

## HARP CHRONIC DISEASE MANAGEMENT (HARP-CDM) REPORT AGAINST IMPLEMENTATION PLAN YEAR 1, 2005-2006

### **Organisation Details/Authorisations**

Name of Health Service	Northeast Health Wangaratta	Authorisation	
Key Contact Person	Bernadine Hamer	Local Alliance Chairperson (print name)	Janine Holland
Position/Title	Program Manager HARP CDM	Chairperson's Title	Director of Community and Aged Care Services
Phone No.	03 57 220 078	Chairperson's Organisation	Northeast Health Wangaratta
Fax No.	03 77 220 419	Chairperson's Signature	
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### **Report Against Implementation Plan Template – Year 1 (2005-06)**

The report against implementation plan should be developed in collaboration with the HARP-CDM Local Alliance.

\* Where asterisks appear, refer to the HARP-CDM Guidelines for definitions.

**The report against implementation plan must be submitted to the  
Department by**

**Friday 14 July 2006**

**Please send to Susan Race**

**By e-mail: [susan.race@dhs.vic.gov.au](mailto:susan.race@dhs.vic.gov.au)**

**Or**

**Mail: Manager**

**Continuing Care and Clinical Services Section, Programs Branch**

**Metropolitan Health and Aged Care Services**

**Department of Human Services**

**Level 19, 50 Lonsdale Street, Melbourne 3000**

**Instructions**

The following report is to inform progress/developments in the mainstreaming of the HARP-CDM service.

In order to track progress/development please either cut and paste responses or summarise key points from the December 2005 document and insert where indicated. Add additional updates in the areas marked July 2006.

Report should be no more than 20 pages long.

Please complete all sections of the report.

For enquiries please contact Zoë Austin-Crowe

[Zoe.austin-crowe@dhs.vic.gov.au](mailto:Zoe.austin-crowe@dhs.vic.gov.au)

Ph 9096 1338

**Background / Vision**

**Question 1. Provide an update of your progress to date in terms of integrating existing HARP projects and/or expanding/establishing the HARP-CDM within your health service's catchment. Please outline key activities.**

**December 2005 (Please cut and paste or summarise key points from December 2005 document)**

- Appointment of Program Manager
- Development of Local alliance and election of chairperson (see attachment 1+2), next scheduled meeting to be held December 21<sup>st</sup> 2005.
- Development of Governance Framework and Terms of Reference
- Development of NHW working group, in supplement to Local Alliance.
- An invitation to participate was extended to Local/ regional Councils, regional hospitals and Integrated Primary Mental Health Team.
- Data collection, analysis and evaluation – Reported to alliance, recommendations for further collection and analysis to be presented February 2006 (see attachment 3)
- Development and discussion of draft client referral pattern (see attachment 4)
- Gathering of information regarding Self Management strategies and guidelines for community management obtained and distributed for discussion with in the Alliance.
- A discussion with Local Physicians has enabled regular access to Friday Clinical meetings as required, at least on a monthly basis to commence in February 2006. This will enable inclusion of acute sector medical staff, primarily medical Registrars, Interns and local GP's rotating through acute services.

**July 2006 (Please provide an update of any developments/changes, if any)**

- Establishment of Alliance meetings – Held monthly, implementation of governance framework and TOR, with the subgroup development at Northeast Health Wangaratta (NHW) HARP CDM advisory committee = a multidisciplinary consultative team from Acute, Sub Acute, Community and Mental teams at NHW, meeting monthly prior to Alliance meeting.
- Appointment of Care Coordinator positions April 2005. 0.5 EFT Nursing and 0.2 EFT Occupational Therapy. Care Coordinator position increased to 1.0 EFT May 2006 to meet referral; demands.
- Commencement of Chronic and Complex Disease Clients – Chronic Cardiac/Respiratory, inpatient referrals – April 24<sup>th</sup> 2006. Acceptance of direct Physician referrals June 2006.
- HARP CDM participation in the Central Hume Primary Care Partnership (CHPCP) Community Health Plan forum and Service Coordination sub group (Monthly).
- HARP CDM participation in the NHW Nurse Practitioner Project Steering Committee
- Education, training and up skilling of staff in association with HARP CDM:
  - COPD Management update; Feb 06, Dr Chris Worsnop, Austin Repatriation hospital – Accessed by 50 staff across all health disciplines at NHW.
  - Asthma Update, March 06; In participation with the Asthma Foundation of Victoria – Accessed by 75 staff from all health disciplines across the HARP CDM Alliance.
  - Advanced Physical Assessment Course, 4<sup>th</sup> Yr elective subject Grad Cert Melbourne UNI – Facilitated by HARP CDM and accessed by 3 District Nurses, NHW. March 06.

