

Lower Hume Primary Care Partnership

2003 - 2004

Community Health Plan

Working together towards better health and wellbeing in Mitchell and Murrindindi communities.

FROM THE CHAIRPERSON

It is my pleasure to present the 2003/2004 Lower Hume Community Health Plan on behalf of the Lower Hume Health and Community Services Forum (The Forum). This plan reflects the time invested in consultation and collaboration with member agencies, undertaken to develop a health plan that is complimentary to individual plans - integrating Lower Hume Primary Care Partnership (LHPCP) work into daily processes, rather than adding an additional workload.

The past year has again been a busy period for The Forum and LHPCP and I welcome the opportunity to report on the range of activities that have already been completed and present our proposed activities for 2003/2004. During the last 12 months The Forum and LHPCP have focused on delivering outcomes in areas identified by the Department of Human Services and the Victorian Government for our region. These outcomes include:

- **Service Coordination** – Development of a Protocols, Processes, Practices and Systems manual for the Service Coordination Tools Templates (SCOTT).
- **Integrated Health Promotion** – Wellbeing Program, four Enhancement Projects and two Community Action Groups (Flowerdale & Pyalong).
- **Partner Engagement** (GPs, Agency, Community) – General Practitioner Engagement Working Group, The Forum and Community Researchers.

In 2003/2004 we will continue to build upon these key areas, encouraging an integrated approach to service coordination and health promotion when responding to the priority health and wellbeing needs of Lower Hume communities.

The Forum have come a long way in achieving the overall goals of the alliance and PCP, however there are still some areas we need to further develop. These include:

- Sustainability – how can we build 'sustainability' into most of the projects we develop? What will remain at the end of the primary care reform process?
- The need to engage new non-traditional partners, such as community and sporting groups and other 'healthy lifestyle' groups.
- Further integration of LHPCP work into day-to-day activities of member agencies and the wider primary care service sector.
- Development of Information Communication Technology (ICT) solution in smaller agencies – at minimum there needs to be ICT to support e-referral projects and the Service Coordination Tools Templates (SCOTT).
- Wider communication of Forum and LHPCP activities – to improve agency involvement and highlight success stories.

Our vision "Working together towards better health and wellbeing in Mitchell and Murrindindi Communities" reflects the direction we want to take during 2003/2004. I believe the coming year is an opportunity for The Forum to build on existing partnerships between agencies in the Shires of Mitchell and Murrindindi – improving Service Integration and creating greater cohesion between Municipal Health Plans and Community Health Plans.

I would like to thank the Lower Hume Health and Community Services Forum, LHPCP Secretariat, GPs, community representatives and LHPCP project workers for their assistance in developing this plan and for their participation in Forum / LHPCP activities during the last 12 months.



MARK AMOS, JP
Chairperson Lower Hume Health and Community Services Forum



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1.0 Lower Hume PCP Strategic Objectives and Key Achievements

1.1 The Purpose and Structure of the 2003/2004 Lower Hume Community Health Plan

The 2003/2004 Lower Hume Community Health Plan is the third for the region and represents the aspirations of the Lower Hume Health and Community Services Forum (The Forum) for 2003/2004 and builds on existing policies, practices, activities and principles.

The Forum sees the 2003/2004 Lower Hume Community Health Plan as an opportunity to:

- Articulate where we have been/come from as a group of agencies, government departments and community members; **to tell our story**.
- Articulate the objectives, tasks, responsibilities and timelines needed to realise the goals of LHPCP in the Lower Hume area; **to plan**.
- Articulate and strengthen our partnerships with each other and the community through working towards a shared vision of the future; **to collaborate**.
- Articulate, concisely and in a targeted way, our actions for 2003/2004, **to deliver**.

The focus of The Forum for the following 12 months is sustainability. The strategies supporting this focus are outlined in section 2.3 of this plan.

The Audience for this Plan

The primary audience for the Community Health Plan is The Forum and participating agencies as well as the communities that they serve. A second audience is Local and State government, in particular the Department of Human Services – both the Central and Hume Regional Offices. The information contained in this document assists these bodies to make informed decisions about health priorities and resource allocation. Existing community engagement mechanisms will be used to “translate” the Community Health Plan and disseminate information regarding the 2003/2004 directions of the Lower Hume PCP. This plan has been written using ‘everyday’ language, making it simple and easy to read – by both health professionals and the broader community. The main body of this plan is a broad overview of the activities in Lower Hume for 2003/2004, with more detailed action plans outlined in section 2.3.

Relationship between the Lower Hume Primary Care Partnership and the Lower Hume Health and Community Services Forum

The Lower Hume Health and Community Services Forum (The Forum) was established in 1996 to provide an interface between hospitals, community health services and local government, in respect to the delivery of healthcare programs and services. The key underlying principle of The Forum is the Social Model of Health and its focus on community health and wellbeing as a whole.

The Forum incorporates the work of the Lower Hume Primary Care Partnership and aims to have a direct impact on the health of the community through joint agency health promotion, service coordination and community engagement projects. The Forum and LHPCP Secretariat have jointly prepared the 2003/2004 Lower Hume Community Health Plan and have incorporated Lower Hume Health and Community Services Forum member’s comments and evaluation of previous Community Health Plans in this year’s plan.



The Forum is a planning and strategic body and as such does not operate an ongoing income/expenditure account and does not have capital infrastructure. Monies are held by the delegated fund-holder. The Forum is aware of and actively references relevant aspects of the Mitchell and Murrindindi Municipal Public Health Plans and any other local, regional and statewide planning documents.

The Forum does not have any enforcement capability. To implement the changes which will be required to achieve its vision, The Forum relies on:

- Willingness of all health and community support services to implement within their own organisations, the changes which will be required to create a better service system;
- A clear understanding of the service system from the consumer (service user) and community perspective;
- A clear understanding and commitment to the social model of health;
- An agreed service system design which provides a diverse range of options responding to the needs of the consumers
- A commitment to an agreed version of good practice.

