Frankston Mornington Peninsula

Primary Care Partnership

Community Health Plan

2004 - 2006

2004–2006 COMMUNITY HEALTH PLAN

The Frankston Mornington Peninsula Primary Care Partnership (FMPPCP) was established as a partnership of local primary care providers and has 28 members - with a number of other agencies that link in as appropriate. The FMPPCP is managed by an Implementation Committee with representation from Local Government, Community Health, Women's Health, Disability Sector, Home Nursing, General Practice and other community providers. The FMPCP is not exclusive of membership or participation and recognises the value of collaboration among planners and service providers in order to maximise the best possible outcomes for our community. A secretariat including an executive officer and specialist support staff is responsible for the day to day operation of the PCP.

The FMPPCP has worked in collaboration with the Frankston City Council and Mornington Peninsula Shire Council to develop a common planning framework and data set for public health and well being. This has ensured that our Community Health Plan is consistent and supportive of local goals and needs.

A major focus for the PCP is to work towards an electronic information and referral system that will also allow sharing of client information, subject to privacy issues and informed consent. Special projects around health promotion, consumer participation and service advocacy based on local needs are also being undertaken.

The FMP PCP has been funded by the DHS to develop and implement a Community Health Plan (CHP). This Plan builds on the previous years' community health plan (FMPPCP CHP 2003-2004).

1. The Context

Community Profile

The FMP PCP comprises two local government municipalities, Frankston City and Mornington Peninsula Shire referred to as the 'sub-region'. The sub-region comprises the City of Frankston, with a population of 114,506 residents in 2001, and the Mornington Peninsula Shire with a population of 132,716 residents in 2001[1]. The sub-region is broadly characterised by a younger population in Frankston City and an older population in the Mornington Peninsula Shire with a number of socio-economic issues impacting on the health and well-being of residents, including, early school leavers, low incomes, and smaller numbers of people with formal qualifications.

Social disadvantage resulting from socio-economic factors has been identified by the study *Unequal in Life*[2], which provides a postcode map of social disadvantage by using ten indicators of disadvantage. The Frankston and Mornington Peninsula areas have four out of thirty postcodes with the highest disadvantage factors' scores. They are, Hastings, Frankston North, Rosebud West, and Rye. It is suggested that these communities are more likely to have a reduced quality of life, particularly in relation to mental health and social connectedness.

Topography of the Mornington Peninsula is such that some communities are relatively isolated and there are significantly lower proportions of its population who do not speak English well, or not at all, compared with Melbourne. An indigenous community is also present and local government, and agencies continue their efforts in meeting the community's needs.

A large number of issues impacting on the health and well-being of residents have been identified[3] including physical health, mental health, social and environmental issues. Risk factors include characteristics that increase the probability of death or disease.

The major risk factors in the sub-region in descending order are:

1. Tobacco
2. Physical inactivity
3. High blood pressure
4. Alcohol harm
5. Obesity
6. Low fruit and vegetable intake
7. High blood cholesterol
8. Illicit drugs
9. Occupation
10. Unsafe sex

According to the Southern Metropolitan Burden of Disease Study: Mortality & Morbidity data, West Frankston and the Southern area of Mornington Peninsula are rated at 2 and 1 respectively in terms of the highest degrees of disadvantage[4]. The highest number of premature deaths and disability for both men and women in

[1] Community Health Plan Data Sets, DHS, Feb. 2004

[2] Vinson, T, 1999. 'Unequal in Life: The Distribution of Social Disadvantage in Victoria & New South Wales', The Ignatius Centre for Social Policy & Research.

[3] op cit CHP Data Sets

[4] DHS, Southern Health Care Network

the sub-region are associated with cardio-vascular disease and cancer respectively. Mental disorders, chronic respiratory diseases, and neurological and sense disorders respectively, also feature highly compared with the Victorian average. Non-communicable diseases are the main causes of deaths and disability followed by a much lower percentage of injuries and communicable, maternal, neo-natal, and nutritional causes respectively.

Broad issues impacting on service access have also been identified and include transport, location of services and facilities and (cultural) responsiveness of services to particular target groups. Specific issues affecting target groups such as women, people with disabilities, indigenous residents and people from culturally and linguistically diverse backgrounds, have also been emphasised by individual agencies.

Burden of Disease data indicates that for many health issues a number of target groups are affected, e.g. cardiovascular disease affects older people as well as younger adults. This makes it difficult to determine how to present information, i.e. discussing target group needs separate to issues, or integrating target group needs within issues discussion - particularly since many agencies are funded to provide services to particular target groups and therefore seek presentations that reflect this.

Structural issues in health and community services impact significantly on the health and well-being of the residents and both local councils, as well as individual agencies have individually and collectively identified problems and strategies for addressing these which are reported in documents such as municipal health plans.

Social Model of Health

Of significant importance in the development of approaches to health and well-being issues has been the application of the Social Model of Health framework, which is increasingly under-pinning how health and well-being issues are conceptualised and responded to.

Local councils and individual agencies have implemented many community consultation activities gauging residents' understandings, attitudes, aspirations and expectations on both specific and broad health and well-being issues. These have been meaningfully used to address community needs. On-going work is required, however, to ensure that residents are informed of services and programs, and of care pathways. The development and delivery of information in appropriate formats is a resource intensive task that must be recognised as a necessary component of service delivery.

Strategic Objectives 2002 - 2006

Since 2002 the strategic objectives for the FMP PCP have been to:

1. Enhance relationships and improve com-munication between service providers including the acute and community care sector
2. Implement a readily accessible and coord-inated access and information system for members and the community
3. Enhance health promotion and early inter-vention strategies
4. Implement an effective health planning process
5. Develop a coordinated response to funding opportunities
6. Implement a marketing strategy for the partnership and member agencies
7. Establish an evaluation process for all PCP initiatives.

