CVHA

Central Victorian
Health Alliance

COMMUNITY HEALTH PLAN 2002 -2003

Foreword

The Central Victorian Health Alliance Community Health is proud of its achievements in 2001 –2002 and has established a comprehensive plan to build on those achievements to meet the health and well-being needs of consumers in the Shires of Central Goldfields, Macedon Ranges and Mount Alexander.

In 2001-2002 CVHA achieved considerable systems change required to enable the comprehensive multi-agency service provision to meet the needs of this community. It increased the engagement of general practitioners in the development of local systems; it enhanced the relationships between general practitioners and other health providers and promoted care planning for consumers with complex or chronic needs.

CVHA has developed comprehensive practices, processes, protocols and systems to support service coordination across all its member agencies. This work, with the work undertaken on the development of the service directory provides a strong basis for the refinement and implementation work to be undertaken in 2002-2003.

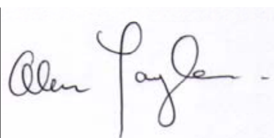
Through the implementation of its health promotion projects in 2001-2002 CVHA undertook a collaborative multi-sectorial approach to the health issues of cardiovascular disease and lack of social connectedness. The collaborative work undertaken by these projects has enabled consumers to access best practice in heart health screening and to participate in the ownership of a project that will both improve their health knowledge and connect them with their community.

The 2002 –2003 Community Health Plan recognises the health issues of this community are complex and that meeting those needs requires the undertaking of multi-layered approaches within varied arenas of activity. The 2002-2003 plan is the result of significant commitment by member agencies to collaborative planning and service provision.

CVHA is committed to undertaking a whole of health approach to priority health issues and the 2002-2003 Community Health Plan aims to use that approach to improve consumer health status particularly in the areas of mental well being and in chronic and/or ambulatory sensitive conditions. It plans to continue the work of service coordination to enable consumer needs to be met through quality systems and multi-agency service provision.

A cornerstone of the 2002 – 2003 Community Health Plan is the development of an integrated health promotion vision that encompasses the whole of health continuum. The development of this vision will enable health promotion to be integrated into all aspects of service delivery and will enable consumers to take better control of their own health.

I commend this 2002 – 2003 Community Health Plan to you and look forward to feedback on the strategies described within.



Alan Taylor
Chair Person
Central Victorian Health Alliance

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Section 1: Key Achievements 2001 - 2002

Partnerships-Priority deliverable 1.

Increase participation of GPs in the coordination of care for consumers with chronic or complex conditions – increase uptake of EPC

Development of collaborative relationships to increase and facilitate coordination of care.

CVHA has developed strong collaborative relationships with the Bendigo and District, Central Highlands and West Vic Divisions of General Practice. These relationships have allowed the targeting of networking and training opportunities designed to enable an increased participation of general practitioners and other service providers in the coordination of care for consumers with chronic or complex conditions. There has been a consequent steady increase in the number of collaborative relationships between individual general practitioners and agency-based service providers.

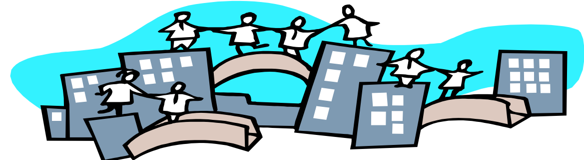
These targeting of networking and training opportunities have included:

- CVHA, in conjunction with the 3 Divisions of General Practice and Department of Human Services (Melb), undertook 4 EPC training sessions. These interactive case study based sessions were attended by 23 general practitioners and 65 allied health, pharmacists and practice staff

- CVHA supported the Bendigo District Division of General Practice, in the undertaking of Adolescent Health training session attended by general practitioners, health, welfare, school and community based service providers.

Development of structural supports to enhance increased participation

In conjunction with Central Highlands Division of General Practice CVHA undertook a technical pilot of the INI and care planning tools. 6 general practitioners participated in a pilot process that involved the active involvement of their practice staff. This piloting enabled the perspective of general practitioners as to the appropriateness and therefore usefulness of the tools to be considered. It also provided a strong foundation for CVHA and the Divisions to



determine the best means of engaging general practitioners, within their practice systems, in the development and implementation of service coordination practices, processes, protocols and systems.

Bendigo and Division of General Practice IT Officer has been a highly active member of the Loddon Mallee Regional Information Management Group and has made a significant contribution to the development of the Regional Information Management Plan and the electronic services directory. His contribution will again ensure the general practitioner perspective is considered in the development of information management supports.

The development of service coordination practices, processes, protocols and systems to support multi-disciplinary care planning has been enhanced by the active participation of a Central Highlands Division of General Practice representative on the Service Coordination Sub-committee and by the development of a Divisions' of General Practice Service Coordination implementation working group. CVHA has targeted this development and implementation work around those chronic and complex conditions identified as priority health issues by CVHA, Divisions and their member general practitioners. This will enable the development to be based in the actual delivery of care planning that will provide it with realistic review and will facilitate the increased delivery of multi-disciplinary care plans.

Section 1: Key Achievements 2001 - 2002

Bendigo and District and Central Highlands Divisions of General Practice have participated in the Integrated Health Promotion Working Group. This has enabled the implementation of health promotion activities to both support and be supported by those activities being undertaken by the Divisions. It has also enabled the development of links between the CVD Integrated Health Promotion project and general practitioners. This work has provided a strong foundation for the further development of service coordination linkages between health promotion activities and general practitioners.

Consumer, carer and community impacts and outcomes

The CVHA work to date has resulted in increased general practitioner knowledge of primary health services and the development of interpersonal relationships between GPs and other health service providers. This has led to a consequent increase in the number of referrals and multi-disciplinary care plans for consumers.

Primary health care services now have a better understanding of the requirements of GPs in the undertaking of multi-disciplinary care planning and are better able to engage GPs in the coordination of care.

This work has also led to a review of agency feedback systems in several locations that has been incorporated into the service coordination work. This work will ensure that all health providers have the information they require to meet the needs of consumers.

The impact of these changes is that consumers with chronic or complex health needs will receive comprehensive and coordinated service provision from all key service providers and will therefore have better health outcomes.

Service Coordination - Priority deliverable 2

Pilot and implement the INI and care planning tools – replaces existing tools, better identifies the needs of consumers including early intervention, facilitates coordinated care planning and referral

A strong service coordination sub-committee (committed to the development of, and capable of the local integration of, quality service coordination practices, processes, protocols and systems) has overseen the service coordination strategy. This sub-committee comprises a broad range of service providers from member organisations, Division of 'General Practice and consumer representation.

Pilot and evaluation of INI and care planning tools

Service providers from the full range of Program areas in the majority of member agencies participated in the piloting of the INI and Care Planning Tools. 6 General Practitioners with active facilitation by their Division of General Practice undertook the technical pilot. This participation enabled staff from member agencies to engage in the implementation process by developing an understanding the tools, their role and future impact. It also enabled them to identify Information Management inadequacies and to commence the development of new IM systems. Agencies were then able to position themselves for the implementation of the tools

The participation of general practitioners in the technical pilot as discussed in Priority Deliverable 2 enabled the tools to be evaluated from the GP perspective and the strategies to engage GPs in future service coordination work to be developed.

Implement the INI and care planning tools, Identification of the needs of consumers including early intervention, Facilitation of coordinated care planning and referral

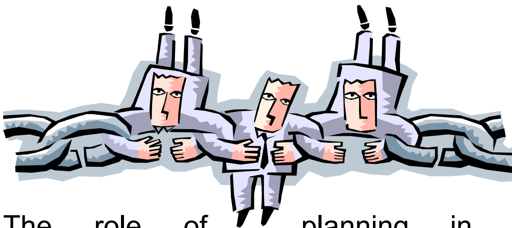
CVHA has undertaken significant work to enable the implementation of the INI and Care Planning tools It has developed practices, processes, protocols and systems for INI and multi-disciplinary care planning and service coordination. Service providers from member agencies have developed and commenced

Section 1: Key Achievements 2001 - 2002

implementing these systems from and within their service networks and agencies. This approach has enabled this implementation to extend across all member agencies and program areas and to become integrated into service provision.

CVHA has developed integrated and comprehensive models of the requirements of INI and multi-disciplinary care planning (see attachment 3). This has enabled the development and implementation of practices, processes, protocols and systems to meet the needs of consumers, the requirements of service provision and underpins the implementation of the tools.

Central to this implementation has been the commencement of an ongoing change to privacy/consent practices, protocols, processes and systems in accordance with requirements of state and federal privacy legislation.



The role of planning in service provision was identified as a central issue and CVHA has developed a feedback model that separates consumer care planning from service and system planning and has commenced the implementation of practices, processes, protocols and systems to meet the requirements of that planning.

Member agencies have either commenced use of the INI and Care Planning (service Coordination) tools or are poised to do.

CVHA engaged INI and Care Planning project workers to develop practices, protocols, processes and systems required to implement the tools. They have developed common skills and knowledge to enable them to provide competent INI and multi-disciplinary care planning and have supported the workforce development of other service providers, from different program areas at different member agencies. As well as each member agency providing INIs as part of their service provision all member 4 community Health Services in the catchment now provide an INI, at duty, that is accessible by all consumers regardless of the service they are requiring.

CVHA has worked in collaboration with Divisions of General Practice to ensure INI and Care Planning (service coordination) practices, protocols, processes and systems are appropriate for GPs and to facilitate GP participation in their development and implementation. It has undertaken this work making it practical and by relating it to the priorities and specific areas of interest of Divisions of General Practice and individual GPs.

Engagement with acute system

CVHA has commenced the development of practices, processes, protocols and systems for managing primary/acute service coordination.

The 5 Loddon Mallee PCPs have obtained 3 year funding from the Federal Government through the Suicide Prevention Strategy to implement an Effective Follow-up of Suicidal and Deliberately Self-Harming Clients of Hospital Emergency Departments Project. Both the Acute and Primary Care systems were actively engaged in the development of the model, the submission process and are members of the local Implementation Group. This project will be integrated into the CVHA service coordination work and will utilise common practices, processes, protocols and systems and the electronic services (and referral) directory. This project contains a significant workforce development component that will reach service providers within community and acute agencies and general practitioners and their practice nurses

Section 1: Key Achievements 2001 - 2002

Consumer, carer and community impacts and outcomes

CVHA implementation of the INI and care planning tools has had the following outcomes for consumers:

Access: At 4 generic sites across the catchment consumers can receive prompt needs identification (INI) and facilitation in their passage to assessment and care planning. They can also receive an INI and referral facilitation at other member agencies as part of service provision.

Consumers with chronic and complex conditions have commenced to increase access to multi-disciplinary care planning that meets their health needs and engages all the relevant service providers

Effectiveness: As so many consumers were involved in the comprehensive CVHA INI and Care Planning (service coordination) tools piloting program the final tools are likely to meet the needs of those consumers.

Privacy: Consumers health information is subject to quality privacy/consent practices, protocols, processes and systems

Carers will, within the Privacy Principles, be informed of the consumer's situation and engaged in their care plans

Service Coordination– Priority Deliverable 3

Develop Service Directory

CVHA is a member of the Connecting Care Users Group and is working with through that group with other PCPs in Loddon Mallee and Grampians regions to ensure that Connecting Care meets the requirements of consumers, carers and the community as well as those of service providers and the state wide core data set both as a services directory and an electronic referral tool.

It has been working with Primary Care Partnerships - Regional Information Management Working Group and the Loddon Mallee Alliance Steering Committee on the development of a Regional Information and Communication Technology (ICT) Strategy.