Membership of Lower Hume Primary Care Partnership is as follows:

- | | |
|--|---|
| ▪ Alexandra and District Hospital | ▪ Mitchell Shire Council |
| ▪ Berry Street Services | ▪ Murrindindi Community Health Services |
| ▪ Central Highlands Division of General Practice | ▪ Murrindindi Shire Council |
| ▪ Goulburn Valley Family Care | ▪ North East Division of General Practice |
| ▪ Goulburn Valley Health | ▪ Seymour District Memorial Hospital |
| ▪ The Kilmore and District Hospital | ▪ Women's Health Goulburn North East |
| ▪ Mental Illness Fellowship | ▪ Yea and District Memorial Hospital |
| ▪ Mitchell Community Health Services | |

Supporting Documents for this Community Health Plan

This Community Health Plan is designed to be a concise management tool for activity implementation in Lower Hume in 2003/2004. Many reports and policy documents underpin the contents of the Plan and can be obtained from Lower Hume PCP Community Development Worker and will be available on the Lower Hume PCP website when it has been developed.



1.2 The Strategic directions of Lower Hume PCP

The Lower Hume Health and Community Services Forum Vision for 2003/2004 is:

“Working together towards better health and wellbeing in Mitchell and Murrindindi communities”.

In May 2003, a Planning Day was held to revisit the goals and aspirations of the Forum. A number of reports were presented that detailed last year's activities. Discussions were also conducted with the group including a review of LHPCP activities, vision for the future and the identification of core activities for 2003/2004 as well as a presentation of summaries of the member agency interviews conducted by the day's facilitator.

A key finding of the Planning Day was the need to continue engagement and capacity building around the development of goals, skill development within the Forum agencies and an induction program for new agency members of the Lower Hume Forum and LHPCP. These discussions recognised that interagency relationships between Forum members remain informal and that recent key staff movements have created a state of flux for the group. The Forum will examine how these relationships can be formalised over the coming year and develop and initiate appropriate strategies to address those issues identified through the individual agency consultation process. These activities have been included in the Action Plans.

Previous research findings from 2001 - 2003

During 2001/2002 Lower Hume PCP was active in conducting quantitative and qualitative research to establish dynamic needs assessment, service profiling and community profiling information. This research was further refined and actions stemming from the findings were implemented during 2002/2003 to address the issues that had been identified (see 1.3 for key achievements).

The key findings from research undertaken between July 2001 and June 2003 are detailed below:

SERVICE COORDINATION

Referral Coordination

- The Service Mapping Project highlighted evidence of “good referral practice” operating within the LHPCP. However, the project also found that parts of the referral system were characterised by informal processes, which were not compliant with the Health Records Act.
- The referral systems had identified gaps, duplications and inefficiencies, which resulted in inefficient business processes and work practices; and perceived and real blockages.
- The development and implementation of a formalised referral system within the LHPCP will improve outcomes for clients, achieve efficiencies in agencies' processes and practice and improve staff satisfaction.
- These issues have been advanced during 2002/2003 but the absence of adequate I.T. support has meant that agencies have had to maintain paper and manual referral systems.



- It is hoped that the inadequacies of the I.T. support can be resolved during 2003/2004 as the Hume Health I.T. Strategy becomes operational.
- A submission for additional funding to support GP e-referrals was submitted this year. (LHPCP was unsuccessful in this funding)

Service Information Directory

- Most agencies build and maintain some form of Service Directory.
- Limited resources mean that service information isn't always up to date.
- Information is sometimes limited, inaccurate, not comprehensive, and out of date.
- The development of a Service Directory is greatly supported by service providers as it will provide: accurate, comprehensive and up-to-date information on services.
- The Directory needs to have a process for updating information, provide access to information for both agencies and the community in a user friendly format, with appropriate information for referring agencies and an avenue for communication and networking.
- The development of an electronic directory has been problematic with the standalone directory "Service Seeker" not being further implemented whilst a statewide e-Service Directory is being developed.

Awareness Raising and Capacity Building

- The mapping process found that the LHPCP work was not integrated into the day to day work of agencies and was generally confined to management.
- Engagement of all stakeholders is integral to the successful implementation of Processes, Practices, Protocols and Systems (PPPS).
- The Service Coordination Working Group has sourced appropriate documentation that is being adapted to LHPCP member requirements. This work has generally been completed.

Information Technology and Telecommunications

- Hardware, software, capacity and practice vary between agencies.
- Almost all agencies expressed frustration in relation to one or more aspects of their I.T. systems.
- Not all services have access to electronic systems and records.
- Internet and e-mail access is limited, poor, or non-existent, long delays for maintenance and repairs of equipment, software etc. and mobile phones have limited/no coverage in a number of areas.
- The Forum acknowledges that the Hume Health I.T. Strategy will build upon the LHPCP's previous research and will continue to provide valuable input to the Strategy until it becomes operational across the region.
- The issue of cost of installation to smaller agencies has not been addressed at this stage.
- Potential cost of e-SCOTT software may be prohibitive.

Better Service Information and Referrals

- There are gaps between the capacity of providers and the capacity of the community to use electronic service information. This would require a very user friendly format and language as well as support to facilitate the up-take of this technology.
- Areas within Lower Hume are not well supported with a quality telecommunication infrastructure to allow an all electronic solution.
- As with Service Providers, a mix of formats (electronic and paper-based) is most acceptable to community members.



HEALTH PROMOTION

- The delivery of health promotion programs tends to be fragmented.
- Agencies tend not to work together in the planning, delivery or evaluation of health promotion programs and activities.
- Health promotion continues to generally focus on the prevention of disease (activities such as health screenings) and encouraging healthy behaviour (eg walking programs) rather than on broader social model of health factors (such as community connectedness).

ENGAGEMENT

Agency Engagement

- Agencies have indicated the need for improved communication strategies.
- The opportunity to expand involvement to non-traditional agencies has been identified.

