CENTRAL EAST

PCP

Primary Care Partnership

COMMUNITY HEALTH PLAN

JULY 2003 TO JUNE 2004

MEMBERSHIP OF CENTRAL EAST PRIMARY CARE PARTNERSHIP

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St Marks Adult Day Care Centre
Uniting Care Community Options
Vision Australia Foundation
Wavecare
Wavelink
WiN Support Services

Acronyms

ACAS	Aged Care Assessment
ADD	Attention Deficit Disorder
CALD	Culturally and Linguistically Diverse
CE PCP	Central East Primary Care Partnership
CHP	Community Health Plan
DALYs	Disability Adjusted Life Years
DHS	Department of Human Services
DTS	Drug Treatment Service
EPC	Enhanced Primary Care
HACC	Home and Community Care
HARP	Hospital Admission Risk Program
HPAG	Health Promotion Advisory Group
IC	Initial Contact
IHP	Integrated Health Promotion
ISP	Integrated Service Planning
LGA	Local Government Authority
MBS	Medicare Benefit Schedule
MOU	Memorandum Of Understanding
PDSS	Psychiatric Disability Support Services
PPPS	Practices Protocols Processes and Systems
RACAS	Residential Aged Care across the Sectors
RDNS	Royal District Nursing Service
YLD	Years Lost due to Disability
MOU	Memorandum Of Understanding

CONTENTS

FOREWORD 3

1. THE CONTEXT 4

3.1 COMMUNITY AND SERVICE PROFILE FOCUSING ON PRIORITIES........ 9

3.2.1 STRATEGIES– REVIEWING FOR FUTURE ACTION 16

3.2.2 PRIORITIES FOR FURTHER ACTION 21

3.2.3 STRATEGIES FOR ACTION 25

3.2.4 HEALTHY COMMUNITIES PROGRAM 34

APPENDIX 1: INTEGRATED HEALTH PROMOTION PROGRAM SUMMARY GRID 45

FOREWORD

The Community Health Plan details the achievements and future plans of the Central East Primary Care Partnership. Key priorities for the partnership in the coming year include increasing the integration of service delivery between the primary and acute sectors, working with divisions of general practice to further strengthen the participation of general practitioners in the work of the partnership and implementing projects to meet the needs of our identified priority population groups – older people, young families, children and young people. Our work in 2003/2004 includes projects designed to decrease the number of injuries due to falls, reduce the incidence of obesity and diabetes and to work with agencies to increase their capacity to provide culturally appropriate services.

The development of this plan and its subsequent implementation would not be possible without the active participation of many individuals and organisations. Members of the Central East Primary Care Partnership have given a great deal of time and energy to its development and will continue their hard work in its implementation. The Governance Committee endorsed the plan at its meeting in June 2003 and commended the project team of Jonathan Pietsch (Manager), Brett Wake (Service Coordination), Heather McMinn (Health Promotion), Maggie Laurie (Partnerships), Carmen Lee (falls prevention), Juliet Frizzell (Effective Change) and Jenny Wood (Administration)

In implementing the 2003/04 Community Health Plan the Central East Primary Care Partnership will support and resource agencies to improve the integration of services to consumers. In 2003/04 a demonstrably improved service for consumers will continue to be at the centre of the partnerships' work.

Sue Herbst
Chairperson

PURPOSE OF THE COMMUNITY HEALTH PLAN FOR 2003/04

The CE PCP Community Health Plan identifies the agreed priority health and well being needs of the Manningham, Monash and Whitehorse communities. The plan also describes how the members of the partnership are working together to:

- Improve health and well-being in their communities.
- Improve people's experience of primary care services.
- Strengthen health promotion and service coordination.
- Reduce preventable hospital admissions.

Community Health Plans define the strategic directions and activities of the partnership and outline the way services are coordinated, targeted and provided. Communities and agencies contribute to the Plan, and agencies are encouraged to use the resulting plan in their own planning.

The audience for the 2003-04 Community Health Plan are the CE PCP member agencies and the State Government at the regional and central office.

We have aimed for the community health plan to be concise and it provides a liftout for members to distribute to staff and management committees.

1. THE CONTEXT

Section two provides a brief outline of the context for the development of the 2003–2004 Community Health Plan. It outlines the partnerships mission, key values, strategic objectives, progress and highlights. It also provides the background for the ongoing priorities for action for 2003/04.

The Community Health Plan for 2002/03 was an ambitious one that aimed to achieve considerable change in service coordination and health promotion activity amongst all member agencies. The mission behind the work of the CE PCP is:

"to create effective partnerships between primary care providers, carers and consumers and the acute sector in order to achieve sustainable development of the primary care system".

And the Key values of the CE PCP are that:

- the relationship among partners is to be based on trust and mutual respect
- each participating agency to be respectful of the philosophy, priorities and service approaches and arrangements of other partners
- a partnership arrangement based on cooperation and collaboration of agencies, committed to sharing expertise
- commitment and preparedness to work together on joint initiatives for achieving improved health outcomes for the Manningham, Monash and Whitehorse community
- each participating agency is to be responsible and accountable for the management, organisation and delivery of its services
- build on the strengths, knowledge and expertise of existing alliances and networks
- the focus of primary care partnerships is based on the social model of health and aims to improve service delivery through improved service coordination and health promotion activities.
- will enable a joint commitment to continuous quality improvement of service delivery to consumers
- will involve consumers in the planning, implementation and evaluation of primary care services.
- each participating agency is to be viewed as an equal partner demonstrated by their commitment to the shared values and the signing of the MOU.

The strategic objectives of the CE PCP at July 2002 were to:

- Focus on initiatives that integrate services.
- Ensure sustainability of current initiatives e.g. Service Coordination work is embedded into agency practice.
- Encourage core agencies to remain engaged – that the core agencies see value in participating.

- Focus on staff training for core agencies that fitted in with agency schedules.
- Have a united focus that gives voice to consumer concerns and influences service planning.

When the strategic objectives were approved, the CE PCP identified what a successful year would mean if the community health operational plan was well executed. Listed below are the ten markers that the CE PCP used to identify if the year had been a successful one or not. (Not listed in priority order)

1. All core agencies are using common protocols, practices and systems and agreed protocols for sharing client information. All relevant staff from the core agencies are trained in the use of the INI, initial contact and referral tools.
2. All primary care staff have access to, and are trained to use, the up-to-date electronic service directory to assist with initial contact, referral and care planning.
3. Electronic referral has been trialed with six agencies and a plan is in place for further development across the catchment.
4. Consumers are closely involved in two PCP projects and in two agencies.
5. A plan has been developed and is being implemented to involve small and specialist agencies from and beyond the catchment.
6. The Consumer service information strategy has assisted to coordinate service information to consumers and reduced duplication of resources and efforts.
7. Agencies are committed to a coordinated approach to health promotion. The health promotion strategy is incorporated into agency policies, planning and procedures.
8. Agencies have adopted best practice in working with CALD communities.
9. A coordinated approach to falls prevention has commenced with best practice identified and training provided across the catchment.
10. Integration of primary care and the acute is being furthered through RACAS and HARP initiatives.

It is pleasing to note that all of the success markers have been achieved either in full or are near completion. The monitoring of the progress of the CE PCP has been determined by looking at the development of the three programs and eleven projects. At the June 2003 meeting with the regional office of DHS it was clear that 95% of the milestones and deliverables had been achieved and the CE PCP had made considerable progress in meeting its project and strategic objectives.

The defining achievement of the partnership is the energy and commitment undertaken by the CE PCP members. This has occurred from management through to health promotion and service delivery practitioners. The involvement of over 100 staff from the member agencies has undertaken challenging work and implemented significant systems change within their organisations. Support from the centralised staff team to member agencies has incrementally brought about the reorientation of services. A change management approach that has encouraged a vision, relied on local expertise as well as skilled up local service delivery teams has been essential to the work of the CE PCP. A locally developed understanding of change management principles has been supported by an evaluation program logic model that has aimed to keep all members informed of progress. This has been built on extensive consultation and engagement of members.

A spread of effort across the core agencies has enabled a solid performance over the past year. The Whitehorse City Council has been the fundholder and provided administrative support. Manningham Community Health Service has acted as employer and Community Health generally has provided leadership in the important health promotion and service coordination functions of the PCP. The Divisions have provided a facilitating role in Integrated Service Planning as well as created opportunities to work with GPs in critical project areas. The specialist organisations have contributed to leading a number of projects and both Women's Health East and the Migrant Information Centre have delivered high quality projects that have built capacity across the sub region. Nearly all projects have had multi partners ensuring that a variety of stakeholder needs have been represented. RDNS has also participated at many levels and ensured that the Hospital Admission Risk Program (HARP) has been integrated with the PCP reform. Eastern Health has supported many initiatives and should be applauded for its efforts in the recent HARP funding round. This funding round will further build primary

care capacity in a way that is well integrated with core PCP work.

Another characterisation of the CE PCP has been the Governance structure that is now in place enabling good local processes that encourage participation as well as accountability. These structures have ensured that important accountability mechanisms are in place and that project milestones have been reached. Over the past 12 months there has been a significant maturation in how the partnership functions and this is evident in the many successes and highlights achieved in this time.

Highlights for the 2002/03 year for the three program areas were:

Partnership Capacity Building

- The Consumer project produced an audit on 20 member agencies that highlighted significant consumer involvement at the agency level, case studies of best practice and a framework on how to improve consumer involvement at the agency level.[1]
- 70 copies of a consumer resource manual were distributed to members with multiple copies to Eastern Health.[2]
- A model for the involvement of consumers was successfully implemented with very positive views from consumers and service providers. This model will be continued through the PCP and will be encouraged to be adopted by local agencies.[3]
- The engagement of small, specialist and multi catchment agencies has progressed with three times as many individuals from the member agencies being involved.[4]
- Information dissemination to all member agencies has been enhanced through the use of the monthly info cast, (now sent to over 140 individuals) where members can obtain resource material, progress and final project reports, the CE PCP newsletter and information on up coming meetings. This enables members to either have all the information or the information that is relevant to them.
- The Consumer Access to Service Information is finalising a plan that will improve access for consumers at agencies across the catchment and establish standards that meet consumer needs.[5]
- The Health Promotion Vision is being implemented in PCP projects and an agency audit is a priority for the 2003/04 Community Health Plan.[6]

Sustaining Service coordination

- Ten agencies (Core & Uniting Care Community Options and the Primary Mental Health Team) have fully implemented or have implementation plans for the full take up of the CE PCP practice standards and the SCOTT tools.
- The Service Coordination Practice manual has been finalised and includes agency implementation plans for the next 12 months.[7]
- Statewide training has involved core and non core agencies including the Primary Mental Health Team and Eastern Drug and Alcohol services.
- The Service Directories on the CE PCP website are being used widely across the catchment. 74 individuals from 16 organisations have participated in the training with positive signs of usage by agencies that participated in the training.
- The E-Referral pilot has gone extremely well with 7 agencies using the messaging system built on the PPPs work of the PCP. Over 100 referrals were sent in the three month trial with all participating agencies interested in participating for the next year.

Integrated Service Planning – demonstration health promoting projects

The demonstration projects were focused on priority population groups. The priority population groups have primarily been the elderly with a more recent focus on young families. The focus on the elderly has been at various levels. The first level was focused on

[1] *Consumer involvement across the catchment – audit report*

[2] *Improving Health Outcomes with Consumer Involvement manual*

[3] *Testing the consumer evaluation model report*

[4] *Effective engagement of the general membership report*

[5] *Planning a coordinated approach for information to consumers report*

[6] *Health promotion Vision and Strategy document*

[7] *Service coordination practice manual*

the needs of the carers of the elderly who were from CALD backgrounds. The seconds level was the elderly in a residential care setting and the third has been the elderly in the community with a focus on preventing falls. All projects have drilled down as specifically as possible with the intention of having real impacts that result in addressing the health needs of the target group. All demonstration projects have progressed to a stage that have provided tangible and concrete outcomes for the member agencies. These demonstration projects have been evidenced based and given agencies an opportunity to build there understanding around the issues, the direction of the projects is to build capacity within the agencies that are providing the services. This means that the impact on the consumer needs to be measured at the agency level. Some examples of these impacts at the agency level are:

Carers from Culturally and Linguistically Diverse (CALD) community's

- A Report on the needs of Chinese Carers was finalised.[8]
- Training for culturally sensitive services was delivered with 139 staff from 52 agencies participating.
- A framework was developed that assisted agencies to consider a range of ways to improve their services to CALD communities.[9]
- Seven agencies were successful in submissions to deliver small projects that assist with access for CALD communities.

