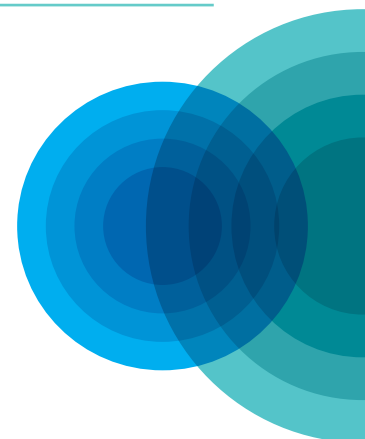




Monash Health acknowledges the Traditional Owners of this land, the Wurundjeri and Boonwurrung People, who are part of the Kulin Nation. We pay respect to their Elders past and present whose ancestral land it is upon which we provide care to the community.

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Foreword

Chronic disease is one of the biggest challenges facing our health system. It is with great pleasure that we present the Monash Health Chronic Disease Strategy: 2016–2021. The Strategy outlines the key areas Monash Health will focus on in the next five years to ensure a considered response to the rising burden of chronic disease in our community.

As the largest health service in Victoria and as provider of primary, secondary and tertiary services across the lifespan, Monash Health is uniquely placed to impact and influence our community's chronic disease service system. Together with our patients and other partners, we have a real opportunity to generate lasting changes that will significantly improve the health and wellbeing of people living in Melbourne's south east.

The Strategy has been developed in close collaboration with our partners including patients. It recognises the need for a coordinated approach to drive regional level system change for people living in our community. Monash Health and partners will need to work together to achieve truly integrated care, which will require improved patient pathways and implementation of large scale information and communication systems.

Recognising the critical importance of partnerships and shared responsibility for a regional response to chronic disease, the Chronic Disease Strategy was co-designed with our partners in two stages. The first stage involved the development of a shared vision and principles to respond to chronic disease. The shared vision and principles set the foundation for regional collaboration.

The second stage was the development of the Monash Health Chronic Disease Strategy: 2016–2021 using the shared vision and principles as the foundation. The Strategy identifies a series of specific one and five year outcomes required for strategic service improvement. These outcomes have been shaped on four themes. These themes are:

1. Empowerment
2. Information and communication
3. Systems and models of care
4. Leadership and coordination

Improving our response to chronic disease will require us to do things differently. The development of the Monash Health Chronic Disease Strategy has been a valuable opportunity work with our partners including patients to set the direction for the next five years.

As we move towards implementation, we look forward to ongoing collaboration across our organisation and with our community-based partners.



Andrew Stripp
Chief Executive



Barbara Yeoh
Chair, Board of Directors

Improving health and wellbeing through partnerships

Chronic disease is Australia's biggest health challenge. With half of all Australians living with a chronic disease and a rising number of people living with more than one disease, there is growing need for our health system to deliver improved outcomes while maintaining financial sustainability.

Chronic diseases are long lasting, usually not curable and require long term management. In order to optimise their health and quality of life, people living with chronic disease need a health system that empowers them to manage their health in partnership with a multidisciplinary care team that provides ongoing, coordinated, holistic patient-centred care.

Our health system, is not currently designed to deliver the best outcomes for people living with more than one chronic disease. Though some people receive excellent care, many, in particular our community's most vulnerable members, are disempowered by fragmented, episodic, single disease-focused care.

Structured as a vast web of public and private service providers with highly complex funding and governance structures, our health system has no single point of accountability for chronic disease services or outcomes. Lack of formalised accountability, however, does not mean that no one is responsible. Rather, it means that responsibility for our community's chronic disease outcomes is shared between service providers, funders and the broader community.

As a major provider of hospital and community care to almost one million people, Monash Health plays an integral role in improving chronic disease outcomes. In 2015, Monash Health committed to developing a Chronic Disease Strategy to address the growing challenge of chronic disease.

The Strategy aims to provide an overarching framework for the Monash Health chronic disease response and to explore opportunities to collaborate with partners from across the community, including patients, carers and their families.

A shared vision and principles for chronic disease

A shared framework for chronic disease was co-designed with Monash Health's partners, including patients, who participated in a series of surveys and workshops. Key to the development of the Strategy, the framework includes a shared vision and principles, and was developed to facilitate regional collaboration, and to use as the foundation of the Monash Health Chronic Disease Strategy. Below is a framework overview, with the full version available in Appendix 1.

Shared Vision:

Our communities are empowered to improve prevention and respond well to chronic disease.

Shared Goal:

Together we create a health care system that: empowers people to improve prevention of chronic disease and manage their health; delivers customised, seamless and flexible care, and is equitable, integrated, safe and high quality.

Shared Principles:

- We design and deliver services as a partnership between a person, their community and health care teams.
- We communicate well with each other.
- We create and support a health care system that works well.

A co-design approach to Strategy development

Using the shared vision and principles as the foundation, the Monash Health Chronic Disease Strategy was co-designed with our staff, patients, and partners (See Appendix 2 for a list of participants).

The Strategy themes, objectives, enablers and outcomes were identified through a series of workshops and key stakeholder consultations to ensure the Strategy meets the needs of our community. The Strategy focuses on collaborative partnerships that deliver the best possible outcomes for our community.

