shire Council</li> </ul> <p>The Group is supported by the Bendigo Loddon Primary Care Partnership. Annual planning sessions have been held each year to develop a Plan for the Group to work to. The most recent planning session was held at Dingee on 10 November 2009 to develop the Group’s Work Plan for the next three years. All members of the Group attended. Assisted by Kate Gilbert, Industry Consultant, Chronic Disease Management, Department of Health, the day was facilitated by Dr Ronelle Hutchinson from Engage Consulting Australia.</p> <p>The Plan has been developed around the key themes of:</p>

- Workforce Development;
- Service Delivery and Coordination;
- Community Awareness/Involvement; and
- Planning and Monitoring Progress.

10.3% of the population of the Loddon Shire were estimated to have diabetes as at June 2008, which was the highest rate in Victoria. In 2006 the prevalence was 8.53% which was also the highest in Victoria. In 2001, the prevalence was 4.64%, which was the second highest rate in Victoria. This data is drawn from the number of people registered with the National Diabetes Services Scheme and includes all forms of diabetes: Type 1, Type 2 and Gestational. For further information, see [www.diabetesepidemic.org.au](http://www.diabetesepidemic.org.au).

One of the key actions contained in the Group's three year Action Plan is to "Deliver the Better Health Self Management Course in Dingee and Korong Vale". Due to the evidence available that demonstrates an increase in the rates of diabetes in the Shire, it was agreed that the Better Health Self Management Course would assist those people living with diabetes to self manage. There had not been any BHSM courses delivered in the Loddon Shire until this project. The fact that we had no trained facilitators of BHSM and that we sought to have peer support people involved, the project needed to include an agency from Bendigo which had expertise in BHSM. The agency selected was being funded by the Department of Health for the Early Intervention in Chronic Disease (EliCD) and it was agreed had the skills required to assist the Group in preparing to deliver this project. The Diabetes in Loddon Action Group became the Reference Group for the project and the Bendigo Community Health Services managed the project.

The project is described as follows:

The PCP obtained a license from Stanford University for its member organisations to deliver the Better Health Self Management Programs in the PCP catchment so each agency did not need to pay for a license. The PCP provided funds to the Bendigo Community Health Services to enable them to arrange training in the facilitation of BHSM Groups for 2 clinicians and 2 peer support volunteers in Melbourne and pay for the accommodation and travel for these potential facilitators. BCHS provided marketing materials and the members of the Group all agreed to promote the courses in BHSM throughout the Shire through various organisations and client groups. The Murray Plains Division of General Practice played a key role in encouraging the four medical practices across the Shire to refer clients to the groups, the Loddon Shire HACC Program promoted the groups to its HACC clients and the other health services in the Shire encouraged clients living with diabetes to attend the groups. Due to the enthusiasm of the Diabetes in Loddon Action Group and the members' partnership arrangements, additional funds were provided by PCP to enable Boort District Health to work with Northern Districts Health Service to deliver a further BHSM course in Boort.

This project fits with the BLPCP Partnership Strategic Plan as Strategy 1.3.7 states: "Maintain the Loddon Chronic Disease Management Group and facilitate the development of a three year Implementation Plan for the prevention and

	management of chronic disease across the Shire.”
<b>Objectives</b>	<p><b>The Objectives for the Project were:</b></p> <ol style="list-style-type: none"> <li>1. Train one clinician from Inglewood and Districts Health Service and one clinician from Dingee Bush Nursing Centre to gain the qualification to conduct BHSM courses.</li> <li>2. Train one peer support volunteer from Inglewood and Districts Health Service and one peer support volunteer from Dingee Bush Nursing Centre to gain the qualification to assist in the conduct of BHSM courses.</li> <li>3. Provide a Better Health Self Management Course for people living with diabetes in the Loddon Shire.</li> <li>4. Recruit 10 or more participants for the BHSM Course.</li> <li>5. Conduct an evaluation by the participants of the BHSM course.</li> </ol>

### **Project participants**

Participants of this project were two Registered Nurses, one who is a diabetes educator and the other who has just completed the diabetes educators' course. Two peer support volunteers one from Korong Vale and one from Dingee who participate and assist in conducting the BHSM courses. Staff from all health services based in the Loddon Shire as well as Local Government and the Division of General Practice staff who have worked in the promotion and governance of the project and the participants of the five BHSM courses that were conducted across the Shire in Inglewood, Korong Vale, Dingee and Boort.