Falls Prevention

- A resource manual was produced with the health promotion framework identifying best practice in the prevention of falls for the elderly.
- The project was established and training has been provided to the reference group that involves 14 agencies and stakeholders.
- Training is to be extended catchment wide beyond July 2003.

Residential Aged Care Across Sectors

- A final report is available along with a training resource manual for residential care facilities.[10]

Well Families project

- Final report released in February (WHE and Monash Link) that paved the way for the 'Ready Set Baby' Project[11]
- Ready Set Baby project to be implemented over the next 12 months

Involvement in the **Hospital Admission Risk Program (HARP)** occurred across the three hospital providers that cover our catchment. The involvement with Eastern Health was much more comprehensive than the other two health providers. Eastern Health's process was very inclusive of primary care agencies and encouraged PCPs to be central in the role of providing representation to the various committees. There was a strong community capacity building approach to the submission, underlined with an Information Strategy based on the Outer East and Central East model.

The CEPCP is now at a critical juncture point with the key challenge being to maintain the momentum of the previous two years. Increasingly members are seeing the relevance of the partnership work and that much of the systems change and across sector work is finally producing positive results for consumers. Maintaining the enthusiasm of agencies and the high level of commitment to embed the changes into agency thinking and practice still requires considerable resources and support. Management of the change process is still required. The other important areas to consider in the forthcoming year are:

- The creation of a new vision for the CE PCP that will take us into the next three year phase of partnership work.
- Developing ways to work even more closely with the acute sector to extend practice standards work and e- referral.
- Increasing the sophistication of the evaluation work of PCP projects that provides evidence of impact and outcome.
- And finally to reiterate an important point, the CE PCP needs to ensure that practical supports continue to be provided to agencies to embed the improved practice.

[8] *Mental Health and Wellbeing of carers from CALD backgrounds*

[9] *Cultural Planning Framework and Resource Kit*

[10] Residential Aged Care Across Sectors report and training manual.

[11] The Well Families project report

Section 3.1 Community and Service Profile focusing on priorities

3.1 COMMUNITY AND SERVICE PROFILE FOCUSING ON PRIORITIES

Introduction

The work completed in service planning for 2003-04 has built on the previous year's work and involved a wider group of stakeholders from the CE PCP in the decision making process. The work for 2003-04 has built on available planning documentation and the analysed available data. The CE PCP has also embarked on a process to clarify the roles of all the important stakeholders. This process has involved inviting the sub regional office of DHS to present its priorities (Nov 2002), encouraging Monash and Whitehorse Councils to align their planing timetable and processes and the development of a paper that articulates the roles of all key stakeholders including the acute sector.[12] The Primary Mental Health Teams community profile and plans have also been considered and a new project funded by Beyond Blue will help to align priority population groups. Relevant data from the 2001 census has been added where applicable.

For 2003-04 priorities were considered within the context of the department's guidelines. The process was simpler this year as the CE PCP confirmed the broad identification of priority population groups, health issues and special needs groups. The following criteria was again applied:

- Is there expressed need across the region?
- Which issues have the greatest impact on health and wellbeing?
- Is the priority area consistent with population groups/health issues/government initiatives identified by the PCP policy documentation?
- For which issues is it possible for the PCP to make a meaningful difference?

Service Planning Priorities

Generally the population in the CE PCP catchment is marked by high levels of socio-economic advantage, relatively low levels of poor health and related high life expectancy. Notwithstanding there are levels of inequity in health and well-being status, socio-economic status and the need for and demand of health services across the catchment area and within the catchment's demographics.

The size of the population in CE PCP (424,378, Census 2001) is such that any one of these disadvantaged, at risk or in need groups would warrant some intervention. The CE PCP continues to have seven priority areas as the focus for project planning in 2003-2004. These priority areas cover population, health issues, risk factors and special needs groups.

The priority areas for 2003-2004 apply across the CE PCP catchment area although any proposed intervention or project may be targeted. An important feature of the priority areas is that they have a significant impact on the overall health and well being of the community and the utilisation of and demand for health resources. The CE PCP seven priority areas are consistent with DHS Primary Care Partnership policy. Most importantly they are areas where the CE PCP has a meaningful role.

It is expected that any project undertaken by members of the CE PCP should aim to enhance client outcomes and produce benefits to the health and community service system in CE PCP.

The priority areas are:

Population Groups
- Older people
- Children and young people

Health Issues
- Asthma
- Diabetes
- Mental Health

Risk Factor and Health Issue
- Alcohol and Drug

Special Needs Group
- Disability Services

The seven priority areas are not mutually exclusive and CE PCP recognises the potential for a high level of intersection between the areas. Whilst these may be the basis of operational planning in 2003-2004, some of the issues and opportunities identified within the priority areas are being addressed through the general service coordination and health promotion work of the partnership. For example the implementation of an electronic

[12] Planning Together discussion paper

service directory in CE PCP will promote awareness and access to services. This has been identified as a key initiative that will improve access to services for consumers.

Community and Service Profile
The following is a brief summary of the seven priority areas. Further detail about the CE PCP community and service profile is available on the CE PCP website in the resources section under Integrated Service Planning.

3.1.1 Population Groups

Older Persons

Persons aged 65 and over are a critical group in CE PCP. In 2000, 14.2% of the population in CE PCP (424,784) were 65 and over. However by 2005 this group will be 15.3% of the total population. In the period 2001 to 2005, the number of persons aged 65 and over will increase by 8.5%. 57% of the increase of over 65 will be female. More significantly the number of persons aged 80 and over will increase by 15.2%. As social connectedness is a determinant of health, it should be noted that 7000 more women live alone than men, mostly those aged 65 years and over. The 2001 census also highlights that over 10% of the Central East catchment population receives an aged pension and this is higher than the metro average of 9%.

Older persons are a major user of health services. In 2000-01, 24.8% of attendances at Box Hill Hospital Emergency Department were by persons living in CE PCP aged 70 and over. A significant concern is the number of patients transferred from residential care settings. In the same period 43.5% of Primary Care services clients in EMR were aged 60 and over.

There are a range of opportunities for service initiatives. Vulnerable groups are those living at home with complex needs, lone person households and carers especially form CALD communities. Whilst heart disease is the major cause of the burden of disease, other causes such as falls and diabetes could be targeted with a view to reducing demand for acute services. The Victorian Ambulatory Care Study identified that diabetes complications made up over one-third of the total expenditure on ambulatory care sensitive conditions. Improved access to services (transport and information) and independent living skills have been identified among the issues and opportunities.

Children/young families and Younger Persons

Interventions in this age group can have a significant impact on a range of outcomes throughout the lifespan. *(Health of Victorians DHS Jan 2002)*

In 2000 23.2% of the population of CE PCP were aged 0-19. Between 2001 and 2005 it is expected there will be a decrease of 0.6% in the 0-4 group and an increase of 0.34% in the 5-19 age group.

Among the main causes of the burden of disease for the 0-4 age-group are asthma, low birth weight, attention-deficit disorder (ADD) and respiratory infections. Asthma is also a leading cause of the burden of disease for persons in the 5-14 age group with ADD, depression and cancer. In young people aged 15-24 alcohol abuse/dependency, depression bi-polar disorder and heroin abuse/dependency are among the major causes of the burden of disease.

There is a substantial commitment to health services targeting children and young people in CE PCP. These include maternal and child health, immunisation programs, school nursing service, school dental service early intervention services and the Child and Adolescent Mental Health Service. As well the primary care services, GPs and disability services have dedicated children and young people services.

Priority groups are families with young children, (11,690 women and 2290 men are lone parents in the Central East) young children with developmental delays and secondary school students. There is a need to focus on preventing risk behaviour and promoting healthy environments and lifestyle. Service development could enhance coordination and collaboration between screening and early intervention service. There is a strong interrelationship between this population group and priority health issues in the CE PCP.

3.1.2 Health Issues

Asthma

Asthma is a health issue for the whole population. In CE PCP it is estimated that about 45,500 persons have asthma.

In the Burden of Disease study 2.37% of the total burden of disease in CE PCP was attributable to asthma. However in the age groups 0-4 and 5-14, 19.5% of the burden of disease was attributable to asthma. The burden attributable to asthma was significantly greater in boys than in girls.

Asthma was the cause of 2.8% of attendances at the Box Hill Hospital Emergency Department in 2000-2001 for persons living in CE PCP. 3.7% of CE PCP patients with multiple attendances at the Emergency Department had a primary diagnosis of unspecified asthma or predominately allergic asthma. Overall the admission rate to hospital for persons living in CE PCP was less than that for Victoria.

Priority target group for CE PCP initiatives would be young persons aged 0-18 and their carers. The proposed Local Asthma Plan for Manningham and Whitehorse (Asthma Victoria) seeks to involve schools, school nurses, asthma educators, community groups and clinicians in asthma management programs.

Diabetes

Over 7.1% of adults over 25 years of age have diabetes. This prevalence rate is slightly less for women than men. The prevalence rate increases with age. It is over 18% for persons over 75. The number of people with diabetes is estimated to double by 2010 in line with the increasing number of elderly; the better recognition of prevalent undiagnosed diabetes; better care for and survival of people with diabetes; and the increased prevalence of a sedentary lifestyle and obesity.

Diabetes is directly responsible for over 3% of the burden of disease in CE PCP. Diabetes is responsible for a proportion of the burden of disease due to ischaemic heart disease, stroke and peripheral vascular disease.

Whilst data about CE PCP is not available, the Victorian Population Health Survey (1999) indicated that 92% of people with diabetes had visited a doctor in the previous 3 months. (65.2% others) In the previous 12 months: 35% had seen a podiatrist; 38% had seen a diabetes educator or nurse; 54% had seen an ophthalmologist or optometrist; 29% had seen a nutritionist or dietician; and 30% had seen a specialist about diabetes. (Based on suggested levels of service provision the rate of use of some of these services (nurses/educators and foot care specialists) is sub-optimal.)

Target group are people with diabetes, people at risk of developing diabetes and the CALD community especially Chinese. The Victorian Ambulatory Care Sensitive Conditions study identified diabetes complications as easily accounting for the highest admission rate to hospital and also accounted for over 25% of the total bed days used in the Eastern Region. Service initiatives could include expansion of the MBS EPC practice incentive program, enhanced podiatry services and the proposed Local Diabetes Service development Program.

Mental Health

Mental health is a significant whole of population health issue.

Mental Disorders were responsible for about 15.3% of the total disease burden in the CE PCP. This was the third highest behind cardiovascular disease and cancer. In each LGA in the CE PCP, the burden was greater for women than men. Principal causes were depression, substance abuse and general anxiety disorders. The burden of disease for men attributable to mental disorders is expected to increase by 19% of the 20 years from 1996. In the first year of operation for the Primary Mental Health Team (2003) GPs were referring a higher than expected number of men. Mental health services are mainly utilised by males aged 20-34 years, and females between 30-39 in the EMR.

In 1999-2000, 2393 registered mental health clients in CE PCP had contact with community based mental health services. The greatest representation was in the age group 15 to 34.

The recently completed 'Well Families' action research project identified that up to 15% of all women experience depression at three months post partum. This review pursued a risk and protective factor approach identifying that some of the risk factors included being a carer, isolation, divorce, bereavement sole parents and unemployment. Protective factors were found to be positive family cognitions and a high degree of social connectedness.

Priority targets groups are young persons aged 18-25, members of the CALD community and women and women as carers, men, clients with dual diagnosis and people of low socio-economic status. There are a range of opportunities for enhanced promotion and information on mental health especially with a focus on depression.

3.1.3 Risk Factors

Alcohol and Drug

Alcohol and drug is a health issue and a health risk factor impacting directly or indirectly on the whole population.

