

# Community Health Plan 2004-2006

## Primary Care Partnerships

### OUTER EAST HEALTH & COMMUNITY SUPPORT ALLIANCE

#### Introduction

The Outer East Health and Community Support Alliance (hereafter called Outer East Alliance) is a voluntary alliance of agencies from the municipalities of Knox, Maroondah and Yarra Ranges, committed to collaborative thinking, planning and action that improves the experiences and outcomes of people who access the primary care system. The Outer East Alliance was established prior to 1998 and is responsible for the Primary Care Partnerships (PCP) strategy in Outer East.

There are 20 member agencies in the Outer East Alliance, including local government, community health services, district-nursing services, community support services, Divisions of General Practice, non-government services and a range of other key stakeholders. (See Appendix 1 for a full list of member agencies.)

This Community Health Plan outlines the goals, health priorities and agreed activities of the Outer East Alliance for the next two years (2004-2006).

#### Vision

The Outer East Alliance is committed to the PCP strategy and best practice in service planning and delivery to ensure efficient, coordinated and consumer focused services. Through local, sub-regional and regional planning mechanisms and protocols, residents of the Knox, Maroondah and Yarra Ranges municipalities will have access to high quality, responsive and integrated primary care services.

#### Aim of Outer East Alliance

***“The Outer East Alliance aims to improve and sustain the quality of life of its residents and the health and wellbeing of the community as a whole.”***

The Outer East Alliance recognises that the functional coordination of services is a key factor in providing high quality and responsive services to the community, particularly for consumers with complex and multiple needs. It also recognises that effective links and collaboration between primary care agencies is fundamental to the achievement of an integrated service system that promotes streamlined access and continuity of care for consumers.

#### Strategic Directions

The Outer East Alliance develops and implements innovative and collaborative solutions to local, sub-regional and regional issues, as well as specific priorities and deliverables set out by the Department of Human Services (DHS).

Strategic directions for the 2004 – 2006 period have been identified through the Outer East Strategic Planning forum in March 2004, planning sessions of the various committees of the Outer East Alliance, and consultation with DHS, consumers and other relevant stakeholders.

Through these mechanisms, the Outer East Alliance has identified five (5) key goals to progress the partnership and strengthen the capacity to support positive systemic change, as well as specific strategies against the two PCP priority areas of Service Coordination and Integrated Health Promotion.

## Strategic Directions (Continued)

### Key Goals:

<b>Targeting</b>	<p><b><i>‘To target resources and effort to collaborative activities, which best support the achievement of the vision, goals and priorities of the Outer East Alliance, and maximise health impacts’</i></b></p> <p>Develop criteria for the identification of key target groups/issues, using a social determinants of health approach, and facilitate a consultative decision making process involving all relevant stakeholders (eg. Outer East Alliance Members, consumers, DHS) for the determination of priorities and the allocation of resources.</p>
<b>Planning</b>	<p><b><i>‘To achieve a more congruent and integrated approach to planning, based around social determinants of health’</i></b></p> <p>Identify, review and utilise relevant planning documents (eg Municipal Public Health Plans) in order to minimise duplication of planning processes, and to support the identification of priorities and future action areas for the Outer East Alliance.</p>
<b>Governance</b>	<p><b><i>‘To review the governance model of Outer East Alliance and refine the model to best support the achievement of the vision, goals and strategies of the Outer East Alliance’</i></b></p> <p>Emphasis on ensuring that the chosen model supports effective decision making, communication and action, and facilitates movement from general coordination of activity to a true partnership approach that promotes a more seamless service system. Governance arrangements also need to take into consideration the time and resource implications for member agencies.</p>
<b>Resources</b>	<p><b><i>‘To ensure resource usage reflects the vision and strategies of the Outer East Alliance and that maximum value is gained’</i></b></p> <p>Review existing resource utilisation to ensure that it best reflects agreed targets and priorities. Identify and develop opportunities for enhanced resource sharing amongst Outer East Alliance members (eg. virtual teams; collaborative projects), and for accessing resources for future collaborative endeavours.</p>
<b>Consumer Engagement</b>	<p><b><i>‘To use the community and consumers as a valuable resource for achieving a service system that is responsive to community need’</i></b></p> <p>Implement the existing Consumer, Carer and Community Engagement Strategy of the Outer East Alliance, which recognises and values their participation and contributions in all aspects of Alliance activity.</p>

### PCP Priority Areas:

<b>Service Coordination</b>	<p>Service Coordination activity over the next 2 years will focus on a number of priorities, including consolidation of existing effort; engagement of new agencies/sectors; increased engagement of GPs; development of regional approaches; investigation of enhanced service access models; and movement towards the implementation of the assessment and care planning components of Service Coordination. (Refer to pages 5 – 12 of this Plan for specific details)</p>
<b>Integrated Health Promotion</b>	<p>Emphasis over the next 2 years will be on the continued development of comprehensive approaches to health issues, involving sustainable and collaborative practices that increase the effectiveness of efforts to address the determinants of health in the community. A specific focus will be the completion of a catchment-wide plan and development of integrated health promotion strategies that respond to the agreed priority of <b>physical activity</b>. (Refer to pages 13 – 26 of this Plan for specific details.)</p>

## Building Healthy Communities in the Outer East

### Outer East Alliance

Members of Outer East Alliance work cooperatively to develop strategic objectives and operational models, protocols and systems to improve integration, collaboration, consumer participation and continuity of care. The Outer East PCP aims to improve and sustain the quality of life of its residents through an effective, functional and coordinated service system, supported by relevant partnerships, linkages and relationships, as outlined below:

<p style="text-align: center;"><b>Community</b></p> <p style="text-align: center;"><i>The primary care system exists to assist in addressing the range of determinants that impact on the health and wellbeing of individuals, groups and the community as a whole. It is therefore essential that the community are effectively engaged and included in all aspects of Alliance activity.</i></p>	Partnerships, Linkages and Relationships
<p style="text-align: center;"><b>Primary Care Agencies</b></p> <p style="text-align: center;"><i>Take up the opportunity to participate in the collaborative endeavours of the Outer East Alliance and to support the aims, objectives and implementation of the PCPs strategy within their organisation. This may require giving up of some autonomy if it is for the greater good of the Outer East Alliance and the achievement of desired service system/consumer outcomes.</i></p>	
<p style="text-align: center;"><b>Municipal Public Health Plans (MPHPs)</b></p> <p style="text-align: center;"><i>MPHPs focus planning on local areas and empower local communities to work together on key health and wellbeing issues. MPHPs deal at a strategic level, focusing on the impacts of built, social, economic and natural environments on public health and the promotion of community health and wellbeing. MPHPs clearly link with, and feed into, the PCP Community Health Plan, which minimises duplication of planning processes and supports the identification of priorities and future action areas for the Outer East Alliance.</i></p>	
<p style="text-align: center;"><b><u>Linkages with other sectors &amp; reforms</u></b>  <b>Hospital Admission Risk Program (HARP)</b></p> <p style="text-align: center;"><i>Members of the Outer East Alliance have worked cooperatively with Eastern Health to identify the underlying causes of increased emergency demand for hospital services and to develop strategies to meet the changing needs of the community. Considerable opportunity exists for further sharing and building on existing planing mechanisms and structures.</i></p>	

Each of these is intrinsically linked and form important elements in the improvement of health outcomes. Local, sub-regional and regional planning mechanisms and protocols will improve access to high quality responsive and integrated primary care services.

## PRIMARY CARE PARTNERSHIPS STRUCTURE & FUNCTIONS

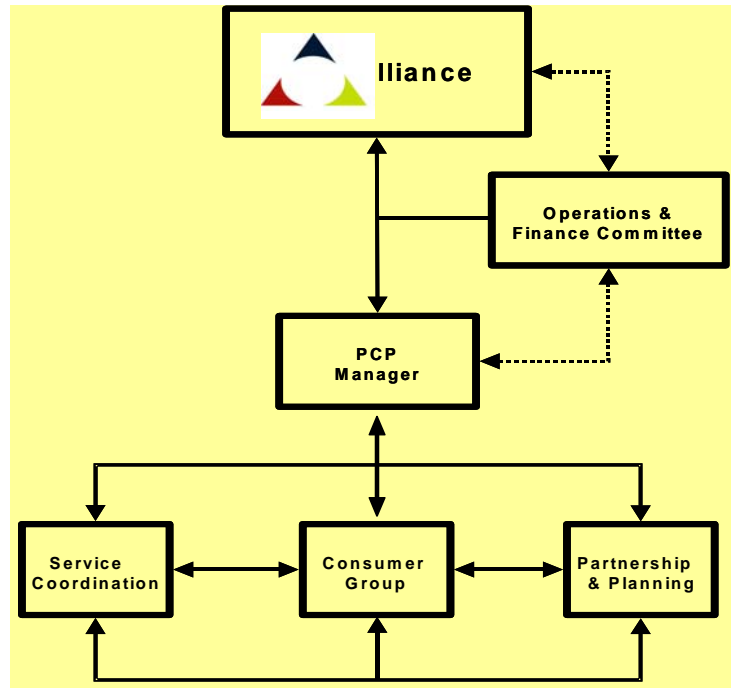
### The Alliance

The Outer East Alliance utilises a collaborative model to bring about systemic change. The priorities, directions and strategies are determined by the Outer East Alliance through a consensual decision-making process, seeing the PCP management implementing an iterative process of engagement and consultation with member agencies. This has resulted in high levels of ownership and commitment by the partners.

