

Community Health Plan

2003-04

Hume Moreland
Primary Care Partnership



Foreword

In June 2001, the Hume Moreland Primary Care Partnership (PCP) submitted a three year plan identifying the priority health and wellbeing needs of the catchment and describing how the members of the partnership will work together with other key stakeholders to respond to these needs.

The Community Health Plan 2003-04 is a continuation of the original three-year plan and has been refined to reflect the achievements to date and the changes in the population health needs, policy direction and other primary care developments. It contains key directions required to continue developing and strengthening a responsive and cohesive primary care system. The main focus is on:

- Strengthening the Partnership;
- Better Access to Services; and
- Integrated Health Promotion.

The preparation of the plan has included contributions by member organisations, consumers, carers and community representatives. The Service Coordination and Health Promotion working groups, and the PCP Project Management Group have been vital in progressing the original plan and for preparing the Community Health Plan for 2003-04.

The plan has been written by the PCP Project Team consisting of:

- Meg Henderson – Executive Officer
- Jacqui Mckenzie – Health Promotion/ Partnerships Project Officer
- Nicole Bouchier – Administration Officer



Roslyn Stevens
Chairperson
Hume Moreland Primary Care Partnership

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Executive Summary

This Hume Moreland PCP Community Health Plan (2003-04) is a continuation of the original three-year plan written in 2001 that detailed the priority health and wellbeing needs of the catchment and described how members of the partnership will work together with other key stakeholders to respond to these needs.

The 2003-04 plan has been refined to reflect progress to date and, the changes in the population health needs, policy direction and other primary care developments. It contains key directions required to continue developing and strengthening a responsive and cohesive primary care system. The main focus is on:

- Strengthening the Partnership;
- Better Access to Services; and
- Integrated Health Promotion.

The plan is organised into two sections. Section one details the plan's context restating the Hume Moreland PCP vision, values, directions and objectives.

The vision, as articulated in 2001, underpins and drives the 2003-04 Health Plan. The vision is committed to a model of health that recognises and responds to varying life settings, promotes and encourages holistic wellbeing, recognises the impact of economic and social health conditions and disadvantages, and recognises the broader global impacts upon health.

The shared values expressed by Hume Moreland PCP advocate that regardless of gender, religious and cultural beliefs, ability or social and economic circumstances, all individuals should be treated with respect, receive equal access to health, be fully informed on their health, experience

confidentially, have access to community health planning, and receive a relevant, responsive and effective health service.

In 2002-03 Hume Moreland PCP refocused to maximise opportunities for collaboration and sharing of information to strengthen the partnership between members. This foundation forms the basis for the 2003-04 approach with a greater emphasis on facilitation rather than active involvement in initiatives and provision of increased opportunities for capacity building.

The Operational Plan (Section Two) outlines the sources used to establish priorities and to inform strategies and approaches in the Community Health Plan. The Hume Moreland Primary Care Partnership has prioritised the objectives to address the emerging issues for the 2003-04 financial year.

The main goal of Partnerships in 2003-04 is to strengthen agency, consumers and community to plan and address population health issues, in particular focusing on: consumer involvement; partnership building; increased communication; implementation of the Partnering Project; regional cross collaboration; and intersectorial relationships.

Service coordination is aiming to continue to improve better consumer access to, and response from, services in the Hume Moreland area focusing on: the implementation of locally developed processes, practices, policies and systems; implementation of uniform referral systems and processes; increased use of technologies to facilitate communication and use of the service coordination tool templates; maximise service coordination and implementation for agencies involved in

maternity services; and, strengthen GP involvement in the service coordination strategy.

Integrated Health Promotion is primarily focused on strengthening capacity and collaboration between services involved in health promotion. The strategies are designed to bring together staff from different agencies and backgrounds to work together to address an issue through skill development and a heightened awareness of resources available. The Social Model of Health provides the framework for all activities undertaken in this strategy. One project will have a focus on younger people and involves many agencies across Hume and Moreland.

The preparation of the plan has included contributions by member organisations, consumers, carers and community representatives. The Service Coordination and Health Promotion working groups, and the PCP Project Management Group have been vital in progressing the original plan and for preparing the 2003-04 Community Health Plan.

SECTION ONE: CONTEXT

1.1 Introduction

The Hume Moreland Primary Care Partnership is an alliance between thirty-five health and community service organisations, and groups in the Cities of Hume and Moreland (see Appendix A for a list of Alliance Members). The Hume Moreland PCP is located to the north west of Melbourne, stretching from the inner city, densely populated suburb of Brunswick (5 kilometres from the GPO) to the semi rural districts around the townships of Craigieburn and Sunbury (over 30 kilometres from the GPO). The total population of the catchment is 276 818 with 140 353 in Hume and 136 465 in Moreland.

Hume Moreland Primary Care Partnership Catchment Area



Source: 1996 Census of Population and Housing Australian Bureau of Statistics

Thirty members formed an alliance and formally signed up to a Memorandum of Understanding (MOU) in late 2000 in response to the Primary Care Partnerships strategy released by the Department of Human Services. The MOU has been renewed every 12 months and currently has thirty-five signatories. The process of review and renewal for the 2003-04 financial year has commenced.

Population characteristics are crucial to an examination of health status. Factors such as age, ethnic background and socio-economic status play a significant role in determining the health status of a population and pose particular health and wellbeing challenges in Hume and Moreland.

There are pockets of poverty, unemployment and overall economic disadvantage located throughout the catchment area, and both Hume and Moreland are in the top six most disadvantaged areas, according to the Index of Relative Socio-Economic Disadvantage. There is also inadequate infrastructure to support people on low incomes; for example, the distribution of health and community support services and public transport do not match the changing needs.




Both LGA's are forecast to experience considerable population ageing over the next two decades, with population growth centred on adults and older persons. Hume has a much lower population density than Moreland. This makes the provision of viable health services throughout Hume least populous areas problematic (this is also an issue in Moreland's northern area).

The catchment includes a large number of residents from non-English speaking backgrounds, reflecting Australia's migrant, humanitarian and refugee intakes over the years, especially since World War II. The diverse range of cultural and linguistic groups poses particular issues for service providers.

1.2 Major Achievements in 2002-03

Since the development of the three year Community Health Plan in 2001, the PCP strategy has evolved to focus on three main objectives: partnerships, service coordination and integrated health promotion. (A full description of the achievements and outcomes for 2002-03 can be found in the Community Health Plan Implementation Agreement report June 2003).

The success of developments and innovative responses is the result of significant input and commitment from the managers and staff from member agencies and consumer and community representatives to focus and collaborate on beneficial reforms for the local community, despite the competing demands on their time.

Major Highlights for 2002-03	
<p>Partnerships</p> 	<ul style="list-style-type: none"> • Development of a sustainable consumer orientation and training package; • A refocusing of the PCP Newsletter to communicate innovative developments, training opportunities and information to assist with capacity building of agencies; • Commencement of the Partnering Project aimed at providing a manual and training to assist agencies to form partnerships to address population health needs; • Implementation of a Consumer Charter of Rights for agencies in the Hume Moreland PCP; • Involvement and leadership by agencies in the HARP process with two major healthcare networks in the Northern Metropolitan Region; • Revision of the Hume Moreland PCP website layout and content; • Several joint funding submissions developed by 2 or more agencies; • Development of the Women's Health in the North/Northern Metropolitan Region PCPs Partnership Protocol; • Consumer and or community involvement in all service coordination and health promotion projects; and, • Revision of PCP governance structures.
<p>Service Coordination</p> 	<ul style="list-style-type: none"> • Development and implementation of agreed Policies, Practices, Processes and Systems to support the use of the Service Coordination Tool Templates (SCoTT); • Agencies have commenced the use of the SCoTT for initial contact, initial needs identification and referral; • Commencement of the Going Home with a Baby: Coordinating Effective Service Response for maternity services in Hume and Moreland; • Completion of Year One of Local Diabetes Service Development project: One Step Ahead; • General Practitioner and consumer involvement in service coordination projects; • Provision of training and forums to support the SCoTT such as privacy and working with Culturally and Linguistically Diverse (CALD) communities; • Development of regional fax coversheets to support referral; • Increased information sharing about innovative service response, service information and training opportunities; and, • Individual agency support and problem solving for the implementation of SCoTT.
<p>Integrated Health Promotion</p> 	<ul style="list-style-type: none"> • Development of the Statement of Cooperation between agencies undertaking health promotion; • Completion of the Recent Mothers project for women with a mental illness; • The formation of a Younger Persons sub committee to inform and guide a project focused on younger people in Hume and Moreland; • Revision of governance and meeting schedules for the health promotion working group and sub groups; • Commencement of the Submission Writing project as a capacity building strategy; • A mapping of health promotion activities and priorities across Hume and Moreland; and, • Consumer participation in all health promotion projects.

1.3 Vision

The Hume Moreland PCP articulated the following vision at a planning day in 2001:

The Hume Moreland Primary Care Partnership is committed to a model of health that –

- *recognises and responds to people within the settings of their everyday life:*
 - *as individuals;*
 - *as family members; and*
 - *as members of the community.*
- *promotes and encourages physical, mental, emotional, spiritual and environmental health and wellbeing by:*
 - *providing equitable and accessible services;*
 - *ensuring services understand and respond to diverse community needs; and*
 - *developing a coordinated and sustainable service system.*
- *recognises the impact of economic conditions and social disadvantage on health; and,*
- *recognises and seeks to address the broader environmental and global factors that impact upon health.*

1.4 Shared Values

The Hume Moreland PCP utilises a social model of health based on the following health promotion values/principles:

- everyone should be treated with respect regardless of their gender, religious and cultural beliefs, ability or social and economic circumstances;
- everyone should have equal access to good quality, timely and affordable health service;
- everyone should have access to relevant, accurate and up to date information;
- everyone should have access to interpreters and information in plain language to enable them to make their own informed choices and decisions;
- everyone should have equal opportunity to have their say about how health services in their community are planned and operated;
- service providers and the service system will ensure that all personal information is kept private and confidential;
- services should be provided in a safe and welcoming environment; and,
- service providers should have access to the resources and training required to deliver a relevant, responsive and effective service to the community.

1.5 Direction for 2003-04

The key focus for Hume Moreland PCP for 2003-04 will be on continued implementation of:


- the service coordination strategy and model;
- strengthening capacity around integrated health promotion; and,
- strengthening partnerships.

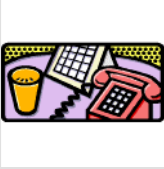

The Hume Moreland PCP has refocused over the past year to maximise opportunities for collaboration and sharing of information to strengthen the partnership between members. This will continue in 2003-04. The project team aims to facilitate rather than conduct initiatives and to provide opportunities for capacity building.

The guiding principles outlined in the 2001-02 and 2002-03 Community Health Plans that continue to remain relevant include:

- Development of sustainable and collaborative partnerships between member agencies, and consumers, carers and community members;
- Participation by consumers, carers and community members as respected and equal partners;
- Genuine and productive engagement with general practitioners;
- Implementation of sustainable policies and practices which will improve and support better access to services;
- Development of the capacity to plan services to meet changing needs, taking account of the role of local government in planning, the cultural and linguistic diversity of the catchment, the adequacy and interpretation of available data, and related infrastructure issues such as transport, housing, disability and family support services; and
- Professional support, training and infrastructure for service providers and consumers, carers and community members to make the reforms work successfully.

1.6 Strategic Objectives

<p>Partnerships</p> 	<p>The strength of the PCP is evident in the partnerships developed by agencies, consumers and communities to plan and address population health issues. Hume Moreland PCP will:</p> <ul style="list-style-type: none">• Continue to facilitate consumer and community involvement in PCP and individual agencies activities;• Provide executive support to the PCP to strengthen the relationships and partnerships between agencies and the community;• Renew the Memorandum of Understanding for the Hume Moreland PCP;• Continue to develop a high quality newsletter and website to facilitate communication and opportunities for members;• Continue the implementation of projects to facilitate partnerships, such as the Partnering Project;• Continue to collaborate on PCP activities across the Northern Metropolitan region; and,• Continue to build relationships between the acute, sub-acute and primary care services to reduce hospital demand by developing innovative approaches.
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<p>Service Coordination</p> 	<p>The service coordination strategy aims to improve better access to and response from services in the Hume Moreland area. Hume Moreland PCP will undertake the following to achieve this:</p> <ul style="list-style-type: none"> • Continue to support the implementation of the statewide Service Coordination Tool Templates and strategy across Hume and Moreland including the implementation of the locally developed processes, practices, policies and systems that underpin the SCoTT; • Facilitate an agreed electronic referral and information system that supports better access to services; • Develop and share information to support the implementation of the statewide service coordination strategy; • Liaison with the Department of Human Services in relation to policy and practice; • Work with member agencies to implement projects that address service coordination issues such as the Going Home with a Baby: Coordinating Effective Service Response project; • Provide and inform agencies of workforce development opportunities to maximise service coordination planning and implementation; and, • Collaborate with the North West Melbourne Division of General practice to support GP involvement in the SCoTT strategy.
<p>Integrated Health Promotion</p> 	<p>The aim of the health promotion strategy is to facilitate planning and implementation of health promotion activities in Hume and Moreland. Hume Moreland PCP will:</p> <ul style="list-style-type: none"> • Develop a health promotion plan in consultation with member agencies; • Facilitate the working groups around key population priorities to collaborate and coordinate the delivery of projects and strategies; • Provide and inform agencies of workforce development opportunities to maximise health promotion planning and implementation; • Disseminate health promotion information including evidence based and best practice; • Engage consumer participants in health promotion activities; • Facilitate agencies involved with younger peoples health promotion to develop and implement a project; and • Promote and conduct forums to show case local initiatives.