Alcohol dependence and harmful use is the leading cause of years lost due to disability in Victoria. In CE PCP the total net burden of alcohol consumption and illicit drug use is about 4% of total DALYS for males and 2.1% for females. Stroke, cirrhosis and road traffic accidents are the leading causes of death due to alcohol. Illicit drugs are a direct cause of death and a risk factor for HIV/AIDS, hepatitis, low birth weight, inflammatory heart disease poisoning, suicide and self inflicted injuries. It is predicted that in Victoria by 2016, illicit drug use will be the third largest cause of years of life lost among men. The proportion of burden due to Years Lost due to Disability (YLD) is particularly large in the 15-24 year age group.

There is little data available about the use of drug treatment services by persons living in CE PCP. Between 1999-2000 and 2000-2001 there was an increase of 12.8% in the number of clients of DTS. In the Eastern Region 19.2% of the clients were less than 20 years of age.

Priority target groups are persons aged 15-24, homeless persons and persons with mental illness. Information and awareness programs could emphasise availability of services and risk behaviour especially with chroming. Consideration of service development opportunities will be in the context of local area drug action planning processes.

3.1.4 Special Needs Group

People with a Disability

It is estimated that in 1998 there were 61,468 persons with a disability in CE PCP. This is about 14.4% of the population. Of these, 24.3% had a profound or severe degree of restriction. In June 2000, 8,398 persons were receiving the Disability Support Pension and 1,551 persons were receiving the carers' pension in CE PCP. The target group for HACC services in EMR in 2000-2001 was 86,491.

The Burden of Disease study found that the main causes of years lost due to disability in CE PCP included depression, hearing loss, osteoarthritis, dementia, alcohol abuse, and asthma.

Service data about the use of disability specialist services is not available. However the EMR PDSS data set 1999 reported that 72% of clients were less than 44 years of age.

There are a range of issues and opportunities in CE PCP. Priority groups are those with high needs and the carers of people with a disability. There is opportunity to better inform the community about the availability of services especially respite services and services for people with a disability from the CALD community. There is a perceived low use of disability services by people from the CALD community. There is ongoing need for more volunteers and a system to support, train and retain volunteers.

Other considerations

When considering broad population groups, issues and risk factors, further work is required to drill down to identify special needs. PCP projects will also consider gender specific groups, Culturally and Linguistically Diverse groups (CALD), Indigenous Australians, homeless persons and persons of low socio-economic status. Any initiatives developed by the CE PCP will examine the needs of these groups as part of the needs analysis.

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3.2.1 Strategies – Reviewing for Future Action

3.2.1 STRATEGIES– REVIEWING FOR FUTURE ACTION

The projects and activities for 2002/03 were evaluated at three levels. These were:

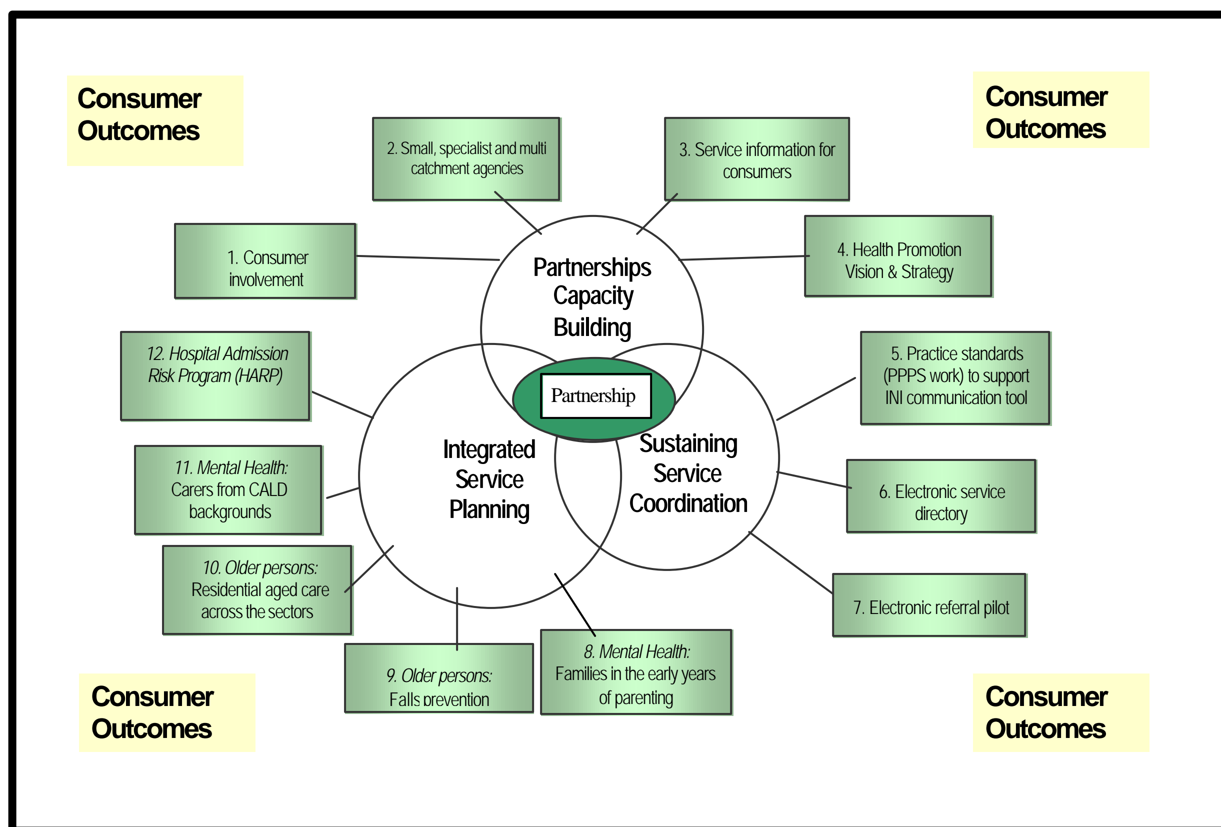
A. From an accountability perspective. This demonstrated if the projects had reached their milestones and key deliverables.
B. From a change management and intuitive evaluative approach. This process monitored progress towards agency adoption, actual implementation of change and then identifying the impact on consumers.
C. From an individual project perspective. All projects collected data and qualitative information through stocktakes, questionnaires and focus groups. This provided a feedback loop on the projects progress, reach and success.

All three approaches were combined and considered at the Governance Committee level and through the six monthly forum of the CE PCP. An evaluation session was held at the local DHS regional office in June 2003, that has also assisted to shape the program for the next 12 months. Final approval of the Community Health Plan occurred at the Governance committee meeting in June 2003.

The strategies continue to be focused on the same areas with activities listed for prioritisation:

Overview of the CE PCP program areas and projects for 2002/03

The diagram below provides a illustration of the three programs and eleven projects that the CE PCP has been managing for the past 12 months. Over the page is a brief description of each project.



PROGRAMS and PROJECTS run in 2002/03

Partnerships Capacity Building

1. A model for **consumer participation** in PCP projects will be developed and trialed in two demonstration projects. At the same time, an audit of the levels and nature of consumer participation in member agencies will be undertaken. This will provide the basis for ongoing work with two partnership agencies, to develop and implement best practice models. All member agencies will be encouraged to adopt the agreed best practice for consumer involvement.

2. Strategy two focuses on the **engagement of small, specialist and multi-catchment agencies** and will identify the optimal form of participation of these agencies for sustainable involvement. This strategy will result in enhanced planning and coordination of services and assist with continuous quality improvement for all agencies in the PCP catchment.

3. Strategy three targets **enhancing consumer access to service information**. It builds on the PPPS work and the electronic service directory. It will result in a sustainable coordinated effort between LGA's and agencies that maximises the usefulness of media products (electronic and print) for consumers. This strategy will also reduce duplication of service provider information.

4. Strategy four identifies that a common **health promotion vision and strategy** is necessary to ensure that an integrated approach to health promotion can occur across the catchment. This short term project with long term impacts will define a vision and a strategy that will be adopted by agencies. Training will be provided to managers and staff to enable acceptance into each agencies every day practice.

Sustaining Service Coordination

5. **Practices, Processes, Protocols and System work (PPPS),** will establish common and agreed protocols for primary care services that covers initial contact with consumers, initial needs identification, care planning and data management. All primary care agencies will have aligned standards.

6. An updated **Electronic Service Directory** will be available for service providers and consumers. Training will be available to maximise the use of the service directory at initial contact with consumers and through care planning.

7. The **Electronic Referral Pilot** will build on the PPPS work and the locally developed referral protocol. The Service Directory will be integrated with an encrypted email that enables confidential transfer of information that meets all privacy requirements.

Integrated service planning - Demonstration projects

8. Mental health and well being of Carers from CALD backgrounds
   The first demonstration project began in January 2002 and came out of a specific community health need identified in the PCPs first community health plan. The mental health needs of CALD Carers is focused on the Chinese-speaking community. On completion of the project agencies will be responding in a more culturally sensitive way to the needs of Chinese carers. In addition to this a set of principles for working with CALD communities will be developed and promoted across the PCP.

9. Falls Prevention of the 'At Risk' elderly
   Project two has identified the **elderly at risk of falling** as a priority population target group. Recognising that a multi faceted approach is required to reduce the incidence of falling. An audit of falls prevention activity will be conducted and optimal falls prevention practice defined. Training will be available to all interested agencies and workers to implement the optimal practice.

10. Residential Aged Care Across Sectors
    This is a multi sector collaboration that focuses on improving systems for **the elderly in residential care facilities.** Fragmented care between primary, sub acute, residential and the acute sector can occur at times due to the complex nature of care that is required. This cooperative venture aims to identify clear pathways of care, increase appropriate referrals and reduce unnecessary referrals.

11. Mental Health and the Wellbeing of Families in the early years of parenting
    Project four will address the rising burden of prevalent mental disorders. This is a two phased project where in the first phase a needs analysis on families in the early years of parenting will be completed. This research will shape the health promotion interventions required to address the identified problems and the specific needs of this target group.

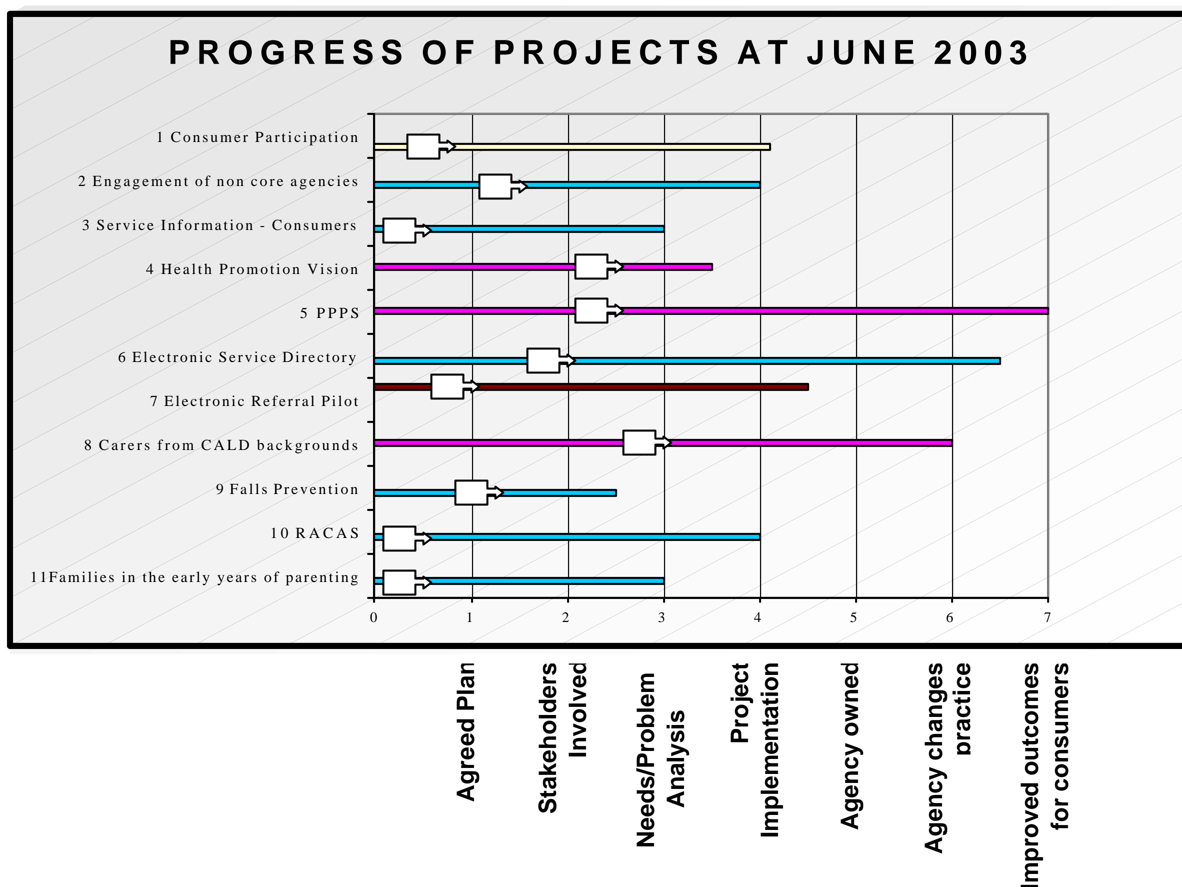
Mapping progress of all the CE PCP projects

Over the past 12 months the CE PCP adapted and extended the Statewide Evaluation model for measuring project progress. A simple way of presenting the project progress was seen as crucial to providing tangible evidence to a broad range of stakeholders on how successful projects have been and importantly, when it is reasonable to expect outcomes for consumers.