General Practitioner Engagement

- Focus on the Service Directory and other projects has diverted LHPCP efforts away from the establishment of relationships between GPs and agencies.
- Uptake of the Service Directory by GP's has been less than hoped for.
- Agencies are unclear about the purpose of the GP Engagement Strategy.

Community Engagement

- A review of the Community Engagement Strategy established that the Community Research model is beneficial for individual researchers and an effective way of collecting detailed information from the community about health and community issues. It also proved effective when used in conjunction with community capacity building health promotion programs (eg Community Action Projects).
- Some agencies have indicated interest in using the Community Engagement Model for their community consultation.



1.3 Summary of Key Achievements

The 2002/2003 Community Health Plan outlined three key areas that Lower Hume PCP would focus on for the year. These were Service Coordination, Integrated Health Promotion and Engagement (GP, Agency and Community). Following is a brief summary of the key achievements in these three areas:

SERVICE COORDINATION

- A Service Coordination Working Group was established with staff representation from all primary care agencies across Lower Hume.
- The Service Coordination Working Group have developed a comprehensive PPS manual to facilitate the smooth integration and use of the Service Coordination Tools Templates (SCOTT) in all primary care agencies across Lower Hume.
- Key agency staff have undertaken the 'Train the Trainer' course with DHS to support agency staff to implement SCOTT by June 2003.
- All primary care agencies have begun preliminary use of the paper based SCOTT tool as required by DHS, pending the availability of an electronic version of SCOTT.
- LHPCP has representation on the Hume Health Alliance and is working closely with the Alliance to research and develop an electronic messaging and referral system to support the use of SCOTT.

INTEGRATED HEALTH PROMOTION

- The Murrindindi Community Action Project (CAP) in Flowerdale is nearing completion with final implementation and evaluation to be conducted in consultation with the local community.
- The Mitchell Community Action Project (CAP) in Pyalong is progressing well with the community group now meeting without the support of LHPCP facilitator. The key project identified by the group has received unprecedented support from VIC Roads and is in initial stages of planning and implementation.
- The Accident and Emergency Project (as outlined in 2002/2003 CHP) has been renamed to better reflect the aims of the project. Now known as Improving Our Response to Mental Illness (IORTMI) this mental health promotion project has undertaken two Applied Suicide Intervention Skills Training (ASIST) workshops to enable staff from LHPCP agencies to provide an effective suicide intervention role in an emergency situation.
- Through interagency collaboration LHPCP completed four Project Enhancement activities: PITSTOP, Wellbeing Program, Looking After Mothers Project (LAMP) and the Girls' Group (three groups completed with a fourth planned for July 2003).
- Project staff have begun initial research and collaboration with LHPCP agencies and a broader range of community service agencies / community groups to establish the framework for the key HP project in 2003/2004 - Tough Times, Tough People. (supporting documentation is attached in Appendix 2)

ENGAGEMENT

General Practitioners (GP)

- LHPCP undertook an initial region-wide consultation process with Lower Hume GP practices to establish the needs of GPs in the area of a Service Directory and electronic referral.
- Involved two GP practices in trial of the Service Seeker Service Directory and received feedback on its suitability and ease of use.
- The Service Directory is complete, but is currently not being further implemented pending a statewide tender for a web based Service Directory.



- LHPCP established a GP Engagement Working Group, which is now chaired by a Seymour General Practitioner. The group has been established to look at ways of developing better links between GPs and health agencies in the areas of a unified Service Directory, electronic referral and Service Coordination.
- LHPCP has sought to strengthen their links with the two Divisions of General Practice covering our region (North East and Central Highlands) and secured their support for a grant submission in the area of GP involvement in the Service Coordination process – in particular electronic referral and messaging.

Agency

- Engaged the LHPCP broader membership in two planning workshops – DHS Quarterly Report and the 2003/2004 Community Health Plan.
- Established a bi-monthly newsletter to inform members of current achievements and to promote important upcoming events.
- Engaged non-traditional partners in Forum and LHPCP activities such as Forum meetings and the CAP in Pyalong (eg Goulburn Broken Catchment Management Authority).

Community

- LHPCP invited community members to undertake Community Research Training – resulting in six trained Community Researchers (CR).
- All Community Researchers (CR) took part in an agency mapping project which identified key resources within agencies.
- CRs undertook focus groups across the Lower Hume region to identify key health and wellbeing issues in local communities.
- CRs assisted in the Flowerdale Community Action Project and facilitated a community Speak Out day – which was an opportunity for residents to identify local health and wellbeing issues.
- All CRs attended an evaluation workshop held in March 2003 to review the process and to identify the future role of CRs in Lower Hume. Information from the day (which was also attended by several LHPCP agency representatives) formed the basis for the draft 2003/2004 Community Engagement Strategy.



2.0 Lower Hume PCP Action Plans for 2003/2004

2.1 Community and Service Profile

Lower Hume Primary Care Partnership covers two neighbouring municipalities - Mitchell and Murrindindi Shire Councils.

Mitchell Shire

Mitchell Shire of 2,864 square kilometres is the southern most shire of the Hume DHS region. The Shire borders the northern outskirts of Melbourne and extends north along the Hume Highway to and includes the township of Seymour. The Hume Highway runs through the centre of the Shire allowing easy access to the rich diversity of farming, military and tourist industries. The main townships within the Shire are Kilmore, Broadford, Seymour and Puckapunyal.

Basic Community profile for Mitchell Shire

			2001		1996		'96 to '01 Variation
	Male	Female	Total	Male	Female	Total	
Total Persons (a)	13,964	13,578	27,542	12,737	12,196	24,933	+ 10.46%
Aged 15 years and over (a)	10,291	10,217	20,508	9,249	8,907	18,156	+ 12.95%
Aged 65 years and over (a)	1,109	1,352	2,461	914	1,105	2,019	+ 21.89%
Total Indigenous Persons (b)	132	131	263	96	91	187	+ 40.64%
Born in Australia	11,480	11,333	22,813	10,848	10,498	21,346	+ 6.87%
Born overseas(c)	1,440	1,318	2,758	1,346	1,251	2,597	+ 6.19%

Source: ABS 2001 Census

NOTE

(a) Includes Overseas visitors.

