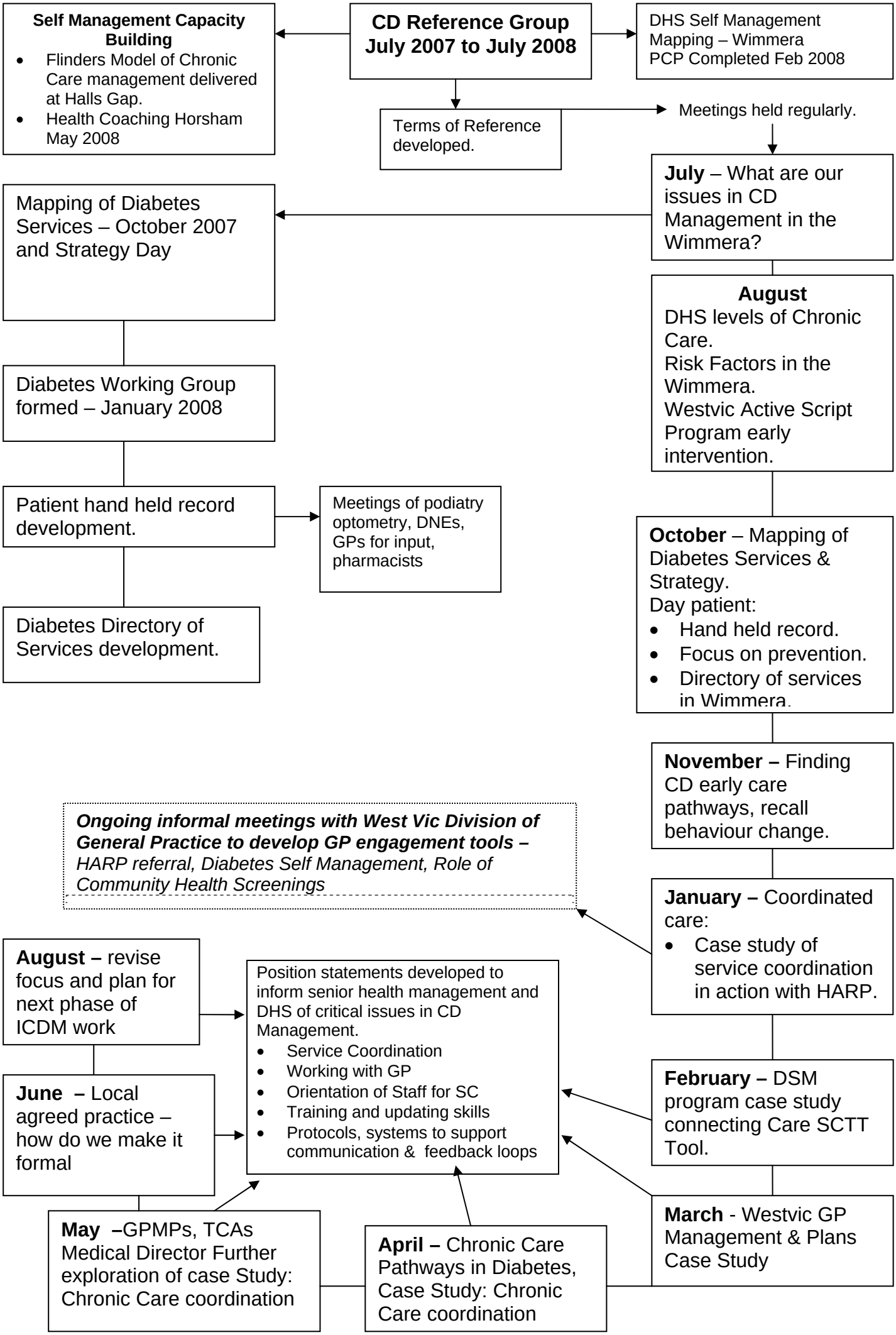
CD Reference Group July 2007 to July 2008
Self Management Capacity Building
Flinders Model of Chronic Care management delivered at Halls Gap.
Health Coaching Horsham May 2008
DHS Self Management Mapping – Wimmera PCP Completed Feb 2008
Terms of Reference developed.
Meetings held regularly.
July – What are our issues in CD Management in the Wimmera?
Mapping of Diabetes Services – October 2007 and Strategy Day
August
DHS levels of Chronic Care.
Risk Factors in the Wimmera.
Westvic Active Script Program early intervention.
Diabetes Working Group formed – January 2008
Patient hand held record development.
Meetings of podiatry optometry, DNEs, GPs for input, pharmacists
Diabetes Directory of Services development.
October – Mapping of Diabetes Services & Strategy.
Day patient:
Hand held record.
Focus on prevention.
Directory of services in Wimmera.
November – Finding CD early care pathways, recall behaviour change.
Ongoing informal meetings with West Vic Division of General Practice to develop GP engagement tools – HARP referral, Diabetes Self Management, Role of Community Health Screenings
January – Coordinated care:
Case study of service coordination in action with HARP.
August – revise focus and plan for next phase of ICDM work
Position statements developed to inform senior health management and DHS of critical issues in CD Management.
Service Coordination
Working with GP
Orientation of Staff for SC
Training and updating skills
Protocols, systems to support communication & feedback loops
February – DSM program case study connecting Care SCTT Tool.
June – Local agreed practice – how do we make it formal
March - Westvic GP Management & Plans Case Study
May –GPMPs, TCAs Medical Director Further exploration of case Study: Chronic Care coordination
April – Chronic Care Pathways in Diabetes, Case Study: Chronic Care coordination