The development of the model was an amalgam of change management principles and program logic evaluation theory. The key change management principles included:

- Creating and communicating a vision.
- Understanding local culture, the wider environment and the psychology of change
- Effective project implementation
- Positive communication between all stakeholders and
- Effective measurement and monitoring

This symbol identifies where the project was at the beginning of the year – July 2002



The program evaluation theory logic provided information on each project and identified what were to be the likely impacts on the local agencies involved and what was the intended health outcome for the consumer. This provided a clear sense of what the end goal or ultimate outcomes where for each project. The chart above provides a seven step guide from having an agreed plan as a partnership through to the client having positive health outcomes. The steps between included drawing the stakeholders together (2,)a needs analysis(3), effective implementation(4), the agency owning and adopting the suggested changes(5) and the agency changing its practice (6). All of these steps are crucial to achieving the ultimate goal of improved health. This model relies heavily on the principal of capacity building amongst agencies to multiply the impacts for consumers.

The progress for each of the projects from the beginning of the community health plan 2002/03 can be seen by the symbol indicating at

what stage the project was. This tells us that all of the projects have moved forward towards delivering improved health outcomes. The projects that are closest to having an impact on consumers are projects 5,6 and 8. The practice standards (PPPS) work, Electronic Service Directory initiative and the CALD carers project. The other projects are generally at the soon to be adopted stage by the local organisations. For the three projects that are most progressed we now have measurable impacts at the agency level that is resulting in positive outcomes for consumers. It is still early yet to canvass the reach of these impacts however it is pleasing to be able to report progress at this stage of the three most progressed projects.

Agency impacts and consumer outcomes

Impacts on the involved agencies in relation to implementation of the practice standards (PPPs), the use of the Electronic Service Directory and the cultural sensitive training are now evident. They have been collected through the individual project evaluations in the form of stocktakes and questionnaires. Listed below is a selection of the comments made by individuals from member agencies.

The adoption of the service coordination Vision and practice standards has resulted in:

Improved Initial Contact (IC) and Provision of Initial Needs Identification (INI)

- Our new intake system provides clients with a single point of entry.
- There is less run-around for the client. We can give them information on the spot by accessing the service directories.
- By building in the INI process we are able to undertake an holistic screening and risk assessment process to identify the client's needs straight away. The client is then given an appointment or a referral.
- The single point of entry means we can look holistically at peoples needs and respond to all referrals within 24 hours.
- Our new intake system enables the client to get an INI at the beginning of the process, and not wait until they see a practitioner, which in the past, could have been weeks and in some cases months.
- Having an intake system has allowed us to build health promotion into the IC and INI processes, for example we are able to give the clients relevant pamphlets or tell them about groups.
- By focusing on and improving IC and INI we are providing a better customer focused service.
- Clients are benefiting from the refinement in our screening process. We are doing a holistic INI and making more appropriate decisions.

Reduction in the duplication of information collected

- Implementation of the SCoTT has resulted in a reduction in the duplication of information collected from clients, just rationalising our own documentation is an improvement.
- The rationalisation of our intake, assessment and consent documentation as part of the information management work we've done to support our new intake system, means that clients only need to give consent once and sign one form – this is very important for older clients.

Effective Referral

- Service Coordination has given staff a greater understanding and awareness of the service system and where to refer clients to for help.
- We can now respond to all referrals within 24 hours.
- We are able to print information from the service directory and give it to clients to take away.

Appropriate services in a timely fashion

- Our new intake system and the employment of a Service Coordinator has contributed to a reduction in almost all waiting lists, as practitioners have been freed up to provide more clinical services.
- Instead of a haphazard IC and INI process we can now provide clients with an immediate response (or at least within 24 hours). Whereas under the previous system clients may have waited up to two weeks to speak to a practitioner. There has been a fall in the number of complaints, in fact we have not had one complaint since the new system was established.
- It is great to have feedback information on the referrals you make, this enables us to put in place strategies to support the client

until we know other services can be obtained.
- We are able to provide consumers with a quicker response.

Improved access to information - Electronic Service Directory

- Having access to the Electronic Service Directory means that we are giving clients' better information more quickly.
- The service directory enables us to empower clients and families, to give them hope. We are able to provide a better quality service.
- The Electronic Service Directory makes life a lot easier, especially for ethno specific clients, for example we can quickly identify Chinese Doctors.
- I was able to help a homeless young person by using the service directory to check the Emergency Accommodation Register and identify straight away where the vacancies were. This meant the young person could go to the right service and not be given the run-around.
- By using the service directory I was able to identify an Albanian Speaking Nursing Home for a family. I gave the family the contact details, this greatly relieved their stress and anxiety.

Impacts on Agencies from the Cultural sensitivity training

A snapshot of comments from the participants involved in the training gives an indication of the changes that are likely to occur back in the workplace.

Frequent comments about immediate changes included:

- Signage at front reception area.
- Training for when and how to use interpreters.
- and how to develop pamphlets.

Comments about change in the short to medium term were:

- This enables us to have a more planned approach to cross cultural delivery of services.
- We currently have no access & equity plan so this provides a framework for the development of one.
- I feel really motivated to review our Access and Equity Plan and our Cultural Planning Tool.
- I am looking to develop the services of the Health Promotion Unit at Box Hill Hospital & offering programs that are culturally relevant to our consumers.
- I am presently writing staff orientation policy and developing pamphlets so will be able to include what I have learnt today.
- This has really helped me in thinking about how to market our organisation.

These impacts are the result of a great deal of work by individual practitioners at the agency level. Some agencies are further advanced than others however all core agencies plus several others have made substantial progress.

The level of support required at the agency level has consumed a high percentage of the PCP budget. The ongoing momentum of bringing about change and positive outcomes for consumers will continue to be somewhat fragile as such things as changes in staffing can slow the progress considerably.

Consolidating the changes already made is essential to maintaining positive client outcomes. Agency information management, staff electronic skills and maintaining the vision are important aspects of consolidating the gains to date.

The need to monitor and provide support at the local level will continue to be crucial as resources for this sort of work are reduced over the next 12 months, we will need to be mindful of how to maximise what we have as well as not push too hard as local agencies make systems changes within their current resource levels.

3.2.2 PRIORITIES FOR FURTHER ACTION

Listed below are the suggestions for future work of the CE PCP for the 2003/04 period. These suggestions have been drawn from the evaluation work of the PCP, project steering committees and the Governance Committee over the past three months.

Consumer involvement

- Use consumer involvement policy for projects in all future project work
- Consider consumer program across the region by pooling resources across PCPs and work closely with the acute sectors program of consumer involvement.
- Consider ways to have consumers involved at the policy and planning level

Small, multi-catchment and specialist agencies

- Incorporate recommendations into the MOU and the operations of the PCP.
- A regular survey that monitors interest, level of satisfaction and communication processes of all member agencies.
- Encourage agency involvement in demonstration projects.

Service coordination
PPPs work

- Need to develop a regional approach that enhances the involvement of Eastern Health. Consider synergies with HARP and integrate activity.
- Further develop interface with sub acute and acute sectors.
- Ongoing support to agencies and resourcing for the practitioners group (Possibly create smaller networks).
- Need to monitor how each agency is implementing the work and what real impact it is having on consumers.
- Need to coordinate with ICT and other IT developments as they occur over the next 2 to 3 years
- Involvement of non-core agencies in a strategic manner based on business partnerships.
- Investigate further cooperative approaches.
- Have a working group that meets quarterly that forms a communication mechanism for members that are not a part of the Governance committee. (This group may also be interested in conducting an expo of all agencies that provide services in the catchment).

Health promotion Vision

- Monitoring of agency implementation of the health promotion vision
- To have agencies further integrate the planning priority work of the PCP.
- To consider which areas agencies could improve coordination of health promotion work.
- Consideration of funds pooling of resources to limit duplication.
- Inclusion of smaller agencies in Health promotion work to encourage capacity building across the catchment.

- Further engage GPs by encouraging the use of the SCoTT tools.

- Identifying the link between INI and health promotion
- Begin to build data base / system for agencies to collect SCOTT information & to use information for planning
- Service coordination work and the achievements to date need to be marketed across the sub region.

Electronic Service directory

- Continued training, marketing, updating and evaluating the use of the service directory.
- Consolidating the local data management approach.
- Having an influence on the state-wide data management approach.
- Focus on IC and ensure all staff can access and use service directory. Encourage central -statewide opportunities that provide training for all PCP member agencies and the acute sector.
- Investigate interface for users of Infocom system (CIS, MIC Women's Health East, others) to be able to share information electronically with ESD phase 2.
- Improving the way information is provided to consumers by staff who are using the ESD.
- Use of the service directory in GP practices and the acute sector requires marketing and resources.
- Availability of alternative formats – CDs and printed.
- Marketing of the Service Directories.
- Start to look at consumer access to service directories

Electronic referral pilot

- Finalise software enhancements
- Continue the pilot and extend to UCCO, EVRC, Do Care and other similar organisations that are important referral points for core agencies.
- Further development of regional approach involving C/E and O/E.
- Interface with the sub acute and acute sector - including consistency across the region, monitor and work closely with HARP information management initiative.
- Upgrading agency client software
- Agencies reviewing / developing record keeping and internal information management approach in the light of the SCOTT and Service Coordination reforms. Provide further support for this.
- ICT developments and internet connectivity and security – telephone communications / systems.

Improving agencies capacity to be culturally sensitive

- Small grants and their effectiveness need to be monitored.
- Due to the high demand of the training program, it could be run again.
- Ongoing monitoring and support for agencies implementing changes to practice.
- Forum of involved agencies about the progress that has been made to implement the framework.

