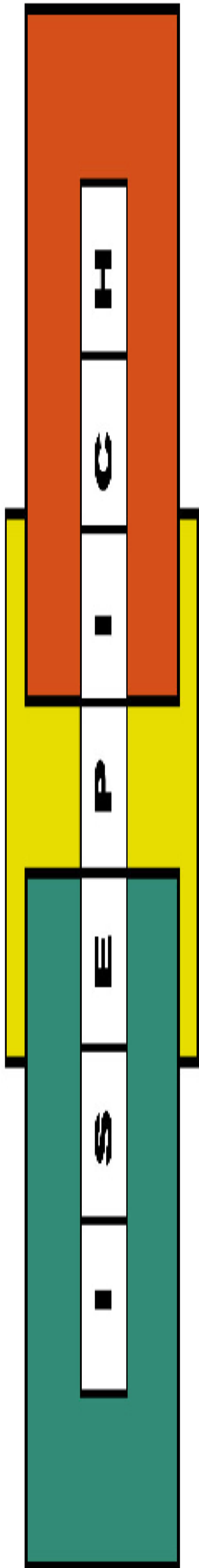

Inner South East Partnership in Community and Health

Community Health Plan

2004-2006

ISEPICH

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Service Coordination Implementation Advisory Group Members

Falls Prevention Community Steering Committee

Strength Training Network Members

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Please make use of this plan!

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For More Information …

Our website includes the following documents and resources:

- Link to Statewide Services Directory
- Community Health Plan
- Health Promotion Practice - Project profiles from ISEPICH member agencies
- ISEPICH's Demographic Profile
- List of ISEPICH member agencies and links to their websites
- Links to key health promotion and research sites
- Our latest newsletter
- Good Governance Guide and Memorandum of Understanding

The ISEPICH Website can be found at: www.isepich.org

Primary Care Partnership Strategy documents produced by the Department of Human Services are available at: www.health.vic.gov.au/pcps

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Introduction

The Inner South East Partnership in Community and Health (ISEPICH) is a Primary Care Partnership, representing over 40 health and community support service providers in the municipalities of Stonnington, Glen Eira and Port Phillip.

For over twenty-five years, since the World Health Organisation declaration of Alma-Ata in 1978, there has been international consensus on the need for health sector reform, to increase resources for primary health care and the promotion of health, rather than directing resources mainly to acute care and illness treatment. In bringing together a large number of community based agencies in a cooperative way, partnerships such as ISEPICH are making a significant contribution to this goal, and also giving a clearer voice to primary care in policy making.

Founded on the social model of health,[1] ISEPICH's vision is:

> "To create and maintain an accessible, responsive and integrated local primary health and community support service system that takes a planned approach to identifying and addressing community need."

In 2001 ISEPICH produced its first Community Health Plan, with a broad vision to 2004. In producing our current Community Health Plan for 2004-06, it is evident that over the years we have come to focus our vision somewhat more closely on the achievable, rather than the ideal. It is also clear, however, that much of what we set out to achieve has been achieved, as discussed under Key Achievements.

Demographic Profile

The ISEPICH catchment is a growing population, estimated at 300,000 people in the 2001 census, and characterised by diversity:

- A population that comprises the very rich and the very poor,
- An extreme range of housing types, including significant numbers of people who live in supported residential services, rooming houses and community housing
- A relatively high proportion of people over 75 years of age in some areas
- A projected increase in the number of people aged 50-70 years
- Significant smaller populations with co-morbidities and high needs
- Pockets of youthful populations and ageing populations (Glen Eira)
- The highest proportion of people over 65 years in Victoria who live alone
- Culturally and linguistically diverse communities with high levels of people born overseas including a large Jewish community, and
- Areas that have the highest concentration of gay and lesbian people in Victoria.

Health Issues

The Victorian Burden of Disease Study and the 2003 Population Health Survey provide a comprehensive review of health and illness at local and regional level in Victoria. Chronic diseases or conditions that cause the greatest burden to the ISEPICH population are heart disease, cancer, mental health, injuries (especially falls) and drug and alcohol abuse.

Significant issues for sections of ISEPICH's catchment population include dementia, diabetes and infectious diseases, including HIV/AIDS. Risk factors influencing the health of the population include social isolation, violence, physical inactivity, poor nutrition, alcohol harm, illicit drug use, and unsafe sex.

[1] The social model of health recognises that political, environmental, economic and social factors affect an individual's health.

Key Achievements and Future Directions

Health Promotion

ISEPICH's first health promotion priority in 2001 was to extend, integrate and plan sustainability of the existing "Foothold on safety" Falls Prevention project. The other priorities were

- the promotion of physical activity
- developing a settings based approach to health promotion
- support for prevention and early intervention in regard to depression

Progress on these issues is discussed below

Falls prevention

The original ISEPICH Community Health Plan in 2001 identified that falls accounted for 48% of the unintentional injuries, or 41% of all injuries that result in hospital admission in the PCP catchment. This was seen as a major area of priority where health promotion could make a difference. Falls were the leading cause of Emergency Department injury presentations in people aged 65 years and over. The average length of stay in hospital for older people with fall injuries was 12 days (VicHealth December 2000). The target populations for Falls Prevention were older people living in the community or in residential facilities, including pension only SRS residents and people from culturally diverse backgrounds. Education of service providers was also seen as a priority. A short-term project was set up to develop a sustainability framework for falls prevention in the PCP, building on the achievements of a "Foothold on Safety" project that had previously been conducted. A report was produced at the end of the sustainability in falls prevention project (available on the ISEPICH website at www.isepich.org under Health Promotion) and a workshop held in November 2003 to disseminate the project findings.

Falls Prevention involves the local community health services and local governments, the Royal District Nursing Service, Bayside Health service, in particular the Rapid Assessment Service and the Caulfield General Medical Centre, and Arthritis Victoria. Community members include the original target populations of older people living in the community or in residential facilities, including pension only SRS residents and people from culturally diverse backgrounds, but the committee also proposes in the longer term to develop broader awareness of falls prevention in younger age groups and the broader community, and to address issues of injuries and falls in other population groups such as people with drug and alcohol, mental health and multiple medication issues.

ISEPICH funded the production of three translated fact sheets on Strength Training from the PCP project budget in 2004. In other respects the committee is self-sustaining. The committee has a number of subgroups, including peer support, education and training and strength training groups.

Strength training has been a particularly successful area, supported by the strength training subgroup. Over 26 strength training sessions per week are held regularly by member agencies and others are in development. A list of all strength training programs is available on the ISEPICH website. A fact sheet has been developed and translated into Greek, Italian and Russian (also available on the website). Programs for CALD communities are offered in conjunction with the South Central Region Migrant Resource centre.

Community awareness has been raised, with local Councils and HACC providers identifying falls prevention as a significant priority; for example, Port Phillip provided education and training on falls prevention to Home and Personal Care workers in 2004.

Sustainable peer support has not developed as successfully yet as other areas, and the committee recognised a need to do more to support the education and training of both workers (such as home and personal carers) and community members/peer educators. A program is planned to commence in November 2004.

A number of related activities such as walking groups and Tai Chi groups have also commenced or developed in the catchment over the same period. These activities, and Falls Prevention in general, will continue to be supported through the Physical Activity Health Promotion priority, which will be ISEPICH's second collaborative priority in the 2004/06 IHP.