CVHA has determined the data required to meet the needs of requirements of consumers, carers and the community as well as those of service providers and the state wide core data set and has commenced collection of that data. It has commenced development of practices, processes, protocols and systems to integrate the service directory into the service coordination information management systems and to ensure its ongoing accuracy and sustainability.

Consumer, carer and community impacts and outcomes

Consumers, carers and the community will have access to an electronic service directory that provides them with accurate services information.

Service providers will have access to accurate services information that enables them to meet the needs of consumers by informing them of services information, access, availability and eligibility criteria.

Service providers will have access to the links that enable them to facilitate the consumer to the services they require.

Duty Workers, and the consumers assist, at all 4 Community Health Services have access to the electronic services directory for the provision of services information and to the Better Health Channel for the provision of health information.

Section 1: Key Achievements 2001 - 2002

Integrated Service Planning – Priority Deliverable 4.

Implement integrated health promotion programs

Implementation of integrated health promotion project: Cardiovascular Health Promotion Project

The Cardiovascular Health Promotion Project aimed to improve cardiovascular health outcomes for communities within the CVHA catchment area through better-integrated health promotion strategies.

The cardiovascular health promotion project was undertaken throughout the catchment. Staff from all community health services, the RITCH Team, hospitals, local government, Divisions of General Practice and Psychiatric Disability Support Service worked together to:

- Systematise the use of a common best practice screening tool
- Engage hard to reach at-risk consumers by targeting workplaces and consumers with a mental health issue
- Undertake workplace screenings that included the implementation of strategies to promote sustainable healthy workplaces
- Develop systems to ensure sustainability of cardiovascular best practice and coordination
- Promote cardiovascular education and health information provision throughout the community including the development of a media strategy and health awareness promotion protocols
- Develop service coordination and care planning links between heart health screenings and general practitioners and other health and non-traditional health providers
- Develop capacity building training links between allied health providers and general practitioners
- Undertake multi-agency service provision by sharing expertise and resources across member agencies as required by the project
- Develop a literature review to inform practice
- Strengthen utilisation of the knowledge of the social determinants of health in the delivery of cardiovascular health promotion

Consumer, carer and community impacts and outcomes

This project has enabled consumers to receive systematised best practice cardiovascular early detection and health education.

It has been able to reach at risk consumers who are traditionally hard to reach by tailoring the project to meet their needs and by taking it to them in their environments. These at risk consumers have therefore had better access to screening activities, been provided with consistent health information and referral processes and have developed an increased awareness of cardiovascular health issues and preventative strategies. Workplaces have been engaged to further the sustainability of these messages by promoting a healthy workplace culture.

Links to general practitioners has enabled those consumers for whom it was required to receive smooth passage between early detection and care planning.

Implementation of rural health promotion project: Wellness Guide

The Wellness Guide (a 2 year project) is being undertaken in Central Goldfields Shire based on a model developed by the University of California. The development of this guide, now termed the Better Living Guide, is a community development project designed to promote social connectedness and provide a large amount of health education to the community.

This project has commenced engaging a highly varied selection of individuals and groups covering all age groups, special interest groups and geographic areas in the development of the guide through the use of focus groups. These groups include such groups as the Rotary Club, youth groups, Farmers Federation, U3A, CWA, Carers Support, the

Majorca Red Cross and the Daisy Hill Community Hall Management Committee

The project has established a reference group that will establish an ongoing media strategy, determine distribution strategies for the community connectedness (evaluation) survey and for the guide itself and to develop a method of ensuring sustainability.

Mental Health Networks comprising staff from member agencies and community representatives have been established in the Shires of Macedon Ranges and Mount Alexander to prepare for extending the project to those shires in the future. These networks have facilitated joint mental health and social connectedness issue identification and planning. They have participated in the Primary Mental Health team consultative process.

Consumer, carer and community impacts and outcomes

This project has begun to empower consumers, carers and the community in the Central Goldfields Shire to have input into issues that affect their health status. It is giving them the means to identify their issues and plan the content and the nature of the health information that will be included in the guide to meet their health and well-being needs. The nature of the process is also promoting their sense of connection to other members of their community.

Integrated Service Planning – Priority Deliverable 5.

Implement Integrated Disease Management Programs

Not applicable

Integrated Service Planning – Priority Deliverable 6

An increased focus on the reduction of avoidable hospital admissions and emergency demand through joint strategies between primary health and acute health agencies

The acute hospitals in the catchment are members of the Alliance and the CVHA has strong relationship with them. The hospitals collaborated with primary care agencies in the development of the Effective Follow-up of Suicidal and Deliberately Self-Harming Clients of Hospital Emergency Departments Project and the Diabetes Prevention and Management Initiative submissions. The successful implementation of these projects will have a positive impact on avoidable hospital admissions.

Many of the service coordination and health promotion strategies undertaken by the CVHA have been based on either chronic and complex conditions or ambulatory sensitive conditions such as asthma, diabetes and cardiovascular diseases. This work has commenced the development of a health continuum approach to service provision, which integrates both health promotion and service coordination, especially of multi- disciplinary service coordination/care planning, across the primary and acute sectors.

The health continuum approach to service provision incorporates GPs, primary care agencies and other health and welfare providers. The 2001 – 2002 formulative work will be built on in the 2002 –2003 when significant work will be undertaken by primary care agencies, Divisions of General Practice, hospitals and CVHA staff that have a particular emphasis on asthma, diabetes, cardiovascular disease and discharge planning.

Section 2: Strategic Objectives 2002 -2003

CVHA has identified 6 strategic objectives that will govern its activities in 2002-2003. Some of these strategic objectives will be undertaken by the Alliance through its partnership structures. Other strategic objectives will be met by the undertaking of strategies identified in the operational plan. These strategies will be undertaken by member agencies working to meet priority health issues identified by the CVHA either collaboratively or individually within their areas of expertise and domain often, but not exclusively, supported by CVHA staff.

The 6 strategic objectives are interrelated, as is their implementation in the strategies identified in the operational plan.

STRATEGIC OBJECTIVE 1:

Consumer health status in the areas of:

- **Mental well-being**
- **Chronic and/or ambulatory sensitive conditions which can involve avoidable hospital admissions**

will be improved by undertaking a whole of health approach to priority health issues.

CVHA will meet this strategic objective by undertaking a number of systemic and programmatic strategies to meet the following key objectives:

1. **Improved Consumer Access – Across The Whole Of Health Continuum**
   In the provision of any CVHA activity or service members will consider the target population or individual, identify any barriers or enablers they have to access and implement strategies to increase access by minimizing barriers.

2. **Improved Consumer Health Outcomes – Care, Management And Maintenance**
   Strategies identified in the operational plan will enhance consumer health outcomes by the undertaking of systems change, workforce development, programme delivery, integration of health promotion, organisational development and capacity building to improve care, management and maintenance

3. **Improved Consumer Health Outcomes – Preventative, Risk Factor, and Social Determinants**
   Strategies identified in the operational plan will enhance consumer health outcomes by the undertaking of systems change, workforce development, programme delivery, integration of health promotion, organisational development and capacity building to enhance preventative strategies and to confront risk factors and social determinants of health

STRATEGIC OBJECTIVE 2:

The integration of Service Coordination Practices, Processes, Protocols and Systems across the continuum of care to support an whole of health approach to service provision

CVHA will integrate service coordination practices, processes, protocols and systems across the continuum of care by:

1. Continuation of the work undertaken in 2001-2002 to refine and implement service coordination practices, processes, protocols and systems in member agencies.
2. Review and refine service coordination practices, processes, protocols and systems ensuring integration into those collaborative activities identified in the community health plan and undertaken by member agencies.
3. Review and refine service coordination practices, processes, protocols and systems ensuring integration into health promotion activities
4. Continued development and implementation of both the electronic services directory, the electronic referral capacity and practices, processes, protocols and systems required for them to support service coordination
5. Development of sustainable mechanisms for the monitoring and review of practices, processes, protocols and systems through CVHA systems and multi-agency service provider networks

Section 2: Strategic Objectives 2002 -2003

STRATEGIC OBJECTIVE 3:

The integration of health promotion approaches into both population and individual based interventions / approaches

CVHA will integrate health promotion approaches into both population and individual based interventions / approaches by:

1. Developing of a common health promotion vision that encompasses the whole of health continuum.
2. The common health promotion vision will guide the undertaking of both population and individual based interventions / approaches
3. The role of primary, secondary and tertiary health promotion strategies across the health continuum, and their integration with service coordination, will be identified and strengthened through CVHA planning structures and the implementation of collaborative activities identified in the community health plan.

STRATEGIC OBJECTIVE 4:

The integration of Consumer, Carer and Community Participation into all levels of service planning and delivery

The Central Victorian Health Alliance is committed to genuine consumer, carer and community participation It will in 2002-2003 build upon its current comprehensive consumer consultation strategy to enhance consumer, carer and community participation in joint problem solving and joint decision-making. The CVHA is committed to implementing a consumer / carer engagement strategy based on the framework below. This framework enables consumers and carers to participate in decision-making at multiple levels of the CVHA service system.

The further development and implementation of this framework will require consideration of linkages between:

- Consumer representatives and broader community reference groups
- The various pre-existing consumer consultation mechanisms

and consideration of the value of value adding to agency based consumer consultation mechanisms.

The implementation will enhance links to the ongoing CVHA service coordination, health promotion, and planning and quality processes. Implementation of this framework will ensure sustainability of consumer, carer, community engagement processes. The refinement and implementation of the strategy will be undertaken with consumer consultation and participation in the decision-making.

CVHA Draft Consumer, Carer and Community Participation Framework

Consultation Level	Consultation Focus
CVHA Executive membership	Strategic planning
CVHA Partnerships, planning, service coordination sub-committees	Multi-agency linkages and strategic planning – focus on needs analysis, protocols and systems
Member and other agency staff networks Ie Aged and Disability networks, Mental Health Networks	Multi-agency service planning – focus on needs analysis, practices and processes
Agency based consumer reference groups	Single agency service planning - needs analysis, and program planning and design
Agency based programme specific consumer reference eg evaluations	Program planning and design
Broad based specific consumer consultations – CVHA initiated	Needs analysis
Broad based specific consumer consultations – Agency initiated eg MPHP	Needs analysis

Section 2: Strategic Objectives 2002 -2003

STRATEGIC OBJECTIVE 5:

The increased participation of GPs in the coordination of care for consumers with chronic or complex conditions and in the delivery of population based interventions

CVHA will continue to work with Divisions of General Practice and individual GPs to increase the participation of GPs in the coordination of care for consumers with chronic or complex conditions and in the delivery of population based interventions by:

1. Developing and implementing Service Coordination and Integrated Health Promotion strategies by relating them to the priorities and specific areas of interest of Divisions of General Practice and individual GPs
2. Ensuring the perspective of general practitioners is heard in the continued development and implementation of the electronic services directory, the electronic referral capacity and practices, processes, protocols and systems required for them to support service coordination
3. The provision for networking and training opportunities between general practitioners and other service providers to encourage and enhance multi-service care planning
4. Linking population based interventions undertaken by Divisions of General Practice to those undertaken by other member agencies and exploring opportunities for collaboration that will enhance those interventions

STRATEGIC OBJECTIVE 6:

The review of partnership arrangements to support integrated and sustainable planning

CVHA recognises that the move to operational integration of partnerships, service coordination and integrated health promotion will require corresponding support from the Alliance structures. It will therefore undertake a review of the Alliance structure to determine its support structural for integrated and sustainable planning, quality improvement, service coordination and integrated health promotion and make appropriate structural changes.