Our Community

Monash Health's diverse community is made up of close to one million people who live or work in the primary catchment including the Cities of Glen Eira, Kingston, Monash, Greater Dandenong and Casey, and the Shire of Cardinia.

Each local area is unique and has different challenges:

- The City of Glen Eira and the City of Monash have ageing populations, established migrant communities and Aboriginal and Torres Strait Islander communities that comprise 0.2% of their respective populations. The City of Monash is also home to many young domestic and international students who attend Monash University.
- The City of Kingston has areas of significant socio-economic disadvantage in suburbs such as Clayton South and Clarinda. In addition, 0.3% of people in the City of Kingston are of Aboriginal or Torres Strait Islander descent.
- The City of Greater Dandenong has a population of established older residents who live alongside the largest refugee and migrant community in the state. Aboriginal and Torres Strait Islander people make up 0.4% of residents in the City. Greater Dandenong has the highest level of socio-economic disadvantage in Victoria.
- The City of Casey and the Shire of Cardinia form the major part of Melbourne's rapidly expanding South East growth corridor. They have large areas of new housing developments alongside established regional/rural communities and farming land. Both the City of Casey and the Shire of Cardinia are home to Aboriginal and Torres Strait Islander communities which make up 0.7% of their total populations.

Though each local area has individual strengths and challenges, all of these communities are impacted by chronic disease.

Health care providers as community members

Health and care providers are integral members of the community. In our community, the major providers and organisations that share responsibility for health outcomes are:

- Monash Health
- Standalone Community Health Services – Central Bayside Community Health Services, Bentleigh Bayside Community Health, and Link Health and Community
- General Practitioners
- Dandenong and District Aborigines Co-operative Limited, including Bunurong Health Service
- Private health care providers – including pharmacies, private allied health and private hospitals
- Aged and Disability service providers – including Residential Aged Care Facilities and organisations providing services in the community and in people's homes
- Royal District Nursing Service
- Local Government
- Primary Health Networks – South Eastern Melbourne Primary Health Network and Eastern Melbourne Primary Health Network
- Primary Care Partnerships – Southern Melbourne Primary Care Partnership and Enliven Primary Care Partnership

A description of the role of each of partner organisation can be found in Appendix 3.

Health and care providers are integral members of the community.

Chronic disease in our community

Chronic disease is Australia's biggest health challenge. Though Australians are living longer, more people than ever before are living with chronic diseases such as heart, kidney and respiratory diseases, diabetes, mental illness, musculoskeletal disorders, poor oral health and cancers.

The impact of chronic disease on our community

Despite the fact that much of chronic disease and its complications are largely preventable, half of all Australians have at least one chronic disease and 90% of deaths in Australia are due to chronic disease.

Though all parts of our community are affected by chronic disease, there is a strong relationship between socioeconomic status and chronic disease risk and prevalence. In our community, this is particularly apparent in the City of Greater Dandenong, where the diabetes prevalence is 36% higher than the Victorian average. With poor access to public transport, the City of Casey is car dependent and has higher than average number of people who are overweight or obese.

Aboriginal and Torres Strait Islander people experience a significantly higher burden of chronic disease than non-Aboriginal people. The rate of diabetes is three times as high as the non-Aboriginal population, and dialysis rates are much greater: 34% of hospital admission for Aboriginal and Torres Strait Islander people are due for dialysis compared to only 18% of non-Aboriginal admissions. Importantly, about 80% of the mortality gap for Indigenous Australians aged 35 to 74 years is due to chronic disease. The gap is caused by higher rates of chronic disease at younger ages as well as increased death rates associated with chronic disease.

The increasing number of people living with multiple chronic diseases, is one of the most significant trends in chronic disease. It is estimated that 10% of all people and 23% of people aged 65 to 74 are living with four or more chronic diseases.

People living with multiple chronic diseases often see multiple general practitioners, medical specialists and allied health professionals, each of whom has different care priorities, will define different goals and care plans and will make changes to medications. In most cases, these professionals will have limited communication with each other. Some people will have multiple case managers or care coordinators allocated to them at the same time. This leads to a fragmented health care experience, which results in rising costs to patients and their families, together with a higher burden of treatment and disease, and impacts on quality of life.

In addition, people with mental health conditions are also likely to have multiple physical chronic diseases. Those diseases are more likely to be managed by multiple and inconsistent health care providers and systems, putting this group at higher risk of complications, reduced quality of life and premature death.

The impact of chronic disease on our health system

Chronic disease is the major driver of health care utilisation in Australia. Almost half of all general practice consultations are about chronic diseases, while heart disease, diabetes and chronic kidney disease alone are responsible for 20% of acute hospital admissions. A 2014 audit found that more than a quarter of admitted patients at Monash Medical Centre had diabetes, with one third of patients at Dandenong and Casey hospitals likely to have diabetes.

As more people live longer with more chronic diseases, the average complexity of people accessing health services has increased significantly. Systems designed to manage people with short-term, single organ disease are not well equipped to manage people with multiple complex health and social issues. The system is fragmented and difficult to navigate for both patients and health professionals, and there is significant duplication, inefficiency and waste. This places a large burden on both the patient and the health system, which bears much of the financial cost of this inefficiency. With a rapidly growing population and chronic disease prevalence showing no signs of reducing, there is an imperative to act now to ensure that we can meet the needs of our community now and into the future.

