

# Integrated Chronic Disease Management Survey 2011 - PCP Report

## Southern Mallee Primary Care Partnership

### List of Responding Agencies

**Buloke Shire Council**

**Cohuna District Hospital**

**East Wimmera Health Service**

**Gannawarra Shire Council**

**Swan Hill District Health**

**Murray-Plains Division of General Practice - SMPCP**

**Northern District Community Health Service - SMPCP**

**Mallee Track Health and Community Service - SMPCP**

**Kerang District Health**

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**37 programs/services\* across Southern Mallee Primary Care Partnership responded to the Service Coordination and Integrated Chronic Disease Management Survey**

**94 programs/services\* across Loddon Mallee Region responded to the Service Coordination and Integrated Chronic Disease Management Survey**

**542 programs/services\* across all DH regions responded to the Integrated Chronic Disease Management Survey**

\* Programs/services are provided by an agency across one or more locations/sites, and in association with one or more Primary Care Partnership.

Prepared By: Integrated Care Branch  
Wellbeing, Integrated Care and Ageing Division  
Department of Health

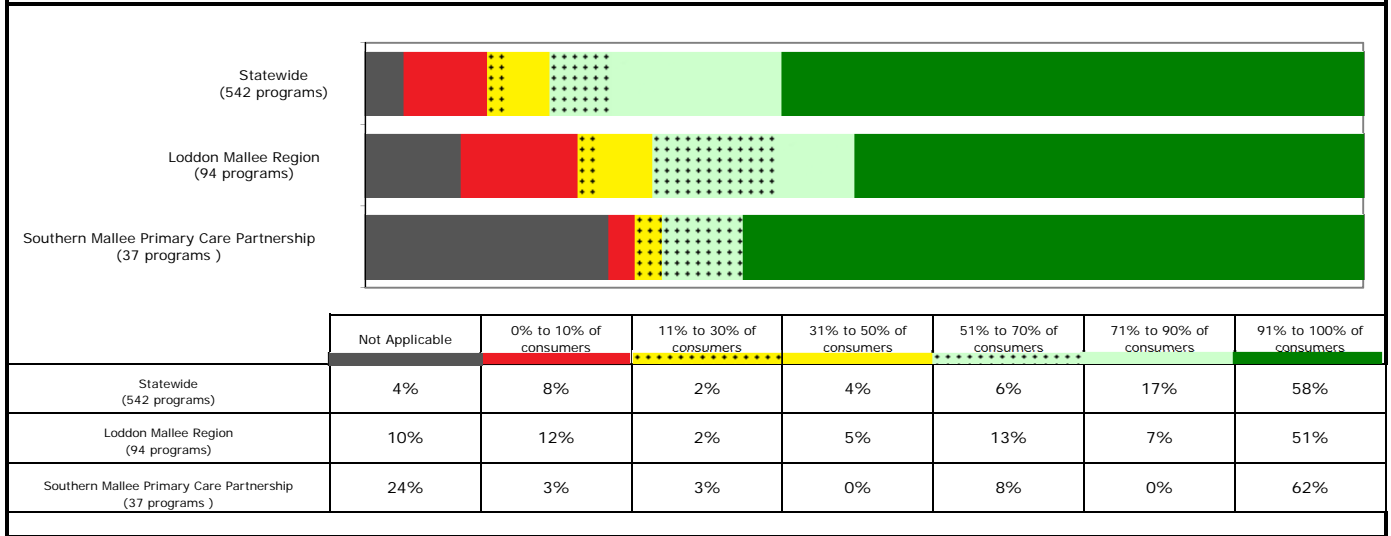
For more information email: [pcp@health.vic.gov.au](mailto:pcp@health.vic.gov.au) Website: [www.health.vic.gov.au/pcps](http://www.health.vic.gov.au/pcps)

**Question 1: Assessments (meeting the criteria listed below, in full) have been documented for consumers.**

Criteria: Assessments are documented in a standardised, common format and identify:

- a) consumer needs beyond the presenting issue(s);
- b) key medical, functional, lifestyle, social and psychological information;
- c) consumer stated issues; and
- d) consumer capability and willingness to change significant health related behaviour(s).

Note: Assessments may be contributed to by multiple service providers and added to or amended over time.