Section 3: Operational Plan
Introduction

The Central Victorian Health Alliance has developed a comprehensive operational plan that supports its undertaking of Integrated Service Planning to meet the identified needs of the CVHA catchment.

In accordance with its strategic objectives CVHA aims to improve consumer health status by undertaking a whole of health approach to priority health issues with particular emphasis on:

- Improving access
- Mental well-being and
- Chronic and/or ambulatory sensitive conditions which cause avoidable hospital admissions

The strategies outlined in this operational plan will both require and support the integration of service coordination practices, processes, protocols and systems across the continuum of care to support an whole of health approach to service provision. They will also require and support the integration of health promotion into both population and individual based interventions and approaches.

The whole of health approach to the priority health issues identified the CVHA requires collaborative planning from infrastructure to individual service planning. The whole of health approach also requires in many cases multi-disciplinary care planning and in some cases collaborative service delivery. The strategies and activities outlined in this operational plan do not encompass the entirety of what member agencies are doing to meet these priority health needs as part of their core business. They do however indicate restructuring of core business that has been undertaken by member agencies as a result of the identification of the priority health issues and planned collaborative service planning and service delivery. They indicate the commitment of CVHA member agencies to collaborative planning to meet the needs of consumers in the CVHA catchment.

The strategies identified in the operational plan recognise the importance of general practitioners in the coordination of care for consumers with chronic or complex conditions and in the delivery of population based interventions and comprehensively engage individual general practitioners and Divisions of General Practice.

CVHA is committed to the integration of Consumer, Carer and Community Participation into all levels of service planning and delivery. Consumers, carers and the community will participate in the decision-making and planning of these strategies in accordance with the implementation of the framework documented with Strategic Objective 4.

The strategies to be undertaken within this operational plan are strongly linked to and should be read in conjunction with the:

- Central Goldfields Shire Council Municipal Public Health Plan
- Central Victorian Disability Access Plan
- Loddon Campaspe Southern Mallee Community Mental Health Plan
- Macedon Ranges Shire Council Municipal Public Health Plan
- Mount Alexander Shire Council Municipal Public Health Plan

Section 3: Operational Plan
Children and Young People (includes families)

Community And Service Profile

Economic and demographic trends in the region present a core issue for young people and children:

- By 2010 24.3% of the population will be 19 years of age or less
- High levels of unemployment in the 15-24 Age Group
- A demographic "gap" among young adults.
- Shires of Central Goldfields and Mount Alexander have a higher incidence of single parent families than the rest of Loddon Mallee region and Victoria as a whole
- Issues of access to services, transport etc.
- Access to health services issues for young people (both attitudinal and structural)

Mental health issues, including substance abuse, depression, bipolar disorder and schizophrenia stand out within BoD data from 1996:

- Rates of alcohol dependency / abuse are considerable among young adult males, representing 28% of recorded prevalence.

Emerging Issues

Community and Service consultations emphasised the following:

- The limited number of preventative programs available (especially for parents with complex needs)
- Significant waiting lists for relationship and family counselling
- Commuting and impact on families/ after school care/ lack of family support
- Family violence
- Protective/risk issues
- Support for families with a disability
- Sexual health issues
- Young parenting issues
- Family stress and well-being issues
- Young people's access to services

Priorities/Gaps

1. Limited support for families with their parenting (especially young parents and parents who have a disability

2. Limited support for families experiencing family stress (Relationship counselling/ health of families/ family counselling)

3. Family isolation

4. Family violence/ child protective issues

5. Access to services

CVHA will undertake work on the following priority health issues

1. Parenting
Need for parenting support and parent education

2. Stress on the health of families
Stress on the health of families related to structural issues such as unemployment, poor transport and commuting exacerbates the need for increased provision of relationship and family counselling and other strategies to promote the health of families.

Section 3: Operational Plan
Children and Young People - Strategies

PRIORITY ISSUE: Parenting

Long Term Goal

The health and well being of parents and children in the CVHA catchment will be increased through the provision of Parenting Support and Education Programs.

Objective 1

Parents gain increased knowledge of parenting strategies through the coordinated provision of Parent Education Programs

Process:

a. Castlemaine, Cobaw, Macedon Ranges and Maryborough Community Health Services and the Shires of Macedon Ranges and Mount Alexander will coordinate and undertake parenting programmes in the CVHA catchment
b. Cobaw Community Health Service in conjunction with Mt Alexander and Maryborough District Health Service and Bendigo community Health Service will commence implementation of an Early Childhood Intervention Service in the Shires of Central Goldfields and Mount Alexander that will incorporate the provision of parent education and support. This program will build upon the existing Cobaw programme servicing the Macedon Ranges Shire

Partnerships And GP Engagement

a. Reorientation of agency service priorities to enable the implementation and coordination of parent education programmes
b. Development of parent education service delivery coordination
c. GPs will be advised via Friday faxes of the availability of parenting programmes

Service Coordination

a. Mapping of parenting programs provided by member agencies
a. Facilitation of access to parenting programs provided throughout the catchment through implementation of INI and use of the electronic service
b. Continued development of the service directory to facilitate access by provision of service information and electronic referral service directory

Integrated Health Promotion

a. Parent education programmes will incorporate community education and health information
b. Parent education programmes will be undertaken, in conjunction with community education/ social marketing campaigns

Progress

Castlemaine, Cobaw, Macedon Ranges and Maryborough Community Health Services have previously or currently run parenting support and education programmes. The implementation of the service coordination practices, processes, protocols and systems and the electronic service directory has commenced.

The Early Intervention Service to be commenced in Central Goldfields and Mount Alexander Shires will be linked to and draw upon the experience of the pre-existing Macedon Ranges Programme.

Section 3: Operational Plan
Children and Young People - Strategies

Objective 2

The ability of couples with mothers who have, or at significant risk of, post-natal depression in Macedon Ranges and Mount Alexander Shires to appropriately parent are supported through the provision of the Integrated Health Promotion – Mental Well-being Project

Process:

See Mental Health Issues – Priority Issue: Depression

PRIORITY ISSUE: Stress on the health of families

Long Term Goal

To increase the health of families in the CVHA catchment through the provision of relationship and family counselling and strategies to promote the health of families

Objective 1

Service providers will have an increase in their knowledge and ability of to work with families through the provision of workforce development in relationship and family counselling

Process:

a. Castlemaine, Cobaw, Macedon Ranges and Maryborough Community Health Services will, through the mental health networks, develop opportunities for workforce development in relationship and family counselling
b. Cobaw will provide workforce development in the training of alcohol and drug counsellors in member agencies in the provision of family centred strategies and techniques
c. Central Highlands Division of General Practice, with CVHA, will develop and undertake training for GPs on adolescent health which will include a focus on relationships and families

Partnerships And GP Engagement

a. Member agencies, including Divisions of GPs will work collaboratively to initiate and participate in workforce development
b. Reorientation of agency training priorities to develop opportunities for workforce development in relationship and family counselling

Service Coordination

CVHA will continue service coordination work on competencies and standards of practice

Integrated Health Promotion

The provision of training is a workforce development strategy

Progress

Cobaw has obtained funding for the provision of training in the provision of family centred strategies and techniques. CVHA has developed in 2001-2002 and/or supported the established Mental Health Networks in each LGA.

Section 3: Operational Plan
Children and Young People - Strategies

Objective 2

Consumers will have improved access to relationship and family counselling and to strategies that promote the health of families.

Process:

a. Castlemaine, Cobaw, Macedon Ranges and Maryborough Community Health Services will continue to provide relationship and family counselling
b. Central Highlands Division of General Practice, with CVHA, will develop and undertake training for GPs on adolescent health which will include a focus on relationships and families
c. Member agencies, through the Mental Health networks, will explore options for increasing opportunities for service provision through staff and resource sharing and through exploring options for the development of group work service provision
d. Member agencies will share information on waiting lists and barriers to service to enhance joint planning and management capacities

e. CVHA and member agencies advocate for and will seek more capacity as funding becomes available

Partnerships And GP Engagement

CVHA will engage St Lukes Anglicare, Castlemaine Family Support Program and Centacare as significant providers of family counselling in the CVHA catchment to determine eligibility, access criteria and to investigate service coordination strategies

Service Coordination

c. CVHA will continue service coordination work on Practices, Processes, Protocols and Systems, particularly for eligibility, priority and access to services
d. CVHA will continue service coordination work on Practices, Processes, Protocols and Systems, for service coordination/care planning
e. Mapping of relationship and family counselling services provided by member agencies and facilitation of access to parenting programs provided throughout the catchment through implementation of INI and use of the electronic service directory.
f. Continued development of the service directory to facilitate access by provision of service information and electronic referral service directory

Integrated Health Promotion

a. Mental health networks will be supported to enhance the capacity of agencies and service providers to promote the health of families
b. Central Highlands Division of General Practice training for GPs on adolescent health is a workforce development strategy

Progress

CVHA has commenced service coordination work on care planning and associated services planning and the electronic services directory with member providers of relationship and family counselling.

CVHA has developed in 2001-2002 and/or supported the established Mental Health Networks in each LGA.

Section 3: Operational Plan
Older People

Community And Service Profile

An ageing community is a key regional issue. The trend in ageing is marked in those areas likely to experience little or no overall population growth. By 2021 over 20% of the region's population is projected to be aged over 65 years. The proportion of people aged over 85 years is also anticipated to increase. The trend in ageing is marked in those areas likely to experience little or no overall population growth.

Emerging Issues

- In a number of urban centres within the region, particularly Castlemaine, Kyneton and Maryborough older people living alone, and with low incomes form a considerable segment of the community.
- Access to transport emerged as a critical concern within consumer and provider consultations. This is particularly evident in smaller towns where frequency and coordination of transport services are lacking.
- Lack of independent living and respite services was nominated as being an issue with both local and regional implications. While regional data exists, localised data (and in fact a sense of what is "local") appears to be deficient.

Community and Service consultations emphasised the following:

- The needs of older people living alone, and with low incomes
- Poor access to services and community activities due largely to limited transport options
- Lack of independent living and limited respite services

Priorities/Gaps

1. Isolation of older people caused by structural and physical issues
2. Lack of coordination and knowledge of respite services availability
3. Lack of independent living units
4. Access to community based services

CVHA will undertake work on the following priority health issues

1. Isolation

2. Respite Services – in home; out of home; residential
   Lack of coordination and knowledge of service availability

3. Lack of independent living units

4. Access to community based services
   Lack of knowledge of services and lack of transport

Section 3: Operational Plan
Older People - Strategies

PRIORITY ISSUE: Isolation

Goals and Objectives to meet the priority issues of isolation and access to community based services are to be read in conjunction with this issue

Long Term Goal

Older consumers in the CVHA catchment will experience less isolation and more social connectedness

Objective 1

Factors that create isolation for older people will be identified and member agencies will develop strategies to reduce the impact of those factors

Process:

Aged services networks in each LGA (include HACC; ACAS; Community Health; District Nursing; Bendigo Healthcare services, eg Carers support) will through their processes identify factors that create isolation and will:

a. Make recommendations for system changes to the CVHA Integrated Service Planning Sub-committee and to their member agencies to reduce isolation as possible
b. Make modifications to their service delivery as appropriate and possible, such as be alert to hearing impairment; develop liaison with Better Hearing Australia and local Maryborough branch of Better Hearing Australia; referral of agencies to devices for HI.
c. Advocate for systems changes and/or seek funding and resources to undertake strategies that will increase inclusion as appropriate

Partnerships And GP Engagement

a. Reorganisation of agency service delivery to enable inclusion
b. Non-member agencies will be engaged as required by the identification process

Service Coordination

Aged services networks in each LGA will through their processes identify factors that create isolation and will with support from the CVHA service coordination project worker implement service coordination responses as appropriate

Integrated Health Promotion

Integrated health promotion strategies will primarily focus on include organisational development in the undertaking of organisational and systems changes to decrease isolation and to improve access. It is likely that they will also include the provision of health information and education and possibly the undertaking of community action.