Chronic disease in our community (cont)

The Australian policy context

It is well recognised that the Australian health care system is not designed to deliver best outcomes to people with chronic disease. As health care spending continues to grow, there is a focus at all levels of government on developing new ways of delivering services to people with chronic disease.

Along with major reforms of the aged care and disability sectors, both the Commonwealth and Victorian Governments are undertaking large scale trials that aim to improve the flexibility and coordination of service provision to people with chronic and complex disease.

The national Healthier Medicare trial, which will deliver bundled payments to general practice for high risk patients, and the Victorian HealthLinks Chronic Care trial, which will deliver bundled payments to public health services for high risk patients, both signal a shift away from the fee-for-service model for specific patient cohorts, and a willingness to address the structural barriers to improving care for people with chronic disease.

Closing the Gap in Indigenous health outcomes is a priority at all levels of government. Koolin Balit is the Victorian Government's strategy for Aboriginal health from 2012-2022 and is the main framework for Monash Health and other community organisations to contribute to Closing the Gap. In 2012 Monash Health, Dandenong and District Aborigines Co-operative Limited and the Department of Health signed a Statement of Intent, which highlights the commitment of all organisations to Close the Gap for our Aboriginal community leading the way in Victoria. The principles of closing the gap remain a priority for all parties and the actions to achieve this are outlined in the Monash Health Reconciliation Action Plan 2015-17.

With clear synergies in existence, the Monash Health Chronic Disease Strategy will be implemented in the context of these and other relevant national, state and local policies.

Chronic disease services at Monash Health

As a provider of primary, secondary and tertiary level chronic disease care to our community, Monash Health has a unique opportunity to develop a truly integrated system chronic disease of care. Monash Health delivers hospital, emergency, community health, mental health and specialist outpatient services to people living with chronic disease. Our chronic disease services are multidisciplinary, and are delivered in hospitals, community health centres and in patient's homes. In some cases, such as the Shared Maternity Care and Refugee Health Programs, services collaborate closely with partner services to improve outcomes for our patients.

Monash Health chronic disease services are mostly designed to target patients with specific chronic diseases. Despite delivering high quality health services, these services often operate with limited coordination between services and other health care providers. This is primarily due to incompatible information sharing and communication systems. For many patients, in particular vulnerable patients and those with multiple chronic diseases, this can lead them to require multiple services in a system that is not coordinated and therefore their experience of health care and their outcomes are not optimised.

There are a number of new initiatives at Monash Health that are beginning to respond to chronic disease at a systems level, such as implementation of a new national model for comorbid diabetes, renal disease and cardiac conditions, and HealthLinks Chronic Care, a Victorian Department of Health and Human Services supported trial to improve management of people with multiple chronic diseases at risk of frequent admission to hospital.

Monash Health is known for delivering high quality health care services to the community. Stronger partnerships that aim to improve coordination, flexibility, communication, patient empowerment and innovative models of care are essential to ensure that Monash Health rises to the challenge of improving chronic disease outcomes.

Stronger partnerships that aim to improve coordination, flexibility, communication, patient empowerment and innovative models of care are essential to ensure that Monash Health is able to rise to the challenge of improving chronic disease outcomes.

Margaret has a passion for arts and crafts and values her close connection with her local church community. At 69 years old, she has kidney and heart disease, arthritis and anxiety. Margaret spends much of her time attending health care appointments and she has had three hospital stays in the past year.

Margaret describes her experience of health care as ‘understanding, helpful and there for you’. However, Margaret and her many care providers sometimes find it difficult to stay up to date with the many changes to her treatment and medication. To attend hospital appointments, Margaret has to take a bus and a train, followed by a difficult uphill walk. Margaret relies on the services at the community health centre which is close to her home.

Margaret, Dandenong Local and Monash Health patient

The Monash Health Chronic Disease Strategy

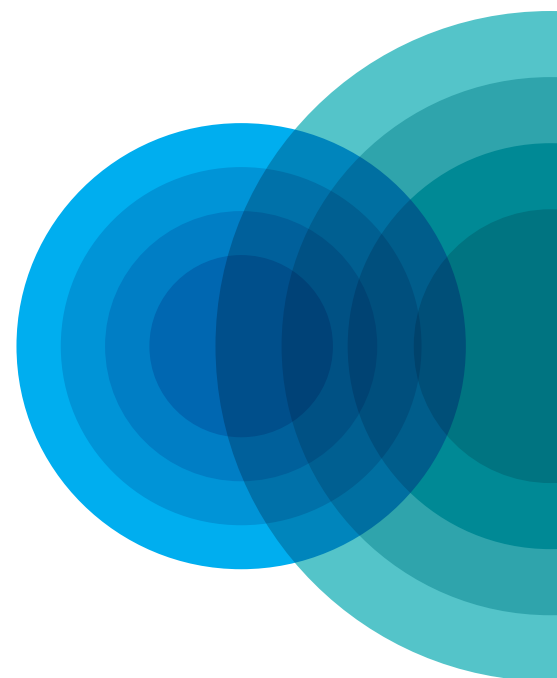
Development of the Chronic Disease Strategy is the first step towards a future where Monash Health services are designed specifically to meet the individual needs of people living with chronic disease.