SECTION TWO: OPERATIONAL PLAN

2.1 Introduction

The Hume Moreland PCP has utilised information from a variety of sources and forums to update the community and service profile, to identify the priorities and develop the strategies contained in this plan. Existing plans drawn upon include: Hume and Moreland City Council's Municipal Public Health Plan; the Northwest Primary Mental Health Plan; and the Hume Moreland PCP Community Health Plans 2001-02 and 2002-03. Forums that information was drawn from include: The Hume Moreland PCP Project Management Group meeting conducted to review this plan; the Community Consultation Forum, consultations with alliance members; consultations with the Service Coordination and Health Promotion working groups; and, The HACC Growth Funding Planning for 2003-2006 forum. Data was also drawn from the DHS Community Health Plan Data sets, the Department of Infrastructure, the Health Status in Moreland, HealthWiz 2002, and the Victorian Population Health Survey, 2001.

2.2 Overview of the Community and Service Profile

The local government areas of Hume and Moreland, in Melbourne's north-west comprise extremely diverse populations with significant health needs. Following is an update of the original Community and Services Profile completed in 2001.

General Demographics	
Population	<p>Hume and Moreland local government areas have similar population numbers estimated at 140,353 and 136,465 respectively¹. The Department of Infrastructure estimates that the population of Hume will be 174,248 by the year 2021 and Moreland, 146,911.</p> <p>There are some distinct differences between the two areas. Hume has a relatively young and growing population whilst Moreland has an older and slightly decreasing overall population. Moreland's population has been declining steadily over the past 15 years whilst Hume's has been increasing 2 – 3 % over each 5 year census period. This is largely due to the older population in Moreland and the increase in single person households and the increasing number of new housing estates in parts of the Hume City Council area that in turn has increased the number of younger family households.</p>
Age Profile	<p>Moreland has a very large older population that has lived in the area for many years, particularly in Glenroy, Fawkner and Oak Park.² Conversely, it has a lower proportion of its population (less than 30%) aged under 25, particularly when compared with the Melbourne Metropolitan area or Hume LGA.</p>
Unemployment	<p>Both Hume and Moreland have high unemployment levels compared to the Melbourne Metropolitan area. Hume has 8.4% compared to 6.6% for Melbourne. In Moreland the rate for adults is 9.6% and for the 15 – 24 year-old age group it is 20.2%.</p>

¹ Department of Infrastructure, 2003

² Health Status in Moreland, April 2002, p.5

General Demographics	
Income	In Moreland 14.4% of the population are in receipt of an Age Pension compared to 6.1% for Hume and 9.5%, 9.0% and 9.5% of the Northern Metropolitan Region, Melbourne Metropolitan and Victorian populations. A very high proportion of households are either dependent on government benefits or are classified as 'working poor'. In Moreland, 11.7% of households are below the poverty line and 40% receive less than \$500 p.w. in income and 23% less than \$300 ³ . In Hume the median weekly income is \$355 for individuals and \$827 for households.
School Retention	Both LGAs also have low school retention rates compared to the rest of Melbourne. For Hume residents aged 15 years and over whose highest level of school completed is Year 10 or less is 38.1% compared 30.85 for the Melbourne Statistical Division.
Cultural Diversity	<p>Both Hume and Moreland have very high proportions of people born overseas and from non-English-speaking backgrounds. In Hume, 35% of the population was born outside Australia, which is commensurate with the proportions in the rest of the Northern Metropolitan area and Melbourne Metropolitan area. In Moreland close to 40% were born overseas. Moreland has significant Italian, Greek and Lebanese communities and Hume has Turkish, Italian, Maltese and Lebanese. Close to one-third of both populations were born in a country where the main language is not English. Moreland in particular is a popular destination for new arrivals to Australia, particularly refugees and those arriving under the 'family' category. Between 1998 and 2002, 3,099 new arrivals to Australia settled in Moreland, mainly from China, Iraq and Lebanon.</p> <p>In Hume, 39% of the population speaks a language other than English at home compared to 30% in the Melbourne metropolitan area. In Hume, 6.68% of the population does not speak English well or at all and in Moreland 8.94%. In Hume, 12% of the population state their religion as Islam (compared to 2.6% for the greater Melbourne metropolitan area).</p>
Aboriginal and Torres Strait Islanders	In 2001 Moreland had 487 residents of Aboriginal and Torres Strait Islander background and Hume had 675. These are both relatively high rates for metropolitan Melbourne and although not a large group in the overall population, they have significant and sensitive health needs ⁴ .
Household composition	<p>Over 16% of all households in Hume and Moreland are one parent families. As a proportion of families with dependent children, single parents make up 21% of families in Hume and 26.6% in Moreland, which is somewhat higher than the average for Victoria of 22.4%.</p> <p>Lone person households are significantly higher in Moreland than Hume at 13,882 and 5,324 respectively. In part this reflects the increasing older population and the gentrification of the inner suburbs of Moreland and the new housing estates of Hume. Lone person households are 26.5% of all occupied private dwellings in Moreland in 2001, which is higher than the metropolitan average of 22.3%. Hume had just 13.4%.</p> <p>Housing tenure in the two municipalities differs markedly. In Moreland, with an older population, there are a much greater proportion of households that own their own home but there is also a high proportion of people in private rental. Hume on the other hand has high proportions of home purchasers.</p>

³ Moreland Municipal Public Health Plan 2003 (draft)

⁴ Source: Australian Bureau of Statistics 2001 Census figures accessed via the DHS Community Health Plan Data Sets of February 2003

Health Specific Areas	
Self-reported Health	Residents of the Northern Metropolitan Region of Melbourne, who were surveyed as part of the Victorian Population Health Survey in 2001, had the highest rate of reporting Fair/Poor Health and the lowest rate of Excellent/Very Good health of any region in Victoria.
Provision of GP Services	Of the 30 Divisions of General Practice in Victoria, the North West Melbourne Division, which covers parts of Hume and Moreland, has the second highest number of fulltime equivalent doctors: 247.6. Melbourne Division at 250 has the highest.
Maternity and Child Health	Mothers and children have a lower participation rate of attendance at Maternal and Child Health Services than the profile for the rest of Northern Metropolitan Region and Victoria as a whole. For instance, in 2000-2001, the participation rate at 12 months of age was 67.9% in Hume and 64.9% in Moreland whereas the NMR average was 75.7% and the Victorian average 75.3%. Breastfeeding rates in Hume were well below the NMR and Victorian Averages but in Moreland they were above the NMR and State averages.
Mental Health	<p>The demographic profile of Hume-Moreland is underpinned by the high level of mental illness, depression and anxiety. The Moreland Municipal Public Health Plan identifies mental illness, stress, depression and anxiety as significant issues in the municipality.</p> <p><i>Higher levels of psychological distress were associated with living in urban areas, being unemployed, being separated, having been born overseas and residing in households with lower incomes. An association was also found between self-rated health status and level of psychological distress, with higher proportion of persons who reported their health as good or better categorized as having lower levels of psychological distress⁵</i></p>
Asthma	Residents of the Northern Metropolitan Region of Melbourne had the highest reported prevalence of asthma of any Victorian regions ⁶ with a prevalence rate approximating 14% compared to 12.3% for the whole of Victoria.
Diabetes	The NMR has the third highest incidence of diabetes of the ten DHS regions in Victoria and the highest of the four metropolitan regions. ⁷ There is a higher prevalence rate for males (8.1%) than for females (4.8%).
Chronic Obstructive Pulmonary Disease (COPD)	In the Ambulatory Care Sensitive Conditions data Hume and Moreland rated as higher than the Victorian average for admissions for COPD.

⁵ Victorian Population Health Survey 2001 p.30

⁶ Victorian Population Health Survey 2001 p.23

⁷ ibid p.24

Services Profile

There have been two significant changes in the service profile since it was developed in 2001:

1. The Northern Metropolitan Migrant Resource Centre ceased providing settlement and multicultural support in the Hume and Moreland area in late 2002. It was anticipated that the North East Migrant Resource Centre would work with services in Moreland to assume settlement services and the Western Migrant Resource Centre would provide services to Hume. Services have recently resumed in Hume and Moreland;
2. A new addition is the Primary Mental Health Team that makes up part of the Northwest Area Primary Mental Health Partnership. The Primary Mental Health Team has developed their own Community Health Plan and has several key roles including to:
 - Improve co-ordination between primary care and specialist mental health services;
 - Develop a comprehensive primary mental health system that meets the mental health well-being of the community; and,
 - Support and enhance the capacity of Community Health Centres and General Practice to recognise and treat mental health problems and disorders more effectively.

2.3 Gaps and Emerging Issues

The gaps and emerging issues in Hume and Moreland remain much the same as last year and are broken down into age related groups. These are predominantly drawn from the Community and Services Profile completed by Hume Moreland PCP in 2001.

Gaps and Emerging Issues	
Carers	<ul style="list-style-type: none"> • Lack of respite for carers, especially culturally specific respite; • High costs and reduced services preclude support to carers and care recipients outside the complex needs end; • Difficulty in immediately accessing information regarding service availability; • The lack of a Carers Support Group in Hume; • Difficult funding regulations/guidelines in complex cases needing more than one assessment; and, • Gender issues affect the delivery of culturally and gender appropriate services, i.e. care responsibilities left to women; HACC programs employ mainly women, few male workers.
Children and Families	<ul style="list-style-type: none"> • Limited support for new mothers following early discharge from hospital; • Socio economic disadvantage; • Family violence; • Drugs and alcohol, including misuse of pharmaceuticals; • The impact of gambling; • Isolation; • The needs of families from CALD communities; • Assistance to families with a disabled member(s); • The lack of parent lobby and support groups; • Limited access to mental health services for Sunbury and Fawkner; and, • Scarcity of public dental services.

Gaps and Emerging Issues	
Younger People (15-24 Years of Age)	<ul style="list-style-type: none"> • Obesity; • Shortage of and access to GPs of both genders; • Youth friendly access to services; • Inadequate services to meet the needs of young people, especially relating to: • Mental health issues particularly depression and anxiety; • Drugs and Alcohol; • Asthma; • Diabetes; • Homelessness; • Social isolation; • Leisure and respite for young people with disabilities; and, • Culturally and linguistically diverse and gender appropriate leisure activities.
Adults (25-64 Years of Age)	<ul style="list-style-type: none"> • 49% of all admissions to hospital for people aged 25 to 64 years in Moreland in 1997/8 were due to mental disorders (1,046 admissions). Mental Illness is particularly an issue for the 35-54 year old group; • Chronic disease management: circulatory disease; cancer; asthma; obesity and dietary issues; and, chronic obstructive pulmonary disease; • Alcohol and drug related illness and death; • Injuries; • Digestive disorders in Hume; • Access to appropriate respite and accommodation services; • Homelessness; • Assessment for core and residential services; and, • Access to bulk billing GP's.
Older People (Over 65 Years of Age)	<ul style="list-style-type: none"> • Chronic disease management: cardiovascular disease; cancer; diabetes; chronic respiratory disease; musculoskeletal disorders; • Difficulties with diagnosing mental health and dementia in older people from CALD backgrounds; • Fragmented service system and consumer confusion on demarcations of the multiple service providers; • Lack of basic services, e.g. current demand and waiting lists for home based care is anticipated to increase as the population ages; hospital admissions and discharge are also adversely affected; • Shortage of bilingual / culturally aware workers across the service system; • Shortage of residential services, especially for CALD communities; • Lack of comprehensive flexible care packages; • Shortage of doctors doing home visits and bulk billing; • Costs of medications; • Advocacy skills in dealing with GPs; • Lack of coordination between consumer and lobby groups; • Insufficient male carers / nurses and social supports for older men; and, • Shortage of Community Allied Health Services; flexible community respite; and, Health Promotion programs aimed at older people

2.4 Priorities for Action

The priorities identified in the 2002-03 Community Health Plan that remain relevant in 2003-04 are:

Population Health Needs

1. Chronic disease management including: diabetes; asthma; obesity; cardiovascular disease; respiratory disease; and, cancer.
2. Maternal and Child Health;
3. Wellbeing of Younger People;
4. Mental health; and,
5. Culturally and linguistically diverse communities.

Service Links and Coordination

6. Access to and communication between primary health services for consumers including strengthening primary care services capacity to streamline the practices, processes, protocols and systems;
7. Collaboration between primary and acute health services to reduce hospital admissions and manage chronic disease;
8. Workforce development and capacity building for primary care services particularly around service coordination and health promotion;
9. Working with consumers as advocates, service users, community representatives and committee members of primary care services;
10. Streamline service coordination and health promotion activities across the Northern Metropolitan Region; and,
11. Maintain communication strategies to alliance members, consumers, government representatives and other interested parties.

In addition to this new and emerging priorities include:

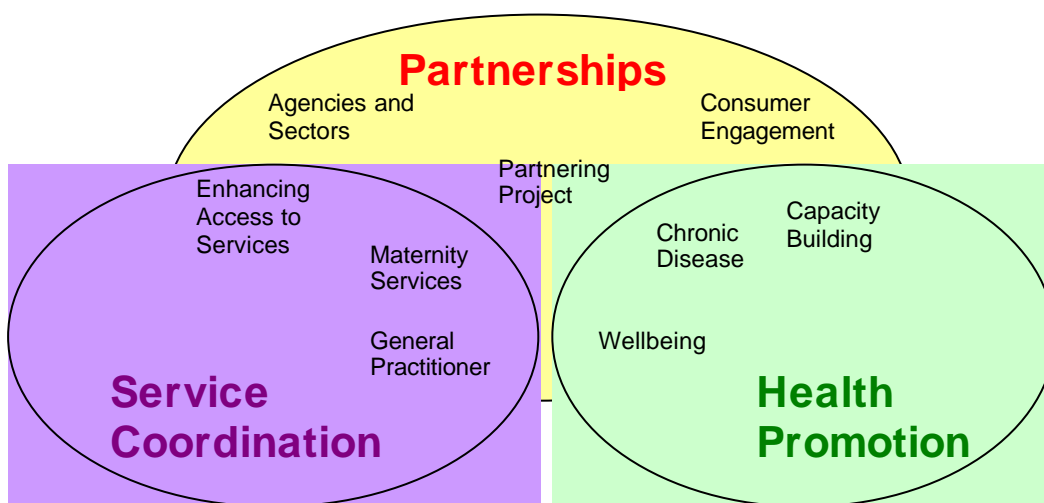
12. Supporting the integration of the SCoTT and PPPS with other sectors of the primary health service such as mental health and drug and alcohol services and general practitioners;
13. Strengthening and facilitating partnering opportunities between member agencies to deliver specific strategies to address population health needs; and,
14. An increase in the availability of ICT to support the practice changes and enhance communication between agencies and sectors.