(b) Applicable to persons who are of both Aboriginal and Torres Strait Islander origin.

(c) Includes 'Inadequately described', 'At sea', and 'Not elsewhere classified'.

Of those residents born overseas, the majority originated from English speaking countries however 1.65 % of the total population originated from Germany, Italy and the Netherlands. There is a small percentage of residents representing a wide variety of NESB countries of origin. 1,077 residents speak a language other than English.

The number of families with children of less than 15 years is approximately 39.3 % of total population, which is well above the rural Victoria average of 32.7%. Single parent families constitute 15.2% of the total population which is greater than the state rural average of 14.8%.



Mitchell Shire has identified in its Municipal Public Health Plan that injury had the highest impact on their residents Disability Adjusted Life Years (DALY) due to road traffic accidents and suicide. Mitchell Shire is rated 6th worst for males and 10th worst for females for injuries in Victoria. "Females in Mitchell Shire have a poorer health status than the Victorian average, due largely to higher rates of injury and cancer".

Murrindindi Shire

Murrindindi Shire extends east along the Goulburn Valley from just outside Seymour to Eildon and south towards Healesville. This area is recognised for its cattle, milk, wool and meat production as well as forestry. This region has a strong tourist industry around wineries, fine food, scenery and access to the Victorian Alps. The Shire is 3,889 square kilometres in total and like Mitchell, is made up of a mixture of small hamlets and reasonable size service towns. The major towns in this municipality include Yea, Alexandra, Eildon, Kinglake, Flowerdale, Buxton and Marysville.

Basic Community profile for Murrindindi Shire

	2001			1996			'96 to '01
	Male	Female	Total	Male	Female	Total	Variation
Total Persons (a)	6,589	6,520	13,109	6,252	6,199	12,451	+ 5.28%
Aged 15 years and over (a)	5,105	5,076	10,181	4,703	4,672	9,375	+ 8.59%
Aged 65 years and over (a)	875	898	1,773	794	850	1,644	+ 7.84%
Total Indigenous Persons (b)	33	42	75	26	35	61	+ 22.95%
Born in Australia	5,337	5,332	10,669	5,220	5,206	10,426	+ 2.33%
Born overseas(c)	766	731	1,497	731	695	1,426	+ 4.97%

Source: ABS1996 & 2001 Census

NOTE

(a) Includes Overseas visitors.

(b) Applicable to persons who are of both Aboriginal and Torres Strait Islander origin.

(c) Includes 'Inadequately described', 'At sea', and 'Not elsewhere classified'.

Of those residents born overseas the majority originated from English speaking countries however 1.90 % of the total population originated from Germany, Italy and the Netherlands. There are a small percentage of residents representing a wide variety of NESB countries of origin. Only 499 residents speak a language other than English.

The number of families with children of less than 15 years is approximately 32.2 % of total population, which is just below the rural Victoria average of 32.7%. Single parent's families constitute 12.6% of the total population which is significantly less than the state rural average of 14.8%.



Number of Residents in Receipt of Social Security Benefits

	Aged Pension		New Start		Disability Support	
	Clients (N)	% pop	Clients (N)	% pop	Clients (N)	% pop
Mitchell (S)	2,065	7.2	789	2.8	824	2.9
Murrindindi (S)	1,332	9.8	321	2.4	413	3.0
Hume	25,476	10.2	6,850	2.7	8,603	3.4
Rural	145,813	10.9	38,962	2.9	48,732	3.7
Victoria	458,529	9.5	129,779	2.7	149,167	3.1

The above table shows that both Shires are well below state average for Aged Pensions and Mitchell is also well below the Hume Regional average. Murrindindi is below all three averages for New Start Benefits, whilst Mitchell is about average with the Region, State and rural indicators for New Start. This would indicate that unemployment is well below average for Murrindindi Shire and about average for Mitchell Shire. Both Shires are below average for Disability Support Benefits, which suggests that there are fewer people identified with a serious disability and on benefits than other Regional, rural and State averages.

2001/2002 Births and Child & Maternal Health contacts over the first 6 years of life for both Shires

LGA	Notification of birth		0-1 years	1-2 years		2-3 years		3-4 years		4-5 years		5-6 years	
	Number	Participation rate (%)*	Total/Active record	Total record	Active record (%)	Total record	Active record (%)	Total record	Active record (%)	Total record	Active record (%)	Total record	Active record (%)
Mitchell (S)	421	98.3	400	391	92.6	411	74.2	398	45.2	444	39.0	414	8.5
Murrindindi (S)	167	100.0	159	149	96.6	161	85.1	141	80.9	154	56.5	174	35.6
Hume	588	96.9	559	3297	87.8	3423	61.6	3335	39.8	3455	36.8	3474	11.5
Statewide	61,385	97.0	58,951	61,670	90.2	63,129	66.8	62,818	37.4	62,242	36.6	62,487	9.2

Data source: Maternal & Child Health Annual Data Report, Community Care Division, DHS

Reference period: 2001/2002

Contact person: Phet Vilaysane (9616 8995)

* Enrolled from birth notifications plus enrolled in other centres within municipality plus enrolled in other centres outside municipality as a percentage of total birth notifications received less stillbirths less deaths within one month less other.