FMPPCP Priorities 2004 - 2006

In February 2004 the Implementation Committee of the FMPPCP held a half day strategic planning workshop in which the following priorities were established:

1. **Better Health Goals**
    - Chronic Illness Priorities- CVD, Diabetes, Cancer
    - Mental Health Priorities - Social Connectedness, Community Mental Health Plan, Primary Mental Health Strategy
    - Alcohol & Drugs
    - Community Participation
2. All PCP Partner Agencies have a single Seamless Access System (SAS)
3. Agreement for a Single Planning framework across the sub-region
4. Coordinated Approach/ Priorities for Plann-ed Health Promotion across PCP agencies

The overall strategic directions for the Partnership were identified at the planning workshop as shown in the table below:

Strategic Directions for FMPPCP 2004 - 2006

	Coordinating, shaping, community building	Service Co-ordination	Population Health	PRIORITIES	Brainstorm: Activities
Potential activities	A platform for linking, coordination and shaping Communication Future acute/sub-acute (eg HARP) Recognition that this involvement is resource intensive for some agencies	GP implementation of SC (local) (high priority) Acute, sub-acute links (high priority) Training (regional & local) Protocols (regional) E-referral/information technology (high priority) tech PKI registration (local) Local service directory: low priority give statewide service directory work	Planning outcomes CHP Time investment Leverage off others	**1. <u>Better Health Goals</u>** • **Chronic Illness Priorities- CVD, Diabetes, Cancer** • **Mental Health Priorities - Social Connectedness** • **Alcohol & Drugs** • **Community Participation**	**Actively seek opportunities to partner acute sector in HARP Projects, Integrated Disease Management, etc.** **Utilise evidence based best practice framework: Lorig Chronic Disease SM Model, Flinders Tool**
Comment	Good management overall is fundamental to an effective PCP. The activities listed are primarily an EO role. In light of the policy context, some capacity should be retained for future `positioning' and `platform' functions as they evolve, and for unknown items	There is an inconsistency between the messages in relation to these tasks and the resources available. $250,000 is needed to implement this however the PCP budget across these 3 priority areas is only $100,000. Given this, as much of the limited resource pool as is available will be allocated to this area. Resources should be targeted to ensure minimal for management and maximum for operational delivery for this priority.	This has largely been achieved by the FMP PCP. In light of the latest PCP DHS documents this appears to be a reduced role with a lower priority than in the past, and not specifically resourced. Minimal activity will occur in this area if it is not funded – the PCP will rely on MHP and leverage off other plans.	**2. All PCP Partner Agencies have a single Seamless Access System (SAS)** **3. Agreement for a Single Planning Framework across the Sub-Region**	**Commitment by PCP members/partners to participate in SAS:** • **Universal use of SCOT Tool:** • **engagement, training & support** • **Technical support** • **Development of referral protocols:** • **Between general practice, primary health, sub-acute and acute sectors (includes referral, feedback, cross referral)** • **Audit and monitor actual uptake of tools by agencies** • **Development of the sub-regional Service Directory and partner agency web pages** **Development of a common planning framework across local government:** **Single database** **Identify key evidence based public health issues in Municipal Health Plans**
Resource Allo-cation	45% 5% Unknown	45%	5%	**4. Coordinated Approach/Priori-ties for Planned Health Promo-tion across PCP agencies**	**H.P. priorities to link to Better Health Goals priorities**

SERVICE COORDINATION

The FMP PCP developed the Seamless Access System (SAS) as its change management response to the Better Access to Services component of PCP development.

This SAS model was developed following extensive agency consultation through a variety of forums including agency workshops, individual agency interviews and focus groups, consumer consultation and survey and consultation with GPs. The SAS model is essentially one of multiple points of entry to a single system. The SAS provides a consumer focused and integrated primary care system that ensures people have ease of access to quality services and information.

The model is underpinned by a Services Directory, which has a Services Gateway component. The primary goal of the Services Gateway is to facilitate the Seamless Access System, in the following ways:

- Service Coordination Tool Templates (SCTTs): The Gateway will contain an electronic version of the SCTTs, which can be encrypted, attached to e-mails and then directed to another SAS agency/organisation with similar privacy protection.
- Electronic Referral & Feedback: The gateway has a built in business logic, which maps and facilitates the referral and feedback loop initiated by the Needs Identification process.
- Information Packs: The proposed gateway has the ability to conduct intensive information searches around specific diseases/conditions. This includes: information about the disease/condition itself, information about self-management, information about related health promotion activities and projects, and services/programs designed to address the particular disease or condition.

The Services Gateway is a shared initiative across two PCPs in the Southern Metropolitan Region (FMPPCP and Kingston Bayside PCP). It operates in conjunction with the statewide Health Services Directory.

During the last two financial years pilots were conducted, testing the pathways, processes, protocols that form the Seamless Access System.

Following successful completion of these trials the Partnership's Service Coordination Working Groups made a strong recommendation to the Implementation Committee to implement the Seamless Access System across the Frankston Mornington Primary Care Partnership in order facilitate the changes in business practices in participating organisations that would enable the SAS system to become part of their core business. This recommendation was adopted and forms a major objective of the current community health plan.

Support for Priority Human Service Agencies

In 2003 the Partnership's Implementation Committee (IC) took a 2-staged approach to implementation of the three elements of service coordination. The IC is composed, by and large of those larger agencies (shown in bold below) that have been participating in trials and early implementation strategies. They decided to lead by example, implementing service coordination as fast as possible in their own agencies, and then invited the remaining member agencies to follow suit. The column on the right uses the 1-4 'implementation stage' scoring used in the CHPIA template.