In the future, patients and their families will be empowered to partner with a coordinated multidisciplinary health care team that includes professionals from Monash Health, their general practitioner and their other care providers. Patients will experience seamless transitions between care environments as they are provided with integrated, patient-centred care that is tailored to their unique needs.

The Monash Health Chronic Disease Strategy has been designed with our partners including our patients and is based on our community's shared vision and goal for chronic disease.

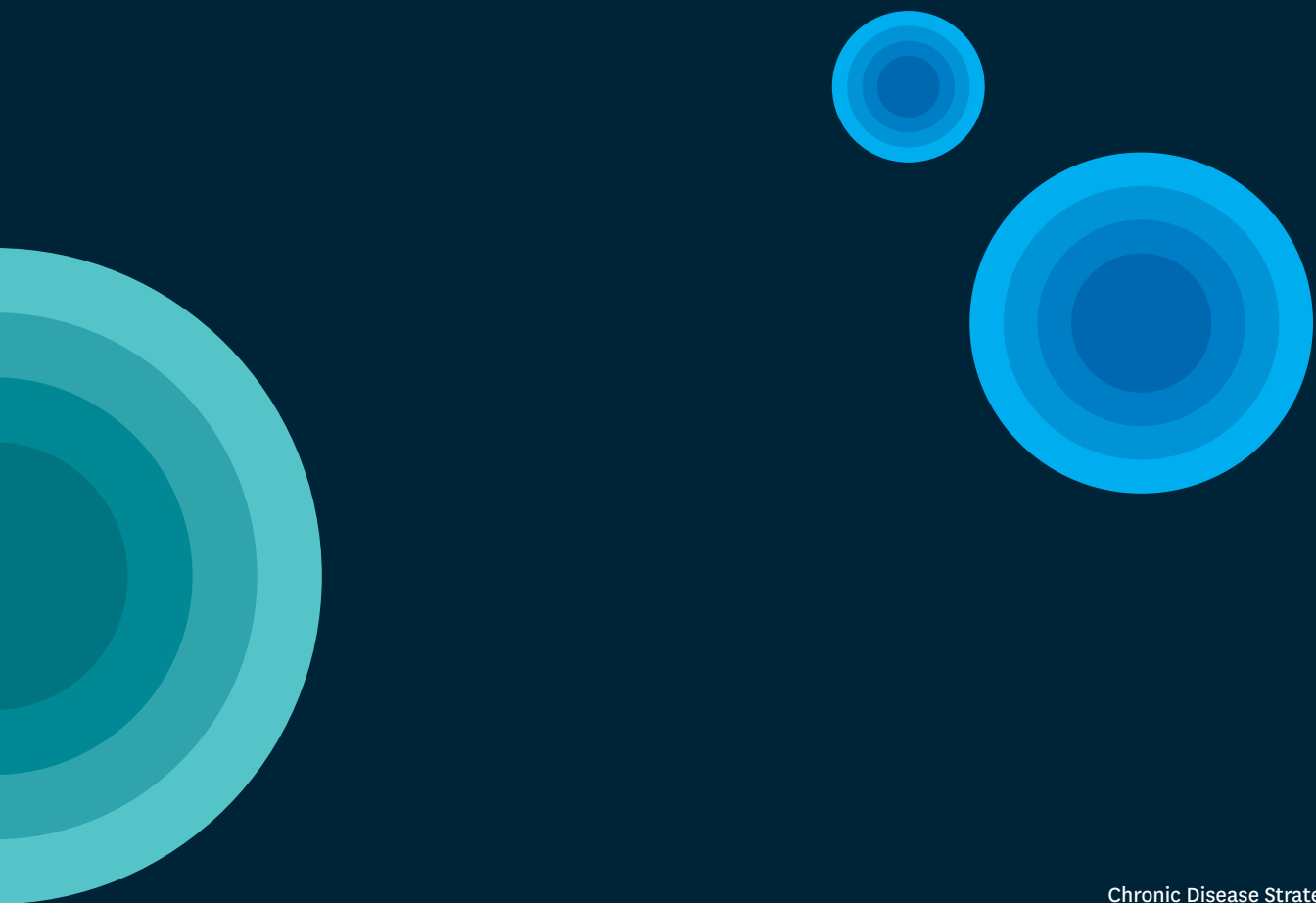
The Strategy is built on four themes that together contribute to achieving the chronic disease vision:

- 1. Patient empowerment**
- 2. Information and communication**
- 3. Systems and models of care**
- 4. Leadership and coordination**



I was on a lot of medication for my mental health. I was not understanding how to use my medication and emotionally I was very distressed. Now I feel the refugee clinic is my home. I have people there to talk to. They are always smiling and ready to help, and now I am feeling so much better. I recommend any new person to go to the refugee health clinic.”

Monash Health patient



Our shared vision

Our communities are empowered to improve prevention and respond well to chronic disease.

Our shared goal

Together we create a health care system that:

- Empowers people to improve prevention of chronic disease and manage their health.
- Delivers customised, seamless and flexible care.
- Is equitable, integrated, safe and high quality.

Our shared principles

We design and deliver services as a partnership between a person, their community and health care teams.

We create and support a health care system that works well.

We communicate well with each other.

Themes

Objectives

Patient empowerment

- > **Patients and their families are empowered through customised, culturally appropriate care and shared decision making.** Patients are actively supported to understand their condition, the service system and the choices available to them in order to manage their health in partnership with their health care team.