Progress

Aged and Disability Service Provider networks have strong pre-existing relationships that encompass both care planning and service planning. The Aged and Disability Service Provider networks commenced work on the service coordination aspects of service planning in 2001-2002.

Section 3: Operational Plan
Older People - Strategies

PRIORITY ISSUE: Respite services

Long Term Goal
Older people in the CVHA catchment will be supported to remain in the community

Objective 1
Consumers will have better access to respite services

Process:
a. Respite services will be mapped, and any gaps, dovetailing or duplications identified, by CVHA staff and Aged and Disability Advisory Groups with consumer, carer, community and other stakeholder consultation
b. A plan to maximise effectiveness of existing respite services will be determined by CVHA respite provider member agencies
c. Advocacy for and/or active pursuit of further respite services to meet gaps will be undertaken by member agencies individually and/or collectively

Partnerships And GP Engagement
a. Central Goldfields, Macedon Ranges and Mount Alexander Shires, Bendigo Health Care Group, Dunnolly, Kyneton and District, Maldon, Maryborough and District and Mt Alexander Hospitals will jointly plan for respite service delivery
b. CVHA will develop links to those non-member agencies that provide respite services
c. General Practitioners, via the Divisions of General Practice will be consulted on the efficacy of current respite systems and possible system modifications

Service Coordination
Practices, processes, protocols and systems for the better coordination of respite services will be developed and implemented by Respite Service Providers and the Aged and Disability Advisory Groups supported by the CVHA service coordination project worker

Avoidable Hospital Admissions
Maximising the effectiveness of existing respite services and advocacy for and/or active pursuit of further respite services to meet gaps will enable consumers with complex needs to remain at home in their communities

Progress
CVHA respite provider member agencies have strong pre-existing relationships, as do members of the Aged and Disability Advisory Groups. These relationships will provide the basis for this strategy. The Aged and Disability Advisory Groups commenced work on the service coordination aspects of service planning in 2001-2002.

Section 3: Operational Plan
Older People - Strategies

PRIORITY ISSUE: Lack of independent living units

Long Term Goal
Older people in the CVHA catchment will have access to appropriate housing within their communities

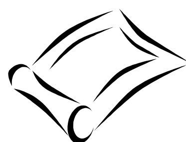
Objective 1
Consumers will have access to independent living units in the CVHA catchment

Process:
a. Opportunities to advocate for and/or actively pursue independent living units in the CVHA catchment will be pursued individually and/or collectively by member agencies. Mt Alexander Hospital is currently pursing independent living units. Macedon Ranges Housing Advisory Committee will pursue supported housing for aged and psychiatric consumers.
b. Macedon Ranges Shire Council will develop and Aged Housing Policy that will consider amongst other issues siteing, need and quality issues. They will make this strategy available for other Local Governments to utilise in their communities

Partnerships And GP Engagement
CVHA will develop strategic relationships as required by the strategy

Service Coordination
CVHA will through its service coordination work explore options for the development of mechanisms to monitor demand for independent living units

Progress
The service coordination project 2001-2002 commenced work on linking service coordination with services planning.



PRIORITY ISSUE: Access to community based services and activities

Long Term Goal
Older people in the CVHA catchment will be engaged in community based services and activities

Objective 1
Barriers to older people's access to community-based services and activities will be identified and strategies to reduce the impact of those barriers developed

Section 3: Operational Plan
Older People - Strategies

Process:

a. Castlemaine and District Community Health Service will undertake a project in the Newstead with the focus on identifying "Barriers to Mobility"
b. Existing Community Health based health promotion activities that function to reduce isolation (eg. Strength Training for Osteoporosis; Tai Chi; Heart Health; Walking Groups) will be examined for barriers to access and access facilitation strategies developed by member agencies
c. Macedon Ranges and Mount Alexander Shires, through their Community Transport Working Group, will continue to seek funds for a Mobility and Access Strategy. CVHA will work collaboratively with that group to support the planning required for its implementation
d. Aged and Disability Advisory Groups will examine older persons' barriers to access and will develop access facilitation strategies
e. Providers of community-based services will be supported in developing access friendly activities and systems by CVHA member agencies supported by the CVHA service coordination project worker.
f. Hearing and vision impairments and incontinence are major causes of isolation in older people. Rural Access will participate in information session especially in the context of health displays, expos and promotions.
g. Central Goldfields Shire will implement the Older Adults Recreation Service (Vic Health funded)
h. Central Goldfields, Macedon Ranges and Mt Alexander Shire Councils will continue to support or (re)creat social networks and through provision of activities which enhance the physical, intellectual and social well being of consumers and carers

Partnerships And GP Engagement

a. Divisions of General Practice and individual GPs will be consulted as to the older persons' access barriers they identify in their implementation of the Active Script Programme
b. Providers of community-based services will be engaged by CVHA as appropriate to meet the needs of strategy c.

Service Coordination

Practices, processes, protocols and systems that reduce barriers and facilitate access to agency based activities will be developed and implemented by CVHA member agencies supported by the CVHA service coordination project worker such as, in the case of older people with hearing impairments, make appropriate modifications to service coordination systems, such as be alert to hearing impairment; develop liaison with Better Hearing Australia and local Maryborough branch of Better Hearing Australia; referral by agencies to devices for HI.

Integrated Health Promotion

Integrated health promotion strategies will primarily focus on include organisational development in the undertaking of organisational and systems changes to improve access. It is likely that they will also include the provision of health information and education and possibly the undertaking of community action.

Progress

There are pre-existing structures for these strategies that will expedite their achievements.

Section 3: Operational Plan
Mental Health

❅This section to be read in conjunction with the Loddon Campaspe Southern Mallee Community Mental Health Plan

Community And Service Profile

The prevalence of depression, social phobia and generalised anxiety disorders is significant with the whole region, in particular among women.

Post-natal depression was raised as a key issue within community consultations and by Maternal and Child Health nurses.

Depression prevalence peaks within teenage age groups in both males and females in the region and in the 45-54 age group.

Emerging Issues

The following significant issues were raised within consultations.

- Mental health staff retention & recruitment of psychiatric nurses
- Housing issues for people with psych disabilities – lack of affordable housing with support
- No equivalent to Psychiatric Disability Support Service for young people and the over 65s
- Limited level of resources
- Lack of supportive infrastructure
- Suicide: High youth rate; High attempted rate in women; High rate in over 65s
- High depression rate in older women
- People being hospitalised out of the region
- Physical health issues for people with mental health issues often overlooked
- Mental health promotion often overlooked
- Poor mental health literacy
- Lack of step up / step down service

In smaller towns there are pockets of intense need- associated with low cost housing for:

- Carers of people with mental illness
- Isolation: Young people; Young women isolated in homes with children
- High incidence of violence
- Lack of respite
- Lack of day programs

Priorities/Gaps

1. Depression
2. Limitations of consumer access to service provision exacerbated by staff shortages, recruitment and training needs
3. Gaps in mental health literacy
4. Supported affordable housing
5. Lack of Step up /Step down programs

CVHA will undertake work on the following priority health issues

1. Depression

2. Limitations of consumer access to service provision
   These limitations are exacerbated by staff shortages, recruitment and training needs

3. Gaps in mental health literacy
   Limited mental health prevention and promotion

Section 3: Operational Plan
Mental Health - Strategies

PRIORITY ISSUE: Depression

Long Term Goal

Consumers with depression in the CVHA catchment will receive accessible and integrated support and treatment

Objective 1

People who are depressed, suicidal or deliberately self-harming will receive effective follow-up

Process:

a. All CVHA member hospitals, Community Health and Psychiatric Disability Support Services, Divisions of General Practice and individual general practitioners will work collaboratively to implement the Effective Follow-up of Suicidal and Deliberately Self-Harming Clients Project between 2002-2005
b. CVHA will participate in the Regional Implementation of the Effective Follow-up of Suicidal and Deliberately Self-Harming Clients Project
d. Central Highlands Division of General Practice will undertake workforce development on Early Detection and referral of people with depression
e. Bendigo and District Division of General Practice will implement the NHMRC Depression Guidelines for Adolescents

Partnerships And GP Engagement

a. These strategies will involve active participation of all CVHA member hospitals, community health, acute and area psychiatric and psychiatric disability support services member agencies, Divisions of General Practice and individual general practitioners. They will further require reorientation of agency service priorities to enable the implementation of the Effective Follow-up of Suicidal and Deliberately Self-Harming Clients Project
b. Strong regional relationships will be maintained to enable the regional implementation of this strategy
f. CVHA and individual member agencies will work with Central Highlands and Bendigo and District Divisions of General Practice on the Early Detection and referral of people with depression and the NHMRC Depression Guidelines for Adolescents strategies

Service Coordination

Practices, processes, protocols and systems will be developed and implemented by member agencies, supported by the CVHA service coordination project worker, to support the Central Highlands and Bendigo and District Divisions of General Practice with the Early Detection and referral of people with depression and the NHMRC Depression Guidelines for Adolescents
and the Effective Follow-up of Suicidal and Deliberately Self-Harming Clients Project with emphasis on:

a. Multi-Disciplinary Care Planning/Service Coordination
b. Initial Contact and Initial Needs Identification and referral
c. Development, refinement and implementation of electronic service directory and its referral capacity to meet the requirements of the provision of service information and provision of referral

Section 3: Operational Plan
Mental Health - Strategies

Integrated Health Promotion

These strategies will emphasise capacity building in the form of organisational and workforce development. They will also have an emphasis on the provision of health information and education.

Avoidable Hospital Admissions

These strategies ensure consumers with depression are linked into appropriate service provision should have a positive impact on the number of presentations and repeat presentations at hospitals.

Progress

Member agencies collaborated on the submission process for the Effective Follow-up of Suicidal and Deliberately Self-Harming Clients Project. A local reference group and a regional reference group has been established. This project will build on the service coordination work undertaken in 2002-2002.