Agency	Stage
Brotherhood of St Laurence	**4**
Frankston City Council	**3**
Lang Park Medical Clinic	**3**
Menzies Inc	**2**
Morn. Pen. Shire Council	**1**
Peninsula Community Health Service	**3**
Peninsula Health: Acute	
Frankston Community Health Centre	**2**
Integrated Care Program: (Acute)	**4**
Mt Eliza ACAS	**2**
Peninsula Complex Care Program	**1**
RAD Team (Acute)	**4**
RAPCS	**3**
RDNS	**4**
South Central Migrant Resource Centre	**1**
Bunarong Aboriginal Health Service	2
Do Care – Southern	1
Peninsula Hospice Service	2
Peninsula Support Service	3
South East CASA	4
Southern Peninsula Community Care	4
Vision Australia: Southern	4

These agencies identified above are the priority agencies that the Partnership will support in relation to the three elements of service coordination. As can be seen from the table, a number of these agencies are well advanced in the implementation process.

Partnerships: Hospital Admission Risk Program

In 2001/2 the Alcohol and Drug/Self Harm, Diabetes and Chronic Cardiac Failure HARP projects were funded and established through Peninsula Health.

Towards the end of 2003 the (Peninsula Health) Peninsula Complex Care Program was funded. It is currently in the establishment phase of development. FMPPCP has been highly involved, first as a member of the small group who wrote the successful submission for funding and then as a member of the Steering Committee for this project.

The Complex Care Program is a project funded under auspices of the Department of Human Services (DHS) Hospital Admission Risk Program (HARP) which specifically targets consumers who have chronic and/or complex health needs and are frequent users of emergency and acute hospital services. Peninsula Health has other disease management models funded through the DHS HARP initiative (mentioned above). These programs are currently being incorporated under the new Peninsula Complex Care Program. All of the Peninsula HARP projects aim to reduce unnecessary hospital admissions and emergency presentations by improving the quality of life and coordination of services for the identified population.

At the current time workers are being employed in the following roles

Project Officer commenced on 27/09/2004;

Community D&A Liaison commencing on 4/10/04;

CHF Case Manager commencing on 18/10/04;

Complex Care Coordinator commencing on 25/10/04;

Complex Care Coordinator commencing on 25/10/04 and

Complex Care Coordinator commencing on 25/10/04.

FMPPCP as a Platform for Human Services in Sub-Region

One of the foundation values of the FMPPCP has been a commitment to ensuring service coordination linkages with multi-catchment, specialist and other relevant providers. The inclusive nature of the partnership has ensured that agencies that are not formally members are welcome to participate in partnership activities, consultations and planning forums and work groups.

In August 2004 the Partnership's Memorandum of Understanding was revised to broaden the scope of membership to include all areas of human services funded by DHS. Accordingly the size of the Implementation Committee was increased from 10 members to 12 to allow it the opportunity to co-opt up to 4 organisations on to the Committee. Menzies Inc has recently been co-opted to the Implementation Committee as an initial step in this objectivity. This broadening of the PCP membership reflects the DHS Strategic Directions for 2004-6.

Engagement of General Practice

Engagement of general practitioners and the Divisions of General Practice in the FMP PCP is crucial for effective population health planning and for integrated primary health care service delivery. General practitioners and the Divisions of General Practice play a critical role in the successful development of Primary Care Partnerships (PCPs). The cultural and structural separateness of general practitioners from other primary care providers can hinder effective communication and restrict GP involvement in the wider service system.

The Practice Incentives Program, the Enhanced Primary Care Package, and a range of collaborative projects and programs are promoting greater integration between GPs and other providers of primary care, and promoting greater integration between the acute and primary care sectors

The Mornington Peninsula Division of General Practice (MPDGP) and individual General Practitioners have maintained active involvement within all levels of the PCP.
Specific examples of successful GP engagement include:

- Representation of MPDGP on the FMP PCP Implementation Committee
- Participation of MPDGP in FMP PCP Working Groups, including service coordination and health promotion.
- Participation of general practitioners in the Seamless Access System trials.
- Participation of GPs in focus groups for the development of the local service directory.
- Discussion with the MPDGP in relation to the utilisation of EPC items as a platform for broader engagement of GPs.
- Successful submission by MPDGP and FMP PCP together, for a DHS small grant to enhance service coordination between general practice and primary health care services
- Successful submission for a second DHS small grant to develop a feedback loop between primary care agencies and general practice.
- Participation of the MPDGP in the development of HARP submissions.
- The MPDGP identifies participation in the FMP PCP within the division's strategic plan.

Service Coordination Goals 2004-2006

The FMPPCP has been activity engaged in developing a Business Plan to cover the 2004-6 period in an effort to achieve its goals within the limitations of the current financial environment. This business plan is shown below. The Health Promotion section of this plan is shown as a separate plan, utilising the template required by DHS for the current Community Health Plan.

DEVELOPMENT & PLANNING PRIORITY: Management of the Frankston Mornington Peninsula Primary Care Partnership (FMP PCP), an alliance of 28 primary health care agencies.

Objective 1: Develop and implement a (Community Health) Plan for the overall strategic direction of the Partnership.

Strategies	Tasks	KPIs	Respon-sibility	Resources	J UNE 04	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	JANUARY 05	FEBRUARY	MARCH	APRIL	MAY	JUNE 05	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	JANUARY 06	FEBRUARY	MAY	APRIL	MARCH	JUNE 06
Assist the Implementation Committee to consult, plan, implement and report on the Partnership's Community Health Plan (CHP).	Strategic planning Develop a business plan to set priorities for achievable outcomes for the community health plan for 2004 - 2006 Consultation, production and implementation of FMPPCPs Community Health Plan 2004 - 2006 Annual reporting via CHPIA	Plan reflects Partnerships' priorities, concerns and requirements of its member agencies Priorities established with business plan for their achievement CHP 2004 - 2006 implemented CHP reported on to DHS using CHPIA template	Implemen-tation Committee portfolio holder (IC PF holder) Executive Officer	FMPPCP member agencies Implemen-tation Committee PCP Secretariat																									
Develop/maintain an appropriate governance framework to support PCP strategies	Assist the Implementation Committee to direct, monitor and evaluate the Committee's working groups: Service Coordination IM/IT Focus Group(s) Health Promotion	Review of the PCPs Memorandum of Understanding Working groups operating effectively PCP members are actively engaged in working groups																											
Implement the business (community health) plan	Initiate projects that will deliver the outcomes identified in the CHP Running an effective secretariat	Outcomes delivered in an effective and timely way Project outcomes evaluated	IC PF holder PCP Secretariat																										
To fulfil the responsibility of Implementation Committee members in relation to the goals of the business plan	Implementation Committee members to take on portfolios focussed on the goals of the business plan, e.g., health promotion, service coordination, IM/IT, GP engagement.	Responsibility for work shared amongst committee members PCP Secretariat would be responsible to each portfolio holder for the relevant area of work																											

PLANNING & DEVELOPMENT PRIORITY: Management of the Frankston Mornington Peninsula Primary Care Partnership (FMP PCP), a voluntary alliance of 28 primary health care agencies.

