

## Part 4 Integrated Chronic Disease Management - Strategic Plan

Goal	Objective	Strategy	Planned Impact
1. Completion of a mapping of self-management interventions (provided by agencies within the catchment). Facilitate planning processes to develop self-management interventions within member agencies that respond to gaps identified in the mapping process.	<p>1. To map current self-management interventions with health agencies by June 2007.</p> <p>2. To identify gaps and barriers to self-management interventions with agencies by August 2007.</p>	<ul style="list-style-type: none"> <li>- Facilitate the completion of mapping survey via face to face interviews with health agencies &amp; completion of online DHS survey.</li> <li>- Identify gaps and barriers with key stakeholders of each agency by August 2007.</li> </ul>	<p>All health agency members to have completed mapping exercise by June 2007</p> <p>Gaps and barriers identified in all project areas by August 2007.</p>
2. Facilitation of a process for agencies to define their roles and responsibilities, especially acute and community health services, in relation to providing self-management interventions for people with chronic disease.	<p>1. To facilitate shared agreement on roles and responsibilities regarding self-management interventions with agency stakeholders according to the following phased approach in project areas: Yr 1 – Hamilton project area, includes Balmoral Yr 2 – Casterton, Coleraine project area, includes Merino Yr 3 – Portland project area, includes Heywood, Dartmoor</p> <p>2. To establish a process for consumer consultation for each project area in parallel to the commencement of each Steering Committee.</p>	<ul style="list-style-type: none"> <li>- Engage Otway Division of General Practice re: involvement in ICDM project.</li> <li>- use existing agency Steering Committee or, where needed, establish a ICDM Steering Committee within each project area, including agency staff and referring partners from acute, primary care, allied health, GP/Otway Division, Shire (HACC services), District Nursing, GP Practice Nurses.</li> <li>- identify existing consumer/carer groups that could act as consumer reference groups or establish a new mechanism if needed, including input from consumers representing different chronic diseases.</li> </ul>	<p>Steering Committee identified or formed in each project area, representing key stakeholders.</p> <p>Agreement reached on roles and responsibilities in each project area.</p> <p>Consumer consultation processes established for each project area.</p>
3. Successful implementation of the Better Access to Services (BATS) framework by progressing common practices, processes, protocols and systems for initial contact, initial needs identification, referral, assessment and care planning by	<p>1. To implement the BATS framework within each project area by: Dec 2007 – Hamilton Dec 2008 – Casterton and Coleraine July 2009 – Portland</p>	<ul style="list-style-type: none"> <li>- facilitate Steering Committees to address implementation of BATS framework, as appropriate to each project area.</li> <li>- Coordinate with PCP e-referral project to ensure local GPs equipped to implement e-referral</li> </ul>	<p>Relevant sections of BATS being used by each agency and their referring partners in each project area.</p> <p>At least 2 GPs using e-referral in each project area.</p>

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member agencies, particularly as it relates to people with chronic disease.		- Include ICDM as standing item on SWARH Primary Care Sub-Committee to ensure coordination between ICDM and Service Coordination	
4. Developed and defined local agreements and systems to identify clients with chronic disease who require comprehensive assessment, by working with PCP member agencies, particularly GPs.	1. To define agreed systems/processes to identify clients requiring comprehensive assessment for each project area by: April 2007 – Hamilton April 2008 – Casterton/Coleraine February 2009 - Portland	Facilitate discussions by Steering Committees to agree on systems/processes to identify clients requiring comprehensive assessment.  To consult with consumers for input into agreed systems/processes.	Agreed system/processes for identifying comprehensive assessment needs in each project area. Total for PCP = 4  At least 2 GPs in each project area engaged in agreeing to common system/processes.
5. Developed and defined local agreements and systems to identify clients with chronic disease who require cross-disciplinary/multi-agency (including GP) care planning, by working with PCP member agencies, particularly GPs.	1. To define agreed systems/processes to identify clients requiring cross-disciplinary/multi-agency care planning in each project area by: June 2007 – Hamilton June 2008 – Casterton/Coleraine March 2009 - Portland	Facilitate discussions by Steering Committees to agree on systems/processes to identify clients requiring cross-disciplinary/multi-agency care planning.  To consult with consumers for input into agreed systems/processes.	Agreed system/processes for identifying cross-disciplinary/multi-agency care planning in each project area. Total for PCP = 4  At least 2 GPs in each project area engaged in agreeing to common system/processes
6. Developed and defined local agreements and systems around initiating and coordinating care planning for people with chronic disease by working with PCP member agencies, particularly GPs.	1. To define agreed systems/processes to initiate and coordinate care planning in each project area by. June 2007 – Hamilton June 2008 – Casterton/Coleraine March 2009 - Portland	Facilitate discussions by Steering Committees to agree on systems/processes to initiate and coordinate care planning.  To consult with consumers for input into agreed systems/processes.	Agreed system/processes for initiating and coordinating care planning in each project area. Total for PCP = 4  At least 2 GPs in each project area engaged in agreeing to common system/processes
7. Strengthened approaches to address disadvantage and health equality in Integrated Health Promotion initiatives, including barriers to participation such as chronic disease.	1. To identify health promotion needs of chronic disease clients by: April 2007 – Hamilton May 2008 – Casterton/Coleraine February 2009 - Portland 2. To map current accessible community based programs relevant for chronic disease clients, including physical activity	Consult with Steering Committee and consumer representatives to identify self-management needs of chronic disease clients.  Survey diverse range organisations to identify local options for accessible physical activity and mental health promotion initiatives – including local	Health promotion needs of target clients identified.  Map of current accessible local programs to meet health promotion needs.

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	<p>and mental health by: June 2007 – Hamilton July 2008 – Casterton/Coleraine April 2009 - Portland</p> <p>3. To address key gaps in accessible community programs, including physical activity and mental health by: October 2007 – Hamilton October 2008 – Casterton/Coleraine July 2009 - Portland</p> <p>4. To facilitate access to current information on community based programs for agencies, GPs and clients by April 2007 for all project areas (ongoing refinement will occur based on consumer input.)</p> <p>5. To facilitate access to current information on chronic diseases for clients by April 2007.</p>	<p>strength and balance programs, Tai Chi, Yoga, community arts.</p> <p>Include Chronic Disease Management as standing agenda item for PCP's Integrated Health Promotion Reference Group.</p> <p>To liaise across PCP agencies to identify strategies to address any gaps in accessible self-management options, eg. including barriers such as transport.</p> <p>To consult with consumer representatives to identify preferred format for information, eg. web based.</p> <p>To provide accessible information on local activity options, including via the Active Script enabler.</p> <p>To provide accessible information on chronic disease, including links to Better Health Chanel, Nurse On Call 24 Hour Hotline etc.</p>	<p>Gaps in accessible self-management options reduced in each project, such that every project area has at least 3 accessible physical activity options.</p> <p>Process in place in each project area to inform all chronic disease clients identified of local physical activity options.</p> <p>Increase in usage of local physical activity programs by chronic disease clients.</p> <p>Access to general chronic disease information available via website or other format.</p>