- Depression and Chronic Disease Study Day April 06 – HARP CDM staff.
- Flinders Model in Self Management training, May 06 – HARP CDM staff.
- Australian Asthma & Respiratory Educators Professional Development Day May 06 – HARP CDM staff
- Stanford Model of Self Management training, May 06: 10 funded positions by HARP CDM nominated by the Alliance to include all areas within the NHW catchment and accessed by Wodonga Regional Health Services and Goulbourn Valley Hospital Chronic disease management unit. Total of 17 participants. Our aim was to increase access to self management programs across the Northeast Region for people with Chronic Disease.

- Development and implementation of Heart Failure diary in consultation with Physician group, NHW HARP CDM advisory committee and HARP Alliance.
- Development of the Heart Failure Research project, to be undertaken 2006/07 by HARP CDM in association with the NHW Research Team and Physician group. Aim: To conduct a trial that compares daily weights with wrist, ankle and girth measurements to determine whether there is a direct correlation in terms of fluid retention and peripheral oedema.
- HARP CDM participation in the integration of NHW Care Coordination services – HARP , PAC and Aged Care Packages; District Nursing, Palliative Care and DVA services to meet the needs of individuals within our communities with chronic and complex disease.
- HARP CDM is currently outreaching across all areas of the Alliance and has provided consultative services at Myrtleford, Benalla and Beechworth Hospitals.

**Question 2. Briefly set out the vision for HARP-CDM in your local alliance.**

**December 2005**

- To broaden, develop and increase commitment of Partnerships between acute care and community sectors in meeting the needs of individuals with Chronic and complex health care issues within our communities.
- To develop services, that meets the individual needs of clients with chronic and complex disease. Maintaining and optimising their health status within the social model of health.
- To reduce length of stay and avoidable admissions for individuals with chronic and complex disease.

**July 2006**

- To broaden, develop and increase commitment of Partnerships between acute care and community sectors in meeting the needs of individuals with Chronic and complex health care issues within our communities.
- To develop services, which meet the individual needs of clients with chronic and complex disease. Maintaining and optimising their health status within the social model of health.
- To reduce length of stay and avoidable admissions for individuals with chronic and complex disease.
- To develop and promote Best Practice in Chronic Disease Management within the communities of Northeast Victoria

**Question 3. Undertake a brief SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis for your HARP-CDM, considering the major implementation issues (such as meeting the Guidelines, human resources, governance, integration of existing projects, data management, change management and relationship with other services).**

**STRENGTHS**

**December 2005**

- Established Services – Rehab, SACs, and Community: Aged Care packages, HITH, DNS, PAC, Palliative Care, and HACC.
- Established relationships in partnerships – PCP, Ovens and King Community Health Service, Delatite, Moira and Indigo, NEVDGP’s, local governments, DHS and regional hospitals.
- Established I.T systems, currently being expanded, link with GP’s and Physicians and some community services
- Established Rapid Assessment Service ED NHW for increased referral processes and discharge planning.
- Established partnerships between acute care and community services.
- Development of alliance between stakeholders and reporting mechanisms with CHPCP and NHW executive.
- Development of NHW HARP CDM group – integrating acute, community, aged care and mental health services to complement the HARP CDM alliance.
- Executive sponsorship

**July 2006**

- Established and enhanced partnerships – PCP, Ovens and King Community Health Service, Delatite Community Health Service, NEVDGP’s, DHS, local governments and regional hospitals (Delatite, Moira and Indigo), which has been facilitated by increased communication and HARP CDM
- Established I.T systems, currently being expanded, links with GP’s, Physicians and some community service providers has been enhanced by communication through HARP CDM Alliance meetings and CHPCP Service Coordination meetings.
- Established Rapid Assessment Service ED NHW for increased referral processes and discharge planning.
- Strengthening of alliance between stakeholders and reporting mechanisms with CHPCP and NHW executive.
- Development of NHW HARP CDM consultative group – integrating acute, community, aged care and mental health services to complement the HARP CDM alliance.
- Established Services and enhanced communication between – Acute care, Rehab, SACs, and Community: Aged Care packages, HITH, DNS, PAC, Palliative Care, and HACC services, which has been facilitated by the monthly NHW HARP CDM consultative committee.
- Executive sponsorship
- Established partnership with Northeast Health physicians group.