OBJECTIVE 3: To adopt a consistent approach to strategic development with other Primary Care Partnerships across Victoria

Strategies	Tasks	KPIs	Responsibility	Resources	J UNE 04	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	JANUARY 05	FEBRUARY	MARCH	APRIL	MAY	JUNE 05	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	JANUARY 06	FEBRUARY	MAY	APRIL	MARCH	JUNE 06
Consider statewide objectives in the context of local priorities	Participate in Statewide PCP Network	Up to date knowledge of statewide strategies	IC PF holder EO,	Time																									
MOU reflects statewide vision in the context of local priorities	Participate in statewide activities that are consistent with business plan	F MPPCP achieves statewide objectives																											
	Broaden the membership of the PCP to include all human services sectors	Revised MOU to increase size of IC to 12 member agencies	IC	Time																									

Objective 4: To keep members informed of progress and issues of relevance to the PCP

Strategies	Tasks	KPIs	Responsibility	Resources	J UNE 04	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	JANUARY 05	FEBRUARY	MARCH	APRIL	MAY	JUNE 05	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	JANUARY 06	FEBRUARY	MAY	APRIL	MARCH	JUNE 06
Develop a 'communication action plan' to maintain the flow of information and communication between all participants in the Primary Care Partnership strategy.	To run meetings, workshops, forums etc and to regularly inform members on progress and outcomes from these activities	Minutes/notes of meetings sent to MOU agencies, including: IC; HPA; GP Project; SC W/group, Statewide networks	IC PF holder PCP Secretariat	Minutes of meetings Catering																									
	To attend meetings with sector colleagues and DHS																												

OBJECTIVE 5: Development of a common planning framework across local government and the Primary Care Partnership

Strategies	Tasks	KPIs	Responsibility	Resources	J UNE 04	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	JANUARY 05	FEBRUARY	MARCH	APRIL	MAY	JUNE 05	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	JANUARY 06	FEBRUARY	MAY	APRIL	MARCH	JUNE 06
Identify health and well-being needs. Set priorities. Develop strategies Implement (and evaluate effectiveness of) planning	Utilise the PCP Integrated Service Planning interim guidelines as developed by DHS	Implementation of a common planning framework for FMPPCP	PCP member agencies	Time Expertise																									

SERVICE COORDINATION PRIORITY: All FMP PCP member agencies to have a single Seamless Access System

OBJECTIVE 1: Commitment by FMPPCP members/partners to participate in the Seamless Access System in their agencies

Strategies	Tasks	KPIs	Respon-sibility	Resources	JUNE 04	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	JANUARY 05	FEBRUARY	MARCH	APRIL	MAY	JUNE 05	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	JANUARY 06	FEBRUARY	MAY	APRIL	MARCH	JUNE 06
Support the ongoing uptake of SCTTs by PCP member agencies across various service sectors and DHS program areas as mandated and negotiated by DHS	Develop process for ongoing monitoring of use of SCTTs for service coordination between member agencies	Number of member agencies taking up SCTT tools (hard copy/electronic)	IC PF holder Member agency mana-gers/ PCP Secre-tariat	Time IT functio n-ality																									
	Support workforce development for new staff and orientation processes, including planned DHS self-learning module																												
	Introduce use of hard copy/electronic SCTT tools for service coordination with other SAS member agencies																												
	Member agencies to work together to develop common electronic pathways for service coordination	E-pathways identified																											
	Build e-referral policies, processes, procedures and systems into their agencies business practices	PPPs (including electronic version) documented and protocol signed off																											
Develop regional approach to primary care reform, maintaining local focus.	Work with Southern Region PCP network to develop common referral protocol	Protocol developed supports region wide e-referral of SCTTs	IC PF holder; PCP Secre-tariat	Time																									
	Monitor ICT roll-out by attending Regional ICT Governance Group	Virtual private network for service coordination in Southern Region		ICT funding																									
Develop/maintain focus on statewide PCP strategy	Attend meetings of the Statewide PCP Chairs & Project Managers Network	Meetings attended minutes distributed Reporting on activities/ of Statewide Network at IC meetings		Time Petrol																									

SERVICE COORDINATION PRIORITY: All FMP PCP member agencies to have a single Seamless Access System