A settings- based approach to health promotion: implementation of the Rooming House project approach

The ISEPICH catchment is an area of marked inequality, with rich and poor in close proximity. There are significant health inequities, including many people who are homeless or in insecure housing, and high levels of

drug and alcohol use and mental health issues. Following the first ISEPICH Health Promotion plan of 2001, a group was set up to develop a settings based approach to health promotion. The group decided to implement a project in a local Rooming House, which was known to have high levels of conflict and significant health issues. The project built on established good practice and existing relationships. It was designed to work with residents in developing responses to issues identified by them. The project commenced in 2002 and by early 2003 preliminary evaluation was showing improvement in residents' reported health and wellbeing, and increased access to services. In the 2003/04 Health Promotion Plan we proposed to extend this approach by disseminating the project evaluation and learnings, and actively encouraging member agencies to undertake projects using this model.

Over 50 rooming house residents and visitors, the Rooming House proprietors and managers, and over 10 primary care agencies were involved in the original project. The potential group that could benefit from the broader implementation of the project's approach includes over 500 residents in Rooming Houses in the area.

The first stage of the Rooming House project was completed in 2003. The key workers and the ISEPICH project worker then completed a final evaluation and project report, documenting the impacts and outcomes for residents, management and workers, and making recommendations to support the implementation of the project's approach more broadly in the catchment. The report was launched at the ISEPICH Community Participation in Health Promotion workshop in April 2004. Fourteen community representatives (including one resident from the original project) and twenty workers from ISEPICH agencies participated in the workshop. A copy of the report was sent to all ISEPICH member agencies and placed on the ISEPICH website. Information about the project was also disseminated to a wide Australian and international audience through a poster display at the World Conference on Health Education and Health Promotion in May 2004.

We held a workshop on the Rooming House project recommendations in June 2004, attended by eighteen representatives from eight agencies that provide services in Rooming House settings. The workshop identified and refined the key features of the project approach, drawing on learnings from other related projects and the experience of workers. A committee has now been set up, convened by the Port Phillip Community Group, which will coordinate and support the provision of services and Health Promotion to Rooming Houses in the ISEPICH catchment, based on the approach developed through the Rooming House project and the workshop. The committee will also advocate for policy and system changes required to improve the health and well-being of Rooming House residents, based on residents' understandings of their own needs and circumstances. It will also work to disseminate the project findings and approach to a wider audience and explore its potential implementation in related settings (for example Supported Residential Services).

There is widespread support and goodwill towards the development of a coordinated approach to the provision of services and health promotion in Rooming Houses in the catchment. There are strong shared understandings between agencies and workers and a willingness to work together in a collaborative way.

Key features of the approach can be summarised as:

- Starting where people are
- A 'Face to Face' approach, being consistent and not rejecting
- Recognising and promoting social wellbeing, for example through sharing meals
- Being flexible and doing what's possible

More details are available in the project report, which is available on the ISEPICH website www.isepich.org under Health Promotion.

Prevention and early intervention for depression: promoting mental health and increasing social connectedness

The Victorian Population Health Survey 2001 found that people with few social networks were more likely to report fair to poor health and to be experiencing some level of psychological distress. They were also less likely to feel valued by society.[2] Numerous other sources, including the World Health Organisation[3] and the Heart Foundation Australia[4] have identified social connectedness as a key determinant of health.

[2] J Pope, A Serraglio & L Vaughan, Attachment 1: Exploring Mediators of Health Inequalities; Using the Victorian Population Health Survey 2001.
3 R Wilkinson & M Marmot (eds.) Social Determinants of Health: The Solid Facts, World Health Organization, 1998
[4] Stephen J Bunker, David M Colquhoun, Murray D Esler, Ian B Hickie, David Hunt, V Michael Jelinek, Brian F Oldenburg, Hedley G Peach, Denise Ruth, Christopher C Tennant & Andrew M Tonkin '"Stress" and coronary heart disease: psychosocial risk factors' National Heart Foundation of Australia position statement update *MJA* 2003 178 (6): 272-276

In 2003 ISEPICH decided to develop an integrated approach that involves community participation and reduces social isolation while seeking to understand it better. We proposed to raise awareness of the importance of the 'social' component of health and well being, as well as the mental and physical, and to identify how the issue is being addressed locally and how the current efforts could be enhanced, extended or sustained.

Members of the ISEPICH Health Promotion Working Group and the ISEPICH Community Advisory Group were involved, particularly through the social cohesion planning subgroup. Numerous local residents, particularly those who are socially isolated, disadvantaged, or experiencing mental health problems such as depression, can potentially benefit from health promotion on this issue.

In 2003 a subgroup of the Health Promotion working group was set up to research social cohesion and develop practical approaches for member agencies to address social isolation. Agencies and community representatives worked together to research the issue and developed a submission for a project to address gambling related issues by increasing social connectedness and participation. The agencies and the community representatives shared and increased their knowledge and understanding of the issue during this process. The Community Advisory Group also developed a list of priority health issues for consideration in Health Promotion planning in early 2004, which included a number of issues related to social connectedness.

The 2003 submission was not successful, but the Working Group and community representatives considered the issue further during a workshop on Community Participation in Health in April 2004. Mental health/Social connectedness emerged as a leading priority in this workshop, and has been included as a priority topic for the 2004/06 Integrated Health Promotion Plan. A number of activities that were suggested in the 2003 submission or at the April workshop are addressed in the IHP. These include community development/mentoring projects, and an audit of measures to address violence and inequality in the catchment. There has also been ongoing work by students on placement to develop a resource listing projects to address social connectedness in the catchment, and a first draft is expected to be available in October 2004.

Further development of community participation within member agencies and in certain parts of the PCP catchment (particularly Glen Eira, where our current representation is limited), will occur as part of the Mental Health/Social Connectedness priority in 2004-06.

Promoting Physical Activity

In 2002 ISEPICH established a Physical Activity network, which holds quarterly breakfast forums. Caulfield Community Health Service began convening the network in 2003. Recent forum topics have included Evaluation of Physical Activity, Environments for Physical Activity, and TravelSmart. All forums have been well-attended, with an average attendance of over 20 workers from a wide range of organisations, and positively evaluated.

There is a strong interest within the network in promoting environments for physical activity, and in interdisciplinary collaboration with transport and infrastructure planners. There is also interest in increasing the range of low cost accessible physical activity options and developing resources to inform the public about these options, especially population groups who have been identified as having low levels of physical activity, including older people, women, culturally and linguistically diverse (CALD) and indigenous groups. The Physical Activity Network is expected to move from a networking role to an action and advocacy role in addressing these issues. Physical Activity has been identified as a key HP priority topic for ISEPICH in 2004/06, and is discussed in more detail in the Integrated Health Promotion Plan in Section.

Service Coordination

ISEPICH's Service Coordination Protocol (OASIS)[5] was developed through an action research process during 2001 and signed off by the ISEPICH Executive in December 2002. OASIS aims to improve the way services work together, with a particular focus on improving the quality of referral and feedback between agencies.

The OASIS protocol is based on multiple points of entry into the service system so that services become "functionally integrated" whilst retaining their organisational autonomy, agreeing to conduct particular functions in a common way. During 2003/04 ISEPICH progressively implemented the protocol within agencies across the catchment.