The agreed structure and functions necessary for improvement of health outcomes occurs through strategic alliances containing the following elements:

- *Addresses the main health problems in the community through collaborative planning and action,*
- *Involves all related sectors in the process,*
- *Sees to involve consumers, carers and the community,*
- *Utilises agreed protocols, practices, processes and systems to support strategic endeavours*

Meetings, newsletters and agreed joint activity occur on a regular bases to assist the Outer East Alliance in achieving its stated goals as agreed in its annual Strategic Planning Forum. The structure and function of the Outer East Alliance are strengthened by Memorandums of Understanding signed by all member agencies.



### The Primary Care Partnership

The PCP program is progressed by the Outer East Alliance through a **Community Health Plan**, which is an operational plan outlining a range of key collaborative priorities and activities to be progressed by member agencies and the Outer East Alliance 'as a whole'. It considers each of the levels described in the '*Linkages, Strategic Alliances and Partnerships*' in the following priority activities:

- Collaborative planning based on a social model of health.
- Development of an Integrated Health Promotion Framework and strategies including a model of collaboration around health promotion planning and action.
- Advanced implementation of Service Coordination activity, including protocol development and the introduction of an electronic referral system that support consumers to better access and navigate the service system.
- A consumer, Carer & community engagement strategy to ensure the system is built around consumers.

The Outer East Alliance's goals, priority activities and DHS requirements are captured in detail in the following sections of the Community Health Plan. Staff resources within the PCP have a key role in keeping member agencies informed of developments in the partnership. This includes the dissemination of information, organising of meetings, forums and program activity on behalf of its membership. It also has responsibilities in the areas of evaluation, consultation and communications and marketing to inform the Outer East Alliance of its progress against agreed activities and impacts on health outcomes. Change management, leadership, innovation, capacity building and advocacy are also important activity of the Outer East Alliance.



## SERVICE COORDINATION

The Service Coordination component of this Community Health Plan has been developed based on the priorities set by the Department of Human Services and those identified through the Outer East Alliance's Strategic Planning Forum in March 2004.

Specific content for the plan has been prepared through planning sessions of the Service Coordination Working Group and Key Practitioner Reference Group, consultation with other relevant stakeholders – including the Central East PCP and DHS – and consideration by the Outer East Alliance.

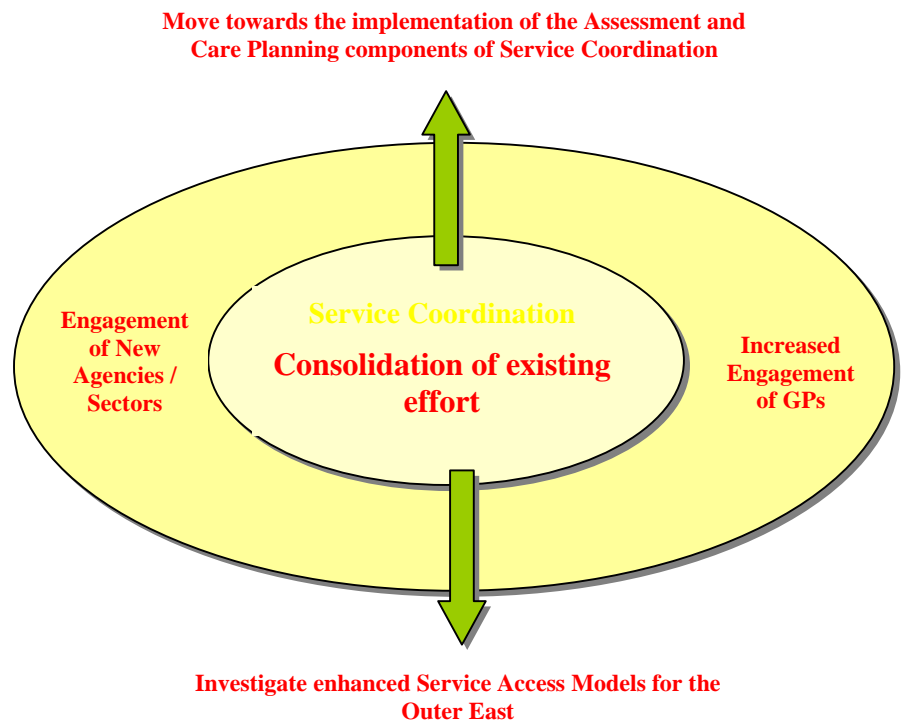
### PCP Priorities

- Consolidation of existing Service Coordination effort and activity
- Development of a Regional approach to Service Coordination
- Investigation of Service Access models for the Outer East

### DHS Priorities

- Support priority human services agencies, which are new to service coordination, to implement the Better Access to Services operational framework
- Support priority General Practice(s) improve the quality of referral and care planning and in particular implement the General Practice Statewide Referral form
- Support agencies that have already successfully implemented the Better Access to Services operational framework for initial contact and initial needs identification, to move on to implement the Better Access to Services operational framework for assessment and care planning

The overarching vision for Service Coordination – *'to provide a framework for a functionally integrated and coordinated service system, with the aim to provide better understanding and improved access for service users and providers'* – will be pursued by the Outer East PCP over the next two years, through the completion of specific tasks against each of the above priorities, as documented in the following Service Coordination Planning Template.



<b>SERVICE COORDINATION PLANNING TEMPLATE</b>				
<b>Outer East Primary Care Partnerships</b>				
<b>MAJOR AREA OF SERVICE COORDINATION ACTIVITY</b>	<b>GOAL</b> <i>(What is the projected outcome over 2 years?)</i>	<b>STRATEGIES</b> <i>(How will the projected outcomes be achieved and by whom?)</i>	<b>TIMELINES</b> <i>(When will each of the key tasks be completed?)</i>	<b>MEASURES</b> <i>(How will the PCP decide whether it has achieved it's goal?)</i>
<b>Consolidation of existing Service Coordination effort and activity</b>	Consistent understanding, uptake and use of the SCoTT, PPPS and E-Referral System by Community Health, HACC and Aged Care Providers in the Outer East	<ul style="list-style-type: none"> <li>▪ PCP member agencies to convene a Service Coordination Working Group (SCWG) and Key Practitioner Reference Group (KPRG) to guide and monitor Service Coordination activity</li> <li>▪ PCP, in consultation with DHS, to identify ways in which representation can be appropriately facilitated/resourced</li> <li>▪ SCWG and KPRG to review their Terms of Reference to ensure ongoing relevance</li> <li>▪ PCP to facilitate 2 'Introduction to Service Coordination' Forums to assist in the orientation of new workers</li> <li>▪ The SCWG to develop a Training Strategy to support the implementation and consolidation of Service Coordination practice, including the E-Referral System</li> <li>▪ PCP to complete an evaluation of the Outer East Electronic Referral System</li> <li>▪ PCP, SCWG and KPRG to provide ongoing support for practice change and workforce development,</li> </ul>	<p>Monthly Meetings of both Groups</p> <p>By June 2005</p> <p>February 2005 &amp; February 2006</p> <p>March 2005 &amp; October 2005</p> <p>May 2005</p> <p>Aug – Dec 2004</p> <p>July 2004 – June 2006</p>	<p>Meetings well attended</p> <p>Terms of Reference reviewed and endorsed</p> <p>Survey of forum attendees indicates an increased understanding of service coordination, including the PPPS and use of the SCoTT, Directories and E-Referral system.</p> <p>Training Strategy drafted, circulated and endorsed, and identified training implemented</p> <p>E-Referral Evaluation completed, with findings used to inform ongoing system and workforce development</p> <p>Service Coordination practice regularly reviewed and included in quality</p>

		including peer support, follow up and trouble shooting.		improvement processes
<b>Contribute to a Regional approach to Service Coordination</b>	A single E-Referral System and PPS, and improved coordination of resources and supports in the Eastern Region	<ul style="list-style-type: none"> <li>▪ Work collaboratively with the Central East PCP, member agencies and DHS to confirm the feasibility and identify the specific features of a Common E-Referral System for the entire Eastern Region</li> <li>▪ Develop and Cost a staged plan for system re-development and roll-out</li> <li>▪ Allocate resources for the initial alignment of the Outer East and Central East systems</li> <li>▪ Implement Version 1 of a single regional system, with articulated governance and support processes</li> <li>▪ Work with the Central East PCP to analyse and compare existing PPS Manuals, and prepare a draft of a single regional manual for consideration and endorsement by the SCWG and Governance bodies of Both PCPs</li> <li>▪ Launch the Eastern Regional PPS Manual and link it to ongoing Service Coordination workforce development and support mechanisms</li> <li>▪ OEPCP and CEPCP Governance Bodies to explore possible models for combining resources and supports around Region-wide Service Coordination Activity</li> </ul>	<p>Aug – Oct 2004</p> <p>Oct – Dec 2004</p> <p>Dec 2004 – Mar 2005</p> <p>April 2005</p> <p>Oct 2004 – Mar 2005</p> <p>April 2005</p> <p>Feb – June 2005</p>	<p>Regional E-Referral System in place by April 2005</p> <p>Regional PPS drafted, circulated and endorsed by both PCPs</p> <p>A model for the sharing of Service Coordination resources and supports developed, endorsed and operationalised by both PCPs</p>