2.5 Strategies

The Hume Moreland Primary Care Partnership has prioritised the strategies to be implemented for the 2003-04 financial year under the following headings:

- partnerships;
- service coordination; and,
- integrated health promotion.

There is considerable overlap from strategy to strategy and the benefits will not be isolated in the area the strategy is listed under. The intended outcomes of the Partnerships strategy is to build and strengthen the collaborative approach already underway between sectors, agencies and organisations and the community. This is the fundamental approach that underpins and interconnects all of the strategies.



Service coordination is aimed at minimising the barriers to accessing services for consumers by streamlining and developing systems and tools to facilitate better collection, sharing and storage of information. The service system is still quite fragmented although developments are occurring with the implementation of systems and tools for change. This process is incomplete and this year will focus on strengthening the developments to date and implementing the next stages.

Integrated Health Promotion is primarily focused on strengthening capacity and collaboration between services involved in health promotion. The strategies are designed to bring together staff from different agencies and backgrounds to work together to address an issue through skill development and a heightened awareness of resources available. The Social Model of Health provides the framework for all activities undertaken in this strategy.

Although specific health issues are listed in the priorities such as chronic diseases, the PCP is aiming to develop capacity and an ability to respond to these issues within the current service sector rather than applying direct solutions. The PCP can value add by providing support and facilitating partnerships and collaboration..

Relationship between the Priorities and the Strategies

		STRATEGIES									
		Partnerships			Service Coordination				Health Promotion		
		Agencies and Sectors	Partnering Project	Consumer Engagement	Enhancing Access to Services	General Practitioners	Maternity Services	Capacity Building	Younger People	Chronic Disease	Diabetes
PRIORITIES AREAS	1. Chronic Disease	○	○	○	○	○		●		●	●
	2. Maternal and Child Health	○	○	○	○	○	●				
	3. Younger People	○	○	○	○	○		●	●		
	4. Mental Health	○	○	○	○	○		●	●		
	5. CALD	○	○	○	●	○				●	○
	6. SCoTT/PPPS			○	●	●	●				
	7. Collaboration	●	●	○	●	●	●	●		●	●
	8. Workforce Development		●		●	●	●	●	●	●	●
	9. Consumers	●		●	●				●	○	●
	10. Regional Approach	●			●	●		●		●	
	11. Communication	●		●		●			○	●	
	12. SCoTT to other program/sectors	○		○	●	●	●				
	13. Partnering	●	●		●		●	●	●	●	●
	14. ICT	○		○	●	●	●				

● Directly addresses ○ Indirectly addresses

2.5.1 Partnerships – Agencies and Sectors

PROBLEM DEFINITION

The philosophy of the Hume Moreland Primary Care Partnership is best demonstrated through this strategy. The PCP aims to develop sustainable and effective partnerships between member agencies, associated agencies and across sectors to maximise resources and opportunities to innovatively address population health needs. The PCP team has played a pivotal role in providing support to sustain the strategy and is driven by the members, the working and project management groups, and the consumers involved with the PCP. The progress of the partnership development has been significant and continued support and facilitation by the PCP team will enhance this throughout 2003-04.

Goals

To ensure all PCP work is implemented in a manner that continues to build networks and facilitates sustainable partnerships between agencies and across sectors.

Objectives

1. Continue to play a role in facilitating communication between agencies, consumers and other sectors;
2. Continue to strengthen the governance of the alliance that is representative of member agencies;
3. Continue to collaborate and participate in PCP activities on a regional and statewide level;
4. Continue to build relationships between the acute, sub -acute and primary care services to reduce the hospital demand and develop innovative approaches;
5. Continue the implementation of projects to facilitate partnerships, such as the Partnering Project; and,
6. Continue to develop the relationship with DHS Northern and Central offices.

Population Target Group

- Consumers
- Service providers
- Other PCPs
- DHS
- Other sectors and programs such as acute, sub acute, mental health, drug and alcohol, etc

Relationship to 2003-04 PCP Priorities for Action (Section 2.3)

- Directly addresses priorities 7, and 9 – 14; and,
- Indirectly addresses priorities 1-5.

SOLUTION GENERATION

Relevant Statewide Action and Evidence Based Practice

- Federal and State Government initiatives to address population health needs through collaborative partnerships
- PCP consumer engagement policy
- HARP policy of intersectorial relationships to address population health needs

Interventions and Activities	Roles and Responsibilities	Timelines
<p>1. Communication</p> <ul style="list-style-type: none"> • Continue to develop a high quality newsletter and website communicating key support information, publicising agency initiatives or achievements and training opportunities. • Agencies to continue to submit articles and training opportunities to the newsletter and the website. • Distribute information to relevant agencies and parties via email, the newsletter or on the website. • Develop or facilitate mechanisms to network where no opportunities currently exist, especially cross-sectorially • Promote and conduct forums and specific events of interest within and external to the PCP. • 	<ul style="list-style-type: none"> • PCP team • Agencies • PCP team • PCP team and agencies • PCP team and agencies 	<ul style="list-style-type: none"> • Monthly • Ongoing • Ongoing • Ongoing • Ongoing
<p>2. Governance</p> <ul style="list-style-type: none"> • Review and renew the Memorandum of Understanding for the Hume Moreland PCP. • Invite a multicultural specialist agency to join the Project Management Group (PMG) to fill the vacancy created by the loss of the Northern Migrant Resource Centre. • Review the frequency of the PMG meetings. • Provide executive support to the PMG and the working groups. • Invite other agencies to join the working groups as appropriate. • Formulate specialist sub groups of the Health Promotion Working Group 	<ul style="list-style-type: none"> • PCP Manager • PCP Manager • PCP Manager • PCP team • PCP team and members • Health promotion project officer 	<ul style="list-style-type: none"> • Sept 2003 • July 2003 • July 2003 • Ongoing • Ongoing • Ongoing
<p>3. Regional and Statewide</p> <ul style="list-style-type: none"> • Continue to attend and contribute to Statewide PCP meetings, sharing the learnings with the PCP. • Seek opportunities to collaborate and coordinate specific projects across the NMR and WMR • Participate and contribute to the NMR PCP Network bi monthly meetings, including organising executive support • Share any successes and developments with the NMR and WMR PCP network to facilitate cooperation and collaboration • Coordinate responses to funding opportunities and/or joint issues across the NMR • Participate and contribute to the NMR ICT Governance Group meetings 	<ul style="list-style-type: none"> • PCP team and chairperson • PCP • PCP team • PCP team • PCP team • PCP team and chairperson 	<ul style="list-style-type: none"> • Ongoing • Ongoing • Ongoing • Ongoing • Ongoing • Ongoing
<p>4. Acute and Sub Acute</p> <ul style="list-style-type: none"> • Be actively involved with HARP projects and committees, seeking opportunities to inform projects and advocate for appropriate community agency leadership and participation. • Attend steering/reference committees as invited by acute sector such as the Population Health Advisory Committee. • Attend Melbourne Health community provider forums. • Explore opportunities for member agencies to be involved in projects that build capacity between acute and community. 	<ul style="list-style-type: none"> • PCP team and members • PCP Manager and members • PCP team • PCP team 	<ul style="list-style-type: none"> • Ongoing • Ongoing • Ongoing • Ongoing

<ul style="list-style-type: none"> • Seek opportunities to assist carers, consumer and community participation in acute sector. • Facilitate cross-sectorial relationships 	<ul style="list-style-type: none"> • PCP team • PCP team 	<ul style="list-style-type: none"> • Ongoing • Ongoing
<p>5. Projects</p> <ul style="list-style-type: none"> • Facilitate projects that will build partnering and collaborative opportunities between agencies and sectors, such as the Partnering Project. • Invite participation of all agencies when specific projects are being developed. • Seek and draw on expertise within agencies and sectors to inform and/or implement projects (including gender and CALD expertise) • Facilitate access to best practice examples and research. • Assist agencies in the development of project briefs and funding applications, as requested. • Support and facilitate processes to problem solve and collaborate between agencies and sectors. • Implement any training to allow not only skill development but also networking opportunities between practitioners. • Convene and coordinate interested parties around a specific issue, as needed. • Continue to share learnings and invite involvement in identified projects such as Going Home with a Baby. 	<ul style="list-style-type: none"> • PCP team • PCP team • PCP team • PCP team • PCP team • PCP team • PCP team • PCP team • PCP team • PCP team 	<ul style="list-style-type: none"> • Ongoing • Ongoing • Ongoing • Ongoing • Ongoing • Ongoing • Ongoing • Ongoing • Ongoing • Ongoing
<p>6. DHS</p> <ul style="list-style-type: none"> • Compile and submit bi annual (or as required) reports. • Inform DHS NMR and central office of implementation and other issues arising with the PCP strategy. • Continue to facilitate DHS involvement in the regional meetings, the PMG and working groups. 	<ul style="list-style-type: none"> • PCP team • PCP team • PCP team 	<ul style="list-style-type: none"> • Dec 2003, June 2004 • Ongoing • Ongoing
<p>7. Involvement in the Planning for New Services</p> <ul style="list-style-type: none"> • Be actively involved with planning for new services, seeking opportunities to inform projects and advocate for appropriate community agency leadership and participation, such as the Craigieburn Superclinic development. • Ensure key people are involved in the decision making processes to ensure the right services are in the right place at the right time. • Support consumer involvement and advocacy. • Advocate for the broad range of CALD communities needs and ensure they are considered in planning. • Request any gender specific data required to be provided by Women's Health in the North. 	<ul style="list-style-type: none"> • PCP team and members 	<ul style="list-style-type: none"> • Ongoing

SUPPORT AND RESOURCES

Resource Allocation

The PCP manager and administrative assistant will play a large role in implementing the three partnership strategies and have the following associated costs:

Description	Budget	Notes
Salaries and on costs	\$107 858	1x EFT for manager and 0.4 EFT for administration
Office support costs	\$67 528	Includes rental, IT support and council administration fee, car etc
Marketing/venue hire/catering	\$1 950	Includes the Consumer Charter of Rights
Project development and implementation	\$21 900	Includes \$6000 for the Partnering Project as per strategy 2.4.2, \$6000 for the Consumer Training and costs of consumer engagement as per strategy 2.4.3
Total	\$199 236	

This strategy also relies heavily on in kind support from agencies in attending meetings, providing news to the PCP for distribution, and input into submission development and implementation.

Key Capacity Building Strategies

- Continued strengthening of partnership and problem solving opportunities between member agencies;
- Continued sharing and connectivity around innovative solutions or developments; and,
- Continued cross-sectorial relationship development between primary and acute health.

PLAN FOR REVIEW AND EVALUATION

The Agencies and Sectors strategy will be reviewed utilising the following evaluation indicators:

Process

- The completion of key tasks;
- Attendance at meetings by key PCP stakeholders including monitoring the types of agencies, number and frequency of PCP meetings;
- The number of opportunities facilitated or supported by PCP to bring staff together;
- Informal meetings and feedback from agencies to ensure the current structure is meeting agency's requirements;
- The distribution of a monthly newsletter that includes submission of articles from agencies (including monitoring the number & type of agencies submitting articles);
- The number of hits on the PCP website and comparing these to previous months and the same time last year;
- Regular reporting, feedback and meetings with DHS;
- The number and type of agencies the PCP facilitates in applications for external funding; and,
- The number of additional projects PCP agencies are involved in (between the acute & community).

Impact

- Six monthly review at Project Management meetings (as a part of regular meetings) to ensure the structure and governance model is meeting agencies requirements;
- Financial monitoring (cost effectiveness of PCP activities, meetings etc);
- The increase in successful funding from external sources for agencies; and,
- The increase in involvement in PCP activities by member agencies.

Outcome

- The increase in collaboration on projects (across the PCP and the Northern Metropolitan Region).

2.5.2 Partnerships – Partnering Project

PROBLEM DEFINITION

Agencies within the Hume Moreland Primary Care Partnership have had successful and complicated partnering examples and experiences. Agencies have reported that one of the barriers in developing partnering agreements is the amount of effort and cost involved in putting together an agreement and identifying resources that can enhance the process and outcome. It became evident through discussion with agencies that there were no identified best practice examples, especially when a small amount of money or resource sharing was involved.

Goals

To facilitate the development of partnering agreements and opportunities between agencies in the Hume Moreland Primary Care Partnership.

Objectives

1. To develop a partnering kit detailing the ideal processes and procedures to follow when entering into a partnering arrangement;
2. To include local case examples to inform agencies of the advantages and pitfalls when entering into a partnering agreement;
3. To provide agencies with sample proforma agreements that can be adapted for their own use; and,
4. To provide training to agencies on the use of the kit and processes to maximise the success of a partnering arrangement.

Population Target Group

- Service providers in the Hume and Moreland catchment.

Relationship to 2003-04 PCP Priorities for Action (Section 2.3)

- Directly addresses priorities 7, 8 and 13 and indirectly addresses priorities 1-5.

SOLUTION GENERATION

Relevant Statewide Action and Evidence Based Practice

There is an expectation from both Federal and State governments that agencies will integrate and collaborate in responding to opportunities to address the needs of the community. Agencies are increasingly taking up these opportunities with varying degrees of agreement on roles and responsibilities.