OBJECTIVE 2: Implementation of e-Referral component of Seamless Access System

Strategies	Tasks	KPIs	Responsibility	Res-ources	J UNE04	JULY	AUGUST	SEPT	OCT	NOV	DEC	JANUARY 05	FEB	MARCH	APRIL	MAY	JUNE 05	JULY	AUGUST	SEPT	OCTOBER	NOV	DEC	JAN 06	FEB	MAY	APRIL	MARCH	JUNE 06
Member agencies implement e-referral technology	Identify agencies that are e-ready	E-ref agencies/GP practices identified	IC PF holder PCP Office, GP Division	Time Exper-tise																									
	Assist identified agencies in installing, testing and rolling out e-referral IT in identified agencies	E-referral IT operational	Agencies, IT, (PCP Office)																										
	Develop PCP interagency e-referral protocol	Protocol developed and agreed	Agencies (PCP Office)																										
	Develop business processes to support e-referral	Processes developed	Agencies (PCP Office)																										
	Conduct trial and evaluate service coordination outcomes	Post implementation report	Agencies (PCP Office)																										
	Project management activities	Project management plan; implementation on schedule	PCP Office, agencies																										
Pilot PH (Post Acute Care) to GP/PCP agency messaging capability using PKI technology	Develop pilot initiation plan (scope, objectives)	Pilot initiation plan, business case	Governance body																										
	Identify agency/ P/ outpatient transaction pathways and (e-ready) participants	E-ref ready participants identified	GP Division, PCP Office																										
	Engage participants and stakeholders	OPS, agencies and IT approval and commitment	Governance body																										
	Develop overall pilot plan and next stage plan for sign-off	Pilot plan and next stage plan; sign-off	PCP Office, Governance body																										
	Implement pilot plan (using stage approach)	Implementation milestones met	Agencies, PCP Office, governance body																										
	Post implementation review	PIR report	Governance																										

	Roll-out to all agencies (reiteration of above	Roll-out recommendation	body, FMP IC PF holder
Lead development of SM Regional Group E-Ref Strategy	Review local, regional and state-wide e-ref strategies	FMPPCP e-referral strategy	PCP Office, FMP Implementation Committee
	Develop and articulate e-referral strategy consistent with FMPPCP/KBPCP service coordination goals		
	Input to regional consultative and strategic group regarding preferred e-ref method		
Develop e-referral best practice approaches to GP – Primary Care feedback processes (GP Feedback Project)	Identify e-ref ready GP practices (Langpark Medical Practice)	GP practice(s) identified PCP agencies identified	PCP Office, GP Division
	Map linkages to PCP agencies (PH ACAS, RDNS)	Linkages mapped	GP Division, agencies
	Identify common pathway/feed-back loop between participating agencies	Pathways identified	PCP Office
	Support implementation of PKI in GP practices	Implementation of pathways/IT complete	
	Collaborate with GP Division in developing	Protocol developed and agreed	GP Division, agencies
	Write up evaluation using GPDV/DHS template	Evaluation report submitted	PCP Office, and all above
Roll out GP/primary care e-referral and feedback pathways to all FMPPCP member agencies	Engage e-referral ready GPs as extension of GP Feedback Project	Roll out and engagement plan	GP Division
	Identify agencies (via E-Referral Transaction Matrix) interacting with GPs as candidate participants	Agencies/practices identified in staged approach	GP Division, PCP Office, agencies
	Roll-out e-referral implementation as per member agency and GP plans above.	E-referral capability and processes successful	
	Conduct post-implementation review	PIR submitted	PCP Office
Involve PH (HARP) Complex Care Programs in SAS	Facilitate entry into SAS via implementation of SCTT for service coordination	PCCP workers using SCTTs for service coordination with PCP member agencies	IC PF holder PCCP Manager PCP Executive Officer

	Facilitate entry into SAS via implementation of e-referral for service coordination	PCCP workers using e-referral for service coordination with PCP member agencies	
	Facilitate entry into SAS via implementation of SAS e-referral protocols	PCCP workers using SAS e-referral protocol for service coordination with PCP member agencies	

OBJECTIVE 3: Development of the sub-regional Health & Community Services Gateway and partner agency web pages

Strategies	Tasks	KPIs	Responsibility	Resources	J UNE04	JULY	AUGUST	SEPT	OCT	NOV	DEC	JANUARY 05	FEB	MARCH	APRIL	MAY	JUNE 05	JULY	AUGUST	SEPT	OCTOBER	NOV	DEC	JAN 06	FEB	MAY	APRIL	MARCH	JUNE 06
Develop a management content and website support strategy for the Gateway	Load and maintain content on FMPPCP on Gateway	PCP secretariat Functional user group Link to repository	IC PF holder IM/IT Project Mana-ger	Time Exper-tise Fund-ing																									
	Formation of a PCP website user group to develop policies and procedures for content management																												
	Develop/provide link to central repository on Gateway																												
Engage member agencies to implement the web strategy	Develop a marketing strategy to promote the services gateway To sign up member agencies to take out a web page on the Gateway	Uptake of agency web pages on Gateway A marketing strategy																											
Develop information package functionality on Gateway	Identify costs/benefits/risks associated with information package functionality	A feasibility report																											
	Develop metadata local search engine, combined with statewide services directory	Seamless local and statewide search engine																											
	Develop service coordination 'information packages'	Developed information packages																											
A central repository of e-referrals to improve service coordination	Explore options for central repository	An options report																											
	Implement identified central repository solution	A functional central repository																											
Facilitate implementation of e-messaging standards	Support member agencies to transmit electronic SCTTs between backend databases	E-referrals can made seamlessly between databases																											

SERVICE COORDINATION PRIORITY: All FMP PCP member agencies to have a single Seamless Access System

OBJECTIVE 4: To participate in the (Southern) Regional Governance Group's roll-out of Growing Victoria Infrastructure ICT connectivity

Strategies	Tasks	KPIs	Responsibility	Res-ources	J UNE04	JULY	AUGUST	SEPT	OCT	NOV	DEC	JANUARY 05	FEB	MARCH	APRIL	MAY	JUNE 05	JULY	AUGUST	SEPT	OCTOBER	NOV	DEC	JAN 06	FEB	MAY	APRIL	MARCH	JUNE 06
To represent our member agencies on ICT matters relevant to them	To participate in the Regional Governance Group and the Metropolitan ICT Steering Committee	Effective representation and assistance provided	IC PF holder PCP Secre-tariat	Time																									
	To participate with other Southern Region PCPs in running an ICT information forum for agencies designated for ICT connectivity	Meetings attended and minutes distributed																											
	To assist agencies designated to receive connectivity decide what form of connectivity would suit their financial and business systems best																												
	To assist member agencies to receive connectivity																												
	To explore 'connectivity' opportunities for interested member agencies who have not so far been designated for connectivity																												

FMPPCP HEALTH PROMOTION PLAN

PCP name: Frankston Mornington Peninsula Primary Care Partnership

Integrated Service Planning:

The Frankston Mornington Peninsula Primary Care Partnership Community Health Plan 2002-2003, was developed through a process of consultation, agency surveys, questionnaires and data analysis. The FMPPCP has reviewed and refined the Community Profile into a user-friendly document. The Community Profile incorporates a broad range of demographic, social and health data that influence health and well being on the sub-region.