Falls prevention/healthy ageing

- A broader communication strategy to inform stakeholders across the catchment of progress.
- Incorporate falls prevention training into ongoing training for health workers
- Involve consumers in project advisory group
- Identify ways to reach isolated frail older people in the community
- Develop social marketing strategy
- Engage GPs to promote specific physical activity and other falls prevention strategies to older clients
- Work with Councils to integrate falls prevention strategies into core business
- Work with service coordination to integrate falls risk assessment

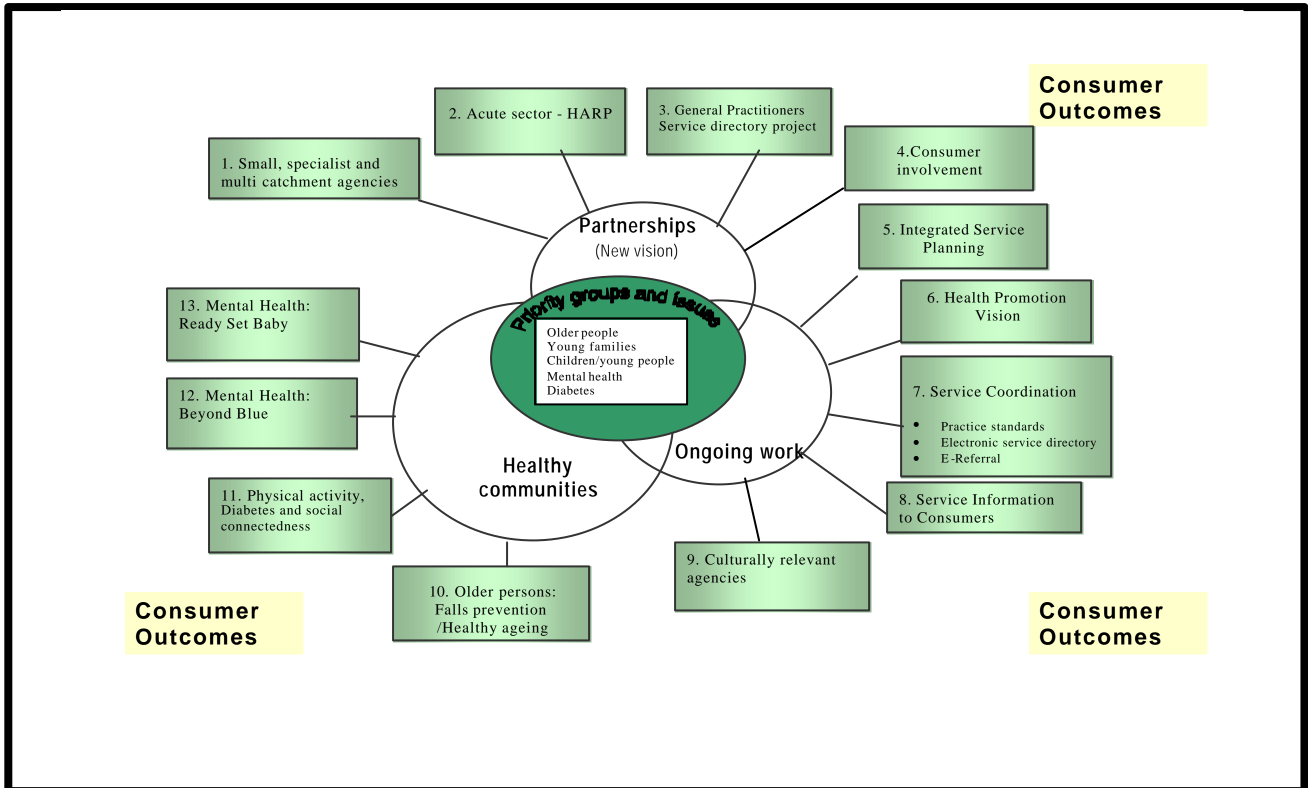
Well Families

- Implement 'Ready Set Baby' project

3.2.3 Strategies for action

3.2.3 STRATEGIES FOR ACTION

The Community Health Plan for 2003/04 is the CE PCP's articulation of its intentions for the next 12 months. In completing a dynamic year the partnership will build on its success and continue to deliver a program that is relevant to its members. The three programs and thirteen standards and electronic referral at critical service delivery points within the acute sector. The Healthy Communities program incorporates service coordination and health promotion principles and



strategies are a variation of the previous year with one program of ongoing work clearly defined to consolidate the work of the CE PCP. The Partnership program will continue to work with small, multicatchment and specialist agencies, the acute sector, general practitioners and consumers. The CE PCP partnership will also renew its own vision during the year ahead. This will particularly identify how the partnership will operate beyond June 2004. The agenda for ongoing work continues to implement important health promotion and service coordination work and it will ensure that the gains made to date will not be lost. Less resources for service coordination work will modify the program significantly for local agencies however it is hoped that some HARP funding will encourage the uptake of the practice will target the identified communities of priority to the CE PCP. Two new programs will be developed and they address the issues of inactivity in the community and care pathways for people with depression and anxiety. The mental health project is funded by Beyond Blue and will work closely with Deakin University and the Primary Mental Team from Eastern Health. Overall it is a balanced program that encourages further development of the Partnership, maximises gains in service coordination with less resources, provides specific initiatives that will result in improving the health and well being in the community and builds on the work to date with the acute sector. Over the page is a description of the strategies, the milestones that mark success and an indication of the impact of each strategy at the agency level.

CE PCP strategies for 2003/04

Partnerships

1. Small, specialist and multi catchment agencies

Small, specialist and multi catchment agencies are significant care providers to the priority health target groups chosen by the CE PCP. Ongoing involvement through the service coordination and health promotion work of the PCP will focus on these member agencies. Building on the Partnership Working Group of 2002/03 agencies will be encouraged to attend a members meeting on a quarterly basis that will serve as a communication mechanism. This forum will enable future involvement of member agencies in the activities that they can contribute to and that will be a benefit to them.

Milestones:

- Three monthly reference group meets
- Agency involvement in healthy communities projects
- Service expo held

Impacts on agencies:

- Increased satisfaction of member agencies in suitable and relevant involvement. (Use partnership evaluation tool to monitor.)

2. Acute sector

Involvement with the acute sector is multileveled.

- Policy and planning

Involvement with the Primary Care and Population Health Advisory Committees of Eastern and Southern Health.

Involvement with the Hospital Demand Management Committee of Eastern Health that oversees the HARP project.

- The involvement of middle management

The CE PCP participates by invitation to Eastern Health's Primary Care Partnership forum. This forum provides an opportunity to update all Eastern Health's middle management of the progress being made in service coordination and health promotion work.

- Through project work.

The CE PCP has active participation in and from Eastern Health. Eastern Health has been involved in service coordination and health promotion subcommittees, specific projects of the PCP such as Well Families, Falls prevention and the Residential Aged Care Across Sectors project. The PCP and member agencies have been involved in key HARP projects such as CHIRP and ROR. Ongoing participation is expected to occur through projects. We look forward to the results of the 'Ready Set Baby' program that is being auspiced by Eastern Health (Box Hill Hospital) as well as the Beyond Blue funded program that involves the Primary Mental Health Team of Eastern Health. This project will provide another excellent opportunity for the acute sector, GPs and primary care agencies to collaborate with a focus on decreasing the incidence of depression and anxiety.

Milestones:

- Participation at all levels
- Work with HARP project with a particular focus on the IM/IT strategy

Impacts on agencies:

- A more fully integrated primary care and acute sector with an extension of the practice standards to key service delivery points of Eastern Health.

3. General Practitioners

The CE PCP recognises that the involvement of GPs in the service coordination reforms is essential for the successful implementation of Better Access to Services (BATS). The CE PCP is keen to build on its current integrated service coordination platform and PPPS work by increasing the involvement of GPs.

A strategy has been developed and recently funded by DHS to incrementally increase the number of GP practices involved in testing PCP products. These products include the service directory, the referral protocol; the PPPS practice standards and electronic referral. Each of these products can stand alone and be used by individual GPs and/or the practice.

This staged strategy requires an incremental roll out. The next immediate step is to broaden the use of the PCP service directory from two practices to eight practices. A total of four from each Division. Practices will be chosen (who are high referrers to

ACAS, HACC and community health services) and have the capacity to access the CE PCP service directory on line.

A total of 6 practices involving between 20-30 GPs and up to 6 practice nurses and 6 practice managers will be aware and have trialed the PCP Electronic Service Directory. Feedback will be received to further inform the potential usage of the electronic service directory in General Practice. [13]

MILESTONES

- Ongoing involvement with GPs on specific projects
- Completion of the GP Practice Service Directory project

Impact on agencies:

- Further integration of GPs into working collaboratively with primary care agencies.

4. Consumer involvement

Ongoing consumer involvement is essential to the work of the Partnership. After the completion of the successful consumer pilots the CE PCP will encourage the use of this model through project work of the PCP and through member agencies. Other areas to consider are consumer involvement at the policy and planning levels of the PCP. This will be a focus when the PCP reconsiders its vision for the next 3 years. In addition to this the consideration of a regional approach needs to occur to maximise the use of resources targeting consumer involvement.

Milestone:

- Consumers engaged in all healthy communities projects.
- Discussed options for a regional approach to consumer involvement.

Impact on agencies:

- Consumer involvement demonstrated to agencies across the CE PCP.

Ongoing work (Consolidation of systems to enhance the partnership)

5. Integrated Service Planning

The CE PCP is currently developing its approach to integrated service planning and is building on the good will and planning processes that have existed to date. The role of the PCP is being defined as:

- Encouraging and facilitating the conceptualisation of what sort of health system we want (vision) and how the health system can be reorientated in a way that meets the consumer needs.
- Providing a collaborative forum that draws together the intellectual resources and expertise in health planning for the purpose of outlining a statement of will that operationalises the vision.
- Taking a subregional approach that draws out common themes from the three MPHP across the catchment.
- Ensuring that the primary care sector has a coordinated and integrated approach to illness prevention and health promotion

Identifying the roles of all the important stakeholders is the next step in cementing an approach to integrated service planning for the CE PCP. A final paper on integrated service planning will document all roles and a new vision for 2004.

Milestones

- A final discussion paper on Planning Together.
- An agreed approach to Integrated service planning work that aligns municipal health plans.

Impacts on agencies

- A cooperative approach across the catchment to integrated service planning.

6. Health Promotion Vision

Many agencies across the CE PCP participating in health promoting activity and have used different frameworks to actively prevent illness. The CE PCP has developed an approach to Health Promotion and is currently using this within the delivery of all its work. The CE PCP will work to build agency capacity for health promotion work through the specific projects that it is developing. Opportunities will be identified to showcase work in a way that assists agencies to adopt best practice in Health promotion.

Milestones

- Completed mapping of agency health promotion activity.
- Smaller agencies included in work.

IMPACTS ON AGENCIES

- Increased capacity for Health promotion within agencies across the CE PCP.

[13] See submission for project detail

7 & 8 Service Coordination and Service Information to Consumers

Consolidating the service coordination work of the CE PCP is crucial to delivering positive impacts for consumers. Four specific projects are being implemented to further enhance the service coordination work of the PCP.
These are:

A. Maintaining, implementing and involving more agencies in the practice standards for initial contact, initial needs identification and care planning. (PPPS work)
B. Maximising the use of the Electronic Service Directory
C. Electronic referral
D. Service Information for consumers

The target population for this work initially focuses on those consumers with chronic and complex health needs but also has the capacity to cater more generically for any consumer that requires primary health care. Generally the service coordination reform will address consumers having a lack of information about up to date and reliable information about service options, community programs and support. The difficulties they experience entering a complex service system where they often have to make many contacts before receiving the right service(s) and having to re-tell story and/or re-submit details at each contact.

Project descriptions

A. Maintaining, implementing and involving more agencies in the practice standards for initial contact, initial needs identification and care planning. (PPPS work)
The Practice Standards will continue to be an important focus of the CE PCP with assistance being provided for core agencies in the implementation of the PPPS work. In addition assistance for non-core agencies to begin implementation will be available. Support and assistance for internal record keeping and information management issues to do with the implementation of the SCoTT data will be a new focus with workforce developments to support the above. Facilitating 'peer' learning opportunities through the support for the Practitioners' Resource Group will be a feature and regional consistency with other EMR PCPs will be a priority.

Milestones

- Ongoing supports to agencies with a particular focus on non core agencies.
- Further develop interface with sub acute and acute sectors.
- The development of a regional approach
- Collation of across agency SCoTT data

Impacts on agencies

- Common practice standards across the majority of CE PCP agencies

B. Maximising the use of the Electronic Service Directory
Further training and support for up-take of the ESD within Agencies will ocur. This is relevant for staff providing Initial Contact, Referral and Care Planning services. To improve capacity within agencies will encourage personnel to take responsibility for further training at the agency level, this will be supported by catchment wide training opportunities and targeted workplace training. Training will be provided in the context of Initial Contact skill sets. Agencies will nominate personnel to take responsibility for updating service information and evaluating data management approach.

Milestones

- Further training opportunities in use of ESD for staff at Initial Contact.
- Information officers at local agencies update ESD
- Market and monitor uptake of ESD in the acute sector.

Impacts on agencies

- Increased usage of ESD enabling more efficient referral and service coordination for consumers.