[5] OASIS: One Access System Inner Southeast

Training and Support
A number of staff from agencies undertook the train the trainer course provided by DHS, providing them with the skills and resources to facilitate the service coordination reform process within their own organisations. ISEPICH developed two training modules and provided tailored training to agencies throughout 2003 and early 2004. The training included the use of the Service Coordination Tool Templates (SCTTs) and electronic service directory. ISEPICH has complemented the availability of the DHS electronic service directory through maintaining a range of local information and a comprehensive range of resources on our website, including:

- ISEPICH's Demographic Profile
- Key documents including the community health plan
- A link to the statewide services directory and other key health sites including the Primary Health Knowledge Base, Better Health Channel and Infoxchange Service Seeker.
- Health promotion resources
- Service Coordination Tool Templates

By the end of 2003 all key agencies had undertaken training and moved to implement the agreed practices in relation to referral and feedback.

Evaluation
In early 2004 ISEPICH commenced a process of evaluation to assess the achievements and future challenges for Service Coordination reform. Information and data collection has occurred through the following processes/forums:

- Discussion of agency concerns and implementation issues by the Service Coordination Implementation Advisory Group (which meets monthly)
- Feedback from agency visits and training sessions conducted by PCP staff
- Feedback from the Practitioners Network (formed in mid 2003)
- An audit of compliance with the OASIS protocol and use of the SCTTs in June 2004 (11 key agencies contributed)
- Focus group discussions held with five agencies between April – June 2004

In summary these processes have led to the following observations:
Overall compliance with the ISEPICH Protocol is 'patchy'. Some agencies have undertaken significant practice change to implement the agreements contained in the protocol, while others have made minimal changes, which appear to be based on DHS requirements (such as mandated use of the SCTTs) rather than full implementation of the inter-agency agreements contained in the protocol. While agencies generally support the aims of the protocol their capacity to implement change is variable.

Although there is general support for a common approach to referrals, use of the SCTT as a paper-based tool is problematic. Practitioners expressed the view that to significantly reduce duplication an e-referral system with a shared client record, or 'central repository' is necessary.

The level of inappropriate referrals appears to be very low. This is a very positive finding given that one of the key drivers for service coordination reforms was a perception that there was an unacceptably high number of inappropriate referrals.

Consistent Practice across the southern metropolitan region
ISEPICH is working collaboratively with the other three PCPs in the SMR to develop a common service coordination protocol by Dec 2004.

Information Management and Information Technology
ISEPICH will work collaboratively with the other SMR PCPs during 2004/06 to develop a joint IM/IT Strategic Plan to build on and integrate the work of the individual PCPs. A number of key ISEPICH member agencies are participating in the Community Hospital on Line Record development (CHORd) project, which aims to provide an information system for a model of shared care through:

- Sharing of client information supported by appropriate consent, privacy and security processes
- Progressive generation of an on-line electronic record with a strong focus on case management, care planning and electronic referrals
- Access to timely and accurate information to support decision making and planning/research
- Interface with other agency systems to avoid duplication of service provision and data entry
- Facilities to generate letters, referrals and operational and management reports
- The ability for external providers to update clients' records

In summary the key priorities for service coordination in 2004/2006 are:

- To expand the number of agencies using the service coordination protocol.
- Undertake capacity building strategy for priority agencies to improve access, initial needs identification and referral. (With a focus on clients from diverse backgrounds/needs, including CALD community members)
- To develop a common service coordination protocol for the three PCPs in the southern metropolitan region
- Provide support to prioritised agencies that have already implemented ISEPICH's service coordination protocol to implement agreed practices for assessment and care planning
- Provide support to prioritised General Practices to improve knowledge of primary care services, health promotion opportunities and quality of referrals including use of the Statewide Referral Form
- To work collaboratively with Bayside Health to improve the continuum of care.
- Development of a demand management strategy and mechanism for the collection of data for service planning
- To work collaboratively with the other three PCPs in the SMR to develop a regional IMIT Strategy
- To increase the use of the CHORd[6] by primary care agencies.
- Develop a Communication and information strategy

Cultural and Linguistic Diversity

ISEPICH developed a Cultural and Linguistic Diversity Strategy in 2003/04, building on the outcomes of a best practice project on Language Services that we conducted in 2001/02. Jewish Care, as the representative of ethno-specific agencies on the ISEPICH Executive until November 2003, convened a planning group to develop the strategy. South Central Migrant Resource Centre facilitated the group, which met throughout 2003 to plan the strategy and agree on the necessary steps and processes to achieve its aims.

The strategy aims to ensure that:

- Community members of culturally and linguistically diverse backgrounds have equitable access to all services and programs in ISEPICH member agencies
- Services are provided in a culturally sensitive manner
- Interpreters and translations are provided when needed

A copy of the strategy is available on the ISEPICH website at www.isepich.org under Cultural and Linguistic Diversity. A network of key workers in member agencies has been set up, and holds regular quarterly meetings and an annual cultural planning workshop. Resources and information to support the implementation of the strategy are available on the website, and updates are provided through email bulletins.

The Minister for Aged Care and the Mayor of Stonnington jointly launched the strategy, in conjunction with the Department of Human Services Cultural Diversity Guide, on 5 August 2004. The launch was held at the South Central Migrant Resource Centre in Prahran and was attended by over 120 people including members of local CALD community groups, representatives of ISEPICH member agencies, and Department of Human Services representatives. Community groups provided entertainment and food at the launch.

ISEPICH member agencies, including the International Diabetes Institute and the Arthritis Foundation, conducted several CALD programs and produced translated information on diabetes (in Russian) and arthritis (in nine languages) in 2003/04. The Strength Training Committee produced strength training fact sheets in Greek, Italian and Russian, funded from the PCP budget as part of Integrated Health Promotion in the catchment. ISEPICH is also producing a guide to member agencies' services in five languages, to improve access for CALD groups. This is currently being reviewed by CALD community members and will be disseminated and evaluated in 2004/06.

ISEPICH will be working on a Diversity Strategy in 2004-06, in both Service Coordination and Health Promotion, to support member agencies in meeting the needs of the diverse communities they serve.

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[6] CHORd aims to provide an information system to best support a model of shared care through:
-Sharing of client information supported by appropriate consent, privacy and security processes
-Progressive generation of an on-line electronic record with a strong focus on case management, care planning and electronic referrals
-Access to timely and accurate information to support decision making and planning/research
-Interface with other agency systems to avoid duplication of service provision and data entry
-Facilities to generate letters, referrals and operational and management reports
-The ability for external providers to update client's records

Health Promotion

Part 1 PCP vision and Priority setting process

1.1 ISEPICH's vision is of a community where health is valued as a basic resource for living, different sectors share the responsibility for creating conditions that support good health, and improved health outcomes are shared equitably.

Integration

Overall, the ISEPICH Health Promotion Working Group rates itself as being at the stage of coordination, however the initiatives are at different stages of integration. Falls Prevention is at the stage of early collaboration and the Rooming House Approach is at the stage of early cooperation. The Physical Activity Network is at the stage of advanced networking, and some coordination has begun. In relation to Mental Health and Social Connectedness, there are several networks in the catchment, including the Port Phillip Alliance, GESAN (Glen Eira South Agency Network), the Inner South Mental Health Alliance (ISMHA), and the Family Violence network. We will seek the involvement of these networks in implementing the plan.