The FMPPCP has strengthened its formal linkages with local planning groups as well as its commitment to an integrated approach to health promotion planning.

The Health Promotion Alliance (HPA) considers that it is working together at the cooperative stage of health promotion planning. The HPA representatives of their agencies/organisations have decided to work together on an integrated approach to the common health promotion priorities of community connectedness, physical activity and capacity building. The planning processes reflect individual agency/organisation resource allocation. Over the last few years a high level of trust has developed between Alliance partners.

Health Promotion

The Health Promotion Alliance was originally formed during 1992. The HPA was expanded in 2002 following two well-attended Health Promotion Network Meetings. The intention of the network was to share information and increase the capacity of agencies in the area to undertake health promotion work. The information shared at these meetings covered social connectedness and health promoting work environments.

The Frankston Mornington Peninsula Health Promotion Alliance continues to meet on a monthly basis during the year. One of the strategic directions for 2001/2002 was to strengthen the health promotion alliance and during the year the membership of the health promotion alliance was increased. During 2002/3 this strengthening developed into a commitment by members to:

- fund one or two major projects rather than a variety of small projects which are difficult to evaluate, and to
- actively take on the health promotion work of the Alliance, rather than delegating it to a health promotion officer.

In September 2003 a Health Promotion Officer was appointed but she regretfully resigned in February 2004. Since that time the Health Promotion Officer role has been carried out by the FMPPCP Executive Officer.

The health promotion officer role within the PCP has been re-defined – to *assist* the Alliance in its planning and project activities and to report on these activities to DHS.

During 2004 – 2006 the Alliance plans to conduct two integrated projects, one related to the PCP's Community Based Foothold on Safety Project funded by the Department of Human Services. The other project will implement the Advocacy, Leadership, Community Participation program[5] developed by North Central Metro PCP

Health Promotion - Mission Statement

Health promotion activities and planning will be enhanced by collaboration, with coordinated health promotion initiatives being complemented and strengthened through the sharing of knowledge, skills and resources (FMP PCP, 2000/2001).

Health Promotion Vision

To promote the health of the community of Frankston and Mornington Peninsula by collectively responding to the health promotion priority issues and increasing the capacity of member agencies of the FMP PCP to undertake health promotion.

Shared Values Underpinning Health Promotion Strategy

The health promotion strategy for 2004/2006 continues the framework of operating within a social model of health. This was demonstrated in 2003/2004 by addressing one of the social determinants of health in social support[6].

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[5] (A training program published May 2004, for health consumers and carers to develop skills in advocacy and community participation.)

[6] Stansfeld, 1999

The framework acknowledges and incorporates both the Ottawa Charter (WHO, 1986) and Jakarta Declaration (WHO, 1997) on health promotion. The framework incorporates the principles from the Ottawa Charter and Jarkarta Declaration by addressing causes of ill health at different levels and in different ways such as working towards healthy working and living environments and policies that protect health. A gendered approach is taken towards ensuring that priorities of reorienting the health service and securing an infrastructure for health promotion are acted upon in this work of coordinated planning for health promotion. The strategies employed are aimed at initiating and consolidating partnerships for the purposes of promoting the health of the community. It is the goal of this PCP that any people or groups that are supposed to benefit from any project/intervention are properly consulted and involved at all stages of the project/initiative.

Health Promotion Priority Issues

In May 2004 a half-day workshop was held by the Alliance to plan its priorities for the 2004-2006 Community Health Plan. The Workshop was facilitated by Melissa Yong, DHS SMR Regional Health Promotion Officer. The Workshop established the following priorities.

Community Connectedness

The integrated service plan identified the important health concerns of the area. In Frankston, the three top disease categories according to the DALY measure were cardiovascular disease, cancer and mental disorders. In Mornington Peninsula the three top disease categories according to the DALY measure were cardiovascular disease, cancer, and neurological and sense disorders. 'Mental disorders' was fourth accounting for 10% of the total disease burden.

The most common mental disorders in both Frankston and Mornington Peninsula were depression and drug and alcohol abuse. The different pattern for the Mornington Peninsula relative to State averages reflects the higher number of older people living in this region.

As identified in the community health plan (CHP) there are a significantly higher percentage of older people living in the Mornington Peninsula area relative to the Melbourne metropolitan area and Southern Metropolitan Region. The CHP also included diabetes as a priority issue given its link with cardiovascular disease and the high admission rate for diabetes complications in the Frankston area.

Cardiovascular disease, diabetes, depression, and drug and alcohol problems all share common risk and protective factors. Increased social activity has been related to a decrease in risk of all cause mortality[7]. Higher levels of social support have been related to decreased incidence of depression[8], and decreased risk of cardiovascular disease[9].

A review of 81 studies found strong evidence linking social support with cardiovascular, endocrine and immune function. It was concluded that social support has a very important role in preventing some of the leading causes of death in cardiovascular disease, cancer and respiratory illnesses[10]. The review also examined studies that concentrated on older populations with a meta-analysis of seven studies finding a significant relationship between decreased social support and poorer immune function. Research has also shown that social support can predict age related differences in blood pressure with individuals higher in social support having lower and more comparable blood pressure across the lifespan. It was argued that social support may influence the aging process with higher levels of social support slowing the biological aging process.

Large scale adolescent studies have found that family connectedness and school connectedness were powerful protective factors against problem behaviours such as drug use and emotional problems[11] . A project conducted in Victoria consulted with teenagers on what they thought were important aspects for their health and well-being. Feeling loved and supported by family was rated as the most important protective factor with communication the key to good family relationships[12]. The importance of connection with family and school is evident from a number of reports. Summary documents of risk and protective factors for depression, and for other teenage health problems such as drug use and crime, all list family and community connection as protective factors[13] .