### **Methodology and approach**

The key project activities included:

- Appointment of Project Officer with appropriate skill set (BCHS).
- Meetings of Reference Group to discuss project (Diabetes in Loddon Action Group).
- Scoping of local context and existing services (BCHS).
- Clinicians and peer presenter volunteers booked in and attend the BHSM Facilitators' Course in Melbourne (BCHS).
- Obtain BHSM Licence for the PCP catchment (PCP).
- Literature review of evidence for BHSM courses in supporting people living with diabetes (BCHS).
- Communication Strategy developed (BCHS + Diabetes in Loddon Action Group).
- Recruitment of participants (General Practices, Loddon Shire, all health services).
- Course conducted (BHSM Facilitators and volunteers).
- Ongoing meetings with Reference Group (BCHS).
- Preparation of final report (BCHS).
- Presentation to Reference Group (BCHS).
- Ongoing mentoring and support to graduates as required (Facilitators).

#### **How the principles of Service Coordination, Integrated Health Promotion, and Integrated Chronic Disease Management were integrated.**

These principles were integrated as part of the work in implementing this project. Participants in the BHSM courses were provided with knowledge on the diabetes pathways that were used by their general practices and links to service providers such as dietitians, podiatrists, physiotherapists and other allied health professionals. Integrated health promotion programs and activities such as access to physical activity programs, QUIT courses, nutrition programs were provided through the BHSM courses.

Capacity building and social equity principles were embedded in the way the BHSM courses were delivered.

## Communication Strategies.

The development of the promotional materials was undertaken by BCHS and these materials were used by all services including general practices, HACC services and each health service to promote the BHSM Groups (see attached).

## Results

<b>Service improvement and innovation</b>	<p>Describe the way the initiative is improving:</p> <ul style="list-style-type: none"><li>• The participants from the 5 BHSM groups that were implemented in the Loddon Shire now have the skills and capacity to self manage their diabetes in conjunction with their health practitioner.</li><li>• Those participants have information about the service system in their own community and how to access the services they require.</li><li>• The clinicians who attended and graduated from the BHSM Facilitators' Course now have the ability to deliver these courses in the local community and are able to continue to empower people living with diabetes to self manage their chronic disease in conjunction with their health practitioners.</li><li>• The health services involved in the project are re-oriented and have continued their commitment to ICDM as a priority with a focus on self management for clients.</li><li>• The partnership work that resulted from this project has been of benefit for each of the agencies involved as well as the community. The Diabetes in Loddon Action Group now has a number of clinicians trained in BHSM and is able to partner in sharing resources to deliver these courses across the Shire.</li></ul>
<b>Outcomes</b>	<p>Forty participants graduated from the BHSM courses that were conducted through this project in the Loddon Shire.</p> <p>Whilst the original aim was to conduct one course for up to 10 people, the project was able to deliver 5 courses for 40 people in total across the Shire. This is 4.8% of people known to be living with diabetes in the Shire.</p> <p>Two clinicians are now qualified as facilitators of the BHSM courses and two peer support volunteers are qualified.</p> <p>The Partnership (Diabetes in Loddon Action Group) in Loddon Shire has a sense of achievement as a result of this project and is now developing plans to implement its next initiative across the Shire.</p> <p>A single license for the conduct of BHSM courses across the Bendigo Loddon catchment is now held by the PCP and can be used by all partners qualified to deliver these courses. This saves over \$500 per agency as they no longer have to hold a separate licence.</p>
<b>Status and sustainability</b>	<p>Further Better Health Self Management courses are being planned for the Loddon Shire including one in Boort, one in Dingee and one in Inglewood.</p> <p>It is proposed that this project will be replicated in Heathcote in the next financial year and the marketing tools and surveys developed will be utilised.</p> <p>This case study will be located on the PCP website in order for PCP partners to access the findings of the project.</p>

## Conclusions

### **Key success factors.**

The capacity building that occurred with the two clinicians and two peer volunteers receiving the training and returning to conduct the BHSM courses in their local communities.

The partnership between the division, Local Government and the health services with the goal of self management by people living with diabetes.

The enthusiasm and commitment of the agencies involved which resulted in 5 BHSM courses being implemented in the Shire instead of just one that was planned.

The funds provided by the PCP as these are very small rural health services with few resources.

### **Key challenges.**

Staff turnovers at Bendigo Community Health Service Integrated Care Team meant that there were delayed time frames, loss of project knowledge and a reduced understanding of the roles of the local agencies in the project.

Lack of clarity about roles and responsibilities of each of the parties.

### **Limitations of the project.**

The project manager(s) for Bendigo (BCHS) had no previous knowledge of Loddon Shire and the lack of resources for integrated care or chronic disease.

The majority of the PCP funds went to the large Bendigo agency and the local agencies believe they could have done more if they had received the funding direct.

The Diabetes in Loddon Action Group felt that instead of being a reference group for BCHS, it would have been better for the Group to manage the project and use BCHS as an advisor only.


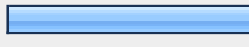
### **How activities and improvements will be sustained.**

The BHSM courses will be continued in the Loddon Shire and are now built into the core business of the health services located in the Shire.