C. Electronic Referral
Following on from the initial E-Ref trial – agencies want to continue piloting and increase the number of agencies involved, in order to engage other important business partners. A consistent approach with Outer East is essential for the agencies that are shared between PCPs such as multi-catchment agencies, Eastern Health and GPs. After the initial trial – further enhancements are required and training continues to be essential for agency staff who will be taking responsibility for administration and protocol settings.

Milestones

- Finalise software enhancements
- Continue pilot and extend to at least two more interested organisations.
- Agencies manage their own protocols and settings.

- Further develop a regional approach with Outer East

Impacts on agencies

- Pilot agencies are able to independently manage e-referral in an interdependent environment.

D. Service Information for consumers.

The development of a common approach to the provision of health and support information to consumers has come about because of the lack of accessible information, and the difficulties consumers have with understanding of a complex system. The project aims to develop an agreed common framework that will

1. Provide information to agencies to assist them to:
   a. Improve the way they provide information to consumers contacting their service
   b. Effectively share service information with other agencies
   c. Participate in catchment-wide promotional activities
   d. Cooperate with other agencies in promotional activities.
2. Encourage the consideration of accessibility and useability by agencies in the production and distribution of service and health promotional information.
3. Establish cooperative arrangements that build on the expertise already available within the Partnership membership and bring together primary care, acute, sub-acute and information service providers.
4. To improve the ways consumers receive information about health and support services and the ease with which they enter the service system.

The project will develop promotional products and activities that can be undertaken by the partnership in an ongoing and sustainable way. The development and fostering of virtual teams will assist in the sharing of expertise and experience between member agencies.

MILESTONES

- The development of a framework for information to consumers on services and health promotion.
- The establishment of a cooperative arrangement that enhances information provision to consumers.
- A promotional product focused on one cohort that has been developed collaboratively.

Impacts on agencies

- Agencies improve structures and processes for the provision of information to consumers.

9. Culturally relevant agencies

The Central East catchment receives almost two thirds of the new arrivals for the Eastern Metropolitan region. The provision of relevant and accessible services is important to these new individuals and communities. The Cultural Planning Framework has been developed and is being implemented at a variety of levels amongst local organisations. Ongoing encouragement and monitoring is required that will detail evaluation of impacts on service delivery and on consumers. Application of 2003-04 funds will enable the Health Promotion Advisory group and the Migrant Information Centre to develop and implement an evaluation framework to assist agencies to identify the impact of the CALD training on delivery of services to CALD consumers. Bringing together participants to reflect on the changes they have implemented and barriers encountered will contribute to ongoing capacity building of CALD services in the CE catchment.

The small grants to agencies will also be evaluated identifying such longer term outcomes for consumers as an increase in participation and access to services. Grant recipients will be asked to complete a report detailing: number of participants, consumer feedback, barriers encountered, new issues identified, recommendations for future CALD work & sustainability. A forum will be held to share learning's from the implementation of the small grants.

Milestones

- Agency audit on uptake of framework.
- A forum held on small grants projects delivered to CALD communities.
- A final report will identify changes, barriers and future work.

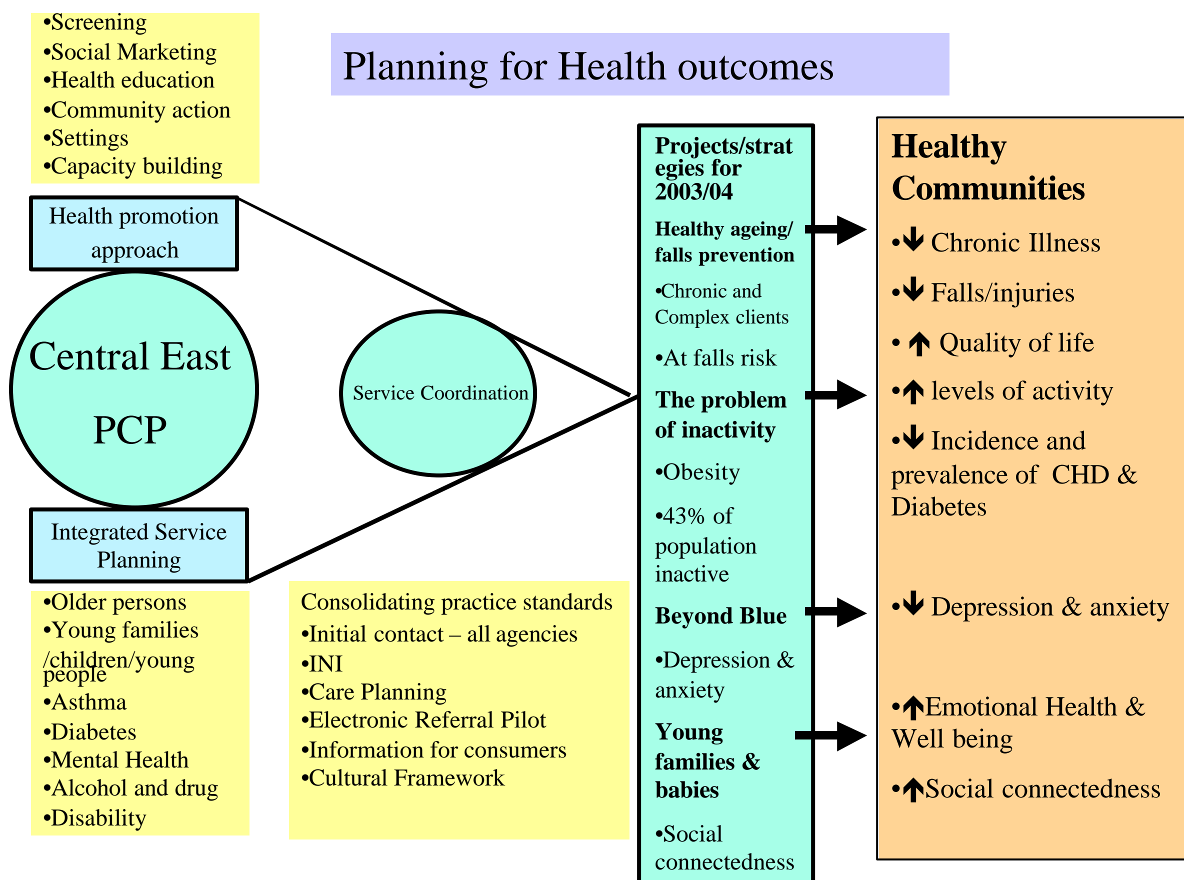
Impacts on agencies

Increased capacity of agencies to be culturally relevant. The implementation of the seven small grants will be completed in this community health plan. An opportunity to share the results of these projects will be built into the health promotion vision work of the CE PCP.

Integrating the work of the CE PCP to produce outcomes for consumers

Several years of planning, project implementation and evaluation are beginning to culminate into a clear picture of how partnership work can directly benefit consumers. Primary Care agencies are well on the way to completing systems work that aligns health promotion and service coordination activity. This has meant agencies are re-thinking how to do things and how they can work cooperatively with clients that have chronic conditions and/or complex care needs.

This diagram below provides an overview of the interrelation of the three key aspects of the work of the CE PCP, Integrated Service Planning, Health Promotion and Service Coordination. The diagram is read from left to right with Integrated Service Planing and Health Promotion being are listed above the health promotion title). The third element of Service Coordination has built on the foundation developed and provided an opportunity for consolidating practice standards that result in a simpler way for consumers to navigate the service system. For the CE PCP this will result in a the delivery of four projects/strategies for 2003/04 that focus on populations at risk and aim to reduce chronic illness, improve emotional health and well being and improve the quality of life of the consumer. The diagram is simple in presentation and complex in actual delivery. Hence the descriptions of the four projects/strategies require more complete documentation to show how the leap from identifying an at risk population to positive health outcomes for consumers occurs.



important foundation work of the Partnership. Integrated Service Planning sits on one side of the partnership that identifies the key priority population groups. (These are listed below the title). The Health promotion approach gives a common framework to design programs that are multi faceted in nature and hence more likely to address the needs of the priority population groups chosen. (Key elements of health promotion

The four projects/strategies of the Healthy Communities Program are:

- Healthy Ageing/Falls prevention.
- Addressing the problem of inactivity
- Developing care pathways for people with depression and anxiety
- And the 'Ready Set Baby' program.

3.2.4 Healthy Communities Program

- ❑✓ **HealthyAgeing/Falls prevention**
- ❑✓ **Inactivity of 'at risk' populations**
- ❑✓ **Shared care pathways for depression and related disorders**
- ❑✓ **'Ready, Set Baby' – Well Families Phase 2**

3.2.4 HEALTHY COMMUNITIES PROGRAM

10. Healthy Ageing/Falls Prevention

Problem definition
Falls among older people represent a significant problem in the Central East Primary Care Partnership catchment. The area contains a large proportion of older residents; after the City of Greater Geelong, the Cities of Whitehorse and Monash contain the state's largest population of people over the age of 65 years.

The scope of the problem among older Victorians (aged 65 years and over) is that:

- one in three people experience at least one fall each year.
- falls account for approximately 250 deaths, 12,000 hospital admissions and at least 12,000 hospital emergency department presentations each year.
- falls can result in loss of confidence and independence and therefore a significantly reduced quality of life.
- the lifetime cost of fall injuries is estimated at $199 million including direct medical costs ($127 million) and indirect morbidity and mortality costs ($72 million).

Solution generation
The project aims to reduce the incidence of falls among community dwelling older people in the CE PCP catchment. Its initial focus is on organisational and workforce development, promoting best practice among agencies with frail, community dwelling clients aged 65 years and over. The focus of the second year will be the development of screening methods for at risk older people and raising awareness of falls risk factors and protective measures among the target group.
Simple measures can drastically reduce the risks for falls. This project uses a multistrategic, multi-agency approach to:

- promote the use of evidence-based best practice for falls prevention among agencies with clients who are over the age of 65 years, community-dwelling and frail.
- increase awareness among the target population of the risk factors for falling and use of protective measures to reduce their risk of falling.

The ultimate goal of the falls prevention program is to promote the positive health, safety and independence of older persons 65+ years living in their own homes in the CE PCP, by reducing the occurrence of falls.

The specific objectives of the falls prevention program are:

1. To improve the coordination of services for community dwelling frail older people in the CEPCP who have fallen or are at risk of falling.

2. To increase awareness and knowledge of the risk factors for falls and their countermeasures among community dwelling older people in the CEPCP catchment.

3. To increase participation in falls prevention initiatives by community dwelling older people in the CEPCP catchment.

Support and resources
A half time staff person will be employed to implement this program. The Falls prevention coordinator will work closely with all stakeholders and focus on capacity building within member agencies. Printed materials will be developed and will include a best practice manual and training package along with printed materials for the health information strategy

Item	Cost
Total staff costs	$31850
Best practice manual – 100 copies @ $20/copy	$2000
Printing and media costs – social marketing strategy	$2000
Training costs	$5000
Small grants program	$8000
Consumer involvement costs	$1150
TOTAL:	**$50,000**

Stakeholders involved in the project are:
Falls Prevention Project Advisory Group (FPPAG) (collaborative approach to development of falls prevention initiatives)
Member agencies (agreement on and adoption of best practice standards)
GPs (adoption of screening tool, referral of older people into appropriate services/ exercise groups)
Consumer representatives (input into program initiatives from consumer perspective)
Service coordination subcommittee (integration of falls screening tool and falls model with PPPS)
Local Government (incorporation of falls prevention into Municipal Public Health Plans)

TIMELINES

- Adoption of best practice standards: July 2003
- Production of training manual: July 2003
- Training of health care workers: August – October 2003
- Development of social marketing campaign: September- December 2003
- Administration of small grants program: February 2003
- Implementation of social marketing campaign: February 2004 onwards

Review and evaluation
Project impacts will include:

- an agency agreement on optimal standards,
- increased knowledge and skills reflecting best practice for staff via training.
- implementation of falls prevention action plans by agencies and integration of a falls risk assessment into the PPPS infrastructure.
- increased awareness of the risk factors for falling and protective actions among older people.
- reduced fear of falling, a reduction in falls-related injury and hence, decreased costs to the acute sector.