**WEAKNESSES****December 2005**

- Geographics
- Distance
- Availability of resources

**July 2006**

- Geographics
- Distance
- Availability and access to resources
- Costs

**OPPORTUNITIES****December 2005**

- To enhance and strengthen current programs in meeting the needs of individuals with chronic and complex disease.
- To enhance and strengthen relationships/partnerships between stakeholders and services.
- To provide an integrated program that provides positive outcomes for our communities
- To reduce avoidable admissions for individuals with chronic and complex disease.
- To build on existing case management/care coordination programs such as aged care packages and lead agency protocol

**July 2006**

- To enhance and strengthen current programs in meeting the needs of individuals with chronic and complex disease.
- To enhance and strengthen relationships/partnerships between stakeholders and services.
- To provide an integrated program that provides positive outcomes for our communities
- To reduce avoidable admissions/presentations to ED for individuals with chronic and complex disease.
- To liaise with existing case management/care coordination programs such as aged care packages, DVA, Palliative Care Services, and Community Supports Northeast and work toward a lead agency protocol.
- To promote and enhance Best Practice management which is consistent in its approach across Northeast Victoria
- To promote research opportunities in chronic disease management within Northeast Victoria

**THREATS (AND MANAGEMENT STRATEGY FOR ADDRESSING THREATS)**

**December 2005**

- Time
- Resources
- Geographics

Ensure clear goals and guidelines approved by the alliance to provide tangible targets.

1. Determine needs of rural city of Wangaratta – Data analysis of admissions/presentations and available services resources.
2. Determine needs of Northeast catchment – Data analysis of admissions/presentations and available resources.
3. Determine number of potential clients at risk of admission within 'other' community services that would benefit.
4. Need to be sure not to over service clients who have current case management under alternative programs

**July 2006**

- Resources –particularly in regard to outreaching within rural and remote areas. HARP CDM is working in partnership with regional hospitals, community health services and agencies in providing and increasing access to resources within these areas and assisting with creating educational opportunities for these services in providing a broad range of programs.
  - Geographics – Access and distances required to travel. HARP CDM is working with the organisation in ensuring staff safety in these areas, particularly in terms of contact – due to “drop out” areas. Further partnerships with local services are being enhanced and supported by HARP CDM.
  - Maintenance of clear goals and guidelines approved by the alliance to provide tangible targets.
1. Determine number of potential clients at risk of admission within 'other' community services that would benefit by access to HARP CDM and promote referrals directly from community service providers.
  2. Need to be sure not to over service clients who have current case management under alternative programs. HARP CDM is working in participation with the CHPCP Service Coordination committee in enhancing activities and communication in this area. Further by HARP CDM's participation and attendance at the NHW Community information forums. Establishing direct communication links between services.
  3. Single point of entry – HARP CDM is utilising the SCoTT to minimise this issue, which is available in all referral areas and electronically within NHW HARP CDM continues to work with NHW community services in improving the efficiency of our referral systems.

**Governance**

**Question 4. Describe the governance structure within your local alliance. Provide a copy of the most recent Terms of Reference and membership.**

**December 2005**

An Alliance has been established in partnership, with Northeast Health Wangaratta, Ovens and King Community Health Service, Northeast Victorian Division of General Practice, Physicians medical group, Northeast Integrated Primary Mental Health Team and Department of Human Services, with invitations to participate extended to representative's from Local government and regional hospitals. A Northeast Health HARP CDM working group complements the alliance, which is a network of Acute, sub- acute and community services within Northeast Health Wangaratta.

**July 2006**

An Alliance has been established in partnership, with Northeast Health Wangaratta, Ovens and King Community Health Service, Delatite Community health Service, Northeast Victorian Division of General Practice, Physicians medical group, Northeast Integrated Primary Mental Health Team, Department of Human Services, Local government and regional hospitals from the Moira, Indigo, Alpine and Delatite Shires. A Northeast Health HARP CDM advisory committee complements the HARP CDM Alliance. This is a multidisciplinary network from the acute, sub acute and community services within Northeast Health Wangaratta.

The elected Alliance Chairperson (Director of Community and Aged Care Services NHW) will report activities to Northeast Health Wangaratta Executive committee (fund Holders) and the Central Hume Primary Care partnership.

Please see attachments 1 & 2:

- Terms of Reference
- Membership
- Governance Flow Chart

The TOR is a current agenda item for discussion at the next Alliance meeting. It is anticipated that the Alliance will meet 4 times per year with a focus on Operational and strategic planning. The NHW consultative group will continue to meet 2<sup>nd</sup> monthly, to facilitate opportunities between, Aged Care, Community and acute sectors.

**Number of Local Alliance Meetings conducted in the 2005 / 2006 financial year**

HARP CDM Alliance meetings 05/06 = 8

NHW HARP CDM Consultative committee = 6

**Data**

**Question 5. For each target group listed below, please provide December 2005 predictions and July 2006 actual number of clients enrolled in HARP-CDM. The Enrolled Patient Population are those clients who have been assessed as eligible and have received services from or coordinated by HARP-CDM. Consider using VAED, VEMD, predicted growth, burden of disease and past experience to guide estimates for 2006-07. You may wish to refer to Section 4.1.1 of the Technical Discussion Paper at <http://www.health.vic.gov.au/harp-cdm/harptechrep.pdf> for data definitions of CHF and COPD.**