Objective 2

Women who have, or are at significant risk of, post-natal depression in Macedon Ranges and Mount Alexander Shires are supported through the provision of integrated support, therapeutic and educative programs that:

a. Reduce the degree of isolation of women with, or at risk of, post natal depression

b. Reduce the rate and degree of depression of women

c. **Increase the mental health literacy of women (and their partners) with, or at risk of post natal depression**

Process:

Castlemaine and Cobaw Community Health Services, Macedon Ranges and Mount Alexander Shire Councils, the Primary Mental Health Team, St Lukes 60and Loddon Mallee Women's Health will collaboratively undertake the programme development, staffing and workforce development of the Mental Well-being – Postnatal Depression Integrated Health Promotion Project. This project, is a response to CVHA priority health issues and to Primary Mental Health Plan priorities

Partnerships And GP Engagement

a. Reorientation of agency service priorities to enable the implementation of sustainable collaborative service provision as part of core business

b. Development of collaborative service provision relationships

c. Bendigo and District, Central Highlands and West Vic Divisions of General Practice will work with CVHA to implement the service coordination and integrated health promotion strategies of this objective

Service Coordination

a. Linking the post-natal depression strategy to Initial Contact, Initial Needs Identification and Care Planning Practices Processes Protocols and Strategies.

b. Development of Practices Processes Protocols and Strategies for joint multi-agency service provision (eg. Eligibility criteria, priority of access, consumer health information collection and storage) by member agencies supported by the CVHA service coordination project worker.

c. Development of links to GPs care planning processes

d. Linking to service directory to facilitate access by provision of service information and electronic referral

Section 3: Operational Plan
Mental Health - Strategies

Integrated Health Promotion

* This strategy is a component of the 2002-2003 Integrated Health Promotion Project

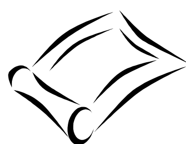
a. Development and undertaking of walking group
b. Provision of health information and social marketing
c. Capacity building – education of workers, relationships between workers
d. Development of links to Divisions of General Practices workforce development

Avoidable Hospital Admissions

The implementation of this project should reduce the need for women with post-natal depression to enter the psychiatric system

Progress

Member agencies have agreed to participate in the undertaking of this project. Service coordination work undertaken in 2001-2002 will provide a strong basis for this project.



PRIORITY ISSUE: Limitations of consumer access to service providers that are exacerbated by staff shortages, recruitment and training needs

Long Term Goal

Consumers with mental health issues in the CVHA catchment will have access to appropriately skilled service providers

Objective 1

Service providers will receive quality education and training in the early detection and treatment of depression

Process:

a. Central Highlands Division of General Practice will undertake work on the early detection and treatment of people with depression
b. The Primary Mental Health Team will provide general practitioners with access to a psychiatrist for secondary consultations
c. Member agencies and general practitioners will undertake collaborative planning and participation in the delivery of Primary Mental Health Team education and training
d. Divisions of General Practice and the CVHA will undertake education on the undertaking of multi-disciplinary care plans and the use of EPC for people with depression
e. Mental Health networks will be utilised to provide a vehicle for peer support and the sharing of knowledge and best practice
f. Mental Health networks will be utilised to provide a vehicle for consideration of systemic care planning, case management and access issues which will then be referred to CVHA and member agency planning processes
g. The implementation of the Effective Follow-up of Suicidal and Deliberately Self-Harming Clients Project will incorporate significant education and training for hospital emergency department staff, GPs and practice nurses and other service providers

Section 3: Operational Plan
Mental Health - Strategies

Partnerships And GP Engagement

a. Member agencies including Divisions of GPs and the Primary Mental Health Team will work collaboratively to initiate and participate in workforce development
d. Reorientation of agency training priorities to enable full utilisation of opportunities for education and training in the early detection and treatment of depression

Service Coordination

a. Service coordination processes will be developed that will inform the determination of education and training needs by member agencies supported by the CVHA service coordination project worker.
b. CVHA and the Primary Mental Health Team will promote and facilitate shared care arrangements between specialist mental health services and primary care providers
c. Service coordination practices, processes, protocols and systems will be refined to ensure consistent facilitation from early detection to assessment and treatment and quality care planning and service coordination by member agencies supported by the CVHA service coordination project worker.

Integrated Health Promotion

Capacity building/Workforce development

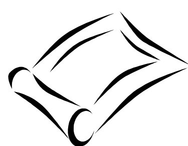
a. GPs, community health and psychiatric disability support services will participate in the training and education, provided by the Primary Mental Health Team, designed to enhance their capacity to recognise and treat mental health problems more effectively
b. Training and education will be provided as part of the Post Natal depression Integrated Health Promotion Project through joint service delivery by Maternal and Child Health nurses, community health social workers and the Primary Mental Health Team
c. Mental Health networks will provide a vehicle for peer support and the sharing of knowledge and best practice
d. Hospital Emergency Department staff and GP practice nurses will undertake training in early detection and monitoring of suicidal and deliberately self harming consumers within the Effective Follow-up of Suicidal and Deliberately Self-harming Clients of Hospital Emergency Departments Project

Avoidable Hospital Admissions

Access to appropriately skilled service providers will enable the undertaking of comprehensive and ongoing care that will decrease the need for consumers to access the acute system

Progress

Funding has been obtained for the Effective Follow-up of Suicidal and Deliberately Self-Harming Clients Project. A local reference group and a regional reference group have been established. This project will build on the service coordination work undertaken in 2002-2002.
CVHA has developed and/or supported the established Mental Health Networks that comprise staff from all providers of mental health services and community members in each LGA.
The CVHA has developed strong collaborative relationships with the Primary Mental Health Team.



Section 3: Operational Plan
Mental Health - Strategies

Objective 2
Strategies that mitigate against poor consumer access caused by staff shortages in the mental health field will be developed by CVHA

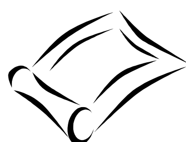
Process:
a. Member agencies will use the CVHA meeting structure and other structures to promote discussion on new, strategic and/or innovative approaches to dealing with staff shortages and recruitment issues (eg. Resource sharing, development of staff absence processes and protocols, staff exchanges)
b. CVHA will advocate for further services and member agencies, collectively or individually, will actively pursue funding opportunities as they become available.

Partnerships And GP Engagement
CVHA will develop strategic relationships as required

Service Coordination
Service coordination practices, processes, protocols and systems will be developed and implemented by member agencies supported by the CVHA service coordination project worker that ensure continuity of multi-disciplinary care planning/service coordination in times of staff shortages

Integrated Health Promotion
The major health promotion approach to be utilised within these strategies is organisational development designed to build capacity

Progress
The service coordination project 2001-2002 has commenced work on linking service coordination with services planning.



PRIORITY ISSUE: Gaps in mental health literacy – limited mental health prevention and promotion

Long Term Goal
Consumers in the CVHA catchment experience better mental health and develop an understanding of means to promote mental health

Objective 1
Consumers will receive mental health literacy, promotion and prevention education

Process:
a. In meeting Strategic Objective 3 CVHA will, in the work of developing a common health promotion vision that encompasses the whole of health continuum, include the promotion of mental health.

Section 3: Operational Plan
Mental Health - Strategies

b. Mental Health service providers (both primary care and specialist), Divisions of General Practice and community groups will participate in Mental Health Networks in each LGA to develop and implement interagency collaborations that promote mental health literacy

Partnerships And GP Engagement

a. Member agencies will develop links to community groups, other non-member service providers and state-wide and specialist agencies as required for the effective implementation of the strategy
b. General Practitioners, via the Divisions of General Practice will be consulted on the implementation of mental health literacy strategies

Service Coordination

Opportunities to incorporate mental health promotion into care planning and other service coordination processes will be facilitated by the service coordination project worker and mental health networks

Integrated Health Promotion

a. The CVHA Health Promotion-Working Group will develop a targeted focus on mental health promotion and seek to build mental health promotion aspects into all health promotion activities
b. Mental health networks will be supported to enhance the capacity of agencies and service providers to promote mental health
c. Service providers will be educated to identify mental health promotion opportunities in their core service provision and supported in their undertaking of mental health promotion
d. A resource guide for mental health literacy and promotion resources will be developed and made available to member agencies

Progress

CVHA has developed and/or supported the established Mental Health Networks that comprise staff from all providers of mental health services and community members in each LGA.

Section 3: Operational Plan
Alcohol and Drug

Community And Service Profile

Tobacco use stands out as a regional health issue, and a significant risk factor. It is considered as a significant contributor to life expectancy and health status in this area.

Alcohol dependence among males was significant in the region, particularly in age groups below 44 years (73% of all cases), while 48% of all cases were in the 15-34 age group

Recorded levels of heroin dependency (BoD 1996 and service provider consultations) were generally low.

Rate of alcohol related assault and alcohol related hospital admissions were much higher in the CVHA region than in Victoria as a whole.

Emerging Issues

The following significant issues raised within consultations.

- Perceptions of community and service providers of drug and alcohol use among young people suggest increased use and risk-taking behaviour

- Access of drug users to health services and their experience of those services – Difficulties in engaging GPs to work with people with alcohol and drug issues

- Service providers' perception of Alcohol and Drug issues and of consumers with those issues

- Dual disability

Priorities/Gaps

1. Consumer access to appropriately skilled and resourced general practitioners
   Alcohol use - Binge drinking in young people and alcohol use in adults
3. Smoking - Current limited focus on smoking and the need to put smoking back on the alcohol and drug agenda
4. Service providers perception of A & D
5. Dual disability

CVHA will undertake work on the following priority health issues

1. Consumer access to appropriately skilled and resourced general practitioners

2. Alcohol use
   Binge drinking in young people

3. Smoking
   Current limited focus on smoking and the need to put smoking back on the alcohol and drug agenda.

Section 3: Operational Plan
Alcohol and Drug - Strategies

PRIORITY ISSUE: Consumer access to appropriately skilled and resourced general practitioners

Long Term Goal
Consumers with drug and alcohol issues in the CVHA catchment will receive accessible and best practice support and treatment

Objective 1
General practitioners in the CVHA catchment will be provided with education and training opportunities that resource them to provide quality and accessible services to consumers with alcohol and drug issues

Process:
Divisions of General Practice will work collaboratively with CVHA providers of alcohol and drug services to provide education and training opportunities for general practitioners.

a. Cobaw Community Health Service will provide training to General Practitioners, in conjunction with Divisions of General Practice, in family centred strategies and techniques for working with consumers, or their families, who have drug and alcohol issues
b. Maryborough and Cobaw Community Health Services will produce and provide training for general practitioners in, a withdrawal management package
c. Central Highlands Division of General Practice will run a CME event which focuses on young people's health and EPC in its undertaking of work on early detection and referral which link to other health issues which may be associated with, or parallel to, drinking and/or other substance abuse

Partnerships And GP Engagement
Divisions of General Practice and member agencies will develop links to Loddon Southern Mallee Dual Diagnosis Service and state wide and specialist agencies as required for the effective implementation of the strategy

Service Coordination
CVHA service coordination work by member agencies, supported by the CVHA service coordination project worker, will focus on the:

1. Implementation of quality systems for Initial Needs Identification and referral
2. Monitoring, promotion and refinement of multi-disciplinary care planning/service coordination and EPC practices, processes, protocols and systems

Integrated Health Promotion
This strategies contained in objective are capacity building, workforce development strategies

Progress
Cobaw Community Health Service has obtained funds to undertake the family centred training. These strategies have been sited in the Divisions' 2002-2003 Plans.

Section 3: Operational Plan
Alcohol and Drug - Strategies

PRIORITY ISSUE: Alcohol use – binge drinking in young people

Long Term Goal

The CVHA catchment will develop a culture of responsible alcohol use

Objective 1

Young people in the CVHA catchment will be provided with alcohol use and health promotion education and activities

Process:

a. Castlemaine Community Health Service will work with the Mount Alexander Shire Youth worker in the development of an organisational youth focus
b. Castlemaine and Maryborough Community Health Services will implement the Rural Outreach Youth Diversion Program and will develop supportive peer relationships with the Rural Outreach Youth Diversion Worker at Cobaw Community Health Service
c. Macedon Ranges Shire Council, Macedon Ranges Health Service and the Central Highlands Division of General Practice will develop an Adolescent Health Clinic that will link young people into existing youth and health services and to improve the provision of health information to young people.
d. Macedon Ranges Shire Council has submitted for funds to develop an integrated shire-wide alcohol and drug strategy (incorporating safety committee- local govt, police, schools, heath services, GPs, community houses). If successful this strategy will be linked to CVHA planning processes.
e. Central Goldfields Shire Council will, through its Youth Activities and Family Liaison Service - MEFY FReeZA Committee continue to provide entertainment in safe, drug and alcohol free environments.
f. Mt Alexander Shire Council has included alcohol use in its draft youth policy (currently under development) and will undertake work as directed by this policy once it is formalised.