Each time a partnership is entered into there is a risk of confusion and conflict if roles and responsibilities are not clearly articulated. The development of an agreement can be both a time consuming and costly exercise, especially if legal opinions are required for more complex agreements.

The implementation of good partnering agreements will enhance the collaboration between organisations to meet the demands of the community they service. The basis of such collaboration is goodwill and there are many practical steps that need consideration to ensure this goodwill is maximized. Strong partnerships should not be made in haste and require time and good process to develop.

This strategy is also consistent with the PCP framework and policy.

Interventions and Activities	Roles and Responsibilities	Timelines
1. Consultant Engagement <ul style="list-style-type: none"> • Develop project brief • Select consultants to develop the kit • Detail project requirements 	<ul style="list-style-type: none"> • PCP Manager and PMG 	<ul style="list-style-type: none"> • April 03
2. Development of the Kit <ul style="list-style-type: none"> • Research current trends and research into partnering • Develop preliminary paper on best practice partnering • Paper to be tabled at Project Management meeting for feedback 	<ul style="list-style-type: none"> • Consultant 	<ul style="list-style-type: none"> • May 2003
3. Development of Case Studies and Proformas <ul style="list-style-type: none"> • Meet with volunteer agencies to detail their experiences of partnering and gather sample agreements • Research sample partnering agreements 	<ul style="list-style-type: none"> • Consultant 	<ul style="list-style-type: none"> • June 03
4. Finalisation of the Resource <ul style="list-style-type: none"> • Full kit developed and circulated for feedback • Kit developed for distribution to agencies 	<ul style="list-style-type: none"> • Consultant 	<ul style="list-style-type: none"> • July 2003
5. Provision of Training <ul style="list-style-type: none"> • Market workshop • Select participants • Provide workshop • Evaluate 	<ul style="list-style-type: none"> • Consultant and PCP staff 	<ul style="list-style-type: none"> • August/ Sept 2003
6. Follow Up Consultations <ul style="list-style-type: none"> • Publicise that the consultant is available to assist individual agencies • Assist with arranging consultations, as needed 	<ul style="list-style-type: none"> • Consultant and PCP staff 	<ul style="list-style-type: none"> • Sept 03

SUPPORT AND RESOURCES

Resource Allocation

A consultant has been employed to develop the resource and to provide the training. The consultant has also offered to provide one to one consultation for agencies entering into a partnering agreement. The cost of the project and training is budgeted at \$6000 and will come out of the project funding as detailed in strategy 2.4.1 including catering and venue hire.

Agencies will provide in kind support by being involved in the project development and attendance at the training.

Key Capacity Building Strategies

- Provision of best practice processes and examples, including proforma agreements for use by agencies when considering and entering into partnering arrangements
- Training to explain and assist agencies to undertake best practice partnering agreements
- Specific assistance for agencies wanting advice and support to develop partnering agreements.

PLAN FOR REVIEW AND EVALUATION

The Partnering Project strategy will be reviewed utilising the following evaluation indicators:

Process

- The completion of key tasks;
- Informal feedback from meetings;
- Formal feedback about the kit;
- The number and types of agencies participating in the training; and,
- The number and type of agencies accepting invitation for a follow up consultation.

Impact

- Evaluation of the effectiveness and efficiency (including financial) of the consultant;
- Formal evaluation of the training sessions;
- Feedback on the Partnering Kit; and
- The number of agencies indicating they will use the Partnering Kit.

Outcome

- An increase in the usage of partnering agreements between agencies entering into collaborative partnerships.

2.5.3 Partnerships – Consumer Engagement

PROBLEM DEFINITION

Full engagement of consumers is a vital process to inform planning, facilitate best practice delivery and maximise health outcomes. There is an increased expectation on agencies to engage consumers and the methods and processes of how they should do this are evolving. Agencies have varying levels of expertise and ability to implement best practice in this area. Opportunities for training and resource identification are required to strengthen the capacity of organisations to facilitate and implement consumer engagement.

Goals

1. To actively facilitate consumers as equal partners in PCP activities and at an agency level.
2. To strengthen capacity within agencies to engage consumers.

Objectives

1. Design and establish a locally accessible and sustainable training package/program that strengthens effective consumer participation; increases the number of skilled consumer representatives; promotes the consumer perspective; and provides orientation for consumers considering or participating with primary care agencies in Hume and Moreland.
2. To facilitate consumer participation in all PCP projects and within alliance agencies.
3. To facilitate connections between consumers and service providers.

Population Target Group

- Consumers
- Service providers

Relationship to 2003-04 PCP Priorities for Action (Section 2.3)

- Directly addresses priorities 9 and 11; and,
- Indirectly addresses priorities 1-7 and 12-14.

SOLUTION GENERATION

Relevant Statewide Action and Evidence Based Practice

The Hume Moreland PCP Partnership Working Group has been meeting for over two years. Throughout these two years the group has provided consumer input into work such as health planning, health promotion and service coordination. One of the recommendations from the Partnership Working group is the provision of consumer advocacy training to enhance the pool of skilled consumer advocates.

This requirement for training has been further reinforced through the results of the 'Hume and Moreland Consumer Participation Survey 2003'. This survey requested information on the model of consumer participation in agencies and asked agencies to identify any key requirements in relation to training needs. Preliminary information identified consumer training as an area of need for many agencies throughout the Hume and Moreland PCP.

The Partnership working group has indicated their preference for the delivery of the training as a local agency that has demonstrated a strong commitment to consumer advocacy and that has consumer advocacy training already in place. There is considerable scope that once the training package has been

designed, that the training may be offered to agencies throughout Hume and Moreland either annually or bi-annually, with the onus on agencies to nominate consumers and provide payment.

Agencies have also reported they require supports to identify and utilise resources to maximise their ability to support effective consumer engagement.

Interventions and Activities	Roles and Responsibilities	Timelines
<p>1. Consumer Training</p> <p><u>Getting started</u></p> <ul style="list-style-type: none"> • Design a project brief • Select an agency or organisation to develop and implement the training project <p>Development Stage</p> <ul style="list-style-type: none"> • Design and develop a training package that encompasses the objectives and recommended topics in consultation with consumer representatives from the Hume Moreland Partnership working group and PCP staff. • The training to include: <ul style="list-style-type: none"> ○ an understanding of the broader health system including funding allocation the framework for the health care system, the social model of health etc.; ○ the role of a consumer representative (consumer advocacy), the importance of consumer representation, the rights of the consumer, and access and equity strategies etc.; ○ Meeting processes, before, during and after meetings, group dynamics, minutes and agendas, acronyms and general meeting terms; and, ○ Working with service providers (including health professionals), decision making and conflict resolution, confidence to speak up in a group (assertiveness skills), dealing with disagreement, arguing your point, listening, asking questions, reflection and networking. <p><u>Implementation Stage</u></p> <ul style="list-style-type: none"> • Recruitment of consumer participants • Facilitation of a series of 4 training sessions for consumers. • Provision of interpreters as required. <p><u>Evaluation</u></p> <ul style="list-style-type: none"> • Evaluate the outcomes of the training • Adapt the training package according to the evaluation. <p><u>Ongoing Training</u></p> <ul style="list-style-type: none"> • Agencies to consider utilising the training for their consumers. 	<ul style="list-style-type: none"> • Partnerships Project Officer (PPO) • Selected organisation, PPO and consumer representatives • PPO • Selected organisation • PPO and selected organisation • Selected organisation 	<ul style="list-style-type: none"> • May 2003 • May/June 2003 • June 03 • June-Aug 2003 • Aug 2003 • Ongoing
<p>2. Market and distribute the Hume Moreland Consumer Charter of Rights to alliance agencies.</p>	<ul style="list-style-type: none"> • PCP team 	<ul style="list-style-type: none"> • Sept 2003
<p>3. Invite consumer representation on all PCP projects to advise and contribute to project development and implementation.</p> <ul style="list-style-type: none"> • provide interpreters to support CALD consumers, as required. 	<ul style="list-style-type: none"> • PCP team 	<ul style="list-style-type: none"> • Ongoing
<p>4. Continue to implement consumer reimbursement policy to facilitate</p>	<ul style="list-style-type: none"> • PCP team 	<ul style="list-style-type: none"> • Ongoing

participation.		
5. Continue to identify opportunities within agencies for consumer participants and facilitate this connection.	• PCP team	• Ongoing
6. Identify existing resources to facilitate consumer participation within agencies such as best practice manuals and models of participation.	• PCP team	• Ongoing

SUPPORT AND RESOURCES

Resource Allocation

The Consumer Training package development and implementation has been allocated a budget of \$6000 and will come out of the project funding as detailed in strategy 2.4.1 including catering and venue hire. Consumer reimbursement costs are also factored into the project funding budget as detailed in 2.4.1. PCP staff time to administer consumer reimbursement and identify opportunities and resources for agencies is also covered in the budget detailed in 2.4.1.

The Partnerships Project Officer has been instrumental in managing the Consumer Training Project. This position is not funded after June 2003 and so full implementation of this project will fall back on the remaining PCP team.

Key Capacity Building Strategies

- Provision of training to consumers;
- The development of a training model that is sustainable and available to all organizations;
- Investment in a local organisation to develop and deliver the training; and,
- Identification of resources to support organisations to implement consumer engagement.

PLAN FOR REVIEW AND EVALUATION

The Consumer Engagement strategy will be reviewed utilising the following evaluation indicators:

Process

- The completion of key tasks;
- Consumer training: observation during sessions, attendance at the sessions, and the variety of consumer advocates from various organisations;
- That each PCP project has consumer representation in attendance;
- Dissemination of consumer advocacy information to agencies including consumer charter and best practice models (via email/newsletter/website); and,
- The number of times the PCP assists agencies in providing consumer advocacy information.

Impact

- A formal evaluation will be conducted by consultant at the completion of the training (including measuring the increase in consumer advocates confidence & knowledge of the role of an effective consumer advocate);
- The financial effectiveness and efficiency of the training;
- The number of agencies who have implemented the consumer charter and follow up interviews with these agencies to ascertain the effectiveness of charter; and,
- The increase in consumer advocates confidence & knowledge of the role of an effective consumer advocate.

Outcome

- Consumer advocates are linked in with agencies; and,
- There is an increase in knowledge of best practice consumer engagement within organisations.

2.5.4 Service Coordination – Enhancing Access to Services

PROBLEM DEFINITION

The current primary care service system is complex and fragmented with a duplication of assessment and information provision by consumers. This makes the system difficult to access and navigate for consumers and carers. The Service Coordination strategy has been implemented in Hume and Moreland to minimise these barriers. Progress has been made on the streamlining of information gathering, storage and sharing, and the simplification for clients to access services. This work is incomplete and ongoing support to implement the changes is required to strengthen the integration of the service system across agencies and sectors.

Goals

1. To maximise client access to and between services in Hume and Moreland.
2. To continue to strengthen service coordination between primary care agencies in Hume and Moreland.

Objectives

1. To select and implement a secure electronic communication platform based on the business needs of agencies, that is compliant with the Privacy Act and consumer needs.
2. To continue to strengthen the implementation of the Service Coordination Tool Templates (SCoTT) for mandated agencies.
3. To facilitate referral to mandated agencies by other programs such as mental health, drug and alcohol, acute and sub acute.
4. To strengthen the implementation of the locally developed processes, practices, policies and systems that underpin the service coordination strategy.
5. To provide training and support to maximise agency's capacity to implement the service coordination strategy.
6. To involve consumers in the decision making processes around service coordination.
7. To facilitate use of the Statewide services directory to support the implementation of the service coordination strategy.

Population Target Group

- Service providers
- Consumers

Relationship to 2003-04 PCP Priorities for Action (Section 2.3)

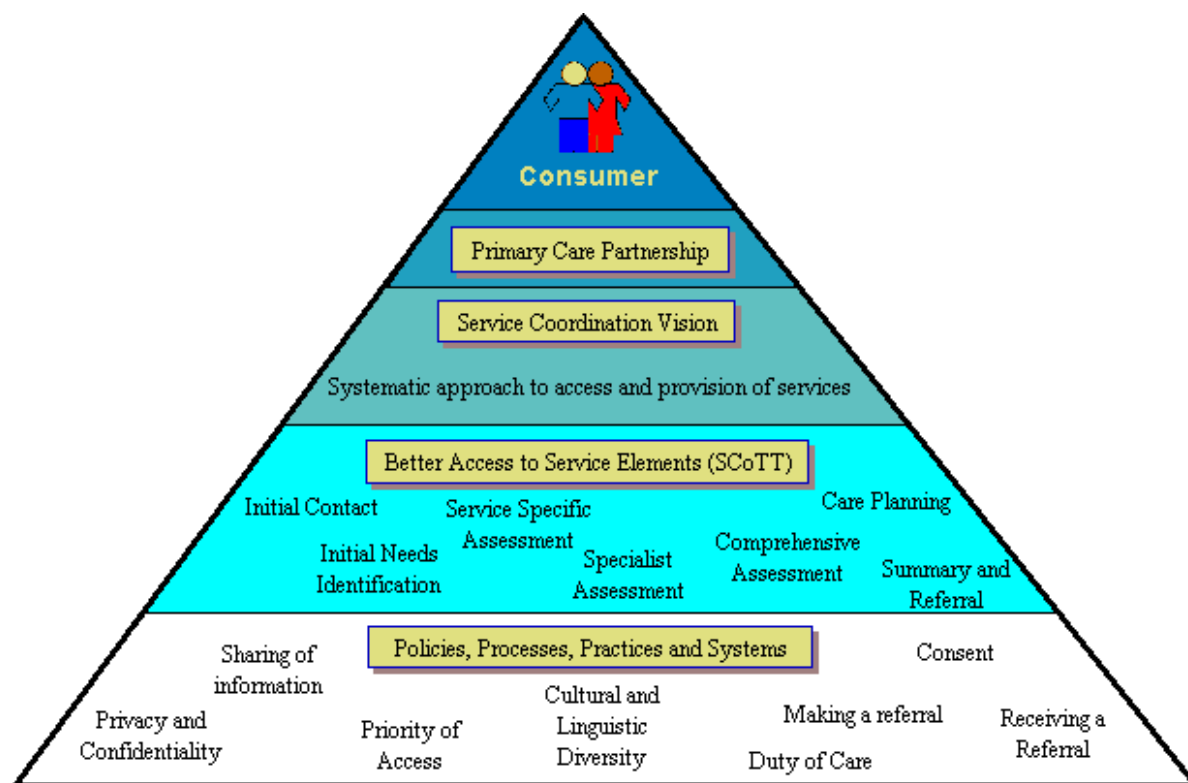
- Directly addresses priorities 5-10 and 12-14; and,
- Indirectly addresses priorities 1-4.