Information & communication

- > **Relevant information is accessible and shared between Monash Health, patients, and partners.** Information sharing platforms and strategies to facilitate collaborative communication enable the delivery of a seamless patient journey which: empowers patients; reduces duplication and fragmentation; and enables impact measurement.

Systems & models of care

- > **The chronic disease system of care is implemented via collaborative partnerships** which support shared decision making and new models of high quality, flexible and customised patient-centred care.

Leadership & coordination

- > **Organisation-wide ownership of chronic disease approaches, outcomes and solutions.** The shared vision, goal and principles are embedded into chronic disease organisational governance and operations, with senior leaders accountable for measurably improved processes and chronic disease outcomes.

Enablers

- Chronic disease governance accountability mechanism
- Clinical leadership
- Access to a communication, information sharing and measurement platform
- Clear goals and measurement tools
- Regional care pathways
- Alliances that deliver integrated care
- Primary care engagement and leadership
- Partner communication and engagement plan
- Regular stakeholder workshops

Partners

- Patients and families
- Primary care practitioners
- Community health services
- Primary Health Networks
- Primary Care Partnerships
- Aboriginal Community Controlled Health Services
- Local councils
- State and Commonwealth governments
- Aged and disability care providers
- Private health care providers
- Other public health service providers
- Monash University and researchers

Outcomes

1 YEAR

- Chronic disease governance and accountability in place internally and with partners
- Agreed implementation plan with specific patient outcomes
- Vulnerable groups strategy, including Aboriginal and Torres Strait Islander people
- Change management strategy to facilitate an organisational chronic disease philosophy
- Strategies for information and communication in place
- Primary health care engagement strategy in place
- Meaningful patient engagement and empowerment
- Chronic disease approaches and goals incorporated into unit business plans

5 YEARS

- Patients experience seamless, holistic, patient-centred chronic disease care and improved health outcomes
- Improved health status for vulnerable groups, including Aboriginal and Torres Strait Islander people
- A suite of tailored, targeted integrated services delivering measurable health impacts
- Information and communication system facilitating safe, integrated & high quality care
- Strong and effective partnerships between Monash Health and partners

Objective 1: Patients and their families are empowered through customised, culturally appropriate care and shared decision making. Patients are actively supported to understand their condition, the service system and the choices available to them in order to manage their health in partnership with their health care team.

People with chronic disease live with their condition every day. Taking medications, monitoring signs and symptoms, making decisions and taking action to avoid complications is part of their daily life. However, in our fragmented chronic disease system, advice and instructions to patients are often confusing or conflicting, making self-management a highly stressful daily activity. Though many people receive support from family and friends, some do not. Sometimes, despite their best efforts, some people will experience a deterioration in their health without it being possible to determine the cause or how it could have been avoided.

Patient empowerment is the key to improving chronic disease outcomes. Patients are empowered when they are supported and enabled by the system of care to ask questions, to understand their condition and their options, to have the confidence to manage their health and, when necessary, to take action. Our current system makes it difficult for patients to do these things, and many patients spend more time and energy navigating the system than they do managing their health.

Improving chronic disease outcomes will require all care teams and systems to prioritise patient empowerment. Allowing time to answer questions, providing patients with accessible, culturally appropriate information and genuine shared decision making are all key features of an empowering system. Empowering patients is vital to the achievement of our chronic disease goal, and requires a shift in paradigm from 'doing to' a patient, to 'working with' a person.

Achieving Objective 1 will require a greater understanding of both the patient and the health professional journey and experience with the chronic conditions and the system providing care. It will require genuine and ongoing engagement, collaboration, improved systems, flexibility and meaningful open communication to co-design, adapt and improve services and the way we provide them.

“I have a nurse coming around to my place almost every Monday. She checks my heart, she arranges everything for me which is marvellous. It is a big help because I care for my husband too.”

Monash Health patient

Information and communication

Objective 2: Relevant information is accessible and shared between Monash Health, patients, and partners. Information sharing platforms and strategies to facilitate collaborative communication enable the delivery of a seamless patient journey which: empowers patients; reduces duplication and fragmentation; and enables impact measurement, innovation and scale-up.

With multiple professionals and organisations involved in a person's care, access to information and communication about care plans, medications, referrals and discharges is challenging, but is essential for the delivery of a seamless and coordinated patient-journey. While existing infrastructure, data systems, and organisational policies and practices can act as barriers, these same elements are key to transforming the way we communicate with our patients and partners.

Access to information will empower both our patients and our partners to communicate with us, and to enhance our connectivity throughout the community.

Monash Health is currently undertaking a considerable amount of work in this area, including development of the Electronic Medical Record and alignment of Monash Community data systems to the acute and sub-acute sectors. These projects will increase the capacity of Monash Health services to communicate with each other, with our patients and with other service providers including general practitioners.

Across the broader health system, there are a raft of initiatives underway, including development of medication management and remote monitoring tools, and shared care, eHealth and telehealth platforms. The My Health Record platform, which is a personalised digital health record storing information such as current conditions, treatments, medications and pathology reports, is being rolled out nationally and is an important step towards cross-organisational information sharing.