<p><b>Investigate Service Access models for the Outer East</b></p>	<p>A Service Access model for the Outer East, which promotes common and streamlined access to services for consumers</p>	<ul style="list-style-type: none"> <li>▪ The PCP, through the KPRG, to complete a preliminary audit of Intake/Access Systems and Practices amongst member agencies</li> <li>▪ PCP to prepare a Discussion Paper to facilitate further concept development by the KPRG, SCWG and Consumer Reference Group</li> <li>▪ A Consultancy Brief to be prepared for the development of possible Service Access models, including costs, implications and consumer feedback</li> <li>▪ Seek funding through the DHS Special Initiatives Fund to support this Consultancy</li> <li>▪ Consultancy outcomes and recommendations to be considered by the OE Alliance, SCWG, KPRG and Consumer Reference Group</li> <li>▪ Future actions to be determined</li> </ul>	<p>Feb – April 2005</p> <p>April – June 2005</p> <p>July 2005</p> <p>July 2005</p> <p>Oct – Nov 2005</p> <p>November 2005</p>	<p>Audit of current systems and practices completed</p> <p>Discussion Paper drafted and circulated</p> <p>Consultancy Brief prepared and used for the development of a funding proposal to DHS</p> <p>Consultancy commissioned and completed</p> <p>Consultancy recommendation considered and used to inform/determine future actions</p>
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<p><b>Support priority human services agencies, which are new to service coordination, implement the Better Access to Services operational framework</b></p>	<p>Implementation of SCoTT, PPPS and E-Referral within HARP, Alcohol and Drug, Mental Health and Disability Support agencies/sectors in the Outer East</p>	<ul style="list-style-type: none"> <li>▪ Work collaboratively with DHS and the Central East PCP to facilitate the 'Service Coordination Orientation Program' for representatives from priority agencies /sectors</li> <li>▪ Implement follow up opportunities for these agencies/sectors to progress planning for implementation (2 workshops to be jointly facilitated by the Outer east and Central East PCPs)</li> <li>▪ Invite representatives from these agencies /sectors to participate in the SCWG and KPRG</li> <li>▪ Identify training needs and confirm resources available</li> <li>▪ Review, monitor and support Service Coordination implementation through the SCWG and KPRG</li> <li>▪ Identify Mentors and Change Leaders from member agencies already advanced in Service Coordination to provide ongoing assistance and support</li> </ul>	<p>Sept – Oct 2004</p> <p>Oct 2004 – Mar 2005</p> <p>From Oct 2004</p> <p>Oct 2004 – Mar 2005</p> <p>Oct 2004 – June 2006</p> <p>From Feb 2005</p>	<p>Program facilitated for 40 attendees, with participant feedback indicating an increased understanding of service coordination principles and practices</p> <p>Pre and post survey of workshop attendees indicates that staff have an increased knowledge of service coordination, and a commitment to future implementation</p> <p>Realistic implementation plan, including timelines, endorsed by targeted agencies and the PCP</p> <p>Representatives from targeted agencies participating in SCWG and KPRG</p>
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<p><b>Support priority General Practices improve the quality of referral and care planning and in particular implement the General Practice Statewide Referral form</b></p>	<p>Improved referral practice by GPs, including increased use of the Statewide Referral Form (SCoTT Equiv) and the E-Referral System</p>	<ul style="list-style-type: none"> <li>▪ Work in partnership with the 3 Outer Eastern Divisions of General practice to support the engagement of 3 General Practices in Service Coordination Activity ('GP Connect' Project)</li> <li>▪ Convene an introductory meeting for practice staff from the 3 General Practices</li> <li>▪ Local Divisions and PCP to provide workforce development and site visits to support change management</li> <li>▪ PCP and SCWG to provide ongoing support for practice change including follow up/trouble shooting</li> <li>▪ PCP and Division staff to collect and analyse data from a trial use of the Statewide Referral Form and the E-Referral System, in order to develop an evidence base and business case for further roll-out within the GP sector</li> </ul>	<p>July 2004 – Feb 2005</p> <p>July 2004</p> <p>July – Sept 2004</p> <p>Sept 2004 – Feb 2005</p> <p>Sept 2004 – Feb 2005</p>	<p>'GP Connect' Implementation plan endorsed by Divisions of General Practice and participating GPs and practice staff</p> <p>GPs and other practice staff indicated an increased Knowledge of service coordination, including the ability to populate the GP Statewide referral form ('GP Connect' Evaluation)</p> <p>Increased number of staff able to refer electronically to partner agencies using the GP Statewide Referral form and E-Referral System ('GP Connect' evaluation)</p> <p>Evaluation report prepared, including recommendations for future roll-out</p>
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<p><b>Support those agencies that have already successfully implemented the Better Access to Services operational framework for initial contact and initial needs identification, to move on to implement the Better Access to Services operational framework for assessment and care planning.</b></p>	<p>Improved assessment and care planning between PCP member agencies that have already successfully implemented the initial contact and initial needs identification components of the Better Access to Services Operational Framework</p>	<ul style="list-style-type: none"> <li>▪ SCWG to review the assessment and care planning components of the Outer East PCP PPPS Manual, and ensure appropriate content is included in any future Regional PPPS Manual</li> <li>▪ OEPCP and CEPCP to consider assessment and care planning as part of the development of a common E-Referral System for the entire Eastern Region</li> <li>▪ Work collaboratively with the Central East PCP to plan and conduct 1 Regional Forum on Care Planning</li> <li>▪ PCP to resource 3 training sessions for staff from member agencies, to support the implementation of improved assessment and care planning practice</li> <li>▪ PCP, SCWG and KPRG to provide ongoing support for practice change and workforce development, including the identification of Mentors and Change Leaders to provide specific assistance and support</li> </ul>	<p>Oct 2004 – Mar 2005</p> <p>Aug – Dec 2004</p> <p>April 2005</p> <p>May 2005, Oct 2005, March 2006</p> <p>Ongoing</p>	<p>Regional PPPS drafted, circulated and endorsed by both PCPs by July 2005</p> <p>Regional E-Referral System with scope to support assessment and care planning</p> <p>Regional forum well attended and attendees report an increase in knowledge (forum evaluation)</p> <p>Training well attended, with participants reporting an increase in knowledge and skills in assessment and care planning (training evaluation)</p> <p>Practice regularly reviewed</p> <p>Feedback to SCWG and KPRG indicating positive and effective supports in place</p>
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## INTEGRATED HEALTH PROMOTION CATCHMENT PLANNING 2004-2006

### PART 1

#### 1.1 PCP Vision

The Outer East Alliance, through their commitment to the PCP strategy, supports the principles of Integrated Health Promotion (IHP). Our vision is to realise genuine collaborative practice that is systematic, inter-agency and inter-sectoral, and that supports best practice, the development of evidence and health equity. The overall aim of both the Health Promotion Framework and subsequently the Health Promotion Strategy is to sustain the quality of life of residents and the overall health, social outcomes and wellbeing of the community.

The key goals of the Outer East Alliance fit with the principles of IHP. The following plan:

- targets resources and effort to collaborative activities,
- develops an integrated approach to health promotion planning,
- is supported by a governance model,
- ensures resources reflect the vision and strategies, and
- uses the community and consumers as a valuable resource.

#### 1.2 Priority Setting Process

In summary, the development of this Community Health Plan is based on planning processes with the following elements:

- Development of Model of Collaboration (2004)
- Health Promotion program/project mapping
- Review of Integrated Planning through Municipal Public Health Plans

The Service Partnerships and Planning Working Group has played a central role in priority setting for the 2004-06 plan. This group initially identified two key priority areas based on their individual and coordinated activities and evidence-based approaches to health promotion; physical activity and mental wellbeing and social connectedness. There is a growing evidence base about the benefits of physical activity for mental health and wellbeing, as well as an adjunct therapy for depressive disorders. Physical activity is a vehicle for mental health and wellbeing through the development of social networks because they provide social support, and opportunities for social engagement (see evidence cited at <http://www.psychologymatters.org/exercise.html>; <http://www.vichealth.vic.gov.au/default.asp?level=2&tid=491>).

Given that the majority of member agencies have a focus on physical activity and have been working towards coordination and cooperation, it was thought that the selection of this priority area would assist the Outer East Alliance to move strategically towards collaboration. Further, because the majority of member agencies have also prioritised mental health and wellbeing, it was also thought that the integration of physical activity into programs addressing social connectedness and social isolation, in particular, has the potential for beneficial outcomes for consumers. Integration of two key priorities also supports the Outer East Alliance's commitment to work from a social determinants of health approach (see Strategic Directions p 2).