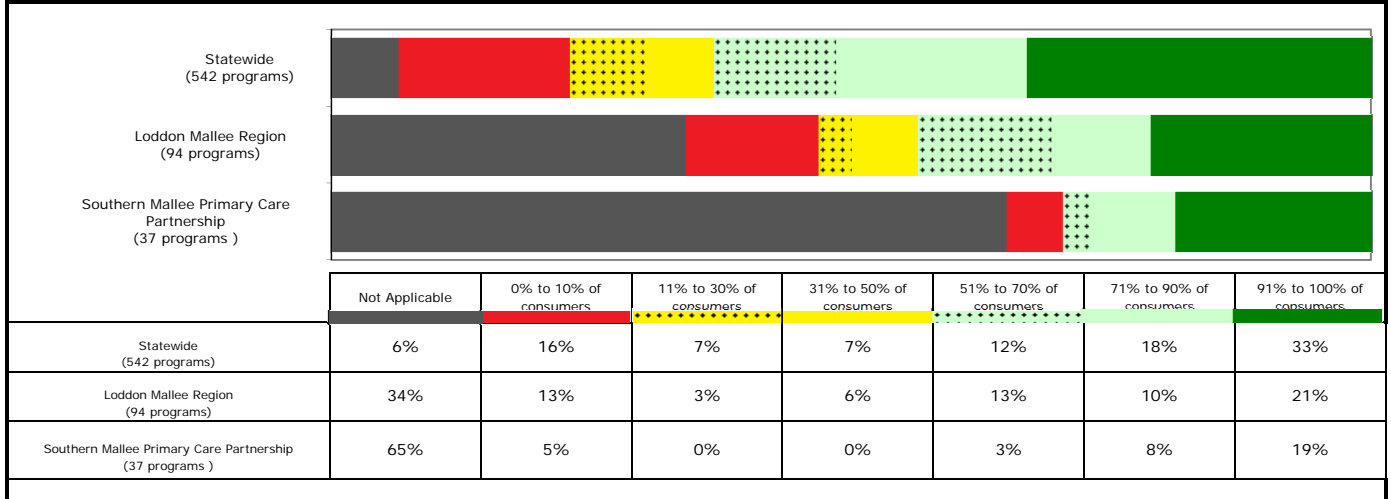


**Question 2: Intra-agency care plans (meeting the VHA criteria listed below, in full) have been documented for consumers.**

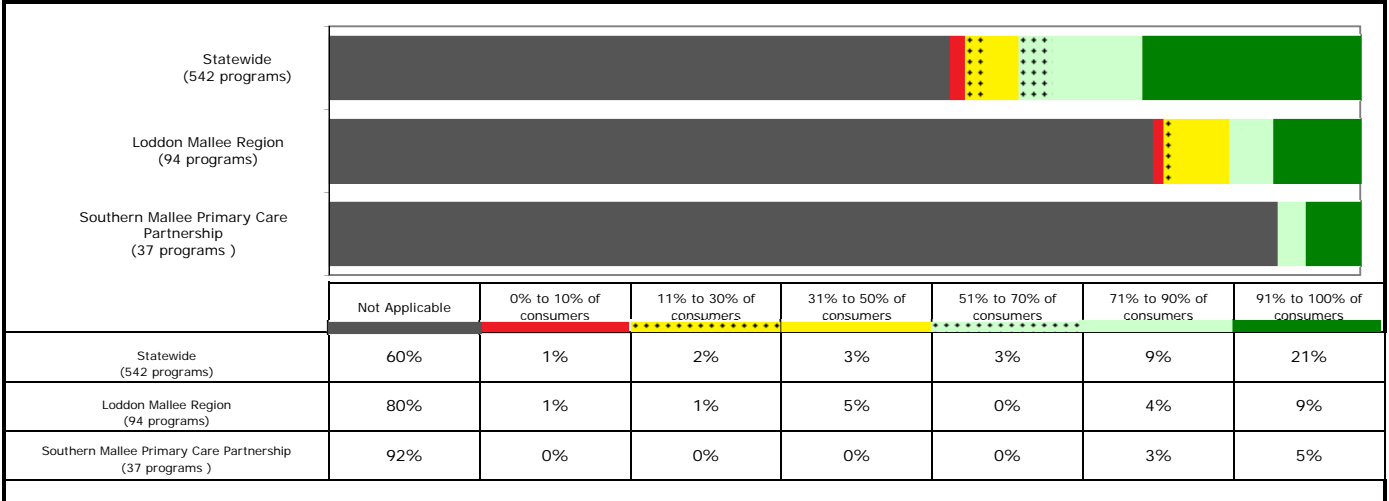
Criteria: A care plan is any documented plan of care that has all of the following 10 elements:

- a) consumer stated or agreed issues/problems; objectives/goals; and strategies/action;
- b) review date of care plan;
- c) timeframe for attainment of objectives/goals;
- d) responsibilities for implementing strategies/action;
- e) participants in development of care plan;
- f) consumer acknowledgement (signed or verbal acknowledgement recorded);
- g) date care plan developed; and
- h) goal/objective attainment. (Victorian Healthcare Association, November 2008.)