SOLUTION GENERATION

Relevant Statewide Action and Evidence Based Practice

This strategy is compliant with the Better Access to Services Policy Framework (July 2000) and builds on the Service Coordination Model developed by Hume Moreland PCP in 2001. This model detailed the information management protocols required to underpin the consistent implementation of the Better Access to Services elements (initial contact, initial needs identification, assessment and care planning). These two

layers are where the practice changes are required to operationalise the vision of having a systemic approach to access and provision of services.



The Hume Moreland PCP has developed and trialed the locally developed processes, practices, policies and systems that underpin the initial contact, initial needs identification, assessment and referral elements. The next stages for the PCP are to strengthen the integration of these protocols for mandated and feeder organisations and to develop and implement protocols for care planning.

To further support this, a secure and confidential method of sharing and communicating information electronically is required that supports the business operations of the main agencies involved including the acute sector. The second part of the communication need is being able to locate relevant and timely information on services available to address client need. The Statewide Services Directory has been developed to assist with this and agencies require some support to integrate into their practice.

Interventions and Activities	Roles and Responsibilities	Timelines
1. Electronic Communication Platform <ul style="list-style-type: none"> Seek advice from DHS central Office to clarify the direction of the ICT strategy Assess business needs of agencies 	<ul style="list-style-type: none"> Serv Coord Project Officer (SCPO) SCPO 	<ul style="list-style-type: none"> Aug 2003 Sept 2003

<ul style="list-style-type: none"> • Select electronic communication options that will meet business needs • Involve consumers and agencies in the selection of the preferred option • Negotiate IT consultant to assist with decision making and system requirements, if required • Determine systems requirements for implementation • Assist agencies to upgrade systems to meet requirements • Determine training needs for implementation • Provide training to key staff to assist with implementation • Develop or revise PPPS to support consistent implementation across the catchment • Work with the other PCPs across the Northern and Western regions to maximise consistent solutions 	<ul style="list-style-type: none"> • Serv Coord Workg Group (SCWG) • SCPO • SCPO & SCWG • SCPO & SCWG • SCPO & SCWG • SCWG • SCPO & SCWG • SCPO & SCWG • SCPO 	<ul style="list-style-type: none"> • Nov 2003 • Nov 2003 • Nov 2003 • Dec 2003 • Feb 2004 • Feb 2004 • Feb-June • June 2004 • Ongoing
<p>2. Implementation of SCoTT</p> <ul style="list-style-type: none"> • Continue to act as an information conduit between DHS and agencies • Provide communication and problem solving opportunities with key people such as the service coordination working group members • Facilitate agencies to strengthen the use of the care planning profiles, as appropriate for client needs • Provide on site training, problem solving and support to agencies • Broaden the service coordination working group by inviting ongoing or intermittent participation by all mandated agencies 	<ul style="list-style-type: none"> • SCPO • SCPO & SCWG • SCPO & SCWG • SCPO • SCPO 	<ul style="list-style-type: none"> • Ongoing • Ongoing • June 2004 • Ongoing • Sept 2003
<p>3. Referral by Non mandated agencies</p> <ul style="list-style-type: none"> • Meet with individual agencies to support the use of SCoTT referral templates when assisting clients to access mandated agencies • Provide agencies with the relevant PPPS to support referral • Invite agencies to relevant service coordination training 	<ul style="list-style-type: none"> • SCPO • SCPO • SCPO 	<ul style="list-style-type: none"> • Ongoing • Ongoing • Ongoing
<p>4. PPPS Implementation</p> <ul style="list-style-type: none"> • Finalise flowcharts and documents detailing PPPS • Distribute to all mandated agencies in a kit form • Identify any training needs • Implement any training required • Provide ongoing problem solving support to agencies 	<ul style="list-style-type: none"> • SCPO • SCPO • SCPO & SCWG • SCPO & SCWG • SCPO 	<ul style="list-style-type: none"> • July 2003 • Sept 2003 • Ongoing • Ongoing • Ongoing

<p>5. Services Directory</p> <ul style="list-style-type: none"> • Communicate any training opportunities to agencies and key contact points in the use of the services directory • Promote the use of the services directory through articles in the PCP News, on the website and through any service coordination training • Consideration will be given to financially supporting participation in services directory training for agencies and individuals who may need subsidy 	<ul style="list-style-type: none"> • SCPO • SCPO • SCWG 	<ul style="list-style-type: none"> • Ongoing • Ongoing • Ongoing
<p>6. Information and Communication Technology</p> <ul style="list-style-type: none"> • Continue involvement in the Regional ICT Governance Group to inform discussions, advocate for ICT resources and solutions in the Northern Metropolitan Region. 	<ul style="list-style-type: none"> • PCP members • NMR ICT Governance Group 	<ul style="list-style-type: none"> • Ongoing

SUPPORT AND RESOURCES

Resource Allocation

The service coordination project officer will predominantly drive the three service coordination strategies, with guidance from the service coordination working group. The Going Home with a Baby project (see strategy 2.4.6) has its own separate budget emanating from the Acute Interface project funding, although the service coordination project officer will be involved in this project by offering advice on referral and SCoTT usage as appropriate and have the following associated costs:

Description	Budget	Notes
Salaries and on costs	\$54 894	1x EFT until April 2004
Office support costs	\$0	Covered in the budget Partnerships strategy
Electronic communication platform	\$20 000	Including any consultant fees and training required to implement the product
Marketing/venue hire/catering	\$2 000	
Project development and implementation	\$39 600	Includes \$15 000 for the General Practitioner Project as per strategy 2.4.5, reimbursement for GP involvement in the working group, other consultants as needed
Total	\$116 494	

This strategy also relies heavy on in kind support from agencies in attending the working group and other meetings and input into submission development and implementation. Organisations are also expected to ensure implementation of the SCoTT and PPS within their own agency, with the support of the PCP team.

Key Capacity Building Strategies

- Staff training and support at an agency level to implement the SCoTT and PPS;
- Developing the tools and PPS to implement new systems;
- Workforce development strategies to ensure staff are well trained;
- Increasing the cooperation and collaboration between agencies; and
- Maximising the consistency of approach across the region.

PLAN FOR REVIEW AND EVALUATION

The Enhancing Access to Services strategy will be reviewed utilising the following evaluation indicators:

Process

- Feedback from agencies and consumers about their requirements for an electronic communication system;
- The number of agencies and consumers involved in informing the electronic referral decision making process;
- The number of staff in attendance and their feedback about the impact of the training;
- The number of agencies who received a copy of the PPPS;
- The number of agencies that are provided with advice and on site training to support the implementation of SCoTT and PPPS;
- The number of people and agencies represented at the Service Coordination Working Group;
- The number of non mandated agencies that are informed of the service coordination strategy; and
- The number of representatives from Hume Moreland PCP at regional ICT Governance meetings.

Impact

- The number of agencies utilising the electronic communication system;
- Feedback from agencies utilising the electronic system;
- The number of agencies utilising the care planning protocols and tools;
- Feedback from agencies on the use of the PPPS and SCoTT;
- The number of services utilising the services directory to assist clients to find out about and access services;
- The number of non mandated agencies that utilise the SCoTT to facilitate client referral and access to services; and,
- The increase in ICT infrastructure to network agencies.

Outcome

- A functional electronic referral system is being utilized by agencies to support the implementation of SCoTT, PPPS and the services directory; and
- A reduction in the complexity of access and navigation of the system by consumers and carers.

2.5.5 Service Coordination – General Practitioners

PROBLEM DEFINITION

To date the PCP has successfully engaged the North West Melbourne Division of GPs in the development of the Service Coordination strategy. Now that service providers have commenced implementation, it is appropriate to commence more strategic engagement of GPs to complement the system changes.

Goals

To actively engage general practitioners in the Hume Moreland PCP service coordination strategy.

Objectives

1. Provide education opportunities for GPs on the SCoTT and PPS;
2. To support GP use of the SCoTT and PPS to facilitate client access to services;
3. To utilise existing PPS processes to inform GPs of referrals being made for clients in common;
4. To continue to support the involvement of the North West Melbourne Division of General Practice (NWMDGP) in PCP activities, in particular the GP representative on the service coordination working group, and Division representatives on the Project Management Group and Health Promotion Working Group.

Population Target Group

- General practitioners
- Consumers
- Service providers

Relationship to 2003-04 PCP Priorities for Action (Section 2.3)

- Directly addresses priorities 6-8, 10-12 and 14; and,
- Indirectly addresses priorities 1-5.

SOLUTION GENERATION

Relevant Statewide Action and Evidence Based Practice

Hume Moreland PCP and the North West Melbourne Division of General Practice have been working together in the implementation of the service coordination strategy for over three years. The Division has had a general practitioner (GP) as the representative on the service coordination working group who has been instrumental in informing and advising on practices standards currently being trialed by agencies within the PCP.

Both the Division and the PCP have been informing GPs of relevant developments in service coordination as they occur through the Division newsletters, faxes and the PCP newsletter. GPs have been directly involved and refer into other service coordination projects such as the One Step Ahead: Local Diabetes Service Development project.

Mandated agencies within the Hume Moreland PCP commenced implementation of the service coordination tools and templates (SCoTT) in November 2002. There has been steady progress and ten of the fourteen mandated agencies have made significant advances. Delays with implementation are

frequently related to the present unavailability of integrated electronic versions of the SCoTT, especially for those agencies that already utilise an electronic records system. A set of processes, policies, practices and systems (PPPS) have also been developed to support consistent practice of the SCoTT.

Comprehensive engagement and full participation of GPs in implementing the SCoTT and PPPS needs to be staged and requires developments in:

- the integration of an electronic version of the tool templates into service provider and GP software including Medical Director;
- availability of and training for the use of an electronic referral platform that has an integrated services directory; and,
- GP understanding and training in the SCoTT and PPPS.

Advances are occurring in the integration of SCoTT into Medical Director and the availability of an electronic referral platform. This is anticipated to continue over the next 12 months. Therefore the rationale for this strategy is to build on the momentum of service provider uptake of the SCoTT and PPPS and link GPs into this process.

Interventions and Activities	Roles and Responsibilities	Timelines
1. Bringing GPs into the Loop <ul style="list-style-type: none"> • Discuss with Service Coordination Working Group members the possibility of including GPs when confirmation of a referral is sent as per the agreed PPPS; • For agencies that wish to participate, identify GPs they most commonly interact with; • Inform GPs of the possibility of receiving a copy of the referral confirmation and explain the service coordination strategy; and, • Assist agencies to fax referral confirmation sheet to GPs once consent is gained from the client. 	<ul style="list-style-type: none"> • SCPO • SCPO and agencies • SCPO • SCPO 	<ul style="list-style-type: none"> • Aug 2003 • Sept 2003 • Sept 2003 • Oct – Dec 2003
2. GP Service Coordination Training <ul style="list-style-type: none"> • Develop training package to inform GPs of the service coordination strategy • Apply for Continuing Professional Development points to reward GPs for undertaking the training; • Trial training package at 2 practices, in conjunction with the North West Melbourne Division of General Practice • Review training package • Select practices where training will be provided • Trainer to provide education to practice staff and GPs 	<ul style="list-style-type: none"> • SCPO and NWMDGP • SCPO • SCPO • SCPO • NWMDGP • SCPO 	<ul style="list-style-type: none"> • Nov 2003 • Dec 2003 • Dec 2003 • Jan 2004 • Jan 2004 • Feb-June 2004
3. Submit articles to the NWDGP Newsletter to inform GPs of service coordination activities	<ul style="list-style-type: none"> • SCPO 	<ul style="list-style-type: none"> • Ongoing

4. Support GP participation on the Service Coordination Working Group.	<ul style="list-style-type: none"> • SCPO 	<ul style="list-style-type: none"> • Ongoing
5. Continue to support NMDGP staff on working groups and PMG	<ul style="list-style-type: none"> • PCP team 	<ul style="list-style-type: none"> • Ongoing

SUPPORT AND RESOURCES

Resource Allocation

The GP strategy has a total of \$15 000 available that will predominantly be spent on reimbursement to GPs for their time and employment of a project officer or reimbursement to the North West Melbourne Division of General Practice if they undertake implementation of the strategy.

Key Capacity Building Strategies

- Strengthening the capacity of GPs to facilitate client access to services using the SCoTT and PPPS;
- Strengthening the communication and information sharing between service providers and GPs;
- Strengthening GPs knowledge on services available and the tools available to assist them to find the best service for their patients;
- Supporting the involvement of the Division of General Practice and GPs in the Hume Moreland PCP.

PLAN FOR REVIEW AND EVALUATION

The GP Engagement strategy will be reviewed utilising the following evaluation indicators:

Process

- The number of faxes and the number of agencies sending a confirmation fax to a GP;
- The number of GPs receiving a confirmation fax;
- GPs and Division staff attendance and participation at meetings; and,
- The number of articles published about the service coordination strategy for GPs.

Impact

- The number of GP practices where the training package is implemented;
- Feedback about the content, financial effectiveness and the subsequent increase in knowledge obtained by GPs after the training;
- The number of GPs who claim the Continuing Education points for participating in the training;
- The number of referrals made by GPs using the SCoTT; and,
- The number of GPs utilising the SCoTT for referral after completing the training.