### 1.3 Moving Towards Collaboration

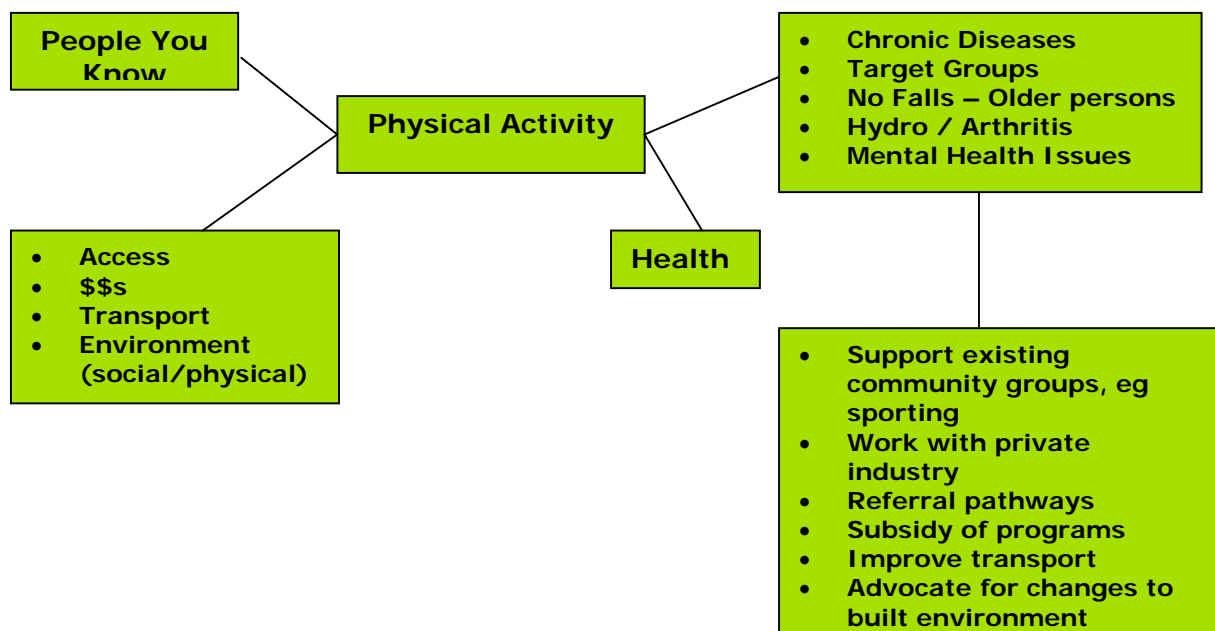
The Outer East Alliance has developed coordinated partnerships since the introduction of IHP. This plan will allow the partnership to develop to become more cooperative and collaborative through the sharing of resources. These will be expanded in the 2006-09 Community Health Plan. This process will be supported by the development and implementation of the Model of Collaboration (see Other IHP Activities). Whilst the frameworks underpinning agency plans differ, there is a consistent commitment to the social model of health, social determinants and population health principles. The Model of Collaboration will support and strengthen these similarities.

The aims of the Model of Collaboration are to develop comprehensive approaches to health issues, and to enable sustainable, collaborative practice across agencies in the catchment of the Outer East Primary Care Partnership, to increase the effectiveness of efforts to address the determinants of health, through integrated, health promoting actions. Outer East Alliance's vision is to realise genuine collaborative practice that is systematic, inter-agency and inter-sectoral, and that supports best practice, the development of evidence, and addresses health equity.

## PART 2

### 2.1 Problem Definition

The following builds upon data and information that exemplifies the range and orientation of health and social indicators that contribute to and inform decision making about local health promotion strategies in relation to physical activity. Understanding the effect of these factors is essential in considering how to increase participation in physical activity in order to enhance physical and mental health and wellbeing.



There is increasing evidence that participation in physical activity can offer lasting health benefits throughout life and that these benefits occur relatively soon after adoption of an active lifestyle, no matter what age physical activity is commenced. Physical activity is an important factor in maintaining good overall health, however, a significant and growing majority of Australians are not physically active enough to gain lasting benefits. The strongest evidence for the benefits of regular physical activity concerns its ability to reduce the risk of cardiovascular disease, particularly coronary heart disease (Garrard et al 2004). People who do not take part in regular moderate-intensity physical activity are nearly twice as likely to have a heart attack as those who do.<sup>1</sup> (Bauman et al 2002).

According to the Commonwealth Department of Health and Aged Care and the Australian Institute of Health and Welfare, the number of people living with cardiovascular disease is set to increase over the next few decades. It has been noted that the major risk factors for the disease are smoking, poor nutrition and physical inactivity. With reductions of tobacco use, obesity due to physical inactivity and poor nutrition has become the leading risk factor. Here cardiovascular conditions include: Coronary Heart Disease, Congestive Heart Failure, Angina, Peripheral Vascular Disease, Stroke and DVT<sup>2</sup>.

Additionally, it has long been claimed that,

- maintaining regular physical activity improves levels of other cardiovascular risk factors such as overweight, high blood pressure, low levels of HDL (the 'good' cholesterol) and Type 2 diabetes, and can help protect against some forms of cancer,
- it strengthens the musculoskeletal system; helping to reduce the likelihood of osteoporosis and the risk of falls and fractures, and
- merely taking part in physical activity also improves mental well-being (in both the short term and longer term) by reducing feelings of stress, anxiety and depression.

There is compelling evidence that physical activity can lead to a reduction in risk from some cancers, as well as cardiovascular disease, diabetes and musculoskeletal disorders. Finally, convincing evidence has been reported that physical activity reduces the risk of 'colon cancer' in both men and women. There appears to be a consistent dose-response relationship, with some studies showing 40% risk reduction in people who are active throughout their life.<sup>3</sup>

Despite these recognised health benefits, physical activity levels remain low in industrialised countries. Labour-saving devices and passive forms of entertainment (such as computers, television and the Internet) have increased the time spent in sedentary or minimally active states. At the same time, increased car ownership and increases in traffic and safety concerns have led to less walking, cycling and transport related physical activity. Research also indicates that people perceive they have less discretionary time available for exercise or sporting activities.<sup>4</sup>

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<sup>1</sup> Blair S, Kampert J, Kohl H et al. 1996. "Influences of cardio respiratory fitness and other precursors on cardiovascular disease and all-cause mortality in men and women". *Journal of the American Medical Association* 276(3): 205-10.

<sup>2</sup> Commonwealth Department of Health and Aged Care and Australian Institute of Health and Welfare, (1999) *National Health Priorities Report: Cardiovascular Health*. Canberra

<sup>3</sup> Batty D et al. (2000) "Does physical activity prevent cancer? Evidence suggests protection against colon cancer and probably breast cancer". *BMJ*; 321(7274): 1424-5

<sup>4</sup> Bauman A, Bellew B, Vita P, Brown W & Owen N 2002. *Getting Australia active: towards better practice for the promotion of physical activity*. Melbourne

Data from the 2000 National Physical Activity Survey showed that more than half (54%) of Australians aged 18–75 years did not undertake leisure-time physical activity at the levels recommended to achieve health benefits. Rates of 'insufficient' physical activity were highest among 30–59-year-olds and lowest among 18–29-year-olds, for both men and women. The proportion of people reporting 'no physical activity' increased with age, from 11% of men and 9% of women aged 18–29 years to 20% of men and 17% of women aged 45 years and over. Participation in physical activity also varies across socioeconomic groups, with people from the lowest socioeconomic backgrounds more likely to have lower-than-recommended levels. In 2000, 61% of people with less than 12 years of education did not undertake physical activity at the recommended levels, compared with 52% of people who completed secondary school and 51% of those with a TAFE or tertiary qualification. Around one in five adults with less than 12 years of education reported 'no physical activity', nearly twice the rate for the TAFE or tertiary-educated group<sup>5</sup>.