Opportunities for transformational information and communication platforms are currently being explored with the potential to link across the care continuum. These systems, such as the Healtheintent platform, enable unprecedented data integration and will not only improve the care of the individual but will enable risk stratification and impact measurement of current and future initiatives, supporting effective innovation and scale up of measures to improve chronic disease care and outcomes.

Achieving Objective 2 will require sustained commitment by Monash Health and its partners to implementing innovative communication, information sharing and measurement solutions that are user-friendly for both patients and health professionals, and that can be integrated with the existing and future infrastructure. Communication and engagement plans will be essential.



02

Objective 3: The chronic disease system of care is implemented via collaborative partnerships which support shared decision making and new models of high quality, flexible and customised patient-centred care.

Shifting from disease-focused episodes of care to integrated, ongoing, holistic care is critical to achieving better long term outcomes for people with chronic disease. As health systems around the world grapple with the chronic disease challenge, evidence is emerging about the types of systems and models of care that deliver the best outcomes for patients and for the health system.

The experience with models such as Accountable Care Organisations in America, the Canterbury Model in New Zealand, the Buurtzorg model in the Netherlands and a range of integrated care models in the United Kingdom have identified four key learnings for developing innovative models to improve chronic disease outcomes:

1. Systems must be tailored to the unique local context if they are to be sustainable.
2. Successful models are flexible, and are designed around the patients' needs, not around the needs of organisations and professionals.
3. Holistic care, rather than disease-based care, is both more effective and efficient.
4. Systems that target initiatives at specific patient groups are most effective. Risk stratification and identification of impact are essential tools that ensures services target those who stand to benefit the most.

As a partner in the Monash Health Translation Precinct, translating medical research into practice for improved patient outcomes is a strength for Monash Health that will enable us to impact chronic disease outcomes across the continuum of care.

Achieving Objective 3 will require implementation of complementary innovative models across the organisation that change the way patients experience care. Key enablers for this objective are integrated data, analytics, partner alliances, regional care pathways and effective communication. Strong alliances with our partners to deliver integrated care across the community are essential to success.

As a partner in the Monash Health Translation Precinct, translating medical research into practice for improved patient outcomes is a strength for Monash Health that will enable us to impact chronic disease outcomes across the continuum of care.

Leadership and coordination

Objective 4: Organisation-wide ownership of chronic disease approaches, outcomes and solutions. The shared vision, goal and principles are embedded into chronic disease organisational governance and operations, with senior leaders accountable for demonstrating improved processes and chronic disease outcomes.

Every program area and staff member at Monash Health is involved in our community's chronic disease system of care. From the Emergency Department to our operating theatres, from the pharmacy to Health Information Systems, our culture, systems and processes have an impact on the experience and outcomes of our patients. How we connect and collaborate with our community partners, including patients and their families, is also critical for delivering good outcomes. Improving outcomes for chronic disease is a cross-organisational challenge that requires a whole-of-organisation approach to continuous learning and improvement.

Moving from a fragmented, single-disease orientated model to a holistic, patient-centred model of chronic disease care will require leadership and coordination across Monash Health. Strong leadership with a clear sense of direction and purpose can engage staff in our shared vision and goals for chronic disease, and engaged staff are able to support the development of systems and frameworks that will enable delivery of holistic, integrated care.

Monash Health is a highly complex organisation operating within a highly complex health system. Understanding what initiatives are underway in different parts of the organisation and how they are inter-connected is essential to developing a cross-organisation approach to chronic disease. Coordination of effort is critical in order to focus on priority areas, to optimise innovation and learning opportunities, and to ensure that fragmentation and duplication of effort is minimised.

Achieving Objective 4 will require maintaining and further developing strong leadership and coordination in chronic disease care across Monash Health and with our partners. The co-design of both the shared vision and principles and the Monash Health Chronic Disease Strategy has built a strong foundation for partnerships. Investment into ongoing engagement and co-design must be prioritised, with support for continuous learning and improvement. Our performance and achievements must also be measured to inform leadership and coordination, and to ensure continued progress toward our shared goal. Formal governance and accountability mechanisms need to be in place to ensure effective coordination and sustainability.



04

Implementation

This Chronic Disease Strategy provides an overarching framework for Monash Health to respond to the growing burden of chronic disease in our community. The Strategy is a high level document that will guide the implementation and coordination of existing and new chronic disease initiatives and the development of strong collaborative partnerships over the next five years.

Implementation of the Monash Health Chronic Disease Strategy will commence in July 2016. Early implementation activities will include:

- Establishing a project charter with the shared vision and principles as the foundation.
- Identification of priority areas across the care continuum including specific outcome measures.
- Detailed planning of the first year of work toward the five year Strategy.
- Development of a five year implementation plan that recognises the importance of ongoing collaboration both across Monash Health and with our partners.

Monitoring and evaluation of the Strategy will be embedded into the governance and accountability mechanisms and in the implementation plan.

Monash Health is committed to implementing the Chronic Disease Strategy, in alignment with the principles as set out in the regional framework for chronic disease. Strong partnerships are fundamental enablers across all four themes of the Strategy, and are the key to delivering sustainable change.