Physical Activity

High levels of overweight and obesity (60.7% of Victorians) and high levels of depression in our community (depression is the fourth leading medical cause of disability in the Australian community)[14] require landmark programs and responses such as those tobacco control managed 20 years ago. In

[7] Berkman & Syme, 1979; Glass, de Leon, Marotolli, & Berkman, 1999; House, Robbins, & Metzner, 1982; Kaplan, Salonen, Cohen, Brand, Syme, & Puska, 1988
[8] Hays et al., 1998; Hraba, Lorenz, & Pechacova, 1997
[9] Hemingway & Marmot, 1999
[10] Uchino, Cacioppo, & Kiecolt-Glaser, 1996
[11] Resnick, Harris, & Blum, 1993; Resnick et al., 1997
[12] Fuller, McGraw, & Goodyear, 1998
[13] Commonwealth Department of Health and Aged Care, 1998; Public Health Division, 2000
[14] VicHealth Strategic Directions 2003-2006, p2

conjunction with the Vic Health Strategic Plan, the FMPPCP Health Promotion Alliance is committed to contributing to creating social, cultural and physical environments that will enable individuals to choose and sustain healthy lifestyles.

The lack of physical activity is a major underlying cause of death, disease, and disability. Preliminary data from a WHO study on risk factors[15] suggest that inactivity is one of the 10 leading global causes of death and disability. More than two million deaths each year are attributable to physical inactivity. In countries around the world between 60% and 85% of adults are simply not active enough to benefit their health.

Capacity Building

Why focus on building capacity?[16]

There are a number of important reasons for the health system to focus on capacity building.

These include:

- Multiplying health gains

A focus on capacity building will increase the likelihood that other people and organisations within health and other sectors will also be able to promote health. This will multiply health gains many times over.

- Visibility

A focus on capacity building increases the recognition given to the diverse efforts of practitioners working with others to take on and sustain programs. It gives a 'name' to a large portion of work carried out by practitioners in developing effective programs.

- Accountability

One of the difficulties of working 'invisibly' is that practitioners are not readily accountable for this part of their work. Similarly, managers have lacked clear guidelines for assessing the quality of work purporting to build capacity for health promotion.

- Responsive systems

Capacity building involves a focus on the processes that support change within and between organisations. It leads to systems which value critical problem solving and leadership across organisations. Responsive systems are more likely to work in partnership to address health challenges.

This is in contrast to a 'silo' approach where organisations may be working on similar problems in isolation from each other.

- Address inequity

There is increasing evidence that poorer health is linked to the conditions that arise out of inequity and social exclusion. Capacity building is promoted across government as a mechanism for addressing inequity and building stronger communities through increasing community and civic participation.

- Unifying theme

The language of capacity building is not owned by any one sector and therefore provides a unifying theme under which government departments and other organisations can work together to address inequities.

- Reorientation of health services

This is one of the main strategies advanced in the Ottawa Charter for Health Promotion. The message is that along with treating ill health, health services need also to take greater responsibility for improving the health of the communities they serve.

Health Promotion Project Goal

To improve social and physical activity opportunities for those at risk of social exclusion in the Frankston and Mornington Peninsula area. In doing so to promote quality of life and reduce the risk of cardiovascular disease, diabetes, mental health problems, and alcohol and drug problems.

Health Promotion Alliance Memorandum of Understanding

The aim of the Alliance is to improve the health and wellbeing of the Frankston and Mornington Peninsula communities through the delivery of integrated and collaborative health promotion programs. Its objectives are:

The objectives for the Alliance are:

1. To develop and implement a strategic framework to facilitate integrated health promotion,
2. To increase the number and scope of collab-orative health promotion activities,
3. To increase the capacity of member organis-ations to conduct integrated, collaborative health promotion programs.

[15] Global strategy on diet, physical activity and health, 57th World Health Assembly, A57/9, 17 April 2004
[16] A Framework for Building Capacity to Improve Health, NSW Health, March 2001

HEALTH PROMOTION PLANNING GRID

Priority 1: Community Connectedness

Priority Goal:	**To improve community health and reduce the burden of disease through community connectedness**				
Objective 1:	To increase the participation of 15 community members in identifying and addressing community connectedness in their own communities.				
Est. Impacts (Qual/Quant) for Objective 1	• Community advocates are identified. • Detailed knowledge about community connectedness, and related gaps, obtained from community advocates. • Increased community participation. • Increased knowledge and skills among community members about participation processes. • A setting created in which community members came together to enhance and strengthen their participation. • Contributions to the health planning processes from within the different communities in the FMP sub-region.				
PCP key stakeholders	**Summary of mix of Interventions & CB strategies**	**Population Target Group/s:**	**Estimated timelines**	**Estimated Reach**	**Resources per key stakeholder for Obj1**
Community Reps **Community Care** **Community Health** **Women's Health** **Local Government** **GPs and Divisions** **Alcohol & Drug Services** **Hospitals**	Conduct the 'Strengthening Community Action Project' in order to increase the capacity of community members in the Frankston Mornington Peninsula sub-region to participate in and influence local decision making about services and programs that directly affect their lives. Through the Project, local community advocates, identified through health consumers and carers of member agencies, are recruited, trained, supported and paid an honorary fee to represent the various views and needs of a particular group or community by: • Providing and gathering information related to community connectedness within the advocates own communities • Building links with local groups and services • Identifying and advocating people's needs and views • Working with member agencies to address identified issues. • Reporting back to the community about what action is taken	• Parents with dependent children • Young people • Men 45+ • Older people • Women	2004-2006	• 15 advocates • reaching 50 people from each target group = 750 people	HPA member agency representative's time overseeing the project Agencies could contribute to the training and ongoing support with: Meeting space, transport, admin support, supervision, etc. Trainers to be identified from within the Health Promotion Alliance
PCP HP capacity blg	As per 'Capacity Building Priority'				
Estimated Total Budget per Objective: $15,000					
Estimated Total Budget per Goal: $15,000					