Role of ISEPICH in health promotion

The Working Group and the ISEPICH Executive Committee have reviewed the role of the PCP in Integrated Health Promotion. We concluded that the most effective role, particularly through the working group and project officer, involves coordination, planning, building partnerships around issues, supporting and extending local projects, and building capacity through means such as:

- strengthening community participation in the PCP and member agencies
- disseminating ideas, knowledge, evidence and good practice examples in health promotion
- promoting effective referral and links between Service Coordination and Health Promotion
- ensuring effective communication within the PCP and with the broader community
- supporting agencies that are not funded for Health Promotion to become health promoting
- promoting cultural sensitivity and inclusiveness in health promotion and service delivery
- supporting workforce development and training (in collaboration with the three other PCPs in the Region and the Department of Human Services Southern Metropolitan Regional Office)

1.2 Priority issues

The Health Promotion Working Group held a workshop on community participation in health promotion in April 2004, with thirteen community representatives. The workshop identified the key priorities as mental health/social connectedness, physical activity and nutrition/food security. Following further consideration, ISEPICH adopted mental health and social connectedness as the first health promotion priority and physical activity as the second. We will monitor nutrition/food security as an emerging issue.

1.2.1 Priority One - Mental Well-being and Social Connectedness

There is widespread recognition that social connectedness is a major determinant of both mental and physical health.[7] It is also recognised that people who are disadvantaged are more vulnerable to mental and emotional health problems. A 2004 World Health Organisation report[8] states:

> *The greater vulnerability of disadvantaged people in each community to mental illnesses may be explained by such factors as the experience of insecurity and hopelessness, rapid social change, and the risks of violence and physical ill-health(p 10)*

Some key messages from the WHO report are:

> *A climate that respects and protects basic civil, political, economic, social, and cultural rights is fundamental to the promotion of mental health … Intersectoral linkage is the key for mental health promotion … Mental health is everybody's business (p 11)*

The report recommends a range of interventions particularly aimed at:

- early childhood
- empowerment of women
- social support to older people
- support to vulnerable groups
- mental health promotion in schools and workplaces
- improved housing

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[7] M Marmot & R Wilkinson *Social Determinants of Health* Oxford University Press New York 1999.

[8] World Health Organisation Department of Mental Health and Substance Abuse in collaboration with the Victorian Health Promotion Foundation (VicHealth) and the University of Melbourne *Promoting mental health: concepts, emerging evidence, practice: summary report* 2004

- violence prevention
- community development

Research and evaluation in Victoria also provide more detail about local issues, including:

- Inequity and violence have a significant effect on health (for example, intimate partner violence is the leading single cause of ill-health in Victorian women between 18-45 years)[9]
- Culturally competent health services contribute to health promotion.[10]

The ISEPICH catchment is characterised by marked inequality, with a higher than average proportion in high-income brackets, and significant pockets of people on low incomes, particularly in public housing. There are significant numbers of people living alone, and at risk of social isolation, particularly in Glen Eira, which has one of the highest rates of older people living alone in Victoria.

The area is culturally diverse, with almost 30% of the population speaking a language other than English at home. The proportion of the over 65 population of CALD background is expected to rise significantly in the coming decade, particularly in Port Phillip and Glen Eira. There is a small but significant Indigenous population of residents and visitors in the area, especially in St Kilda, which includes a traditional gathering ground.

Both Stonnington and Port Phillip include well-known entertainment precincts, and are popular with young people, however this has also been associated with drug and alcohol use, violence and accidents. There is a high rate of sexually transmitted disease in both municipalities. There are significant numbers of people who are homeless, or in temporary or insecure housing such as Rooming Houses, particularly in Port Phillip and some parts of Stonnington. There is a high rate of drug use and street sex work in Port Phillip. A key dynamic affecting health in the area is:

> *an intricate and complex relationship between various layers of disadvantage – mental illness, (street) sex work, poverty, homelessness, social stigma and social isolation and marginalisation.* [11]

In 2003 ISEPICH produced a document *Not the Rich List: an ISEPICH profile of risk factors affecting the health of our community*, which provides more detail on these issues.

Parts of the area have historically had high crime rates, and local workers report ongoing problems with bullying, family violence, and child abuse, particularly in disadvantaged areas. However, it is important to note that violence is not confined to disadvantaged groups, though it may be more apparent there. Individual violence takes place within a context of social inequity. As the 2004 World Conference on Health Promotion and Health Education stressed, health promotion must be prepared to challenge and reshape the power structures that contribute to health inequity, if it is to be effective. 'Target groups' therefore need to include the powerful as well as the powerless. ISEPICH members have developed many innovative and effective initiatives to promote social connection and reduce inequities and violence. This plan aims to build on these achievements.

1.2.2 Priority Issue Two – Promote Physical Activity

Physical activity contributes to the maintenance of healthy weight and improved wellbeing, however it is estimated more than half of all Australian adults "are not achieving sufficient levels of physical activity for a health benefit, and almost 15% are completely sedentary".[12]Physical inactivity is a major contributor to ill-health, particularly common conditions such as cardiovascular disease and diabetes. Direct health costs associated with physical inactivity in Australia are conservatively estimated at $400 million per year. [13] Garrard et al (2004) recommend that the greatest health gains are likely to be made by encouraging small increases in physical activity, particularly amongst the least active groups:

- Women, particularly those with pre-school children and those over 30
- Men and women over 40
- People of low socioeconomic status, particularly those with limited education
- People of Indigenous background and of culturally and linguistically diverse background.[14]

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[9] VicHealth and the Victorian Department of Human Services *Measuring the health costs of violence: measuring the burden of disease caused by intimate partner violence: a summary of findings* 2004

[10] J Garrard, B Lewis, H Keleher, N Tunny, L Burke, S Harper & R Round *Planning for healthy communities: reducing the risk of cardiovascular disease and type 2 diabetes through healthier environments and lifestyles* Victorian Department of Human Services Melbourne 2004 p 86

[11] Borderlands Cooperative Inc 'Vulnerable Groups Project report' Gambler's Help Southern, December 2002

[12] Garrard et al p 40

[13] Garrard et al p 40

[14] Garrard et al

Health promotion across the continuum is needed, from health education and skill development to community wide interventions, policy and environmental changes. An approach that relies on one strategy (for example health education) alone, without addressing factors such as social support and environmental issues, is likely to have limited impact.

The ISEPICH Community Participation workshop in April 2004 identified a number of barriers to physical activity, including a lack of low cost accessible options, especially for older people. Community representatives were involved in developing a resource for low cost physical activity options in Port Phillip, and similar resources may be developed for other areas.

ISEPICH has had a Falls Prevention program for several years, including Strength Training programs now reaching over 400 people per week. Strength Training information in Russian, Greek and Italian, and programs for CALD community members, have been established, in collaboration with the South Central Migrant Resource Centre. Other member agencies including International Diabetes Institute and the Arthritis Foundation have produced related information in community languages.

ISEPICH has an established Physical Activity network, which holds quarterly breakfast forums. There is a strong interest in promoting environments for physical activity, and interdisciplinary collaboration with transport and infrastructure planners. There have been significant initiatives in local Councils, including sustainable transport and 'walkability' projects. Planners have identified further opportunities for transport substitution from cars to walking, cycling and public transport. Ensuring physical and emotional safety for walkers, cyclists and travellers is important. In July 2004 ISEPICH (through Caulfield Community Health Service) made a submission for an Active Participation partnership grant through VicHealth, based on the environments for health approach. The outcome will be known in October 2004. Significant work on evaluation is also being done, including a program in Inner South Community Health Service through which allied health workers are establishing baselines measures of physical activity in clients. This will provide important information for the evaluation of health promotion.