On completion of the training local agencies will be encouraged to identify their current practice and develop a plan that will incorporate the best practice into their current work. Agency case studies will show how information can lead to behavioural change in the agency that then results in improved services for consumers.

Desired outcomes for older people are:

- Older people at risk of falls are identified and appropriately assessed.
- Older people at risk of falls receive multifaceted interventions according to their assessed needs.
- Older people at risk of falls have greater access to appropriate physical activities and services.
- Older people at risk of falls accept the information and participate in the services offered.
- Older people at risk of falls have an improved risk status (or deterioration in risk status has been slowed).
- Older people at risk of falls have fewer falls than otherwise would have been expected and/or have less falls related morbidity.

11. Addressing inactivity of 'at risk' populations

Phase 1 – Action Research.
Address the problem of inactivity for 'at risk' population groups within the Central East Primary Care Partnership catchment.

Problem definition:
The prevalence of inactivity in the 20-75 year age range is 46%. This means that a little over half of the Victorian population is active enough to accrue a health benefit from being active. (AIHW Physical activity patterns of Australian adults (2000). Participation in physical activity has far reaching health benefits. The strongest evidence is in the prevention of disease of the blood vessels and the heart. Some studies indicate that up to a two fold increase in cardiovascular disease is associated with those who are sedentary as opposed to those who are moderately active (Berlin & Colditz 1990, Powell et al 1987). Evidence is also mounting identifying the positive benefits of physical activity on the prevention of stroke, types of cancers, Type 2 diabetes, musculoskeletal health and mental health (Active for Life 1998).

In Australia, direct health care costs attributable to inactivity are conservatively estimated as $377 million per year. In Victoria alone, physical inactivity is estimated to be responsible for 6.6% of the disease burden. This estimation was achieved by analysing the population's attributable risk of disease and injury due to physical inactivity using a standard attributable risk approach (Victorian Burden of Disease 1999).

Solution generation:
This project will be developed over two or more phases including: Multifaceted Action Research, Implementation of Health Promotion recommendations, which may in turn lead to identification of additional interventions. This multi-phase model has already been implemented through the CALD Communities Projects and the Well families projects involving increasing diversity of partnerships across the health services sector in the central east catchment.

Additional phases could include:

- Workforce development through sharing of best practice models and frameworks for increasing activity that are evidence based and contribute to sustained health outcomes.
- Encouragement of co-ordinated service delivery/partnerships where duplication of similar programs occurs.
- Increase in access of programs by at risk groups who are currently inactive.
- Development of evaluation frameworks to identify sustainability of current programs in relation to regular/monitored consumer access.
- Networking across sectors to support consumer referrals to physical activity within complexity of barriers to sustained health and wellbeing.
- Development of new programs to meet needs of gaps in consumer access and physical activity.
- Exploration of additional funding opportunities for partnerships in service delivery and co-ordination.

Target population groups:
The initial development of a framework for the Action Research phase recognised that older women and men could be one target group where the level of physical activity is often poor and not sustained at a level to make any positive contributions to disease prevention and wellbeing. However, as the CEPCP already has a focus on older people through the Falls Prevention Project the target groups to be mapped in this project will not include older people, focussing instead on 'at risk' population groups.
These include: -

- Single parent's in particular women.
- Children & young people
- CALD Communities
- People living with disabilities – physical, intellectual, psychiatric.
- Socially isolated people
- Low socio-economic groups

For these population groups barriers to physical activity include: lack of knowledge, perceived lack of safety and inactivity itself, the venue or neighbourhood of activity, fear of injury or health problems, particularly where safe practices are not well understood or

practiced, lack of self confidence, inadequate transport, lack of facilities, poor design-access, location, culturally inappropriate, lack of time or motivation, affordability, lack of support through social encouragement and professional advice, lack of physical skills. (Active for Life Physical Activity Framework – 2000).

Program Goal:
To implement a multi-faceted health promotion program that addresses the problem of inactivity using the population health framework with specific identified 'at risk' population group/s

Objective for phase 1:
Undertake an action research project that maps current activity, provides a literature review and recommends a way forward to address the problem of inactivity in the CE catchment. This will include a general population health approach and identify specific at risk groups that require increased attention.

Strategies for implementation of objectives:

Health Promotion interventions	***Method of implementation***	***Tools to be used***
Community Action	Consumer & KSP engagement on ref group	PCP Cons Strategy
Social Marketing /Health	Conduct a Forum to share results	
Organisational development	Define literature parameters	Ref & HP WG
	Undertake Literature review	
	Develop Mapping Framework	Modify Well Families Mapping tool
	Undertake Mapping exercise	Email/Phone/Interview
	Identify Best Practice models	Document/report
	Identification of recommendations	
	Evaluation of mapping process	Develop framework
Resource Allocation	Develop Phase 2 Framework	DHS HP Template & Narrative
	Identify funding sources	
Capacity building strategies Community Action	Consumer & KSP engagement on ref group	CEPCP Consumer Engagement Strategy
Organisational development	Review of service practices against the literature review	Audit tool/questionnaire

Support & resources:
CE PCP Staff:
- Project auspice to liaise with CEPCP HP Co-Ord.
- Manager of CE PCP to liaise with GOV Com
- Reference committee

Time:
Staff time in liaison/reporting processes throughout.

Materials:
Support for Production of a Final Report

Resource cost:
Staff salary & admin costs for project liaison Reporting stages and final report.

Potential Stakeholders:
With previous projects the CEPCP has a history of drawing together a of range service providers extending the partnership opportunities each time. As physical inactivity is a factor in chronic disease management programs and health promotion plans, of a diverse range of service providers, the potential for this project to form a broader partnership opportunity has already been identified. Potential agencies are:
- Eastern Health
- City of Whitehorse – Community Services, Family Services & Urban Planning.
- City of Monash - Community Services, Family Services, Urban Planning etc

- Whitehorse Community Health Service
- Manningham Community Health Service
- Monashlink Community Health Service
- Whitehorse Division of general practitioners
- Greater South East Division of General Practice
- Multi-catchment agencies
- Small specific agencies
- All PCP Member agencies

Timelines:
Establish Ref Group (July 2003)
Undertake action research (Aug- Novmber)
Final report (December 2003)

Review & evaluation:
Milestones:
- Establishment of reference group.
- Identification of target group/s.
- Conduct and review current activities and evidence-based approaches to physical activities in CEPCP catchment targeting 'at risk' population groups who are likely to develop chronic disease.
- Identification of best practice models for sustainable physical activity targeting at risk population who are likely to develop chronic disease.
- Identification of duplication of models and gaps.
- Recommendations for HP interventions to provide a population health approach and target at risk population/s and issue/s.

Methods:
- Literature review to be conducted focusing on evidence, other PCP activity, Health Promotion networks, acute & allied health resources, DHS/PCP program reports and current projects.
- Development of data collection tool to be used via email, telephone contact and network/forum of service providers.
- Data analysis of existing information and mapped information.
- Report writing
- Information dissemination through report/forum/workshop.

Evaluation:
- Identification of mapping gaps, process flaws.
- Recommendations for undertaking successful action research.

See Appendix 1 IHP summary grid P.45-47

References:

Active For Life (1998). Physical Activity Patterns & Health Impacts in Victoria. Department of Human Services. Health Promotion Strategy Unit. Melbourne Victoria (P.13).

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Berlin JA & Colditz GA (1990). The meta-analysis of physical activity in the prevention of coronary heart disease. American Journal of epidemiology. 132(4): 612-627.

Powell K E, Thompson P D, Caspersen C J, & Kendrick J S (1987). Physical activity and the incidence of coronary heart disease. Annual Review of Public Health 8: 253-287.

(VBOD) Victorian Burden of Disease Study - Mortality (1999). Public Health and Development Division. Department of Human Services. Victoria Australia

11. Mental Health (Beyond Blue)

Shared care pathways for depression and related disorders

Problem definition
There is an acknowledged need to build the capacity of primary care providers to effectively treat and manage people with mental health disorders, particularly in terms of educational resources to enhance responsiveness and for the coordination of care (Department of Health and Ageing 1999).In particular, the general practice sector, which manages the majority of people who seek treatment, is seeking improved resources (Eastern Health Community Mental Health Plan 2002-2003). The establishment of shared care is recognised as challenging, with a sense of urgency for research about shared care 'to evaluate different models in various contexts to ensure the most optimal outcomes' (Keks N, et al (1998). Despite the incidence and prevalence of depression and related disorders at a population level, community opinion is that mental health is a marginal issue, a situation not assisted by less than optimal consumer experiences of treatment services (Hickie I. 2002). Consumer rating of different models of shared care is also required and consumer involvement with clinicians and mental health practitioners, in the design of the guidelines, is essential (National Health and Medical Research Council 1998). There is recognition of the need for greater involvement of consumers in partnerships and programs (Department of Health and Ageing 1999) and in assisting communities to recognise, manage and prevent depression as well as reduce stigma and discrimination associated with depression (National Action Plan for Depression and Related Disorders 2002). This project seeks to address these issues.

Solution generation
This is a community based, capacity building project designed to fill gaps in knowledge and resources in relation to shared care for depression and related disorders, which have been identified as priorities by the member agencies of the CEPCP in the Eastern Metropolitan Region.
The **aims** of this project are to:

1. enhance understanding of shared care within the mental and primary health care sectors;
2. enhance the primary care-health promotion interface for depression and related disorders;
3. broaden understandings of the term "mental health literacy";
4. explore the impact of social determinants of mental health on shared care pathways in relation to depression and other disorders; resources within the primary care sector.
5. improve co-ordination and responsiveness of services for consumers experiencing depression and related disorders by developing and consolidating resources in the primary care sector .

Support and resources
Initially three years of funding were sought to complete a needs analysis and develop protocols and clinical guidelines for shared care that integrate prevention and health promotion. One years funding of $50,000 has been received and hence the focus of this years work will be on the needs analysis. The project will work towards further funding to achieve its original aims.

Stakeholders
The project is a collaboration of Deakin University and the CEPCP and its member agencies and the Primary Mental Health Team from Eastern Health.

Timelines

Reference group	(July 2003)
Staff employment	(August 2003)
Project implementation	(Sept to March)
Final report	(June 2004)

Review and evaluation
This project will conduct a study of shared care with providers and consumers, taking account of cultural and linguistic diversity for priority population groups: youth, mothers of young children, men and older people, investigating their understanding of current models and definitions. A parallel study of consumers' emotional wellbeing, social functioning, social support and other social determinants in health will also be achieved. This consumer focus will contribute to the

evidence base about the impact of the social determinants of health inequities on care pathways.

Over the 12 months the project will recruit consumers with mental health disorders across the CE PCP and relevant providers. Recruitment will be through member agencies of the CEPCP, with inclusion-exclusion criteria agreed by the Steering Group. Providers will be interviewed for their experiences of shared care. For the consumer study, convenience sampling (non-probability design) will be used, with theoretical sampling ie, cases are chosen for theoretical, not statistical, reasons to fill particular categories and provide examples of polar types (Huberman and Miles 2002), to ensure that data is captured from priority population groups. Respondents will be asked to complete a survey comprising demographic and socio-economic data (employment history, material circumstances), illness history, the range of treatments undertaken, what has worked or not worked, plus the SF 36 (Ware et al 19993) or subsets thereof, particularly those for emotional and social functioning, and appropriate scales to measure social support, such as the SSQ6 Measurement of Social Support (Sarason and Sarason 1985). Data will be delinked to assure anonymity of respondents. Data will be managed using SPSS (Green et al 2000). Each consumer will then be interviewed to explore experiences of shared care, barriers and facilitators, access issues and consumer perceptions of unmet needs. Provider and consumer interviews will be audiotaped with consent. In keeping with accepted practice, transcripts will be selectively transcribed with more detailed transcription of selected portions for analysis (Huberman and Miles 1999). Qualitative data will be managed using Nvivo (Qualitiative solutions 1999). Qualitative and quantitative data will be integrated by importing SPSS into Nvivo. The analysis will test working definitions of shared care and consumers' experiences of shared care, exploring social issues and determinants of their experiences with depression and related disorders.