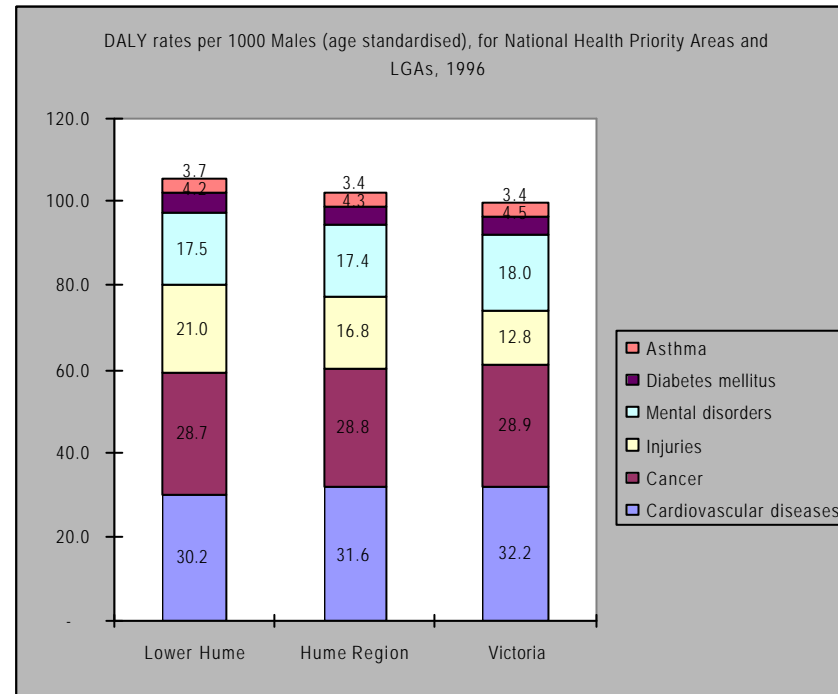
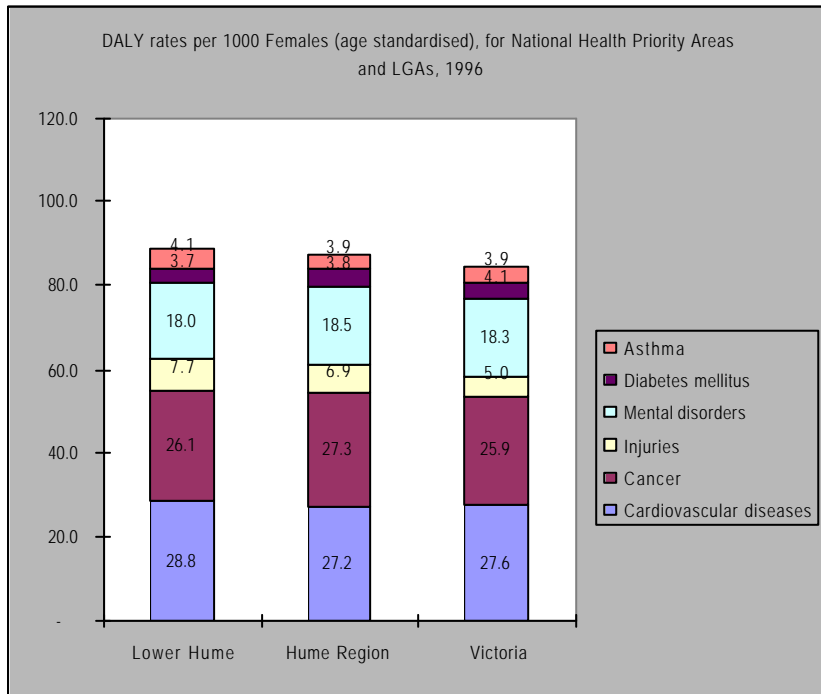


2.2 Health Priorities for 2003/2004

The key research and needs assessment findings, with respect to Lower Hume services and community, are that **Disease and Illness data indicates** that:

- **Three Critical Disease Priorities** - As is the case in the rest of the State, cardiovascular disease, cancer and mental disorders are the main contributors to ill health in Lower Hume.

Although this data is based upon the 1996 Burden of Disease studies which have not been updated, more recent research like the Victorian Ambulatory Care Sensitive Conditions (ACSC) study (May 2001) shows that there has been very little change in these priorities and further that there is a direct correlation between people being admitted to hospital for preventable conditions and the socio-economic status of a community. That is, the lower the socio-economic status of a community, the admissions to hospital are generally higher for both acute ACSCs (e.g. hospitalisation for acute diseases like ears, nose and throat infections) and chronic ACSCs (hospitalisation for selected chronic illnesses like diabetes, asthma, hypertension, congestive heart failure and chronic obstructive pulmonary disease).



- **Differing Risk Factors within the Population** – Illness and disease are experienced differently by different people and different people are at different risk. For example, there are gender differences in ill health reported in Lower Hume.

Top Five Risks (as percentage of DALY ranking) of Illness for Lower Hume by Gender

Females		Males	
Cancer	19%	Cardiovascular diseases	19%
Cardiovascular diseases	18%	Cancer	18%
Mental disorders	17%	Mental disorders	14%
Neurological and sense disorders	9%	Unintentional injuries	12%
Chronic respiratory diseases	8%	Chronic respiratory diseases	8%

In addition to the above information, Australian Bureau of Statistic data supports the local advice that there is a significant growth pattern in the lower reaches of the LHPCP region, in particular in the communities of Wallan and Kilmore. Due to this rapid growth, qualitative data for these communities needs further research with an emphasis on social isolation, the impact of childcare and child and maternal health support for new mothers and programs for both before and after school support for parents working in the city. This research should also include an examination of the social impact upon the original rural community residents who chose to live in these small country towns, before this significant growth from predominantly metropolitan employed families.

Responding to Government Directions

In a letter from The Honourable John Thwaites, Minister for Health, dated 6 May 2002, the priority areas for the Department of Human Services and the government with respect to PCPs have been articulated as:

- Involving “two main deliverables” – Service Coordination and Integrated Health Promotion.
- Simplifying and expediting the implementation of PCP and broader health reform goals.
- Aligning reform directions with imperatives of programs and agencies rather than being “add-ons”.
- Concentrating on service coordination reform (ie INI and Care Planning roll out) with Community Health Services, HACC, Aged Care Assessment, GP services, Primary Mental Health and primary Drug Treatment service providers in the first instance.
- Continuing to incorporate hospital demand reduction and community engagement as priorities within the deliverable areas of Service Coordination and Health Promotion.