1.2.3 Emerging/Flexible component - Nutrition and Food Security
Several ISEPICH agencies have an interest in food and nutrition issues (often in relation to social connection), and some are developing knowledge on the related issue of food security. The Working Group has decided to adopt Nutrition and Food Security as a flexible component/emerging priority. We will monitor and disseminate information in 2004-05, and review the issue in 2005.

Part 2 Program outline for each priority issue

2.1 Improve mental wellbeing and social connectedness

- Program Objective:

Support and build partnerships in mental health promotion to improve social connectedness and reduce inequity and violence.

Definitions

Inequity refers to inequalities of income, wealth, power, status and resources, where they lead to reduced health and wellbeing for some sections or classes of society. Public health research is somewhat divided on the impact of income inequality,[15] but there is agreement that greater relative disadvantage (more 'unfairness') is associated with worse health outcomes. Thus, for example, a community where there are marked inequalities in income but a strong system of community support, and universal access to good public health and education systems, would be expected to have better population health outcomes than one that has similar inequalities in incomes but where access to community support, education and health services is directly dependent on income.

Violence refers to emotional and psychological, as well as physical, violence. Streker has proposed a definition of "psychoemotional abuse" as "a process where one or more people, via a wide range of means (e.g. verbal, the enactment of legislation or policy), use primarily psychological or emotional processes to overpower another and gain advantage from the other's subordinate position". [16]

- Population Target Groups

Whole of community, including: people at risk of, or experiencing, social isolation, inequity or violence; people who practise, or benefit from, exclusion, inequity or violence. Population groups particularly at risk may include older people, children and families, women, young people, and people of Indigenous and CALD background. The

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[15] See for example John Lynch 'Is Income Inequality a Determinant of Population Health?' Available on the Vichealth website at www.vichealth.vic.gov.au

[16] P Streker, unpublished PhD thesis (in preparation) Monash University 2004.

program will also aim to reach opinion leaders and influential community members such as employers, teachers, and welfare workers.

2.1.2 Interventions

The working group has identified the following collaborative action areas:

- Programs to increase community and individual understanding of mental health issues
- Increasing social connectedness options such as social meals for older and isolated people
- Promoting mental wellbeing and social connectedness through community events such as Community arts project, Mind Body Spirit Expo, Mental Health Dance
- Support to new families, particularly to reduce post-natal depression, and to carers
- Working with young people through schools, on issues including sexuality, relationships, bullying and violence (this also links to the reducing violence action area)
- Education and support on midlife issues for women
- Inclusive and diverse health promotion to include men, women, youth, gays and lesbians, CALD and Indigenous, people with disabilities and older people (includes transport)
- Settings based approaches in Rooming Houses, Supported Residential Services (SRS's) and public housing, in conjunction with community and individual advocacy, to reduce inequity
- Programs and events to raise awareness of the impact of violence on health and to reduce violence in the community.

Strategies that will be adopted for these action areas include capacity building in member agencies and community development. Illustrative timelines are shown below. Please note these will vary in practice, due to the differing level of current health promotion practice in the action areas.

1. Preliminary audit and resource development - from June 2004

Establish baseline information and indicators for evaluation for each action area and develop resources, such as:

- Description of the health impacts of isolation, inequity and violence, building on *Not the Rich List*, and including accounts of personal experience ('life stories')
- Guides to relevant health promotion initiatives and strategies currently in place to address these issues, tailored to relevant audiences (eg GPs, intake workers, community members)

Build capacity and strengthen partnerships in member agencies - from October 2004

Screening, health education

- Involve GPs, allied health workers, counsellors and intake workers
- Support practitioners to use SCTTs/care plans/health assessments to identify baseline measures and identify health promotion needs
- Support practitioners to refer to relevant programs and initiatives through provision of appropriate resources, training and referral information/links
- Support practitioners to provide culturally relevant Health Promotion to diverse communities
- Support practitioners to monitor and evaluate the outcomes of health promotion

Community action, settings and supportive environments

Build capacity around specific issues, such as:

- Addressing mental health promotion across the continuum – bring together services and practitioners in mental health to identify how they can promote mental health
- Support effective responses to violence and inequity through increased awareness and advocacy

Evaluation

- Practitioner impacts and outcomes (eg increased knowledge and awareness, improved referral)
- Patient/client outcomes (self-assessment and clinical outcomes)
- Numbers of referrals
- Participation in programs (including indicators of diversity).

Community development – from October 2004

Community action, settings and supportive environments

Plan and implement a community mentoring/development project to build community capacity, for example through forums and workshops addressing topics such as:

- What is health promotion, how social factors affect health and wellbeing
- Understanding our health system and what is currently being done in our area to promote health
- Building a more connected and caring community – what can *I* do? (Workshops)

This approach builds on the WHO view that mental health is everybody's responsibility. Examples of specific workshop topics might include:

  - Community building in neighbourhoods, schools, workplaces and housing
  - Supporting families

  - Working with diverse groups
  - Non-violent conflict resolution, promoting community and individual safety

Adapted workshops could also be presented to workplaces, schools, and community groups.

Social marketing

The following opportunities for social marketing have been identified:

- Community arts project (CCHS), Mind Body Spirit Expo (BBCHS), Mental Health Dance (ISCHS)
- A communication strategy for the PCP will be developed

Evaluation

- Media monitoring
- Awareness and knowledge in participants – self assessment
- Participation in existing community building/social connectedness activities – self assessment
- New initiatives established – number and participant assessment
- Mental well-being and capacity to support others – self assessment
- Social connectedness of participants – survey instrument
- Measures/policies adopted in organisations and groups

Overall Evaluation (2004 & 2006)

- Baseline and follow up surveys of social connectedness indicators (with local governments)

These indicators won't only measure the impacts or outcomes of initiatives or programs in the PCP, as there are an enormous number of things outside our control that affect community well-being; however they can show, for example, whether the impacts and outcomes in our projects are trending in the same direction as (and/or contributing to) the trends in community surveys.

2.2 Increase Physical Activity

- Program Objectives:

Increase the levels of physical activity in the community by increasing opportunities for physical activity and developing supportive environments.

- Population Target Groups

Whole of community, including: people at risk of, or experiencing, low physical activity levels; older people, women, people of Indigenous and CALD background; planners and policy makers.

2.2.1 Interventions

Collaborative action areas

- Increase the range of low cost accessible Physical Activity options for diverse groups
- Provide community information on physical activity benefits and options
- Provide workforce development and advocacy for environments for physical activity
- Continue and extend the Falls Prevention Program

Strategies

Audit and Resource Development from June 2004

Audit existing programs to promote physical activity (includes Falls Prevention Strength Training)

Develop resources to provide information about low cost and accessible PA opportunities across the ISEPICH catchment, with emphasis on target groups.