Note: Service specific care plans are sufficient where a consumer is receiving care from only one care provider within the organisation.

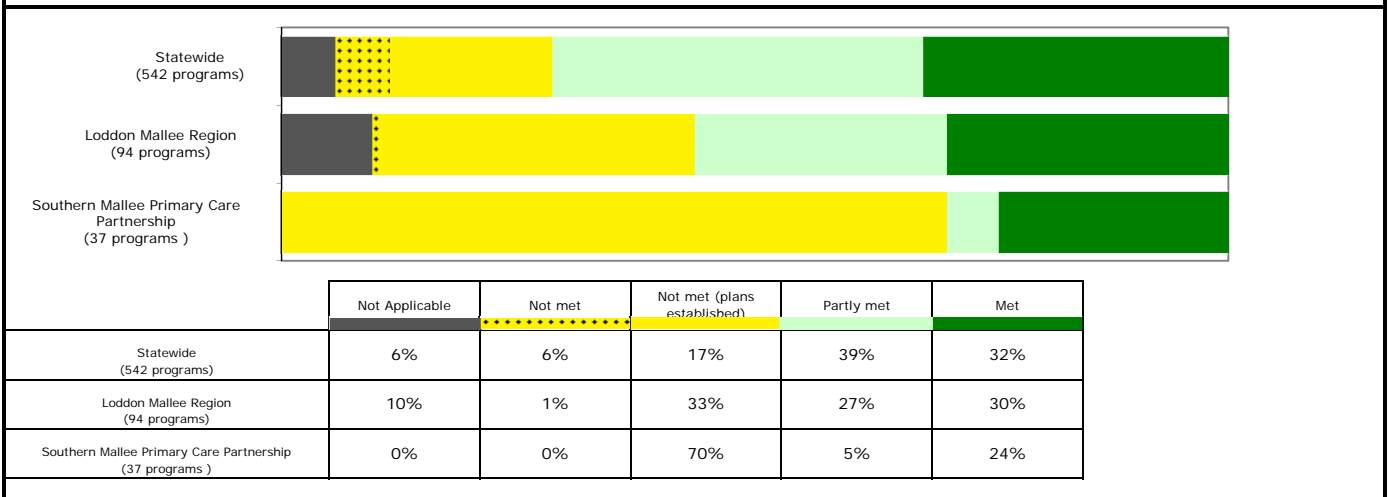


**Question 3: Feedback to General Practice has been documented for consumers, in accordance with local agreements developed with input from General Practice.**



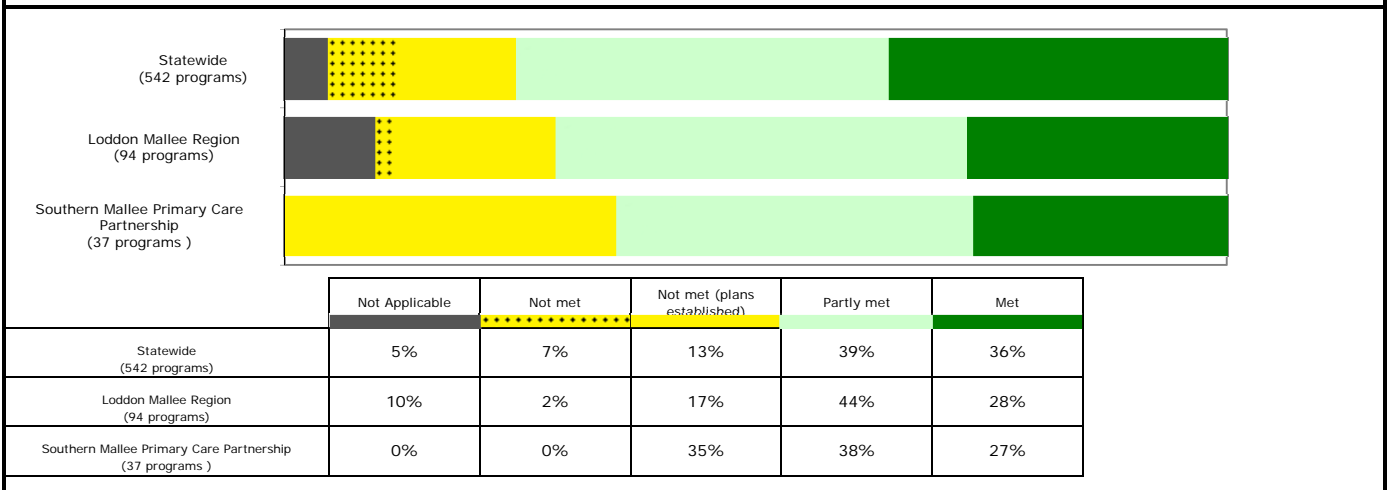
**Question 4: Clinical care protocols, pathways and decision support tools that demonstrate delivery of best practice clinical care (meeting the criteria listed below, in full) have been developed (or endorsed).**