### **Relevance of your findings to other areas of PCPs activity.**

This project has been a great learning experience specifically about the governance and management of projects conducted in partnership with small health services in the Shire. In future any funds will be provided to a management group made up of the small services in the Shire and outside expertise will be purchased on behalf of the management group. It is clear that small services with few resources are skilled and creative about the way they use funds provided for them to achieve outcomes. They are able to provide high value for the dollars provided and this is the way we will approach further projects in that locality in future.

## Better Health Self Management Post Evaluation

1. Please indicate whether you are person living with diabetes or carer or partner			
		Response Percent	Response Count
Person living with Diabetes		60.0%	3
Carer or Partner		40.0%	2
	<i>answered question</i>		5
	<i>skipped question</i>		1

2. How confident do you feel that you can eat your meals every 4-5 hours every day including breakfast?									
	Not Confident.1	2	3	4	5	6	7	8	9
Please tick the number that applies to your level of confidence	16.7% (1)	0.0% (0)	0.0% (0)	0.0% (0)	16.7% (1)	0.0% (0)	16.7% (1)	33.3% (2)	0.0% (0)

3. How confident do you feel that you can follow your diet when you have to prepare or share food with other people?									
	Not Confident.1	2	3	4	5	6	7	8	9
Please tick the number that corresponds to your confidence level.	0.0% (0)	20.0% (1)	0.0% (0)	0.0% (0)	0.0% (0)	20.0% (1)	40.0% (2)	20.0% (1)	0.0% (0)

4. How confident do you or the person you care for or live with can choose an appropriate food to eat when hun									
	Not Confident .1	2	3	4	5	6	7	8	9
Please tick the number that corresponds with your level of confidence.	0.0% (0)	0.0% (0)	20.0% (1)	0.0% (0)	0.0% (0)	<b>40.0% (2)</b>	0.0% (0)	20.0% (1)	20.0% (1)

5. How confident do you feel that you can exercise 15-30 minutes 4-5 times a week?									
	Not Confident 1	2	3	4	5	6	7	8	9
Tick the corresponding number to your level of confidence	0.0% (0)	0.0% (0)	16.7% (1)	16.7% (1)	<b>33.3% (2)</b>	0.0% (0)	<b>33.3% (2)</b>	0.0% (0)	0.0% (0)

6. How confident do you feel that you can do something to prevent your blood sugar level ,or the person you ca form dropping when you / they exercise?									
	Not Confident 11	2	3	4	5	6	7	8	9
Please tick the corresponding number to your confidence level.	0.0% (0)	0.0% (0)	20.0% (1)	0.0% (0)	20.0% (1)	0.0% (0)	0.0% (0)	20.0% (1)	<b>40.0% (2)</b>

**7. How confident do you feel that you know what to do when your blood sugar levels are either too high or too low? How confident do you feel that you can encourage your partner or person living with Diabetes to see the doctor? How confident do you feel that you can help the person you care for or live with to maintain good control of their diabetes to prevent it from interfering with things you want to do?**

	Not confident 1	2	3	4	5	6	7	8	9	10
Please tick the most appropriate number for you.	0.0% (0)	0.0% (0)	0.0% (0)	<b>33.3% (2)</b>	0.0% (0)	16.7% (1)	16.7% (1)	16.7% (1)	0.0% (0)	0.0% (0)

**8. How confident do you feel that you can judge when change in your illness mean you should visit the doctor? How confident do you feel that you can encourage your partner or person living with Diabetes to see the doctor? How confident do you feel that you can help the person you care for or live with to maintain good control of their diabetes to prevent it from interfering with things you want to do?**

	Not Confident. 1.	2	3	4	5	6	7	8	9	10
Tick the number that corresponds to your level of confidence	0.0% (0)	0.0% (0)	<b>20.0% (1)</b>	0.0% (0)	0.0% (0)	<b>20.0% (1)</b>	<b>20.0% (1)</b>	<b>20.0% (1)</b>	0.0% (0)	0.0% (0)

**9. How confident do you feel that you can control your diabetes so that it dose not interfere with things you want to do? How confident do you feel that you can encourage your partner or person living with Diabetes to see the doctor? How confident do you feel that you can help the person you care for or live with to maintain good control of their diabetes to prevent it from interfering with things you want to do?**

	Not Confident 1.	2	3	4	5	6	7	8	9	10
Tick the number that corresponds to your confidence level.	0.0% (0)	0.0% (0)	16.7% (1)	16.7% (1)	0.0% (0)	<b>33.3% (2)</b>	0.0% (0)	16.7% (1)	16.7% (1)	0.0% (0)

10. Thank you for taking the time to complete this survey. It will be compared to the first one to determine any improvements being made by you or your partner after attending the classes. Please feel free to make any suggestion or comments.

		Response Count
		1
	<i>answered question</i>	1
	<i>skipped question</i>	5