**In addition please provide information on your staffing at the start and end of the 2005-06 financial year. Include staff who HARP-CDM funds as part of the HARP-CDM team both within the health service and employed by other agencies.**

**Please contact Zoë Austin-Crowe to seek advice about counting clients who have received HARP-CDM services, but that don't meet one of the four target group criterion.**

Main reason for enrolment (please count client only once)	Total clients enrolled in 2004-05 ^	Total clients to be enrolled in 2005-06		Total client to be enrolled in 2006-07		As at July 2006 total capacity of enrolled clients at any one time	
		Predicted December 2005	Actual July 2006	Predicted December 2005	Predicted July 2006	Predicted December 2005	Actual July 2006
People with chronic heart disease	0	0	16	10-20	150	15	16
People with chronic respiratory disease	0	0	16	10-20	240	15	16
Older people with complex needs	0	0	11	5-10	50	5	11
People with complex psychosocial needs	0	0	0	5-10	0	0	0
<b>Total</b>	0		43	45-50	440	35 30 active per 1.0 EFT current 1.2 EFT	43

<b>Aboriginal and Torres Strait Islander clients</b>	ATSI* clients enrolled in 2004-05 ^	Predicted (December 2005) ATSI* clients enrolled in 2005-06	Actual (July 2006) ATSI* clients enrolled in 2005-06	Predicted ATSI* clients enrolled in 2006-07	<b>Staffing EFT</b>	July 1 2005	June 30 2006
					Management EFT	0	1.0
					Clinical EFT	0	1.2
					Administration EFT	0	0
<b>Total</b>	0	0	0	<b>0</b> ATSI clients are referred to services in Wodonga, Alexandra or Goulbourn Valley	<b>Total</b>	0	2.2

^ Not applicable to newly funded health service in 2005-06

**Model of Care**

**Question 6. Provide a flowchart or diagram describing the client's pathway through your model of care from client identification and referral to discharge.**

**Include details of key decisions that are made such as when referral to another program is more appropriate (eg Early Intervention in Chronic Disease in Community Health Services Initiative).**

**This may be the same model as submitted in December 2005, or altered, depending on the particular situation of the HARP-CDM service.**

See Attached Flow charts for client pathway.

Attachment 3 Indicates basis of referral pathway distributed in December 05 and remains current.

Attachment 4 Indicates current existing referral patterns with detail of service provision.

**Question 7. Please provide 2 or 3 de-identified case studies demonstrating the model of care in your HARP-CDM program. Outline the case study in column one and provide the programs response in the second column.**

<p><b>Case Study 1:</b>  <b>Medical Assessment Planning Sub unit Referral:</b>  <b>43 Year Old female: Diagnosis Chronic Respiratory Disease - Congenital</b>  Multiple admissions over past 2years, 3 in 2006, with increasing length of stay, infective exacerbation of condition.  Married with 3 children, 1 School aged and living at home.  Case Manager – Community Service Package – HC, Medication assistance and physiotherapy 1 per week.  Refused other services previously – felt they were managing.</p>	<ol style="list-style-type: none"> <li>1. Consent for HARP CDM referral attained</li> <li>2. Consent to contact Case Manager</li> <li>3. Comprehensive Health assessment and evaluation of needs</li> <li>4. Negotiated inpatient physiotherapy session – client experiencing pain with session, directed pain management and physiotherapy sessions to achieve positive outcomes.</li> <li>5. Accepted Social Work referral to help address social issues in home environment and child’s needs, to provide long term support.</li> <li>6. Dietetics referral based on weight loss over past 3 months of 6 Kg’s.</li> <li>7. Case conference – Client, Physician (attending for GP as well), Case manager, multidisciplinary team, HARP CDM: discussion of issues and barriers. Established ongoing plan: HARP CDM will liaise with the medical team for monitoring of health issues in the community and will complete assessment and develop management plan for any future admissions.</li> <li>8. Establish monthly visit and weekly follow up phone calls.</li> <li>9. Development of an alternative physiotherapy plan, to minimise discomfort, maximise airway clearance and explore options for commencing Non-invasive Ventilation therapy.</li> <li>10. Client preferred home therapy, education and monitoring over group management.</li> </ol>
<p><b>Case Study 2:</b>  <b>ED Referral:</b>  <b>60 year old male with COPD and right side heart failure, multiple hospital admissions, presentations to ED and GP calls.</b>  Oxygen dependent and Acquired Brain Injury.  Lives with an intellectually challenged wife, in a low socio economic area.  Nil case manger, financial management and CADLS assistance provided through a local community service group.</p>	<ol style="list-style-type: none"> <li>1. Consent for referral to HARP CDM</li> <li>2. Consent for communication with other services attained</li> <li>3. Comprehensive Assessment and planning of individual goals</li> <li>4. Referrals to: <ul style="list-style-type: none"> <li>- DNS for assistance with Cardiac and respiratory monitoring.</li> <li>- CRC for home physiotherapy and OT assessment (to determine needs long term for respite intervention and ADLS, attended in conjunction with HARP CDM Care Coordinators)</li> </ul> </li> <li>5. Weekly feedback and Case conferencing as required with Physician and GP, including establishment of emergency management/medication plan.</li> </ol>