Outcome

- GPs are involved in and are integrating the service coordination strategy to facilitate consumer access to services by utilising the SCoTT and PPPS for referral.

2.5.6 Service Coordination – Maternity Services (Going Home with a Baby)

PROBLEM DEFINITION

There are a myriad of possible issues for women being discharged from hospital following the birth of a child. Currently there is an inconsistent approach to the sharing of information between providers across the acute and community services.

Goals

1. To strengthen service coordination and communication between the acute and community based maternity services.
2. To continue to implement this project and complete by December 2003.

Objectives

1. To promote a collaborative approach to postnatal planning and community services to ensure an effective service response.
2. To develop and implement a best practice model that addresses coordination, communication and collaboration between the acute and community service providers.
3. To facilitate sustainable and active support networks and peer based resources for the community and acute sectors.

Population Target Group

- Acute services providing maternity services to Hume and Moreland (Royal Women's, Mercy, Royal Children's, The Northern and Sunshine Hospitals)
- Maternal and Child health Services in Hume and Moreland
- Consumers utilising these services.

Relationship to 2003-04 PCP Priorities for Action (Section 2.3)

- Directly addresses priorities 2, 6-8, and 12 – 14.

SOLUTION GENERATION

Relevant Statewide Action and Evidence Based Practice

Women are discharged from hospital earlier and with smaller babies that require more intensive support. The burden of disease data for Hume Moreland indicate Neonatal conditions (21%), including low birth weight (9%) are a significant concern. Also, 21% of cases for admission to hospital of 0-4year age group, were conditions originating in the perinatal period. (HMPCP Community Profile 2001, Adamas Consultancy).

Early discharge impacts on the skill level and confidence of mothers including breastfeeding or caring adequately for their baby. Maternal and Child Health nurses report they are inadequately funded to fully accommodate this role. Community service providers have raised concerns about the capacity of the current service system to meet the demands and needs of women and babies following discharge from hospital.

Problems that develop in the post natal period can have a far reaching impact on breast feeding, the mother's emotional health, the relationship between mother and baby and the child's ongoing

development. The Victorian average for breastfeeding at three months is 52.4%. The level within Hume was considerably lower with a breastfeeding rate of 41% and Moreland was slightly above average, at 54%. (Source: HMPCP Community Profile 2001, Adamas Consultancy).

Both community and hospital providers recognise the need to improve collaboration and have expressed interest in participating in a project that develops better links between services and ensures consistency across the system. There is also a Statewide working party undertaking similar work around addressing some of the maternity services issues of meeting the demand and complexity of need.

Interventions and Activities	Roles and Responsibilities	Timelines
Getting Started <ul style="list-style-type: none"> Appointment and introduction of auspice agency 	<ul style="list-style-type: none"> Project Manager 	<ul style="list-style-type: none"> March 2003
2. Consultation with Key Stakeholders <ul style="list-style-type: none"> Identify gaps in the communication between the services; Clarify roles and expectations between service providers; Conduct a forum to share the model of care options available for pregnancy and birth at different maternity hospitals; Map the service system available in Hume and Moreland; Identify gaps in service delivery; and Identify strategies to improve service delivery. 	<ul style="list-style-type: none"> Project Officer and agencies involved in the project 	<ul style="list-style-type: none"> April to Nov 2003
3. Identifying Best Practice <p>3.1 <u>Sharing Information</u></p> <ul style="list-style-type: none"> Type of information (eg. Special needs, mother, baby, risk factors/alerts); transfer of information; timeliness Explore the possibility of using the SCoTT. <p>3.2 <u>Discharge Planning</u></p> <ul style="list-style-type: none"> What information is recorded Identifying risk factors and response to risk factors Responding appropriately to cultural needs Collaboration/interaction with the community sector <p>3.3 <u>Referral Platform</u></p> <ul style="list-style-type: none"> Timeliness – sending referral, response to referral and delivery of service Accuracy of information Protocols around receipting and response <p>3.4 <u>Community Sector Response</u></p> <ul style="list-style-type: none"> Timeliness – determining what is a reasonable response given the identified issues. <p>3.5 <u>Consent/Privacy Requirements</u></p>	<ul style="list-style-type: none"> Project Officer and agencies involved in the project 	<ul style="list-style-type: none"> April to July 2003
4. Implementing Best Practice <ul style="list-style-type: none"> Facilitate the development of agreed protocols, practices, processes, and systems to implement the changes suggested through Steps #3.1 to #3.5. Provide support and training to community and acute sectors to implement the changes. 	<ul style="list-style-type: none"> Project Officer and agencies involved in the project 	<ul style="list-style-type: none"> July to Nov 2003

<p>5. Developing Networks</p> <ul style="list-style-type: none"> Facilitate the development of a regular network meeting in Hume Moreland where the agenda is designed to facilitate problem solving of particular issues, or to plan training. Facilitate the development of a calendar of forums that offers peer education opportunities on innovations in the maternity field. The forums can be distributed across the participating local government areas. 	<ul style="list-style-type: none"> Project Officer and agencies involved in the project 	<ul style="list-style-type: none"> April to Nov 2003
<p>6. Evaluation</p> <ul style="list-style-type: none"> Measure key performance indicators at end of project. 	<ul style="list-style-type: none"> Project Officer 	<ul style="list-style-type: none"> Dec 2003

SUPPORT AND RESOURCES

Resource Allocation

A total of \$28 000 will be spent on this project (acute project funding received in 2002). This project has been contracted to Women's Health in the North who has employed a project officer from March to December 2003, 2 days per week.

In kind support for meeting rooms and catering mainly provided by Moreland Council.

Representatives on the working and reference groups will include:

- A representative from DHS Northern Metropolitan Region Office;
- Royal Women's, Northern, Mercy, Sunshine, and Royal Children's hospitals;
- Maternal Child Health Coordinators and Nurses from Hume and Moreland local governments;
- The North West Melbourne Division of General Practice; and,
- The Service Coordination Project Officer from Hume Moreland PCP.

Key Capacity Building Strategies

- Improved access and coordination of service for women and their babies, particularly those identified with social/clinical risk factors;
- Increased collaboration and communication between local community providers (Maternal Child Health Services) and hospitals providing maternity/children services (Northern Hospital, Royal Women's Hospital, Mercy Hospital, Royal Children's Hospital and Sunshine Hospital);
- Adaptation of the SCoTT and PPPS as a means of consistent referral and communication between the sectors;
- Clarification of roles and expectations between service providers;
- Improved information provision and links to maternal and child health services in Hume and Moreland for recent mothers;
- Identification of gaps in service provision; and,
- Development of a service network to facilitate problem solving and information sharing between providers.

PLAN FOR REVIEW AND EVALUATION

The Going Home with a Baby strategy will be reviewed utilising the following evaluation indicators:

Process

- The number and type of staff attending meetings ;
- The number of agencies contributing to the gathering of information about the current service system;
- The number of communication gaps and issues identified and solved or advocated to the appropriate body's;
- The identification of examples of best practice within the current system; and,
- The number of staff who participate in any training.

Impact

- Feedback form staff demonstrates a better understanding of the issues and limitations confronting all agencies providing maternity services;
- Follow up with the agencies involved with the project to ascertain their feedback as to the impact the project had on streamlining communication;
- The number of network meetings organised after the project is completed;
- The number of staff and agencies represented at the networks;
- Feedback form staff attending training as to the training impact on their understanding and ability to implement the practice change;
- The number of agencies who agree to implement the agreed to changes in referral and communication systems; and,
- Formal evaluation conducted by the auspice agency including the cost effectiveness of the project; achievement of goals and objectives; and, the identification and implementation of alternate communication strategies and tools.

Outcome

- Women being discharged from the acute sector to the community will all have relevant information that they consent to being shared, transferred between the agencies to ensure an effective service response.
- Agencies are utilising all agreed processes, practices, policies and systems to facilitate this streamlining of service delivery.

2.5.7 Integrated Health Promotion – Capacity Building

PROBLEM DEFINITION

The Health Promotion Working Group has identified the need to improve and expand expertise through greater visibility and support for the role of health promotion in Hume and Moreland. The major areas the group identified include the need for mentoring, direct training and access to information.

Goals

To continue to develop a best practice model of capacity building that will provide a platform for an enhanced, coordinated and sustainable approach to health promotion activities in Hume and Moreland.

Objectives

1. To increase opportunities to improve and expand expertise in health promotion through direct training, access to information and resources;
2. To establish and facilitate subcommittees around Hume and Moreland health promotion priority areas as identified in the health promotion plan (chronic illness and mental health); and,
3. For the Health Promotion Working Group to assume a mentoring role to agencies and staff throughout Hume and Moreland.

Population Target Group

- Service providers in Hume and Moreland.

Relationship to 2003-04 PCP Priorities for Action (Section 2.3)

- Directly addresses priorities 1,3,4, 7, 8, and 10.

SOLUTION GENERATION

Relevant Statewide and Evidence Based Practice

This strategy is consistent with evidence based practice stating that capacity building increases the likelihood that effective health promotion programs will be sustained. This is also in line with Department of Human Services workforce development initiatives in health promotion. Best practice models from other PCP's/organisations will be utilised in the development of interventions.

This strategy also links well with the Partnerships strategies and will utilise the tools (such as the newsletter to enhance communication and publicise events) to support implementation

Interventions and Activities	Roles and Responsibilities	Timelines
1. Organisational Development <ul style="list-style-type: none">• Facilitate the bi-monthly meeting of the HPWG• Strengthen the role of the existing members of the group• Establish, monitor and evaluate the formation of subcommittees formed around key priority areas.	<ul style="list-style-type: none">• HPPO• HPWG/HPPO• HPWG	<ul style="list-style-type: none">• Ongoing• Ongoing• Sept – June 2003
<ul style="list-style-type: none">• Provide advice and mentoring to projects and agencies engaged in health promotion activities.	<ul style="list-style-type: none">• HPWG	<ul style="list-style-type: none">• Ongoing

<ul style="list-style-type: none"> To monitor the effectiveness of the Statement of Cooperation (SOC) through the establishment of subcommittees. To review the Terms of Reference for the HPWG. 	<ul style="list-style-type: none"> HPWG HPWG/HPPO 	<ul style="list-style-type: none"> Ongoing March 2004
<p>2. Workforce development</p> <ul style="list-style-type: none"> Develop a database of staff who have completed the Health Promotion short course and where possible link them into the work of the HPWG and invite them to participate in forums etc. Develop a web based health promotion resource kit including local contacts and resources (based on an updated version of the mapping exercise completed in 2003). Conduct a series of health promotion forums within Hume and Moreland around health promotion with internal and external guest speakers. Conduct a one-day mini-conference with another rural PCP to showcase health promotion activities. Identify and where relevant, facilitate training opportunities for agency staff involved in health promotion activities, such as working with CALD communities. Disseminate and market health promotion activities and training opportunities in Hume Moreland. Respond to agencies requests for health promotion information, resources etc. Conduct a submission writing workshop. Assist agencies to develop strategic approaches to funding opportunities & where relevant to facilitate agencies applying for external funding. Establish opportunities and mechanisms for service providers to: <ul style="list-style-type: none"> Utilise networks to promote health promotion information/activities Integrate health promotion plans Identify and respond collaboratively to projects. Facilitate a gender sensitive health promotion planning workshop (conducted by Women's Health in the North) 	<ul style="list-style-type: none"> HPPO HPWG/HPPO HPWG/HPPO HPWG/HPPO HPWG/HPPO HPPO Consultant HPWG/HPPO HPWG/HPPO HPWG/HPPO/WHIN 	<ul style="list-style-type: none"> October 2003 October 2003 October – June 2004 April 2004 Ongoing Ongoing Ongoing July 2003 Ongoing Ongoing May 2004

Note: Health Promotion Project Officer (HPPO) and Health Promotion Working Group (HPWG)

SUPPORT AND RESOURCES

Resource Allocation

The health promotion project officer will predominantly drive the three health promotion strategies, with guidance from the Health Promotion Working Group and subcommittees.

The overall Health Promotion budget for 2003- 04 is summarised as:

Surplus FY03 +	45 500	Approximate
New Grants =	53 814	
Available Budget	99 314	

Description	Budget	Notes
Salaries and on costs	\$54 894	1x EFT project officer until April
Office support costs	\$4 920	
Venue hire/catering	\$4 500	
Project development and implementation	\$35 000	\$ 10 000 for the Capacity Building strategy, \$15 000 for Younger People Project and \$10 000 for the Chronic Disease strategy
Total	\$99 314	

The Health Promotion Working Group has allocated \$10,000 specifically to the priority area of capacity building and will include consumer reimbursement and payment to consultants, including engagement of guest speakers etc.

PLAN FOR REVIEW AND EVALUATION

The Capacity Building strategy will be evaluated against the following indicators:

Process

- Attendance at HPWG meetings/subcommittee meetings (including type of staff and variety of agencies);
- Number and frequency of HPWG/subcommittee meetings;
- Informal feedback on the Statement of Cooperation;
- Database of staff who have completed the Health Promotion short course to completed and utilised by HPWG and others (number of agencies the information is disseminated, number of enquiries for information, number of staff who have completed the course participating in forums/training etc.);
- Number of times health promotion information is disseminated via newsletters/emails/web (number of hits of website);
- Number of funding opportunities disseminated; and,
- Number of forums/mini-conference/training sessions conducted. These will be measured via satisfaction surveys, attendance by wide variety of practitioners & agencies, usefulness & relevance and increase in knowledge.

Impact

- A component of HPWG meetings (every six months) will be directed at asking representatives for feedback on structure, relevance, content etc.;
- Statement of Cooperation: via observation of health promotion knowledge and application in subcommittee meetings, project planning and development etc.; and,
- Increase in external funding applied for & received (facilitated by the PCP).