2.3 Lower Hume PCP Action Plans for 2003/2004

Looking Forward

In 2003/2004 Lower Hume PCP is looking to develop a framework for more cohesive service provision and health promotion, creating a primary care service sector that responds to individual and community needs. The Plan has been developed in collaboration with LHPCP member agencies producing a health plan that is complimentary to their individual plans and integrating LHPCP work into daily processes.

Building on Achievements

The 2003/2004 Strategic Plans reflect the work undertaken to date and aims to build upon key achievements. This is particularly true in the areas of Service Coordination and Integrated Health Promotion, where the focus is now on primary care reform through collaboration and facilitation of best practice, rather than a program based approach.

Sustainability

In 2003/2004 LHPCP is shifting the focus from Project Workers to Agency collaboration and implementation. Sustainability is the key to continued primary care reform and in 2003/2004 LHPCP Project Workers will be the facilitators of the process rather than solely responsible for program generation and implementation.

Population Target Groups

The basis for this plan is the Social Model of Health. To achieve a whole of community response the LHPCP Community Health Plan will predominantly focus on improving agency capacity to reach their identified target groups.

Evaluation

Where possible LHPCP will be using Quality Improvement Program Planning System (QIPPS) to plan, implement and evaluate our Strategic Plans. QIPPS incorporates an action research approach as part of an integrated and systematic method to service planning, delivery and evaluation. The system operates as part of an inter-relational database package with both qualitative and quantitative capacities that links theory with practice and ensures that proposed programs are evidence based, responsive to community need and rigorously evaluated.

Benefits of Using QIPPS

- The package provides an evaluation framework to systematically record outcomes.
- It provides a dictionary of Community Health and Health Promotion terms to assist in the interpretation of 'health-speak'.
- The format is consistent with the reporting requirements of DHS.
- The package assists in needs analysis to enable staff to respond to 'needs' of the clients/community.
- It supports evidenced based practice linking health promotion practice to outcomes and research.



**2003/2004 Lower Hume PCP Action Plan
Service Coordination**

Rationale

Documentation - Protocols, Processes, Practices and Systems (PPPS) still to be fully implemented.

GOAL: To consolidate and incorporate the Service Coordination Tools Templates (SCOTT) and its Protocols, Processes, Practices and Systems (PPPS) into every day practice within the primary care sector.

Objectives	Strategies	Timeframe	By Whom
Objective 1 To improve the uptake of SCOTT and PPPS by Agencies	Conduct further train the trainer sessions on SCOTT and PPPS implementation.	Commence August 03 Complete March 04	Team Leader Service Coordination Working Group
	Support agencies in identifying suitable staff to undertake LHPCP project activities.		
	Negotiate and liaise with agency members to develop a strategy that will enable agencies to release suitable staff to undertake LHPCP activities.		
	Where possible, all consultancy activities or projects to have locally seconded staff appointed to assist and learn from the Consultant/Project Worker.		
Objective 2 Increase uptake of the SCOTT and PPPS by non - member agencies and practitioners	Promote PPPS / SCOTT into GP/Agency practices.	Commence October 03 Complete May 04	Team Leader Service Coordination Working Group
	Conduct train the trainer sessions on SCOTT and PPPS implementation for non-member agencies and practitioners.		
	Support the uptake of tools e.g. SCOTT.		
Objective 3 To ensure long term sustainability of common protocols, practices, processes and systems.	Establish an ongoing support and networking group for service coordination staff.	By June 04	Team Leader Service Coordination Working Group Agency Management



**2003/2004 Lower Hume PCP Action Plan
Integrated Health Promotion**

Rationale

- Lack of connection between agencies in relation to Health Promotion delivery.
- Fragmented delivery of Health Promotion programs.
- LHPCP not using information gathered in the 2001/2002 agency skills audit.

GOAL: To increase the degree to which effective Integrated Health Promotion is delivered across Lower Hume (Mitchell and Murrindindi Shires).

Objectives	Strategies	Timeframe	By Whom
<p>Objective 1 To increase the degree to which Integrated Health Promotion occurs between agencies in Lower Hume.</p>	Establish an Integrated Health Promotion Working Group.	<p>Commence July 03 Then Ongoing</p> <p>Review December 03 May 04</p>	Team Leaders
	Identify key individuals within agencies with whom to undertake Integrated Health Promotion activities.		Health Promotion Project Staff
	Support existing health promotion programs.		Health Promotion Working Group
	Use the Tough Times, Tough People framework to promote and support Integrated Health Promotion programs and activities in Lower Hume. (See TTTP strategy document in Appendix 2)		Key Agency Staff
	Undertake a collaborative workshop to develop a 2004/2005 Lower Hume Integrated Health Promotion Plan.		
<p>Objective 2 To increase community participation in Integrated Health Promotion activities.</p>	Assist agencies to identify relevant health promotion programs in their own communities.	<p>Commence October 03</p> <p>Review May 04</p>	Team Leaders
	Work with a broad range of agencies – both health and community.		Health Promotion Project Staff
	Engage with non-traditional health promoting agencies to reach difficult target groups (young people, farmers, isolated communities).		Health Promotion Working Group
	Work with agencies in identifying and utilising alternate avenues of event promotion.		



**2003/2004 Lower Hume PCP Action Plan
Engagement**

Rationale

- The reform process has concentrated on traditional 'health' organisations.
- GP's and community have not been sufficiently included in the primary care reform process.

GOAL: To continue to support and enhance the activity and involvement of all project partners.