Partnerships And GP Engagement

a. Reorganisation of agency service delivery to enable engagement of young people
b. Development of internal processes and external agency relationships to enable integration of Rural Outreach Youth Diversion Program to service system
c. Macedon Ranges Adolescent Health Service directly links general practitioners with other health services providers in the provision of care planning and health promotion for young people

Service Coordination

a. Integration of CVHA service coordination practices, processes, protocols and systems with the requirements of ASCO-Coats will be undertaken by Castlemaine, Cobaw and Maryborough Community Health Services supported by the CVHA service coordination project worker
b. Input on service coordination practices, processes, protocols and systems from the implementation of Macedon Ranges Shire Council, Macedon Ranges Health Service and the Central Highlands Division of General Practice Adolescent Health Clinic will enable them to be modified for the youth appropriateness.

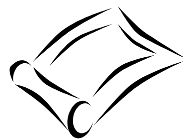
Section 3: Operational Plan
Alcohol and Drug - Strategies

Integrated Health Promotion

Health information, health education, community action and organisational development will be undertaken within this objective

Progress

Funding has been obtained and planning undertaken for the Rural Outreach Youth Diversion Program and the Adolescent Health Clinic. Castlemaine Community Health Service has developed the relationship with the Mount Alexander Shire youth worker required to implement an organisational youth focus.



PRIORITY ISSUE: Limited focus on smoking

Long Term Goal

There will be a reduction in the amount of smoking in the CVHA catchment

Objective 1

There will be an increased focus on community education programs that are linked to QUIT, and other smoking cessation programs/strategies

Process:

a. Castlemaine, Cobaw, Macedon Ranges and Maryborough Community Health Services will promote and undertake innovative delivery of QUIT programmes
b. Kyneton District Health Service, Maryborough District Health Service and Mt Alexander Hospitals will continue to have a focus on smoking for pregnant women attending their ante-natal classes
c. Mt Alexander Hospital will implement a smoke free policy for its whole site

Partnerships And GP Engagement

a. Castlemaine, Cobaw, Macedon Ranges and Maryborough Community Health Services will enhance the community education programs aspect of their smoking cessation programs/strategies in their program planning.
b. General practitioners will be informed of smoking community education programmes and of planned undertaking of QUIT, and other smoking cessation programs/strategies by member agencies and the Divisions of General Practice via Friday faxes.

Service Coordination

The refinement of service coordination practices, processes, protocols and systems by member agencies, supported by the CVHA service coordination project worker, will:

a. Incorporate the facilitation of links between smoking health promotion activities and QUIT, and other smoking cessation programs/strategies

Section 3: Operational Plan
Alcohol and Drug - Strategies

b. Facilitate referral to QUIT, and other smoking cessation programs/strategies undertaken by member agencies, particularly by general practitioners

Catchment wide access to these programmes will be facilitated by the implementation of the electronic services directory

Integrated Health Promotion

QUIT programs will be offered in conjunction with a health information provision, community education and social marketing programme

Avoidable Hospital Admissions

Smoking is a risk factor for cardiovascular disease, diabetes and chronic obstructive pulmonary disease. A reduction in smoking will have an impact on avoidable hospital admissions

Progress

Castlemaine, Cobaw, Macedon Ranges and Maryborough Community Health Services currently offer QUIT programmes and are therefore have a good basis for their community education enhancements. CVHA have commenced implementation of the electronic services directory.

Section 3: Operational Plan
DisAbility

❄This section to be read in conjunction with the Central Victorian Disability Access Plan

Community and Service Profile

Estimates for 1998 suggest that 19.4% of the population of the CVHA catchment can be classified as having a disability.

6% of the population is estimated to have a profound or severe disability

6% is estimated to have a mild disability.

1.5% of the population were estimated to have schooling/employment restrictions

The majority of disabilities were physical (14.84% of the population and 76% of all disabilities)

2.23% of the population was estimated to have a sensory disability.

Emerging Issues

Consultations raised issues of:

- Access
- The need for age-appropriate respite care
- Housing Issues – the impact of deinstitutionalisation, of Office of Housing practices and policies, the lack of residential or respite care for younger people with a disability
- Parenting issues for parents with an intellectual disability
- Limited access to recreational activities
- Fragmented and insufficient case management
- The value in investigating some day programs, that are not sheltered workshops, for people who won't fit the mainstream
- ABI – service response

Priorities/Gaps

1. Limited access to meaningful activities
2. Lack of specialist services for consumers with complex behaviours and the need to up skill service providers to work with people with complex needs
3. Limited access to local and accessible case management and case management funds for people with disabilities
4. Limitations of respite services
5. Limitations of parenting support for people with disabilities

CVHA will undertake work on the following priority health issues

1. Limited access to meaningful activities

2. Limited access to local and accessible case management and case management funds for people with disabilities

Section 3: Operational Plan
DisAbility - Strategies

PRIORITY ISSUE: Limited access to meaningful activities

Long Term Goal

Consumers with disabilities in the CVHA catchment will be connected to their communities and experience optimal health and well-being

Objective 1

Barriers to physical access as well as to information about activities and existing community programs, for consumers with disabilities in the CVHA catchment will be identified and strategies to minimise those barriers and to develop new activities will be developed.

Process:

a. CVHA member agencies will support the work of Central Victoria Rural Access including the pending Central Victoria Rural Access survey work in:
   - youth:(services presently available for young people with disabilities, and the gaps in such services)
   - the hearing-impaired,
   - scooter travel routes
   - disability parking

b. Macedon Ranges and Mount Alexander Shires, through their Community Transport Working Group, will continue to seek funds for a Mobility and Access Strategy. CVHA will work collaboratively with that group to support the planning required for its implementation

c. Macedon Ranges Shire Council will develop a Disability Advisory Committee to Council and will commence a 5 year program of disability access audits. The results of these audits will be linked into CVHA planning processes.

d. All member agencies will respond to access issues raised by Central Victoria Rural Access, consumer/carer, and community and service provider consultation and utilise the results in making their own programs more accessible both through the CVHA Integrated Service Planning sub-committee and individual agency responses.

e. Planning links to, and advocacy with, non-member agencies will be undertaken as required to meet access barriers

Partnerships And GP Engagement

The implementation of this strategy requires CVHA member agencies to work collaboratively with Central Victoria Rural Access and other non-member agencies as required. Member agencies will respond to access issues by reorienting their service delivery as possible to increase access.

Service Coordination

a. CVHA service coordination sub-committee, in conjunction with disability support services, will examine the need for the development of better pathways to allied health and other support services and implement the required systems changes.

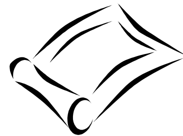
b. CVHA service coordination project worker will support Central Victoria Rural Access in working with member agencies in developing systems that recognise the situation faced by hearing-impaired people in utilising health services

Section 3: Operational Plan
DisAbility - Strategies

Integrated Health Promotion

a. CVHA Health Promotion sub-committee will incorporate recognition of barriers to access in the planning and implementation of both CVHA-wide and agency based health promotion activities.
b. As physical health issues are often neglected in the provision of community activities and services the Health Promotion working group will examine the opportunities for coordinating with disability services in the undertaking of health promotion strategies.
c. Rural Access will support the development of access groups in the shires of Mount Alexander and Central Goldfields, (there is a pre-existing group Macedon Ranges) plus other disability-related groups as may form from time to time, for example groups of users of motorised scooters. Such groups may have elements of self-help, advocacy and social participation, depending on the wishes and needs of participants.

Progress
Central Victoria Rural Access is located in all 3 CVHA local government areas and has strong links to local government planning processes. The Disability Access worker is a member of the CVHA Planning Sub-committee and therefore has immediate input into CVHA planning processes.



PRIORITY ISSUE: Limited access to case management for people with disabilities

Long Term Goal
Consumers with disabilities in the CVHA catchment will be supported in attaining and maintaining their health and well being.

Objective 1
Consumers with disabilities will be provided with support in their housing and in their access to case management

Process:
a. Consumers with disabilities will be supported in their access to, and maintenance of, safe affordable housing
   i. CVHA will identify barriers to safe affordable housing for consumers with disabilities through its, and member agencies' planning processes and will develop service delivery strategies to mitigate against those barriers
   ii. Consumers will be facilitated in their knowledge of and access advocacy services by member agencies
b. Improved access to case management for consumers with disabilities will be supported by:

Section 3: Operational Plan
DisAbility - Strategies

i. CVHA member agencies will monitor unmet need for case management through service coordination care planning processes and will input that information into CVHA planning processes
ii. Opportunities to advocate for and/or actively pursue case management for people with disabilities in the CVHA catchment will be pursued individually and/or collectively by member agencies

Partnerships And GP Engagement

a. As access to suitable housing is an issue for many people with a disability CVHA member agencies will develop service coordination and planning links with supported accommodation providers
b. St Lukes Consumer and Tenancy Service will be engaged in the promotion of advocacy

Service Coordination

a. CVHA will develop practices, processes, protocols and systems between supported accommodation providers, local government, and community health and disability services to ensure better Initial Needs Identification, referral and service coordination for consumers with disabilities.
b. The capabilities of service coordination systems to inform planning of consumer's with disabilities access to case management will be investigated and links to planning processes developed.

Integrated Health Promotion

St Lukes Consumer and Tenancy Service, Cobaw Community Health Service – SAAP and Maryborough District Health Service – SAAP will provide disability support services and other member agencies that work with consumers with disabilities with information on housing opportunities, rights and advocacy avenues

Progress

Cobaw, Macedon Ranges and Maryborough community health services auspice or house SAAP services, St Lukes has a Consumer and Tenancy service. This provides a basis for the development of links between housing and disability support services. The service coordination project 2001-2002 has commenced work on linking service coordination with services planning.

Section 3: Hospital Emergency Demand

Community And Service Profile

Data on ambulatory care sensitive conditions such as hypertension, angina, cardiac failure and chronic obstructive pulmonary disease reveal that the CVHA region is characterised by much lower rates of admissions than the Loddon Mallee region. The CVHA data is close to state averages.