Outcome

- There is an enhanced, coordinated and sustainable approach to health promotion activities amongst agencies; and,
- Enhanced capacity of agencies to deliver quality health promotion programs for consumers.

2.5.8 Integrated Health Promotion – Wellbeing of Younger People

PROBLEM DEFINITION

The Health Promotion working group has identified the need to co-ordinate service delivery across Hume and Moreland with an emphasis on the well being of younger people. Staff from agencies throughout Hume and Moreland have also identified that while existing networks are useful for the purpose of information exchange, the opportunity to collaborate in projects across agencies is limited. Staff involved in youth related health promotion activities have identified that there is a need to improve services to be more friendly and inviting for youth.

Goals

To strengthen the capacity of agencies to coordinate and collaborate on health promotion activities throughout Hume and Moreland with a focus on enhancing the well being of younger people.

Objectives

1. To facilitate a short-term project that focuses on training young people to conduct an audit of the youth friendliness of agencies;
2. To assist agencies in identifying opportunities to collaborate on health promotion projects related to young people and to strengthen networking opportunities;
3. To enhance participating agency staff to become more familiar with health promotion concepts and models (including evaluation techniques) to integrate into daily practice; and,
4. To assist agencies in identifying external funding opportunities.

Population Target Group

- Service providers in Hume and Moreland
- Younger people (aged 15 – 19) studying the Victorian Certificate of Applied Learning

Relationship to 2003-04 PCP Priorities for Action (Section 2.3)

- Directly addresses priorities 3, 4, 8, 9 and 13.
- Indirectly addresses priority 11.

SOLUTION GENERATION

Relevant Statewide Action and Evidence Based Practice

- The Community Health Profile has identified a number of issues affecting young people in Hume and Moreland including high levels of unemployment and lower retention rates at school. The region covering the catchment area has below average Year 12 school retention rates. This may be partly due to the high level of socio-economic disadvantage in many LGAs within the region, as the Year 12 retention rate has been found to be considerably lower for younger people from low – income families (HMPCP Community Profile 2001, Adamas Consultancy).
- The Burden of Disease data indicate relatively high levels of mental disorders including alcohol abuse/dependency, depressions and bipolar disorder, asthma and diabetes for younger residents in Hume and Moreland.

- Participating agencies in the youth health promotion subcommittee have identified the importance of networks however comment on the lack of opportunities to collaborate on projects, therefore this priority area will primarily be a capacity building strategy.
- The project to be conducted by the subcommittee is based on a similar project that was completed successfully by Melbourne Moonee Valley PCP. Therefore best practice models will be referred to and utilised during the project development and implementation phases.
- Other relevant information will be referred to in the development of the project including evidence around risk and protective factors for young people.
- The provision of skills to the younger people involved in the project to allow them to audit agencies, are skills that are transferable to everyday life, such as conflict resolution. This skill development is aimed to contribute to the well being of younger people.

Interventions and Activities	Roles and Responsibilities	Timelines
1. Organisational development <ul style="list-style-type: none"> • Facilitate the on-going meeting of the youth health promotion working group. • Pilot the statement of cooperation developed by the HPWG. • Assist agencies with the implementation of any successful projects as required. • Provide ideas and information around funding opportunities. • Facilitate agencies own work in health promotion around younger people. • Disseminate key health promotion information to representatives. 	<ul style="list-style-type: none"> • HPPO • HPPO/HPWG • HPPO/HPWG • HPPO/HPWG • HPPO/HPWG • HPWG/HPPO 	<ul style="list-style-type: none"> • July – Nov 2003 • July – Nov 2003 • Ongoing • Ongoing • Ongoing • Ongoing
2. Workforce Development <ul style="list-style-type: none"> • Facilitate agencies to participate in PCP training (and other) that builds capacity around youth. • From the work of the subcommittee identify any training needs and advocate for this training. 	<ul style="list-style-type: none"> • HPWG/HPPO • HPWG/HPPO 	<ul style="list-style-type: none"> • Ongoing • Ongoing
2. Young people project (Project plan currently being developed) <u>Getting started</u> <ul style="list-style-type: none"> • Identify priority areas for young people in Hume Moreland. • Identify one priority area to develop as a project. • Consult with other PCPs who have completed projects around young people to identify best practice projects. • Involve young people in developing the project <u>Development stage</u> <ul style="list-style-type: none"> • Identify target group and proposed outcomes. • Develop a project brief around proposed project concept. • Recruit a short-term facilitator to run focus groups. • Recruit young people to participate in the project 	<ul style="list-style-type: none"> • YHPSC/HPPO • YHPSC/HPPO • YHPSC/HPPO • YHPSC/HPPO • YHPSC/HPPO • YHPSC/HPPO • YHPSC/HPPO • YHPSC/HPPO 	<ul style="list-style-type: none"> • May 2003 • June 2003 • June 2003 • Ongoing • June 2003 • June 2003 • June 2003 • June 2003

<u>Implementation:</u> <ul style="list-style-type: none"> • Run workshops (including training for younger people) • Facilitate younger people to conduct interviews with agencies • Facilitate feedback to agencies from young people 	<ul style="list-style-type: none"> • Consultant/YHP SC/HPPO 	<ul style="list-style-type: none"> • Aug – October 2003
<u>Evaluation</u>	<ul style="list-style-type: none"> • Consultant/YHS C/HPPO 	<ul style="list-style-type: none"> • Nov – Dec 2003

Note: Youth Health Promotion Subcommittee (YHPSC)

SUPPORT AND RESOURCES

Resource Allocation

The Health Promotion working group has allocated \$15,000 to facilitate the sub-committee and to conduct a project. The Hume Moreland PCP project officer will provide executive support to the subcommittee and support the implementation of the project. A consultant will be engaged to conduct focus groups with young people.

Representatives on the Youth Health Promotion subcommittee include:

- School Focused Youth Services (Moreland and Hume)
- Moreland and Hume City Councils
- Centrelink
- YMCA
- Secondary Colleges (Moreland City College, Sydney Road Community College, Erinbank and Hillcrest)
- Dianella and Moreland Community Health
- A Bit Bent

Key Capacity Building Strategies

- The provision of specific health promotion related training.
- Development of a project based on key health promotion principles including the Ottawa Charter, health promotion planning and evaluation methods etc.
- Strengthen the ability of agencies to problem solve on a collaborative basis, through the development and implementation of a project.
- Provision of training to enhance life skills in younger people such as conflict resolution.

PLAN FOR EVALUATION AND REVIEW

The Capacity Building strategy will be evaluated against the following indicators:

Process

- Subcommittee: attendance at meetings (variety of agencies, numbers, frequency)
- Throughout the life of the subcommittee, opportunities will be provided for participants to reflect on whether the subcommittee is meeting the needs of the participants
- Number of funding opportunities disseminated/discussed
- Number of staff participating in PCP (and other) training opportunities

- Number of times youth health promotion related information disseminated to representatives (web, email, newsletter),
- Consultation with other PCPs and information disseminated to YHPSC (the numbers of projects drawn upon as models in which to develop their own project)
- A number of measures will be employed during the project roll out including observation,
- young people providing feedback during focus groups, diaries, meetings with school
- contacts, survey (pre-post) to ascertain change in knowledge
- Number of young people participating in project (including % from Hume and Moreland), including the % who were involved in developing the project

Impact

- Part of the final subcommittee meeting will be allocated to reflecting on the achievements of the group, success, barriers etc.
- The acquisition of health promotion knowledge for agency representatives will be measured via observation including the level of health promotion theory that has been applied to the development and implementation of the project etc.
- Increased knowledge for the project participants will be measured via observation, journal entries, interviewing etc.
- The percentage of agencies that implement change on the basis of feedback from young people.
- The percentage of young people participating in project who pass the 'Personal Development' unit as a part of their VCAL studies.

Outcome

- Evidence of enhanced coordination and collaboration on health promotion projects.
- Young people – there is insufficient funds available to adequately measure the longer-term outcomes of the project.

2.5.9 Integrated Health Promotion – Chronic Disease

PROBLEM DEFINITION

The Health Promotion working group has acknowledged the importance of self-management for consumers with a chronic disease and has highlighted the need for staff to increase skill levels in this area.

Goals

To strengthen integrated health promotion activities related to chronic disease, with a particular emphasis on selfmanagement programs and prevention.

Objectives

1. To increase knowledge of evidence based practice in chronic disease self-management programs;
2. To link in with existing networks (HARP/Diabetes) to integrate agency health promotion activities; between projects and agency work in the area of chronic disease;
3. To ensure that resources available to support interactions with CALD communities are promoted; and,
4. To establish and facilitate a subcommittee/s around chronic disease to increase knowledge of chronic disease self-management and prevention.

Population Target Group

- Service providers
- Consumers with chronic disease

Relationship to 2003-04 PCP Priorities for Action (Section 2.3)

- Directly related to 1, 5, 7, 8, 10, 11 and 13
- Indirectly related to 4

SOLUTION GENERATION

Relevant Statewide Action and Evidence Based Practice

There are five areas that have been designated as national health priority areas. These are:

- cardiovascular health;
- cancer control;
- injury prevention and control;
- mental health; and
- diabetes mellitus.

Residents of the Northern Metropolitan Region of Melbourne have the highest reported prevalence of asthma of any Victorian regions with a prevalence rate approximately 14% compared to 12.3% for the whole of Victoria. In the Ambulatory Care Sensitive Conditions data, Hume and Moreland are rated as higher than the Victorian average for admissions for COPD.

The strategy will link in with evidenced based practice occurring in other Primary Care Partnerships in Victoria.

Interventions and Activities	Roles and Responsibilities	Timelines
<p>1.Organisational Development</p> <ul style="list-style-type: none"> • Conduct a mapping exercise of chronic disease self management programs throughout Hume Moreland and other PCPs to identify best practice in the area (placed on website & advertised widely throughout Hume and Moreland) • Identify opportunities to strengthen linkages with existing networks (HARP/Diabetes). • Disseminate information on chronic disease, with a particular emphasis on self-management programs (web-site, newsletter, emails). • Organise forum/s around chronic disease self-management, show casing local programs in and outside the area, with guest speakers (etc.) The forum/s will be dependent on the outcomes of the subcommittee/s 	<ul style="list-style-type: none"> • HPPO • HPWG/HPPO • HPWG/HPPO/ sub-committee • HPWG/HPPO 	<ul style="list-style-type: none"> • Oct 2003 • Aug-Sept 2003 • Ongoing • October-April 2004
<p>2. Workforce Development</p> <ul style="list-style-type: none"> • Establish a subcommittee/s focusing on chronic disease (this may involve conducting further investigation on best practice models currently available, identifying training needs etc. The outcomes are dependent upon the needs identified by the subcommittee hence there is some flexibility in this intervention/activity). • Identify training opportunities for agency staff to participate in chronic illness self management training and where relevant , facilitating these opportunities. • Support collaborative partnerships & applications for funding to develop chronic disease self-management programs. • Identify and promote resources for CALD communities such as disease fact sheets and community languages. 	<ul style="list-style-type: none"> • HPWG/Subcommittee • HPWG/Subcommittee • HPWG/Subcommittee • HPWG/Subcommittee 	<ul style="list-style-type: none"> • Formation: Oct – Nov 03 Intended to be short term committee/s • Ongoing • Ongoing • Ongoing

SUPPORT AND RESOURCES

Resource Allocation

The Health Promotion working group has allocated \$10,000 to this priority area. Expenditure will relate to consumer reimbursement, the running of forums and the engagement of guest speakers. The Health Promotion Project Officer will provide executive support to the subcommittees.

Key Capacity Building Strategies

- Provision of information sharing and encouraging problem solving through the establishment of subcommittees.
- Conducting forums.
- Strengthening knowledge and collaboration around chronic disease self-management.

PLAN FOR REVIEW AND EVALUATION

The Capacity Building strategy will be evaluated against the following indicators:

Process

- Number of representatives (including position type & agency) attending subcommittees;
- Frequency of meetings;
- Number of times information relating to chronic disease self management is disseminated via website, newsletter, emails;
- Number articles submitted to newsletter highlighting local initiatives in chronic disease self management; and,
- Number of agency staff (and type) participating in training opportunities and forums.

Impact

- Regularly review the purpose & direction of the subcommittee(s) to ensure it is meeting the needs of representatives;
- Forum/s & training will be measured through satisfaction surveys;
- The number of submissions completed around chronic disease management facilitated by the Hume Moreland PCP; and,
- Identification and use of CALD resources.

Outcome

- Increased knowledge of self-management programs by staff throughout Hume and Moreland and enhanced linkages between agencies in this area.

2.5.10 Integrated Health Promotion and Service Coordination

Diabetes: One Step Ahead

PROBLEM DEFINITION

The "One Step Ahead" Diabetes Project is funded by DHS through the Diabetes Prevention and Management Initiative (DPMI). The project is funded for 3 years, with different objectives for each year.

Year 1: Prevention of diabetic complications, specifically cardiovascular disease and foot disease

Year 2: Primary prevention of Type 2 Diabetes

Year 3: Early detection of Type 2 Diabetes

The project team has recently commenced planning on the year two strategy that will be finalised in October 2003.

Goals

To develop, coordinate and extend diabetes prevention services and programs to ensure a cohesive continuum of care that meets the needs of our culturally diverse community, which may delay or prevent the onset of diabetes in individuals at high risk of developing the disease.

Objectives

1. To develop diabetes prevention systems which demonstrate sustainability within the context of the current Victorian health system;
2. To develop strategies for diabetes prevention that addresses the socio-environmental determinants of health;
3. To enhance service linkages for the early detection, prevention and management of diabetes.
4. To undertake health promotion and primary health care activity focusing on diabetes detection and prevention; and,
5. To involve consumers in the development and implementation of specific activities throughout the duration of the project.