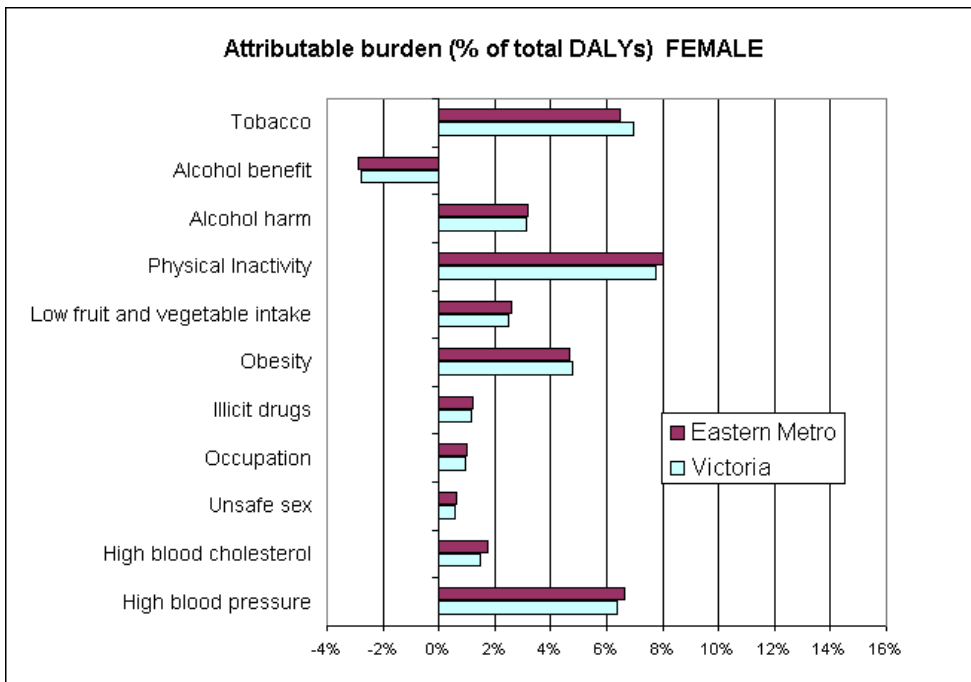
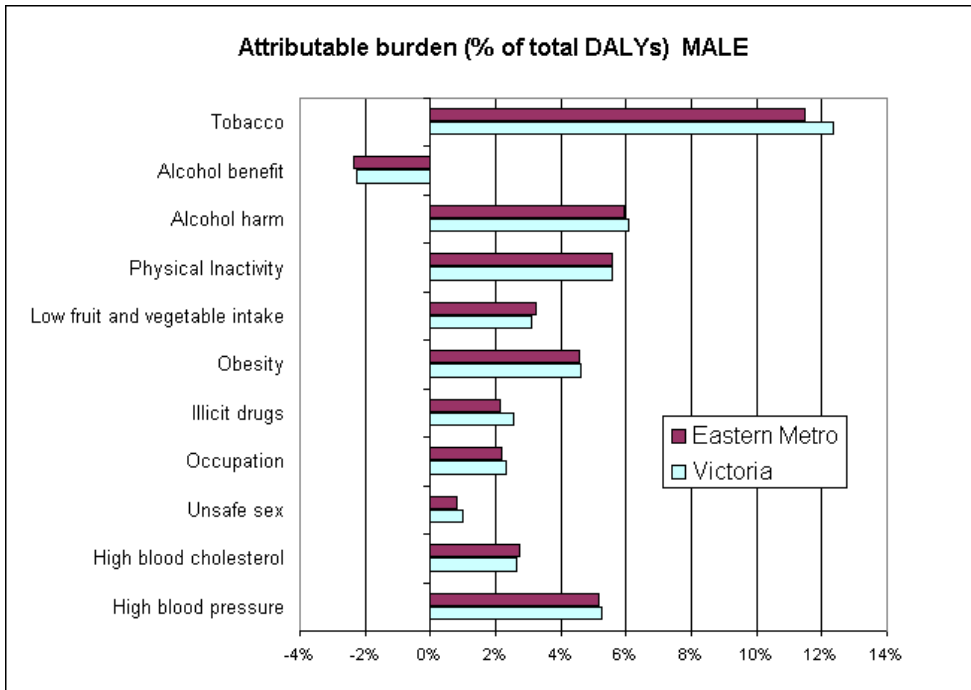
In 2004 the report on Australia's Health provided a statistical analysis update on the National Health Priority Areas, indicating that arthritis and other musculoskeletal conditions are the most prevalent with almost one in three Australians (32.0%) having the condition. In addition, the 2001 National Health Survey reported arthritis and other musculoskeletal conditions are also the main disabling condition for more than one in three Australians with a disability (34.4%). On the other hand cardiovascular disease is the largest contributor to the burden of disease in Australia (21.9% of all Disability Adjusted Life Years (DALY)<sup>6</sup> in 1996), along with being the most common underlying cause of death (37.6% of all deaths in 2002 and 43% of all deaths in the EMR in 1996). Cardiovascular problems affecting almost one in six Australians (16.8%) (DHS 2004)<sup>7</sup>. In the Outer East the major conditions contributing to the burden of disease are cardiovascular disease, cancer, mental disorders, and respiratory conditions. Physical inactivity is a leading risk factor attributable to DALYs for both males and females in the EMR and is connected to all major risk factors and to mental health and wellbeing.

VicHealth estimates that intimate partner violence is responsible for nine (9) per cent of the total disease burden in women under 45 years of age (VicHealth 2004). The greatest proportion (60%) of this burden is associated with mental health problems (VicHealth 2004).

<sup>5</sup> AIHW Analysis of the 2000 National Physical Activity Survey

<sup>6</sup> Disability Adjusted Life Year (DALY) is a measure of population health used by the Burden of Disease studies (see glossary).

<sup>7</sup> Australia's Health 2004 Appendix: National Health Priority Areas p.389



In 2000-01 the Victorian Ambulatory Care Sensitive Conditions (ACSCs) Study, *Opportunities for Targeting Public Health and Health Services Interventions*, indicated the Top 10 ACSCs in Region 8—Eastern Metropolitan Region (EMR) as follows:

ACSCs	Number of Admissions	Rate per 1000 Persons	Lower 95% CI	Upper 95% CI	Average Bed Days	Total Bed Days	Average Co morbidity
<b>Diabetes complications</b>	<b>5486</b>	<b>5.50</b>	<b>5.35</b>	<b>5.64</b>	<b>7.77</b>	<b>42635</b>	<b>1.67</b>
Angina	2835	2.80	2.70	2.90	2.55	7217	0.31
Dental conditions	1911	2.02	1.93	2.11	1.16	2213	0.06
<b>Congestive cardiac failure</b>	<b>1841</b>	<b>1.77</b>	<b>1.69</b>	<b>1.86</b>	<b>8.06</b>	<b>14839</b>	<b>1.82</b>
Dehydration and gastroenteritis	1759	1.76	1.68	1.85	2.80	4918	0.39
<b>Chronic obstructive pulmonary disease</b>	<b>1745</b>	<b>1.74</b>	<b>1.66</b>	<b>1.83</b>	<b>8.05</b>	<b>14046</b>	<b>1.50</b>
Asthma	1654	1.78	1.69	1.87	2.59	4292	1.08
Convulsions and epilepsy	1222	1.30	1.22	1.37	3.29	4026	0.32
Cellulitis	1202	1.20	1.13	1.27	5.80	6966	0.31
Ear, nose and throat infections	982	1.09	1.02	1.16	1.64	1608	0.10

In terms of total bed days Diabetes, Congestive Cardiac Failure and Chronic Pulmonary Disease (CPD) are the most costly health problems in EMR. In addition the Diabetes risk/cost factor remains high for both the number of admissions and average co-morbidity. This later statistic reflects that rates for Diabetes are slightly higher than CPD, actually recording a close second overall to Congestive Cardiac Failure. Because physical activity is implicated as an adjunct therapy in all of these conditions, there is strong rationale for selecting physical activity as a priority in a concerted catchment wide approach.

Based on the above review and the experience of the Outer East Alliance, the following goal and objectives were established using a capacity building framework:

## 2.2 Program Goal:

***To build capacity to increase participation in physical activity in the Outer East catchment.***

## 2.3 Program Objectives

1. Use an equity focus to identify barriers and increase opportunities for participation in physical activity by 2006.
2. To strengthen the links between physical activity and mental health and wellbeing initiatives across the catchment by 2006.
3. By 2005 establish mechanisms to support for the implementation of evidence-based physical activity interventions.
4. To develop and support catchment-level evaluation for physical activity interventions by 2006.

## 2.4 Population Target Groups

Children (4-11) and their families

Youth

Older adults

## **2.5 Solution Generation**

A catchment planning reference group was established to generate the goal, objectives and strategies. This reference group included 27 participants from 16 agencies/organisations. Objectives 1 and 2 focus on established partnership activities but build on those with opportunities for innovation. For example, Objective 1 includes the development of a physical activity directory and also builds on the work already undertaken with the *SAFE/Moves* project. Likewise, to link physical activity and mental wellbeing and social connectedness, the Outer East Alliance has agreed to continue to evaluate both impacts. Interventions within these objectives focus on a range of individual and population-wide health promotion interventions.

Objectives 3 and 4 focus specifically on projects that support collaborative action. Progress on these two projects will strengthen the partnerships between agencies and highlight the value in collaborative action. Objective 3 will enhance capacity for evidence-based approaches to physical activity. It focuses on older adults and youth, which contain the depth and breadth of the project for this plan. Objective 4 will support catchment-level evaluation of physical activity interventions. Demonstration projects will work cooperatively although there is potential for collaboration to occur if program clusters are selected. Interventions within these objectives focus on population-wide systems based health promotion interventions.

In late 2004-early 2005, the Outer East Alliance undertook a mapping exercise of existing physical activity and mental health projects and programs across the catchment. This will be enhanced by the development of an audit of 'opportunity structures' for physical activity, to identify the assets, resources and existing networks that exist to support physical activity in the OEA catchment.

## **2.6 Capacity Building-Support and Resources**

The Outer East Alliance, particularly through the resource represented by the Health Promotion Officer, will provide support for the catchment plan. This will focus on building the capacity amongst member agencies to meet the estimated impacts outlined in this plan. The Outer East Alliance will also play a key role in the dissemination of resources and sharing of ideas relevant to physical activity.

The Plan will be implemented through the establishment of sub-working groups to focus on each objective. The groups will work with the Health Promotion Officer to identify training needs for support of practitioners from member agencies. One of the focuses of the Plan is the emphasis on the provision of evidence-based guidelines, drawing on existing resources developed by VicHealth, the DHS, and other national and international agencies to ensure that resources available in the catchment for physical activity are being used as effectively as possible.