	<ol style="list-style-type: none"> <li>6. Facilitation of required investigations – RFT’s, Echocardiogram and weekly pathology.</li> <li>7. Carers support and education regarding monitoring – managed extremely well by the wife with support.</li> <li>8. Establishment of weekly visit and daily phone call if required.</li> <li>9. Monitoring and intervention of health issues</li> </ol>
<p><b>Case Study 3:</b>  <b>Physician Referral:</b>  <b>79 year old lady with G4 dilated cardiomyopathy and COPD.</b></p> <p>Request for education and monitoring of heart failure and airways disease</p>	<ol style="list-style-type: none"> <li>1. Phone contact and home appointment scheduled</li> <li>2. Comprehensive assessment and goal planning attended</li> <li>3. Referral to CRC for slow stream Cardio pulmonary Rehabilitation and assessment for the Falls and Balance program.</li> <li>4. Scheduled appointments weekly, for introduction and education of Heart Failure monitoring diary.</li> <li>5. Referral feedback form forwarded to referring Physician and GP regarding strategies put in place.</li> <li>6. Review date set for midway through the cardio pulmonary rehabilitation program.</li> </ol>

**Question 8. Provide details of the specific number of staff (ie managers, nurses, allied health professionals, etc.) and other resources required to deliver HARP-CDM in 2005-06. Provide a budget outline for 2006-07, identifying how the allocated funding will be used to provide services, including expenditure on staffing, and if relevant, training and workforce development (use the attached budget template). The 2006-07 figures should not include growth or any CPI adjustments. Please provide a staff structure, outlining people's roles, if available. Please include staff employed in organisations other than the Health Service, as well as those employed by the Health Service in "1. Direct Staffing". "4. Payments to other organisations" should be used for flexible funds / brokerage arrangements, not staff core to the HARP-CDM team.**

Average EFT refers to the predicted or actual average employment of staff over a one year period

		2005-06 Budgeted Expenditure			Actual 2005-06 Expenditure			Proposed 2006-07 Budget Expenditure					
		One off costs	Recurrent	Total cost	One off costs	Recurrent	Total cost	One off costs	Recurrent	Total cost			
<b>1. Direct Staffing</b>													
Position Title	Average Salary (incl. on costs)	Average EFT	One off costs	Recurrent	Total cost	Average EFT	One off costs	Recurrent	Total costs	Average EFT	One off costs	Recurrent	Total cost
Program Manager													
Nursing	81,224	1.0				1.0							
Registered Nurses (Div 1)	40,612	0.5				1.0							
Enrolled Nurses (Div 2)	164												
Allied Health													
Physiotherapists													
Occupational Therapists						0.2							
Therapy Assistants & Aides													
Social Workers													
Psychologists													
Pharmacists													
Other - please specify													
Medical													
Geriatrician / Specialist													
Other medical including GP						0.2							
Administration													
Other - please specify													
<b>Sub total of directing staffing</b>		<b>1.7</b>	<b>0</b>	<b>0</b>	<b>122,000.00</b>	<b>2.4</b>	<b>0</b>	<b>0</b>	<b>72,000.00</b>	<b>3.2</b>	<b>0</b>	<b>0</b>	<b>221,000.00</b>
<b>2. Equipment</b>													
<b>Sub total of equipment</b>			<b>0</b>	<b>0</b>	<b>10,000.00</b>	<b>0</b>	<b>12,000.000</b>	<b>0</b>	<b>12,000.00</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>

Health Service:	2005-06 Budgeted Expenditure			Actual 2005-06 Expenditure			Proposed 2006-07 Expenditure		
	One off costs	Recurrent	Total cost	One off costs	Recurrent	Total costs	One off costs	Recurrent	Total cost
<b>3. Other Costs</b>									
Operating costs eg. Electricity, rates etc					15,000.00			25,000.00	
Training	15,000.00			12,000.00				8,000.00	
Administration	10,000.00				2,000.00			5,000.00	
Medical goods & services eg. Drugs, diagnostic				1,000.00				10,000.00	
Travel (including vehicles)	12,000.00			21,000.00				9,000.00	
Insurance									
IT (Database)	80,000.00			38,000.00				6,500.00	
Evaluation									
Other	18,000.00				10,000.00			1500.00	
<b>Sub total of other costs</b>	<b>0</b>	<b>0</b>	<b>135,000.00</b>	<b>0</b>	<b>0</b>	<b>95,000.00</b>	<b>0</b>	<b>0</b>	<b>65,000.00</b>
<b>4. Payments to Other Organisations</b>									
Flexible funds									
Personal Care	27,000.00								
Transport									
Respite									
Allied Health	6,000.00								
Equipment									
Other				1000.00				10,000.00	
<b>Sub total of payments to other organisations</b>	<b>0</b>	<b>0</b>	<b>33,000.00</b>	<b>0</b>	<b>0</b>	<b>1,000.000</b>	<b>0</b>	<b>0</b>	<b>10,000.000</b>
<b>GRAND TOTAL</b>	<b>0</b>	<b>0</b>	<b>300,000.00</b>	<b>0</b>	<b>0</b>	<b>184,000.00</b>	<b>0</b>	<b>0</b>	<b>296,000.00</b>