A governance framework will be established to:

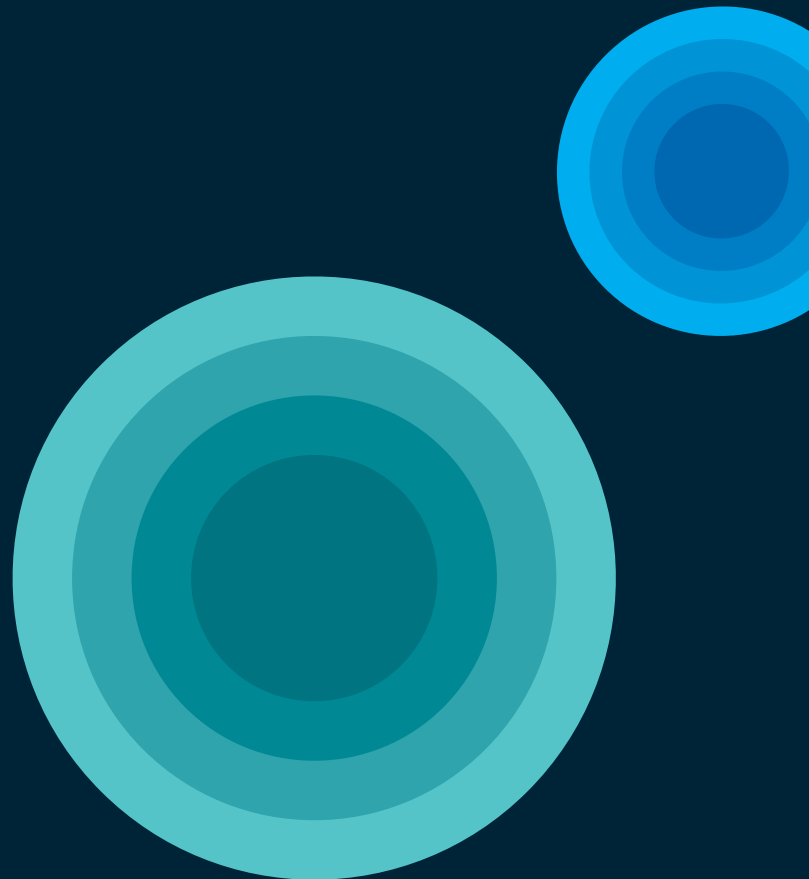
- Embed the vision and principles into organisational strategic, service and site plans.
- Oversee achievement of the Strategy objectives.
- Facilitate collaborative partnerships with our community.

“ When I was in hospital, they explained everything to me. They gave me a piece of paper to read and they came back several times to ask me if I understood it, and I did. It was a big help, because you are lying there wondering what is wrong with you and they came in and explained everything.”

Monash Health inpatient

“I have learnt that my mind says ‘yes I can do this’ and my lungs say ‘no you can’t’. I try to pace myself but usually end up huffing and puffing trying to gasp for air. I am still learning to pace myself but it is a hard thing to do. I have ups and downs, good days and bad days. How very scary it is when you just can’t get enough air to breathe.”

Monash Health patient



Appendix 1 – The shared vision and principles

Our Region's Framework for Responding to Chronic Disease: Monash Health and Partners

Responsibility for reducing the impact of chronic disease is shared by all members of our community, including patients and their families, health care providers, and all other community organisations. This framework, co-designed by Monash Health and its partners, represents a community approach to chronic disease. By collectively defining what we aim to achieve and how we will work together to achieve it, our community is empowered to work together in new ways to meet the many challenges of chronic disease.

Our Vision

Our communities are empowered to improve prevention and respond well to chronic disease.

Our Goal

Together we create a health care system that:

- Empowers people to improve prevention of chronic disease and manage their health.
- Delivers customised, seamless and flexible care.
- Is equitable, integrated, safe and high quality.

Our Principles

We design and deliver services as a partnership between a person, their community and health care teams.

Which means:

- We appreciate each person's knowledge of their body and their condition.
- We listen and respond to what each person is saying.
- We make decisions together.

We communicate well with each other.

Which means:

- We are respectful and transparent in everything we say and do.
- We openly share information that can improve a person's care or experience.
- We collaborate and build trust.
- We are clear about our roles and how our work interconnects.

We create and support a health care system that works well.

Which means:

- Services are as simple as possible to use and deliver.
- People get the care they need when and where they need it.
- It is a self-learning system that continuously improves.
- Care is inclusive, affordable and is based on best practice.

Defining Chronic Disease

Chronic disease is a long-term health condition that a person can manage in partnership with their community*.

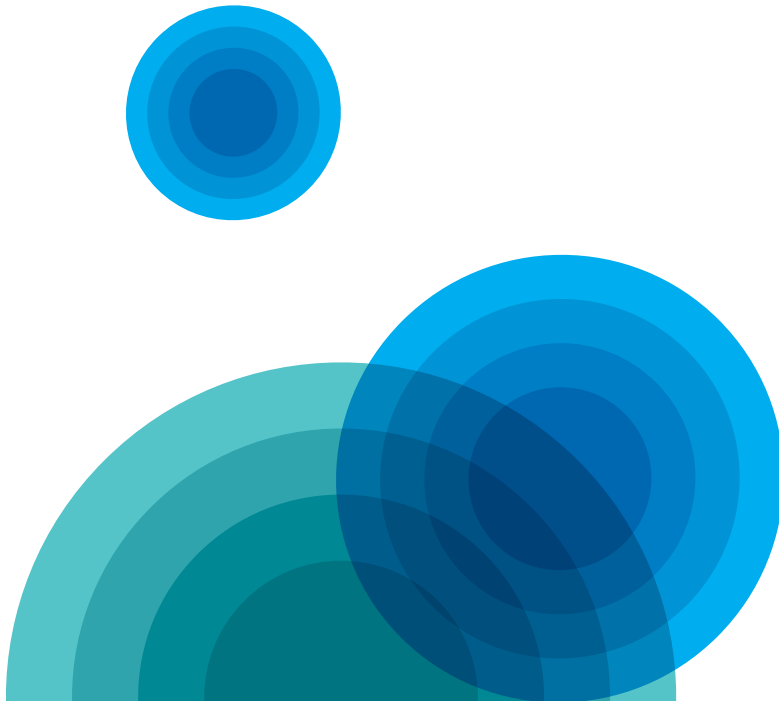
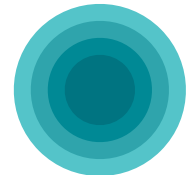
Community includes family, friends and all health services.