Capacity building and community development from October 2004

Screening, health education

Develop capacity through stronger partnerships and improved referral - involve GPs, allied health workers, Home and Community Care workers, and community representatives through:

- Support practitioners to use SCTTs/care plans/health assessments to establish baseline measures of physical activity and identify health promotion needs
- Support practitioners to refer to physical activity opportunities through provision of appropriate resources, training and referral information/links
- Support practitioners to provide culturally relevant and diverse PA options
- Support practitioners to monitor and evaluate outcomes

Continue the ISEPICH Falls Prevention program

Evaluation

- Practitioner impacts and outcomes (eg increased knowledge and awareness, improved referral)
- Patient/client outcomes (self-assessment and clinical outcomes)
- Numbers of referrals and participation in PA programs (including diversity).

Community action, settings and supportive environments

Build capacity around specific issues, such as working with the target groups, by the development and dissemination of appropriate resources, the provision of training and the community development program.

Continue the ISEPICH Falls Prevention program, including

- Workforce development and training to home and community workers and other practitioners
- Peer support programs (links with community development program)

Continue the Physical Activity Breakfast network and investigate/develop an advocacy role
Promote Environments for Physical Activity through

- Implement the Active Partnerships project (if funding application successful)
- Support and strengthen the capacity of practitioners and community members for advocacy
- Investigate the possibility of working with TravelSmart to implement local projects

Evaluation

- Impacts and outcomes for target groups (e.g. number of programs and resources, participation levels and assessment by target groups)
- Impacts and outcomes for practitioners/peers in Falls Prevention (e.g. increased knowledge and awareness, number of contacts, referral, peer led groups)
- Impacts for whole community (e.g. environmental changes).

2.3 Capacity Building-Support and Resources

- Roles and responsibilities of key stakeholders

The Health Promotion Working Group (which includes one community representative) and the relevant subgroups will lead the development and implementation of the agency capacity building programs. The Community Advisory Group will be involved in the development of the community mentoring/development project. There will be regular liaison between the groups.

- Key capacity building strategies

Continue regular meetings of the Health Promotion working group and quarterly Physical Activity forums. Develop action subgroups for mental wellbeing/social connectedness and physical activity. Develop resources outlining the range of health promotion initiatives for mental well-being/social connectedness and physical activity and provide training to key staff in member agencies for the purposes of information and referral, including use of directories. Continue the relationship of the Health Promotion Working Group and the CAG, through the liaison by Health Promotion Coordinators of the Community Health Services and joint forums/workshops as required. Support community participation in member agencies, and strengthen community participation in the PCP from Glen Eira. Continue to use the ISEPICH website as a central repository. Continue to disseminate information to the Health Promotion Working Group and Physical Activity network. Continue to implement the ISEPICH Integrated CALD strategy and utilise the CALD network to identify opportunities/disseminate information re CALD Health Promotion. Develop a PCP Diversity strategy. Support workforce development in collaboration with other PCPs and DHS Southern Region.

- Resource allocation

PCP HP project worker time (estimated 4 days per week in 2004-05 and 3 days per week in 2005-06) – 60% of time will be spent on mental well-being/social connectedness, 35% on Physical Activity and 5% on Nutrition/Food Security. Student on placement (2004) for 70 days – estimated 50% of time on mental wellbeing/social connectedness, 30% on Physical activity and 20% on Nutrition/Food security. Further placements will be sought in 2005-06. Project Manager – estimated one day per week on activities related to Health Promotion in 2004-05 and 2005-06 (not IHP funded). Health Promotion working group members will spend approximately one day per month on activities directly related to PCP capacity building, plus certain members e.g. Community Health Services, IDI, GP Division and representatives taking part in Certificate IV IHP training will spend up to approximately an additional 2-3 days per month on PCP capacity building activities.

Please note that the allocation of key stakeholders' funding shown in Part 3 does not include all HP funding that the CHS's and IDI are allocating to the key priority issues, because we are not yet working collaboratively on all areas. We have identified nine key action areas for mental wellbeing and social connectedness, and four for physical activity, where the PCP is or aims to work collaboratively. The proportion of agency resources that is allocated to each priority issue reflects the degree of collaboration in each area. For example there is a high level of collaboration in Falls Prevention so almost all resource allocation by individual member agencies is summarised in this IHP, whereas in working with families, or young people through schools, we are only working towards collaboration, so a lesser proportion of resources are summarised in this IHP for 2004-05. In 2005-06, however, it is likely that there will be a much more collaborative approach in these areas, and resource allocation will reflect this. While this IHP is for 2004-06, figures shown in Section 3 are for 2004-05 only. The IHP will be reviewed at the end of the 2004-05 financial year, and new resource allocations for 2005-06 will be submitted at that time.

- Summary of PCP IHP funding to support the PCP alliance capacity building.

ISEPICH will spend approximately $74,000 PCP funding on IHP in 2004-05, which includes direct IHP funding of $57,000 and other funding from carry-over. In 2005-06, we do not expect to have any carryover and will therefore spend only $57,000 plus some contribution from Community Health Plan funding (Project Manager). The approximate break up of funding allocation for 2004-05 is:

- 78% PCP Project worker salary and oncosts ($58,000)
- 5% PCP Cultural and Linguistic Diversity strategy – Interpreters and Translations ($4000)
- 5% PCP Community Representative Honorariums ($4000)
- 3% PCP Workforce Development direct contribution (Certificate IV IHP training - $2000)
- 3% PCP forums and workshops (catering, printing and distribution of materials, etc – $2000)
- 5% PCP associated costs (office and equipment etc - $4000)

The break-up in 2005-06 is expected to be similar except that there will be more spent on community representatives as part of the community mentoring/development program.

Evaluation and dissemination planning

Evaluation methods and indicators have been included above as an integral part of the program plan. We will seek to disseminate the results of our program (and the related projects conducted by member agencies) through appropriate journals including the Australian Journal of Health Promotion, through conferences and through local, regional and statewide networks, and through the ISEPICH website, forums, workshops and email bulletins to member agencies and regular updates in the joint HARP/ISEPICH newsletter 'PITCH (Partners in the Community and Hospitals)'. A minimum of 10% of the IHP budget will be spent on evaluation and dissemination.

Integrated Health Promotion Summary planning grid

Priority Goal:	Improved mental wellbeing and social connectedness
Objective 1:	Support and build partnerships in mental health promotion to improve social connectedness and reduce inequity and violence
Est. Impacts[2] (Qual/ Quant) for Objective 1	Build capacity in member agencies, improve awareness, knowledge and referral, improve capacity to advocate Build awareness and knowledge in community, increase community connectedness and capacity to address/advocate in relation to inequity and violence