References

Department of Health and Ageing (1999) Mental Health Promotion and Prevention National Action Plan

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Hickie I. (2002). Responding to the Australian experience of depression. EMJA

National Health and Medical Research Council. (1998). A guide to the development, implementation and evaluation of clinical practice guidelines

Department of Health and Ageing (1999) Mental Health Promotion and Prevention National Action Plan, Canberra, DoHA; Victorian Centre of Excellence in Depression and Related Disorders (2002) Melbourne, *beyondblue: the national depression initiative.* Barry (2002) Challenges and opportunities in strengthening the evidence base for mental health promotion. Promotion and Education Vol IX/2;44-48

Huberman A.M. & Miles M. (2002). The qualitative researcher's companion. Thousand Oaks, Sage, pp 249-252.

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Sarason K. & Sarason B. (eds) (1985) Social support: theory, research and applications. Boston, MA.

Ware J., Snow K., Kosinski M. & Gandek B. (1993). SF36 health survey: manual and interpretation guide. Boston, New England Medical Centre Health Institute.

12. Mental Health 'Ready, Set Baby' – Well Families Phase 2

To improve the health and wellbeing of families in the early years of parenting with particular focus on reducing depression and anxiety first-time parents

Problem definition:
Phase 1 of the Well Families Project – 2002-03 was an Action Research plan mapping a snapshot of services in the CEPCP catchment focussing on young families. Combined with a literature review and consumer/service provider consultation the research identified the need for a more intentional approach to the emotional and psychological preparation for first time parents. The recommendations highlighted the need to develop a detailed pre&post natal course that could compliment the existing program in birthing services but offered over a longer time frame and to include additions such as peer support, pre-birth links with Maternal & Child Health Services and the provision of more accurate and consistent information around first time parenting.

As these recommendations cut across the Acute sector practices, maternal & Child health, General practice and allied services the negotiations between stakeholders and the complexities of piloting a 9 month+ required more time than was originally predicted for implementation of Phase 2. This has resulted in Phase 2 of the Well Families Project running across the 2003-04 funding period but will used funds carried over from 2002-03.

Solution Generation:
Target group/s:
Consumers
- First time mothers and their partner's

Service providers
- Box Hill Maternity Staff
- Mitcham Private Hospital Maternity Staff
- Maternal & Child Health Nurses - Manningham & Whitehorse LGA's
- Community Health Staff – engaged with consumers who are first time parents
- Shared care GP's through Whitehorse Division & Birralee Maternity
- Obstetricians – Eastern Health (BHH), Mitcham Private
- Women's Health East & BHH HP Unit Staff
- MIC staff working with young families

Goal:
Enhanced preparation for parenting for families within the Central East PCP - with a focus on the first time mothers who are at higher risk of experiencing anxiety and depression.

Objectives:
Objective 1: To increase the social connectedness and extent of social supports available to first time mothers and their partners.
Strategy: Develop & implement a pre& postnatal course focussing on physical, emotional and well being issues associated with a new first baby

Objective 2: To raise the awareness of health services and community support options for new mothers.
Strategy: Identify appropriate community information & supports for first time parents, collate and distribute to identified parents at time of birth and service providers who work with them.

Strategies for implementing objectives:

Health Promotion intervention:	*Method of implementation*	*Tools to be used*
Objective 1:		
Community Action	Consumer & KSP engagement on reference group	PCP Cons Strategy
Health information	Consumer participation Pre& Post natal group	
	New program development.	Publicity Brochure
	Recruitment process via KSP	
Workforce development	Training for GP's & KSP re program	Training model
	Design & implement evaluation	Evaluation Framework
Objective 2:		
Community Action	Consumer & KSP engagement on reference group	PCP Cons Strategy
	Establish content of kit	
Health information	Identify/review 'good practice' resources	Existing resources
	Develop kit – new & existing resources	
Organisational development	Negotiate distribution of kits	Kit
Workforce development	Provide training to staff of birthing units	Training model
	Design & implement evaluation	Evaluation Framework

Capacity building:
Consumer & KSP engagement on ref group
* See list of key service providers in target groups listed above.
Training for GP's & KSP re program
Provision of training to staff of birthing units
Training of peer support consumers through pre/post natal course & Ref Group

Support and resources:

- Staff

Project auspice to liaise with CEPCP HP Co-Ord.
Manager of CE PCP to liaise with GOV Com

- Partners – Liaison with project team as required by timelines
- Advisory committee – CEPCP Governance & HP Working Group
- Time - Staff time in liaison/reporting processes throughout.
- Materials – Support for Production of a Final Project Report
  - Production of training manual depending on evaluation outcomes
- Resource cost:
- Staff salary & admin costs for project liaison -
- Reporting stages and final report.

Stakeholders:
Project Tenders - Eastern Health – Boxhill Hospital Health Promotion Unit & Birralee Maternity Unit and Women's Health East

Partners:

- City of Manningham - Maternal & Child Health
- City of Whitehorse - Maternal & Child Health
- Whitehorse Division of General Practice
- Whitehorse Community Health Service
- Migrant Information Centre – Eastern Region

Timelines:

Finalise model	Early May
Re-establish Reference Group (RG) of key stakeholders	Mid June
Submit Ethics proposal	June
Employ project worker/s,	Mid July
Program Development	August

Evaluation Development	August
Implementation of Program	September
Evaluation	Sept - Apr
Final Report	May 2004

Review & evaluation:

Milestones

- Levels of accurate knowledge about parenting (eg. settling & developmental difficulties)
- Application of knowledge, that is, the ability to cope with the baby and transition to parenthood (measure extent of psychological distress)
- Social networks and sense of connectedness among participants (eg. participants contact each other independently, meet together, share information, feel less isolated)
- Screening for mental/emotional wellbeing, perceptions of ability to cope with parenthood
- Levels of knowledge about available services
- Service usage rates

Methods:

- Questionnaire to program participants and non-program participants (control group), pre and post class implementation, using Dukes & Kessler 10 screening tools
- In-depth interviews with 2 3 cases from each class (new and control), based on questionnaire responses
- Interview staff about effectiveness of program to meet objective
- Questionnaire to program participants and non-program participants (control group), pre and post class implementation, using Dukes & Kessler 10 screening tools
- Questionnaire to program participants and non-program participants (control group), pre and post class implementation, using Dukes & Kessler 10 screening tools
- In-depth interviews with 2 3 cases from each class (new and control), based on questionnaire responses
- Interview staff about effectiveness of program to meet objective
- Additional questions on pre and post implementation questionnaire, regarding levels of awareness of health services and their usage
- Interview staff about effectiveness of new model of kit
- Negotiate with services to measure numbers of new mothers accessing services as a result of referring to the kit.

Evaluation:

An evaluation matrix has been developed to guide data for recording & evaluation

- Increased capacity of first time parent's to cope with the transition to parenthood, through increased knowledge about changes leading to - changed behaviour & attitudes.

Stronger social networks & decreased levels of social isolation & psychological distress among first time parents.

APPENDIX 1: INTEGRATED HEALTH PROMOTION PROGRAM SUMMARY GRID

Addressing Inactivity of 'at risk'populations

Program Goal: Address the problem of inactivity for 'at risk' population groups within the Central East Primary Care Partnership catchment.

Population Target Group/s: Target group or groups.

- *Consumers*

The results of the service mapping will aim at providing data on physical activity/inactivity of who are often identified in the highest 'at risk' categories as they generally have the most barriers to engaging in positive lifestyle changes for health and wellbeing. This focus will provide a range of: age groups, gender, ethnicity, socio-economic status and social connectedness.

- Single parent's in particular women.
- Children & young people
- CALD Communities
- People living with disabilities – physical, intellectual, psychiatric.
- Socially isolated people
- Low socio-economic groups

- *Service providers*

As this phase is an action research model the service providers will include:
acute and allied/community health, GP's, Neighbourhood Houses, Local Government departments. This process will also identify small agencies or groups in the catchment who contribute to the physical activity such as church based services, youth services, respite services, schools etc.

Program Objectives	Health Promotion Interventions & Capacity Building strategies[14]	Estimated Impacts[15] (Qualitative &/or Quantitative)	Estimated[16] Reach	Timelines & by which agency[17]	Estimated Costs)[18]
Objective 1: Undertake a defined literature review and service mapping exercise to identify the level and types of physical activity of 'at risk' population groups in the central east catchment.	**Screening, individual risk assessment and immunisation**				
	Social marketing /Health information Conduct a Forum to share results of Action Research.	Share outcomes of each funded grant to KSP & Consumers in CEPCP.	CE PCP Member agencies	Hp Co-Ord & HP Working Group **DEC**	
	Health education and skill development				
	Community action Consumer participation on reference group	Consumers identified & payment allocated	2 consumers	Hp Co-Ord & HP Working Group **JUL**	
	Settings and Supportive Environments				

1. [14] PLEASE REFER TO THE DOCUMENT *INTEGRATED HEALTH PROMOTION INTERVENTIONS AND CAPACITY BUILDING STRATEGIES NOVEMBER 2002* (THIS IS AN INTERIM RESOURCE DEVELOPED WHILST THE HEALTH PROMOTION GUIDELINES ARE BEING UPDATED. IT CAN BE DOWN LOADED FROM WWW.DHS.VIC.GOV.AU/PHKB UNDER HEALTH PROMOTION IN PRIMARY CARE PARTNERSHIPS) WHICH DESCRIBES THESE INTERVENTIONS AND STRATEGY TYPES. AN APPROPRIATE MIX OF INTERVENTIONS AND STRATEGIES SHOULD BE DOCUMENTED, TO ADDRESS THE STATED OBJECTIVE (SOLUTION GENERATION IN SECTION 2.3 ABOVE). PCPS ARE ONLY REQUIRED TO FILL IN INTERVENTIONS/STRATEGIES THAT ARE RELEVANT; ALL OTHER INTERVENTIONS/STRATEGIES CATEGORIES CAN BE DELETED.

[15] **Estimated Impacts** (Qualitative &/or Quantitative): Planning requires the development of impact indicators to measure the achievement of program objectives. PCPs are required to identify intended impacts as part of their planning process and report against these in 2003-2004.

[16] **Estimated Reach**: Planning requires the development of process indicators for each program. However, the Department only one type of process indicator -Reach to be documented in the health promotion summary grid. For further information please refer to the document *Process Evaluation-Reach* that can be downloaded from www.dhs.vic.gov.au/phkb under Health promotion in Primary Care Partnerships.

[17] **Timelines& By Whom**: Timelines for implementation need to be identified as well as the agency responsible for carrying out the action.

[18] **Estimated Costs** (Staff and consumables): Where possible include the estimate cost per intervention/strategy. Also include total cost per objective and total overall cost per program goal.

	Organisational Development Establish project reference group with key agencies Consumers Define literature review process Develop Mapping Framework Identify Best Practice models Analyse data & document Develop evaluation framework for mapping process	Project reference group established Literature parameters identified and review undertaken Engage in mapping exercise Document best practice examples Results of mapping exercise documented and interpreted Evaluation complete	2 consumers 8 Key service agencies Consumers, CEPCP Service agencies & identified groups in catchment Consumers, CEPCP Service agencies & identified groups in catchment	HP Co-Ord & HP Working group **JUL** HP Co-Ord **JUL** HP Co-Ord & HP Staff **JUL - AUG** HP Co-Ord & HP Working group **JUL - AUG** HP Co-Ord & HP Working group **JUL – AUG** HP Co-Ord & HP Working group **JUL - AUG**	
	Workforce Development Develop EOI outline for Mapping Tender Invite tender	EIO Tender completed & distributed Tender allocated	CEPCP agencies	Hp Co-Ord, Ref group & **AUG**	$10,000
	Resources Develop Phase 2 Framework Develop Phase 2 EOI Tender document Identify funding sources Management support &Project integration & on-costs HP Co-Ord Time & Project support costs	Framework & narrative identified EOI tender completed & distributed Funding sources identified and contacted Infrastructure support maintained for project/s	Consumers, CEPCP Service agencies & identified groups in catchment Agencies/staff participating in project Project Team/ Consumers & Service providers.	Hp Co-Ord, Ref group & 2 team participants & HP Working Group **DEC** *CEPCP ongoing* CEPCP ongoing	$20,000 $ 2,459 $ 23,440
Total Budget per Objective					S55, 899