## **2.7 Evaluation and Dissemination Planning**

The sub-working groups will develop an evaluation plan for each objective. The evaluation plans will identify appropriate and relevant tools to evaluate physical activity interventions. Participants in the Evaluation Skill Development project will also be consulted in the development of evaluation plans.

The development of a logic model framework to support the evaluation of physical activity will be undertaken for 3-5 demonstration projects. This will involve a cooperative, and in some cases collaborative approach to the evaluation of physical activity interventions. It is envisaged that this will inform the strategic development of catchment evaluation for periods beyond 2006.

## 2.8 Glossary of terms

The following glossary provides definitions of key terms used in the Plan.

Opportunity structures	An audit of opportunity structures for physical activity would identify the array of leisure and recreational infrastructure, and existing networks that potentially offer resources to promote physical activity.
Disability adjusted life years (DALYs)	A population measure of incident lost years of healthy life due to a wide range of diseases, injuries and selected risk factors (DHS 2004).
Integrated health promotion	Agencies within a catchment working in a collaborative manner using a mix of health promotion interventions and capacity building strategies to address priority health and wellbeing issues (DHS 2003).
Catchment-level planning and evaluation	Planning and evaluation within a catchment that involves collaborative partnerships amongst PCP member agencies.
Capacity building	An approach to the development of sustainable skills, organisational structures, resources and commitment to health improvement in health and other sectors, to prolong and multiply health gains many times over (Health Promotion Strategies Unit 1999).
Equity focus	The fair distribution of resources in relation to needs

Department of Human Services (DHS) 2003. Integrated health promotion resource kit. Primary and Community Health Branch, Department of Human Services, Melbourne.

Department of Human Services. 2004. Burden of Disease - DALY (YLD & YLL) worksheets. Available online:  
<http://www.health.vic.gov.au/healthstatus/bod/daly.htm> (2-3-05).

Health Promotion Strategies Unit. 1999. A framework for building capacity to improve health. NSW Health, Sydney.

## 2.9 Reference group participants

Member Agencies		No
Angliss Hospital		
Care Connect		1
Eastern Access Community Health	(EACH)	2
Eastern Drug & Alcohol Service Consortium		
Eastern Health		
Eastern Ranges GP Association		
Knox City Council		2
Knox Community Health Services		2
Knox Division of General Practice		1
Maroondah City Council	(MCC)	4
Maroondah Hospital		
Outer East Aged Care Assessment Service		
Ranges Community Health Service	(Ranges CHS)	3
Royal District Nursing Service		1
Richmond Fellowship of Victoria		
Shire of Yarra Ranges	(SoYR)	2
Villa Maria Society		2
Whitehorse Division of General Practice	(WDGP)	2
Women's Health East	(WHE)	1
Yarra Valley Community Health Service	(Yarra Valley CHS)	1
Other Agencies		
Vision Australia		1
Donwood		1
Consumer		1
<b>TOTAL (as at 1/2/05)</b>		<b>27</b>

**Part 3: Integrated Health Promotion Summary planning grid  
Outer East Primary Care Partnerships**

<b>Priority Goal:</b>	To build capacity to increase participation in physical activity in the Outer East catchment.				
<b>Objective 1:</b>	Use an equity focus to identify barriers and increase opportunities for participation in physical activity by 2006.				
<b>Est. Impacts<sup>2</sup> (Qual/Quant) for Objective 1</b>	20% increase in participation by target populations in physical activity interventions. 70% of participants in PCP training report increased knowledge of methods to increase participation Increase the number of programs with an active to school focus by 30%. 70% of consumer leaders report increased knowledge of physical activity and opportunities for participation.				
<b>PCP key stakeholders<sup>3</sup></b>	<b>Summary of mix of Interventions &amp; CB strategies<sup>4</sup></b>	<b>Population Target Group/s:</b>	<b>Estimated timelines</b>	<b>Estimated Reach<sup>5</sup></b>	<b>Resources per key stakeholder for Obj1<sup>6</sup></b>
EACH Primary Health Care Service, WDGP, Ranges CHS, Knox Division of General Practice, WHE, Yarra Valley CHS MCC Major Leisure Facilities	Participate in Physical Activity Working Group		Ongoing	All member agencies and/or affiliates	Allied Health practitioner or Health Development Manager (EACH)  2 hours per month (WDGP)  2 hours per month (Ranges CHS)  2 hours per month MCC – Major Leisure Facilities
EACH Regional Services, WDGP, Ranges CHS, Knox Division of General Practice, WHE, Yarra Valley CHS	Participate in workforce development initiatives that will assist agencies to increase participation in physical activity interventions through social marketing.	Catchment-wide	April-June 2005	10 agencies	Dependent on training budget. At least 2 staff to participate. (EACH)  Participation in one workshop (WDGP)  Two hours per month for 3 staff (Ranges CHS)

<p>EACH Disability Services, Ranges CHS, WDGP, WHE, Yarra Valley CHS, MCC Major Leisure Facilities</p>	<p>Explore models for the development of a community audit of opportunity structures<sup>8</sup> (eg walking groups, strength training, recreation facilities) for physical activity and recreation across the catchment.</p>	<p>Whole of community</p>	<p>2005</p>	<p>20 agencies and PCP consumer group.</p>	<p>EACH staff member allocated task of identifying opportunity structures open to people with disabilities in the Upper Yarra area.</p> <p>PAWG commitment (WDGP)</p> <p>3 hours once per month (Ranges CHS)</p> <p>MCC Major Leisure Facilities commitment</p>
<p>Local Government, Community Health and GP Association, EACH Disability Service, WDGP, Ranges CHS, Knox Division of General Practice, Shire of Yarra Ranges</p>	<p>Expand physical activity directory and physical activity mapping to focus catchment-wide (using mapping data). Develop and implement a catchment-wide dissemination strategy.</p>	<p>Whole of community</p>	<p>2006</p>	<p>20 agencies and PCP consumer group</p>	<p>EACH Disability Services staff to contribute. Other staff to contribute as required.</p> <p>PAWG commitment (WDGP)</p> <p>Contribute to information (Ranges CHS)</p> <p>Link &amp; promote directory (SoYR)</p>

<sup>8</sup> An audit of opportunity structures for physical activity would identify the array of leisure and recreational infrastructure, and existing networks that potentially offer resources to promote physical activity.

EACH, Yarra Valley CHS, MCC Community Development, Shire of Yarra Ranges	Identify opportunities to expand "active to school" messages (particularly through Walking School Bus and After School hours new physical activity program).	Children/families	2005-06	5 agencies	Can contribute as required (EACH)  MCC Community Development commitment  Continue to implement Walking School Bus Program in 7 primary schools (SoYR)
Ranges CHS, Local Government, GPs and Divisions, EACH Primary Health Care service, Consumer, carer and community representatives, Knox Division of General Practice, Shire of Yarra Ranges	Develop sustainability plan for SAFEMoves and SAFEMmoves2 within the catchment.	Older adults		Eligible people in the city of Maroondah	Allied Health practitioner from EACH's Community Health program (approx. 2 hours per month).  0.2 EFT per week (Ranges CHS)  Walking trips, training sessions, promote, meetings (SoYR)

PCP HP capacity building <sup>7</sup>	Support and resource Physical Activity Working Group	PAWG	Monthly	All member agencies	HP Officer – 50 hrs PO – 30 hrs
	Support a training workshop (using existing PCP training materials <sup>9</sup> ) to enhance skills for social marketing and physical activity.	All agencies	April - June 2005	6-10 agencies	Trainer/HP Officer – 100 hours Venue & catering PO – 40 hours
	Support the community audit and assist Physical Activity Working Group to integrate information into the directory. Highlight barriers (e.g. gender) to participation where they emerge.	All agencies	Ongoing	Agencies in sub-working groups	HP Officer – 100 hours Admin/ PO Support – 40 hours
	Support relevant Healthy Active Living activities.	Specific agencies	Ongoing	Agencies involved in HALS projects	[HALS Officer]
	Develop and support sustainability plan for SAFEMoves and SAFEMoves2 within the catchment	Specific agencies	Ongoing	Agencies involved in SAFEMoves projects	[SAFEMoves Officer/s]
	Negotiate with Health Issues Centre to provide workshops to support consumer leadership in physical activity participation.	All agencies	May-September 2005		
	Assist in the dissemination of directory.	All agencies	2006		Consumer Chair/ HIC/ HP Officer – 50 hours PO - Venues & catering
	Health Promotion worker to develop key role in linking and resourcing agencies, and disseminating information around physical activity across catchment.	All agencies	Ongoing	All agencies	PO/Admin. Support  HP Officer – 130 hours
	Development of webpage to hold all relevant information relevant to physical activity across catchment.	All agencies	June 2005	Catchment-wide	Website contractor /HP Officer
<b>Estimated Total Budget per Objective <sup>6</sup>:</b>			<b>TOTAL: Health Promotion</b>		<b>380 hours</b>
			<b>Project Officer/Admin Support</b>		<b>145 hours</b>

<sup>9</sup> Eg North Central Metropolitan PCP (2002) *Promoting a healthy life for our community*: a guide to social marketing, published by North Central Metropolitan PCP. Downloadable from <http://www.ncmpep.org.au>