PCP key stakeholders	**Summary of mix of Interventions & CB strategies**	**Population Target Group/s:**	**Estimated timelines**	**Estimated Reach**	**Resources per key stakeholder for Obj1**
Community Reps	Participate in the development and implementation of the community development program Provide advice and advocacy for systemic and policy change in PCP & community	Community, including disadvantaged/at risk groups	June 2004 – June 2006	30 community representatives. 50 organisations. 20 PCP agencies.	PCP honorariums $2400
BBCHS, ISCHS, Southcity Div, Sacred Heart, CAMHS	Increase community and individual understanding of mental health issues - identification, health education, community action, workforce development	Individuals who are depressed or socially isolated	October 2004 – June 2006	100 individuals, 50 GPs, 50 allied health workers	Southcity est. 1600 Sacred Heart est. 1000
All CHSs & local govt's (focus on GE), Vision Aust	Improve social connectedness options for older and isolated people - community action, settings	Older and isolated people	October 2004 – June 2006	50 older people	(CHS – see totals)
All CHSs	Events including Community arts project, Mind Body Spirit Expo, Mental Health Dance – community action, social marketing	Whole community	October 2004, October 2005	300 participants plus community	
All CHSs, local govts, CAMHS	Increase support to new families, particularly to reduce post-natal depression, and carers – identification, health education, community action, settings	Disadvantaged and isolated families and mothers	October 2004 – June 2006	50 families, mothers, 20 carers	
All CHSs, SFYS, CAMHS	Work with young people through schools – identification, health education, community action, settings	All schools, focus on 10 schools	October 2004 – June 2006	Total 103 schools, c 40,000 students – 10 schools c 4,000	SFYS $7000
All CHSs	Education and support on midlife issues for women – identification, health education, community action	Women at midlife, especially isolated or depressed women	October 2004 – June 2006	50 women	

All CHSs, MRC, local govt's (inc CoPP indig officer), CALD network[17], South Port, **Port Phillip Comm'y group, CHSs, local govts, Access Health** **SECASA, all CHS's, Port Phillip, WHISE, Southcity Div**	Inclusive and diverse health promotion – health education, community action, settings, workforce development Settings based approaches in conjunction with community and individual advocacy – health education, community action, settings Raise awareness of the impact of violence on health and work to reduce violence – identification, health education, community action, settings, workforce development	CALD, indig, men and women, all ages, GLBTI, people with disabilities Residents of Rooming Houses, SRSs public housing Community, health and community workers, opinion leaders, employers, people at risk eg children, women, young people, and young men as perpetrators			Not specified Not specified WHISE - $1000 (not IHP funding) others not specified CHS totals CCHS $70,552 ISCHS $38630 BBCHS $24, 420
Bayside Health	Health promoting hospital, represented on ISEPICH HPWG by community development officer. Mental health reps to be nominated. Staff to participate in forums and workshops for relevant action areas.				Not yet specified
PCP HP capacity building[7]	Support Health Promotion working group[18] and subgroups/networks. Maintain HP Working Group and CAG liaison. Strengthen community participation in PCP and agencies. Maintain website. Hold forums and workshops as required. Develop resources and provide training for information and referral (link Service Coordination to Health Promotion). Participate in and support workforce development on a local and regional basis including Cert IV training and evaluation workshops.				PCP project worker $34,800 Other $7,200 ISCHS $4828 BBCHS $960 CCHS not separate
Estimated Total Budget per Objective [6]:					**$194,390 (plus contributions not yet specified)**
Estimated Total Budget per Goal [6]:					**$194,390 (plus contributions not yet specified)**

[17] The CALD network includes 40 members representing 32 ISEPICH agencies

[18] The Health Promotion working group includes 32 members representing 20 ISEPICH agencies

Priority Goal 2:	Promote Physical Activity				
Objective 1:	Increase the levels of physical activity in the community by increasing opportunities for physical activity and developing supportive environments.				
Est. Impacts (Qual/ Quant) for Objective 1	Build capacity in member agencies, improve awareness, knowledge and referral, improve capacity to advocate. Improvements in local environment. Build awareness and knowledge in community, increase access and options, increase physical activity levels in community.				
PCP key stakeholders	**Summary of mix of Interventions & CB strategies**	**Population Target Group/s:**	**Estimated timelines**	**Estimated Reach**	**Resources per key stakeholder for Obj1**
Community Reps	Participate in the development and implementation of PCP community development program Provide advice and advocacy for systemic and policy change in PCP & community	Community, including disadvantaged/at risk groups	June 2004 – June 2006	.	PCP honorariums $1200
All CHS's, local government, community representatives **All CHSs, IDI, local government, community representatives** **PA network, convened by CCHS**[19] **All CHSs (CCHS as lead agency) IDI, Arthritis Foundation, community reps**	Increase the range of low cost accessible Physical Activity options for diverse groups - community action, settings Provide community information on physical activity benefits and options - health education, social marketing, community action Provide workforce development and advocacy for environments for physical activity - settings and supportive environments Continue and extend the Falls Prevention Program - screening, health education, community action, settings	Older people, women, CALD, Indigenous Whole of community inc diverse groups Health workers, planners, community Health workers, community especially older people	October 2004 – June 2006 October 2004 – June 2005 Regular quarterly breakfasts, project from Nov 2004 (if funded) Peer support and WFD from November 2004	20 settings 50 community groups including 20 CALD and GLBTI 60 workers, 10 planners, (3 LGAs if funded) 20 peer educators, 200 community members, 100 participants, 60 staff	(plus $30,000 Vic Health if successful) Total CHS: CCCHS$52162 ISCHS $33800 BBCHS $64360 IDI – PA $7600 - CALD $6500

[19] The PA network includes 35 members from 13 agencies

Bayside Health	Provide key contact for PA. Support health education. Staff to attend forums etc. Link to falls prevention..				Not spec
PCP HP capacity building[7]	Support Health Promotion working group and subgroups/networks. Maintain HP Working Group and CAG liaison. Strengthen community participation in PCP and agencies. Maintain website. Hold forums and workshops as required. Develop resources and provide training for information and referral (link Service Coordination to Health Promotion). Participate in and support workforce development and networking on a local and regional basis.				PCP project worker $16,400 Other $3,600 BBCHS 3040 ISCHS 4828 IDI 1000 CCHS not spec
Estimated Total Budget per Objective [6]**:**	**$194.490 plus unspecified contributions (plus $30,000 if VicHealth submission successful)**				
Estimated Total Budget per Goal [6]**:**	**$194.490 plus unspecified contributions (plus $30,000 if VicHealth submission successful)**				

Priority Goal 3:	Nutrition and Food Security				
Objective 1:	Monitor Nutrition and Food Security as emerging issues				
Est. Impacts (Qual/ Quant) for Objective 1	Build capacity in Health Promotion working group				
PCP key stakeholders	**Summary of mix of Interventions & CB strategies**	**Population Target Group/s:**	**Estimated timelines**	**Estimated Reach**	**Resources per key stakeholder for Obj1**
All CHS's, CoPP	Provide information to the HP working group on the progress of strategies for consideration in IHP review 2005	Community, including disadvantaged/at risk groups	June 2004 – June 2005	HPWG	ISCHS 4829 PCP 1000
Estimated Total Budget per Objective [6]**:**					**$5829**

