



**Central Highlands Primary Care Partnership
Chronic Disease Plan 2009 – 2012**

Preamble:

The Chronic Disease Plan 2009 – 2012 of Central Highlands Primary Care Partnership (CHPCP) is the operational plan for the work that will occur by member agencies as a part of the two strategic priorities of the CHPCP:

1. Chronic Disease Prevention and Management
2. Social Connection and Inclusion (including mental health)

These directions have been informed by the Health and Wellbeing Analysis of the Central Highlands Primary Care Partnership 2009 undertaken by the University of Ballarat to inform planning. The document is available at www.chpcp.org

The plan is a living document and with some of the new structures proposed by the CHPCP, it is expected that additional work or emerging issues may be identified.

Goal Area	People Involved	Objective	Strategy	Linked actions	Key Result Areas	Planning Links	Time Frame	Responsibility
Chronic Disease Group - CEO	BDDGP, BCH, BDNH, BHS, DJHS, HHS, SJOG, BDH&C, HESSE Chronic Disease Coordinator (PCP) Other partners as identified	Making key decisions in terms of chronic disease management in consultation with other CHPCP groups	<ul style="list-style-type: none"> - Develop Chronic Disease group to identify ICDM issues where collaborative work can occur - Development of strategic direction and planning for ICDM across the Central Highlands 	CHPCP Strategic Plan Chronic Disease Groups including Chronic Disease Practitioners Group, Diabetes Steering Group, EliCD teams	. Strategic directions developed for ICDM		Ongoing	Chronic Disease Group - CEO
			<ul style="list-style-type: none"> - Create a governance structure for reporting between the CEO's group and other groups working on ICDM. 		Governance structure formalised			

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Diabetes Steering Group (DSG):	BCH, BDDGP, HHS, Daylesford Medical Practice, HESSE, BHS, BDNH, Consumers Chronic Disease Coordinator (CHPCP)	Support the networking of other allied health practitioners that are involved with service delivery for Diabetics	Facilitate the monthly meetings Provide support which includes minutes and any actions or resources required Develop a reporting mechanism to the CEOs group		Number of agencies in attendance Annual performance review		Ongoing	Chronic Disease Coordinator (CDC) Chair of DSG
		Promote the services available for diabetics in the Central Highlands region.	Planning for a shared Diabetes expo in 2010 Hold the Diabetes Expo in Ballarat Evaluation of the Expo	IHP – Healthy Lifestyle priority	Number of people attending. Feedback from consumers and participants Participation from agencies		Year 1 - July 2010	DSG
		Improve the referral pathways for General Practice in the Central Highlands	- To develop a Referral Pathways resource to assist General Practice inral pathways available for Diabetics within the Central Highlands region.	Service Coordination – John Dixon. Industry Advisor (Sarity Dodson – DoH central)	General practice to use the resource and implement into their practice		Year 2 - 2011	DSG working group: - Caroline - Tanya - John Dixon (CHPCP) - Linda Sheree

			- Create a working group made up of members from the DSG.		Resource produced			
		Evaluation and updating of the Diabetes Information Resource	- Gain consumer and agency feedback on the resource to see if anything needs to be updated. - Information updated as required		Updated resource with correct information that can be used by diabetics and health professionals'		July 2010 Update information 2011 - Evaluate	DSG – info. brochure working group: - Caroline - Marg - CDC (PCP) - Barbara - Leanne (Consumer)
		Review GP feedback that was collected by the Ballarat & District Division of General Practice	Work with Division of GP to reduce the barriers for General Practice in accessing the Life program.		A report produced by BDDGP outlining the barriers between the GP's and the Life program.		Year 1 - Early 2010	DSG & BDDGP
		Consumer engagement	Use the Type 1 support as the first focus groups to seek their opinion on the diabetes services around the Central highlands region.				Every 12 months	DSG
		Identify	Identify what the		Produce a		Year 1 –	DSG

		consumer roles	consumer roles are within the DSG.		document that provides information on consumer roles.		2010	
		Review insulin initiation practices	Diabetes educators (DE's) to work with the DSG about insulin initiation procedures				Ongoing	DE's & DSG
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Chronic Disease Group - Practitioners	Kerri Gordon Linda Govan Jenelle Collins	Support the networking between managers/senior clinicians	Facilitate Chronic Disease practitioners meeting.	ICDM Industry Advisor (Sarity Dodson – DoH Central)	Good attendance Feedback from agencies		Ongoing	CDC
	Tanya Gradolf Erin Richardson Liz Rhook Raylene Liddicoat Marion Wilde Chronic Disease Coordinator (PCP)	Identifying gaps in Chronic Disease within service delivery across the region	- The group to look at each of the major chronic diseases and identify gaps through the use of the Wagner Chronic Care model including Obesity. - Identify opportunities in gathering local data on Obesity	- IHP - SC	To produce resources that will help build on improving service delivery and data collection across the region.	Wagner Chronic Care model Expanded Chronic Care model (when needed)	Year 1 – To look at least 2 of the major chronic diseases	Chronic Disease Group