<b>Priority Goal:</b>	<b>To build capacity to increase participation in physical activity in the Outer East catchment.</b>				
<b>Objective 2:</b>	<b>To strengthen the links between physical activity and mental health and wellbeing initiatives across the catchment by 2006.</b>				
<b>Est. Impacts<sup>2</sup> (Qual/Quant) for Objective 1</b>	<p>50% increase the number of agencies that link their physical activity programs to mental health and wellbeing.</p> <p>All agencies have access to evidence-based information about PA and MHP programs</p> <p>Information sheet disseminated to 100% of member agencies</p> <p>60% of member agencies report use of the information sheet during client interactions</p>				
<b>PCP key stakeholders<sup>3</sup></b>	<b>Summary of mix of Interventions &amp; CB strategies<sup>4</sup></b>	<b>Population Target Group/s:</b>	<b>Estimated timelines</b>	<b>Estimated Reach<sup>5</sup></b>	<b>Resources per key stakeholder for Obj1<sup>6</sup></b>
EACH PDRSS, Knox Division of General Practice, WHE, Yarra Valley CHS	Agencies to make increased connections between physical activity and recreation and social connectedness/social isolation in program plans.	Focus on high needs populations and non-traditional partners.	Ongoing	First-time mothers PND groups  People with psychiatric disabilities across the Outer East	Staff of Day Programs in EACH PDRSS. Expansion to other programs as negotiated.
EACH (PDRSS, Walk & Talk program), WDGP	Explore and document opportunities for consumer led physical activity included in projects addressing social connectedness/social isolation		April-June 2005	PA Working Group and Consumer Group	Staff of Day Programs in EACH PDRSS. Staff handover.  PAWG commitment (WDGP)
WDGP, EACH, WHE	Evaluate for increase in social connectedness through physical activity interventions.	All age groups	Ongoing	PA working group	PAWG commitment (WDGP)  Where appropriate. Requires reliable evaluation tool. (EACH)

EACH PDRSS, WDGP, Yarra Valley CHS, MCC Major Leisure Facilities	Use the community audit to advocate for strategic approaches to overcoming transport barriers to physical activity participation		Ongoing	Alliance	Staff of Day Programs in EACH PDRSS. Others as appropriate.  Attendance at Alliance meetings (WDGP)  MCC Major Leisure Facilities commitment
WDGP, WHE, Knox Division of General Practice, Yarra Valley CHS	Advocate for financial discounts and subsidised tickets to pay for socially disadvantaged community members to access more affordable arts recreation and physical activities.	Across catchment	Ongoing	Low income groups	Attendance at Alliance meetings (WDGP)

PCP HP capacity building <sup>7</sup>	Workshop on mental health promotion and physical activity to share learning from staff who have attended MHP training	Agencies and consumer reps	July – August 2005	Catchment-wide	MHP staff/ HP Officer – 70 hours Venue/catering
	Website to include information highlighting potential for links between mental health and wellbeing and physical activity.	All agencies	July 2005	Catchment-wide	HP Officer – 30 hours PO – 10 hours/Website contractor
	Assist agencies to develop links between a range of community provider groups and PCP members around mental health and wellbeing and physical activity.	Specific agencies	Ongoing	3-5 agencies	HP Officer – 40 hours PO/Admin. Support/CCC
	Identify and disseminate information sheets that include social and physical benefits of physical activity.	All agencies	December 2005	All agencies	HP Officer – 20 hours PO/ Admin. Support – 5 hours Printing
	Support agencies to make increased connections between physical activity and recreation and social connectedness/social isolation in program plans.	Focus on high needs populations & non-traditional partners	Ongoing		HP Officer – 40 hours
	Resource agencies to explore and document opportunities for consumer led physical activity included in projects addressing social connectedness/social isolation.	All agencies	Ongoing		HP Officer – 7.5 hours
	Support agencies to evaluate increase in social connectedness through physical activity interventions.	All agencies	Ongoing		HP Officer – 40 hours
<b>Estimated Total Budget per Objective <sup>6</sup>:</b>					
<b>Estimated Total Budget per Goal <sup>6</sup>:</b>			<b>TOTAL: Health Promotion</b>		<b>247 hours</b>
			<b>Project Officer/Admin. Support</b>		<b>15 hours</b>

<b>Priority Goal:</b>		To build capacity to increase participation in physical activity in the Outer East catchment.			
<b>Objective 3:</b>		By 2005 establish mechanisms to support the implementation of evidence-based physical activity interventions.			
<b>Est. Impacts<sup>2</sup> (Qual/Quant) for Objective 1</b>		<p>60% of participants in training improve their knowledge about evidence-based physical activity interventions.</p> <p>80% of member agencies incorporate physical activity guidelines into their 2006 organisational and/or health promotion plans.</p> <p>50% of agencies report development of new partnerships</p>			
<b>PCP key stakeholders<sup>3</sup></b>	<b>Summary of mix of Interventions &amp; CB strategies<sup>4</sup></b>	<b>Population Target Group/s:</b>	<b>Estimated timelines</b>	<b>Estimated Reach<sup>5</sup></b>	<b>Resources per key stakeholder for Obj1<sup>6</sup></b>
EACH, WDGP, WHE, Yarra Valley CHS, MCC Major Leisure Facilities	Participate in Physical Activity Working Group to continue to identify best practice /evidence-based physical activity interventions.	Older adults (>65 years) Youth Children	Meet bi-monthly  2005	10 agencies and PCP consumer group representative	EACH Health Development Coordinator (5 hours per month as per PAWG)  PAWG commitment (WDGP)  MCC Major Leisure Facilities commitment

<p>EACH, WDGP, WHE, MCC Major Leisure Facilities</p>	<p>Physical Activity Working group to develop guidelines for PCP Physical Activity website on evidence-based approaches to physical activity.</p>		<p>November 2005 - March 2006</p>	<p>10 agencies and PCP consumer group representative</p>	<p>EACH Health Development Coordinator (5 hours per month as per PAWG)  PAWG commitment (WDGP)  MCC Major Leisure Facilities commitment</p>
<p>EACH, WDGP, WHE</p>	<p>Participate in a workshop to disseminate guidelines and extend dialogue about evidence-based approaches.</p>		<p>April 2006</p>	<p>30 agencies and PCP consumer group</p>	<p>Various staff of EACH. Funded through training budget.  Participate in one workshop (WDGP)</p>
<p>EACH, WDGP, WHE, Yarra Valley CHS</p>	<p>Review current physical activity practice based on guidelines</p>		<p>June 2006</p>	<p>Member agencies</p>	<p>Within teams. Difficult to give time or \$ value (EACH)  PAWG commitment (WDGP)</p>

PCP HP capacity building <sup>7</sup>	Support and participate in the Physical Activity working group.	PAWG	Ongoing	Participating agencies	HP Officer – 50 hours PO/Admin. Support – 50 hours (Venues)
	Work with working group to develop guidelines for PCP Physical Activity website to support the implementation of evidence-based approaches to physical activity.	PAWG	November 2005-March 2006	Participating agencies	HP Officer – 30 hours Admin. Support Printing
	Make links with HALS where appropriate.	Specific agencies	Ongoing	Agencies participating in HALS projects	HP Officer
	Assess the degree to which this area of activity could be expanded to other population groups.	All agencies	Ongoing	Catchment-wide	HP Officer – 15 hours
	Provide training to accompany dissemination of guidelines.	All agencies	April 2006	All member agencies	Trainer HP Officer – 20 hours PO – 20 hours Venue/catering
	Provide training to assist agencies to contribute to the local evidence-base.	All agencies	2006	All member agencies	Trainer HP Officer – 15 hours Venue/catering
	Incorporate findings from mapping project into guideline development.	PAWG	November 2005-March 2006	All member agencies	HP Officer – 40 hours
	Disseminate the guidelines and support the introduction of evidence-based physical activity approaches.	All agencies	April 2006	All member agencies	HP Officer– 50 hours PO/Admin. Support – 15 hours
<b>Estimated Total Budget per Objective <sup>6</sup>:</b>					
<b>Estimated Total Budget per Goal <sup>6</sup>:</b>			<b>TOTAL: Health Promotion</b>		<b>205 hours</b>
			<b>Project Officer/Admin. Support</b>		<b>85 hours</b>

<b>Priority Goal:</b>	<b>To build capacity to increase participation in physical activity in the Outer East catchment.</b>				
<b>Objective 4:</b>	<b>To develop and support catchment-level evaluation for physical activity interventions by 2006.</b>				
<b>Est. Impacts<sup>2</sup> (Qual/Quant) for Objective 1</b>	<p><b>3-5 demonstration projects to use the evaluation planning framework for physical activity interventions.</b></p> <p><b>80% of demonstration projects to find the evaluation planning framework to be effective.</b></p> <p><b>50% of demonstration projects incorporate evaluation planning framework into organisational health promotion plans.</b></p> <p><b>100% of working group members to improve their knowledge of catchment evaluation processes.</b></p> <p><b>80% of training participants to increase knowledge of catchment evaluation processes.</b></p>				
<b>PCP key stakeholders<sup>3</sup></b>	<b>Summary of mix of Interventions &amp; CB strategies<sup>4</sup></b>	<b>Population Target Group/s:</b>	<b>Estimated timelines</b>	<b>Estimated Reach<sup>5</sup></b>	<b>Resources per key stakeholder for Obj1<sup>6</sup></b>
EACH, WDGP, WHE, MCC	Participate in a physical activity working group to: <ul style="list-style-type: none"> <li>• identify existing evaluation plans relevant to physical activity in the catchment</li> <li>• refine and develop evaluation planning processes as necessary</li> <li>• identify 3-5 demonstration projects (or clusters of projects) that have an established evidence base.</li> </ul>	Catchment-wide	June 2005- June 2006	10 agencies	Health Development Coordinator (EACH) (5 hours per month as per PAWG)  PAWG commitment (WDGP)  MCC commitment