Average EFT refers to the expected employment of staff in 2005-06 and 2006-07.

## Business Plan

**Question 9. Provide a progress update to the business plan developed by the HARP-CDM Local Alliance for December 2005 reporting requirements. Consider both short and long term key priority areas, as well as emerging issues. These may form new key priority areas.**

Key Priority Areas	Objective	Key Activities	Target completion date	Person responsible	Progress Update (to July 2006)
1.1 Defined point of access	<ul style="list-style-type: none"> <li>▪ To be provide a single point of entry and common referral tool</li> <li>▪ Establish clear lines of communication between services and multidisciplinary team.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Utilisation of SCoTT and education of staff utilising the tool</li> <li>▪ Engagement with the CHPCP Service Coordination sub group</li> <li>▪ Establishment of multidisciplinary team meetings monthly to review processes.</li> <li>▪ To MAP Chronic and Complex needs in the ED department to determine future program development.</li> </ul>	Ongoing	HARP CDM Manager	<ul style="list-style-type: none"> <li>▪ Scott tool is the referral tool for and by HARP CDM for services</li> <li>▪ HARP CDM participate monthly in CHPCP Service Coordination meetings</li> <li>▪ HARP CDM participates in multidisciplinary /transdisciplinary meetings; Unit, Discharge, Case Conferencing, Medical and Advisory committee.</li> <li>▪ Employment of Care Coordinator Occupational Therapist in a 0.2 EFT position into the ED department to MAP presentations and admissions in ED in Chronic and complex patients and to assist the development and utilising of the Rapid Assessment Service in the ED environment.</li> </ul>

Key Priority Areas	Objective	Key Activities	Target completion date	Person responsible	Progress Update (to July 2006)
1.2 to 1.4 Assessment, stratification, Care Coordination, monitoring and review	<ul style="list-style-type: none"> <li>▪ To promote comprehensive Assessment of clients with chronic and complex needs to establish long term and short term needs within the acute sector through to the community environment.</li> <li>▪ To provide quality Care Coordination that meets the individual health care needs and goals of client within the program.</li> <li>▪ To provide a multidisciplinary/transdisciplinary model of care that meets individual client goals.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Provision of comprehensive assessment and consultation within the acute care, aged care, community and regional health care services of Northeast Victoria.</li> <li>▪ Utilisation and promotion of the extended Assessment tools within the SCoTT referral tool.</li> <li>▪ Early referral to complimentary allied health teams in meeting individual client needs.</li> <li>▪ Establishment of clear lines of communication amongst services providing care.</li> </ul>	Ongoing	HARP CDM program manager	<p>Employment of Care Coordinators. Nursing 0.5 increased to 1.0 EFT to meet referral needs of program.</p> <p>Occupational Therapy 0.2 EFT. Intention to increase OT position to 0.4 EFT at the end of July 06 to meet increasing program needs.</p> <p>Development of a Paediatric Asthma education and support services for children and adolescents within Northeast Victoria with Asthma. Strategy submitted to executive - Intention to appoint Paediatric Care Coordinator 0.4 EFT August 06. Intention to appoint 0.2 EFT ED position.</p> <p>Exploration of Home Oxygen Assessment and coordination needs within Northeast Victoria.</p>

Key Priority Areas	Objective	Key Activities	Target completion date	Person responsible	Progress Update (to July 2006)
1.5 Interdisciplinary approach and multidisciplinary team	<ul style="list-style-type: none"> <li>▪ To promote and foster a multidisciplinary /transdisciplinary approach to care and management of clients with chronic and complex disease</li> <li>▪ To develop and promote partnerships within Northeast Victorian health and community services</li> </ul>	<ul style="list-style-type: none"> <li>▪ Attendance at multidisciplinary meetings.</li> <li>▪ Participation in CHPCP Service Coordination meetings and Health Planning forums</li> <li>▪ Facilitation and participation in Case Conferences</li> <li>▪ Establishment of linkages with Physicians and GP's in providing care for clients with chronic and complex disease.</li> <li>▪ Development of opportunities to foster and develop a team approach to care.</li> </ul>	Ongoing	HARP CDM team	<p>Attendance at monthly CHPCP Service Coordination meetings</p> <p>Coordination of multidisciplinary meetings monthly.</p> <p>Facilitation and coordination of case conferences for clients with chronic and complex disease – Attendance at 5, May/June 06.</p> <p>Development and implementation of a transdisciplinary / multidisciplinary Client self Management Heart Failure Diary - currently being utilised and accessed by all services.</p> <p>Participation of HARP CDM in Nurse Practitioner Project Steering commission – Facilitation of Nurse Practitioner role within Chronic Disease management through HARP CDM.</p> <p>Position to be developed over a 5 year plan, commencing 2007. EOI and business plan to support role to be developed over 2006.</p>