Priority 2: Physical Activity

Priority Goal:	**To increase the health of older people through physical activity**				
Objective 1:	To increase opportunities for 240 older people over two years to participate in physical activity that will reduce falls.				
Est. Impacts (Qual/Quant) for Objective 1	• Agencies in the FMPHPA working collaboratively on an initiative targetting physical activity • Decrease falls in older people • Expanded membership of the Strength is for Life Network • A sustainable model of distribution for the Physical Activity Directory • Increased community awareness of the benefits of physical activity and strength training for older people				
PCP key stakeholders	**Summary of mix of Interventions & CB strategies**	**Population Target Group/s:**	**Estimated timelines**	**Estimated Reach**	**Resources per key stakeholder for Obj1**
Community Reps **Community Care** **Community Health** **Women's Health** **Local Government** **GPs and Divisions** **Hospitals**	• Conduct 8 sustainable strength and balance groups within targeted PCP agencies and public sector hospital, respite and residential care settings and develop appropriate links with existing groups in the community. • Expand the membership of the Strength is for Life Network to include additional agencies (who service older frail adults or adults with chronic health conditions). • Update and expand distribution through the PCP of the Physical Activity Directory for Older Adults. • Develop a model for sustainability of distribution of the physical activity directory. • Run (a) forum(s) for the community on the benefits of physical activity and strength training for the prevention of falls. • Conduct a pooled evaluation of the benefits of strength training and the enablers of sustained participation.	Older people at risk of falls The older old Adults with chronic health conditions that impact on mobility	2004 - 2006	• 240 • 3 additional member agencies • Relevant FMPPCP member agencies • 150 members of the community • All participants in the PCP strength groups	$10,000 - (CBFP funding)
PCP HP capacity building	Increasing the capacity of Health Promotion Alliance agencies to run strength training groups and/or to facilitate links to groups for consumers.				
Estimated Total Budget per Objective: $10,000 (CBFP)					
Estimated Total Budget per Goal: $10,000 (separate funding –Community Based Falls Prevention project)					

Priority 3: Capacity Building

<table>
<tr><td>Priority Goal:</td><td colspan="5">To increase the health promotion capacity of member agencies of the FMP PCP</td></tr>
<tr><td>Objective 1:</td><td colspan="5">To increase the competencies of service providers, to deliver consistent health promotion information across the DHS Southern Metropolitan Region</td></tr>
<tr><td>Est. Impacts (Qual/ Quant) for Objective 1</td><td colspan="5">• Increased capacity of service providers to deliver of Health Promotion training
• Consistent level of delivery of the HP package and commitment of use amongst trainers</td></tr>
<tr><td>Responsible PCP</td><td>Summary of mix of Interventions & CB strategies</td><td>Population Target Group/s:</td><td>Estimated timelines</td><td>Estimated Reach</td><td>Resources per key stakeholder for Obj1</td></tr>
<tr><td>Community Reps
Community Care
Community Health
Women's Health
Local Government
GPs and Divisions
Alcohol & Drug Services
Hospitals</td><td>A series of six 'train the trainer' full-day workshops - Certificate IV in Assessment and Work-place Training, facilitated by Swinburne TAFE, following which the five participants will, in pairs, deliver at least one 4-hour Health Promotion Orientation course in the FMP sub-region.</td><td>Service providers</td><td>2004-2006</td><td>5 HP 4 hour sessions per year with an average of 15 participants per session = a total of 75 people reached.</td><td>Service provider time from member agencies to deliver the training
$2,000 to cover cost of training</td></tr>
<tr><td>PCP HP capacity building</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="6">Estimated Total Budget per Objective: $2,000</td></tr>
<tr><td colspan="6">Estimated Total Budget per Goal: $2,000</td></tr>
</table>

Priority Goal	**To increase the health promotion capacity of member agencies of the FMP PCP**				
Objective 2:	To further develop a coordinated approach to Health Promotion (HP) capacity building in the Southern Region				
Est. Impacts (Qual/ Quant) for Objective 1	• Resources shared • Duplication prevented • HP systems developed • HP capacity building resources streamlined and efficient • HP capacity building planning integrated				
Responsible PCP	**Summary of mix of Interventions & CB strategies**	**Population Target Group/s:**	**Estimated timelines**	**Estimated Reach**	**Resources per key stakeholder for Obj1**
FMPPCP ISEPICH KBPCP SEPCP	▪ Identify current regional HP Groups/Networks/Forums	4 PCP Member Agencies Other Network agencies who are not part of a PCP	November 2004	4 PCP Member Agencies Other Network agencies who are not part of a PCP	HPA member agency representative's time conducting the project
	▪ Collect Terms of Reference for each of these groups	Regional HP Groups		Regional HP Groups	
	▪ Identify/collect any HP plans that these groups have developed and are implementing (specifically Capacity Building)	Regional HP Networks/Groups Agencies		Regional HP Networks/ Groups Agencies	
	▪ Identify which agencies are represented on Regional Groups – including time commitment/ resources being contributed to participate	PCP Member Agencies Agencies who are not members of PCP but are part of the networks	December 2004	PCP Member Agencies Agencies who are not members of PCP but are part of the networks	
	▪ Identify whether agencies have included these groups in their agency HP Plans	Member Agencies, Agencies who are part of Networks but are not PCP members		Member Agencies, Agencies who are part of Networks but are not PCP members	
	▪ Consult with agencies to gain a better understanding of why they participate in Regional HP Groups/Networks/Forums – perceived benefits	Participating agencies		Participating agencies	
PCP HP capacity building	As per 'Capacity Building Priority' above				
Estimated Total Budget per Objective: 0					
Estimated Total Budget per Goal: $2,000					