For example:

- Rates of admission (3.46 per 1000) for angina in the CVHA region were lower than the Loddon-Mallee region as a whole, and slightly above the State average. This is probably due to a protocol which requires patients are treated and then referred on (to Bendigo and other larger hospitals)

- Rates of admission for congestive cardiac failure are lower than the state average, and significantly lower than those in the Loddon Mallee region - probably due to a series of programs that have had a dramatic impact on readmission rates

The CVHA region exhibits above-average admission rates for diabetes complications, asthma and the combined influenza and pneumococcal pneumonia dataset. Everyone admitted for an acute admission receives an emergency management plan and an ongoing management plan

Transport, services, facilities and the relationship between hospitals in the CVHA region and those in other areas require further investigation

Priorities/Gaps

1. Above-average admission rates for diabetes complications, asthma and the combined influenza and pneumococcal pneumonia dataset

2. Transport, services, facilities and the relationship between hospitals and primary care providers in the CVHA region

CVHA will undertake work on the following priority health issues

1. The need to develop better primary and acute liaison

2. Cardiovascular disease

3. Diabetes

4. Chronic Obstructive Pulmonary Disease

Section 3: Hospital Emergency Demand Strategies

PRIORITY ISSUE: The need to develop better primary and acute liaison

Long Term Goal

Consumers will experience seamless multi-agency (acute and primary) service provision and will not experience avoidable hospital admissions

Objective 1

Hospital discharge systems will incorporate referral pathways to and multi-agency service coordination systems with primary care providers

Process:

a. Central Highlands Division of General Practice will undertake with Kyneton and District and Mt Alexander hospitals, Macedon Ranges and Mount Alexander Shire Councils, Cobaw, Macedon Ranges, Castlemaine District Health Services a project to build upon existing Effective Discharge Programmes practices, processes, protocols and systems
b. The implementation of the Effective Follow-up of Suicidal and Deliberately Self-Harming Clients Project (see Mental Health Issues)
c. Active participation in the development and implementation of the Regional Information Management Plan
d. Development of Cardiovascular Health Pathway (see Priority Issue 2)
e. Implementation of Diabetes Management and Prevention Project (see Priority Issue 3)
f. Review of Chronic Obstructive Pulmonary Disease Protocol (see Priority Issue 4)

Partnerships And GP Engagement

a. Member agencies will develop processes to enable acute/primary participation in hospital discharge systems.
b. General Practitioners will be engaged in the development and implementation of the discharge system
c. Regional relationships will be further developed in the development and implementation of the Regional Information Management Plan
g. Cardiovascular Health Pathway (see Priority Issue 2)
d. Diabetes Management and Prevention Project (see Priority Issue 3)
e. Chronic Obstructive Pulmonary Disease Protocol (see Priority Issue 4)

Service Coordination

CVHA service coordination work by member agencies, supported by the CVHA service coordination project worker, will focus on the:

a. Development and documentation discharge practices, processes, protocols and systems
b. Development and implementation of any tools required to facilitate discharge systems
c. Implementation of quality systems for Initial Needs Identification and referral
d. Monitoring, promotion and refinement of multi-disciplinary care planning/service coordination and EPC practices, processes, protocols and systems

Integrated Health Promotion

The type, content and provision of health promotion to be integrated into these projects will be determined through the projects. This work will consider:

Section 3: Hospital Emergency Demand Strategies

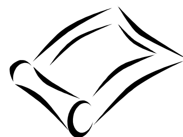
a. Provision of health information and health education
b. Capacity Building:
   Development of collaborative working relationships between hospitals, GPs, practice staff and other service providers
   Collaborative workforce development as possible and as required
c. Undertaking of organisational development to build environments supportive of cardiovascular health

Avoidable Hospital Admissions

The development of seamless multi-agency (acute and primary) service provision and will limit the number of avoidable hospital re-admissions

Progress

a. Central Highlands Division of General Practice and Kyneton and District and Mt Alexander Hospitals have reached an agreement to undertake the hospital discharge project.
b. Macedon Ranges and Mount Alexander Shire Councils, Cobaw, Macedon Ranges, Castlemaine District Health Services have agreed to participate in the hospital discharge project.
c. Cardiovascular Health Pathway (see Priority Issue 2)
d. Diabetes Management and Prevention Project (see Priority Issue 3)
e. Chronic Obstructive Pulmonary Disease Protocol (see Priority Issue 4)
f. Community health and Central Goldfields Shire HACC service are currently involved in the Maryborough District Health Service Discharge Planning meetings and this provides a strong basis for further work on acute/primary interface.



PRIORITY ISSUE: Cardiovascular Disease

Long Term Goal

Consumers in the CVHA catchment will experience cardiovascular health

Objective 1

Member agencies will undertake best practice cardiovascular health strategies across the whole of health continuum that are targeted to at risk populations

Process:

Central Highlands Division of General Practice, Cobaw and Macecdon Ranges Community Health Services, Macedon Ranges Shire Council and CVHA staff will develop a cardiovascular health pathway in Macedon Ranges Shire that encompasses primary prevention through early detection to care planning and discharge processes.

Section 3: Hospital Emergency Demand Strategies

The cardiovascular health pathway will be developed in conjunction with the asthma and diabetes projects enabling the development of common service coordination and integrated health promotion practices, processes, protocols and systems as appropriate.
CVHA service coordination and health promotion sub-committees will ensure the development of service coordination and integrated health promotion practices, processes, protocols and systems is consistent with the CVHA model and will explore the possibilities of facilitating expansion of the developed pathway across the catchment

Member agencies will also:

a. The 4 Community Health Services, 3 hospitals and general practitioners will continue to undertake Heart Health Programmes, screenings and cardiac rehabilitation programmes
b. Develop and implement a focus on the risk factor preventative strategy - physical activity
   Existing health promotion activities that function to reduce isolation (eg. Strength Training for Osteoporosis; Tai Chi; Heart Health; Walking Groups) will be examined for barriers to access and access facilitation strategies developed by member agencies
c. Develop and implement a focus on the risk factor preventative strategy smoking (see Alcohol and Drug - Smoking strategy)
d. Through the Health Promotion Working Group, Community Health Services and Divisions of General Practice will continue the implementation and review of the Heart Smart Kit, commenced in 2001-2002
e. Through the Health Promotion Working Group, will remain cognisant of, and utilise, best practice in heart health promotion and cardiovascular disease prevention
f. Continue collaborative work to engage hard to reach consumers
g. Macedon Ranges Shire Council will continue implementation of its Shire wide Bicycle Strategy and its Leisure Strategy to support physical activity in the Shire
h. Central Goldfields Shire will continue to implement its Recreation Strategy Plan to support physical activity in the Shire

Partnerships And GP Engagement

a. Central Highlands Division of General Practice, Cobaw and Macedon Ranges Community Health Services, Macedon Ranges Shire Council and CVHA staff will engage individual general practitioners, consumers and carers and other service providers and stakeholders in the development and implementation of the cardiovascular health pathway.
b. Central Highlands Division of General Practice and member agencies will engage individual general practitioners, consumers and carers and other service providers and stakeholders in the review and the development and implementation of the cardiovascular pathway.
c. The development of functional systemic relationships with general practices and general practitioners
d. Reorientation of agency service priorities and individual practice methods as appropriate to enable the implementation of sustainable collaborative service provision as part of core business

Service Coordination

CVHA service coordination work by member agencies, supported by the CVHA service coordination project worker, will focus on the:

e. Development and documentation of cardiovascular health pathway
f. Development and implementation of any tools required to facilitate the cardiovascular health pathway
g. Implementation of quality systems for Initial Needs Identification and referral

Section 3: Hospital Emergency Demand Strategies

h. Monitoring, promotion and refinement of multi-disciplinary care planning/service coordination and EPC practices, processes, protocols and systems
i. Service coordination work will be undertaken to ensure integration of the Heart Smart Kit into service coordination INI and referral practices, processes, protocols and systems.

Integrated Health Promotion

- Many of the health promotion strategies are common to and supportive of the cardiovascular disease, diabetes and Chronic Obstructive Pulmonary Disease projects

In meeting Strategic Objective 3 CVHA will, in the work of developing a common health promotion vision that encompasses the whole of health continuum, include the integration of cardiovascular health promotion from primary prevention through early detection to care planning and discharge processes.

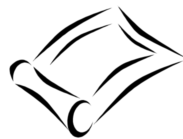
a) Provision of health information and health education to be included in pathway
b) Provision of screening and risk assessment
c) Provision of social marketing
d) Capacity Building:
   Development of collaborative working relationships between GPs, practice staff and other service providers
   Collaborative workforce development as possible and as required
e) Undertaking of organisational development to build environments supportive of cardiovascular health

Avoidable Hospital Admissions

Avoidable hospital admissions will be reduced by the integration of comprehensive management, primary prevention and early detection of Cardiovascular Disease strategies

Progress

This project builds on the 2001-2002 CVHA Cardiovascular Health – Health Promotion Project, the 2001-2002 CVHA Service Coordination work and the pre-existing work of member agencies. An agreement has been reached with Central Highlands Division of General Practice to undertake the project.



PRIORITY ISSUE: Diabetes

Long Term Goal

Consumers in the CVHA catchment with diabetes will experience best health and a reduced incidence of diabetes complications

Objective 1

Consumers with diabetes will receive comprehensive health information, education and care planning

Section 3: Hospital Emergency Demand Strategies

Process:

CVHA will implement year 1(of 3) of the From the Individual to the Population and Back Again- Diabetes Management and Prevention - An Integrated Approach Project.

Community Health Services, hospitals and general practitioners will, with the facilitation of the Divisions of General Practice and CVHA staff, develop diabetes management and care planning practices, processes, protocols and systems with a focus on the complications of retinopathy, renal complications and hypertension.

Strategies will include the development of mini clinics (utilising staff from a number of member agencies), retinopathy screenings and the development of a systematised focus on the management of the risk factors for diabetes complications.

CVHA service coordination and health promotion sub-committees will ensure the development of service coordination and integrated health promotion practices, processes, protocols and systems is consistent with the CVHA model.

This project will in years 2 and 3 focus on primary prevention and early detection allowing CVHA to implement a fully integrated diabetes prevention and management approach.

Member agencies will also:

a. The 4 Community Health Services, 3 hospitals and general practitioners will continue to undertake diabetes screening, education and prevention programmes
b. Develop and implement a focus on the risk factor preventative strategy - physical activity
   Existing health promotion activities that function to reduce isolation (eg. Strength Training; Tai Chi; Heart Health; Walking Groups) will be examined for barriers to access and access facilitation strategies developed by member agencies
c. Develop and implement a focus on the risk factor preventative strategy smoking (see Alcohol and Drug - Smoking strategy)
d. Macedon Ranges Shire Council will continue implementation of its Shire wide Bicycle Strategy and its Leisure Strategy to support physical activity in the Shire
e. Central Goldfields Shire will continue to implement its Recreation Strategy Plan to support physical activity in the Shire

Partnerships And GP Engagement

a. CVHA member agencies and staff will engage individual general practitioners, consumers and carers and other service providers and stakeholders in the development and implementation of the diabetes project.
b. Reorientation of agency service priorities and individual practice methods as appropriate to enable the implementation of sustainable collaborative service provision as part of core business
c. The development of functional systemic relationships with general practices and general practitioners

Service Coordination

CVHA service coordination work by member agencies, supported by the CVHA service coordination project worker, will focus on the:

Section 3: Hospital Emergency Demand Strategies

a. Development and documentation of diabetes care planning practices, processes, protocols and systems
b. Development and implementation of any tools required to facilitate diabetes care planning
c. Implementation of quality systems for Initial Needs Identification and referral
d. Monitoring, promotion and refinement of multi-disciplinary care planning/service coordination and EPC practices, processes, protocols and systems

Integrated Health Promotion

- Many of the health promotion strategies are common to and supportive of the cardiovascular disease, diabetes and Chronic Obstructive Pulmonary Disease projects

In meeting Strategic Objective 3 CVHA will, in the work of developing a common health promotion vision that encompasses the whole of health continuum, include the integration of diabetes health promotion from primary prevention through early detection to care planning and discharge processes.