Objectives	Strategies	Timeframe	By Whom
<p align="center">LHPCP Agency</p> <p>Objective 1 To increase member agency participation in primary care reform in Lower Hume.</p>	Publish a bi-monthly newsletter.	Newsletter Bi-monthly	Team Leader
	Develop an on-line LHPCP community to simplify access to documents and other information.	Website Commence July 03	Community Development Worker
	Investigate practitioner based working groups in the areas of Service Coordination and Integrated Health Promotion.	Working Groups August 03	LHPCP Secretariat Lower Hume Health and Community Services Forum
	Examine the issues of travel and communication to improve access to LHPCP.		
<p align="center">General Practitioner</p> <p>Objective 1 To increase GP participation in primary care reform in Lower Hume.</p>	Conduct a workshop with GP Engagement Working Group, Forum and key stakeholders.	Workshop August 03	Team Leader GP Engagement Working Group
	Develop a revised GP Engagement Strategy focusing on sustainability.	Strategy / Implement September 03	Community Development Worker
	Engage project worker to implement strategy.	Review March 04	



<p align="center">Community</p> <p>Objective 1 To increase community participation in primary care reform and health promotion in Lower Hume service providers.</p>	Establish Community Engagement Working Group.	Working Group August 03	Team Leader
	Introduce the Community Research (CR) process to agencies.		First CR Training October 03 Pilot Projects Feb / March 04
	Conduct agency and community training in Community Research.	Community Engagement Working Group	
	Conduct pilot research projects with two agencies	Community Development Worker	
	Link with key health promotion activities eg Community Action Projects (CAP)		
<p align="center">Non- LHPCP Agencies</p> <p>Objective 1 To increase non-traditional (ie non-health) agency participation in the activities of The Forum and the process of primary care reform in Lower Hume.</p>	Identify agencies that have access to components of the community which are traditionally difficult to reach with health promotion (e.g. Farmers and the VFF) and invite those agencies to The Forum.	Ongoing	Team Leader
	Develop a 'broader network' communication strategy to keep all agencies engaged in Forum activities and the action plan (e.g. Catchment Management Authority).		Community Development Health Promotion Worker
	Identify possible new members and participants and invite them to join The Forum (e.g. Victoria Police).		Community Development Worker
	Identify new strategies to engage appropriate Agencies representation in LHPCP activities e.g. Working Parties, The Forum etc.		Secretariat Lower Hume Health and Community Services Forum



2003/2004 Lower Hume PCP Action Plan

EVALUATION

Key Area	Outcome	Impact	Process
<p>SERVICE COORDINATION</p> <p>GOAL To consolidate and incorporate the Service Coordination Tools Templates (SCOTT) and its Protocols, Processes, Practices and Systems (PPPS) into every day practice within the primary care sector.</p>	<p>The goal will be measured through consultation and formal evaluation methods.</p>	<p>The objectives will be measured through a mixture of quantitative and qualitative research methods. Focus will be:</p> <ul style="list-style-type: none"> ▪ Attendance at meetings and training ▪ Satisfaction with process and outcomes ▪ Formal evaluation ▪ Consultation 	<p>The strategies will be measured by a mix of quantitative and qualitative research methods such as:</p> <ul style="list-style-type: none"> ▪ Numbers attending training ▪ Minutes from meetings ▪ Formal six-monthly review ▪ Consultation with management and staff
<p>INTEGRATED HEALTH PROMOTION</p> <p>GOAL: To increase the degree to which effective Integrated Health Promotion is delivered across Lower Hume (Mitchell and Murrindindi Shires).</p>	<p>The goal will be measured by the Health Promotion Capacity Audit (developed by Upper Murray Health and Community Services)</p> <p>The audit will occur pre and post 2003/2004 Community Health Plan and involve both LHPCP and non-traditional health agencies in Lower Hume.</p>	<p>The objectives will be measured by a pre and post survey and via agency and community consultation.</p>	<p>The strategies will be measured by a mix of the following:</p> <ul style="list-style-type: none"> ▪ Questionnaire evaluations ▪ Diary entries ▪ Participant observations ▪ Minutes of meetings
<p>ENGAGEMENT</p> <p>GOAL: To continue to support and enhance the activity and involvement of all project partners.</p>	<p>The overall engagement goal will be measured by the use of both quantitative and qualitative research tools such as:</p> <ul style="list-style-type: none"> ▪ Attendance at meetings and activities ▪ Satisfaction with process and outcomes. 		
<p style="text-align: center;">LHPCP Agency / Non- LHPCP Agency</p>		<p>The objectives will be measured by the use of both quantitative and qualitative research methods such as :</p> <ul style="list-style-type: none"> ▪ Attendance at meetings and activities ▪ Satisfaction with process and outcomes. ▪ Formal evaluation sheets ▪ Consultation ▪ Documenting the variety of new members 	<p>The strategies will be measured by a mix of quantitative and qualitative methods such as:</p> <ul style="list-style-type: none"> ▪ Questionnaire evaluations ▪ Diary entries ▪ Participant observations ▪ Minutes of meetings ▪ Formal evaluation sheets



<p style="text-align: center;">General Practitioner</p>		<p>The objectives will be measured by the use of both quantitative and qualitative research methods:</p> <ul style="list-style-type: none"> ▪ Attendance at workshops and GP Engagement Working Group meetings ▪ Attendance at training sessions ▪ Satisfaction with process and outcomes ▪ Formal evaluation sheets ▪ Consultation 	<p>The strategies will be measured by a mix of quantitative and qualitative research methods such as:</p> <ul style="list-style-type: none"> ▪ Questionnaire evaluations ▪ Diary entries ▪ Participant observations ▪ Minutes of meetings ▪ Formal evaluation sheets
<p style="text-align: center;">Community</p>		<p>The objectives will be measured by the use of the Primary Care Self Assessment Tool for Community and Consumer Participation.</p>	<p>The strategies will be measured by a mix of quantitative and qualitative methods such as:</p> <ul style="list-style-type: none"> ▪ Questionnaire evaluations ▪ Diary entries ▪ Participant observations ▪ Minutes of meetings ▪ Formal evaluation sheets



