

Lower Hume Primary Care Partnership

Community Health Plan for Lower Hume PCP 2006 - 2009

Deliverable 4: Integrated Chronic Disease Management

December 2006

Primary Care Partnerships
Community Health Plan

Endorsed by PCP Chair:

Name: John Thompson

Signature:

Date:

All PCPs

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.	Determine the type and number of self-management interventions currently delivered in the catchment	<ul style="list-style-type: none"> ▪ Use DHS' information collection tool ▪ Contact service providers, members and non-members to collect data ▪ Analyse/collate data ▪ Identify gaps in service deliver 	<p>Map of number and type of self-management interventions in catchment</p> <p>Gaps in service delivery capacity</p>
	Develop a strategy for addressing service delivery gaps in self-management interventions	<ul style="list-style-type: none"> ▪ Identify agencies best placed to address gaps ▪ Identify strategies to build capacity of agencies to implement/improve self-management interventions 	Implementation strategy with identified gaps and outcomes
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.	Define roles and responsibilities in delivering self-management interventions	Facilitate consultation process with stakeholder through various forums to achieve clarity and agreement on roles and responsibilities	Roles and responsibilities clearly identified and agreed on
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 member agencies, particularly as it relates to people with chronic disease.	Continue to support LH PCP members to implement the BATS framework and especially to incorporate CDM into business practice	<ul style="list-style-type: none"> ▪ Consolidate BATS mplementation in member agencies ▪ Develop change management practices to support CDM 	<p>Progress implementation of BATS framework throughout catchment</p> <p>Business practices tailored to CDM as part of framework</p>
4. Developed and defined local	Improve access to comprehensive	<ul style="list-style-type: none"> ▪ Identify current models used to 	Model adopted that supports

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agreements and systems to identify clients with chronic disease who require comprehensive assessment, by working with PCP member agencies, particularly GPs.	assessment for clients with a chronic disease	<p>identify chronic disease clients needing comprehensive assessments</p> <ul style="list-style-type: none"> Reach agreement with service providers on optimal model for comprehensive assessment 	improved access to comprehensive assessment for chronic disease clients
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.	Improve access to cross disciplinary / multi-agency planning for those with a chronic disease	<ul style="list-style-type: none"> Research current care planning models for clients with chronic disease Reach agreement with service providers on optimal model for care planning 	Model adopted that supports improved access to cross disciplinary care planning for chronic disease clients
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.	Develop and define protocols and systems for care planning for those with chronic disease	<ul style="list-style-type: none"> Research current care planning agreements and protocols for clients with chronic disease Reach agreement with service providers on protocols and system to support care planning 	Agreements describing protocols and systems to support chronic disease clients
7. Strengthened approaches to address disadvantage and health equality in Integrated Health Promotion initiatives, including barriers to participation such as chronic disease.	Build the capacity of member agencies to include access and equity in service delivery planning, implementation and evaluation	<p>Map current practices for access and equity in service delivery</p> <p>Identify best practice approaches to access and equity</p> <p>Reach agreement on optimal model for implementation by member agencies</p>	<p>Clients with have better access to services</p> <p>Best practice approach to access and equity adopted</p>