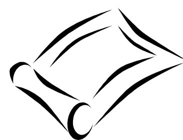
a. Provision of health information and health education particularly in relation to prevention and minimisation of complications of retinopathy, renal complications and hypertension
b. Provision of social marketing
c. Capacity Building:
   Development of collaborative working relationships between GPs, practice staff and other service providers
   Collaborative workforce development as possible and as required

Avoidable Hospital Admissions

Avoidable hospital admissions will be reduced by the provision of comprehensive care planning and integrated health promotion to reduce diabetes complications. Work to be undertaken in years 2 and 3 to integrate comprehensive management with primary prevention and early detection will further reduce avoidable hospital admissions

Progress

Funding has been obtained from Public Health - Diabetes Prevention and Management Initiative, Local Diabetes Service Development Program to undertake this project. Member Divisions of General Practice, hospitals and community health services collaborated in the development of the submission and are committed to its undertaking.



PRIORITY ISSUE: Chronic Obstructive Pulmonary Disease

Long Term Goal

Consumers in the CVHA catchment with Chronic Obstructive Pulmonary Disease will experience better health status

Section 3: Hospital Emergency Demand Strategies

Objective 1

Consumers with asthma will receive comprehensive health information, education and care planning

Process:

a. West Vic Division of General Practice, Maryborough District Health Service and CVHA staff will undertake a review of the current central Goldfields asthma protocol to incorporate the asthma pathways from primary prevention through early detection to care planning and discharge processes and the requirements of privacy legislation and the Asthma 3+ Plan.
b. Asthma pathway to be developed in conjunction with the cardiovascular disease and diabetes projects enabling the development of common service coordination and integrated health promotion practices, processes, protocols and systems as appropriate.
c. CVHA service coordination and health promotion sub-committees will ensure the development of service coordination and integrated health promotion practices, processes, protocols and systems is consistent with the CVHA model and will explore the possibilities of facilitating expansion of the developed protocol across the catchment

Member agencies will also:

a. 4 Community Health Services will continue to undertake Asthma Education Programmes
b. Develop and implement a focus on the risk factor preventative strategy - physical activity
   Existing health promotion activities that function to reduce isolation (eg. Strength Training; Tai Chi; Heart Health; Walking Groups) will be examined for barriers to access and access facilitation strategies developed by member agencies
c. Develop and implement a focus on the risk factor preventative strategy smoking (see Alcohol and Drug - Smoking strategy)
d. Macedon Ranges Shire Council will continue implementation of its Shire wide Bicycle Strategy and its Leisure Strategy to support physical activity in the Shire
e. Central Goldfields Shire will continue to implement its Recreation Strategy Plan to support physical activity in the Shire

Partnerships And GP Engagement

a. West Vic Division of General Practice and Maryborough District Health Service will engage individual general practitioners, consumers and carers and other service providers and stakeholders in the review and the development and implementation of the asthma project.
b. Reorientation of agency service priorities and individual practice methods as appropriate to enable the implementation of sustainable collaborative service provision as part of core business
c. The development of functional systemic relationships with general practices and general practitioners

Service Coordination

CVHA service coordination work by member agencies, supported by the CVHA service coordination project worker, will focus on the:

a. Development and documentation of asthma pathways
b. Development and implementation of any tools required to facilitate the asthma pathway
c. Implementation of quality systems for Initial Needs Identification and referral
d. Monitoring, promotion and refinement of multi-disciplinary care planning/service coordination and EPC practices, processes, protocols and systems

Section 3: Hospital Emergency Demand Strategies

Integrated Health Promotion

- Many of the health promotion strategies are common to and supportive of the cardiovascular disease, diabetes and Chronic Obstructive Pulmonary Disease projects

In meeting Strategic Objective 3 CVHA will, in the work of developing a common health promotion vision that encompasses the whole of health continuum, include the integration of Chronic Obstructive Pulmonary Disease health promotion from primary prevention through early detection to care planning and discharge processes.

a. Provision of health information and health education to be included in pathway
b. Provision of social marketing
c. Capacity Building:
d. Development of collaborative working relationships between GPs, practice staff and other service providers
e. Collaborative workforce development as possible and as required

Avoidable Hospital Admissions

Avoidable hospital admissions will be reduced by the integration of comprehensive management, primary prevention and early detection of Chronic Obstructive Pulmonary Disease strategies

Progress

The pre-existing Asthma Protocol that will be the basis for this project includes the Maryborough and District Hospital (includes Community Health), general practitioners and the ambulance service. Agreements have been reached with West Vic Division of General Practice to undertake the project.
This project builds on the 2001-2002 CVHA Service Coordination work and the pre-existing work of member agencies.
This project builds on the current Federal Government's Asthma 3+ Initiative.

Section 3: Other Issues

Community And Service Profile

Significant issues that emerge relate strongly to the capacity of the region's communities to address a range of issues including access, equity and socio-economic growth.

The socio-economic status of the communities within the CVHA region, while reflecting the comparative disadvantage of regional Victoria as a whole is distinctive and magnified.

While this is less noticeable in those communities of the Macedon Ranges that form part of exurban Melbourne, communities including Castlemaine and Maryborough are noted for their significant comparative disadvantage.

- GP Access – out of hours/ bulk billing/ attraction and retention
- Carer support
- Road safety
- Shortage of emergency relief

Growth of structural issues such as unemployment, poverty, affordable housing (includes office of housing practices – placing disadvantaged people in areas with few services, "block" housing)

Key elements of disadvantage that require consideration include:

- Impacts of an ageing population and future priorities for service delivery,
- Structural change in rural areas and other changes to employment options, especially for young people
- Environmental change, including land and water management and the socio-economic impacts of response to these challenges
- Housing accessibility and affordability, especially in communities increasingly influenced by commuter growth (and consequently by metropolitan property trends)
- Gambling
- Limited local transport

Priorities/Gaps

1. Lack of social connectedness -Physical, psychological and structural barriers to social connectedness
2. Housing - Lack of affordable housing and areas of low cost housing coupled with limited public infrastructure
3. Lack of local transport
4. GP Access – out of hours/ bulk billing/ attraction and retention
5. Limited carer support

CVHA will undertake work on the following priority health issues

1. Lack of social connectedness
   Physical, psychological and structural barriers to social connectedness

2. Housing
   Lack of affordable housing and areas of low cost housing coupled with limited public infrastructure

6. Lack of local transport

Section 3: Other Issues Strategies

PRIORITY ISSUE: Lack of social connectedness

Long Term Goal
Consumers in the CVHA catchment will be connected to significant others and/or to their community

Objective 1
Barriers to social connectedness will be identified and strategies implemented to increase connectedness

Process See:
Children and Young People:	Priority issue - Parenting: Objective 1
	Priority issue - Stress on the health of families: Objective 2
Older People:	Priority issue - Isolation: Objective 1
	Priority issue - Access to community based activities: Objective 1
Mental Health:	Priority issue - Depression: Objectives 1&2
Alcohol and Drug:	Priority issue - Alcohol: Objective 1
DisAbility:	Priority issue - Limited access to meaningful activities: Objective 1
Hospital Emergency Demand	Priority issue - Cardiovascular Disease
	Priority Issue – Diabetes
	Priority Issue – Chronic Obstructive Pulmonary Disease

Objective 2
To increase the sense of social connectedness in the Central Goldfields Shire through community participation in the production of a Wellness Guide

Process:
CVHA will continue work commenced in 2001-2002 on the production of a (Better Living) wellness guide in Central Goldfields Shire

Partnerships And GP Engagement
The reference group for this project includes Maryborough District Health Service – Community Health and Outreach Nursing, St Lukes – Psychiatric Disability Support, Central Goldfields Shire, RITCH programme, Maryborough Community House, Wattle Human Services, Community Information Centre and a community representative. Other agencies, community groups and members are being engaged in the strategy as required to meet its goals

Integrated Health Promotion
See rural health promotion project 2002 – 2003 (attachment 2)

Progress
This strategy was commenced in 2001 – 2002 as a rural health promotion project. A reference group has been established and focus groups commenced. The evaluation process to measure changes in community connectedness has commenced.
Mental health networks have been established in the other local government areas to facilitate possible future undertaking of similar projects.

Section 3 – Other Issues Strategies

PRIORITY ISSUE: Housing

Long Term Goal

Consumers in the CVHA catchment will not be disadvantaged in their health status by their housing

Objective 1

Health and well-being programmes will be made available to consumers who are disadvantaged in their health status by their housing

Process:

a. Castlemaine and District Community Health Service will offer group work programmes in smaller towns
b. The RITCH program will continue to undertake health and well-being programmes to consumers living in small towns in Central Goldfields Shire
c. CVHA member agencies will consider the target population or individual for any activity or service and will identify any barriers they have to access caused by their housing and will link this information into CVHA and agency planning strategies for the development of strategies to minimize those barriers
d. Member agencies will continue to work collaboratively with the Community Connections Programme and SAAP programmes to meet the needs of at risk consumers with housing issues.

Partnerships And GP Engagement

a. Castlemaine and District Community Health Service will reorient agency service priorities and delivery methods as appropriate to enable the implementation of accessible service provision as part of agency core business
b. Loddon Mallee Transitional Housing's Community Connections Programme worker is a member of the Service Coordination Sub-committee

Service Coordination

Information management and other service coordination practices, processes, protocols and systems will be monitored and refined for their applicability to service delivery outside of major service centres and to maximising access for consumers with housing issues

Integrated Health Promotion

Health promotion strategies undertaken by member agencies will be reviewed for barriers to access for people with housing issues and access facilitation strategies developed by member agencies.

Progress

Cobaw, Macedon Ranges and Maryborough community health services auspice or house SAAP services. This provides a basis for the identification of barriers to access and the formulation of strategies to improve access. The service coordination project 2002-2002 has commenced work on linking service coordination with services planning.

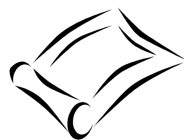
Section 3 – Other Issues Strategies

Objective 2
Structural disadvantages to consumer's health status caused by their housing will be addressed.

Process:
Opportunities to mitigate against structural disadvantage by advocating for and/or actively pursuing improved housing in the CVHA catchment will be pursued individually and/or collectively by member agencies

Integrated Health Promotion
Organisational development and community action opportunities will be undertaken by, or supported by, CVHA and member agencies wherever possible to create an environment supportive good health through an improvement in consumer's housing status

Progress
The service coordination project 2001-2002 has commenced work on linking service coordination with services planning.



PRIORITY ISSUE: Lack of local transport

Long Term Goal
Consumers in the CVHA catchment will not be disadvantaged in their health status by lack of local transport

Objective 1
Consumers will have improved access to local transport.

Process:
a. Opportunities to advocate for and/or actively pursue improved local transport in the CVHA catchment will be pursued individually and/or collectively by member agencies
b. Macedon Ranges and Mount Alexander Shires, through their Community Transport Working Group, will continue to seek to improve consumer's health status by improving their access to local transport.
c. Central Goldfields member agencies will support the work of the Strengthening Goldfields - Transport Project and other proposed or formative strategies

Partnerships And GP Engagement
CVHA and member agencies will develop strategic partnerships to improve consumer's access to local transport as is opportune and appropriate.

Section 3 – Other Issues
Strategies

Service Coordination
The capabilities of service coordination systems to inform planning of consumer health disadvantage caused by lack of local transport will be investigated.

Integrated Health Promotion
Organisational development opportunities will be undertaken by CVHA and member agencies wherever possible to create an environment supportive good health through an improvement in local transport wherever possible

Progress
Macedon Ranges and Mount Alexander Shires Community Transport Working Group and the Strengthening Goldfields Project are already undertaking work to improve consumer's access to local transport.