Criteria: These care protocols, pathways and decision support tools demonstrate:  
 a) concordance with local agreements developed within and across agencies; and  
 b) concordance with evidencebased clinical guidelines.



**Question 5: Clinical care protocols, pathways, and decision support tools that demonstrate continuity of care and the provision of proactive and ongoing support (meeting the criteria listed below, in full) have been developed (or endorsed).**

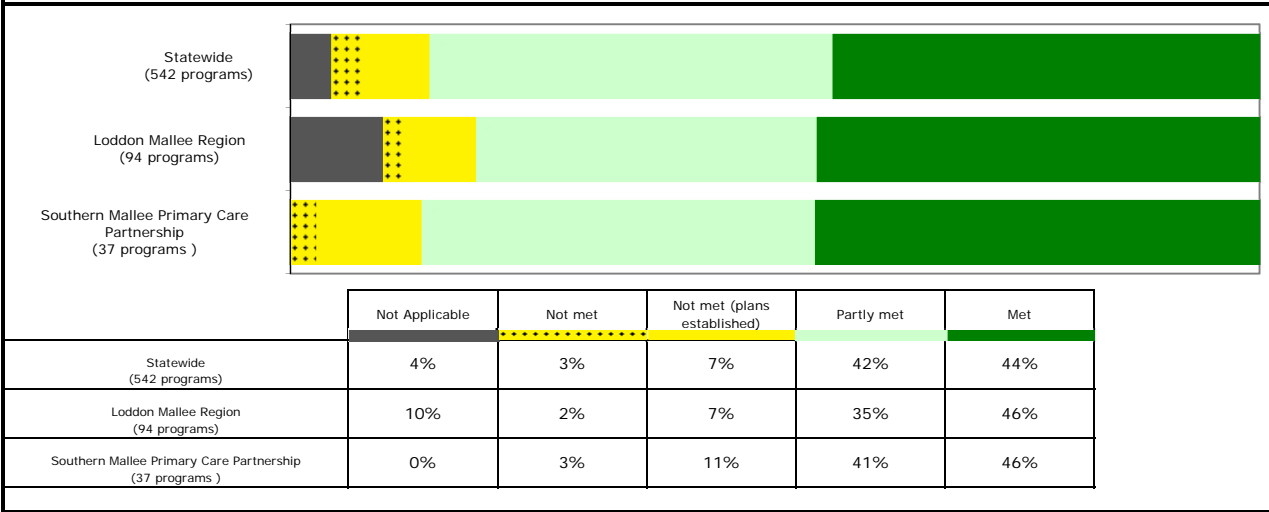
Criteria: These care protocols, pathways and decision support tools demonstrate:  
 a) concordance with local agreements developed within and across agencies;  
 b) systems for routine monitoring of progress and review of goals;  
 c) systems for proactive recall of consumers not currently receiving active care; and  
 d) simple systems for consumer re-entry and crisis support.



**Question 6: Health behaviour change support (meeting the criteria listed below, in full) is provided, as an element of self-management support.**

Criteria: This health behaviour change support:

- a) demonstrates concordance with local agreements developed within and across agencies;
- b) is individualised to meet the needs, circumstances, and capabilities of individual consumers;
- c) aims to strengthen consumer knowledge, skills, self-efficacy, motivation, and resources; and
- d) is provided by appropriately trained clinicians.



**Question 7: A formalised quality improvement system (meeting the criteria listed below, in full) is in place.**

Criteria: This quality improvement system:

- a) has chronic disease management as a priority focus;
- b) includes intra- and inter-agency elements;
- c) represents the full range of stakeholders (including consumers);
- d) is supported by leadership and mechanisms within the organisation to effectively implement agreed improvement initiatives;
- e) uses relevant data to set priorities;
- f) measures performance; and
- g) evaluates outcomes.