		Identify needs for ICDM training for CHPCP member agencies.	- Complete a training needs analysis to identify opportunities for training.		- At least one Health coaching course is provided within the region - Training is provided to agencies that were identified in the needs analysis task.		Ongoing	CDC & Chronic Disease Group
		Explore opportunities for funding that will support the ICDM work	Identify funding opportunities collaboratively.	Work with Department of Health (DoH) for funding opportunities. Industry advisors (Sarity Dodson DoH – central)	One collaborative funding submission		Ongoing	Chronic Disease Group
Early Intervention in Chronic Disease (EiCD)								
<u>General:</u>		Work to strengthen partnerships between organisations that are involved in ICDM and other agencies	- Facilitate meetings that will bring organisations together.	Hepburn Health Service, Ballarat & District Division of General Practice			Ongoing	CDC

<u>Ballarat:</u>	Kerri Gordon (Coordinator)	Evaluation of the Health Independence Program (HiP)	Perform an evaluation of the HiP program to gain a consumer's insight into the program		- Measurement of improvements in past 12 months - Produce a report outlining the consumer's insight and present to the EliCD team and CEO.	Previous report – Health Independence Program: a consumer's insight.	Every 12 months (Sept/Oct)	CDC UoB (student placement)
		Identify training needs for the HiP team	- Improve the ICDM of the HiP team - Engage BCH staff in understanding ICDM. - Perform a training needs analysis		Ensure that each staff member is trained up in the relevant courses to ensure they are following best practice guidelines.	Health Coaching Australia Motivational Interviewing – Kylie McKenzie/Rochelle Cairns (Ballarat Health Services)	Ongoing	CDC, Coordinator of HiP
Goal Area	People Involved	Objective	Strategy	Linked actions	Key Performance Indicator	Planning Links	Time Frame	Responsibility
		Increase the community awareness of the HiP	CHPCP to support Ballarat Community Health to raise the profile of HiP.		Having more people access the program and understanding the program		Ongoing	CDC, Coordinator of HiP
<u>Hepburn:</u>	Erin Richardson (Project Manager) Liz Rhook (EliCD team) Brian Dunn	Work with the EliCD team to identify any training needed for the staff members	- Perform a training needs analysis to see what staff maybe lacking in and what available training is out there to help with the up skilling of staff	CHPCP, HHS	Ensure that each staff member is trained up in the relevant courses to ensure they are following best practice guidelines.	Health Coaching Australia Motivational Interviewing – Kylie McKenzie/Rochelle Cairns (BHS)	Ongoing	CDC, Project Manager

	(EliCD team)		members					
		Provide support to the EliCD team in planning and implementation.	<ul style="list-style-type: none"> - Ensure that the Hepburn EliCD team is supported with resources. Also work with DoH to ensure planning is on track. - Use the ICDM resource provided by DoH, '<i>Checklist for Monitoring Progress of PCP ICDM Activity</i>' 	CHPCP, DoH (both regional & central offices), HHS (both regional & central offices)	To see the program up and running by the end of Year 1.	Checklist for Monitoring Progress of PCP ICDM Activity	Year 1 – program started. Years 2 & 3 – program evaluated	CDC, EliCD team
		Increase the community awareness of the EliCD program	<ul style="list-style-type: none"> - Supporting Hepburn in raising profile of their new program with community, agencies and General Practice. - Identify referral pathways into the new program. 	CHPCP, DoH (both regional & central offices), HHS (both regional & central offices)	<ul style="list-style-type: none"> - Ensure that the community are aware of the programs and the services it can offer. - Health professionals know the correct referral pathways 		Ongoing	CDC, EliCD team
		Evaluation of the program	<ul style="list-style-type: none"> - Identify an evaluation system for the program. 		Produce an evaluation report on the program	Health Independence Program: a consumer's insight	Year 2 Year 3 – consumer evaluation	CDC, UoB (student placement)
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Grampians Integrated Cancer Services (GICS)	Cancer services across the Grampians region University of Ballarat Consumers	To gain an understanding of consumers' cancer experiences in the Grampians region.	<ul style="list-style-type: none"> - Support independent service review of consumer experience of cancer services in the Grampians region - Undertake consumer consultation 	<ul style="list-style-type: none"> - CHPCP Strategic plan - CHPCP Health & Wellbeing Analysis - GRASP 	<ul style="list-style-type: none"> - To produce a report which can help health agencies understand the experiences of consumers' with cancer. - Consumer consultation occurs through forums, focus groups, interviews and questionnaires 	GICS Action Plan	Year 1 - 2010	UoB, CHPCP
Integrated Chronic Disease Management/Service Coordination Survey	All agencies involved in ICDM	Agencies to complete the ICDM/SC survey	<ul style="list-style-type: none"> - Promote the survey to agencies to ensure they understand what the survey is and what the benefits are by completing the survey. 	<ul style="list-style-type: none"> - Service Coordination 	<ul style="list-style-type: none"> - Most of the agencies that are involved in ICDM work complete the survey 	<ul style="list-style-type: none"> - DoH resources on the survey. - ICDM/SC survey 	Every 12 months	CDC, SC @ CHPCP Agencies involved in ICDM work
Intake workshop		Enhance the intake system within the Central Highlands region	<ul style="list-style-type: none"> - Organise an intake workshop that will help agencies understand the different types of intake systems. 	<ul style="list-style-type: none"> - Service Coordination 	<ul style="list-style-type: none"> Agencies to have a better understanding of an intake model that would best fit their organisation. 		Early 2010	