Key Priority Areas	Objective	Key Activities	Target completion date	Person responsible	Progress Update (to July 2006)
1.6 Education and self management	<ul style="list-style-type: none"> <li>▪ To promote and enhance self management strategies in clients with chronic and complex disease</li> <li>▪ To provide increased opportunities and access to resources for clients with chronic and complex disease within NE Victoria</li> </ul>	<ul style="list-style-type: none"> <li>▪ Education and training of HARP CDM staff in self management strategies</li> <li>▪ Increased access to training and resources for development of programs within NE Victorian health services</li> <li>▪ Implementation of the NHW Heart Failure Diary</li> </ul>	Ongoing	HARP CDM Manager and team	<ul style="list-style-type: none"> <li>- COPD Management update; Feb 06, Accessed by 50 staff</li> <li>- Asthma Update, March 06; Accessed by 75 staff</li> <li>- Advanced Physical Assessment Course, accessed by 3 staff, March 06.</li> <li>- Depression and Chronic Disease Study Day April 06</li> <li>- Flinders Model in Self Management training, May 06</li> <li>- Australian Asthma &amp; Respiratory Educators Professional Development Day May 06</li> <li>- Stanford Model of Self Management training, May 06. Total of 17 participants.</li> <li>- Increased number of referrals to CRC and community programs by HARP CDM, within local settings. HARP CDM is currently servicing clients in Benalla, Mansfield, Indigo, Moira, Alpine and Wangaratta shires.</li> </ul>

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1.7 to 1.9 Role of GP, psychosocial support and specialist services	<ul style="list-style-type: none"> <li>▪ To facilitate, develop and compliment partnerships with Medical practitioners, Integrated Mental health team and specialist service providers within Northeast Victoria</li> </ul>	<ul style="list-style-type: none"> <li>▪ Regular attendance and presenting to Clinical physicians meeting at NHW</li> <li>▪ Participation with GP's in case conferencing in clinics.</li> <li>▪ Attendance at Medical appointments on request and Medical rounds with acute sector.</li> <li>▪ Attendance at regional health services on request for clients of HARP CDM and for consultation.</li> <li>▪ Facilitation of referrals to specialist services and management of clients in common care.</li> </ul>	Ongoing	HARP CDM team	<ul style="list-style-type: none"> <li>▪ Development of Heart failure diaries consultation with Physicians.</li> <li>▪ Development of Research study to be undertaken by HARP CDM in Heart Failure monitoring in consultation with Physicians.</li> <li>▪ Development of referral feedback and emergency management plans with GP's and Physicians.</li> <li>▪ HARP CDM has provided consultation services to the following hospitals – Benalla, Beechworth, Myrtleford and Bright.</li> <li>▪ HARP CDM is liaising with Aged Care, Aged Care Psychiatry and CADM services to meet the long term needs of individual clients.</li> <li>▪ Exploration with Northeast Victorian Division of GP's in establishment of GPLO role in participation with HARP CDM. Discussions are current in regard to developing a strategy to determine needs between, NHW, GP's and regional hospitals</li> </ul>

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<p>1.10 to 1.12 Flexible service, 24/24 access, referral and links to services</p>	<ul style="list-style-type: none"> <li>▪ To enhance and develop access to best practice chronic and complex care throughout NE Victoria for people with chronic and complex disease.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Facilitation, promotion and development of chronic disease management programs within local environments across the Northeast.</li> <li>▪ Increased access to support and education in chronic disease management for health services within northeast Victoria.</li> <li>▪ Up skilling of Home based nursing services in broadening of skill mix in CDM at NHW.</li> <li>▪ Provision of central contact point for HARP CDM via telecommunication and electronically</li> </ul>	<p>Ongoing</p>	<p>HARP CDM team</p>	<ul style="list-style-type: none"> <li>▪ Provision of access to training and support for Health care services within Northeast Victoria.</li> <li>▪ Provision, Central Call Phone with answering machine, mobile phones and pagers for HARP CDM Team. Central Referral tool. Central Email contact for HARP CDM</li> <li>▪ Increased number of referrals to local programs for clients with chronic disease.</li> <li>▪ Utilisation of after hour services such as DNS to support HARP CDM service for clients with increased need.</li> </ul>