Population Target Group

- Service providers
- Consumers who are considered to be at high risk of developing diabetes. For Year 2, it is likely that the target group will be either women who have had gestational diabetes, or individuals with impaired glucose intolerance.

Relationship to 2003-04 PCP Priorities for Action (Section 2.3)

- Directly related to 1, 5, 6, 7, 8, 9 and 10; and,
- Indirectly related to 11.

SOLUTION GENERATION

Relevant Statewide Action and Evidence Based Practice

Diabetes is recognised as one of the fastest growing chronic health conditions in Australia and if undetected or poorly managed can result in debilitating and costly long-term health problems. It is a key health problem for both Hume and Moreland residents.

Both Hume and Moreland are in the top six disadvantaged areas based on the Index of Relative Socio-Economic Disadvantage. The Community Profile from Hume Moreland Community Health Plan 2001 – 2002 indicates:

- High levels of poverty, unemployment and overall socio-economic disadvantage across the catchment;
- A high proportion of the population from a wide range of culturally and linguistically diverse communities;
- People on low incomes have limited access to public transport;
- Community based services are not adequately distributed, particularly in the fast growing areas of Hume City Council;
- Population growth for age group 25 – 64 years over the next twenty years projected at 26.4% across Hume and Moreland; and,
- Population growth for ages 65 & over the next twenty years projected at 43.8% across Hume and Moreland.

Interventions and Activities	Roles and Responsibilities	Timelines
Formation of a working party for the planning of the year two strategy. The planning for Year Two will be completed between July and October 2003.	<ul style="list-style-type: none"> • Planning and implementation of the project 	<ul style="list-style-type: none"> • July- Sept 2003

Resource Allocation

\$99,000 per year for three years (October 2002 – September 2005)

Project Coordinator: 0.5 EFT

Physiotherapist: 0.3 EFT

Dietitian: 0.1 EFT

Diabetes Nurse Educator: 0.2 EFT

Podiatrist: 0.2 EFT

Key Capacity Building Strategies

The "One Step Ahead" program is supported by a Workforce development project funded by DHS. The Workforce Development Project has 3 broad aims:

1. To recognise the skills across PCP agencies delivering diabetes services;
2. To identify opportunities for workforce development within the PCP; and,
3. To provide workforce development training in these areas.

The first stage of the Workforce Development Project is to implement the Diabetes Workforce Development Needs Analysis Tool, which has been designed to assist agencies to review their current skills in diabetes care and prevention. The tool is also used to establish priority areas for skill development.

Information obtained from the Tool will be used to develop an action plan for workforce development training that will be offered to all agencies that have participated in the process. The tool has recently been implemented and the workforce development team are collating the information.

PLAN FOR REVIEW AND EVALUATION

The Centre for Health Program Evaluation (The University of Melbourne) is undertaking a structured evaluation of the three-year project using the REAIM framework. Process, impact and outcome objectives are being evaluated.

SECTION THREE: APPENDICES

Appendix One: Hume Moreland PCP Alliance List

1. Action of Disability within Ethnic Communities
2. Anglicare Victoria
3. Australian Greek Welfare
4. Baptist Community Care
5. Broadmeadows Disability Services
- 6. Broadmeadows Health Service**
7. Brotherhood of St Laurence
8. Brunswick Neighbourhood House
- 9. Care for Carers**
- 10. Carinya Society**
11. CASA House
- 12. CoAsIt Italian Assistance Association**
- 13. Dianella Community Health Service**
14. Distinctive Options
- 15. Hume City Council**
- 16. Interchange Northwest**
17. Kurdish Association of Victoria
- 18. Melbourne City Mission**
- 19. Melbourne Health**
- 20. Moreland City Council**
21. Moreland Community Health Service
22. Moreland Hall
- 23. North West Melbourne Division of General Practice**
24. Northern Care and Share
25. Northern Health
- 26. Northern Metropolitan Migrant Resource Centre (HACC Services)**
- 27. Northern Metropolitan Multicultural Seniors Clubs Network**
28. Orana Family Services
29. Richmond Fellowship of Victoria
- 30. Royal District Nursing Service**
31. Royal Victorian Institute for the Blind
- 32. Sunbury Community Health Service**
33. Victorian Cooperative on Children's Services for Ethnic Groups
- 34. Vision Australia Foundation**
- 35. Women's Health in the North**

Bold indicates agencies that have active representation on the Project Management Group or working groups of the PCP.

Appendix Two: Integrated Health Promotion Program Summary Grid

Program Goal One: Capacity Building – Continue to develop a best practice model of capacity building that will provide a platform for an enhanced, coordinated and sustainable approach to health promotion activities.

Target Group: Service Providers in Hume and Moreland

Program Objectives	Health Promotion Interventions & Capacity Building strategies	Estimated Impacts	Estimated Reach	Timelines & by which agency	Estimated Costs)
<p>Objective 1: To increase opportunities to improve and expand expertise in health promotion through direct training, access to information and resources.</p> <p>Objective 2: To establish and facilitate subcommittees around Hume and Moreland health promotion priority areas as identified in the health promotion plan.</p> <p>Objective 3: For the Health Promotion Working Group to assume a mentoring role to agencies and staff throughout Hume and Moreland.</p>	<p>Organisational Development Continue to facilitate the HPWG to meet bi-monthly.</p> <p>Strengthen the role of the existing membership of the group.</p> <p>Review the terms of reference for HPWG.</p> <p>Establish, monitor and evaluate subcommittees around key priority areas, as required.</p> <p>Provide advice and mentoring to projects and agencies engaged in health promotion activities.</p> <p>Monitor the effectiveness of the Statement of Cooperation (SOC) through the establishment of subcommittees.</p> <p>Workforce Development Develop a database of staff that have completed the Health Promotion short course and link them into the work of the HPWG.</p> <p>Develop a web based health promotion resource kit including local contacts and resources (based on an updated version of the mapping exercise completed in 2003).</p> <p>Conduct a series of health promotion forums within Hume and Moreland around health promotion with internal and external guest speakers.</p> <p>Conduct a one day mini-conference with another rural PCP to showcase health promotion activities</p> <p>Identify and where relevant, facilitate training opportunities for agency staff in involved in health promotion activities.</p>	<p>Establishment of a PCP wide approach that enhances health promotion practice.</p> <p>Greater cohesiveness in health promotion activities.</p> <p>Increased visibility of health promotion.</p> <p>Enhanced the health promotion knowledge base for more staff.</p> <p>Reinforce skills developed in the short course and integrate into daily work.</p> <p>Strengthened integrated knowledge and practice of health promotion.</p> <p>Shared and enhanced the knowledge base of health promotion (including within and external to the PCP)</p> <p>Increased knowledge and exposure to best practice projects and evidence based health promotion practice</p> <p>Increase skill level of workforce.</p>	<p>Core agencies involved in the Health Promotion Working Group include eight agencies.</p> <p>It is anticipated that the formation of subcommittees and by conducting forums will involve a greater number of agencies.</p>	<p>HPWG Ongoing HPWG On-going</p> <p>HPWG March 2004</p> <p>HPWG Sept - June</p> <p>HPWG Ongoing</p> <p>HPWG Ongoing</p> <p>HPWG October 2003</p> <p>HPWG October 2003</p> <p>HPWG Oct - June</p> <p>HPWG April 2004</p> <p>HPWG Ongoing</p>	<p>Health Promotion Project Officer \$15, 645</p> <p>Office support costs \$ 1,402</p> <p>Venue Hire/catering \$ 1,283</p> <p>Project Development \$10,000</p> <p>Total \$28,330</p>

Program Goal Two: Well being of younger people – To strengthen the capacity of agencies to coordinate and collaborate on health promotion activities throughout Hume and Moreland with a focus on enhancing the well being of younger people.

Target Group: Service providers in Hume and Moreland
Young People (aged 15 – 19)

Note: Youth Health Promotion Subcommittee (YHPSC)

Program Objectives	Health Promotion Interventions & Capacity Building strategies	Estimated Impacts (Qualitative &/or Quantitative)	Estimated Reach	Timelines & by which agency	Estimated Costs
<p>Objective 1: To facilitate a short-term project that focuses on training young people to conduct an audit of the youth friendliness of agencies.</p>	<p>Social marketing /Health information Dependent upon funding and the desired outcomes by young people, health information may be developed</p>	<p>Increased knowledge of youth friendly services available for young people.</p>	<p>At least 4 schools</p>	<p>Schools: Nov - Dec 2003</p>	<p>Health Promotion Project Officer \$23,604</p>
	<p>Health education and skill development Provision of information on conflict resolution and stress management throughout workshops with young people. These people will also be developing skills in interviewing techniques.</p> <p>Community action Young people will be empowered to interview local agencies to assess the youth friendliness of agencies.</p>	<p>Increased capability to deal with conflict and stress management.</p> <p>Stronger linkages between agencies and schools.</p>	<p>Approx. 30 students</p> <p>Approx. 30 students</p>	<p>YHPSC Nov- Dec 2003</p> <p>YHPSC Nov- Dec 2003</p>	<p>Office support costs \$ 2,115</p> <p>Venue Hire/catering \$ 1,935</p>
<p>Objective 2: To assist agencies in identifying opportunities to collaborate on health promotion projects related to young people and to strengthen networking opportunities.</p> <p>Objective 3: To enhance participating agency staff to become more familiar with health promotion concepts and models and to encourage integration of this knowledge into daily work.</p> <p>Objective 4: To assist agencies in identifying external funding opportunities.</p>	<p>Organisational Development</p> <p>Facilitate the on-going meeting of the youth health promotion working group</p> <p>Pilot the statement of cooperation developed by the HPWG</p> <p>Assist agencies with the implementation of any successful projects are required</p> <p>Provide ideas & information around funding opportunities</p> <p>Facilitate agencies own work in health promotion around younger people</p> <p>Disseminate key health promotion information to representatives</p> <p>Workforce Development</p> <p>Facilitate agencies to participate in PCP training (and other) that builds capacity around young people</p> <p>From the work of the subcommittee identify any training needs and advocate for this training</p>	<p>Strengthened linkages between agencies (including health, recreational and government).</p> <p>Increased breadth of agencies involved in PCP activities.</p> <p>Increased knowledge of health promotion theories (including project development with a health promotion framework, evaluation strategies etc.)</p> <p>Increased knowledge of external funding opportunities available.</p> <p>Increased skill development in the area of health promotion related to young people.</p>	<p>Service providers (approx 12 agencies including government, health and recreational)</p> <p>Service providers</p>	<p>YHSC & HPWG July-Nov 2003</p> <p>YHSC & HPWG July-Nov 2003</p> <p>YHSC & HPWG Ongoing</p> <p>YHSC & HPWG Ongoing</p> <p>YHSC & HPWG Ongoing</p> <p>YHSC & HPWG Ongoing</p> <p>YHSC & HPWG Ongoing</p>	<p>Project Development \$15,000</p> <p>Total \$42,654</p>

Program Goal Three: Chronic Disease – To strengthen integrated health promotion activities related to chronic disease, with a particular emphasis on selfmanagement programs and prevention.

Target Group: Service providers in Hume and Moreland.

Program Objectives	Health Promotion Interventions & Capacity Building strategies	Estimated Impacts (Qualitative &/or Quantitative)	Estimated Reach	Timelines & by which agency	Estimated Costs
<p>Objective 1: To increase knowledge of evidence based practice in chronic self-management programs.</p> <p>Objective 2: To link in with existing networks (HARP/Diabetes) to integrate agency health promotion activities between projects and agency work in chronic disease.</p> <p>Objective 3: To ensure resources available support interactions with CALD communities are promoted.</p> <p>Objective 4: To establish subcommittee(s) around chronic disease to increase knowledge of chronic disease self management and prevention.</p>	<p>Organisational Development</p> <p>Conduct a mapping exercise of chronic disease self-management including CALD programs throughout Hume and Moreland and other PCPs to identify best practice in the area</p> <p>Identify opportunities to strengthen linkages with existing networks (HARP/Diabetes)</p> <p>Disseminate information on chronic disease, with a particular emphasis upon self-management programs</p> <p>Organise forum/s around chronic disease self management, showcasing local programs in and outside the areas, with guest speakers (etc.) The type of forum/s will be dependent on the outcomes of the subcommittee/s</p>	<p>Increased knowledge of self-management programs available including best practice models.</p> <p>Strengthened networks with other initiatives in the area of chronic disease.</p> <p>Increased capacity of agencies to collaborate around self management initiatives in chronic disease.</p> <p>Increased numbers of staff involved in PCP activities.</p> <p>Increased skill base in the area of self-management of chronic disease (including information available for CALD communities).</p> <p>Increased knowledge of external funding opportunities available and strengthened skills in preparing submissions for funding.</p>	Service providers	<p>HPWG and subcommittee(s) September 2003</p> <p>HPWG and subcommittee(s) Ongoing</p> <p>HPWG and subcommittee(s) Aug - Sept 2003</p> <p>HPWG and subcommittee(s) Oct - April</p> <p>HPWG and subcommittee(s) October 2003</p> <p>HPWG and subcommittee(s) Ongoing</p> <p>HPWG and subcommittee(s) Ongoing</p> <p>HPWG and subcommittee(s) Ongoing</p>	<p>Health Promotion Project Officer \$15, 645</p> <p>Office support costs \$ 1,402</p> <p>Venue Hire/catering \$ 1,283</p> <p>Project Development \$10,000</p> <p>Total \$28,330</p>
	<p>Workforce Development</p> <p>Establish a subcommittee/s focusing upon chronic disease (this may involve investigating best practice models currently available, identifying training needs etc. The outcomes are dependent upon the needs identified by the subcommittee hence there is some flexibility in this intervention/activity).</p> <p>Identify training opportunities for agency staff to participate in chronic illness self management training and where relevant, facilitating these opportunities.</p> <p>Support collaborative partnerships and applications for funding to develop chronic disease self management programs</p> <p>Identify and promote resources for CALD communities such as disease fact sheets in community languages</p>				