**2003/2004 Lower Hume PCP Action Plan
Resources**

Priority Area	Activity	Resources (\$)	
Service Coordination	Backfill	\$24,000	
	Information Technology Management	\$7,000	
	Agency training	\$1,020	
	GP Training	\$2,500	
	Manuals and distribution	\$750	Subtotal: \$35,270
Integrated Health Promotion	Project Workers/ Implementation	\$93,000	
	Back-fill	\$14,800	
	Programs	\$38,000	Sub total \$ 145,800
Engagement			
Member Agency Engagement	Project worker*	\$30,250	
	Chair Remuneration	\$8,000	
	Communication	\$5,000	
	Meeting support and administration	\$11,000	Subtotal: \$54,250
General Practitioner (GP) Engagement	Project Worker / Implementation	\$ 18,720	
	GP payments	\$ 2,400	
	Workshops	\$ 6,000	Subtotal:\$27,120
Community Engagement	Project Worker/ Implementation	\$ 24,960	
	Community Researchers Expenses	\$ 6,000	
	Training	\$16,000	Subtotal: \$46,960
Non-traditional Agency Engagement	Project Worker/ Implementation	\$ 8,250	
	Training	\$ 2,000	Subtotal: \$10,250
Total resources			\$319,650

* Includes Forum administration.



Appendix 1

Integrated Health Promotion

Program Summary Grid



Program Goal: To increase the degree to which effective Integrated Health Promotion is delivered across Lower Hume (Mitchell and Murrindindi Shires).

Population Target Group/s: Mangers and staff from LHPCP member and non-member agencies in Lower Hume.

Program Objectives	Health Promotion Interventions & Capacity Building strategies	Estimated Impacts (Qualitative &/or Quantitative)	Estimated Reach	Timelines & by which agency	Estimated Costs	
Objective 1: To increase the degree to which Integrated Health Promotion occurs between agencies in Lower Hume.	Social marketing /Health information <ul style="list-style-type: none"> Tough Times, Tough People Project 	LHPCP Agencies We expect that more than 90 percent of the total 15 LHPCP member agencies to have increased their health promotion capacity as measured by the Health Promotion Capacity Audit (Upper Murray Health and Community Services)	10 Articles – reaching an estimated 4,000 people (Newsletters, local papers, website)	For details please see IHP Action Plan in section 2.3	For details of estimated IHP costs please see Resource Grid in section 2.3	
	Health education and skill development <ul style="list-style-type: none"> Tough Times, Tough People Project Support existing health promotion programs. 		All 15 LHPCP member agencies.			
	Community action <ul style="list-style-type: none"> Integrated Health Promotion Working Group Tough Times, Tough People Project 		Non-LHPCP Agencies We expect that of the total number of non-LHPCP agencies covered by the relevant strategies in Objective 1 will have a 40 per cent increase in their capacity to incorporate health promotion principals into their day-to-day practices. This will be measured by the Health Promotion Capacity Audit (Upper Murray Health and Community Services) and through in-depth pre and post interviews.			IHP Working Group – 7 people 70 per cent of PCP agencies and key staff and 40 per cent of non-LHPCP agency staff.
	Settings and Supportive Environments <ul style="list-style-type: none"> Identify key individuals within agencies with whom to undertake Integrated Health Promotion activities. Tough Times, Tough People Project Support existing health promotion programs. Undertake a collaborative workshop to develop a 2004/2005 Lower Hume Integrated Health Promotion Plan. Integrated Health Promotion Working Group 		<ul style="list-style-type: none"> Schools Neighbourhood House Other Community Groups PCP Agencies Emergency Services Non-PCP agencies 			At least two representatives from each of the above groups participating in each Shire.
	Organisational Development Integrated Health Promotion Working Group		Seven LHPCP agencies with at least one representative each.			
	Workforce Development One Project Worker undertaking the HP Short Course – with other opportunities to be identified.		One – with future opportunities yet to be identified.			
	Resources All 15 LHPCP member agencies – as per Lower Hume Health and Community Services Forum minutes.		All 15 LHPCP agencies.			
Total Budget per Objective					NA	



Program Objectives	Health Promotion Interventions & Capacity Building strategies	Estimated Impacts (Qualitative &/or Quantitative)	Estimated Reach	Timelines & by which agency	Estimated Costs
Objective 2: To increase community participation in Integrated Health Promotion activities.	Social marketing /Health information <ul style="list-style-type: none"> Assist agencies to identify relevant health promotion programs in their own communities. Work with agencies in identifying and utilising alternate avenues of event promotion. 	It is estimated that by implementing the strategies outlined under Objective 2 there will be a 60 per cent increase in the numbers of community participants taking part in LHPCP agency's Integrated Health Promotion activities.	70 per cent of LHPCP agencies reporting an increase in the numbers attending activities as a result of strategies.	For details please see IHP Action Plan in section 2.3	For details of estimated IHP costs please see Resource Grid in section 2.3
	Health education and skill development <ul style="list-style-type: none"> Assist agencies to identify relevant health promotion programs in their own communities. Work with agencies in identifying and utilising alternate avenues of event promotion. 		70 per cent of LHPCP agencies taking part in training and capacity building.		
	Settings and Supportive Environments <ul style="list-style-type: none"> Work with a broad range of agencies – both health and community. Engage with non-traditional health promoting agencies to reach difficult target groups (young people, farmers, isolated communities). Assist agencies to identify relevant health promotion programs in their own communities. Work with agencies in identifying and utilising alternate avenues of event promotion. 		All 15 LHPCP agencies taking part, either directly or through periodic consultation.		
	Organisational Development <ul style="list-style-type: none"> Assist agencies to identify relevant health promotion programs in their own communities. Work with agencies in identifying and utilising alternate avenues of event promotion. 		70 per cent of LHPCP agencies taking part in strategies.		
	Resources All 15 LHPCP member agencies – as per Lower Hume Health and Community Services Forum minutes.		All 15 LHPCP agencies.		
Total Budget per Objective					NA



Appendix 2

Tough Times, Tough People

Strategy Document