ISEPICH Service Coordination Plan 2004 – 2006

KEY FOCUS	GOALS	MAJOR STRATEGIES	TIMELINES	EVALUATION/MEASURES
Provide support to a wider group of agencies to implement ISEPICH's service coordination protocol.	To extend the number of agencies using the protocol including SCTTs for referral purposes.	Consultation to ascertain agencies wishing to implement the protocol, including assessment of their training and support needs.	Feb 2005	Expanded number of agencies which have implemented the SC protocol.
	To increase the number of agencies using full range of available information resources including the SSD and ISEPICH Website	Provision of support and training, including orientation for new staff. Promote the use of the DHS self-paced learning module	Mar – Dec 2005 Ongoing	Audit of interagency referral patterns/compliance with protocol to be conducted Number of staff trained
Undertake capacity building strategy for priority agencies to improve access, initial needs identification and referral. *(With a focus on clients from diverse backgrounds/needs, including CALD community members)*	To increase the skills and knowledge of reception and intake staff of priority agencies to ensure: -Comprehensive knowledge of the full range of services and supports available -Optimum use of available resources such as the SSD, ISEPICH Website etc -Implementation of the SC protocol and ability to make appropriate referrals	Engage the ISEPICH Community Advisory Group in consulting with/providing feedback to agencies regarding reception and intake functions, including the provision of information.[20] Develop discussion paper and consult with and engage priority agencies. Form a reference group comprising at least one community representative, agency personnel including reception and intake staff. Identify training and support needs. Develop and implement strategy for addressing priority issues.	Ongoing Nov 04 – Feb 05 Mar 05 May – July 2005 July – Dec 2005	CAG members involved in the ongoing process. Agencies committed to and actively engaged in the process Reference group with clear terms of reference functioning effectively Workforce development strategy endorsed by agencies and ISEPICH Executive.
Develop a common service coordination protocol for the Southern Metropolitan Region[21]	Consistent service coordination practice across the SMR, with an emphasis on referral and feedback.	Conduct workshop with representatives from all PCPs to identify elements of common protocol Provision of training and support to agencies	Draft protocol to be developed by Dec 04. Feb – Dec 2005	Conduct an audit to determine level of compliance/successful implementation

[20] ISEPICH has a set of Principles for Information Provision developed in 2003 by member agencies as a quality initiative
[21] Refer to Appendix One

KEY FOCUS	GOALS	MAJOR STRATEGIES	TIMELINES	EVALUATION/MEASURES
Provide support to prioritised agencies that have implemented ISEPICH's service coordination protocol to implement agreed practices for assessment and care planning.	To fully implement the ISEPICH protocol for agencies. *(Link to health promotion activities/HARP projects)*	Consult with key agencies to identify core group which will participate Identify appropriate tools and resources Undertake capacity building/workforce development	July/Aug 2005 Sept 2005 late 2005/early 2006	Number of agencies implementing protocol in relation to assessment and care planning Provision of range of appropriate tools and resources Number of agencies/workers trained
Provide support to prioritised General Practices to improve knowledge of primary care services, health promotion opportunities and quality of referrals, including use of the SRF	To improve GPs knowledge of primary care services and opportunities for health promotion. To improve the quality and consistency of referral to primary care agencies.	Develop targeted resources for GPs to improve their knowledge of services/health promotion opportunities Provide individual support to GPs/Practice staff on how to do referral using the SRF	Sept 2004 – June Sept 04 – June 2006	Increased knowledge and use of such resources by GPs Number of GPs using SRF for referral purposes
To work collaboratively with Bayside Health to improve the continuum of care. [22]	That patients will have access to appropriate primary care services and supports on discharge. To increase the use of the CHORd[23] by primary care agencies.	Ongoing liaison with key Bayside Health personnel to identify training and support needs. To monitor the progress and evaluation of the three HARP funded projects in the ISEPICH catchment to ensure that key learning's are implemented more widely in the service system where appropriate. To work collaboratively with Bayside Health to identify opportunities to expand the uptake of CHORd and to enhance its functionality to include e-referral.	Ongoing Ongoing	Key staff in relevant departments will: ▪ Have improved knowledge of the full range of services and supports available in the primary care sector ▪ Make optimum use of available resources such as the SSD, ISEPICH Website etc ▪ Implement relevant elements of the SC protocol, including using the SCTTs for referral

[22] ISEPICH will also work collaboratively with Bayside Health in regard to IM/IT strategies
CHORd aims to provide an information system to best support a model of shared care through:
Sharing of client information supported by appropriate consent, privacy and security processes, Progressive generation of an on-line electronic record with a strong focus on case management, care planning and electronic referrals, Access to timely and accurate information to support decision making and planning/research Interface with other agency systems to avoid duplication of service provision and data entry, Facilities to generate letters, referrals and operational and management reports

KEY FOCUS	GOALS	MAJOR STRATEGIES	TIMELINES	EVALUATION/MEASURES
To work collaboratively with the other three PCPs in the SMR to develop a regional IMIT Strategy	To improve the capacity of primary care agencies to effectively provide care to people with complex needs, who concurrently receive services from a number of providers	To participate in the Regional Governance Group and the Metropolitan ICT Formation of regional IM/IT reference group. Development of strategy Consultation with key stakeholders Identify opportunities for funding and collaborative effort to implement strategy	Ongoing Late 2004 Early 2005 Early 2005 Ongoing	Increased number of agencies using the CHORd for clients with complex needs.
The following two areas of focus will be considered and implemented in 2005 if feasible				
Development of a demand management strategy and mechanism for the collection of data for service planning	Develop and implement a catchment wide approach to utilising the SCTT and intake data for collaborative planning and advocacy.	Consult with DHS and other PCPs regarding possible mechanisms Consult with ISEPICH member agencies Provide support/capacity building to implement	Mar – May 2005 July/Aug 2005 Sept/Oct 2005	Development of an effective strategy to measure unmet demand for services.
Develop an integrated communication and information strategy	To improve the availability of and access to information by service providers and community members *(with a focus on clients from diverse backgrounds/needs, including CALD community members)*	Document existing strategies for communication and information provision Consult with key agencies and community members to identify areas for improvement/new approaches to information provision. *(Including greater integration of existing mechanisms such as the PCP and individual agency web sites, written materials/brochures etc)* Implementation of new approaches.	Early 2005 Mar/April 2005 Late 2005/early 2006	Development of an integrated approach for the provision of information about services and health promotion programs operating within the catchment.

ISEPICH Quality of Health Information Principles

The importance of quality information and good communication in health is widely recognised. One of the major underlying causes of complaints to the Health Services Commissioner is poor communication.

The principles of quality health information below were developed by a working group of ISEPICH member agencies and community representatives in 2002. They were endorsed by the ISEPICH Executive Committee and now form an attachment to the Memorandum of Understanding that all member agencies sign when they join ISEPICH. They are intended as a guide to agency practice.

PRINCIPLE	ISEPICH MEMBER AGENCIES UNDERTAKE TO:
1. Respect and Relevance	• recognise that health information is most likely to reach people if it takes into account their needs and circumstances, their level of knowledge and their ability to take in the information at the time
2. Creativity	• be creative in presenting information, using a variety of methods, such as audiovisual, shop front display, poster/pictorial, plays, personal contact and outreach, as well as written information
3. Plain Language	• present core information in plain language and, where appropriate, in ways that are suitable for people of low literacy, and make more detailed information available for people who want it
4. Sensitivity	• be aware that people do not take information in readily when they are stressed, and it is important not to overwhelm them, and make information available as and when people need it
5. Diversity	• recognise diversity of culture, religion, gender, sexuality, and social circumstances in all information
6. Community Languages	• make information available in community languages and provide interpreters and translations when needed
7. Participation	• involve community members, carers and consumers (people who use or may use the health services) in the development of health information
8. Resources	• ensure adequate resources for the development of health information
9. Training	• ensure staff receive regular training in the use of health information
10. Timeliness	• include date of production in all information and review and update information regularly
11. Authorisation and Contact	• ensure contact details for the agency providing the information are included in all information
12. Objectivity	• ensure to the best of their ability that information is evidence based and objective, and that any commercial interest is declared