Appendix 2 – Our partners

Monash Health would like to thank...

Bentleigh Bayside Community Health
Betty Wilderman (Consumer advisor)
Central Bayside Community Health Services
Claire Jennings (Consumer advisor)
Dr Pam Williams (Consumer advisor)
Dr Tim Foo (Mackie Road Clinic)
Dr Trevor Adcock (Langton Medical Centre)
Dandenong and District Aborigines Co-operative Limited
Eastern Melbourne Primary Health Network
Enliven Victoria
Link Health and Community
Peter McDonald (Consumer advisor)
Prof Grant Russell (Monash University and Sandringham Medical Centre)
South Eastern Health Providers Association

South Eastern Melbourne Primary Health Network
Southern Melbourne Primary Care Partnership
Sue Viney (Consumer advisor)
The City of Casey
The City of Glen Eira
The City of Greater Dandenong
The City of Monash
The Royal District Nursing Service
The Shire of Cardinia



Appendix 3 – Our community’s major health care partners

ORGANISATION	ROLE IN THE SYSTEM AND SERVICES PROVIDED
Monash Health	<ul style="list-style-type: none"> • Monash Health provides primary, secondary and tertiary level medical, nursing and allied health services in acute, subacute, community and home-based settings, including: <ul style="list-style-type: none"> › Four acute hospitals - Casey Hospital, Dandenong Hospital, Monash Medical Centre Clayton and Moorabbin Hospital. › Subacute and community-based services including the Kingston Centre, the Cranbourne Integrated Care Centre, and the Springvale, Dandenong, Pakenham and Cockatoo Community Health Services. › Home based services including Hospital in the Home, allied health, InReach to residential aged care facilities, and the Complex Care Program for clients with complex needs. • In the south east end of the catchment (Greater Dandenong, Casey and Cardinia), Monash Health operates all of the community health services. • In the northern end of the catchment (Kingston, Glen Eira and Monash), some community health services are independent from Monash Health.
Standalone Community Health Services	<ul style="list-style-type: none"> • Bentleigh Bayside Community Health, Central Bayside Community Health Services and Link Health and Community provide a range of primary care services to their local communities in the Cities of Kingston, Glen Eira and Monash.
General Practitioners	<ul style="list-style-type: none"> • More than 1000 general practitioners provide primary care services to the community at hundreds of privately owned general practices across the region. General Practitioners are often the first point of contact in the health system for community members, and are integral to managing chronic disease in the community. Some practices employ practice nurses to assist with provision of services.
Dandenong and District Aborigines Co-operative Limited	<ul style="list-style-type: none"> • The Dandenong and District Aborigines Co-operative Limited (DDACL) is a community controlled health organisation established in 1975 by Aboriginal families in the local area who saw the need to provide support for the growing Koori community. • The DDACL has first-hand knowledge of issues affecting the local Aboriginal community and take a flexible, holistic, culturally sensitive approach to all services. The DDACL delivers holistic and culturally appropriate health and wellbeing services via its Bunurong Health Service to the local Aboriginal community.
Private health care providers	<ul style="list-style-type: none"> • Many health services are provided by private organisations, including general practice, private hospitals, private allied health clinics, pharmacies and pathology services. Most people in the community access a combination of public and private services.
Aged & Disability service providers	<ul style="list-style-type: none"> • There are a significant number of public, private and non-profit organisations that deliver a variety of aged and disability services across the region. Services may be provided on a short or long term basis.
Royal District Nursing Service	<ul style="list-style-type: none"> • Funded largely by the Home and Community Care program, the RDNS is Australia's oldest provider of home nursing and health care services.
Local Government	<ul style="list-style-type: none"> • The six local councils across the region fund and/or provide a range of health, aged and disability services, social services and health promotion activities
Primary Health Networks	<ul style="list-style-type: none"> • The South Eastern Melbourne Primary Health Network and the Eastern Melbourne Primary Health Network are Commonwealth funded organisations established to increase the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes, and to improve coordination of care to ensure patients receive the right care in the right place at the right time.
Primary Care Partnerships	<ul style="list-style-type: none"> • Primary Care Partnerships (PCPs) are voluntary alliances funded by the Victorian Department of Health and Human Services to improve access to services and provide continuity of care for people in their community. PCPs focus on better coordination among services, management of chronic disease management, integrated prevention and health promotion, and strong partnerships.

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