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2.1 to 2.2 Governance Program and accountability	<ul style="list-style-type: none"> <li>▪ To maintain partnerships within the HARP CDM Alliance across the Northeast region to ensure the program meets the needs of people with chronic disease across all its communities.</li> <li>▪ To ensure HARP CDM reports activity, progress and developments on a regular basis as directed by the governing bodies. – DHS, NHW Executive and Alliance.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Regular alliance meetings.</li> <li>▪ Circulation of DHS reports to key stakeholders for consultation bi annually.</li> <li>▪ Regular meetings and reports to NHW executives as directed.</li> </ul>	Ongoing	HARP CDM Manger	<ul style="list-style-type: none"> <li>▪ Monthly Alliance meetings to become quarterly targeted for strategic and operational planning.</li> <li>▪ DHS reports forwarded to all key stakeholder for comment prior to submission.</li> <li>▪ HARP CDM Program Manager meets monthly with Aged Care and Community services Manager and 3 monthly with Director of Community and aged Care Services.</li> <li>▪ Meets with Director for Corporate Services as directed – held 2<sup>nd</sup> monthly in view of program development and needs.</li> </ul>
3.1 to 3.2 Staff competency and professional accountability	<ul style="list-style-type: none"> <li>▪ HARP CDM staff will practice within organisational policy, guidelines and complete mandatory competencies as directed.</li> </ul>	<ul style="list-style-type: none"> <li>▪ HARP CDM participate in the development and updating of appropriate policy and remain informed in regard to organisational requirements.</li> </ul>	Ongoing	HARP CDM Team	<ul style="list-style-type: none"> <li>▪ HARP CDM is informed and has participated in education in regard installation of VIGILENT policy system within NHW.</li> <li>▪ HARP CDM ensures they practice within current service agreements at NHW.</li> </ul>

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4.1 to 4.3 Client record management, Privacy and consent and Program Data outcomes.	<ul style="list-style-type: none"> <li>▪ HARP CDM will maintain records and client files within organisational policy and regulations.</li> <li>▪ Data collection and evaluation will meet Program, DHS and organisational requirements.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Development of secure IT systems and filing of client records according to organisational and legal requirements.</li> <li>▪ Provision of education and training of staff accessing systems within HARP CDM.</li> <li>▪ Utilisation of SCoTT referral tool, privacy and consent form. Including organisational patient rights pamphlet.</li> </ul>	Ongoing	HARP CDM team	<ul style="list-style-type: none"> <li>▪ HARP CDM staff have been trained in IT systems and legal requirements, electronically and hard file systems.</li> <li>▪ HARP CDM provides weekly activity reports to HIS to ensure location of community files.</li> <li>▪ Accepted utilisation of SCoTT, privacy, consent form and NHW patient's rights pamphlet, including documentation within files of client consent.</li> <li>▪ Ongoing discussions with IT in regard to mandatory reporting requirements of HARP CDM to: DHS and Organisation. We are currently developing our systems to import VINAH , KPI's and productivity requirements.</li> </ul>
5.1 Risk management and staff safety	<ul style="list-style-type: none"> <li>▪ HARP CDM maintains practice within organisational and program Operational Plan.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Risks are reported and documented according to organisational policy as they are identified or anticipated.</li> </ul>	Ongoing	HARP CDM team	<ul style="list-style-type: none"> <li>▪ HARP CDM Manager liaises with NHW Risk Manager to seek guidance and clarification as required and has participated in alteration of organisational policy as directed to meet community needs of the HARP CDM program. Eg: Development of a community clause within the Medication Administration and storage policy.</li> </ul>

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6.1 Quality Improvement plan	<ul style="list-style-type: none"> <li>▪ To provide quality service that demonstrates best practice management in chronic and complex disease.</li> <li>▪ To provide opportunities for development and research in chronic and complex disease management within Northeast Victoria</li> </ul>	<ul style="list-style-type: none"> <li>▪ To develop a Paediatric component of chronic disease management within Northeast Victoria, with a current focus on Asthma</li> <li>▪ To undertake a research study in heart failure 06/07</li> <li>▪ Regular Data analysis and evaluation to determine whether the program is meeting set goals.</li> </ul>	Ongoing	HARP CDM Manager	<ul style="list-style-type: none"> <li>▪ Development and maintenance of multidisciplinary team meetings.</li> <li>▪ Exploration of new opportunities for development of the HARP CDM framework and delivery – GPLO, Nurse Practitioner, ED mapping, Paediatric Asthma program and development of current service.</li> <li>▪ Engagement of Physicians and NHW Research team in assistance with undertaking Heart Failure research study.</li> </ul>