EACH, WDGP	Evaluation Skill Development participants and Physical Activity Working Group to develop a logical model framework to support evaluation of physical activity across the catchment.		January – June 2006	10 agencies and PCP consumer representative	Health Development Coordinator (EACH) (5 hours per month as per PAWG)  One 2 hour meeting (WDGP)
EACH, WDGP	Establish processes to incorporate evaluation planning framework into local project planning		Last quarter 2005 for 2006 plan	10 agencies	Health Development Coordinator (EACH) (5 hours per month as per PAWG)  One 2 hour meeting (WDGP)
EACH, WDGP	Participate in implementation of evaluation framework in local projects.			3-5 demonstration projects	Health Development Coordinator and allied health staff (as required) (EACH)  Would like to be involved in one demonstration project (WDGP)
EACH, MCC Major Leisure Facilities	Physical Activity Working Group to assist in the preparation of report on 5 demonstration projects. In doing so, assist in the development of recommended changes to the framework.		June 2006	Catchment-wide, DHS RHPO	Health Development Coordinator (EACH) (5 hours per month as per PAWG)  PAWG commitment (WDGP)  MCC Major Leisure Facilities commitment

PCP capacity building <sup>7</sup>	HP	Support local agencies to establish processes to incorporate evaluation planning framework into local project planning	All agencies			HP Officer – 45 hours
		Assist working group to identify 3-5 demonstration projects and identify resources available for evaluation.	Specific agencies		3-5 demonstration projects	HP Officer – 65 hours
		Provide evaluation support to the physical activity working group as required (3-5 demonstration projects). Explore links with Evaluation Skill Development project.	All agencies/ demo projects		10 agencies	HP Officer – 65 hours
		Provide training to support evaluation of physical activity interventions. This will include an orientation to current DHS resources including the website and evidence based resources.	All agencies		Member agencies	Trainer HP Officer – 30 hours
		Coordinate feedback from demonstration projects about the effectiveness and usefulness of the framework. Report findings to working group.	Demo projects/PAWG		3-5 demonstration projects	HP Officer – 30 hours PO/ Admin. Support
		Prepare report on the five demonstration projects. This will identify the potential for rollout to other agencies/program areas. Present findings to catchment at forum.	Demo projects/PAWG /all agencies			HP Officer – 10 hours PO – 10 hours Venue/catering
		Coordinate the Partnership Evaluation Tool process.	All agencies			HP Officer – 30 hours Support
		Implement the partnerships analysis tool to support the development of the Model of collaboration specific to physical activity.	All agencies	Pre-test: first quarter 2005 Post=test: second quarter 2006		HP Officer – 10 hours PO – 10 hours
<b>Estimated Total Budget per Objective <sup>6</sup>:</b>						
<b>Estimated Total Budget per Goal <sup>6</sup>:</b>			<b>TOTAL: Health Promotion</b>		<b>285 hours</b>	
			<b>Project Officer/Admin. Support</b>		<b>20 hours</b>	

## Other Integrated Health Promotion Activities

### 1. Model of Collaboration

The 'Model of Collaboration' relates to the consideration and development of sound collaborative mechanisms and practices that support the implementation and progress of the Outer East PCP Health Promotion Framework and Integrated Health Promotion Activities. The overarching vision for the Model is that it:

*"Seeks to establish genuine collaborative practice that is systemic, involves inter-agency and inter-sectoral relationships, and supports best practice in the development of evidence-based approaches and health equity".*

A Model of Collaboration Sub-Committee was formed in January 2004 following a Health Promotion Planning Day of the Outer East PCP, which identified the need to define, develop and document a collaborative framework and associated approaches that would guide future endeavours and strengthen the capacity to achieve quality health promotion actions and outcomes.

The sub-committee progressed work on the model through the development of a project plan outlining specific tasks and strategies, and the facilitation of two developmental workshops conducted by Dr Helen Keleher from the School of Health Sciences at Deakin University.

The Model has been developed as an adjunct to the Health Promotion Framework, and aims to:

- *develop comprehensive approaches to health issues*
- *enable sustainable collaborative practice across agencies in the Outer East Primary Care Partnership catchment*
- *increase efforts to address the determinants of health, through integrated health promotion activities*

The Model encompasses two key, but equally weighted, components:

1. The Collaboration itself, and
2. The priority health/social issue to be addressed

In addition, the model emphasises the approach of "learning through doing", and is supported by the preparedness of the member agencies to work collaboratively to achieve collective outcomes.

#### Directions for the 2004 – 2006 Period

As indicated earlier, work on the Model of Collaboration has been guided by a project plan, implemented and monitored by the sub-committee and the Partnerships and Planning Working Group of the Outer East PCP. Specific activities to be carried forward from this original plan include:

- Completion of an evaluation of the 'Model of Collaboration' project;
- Development and implementation of an Action Research approach for supporting ongoing monitoring and improvement of the Model;
- Facilitation of workforce and organisational development initiatives that support good collaborative practices, as articulated in the Model;
- Completion of a report on the development and implementation of the Model.

A key focus for the future will be to apply the Model of Collaboration to the 'Catchment Planning' process already outlined in the Integrated Health Promotion Component of this Community Health Plan, and to evaluate the effectiveness of this approach. Achievement of a quality, catchment-wide health promotion plan requires strategies to address both components of the Model of Collaboration – that is, an agreed approach to collaborative practice and a focus on a priority health/social issue. The Outer East PCP has agreed to

pursue this by applying the Model of Collaboration to health promotion planning and action on the issue of 'physical activity'.

Although the Model of Collaboration has its origins and an ongoing focus in the health promotion component of the PCP, the Outer East PCP will endeavour, over the next two years, to further develop the model to the point where genuine and committed collaborative frameworks and practices underpin all aspects of PCP activity.

## **2. Footholds on Safety**

### **SAFEMoves**

SAFEMoves has been an Integrated Health Promotion Project of the Outer East PCP since 2002, with an aim of 'reducing falls and injuries from falls among older people (65+) living in their own homes'. Continued funding for this project will focus on the consolidation of the achievements of years 1 and 2, with an emphasis on ensuring the accessibility and long-term sustainability of project initiatives throughout the Outer East. Core strategies for the 2004 – 2006 period are outlined below:

- To continue dissemination of SAFEMoves resources to health, aged care and aged support agencies in the Outer East. Year 3 will enable the project to reach smaller service providers, and agencies associated with CALD and Indigenous communities.
- To continue development of coordinated, region-wide access to the No Falls Exercise Program. This will involve further organisational development, training, service mapping and establishment of a region-wide referral system.
- To undertake process and impact evaluation of the No Falls Exercise Program initiative.
- To develop and distribute a standardised community education resource on 'Falls Prevention', available for use by health and community support agencies that implement community education programs.
- To investigate and implement strategies for sustaining significant initiatives developed by the project, including the production and distribution of other relevant resources.
- To evaluate the collaborative process undertaken during the SAFEMoves project.

### **SAFEMoves 2**

The Outer East Health & Community Support Alliance recently received funding to establish ongoing, sustainable programs - or to further develop and enhance established programs on Falls Prevention in the Outer East. The Outer East Alliance has, over recent years, implemented a highly successful 'SAFEMoves' project as part of the DHS Footholds on Safety: Phase 3 initiative.

SAFEMoves 2 aims to build on the strength of this former initiative, utilising similar strategies and resources, but applying them to a more defined geographic area and a much smaller target group. It is anticipated that through shared responsibility for the development and implementation of a broad range of health promotion strategies and activities regarding 'Falls Prevention', that we can lessen the impact of "falls" on not only individuals but also the community as a whole.

The 'SAFEMoves 2' Project is a logical progression to the 'SAFEMoves', 'Preventing Falls in a Residential Setting' and 'Working Together to Prevent Falls' Projects. The core focus of this project will be to build on these earlier initiatives by increasing consistency and coordination of approaches to falls prevention, specifically in the Shire of Yarra Ranges. The project will strongly emphasise community-based involvement, capacity building and planning of approaches that target people in their homes.

The key strategies of the 'SAFEMoves 2' Program over the 2004 – 2006 period will be:

- Roll out of the Outer East Falls Prevention Models to relevant agencies servicing the Shire of Yarra Ranges, particularly targeting GPs;
- Improve the coordination of existing falls prevention initiatives and services in the Shire of Yarra Ranges, particularly those targeted at people in their own homes;
- Development of an Outer East Falls Prevention Education Resource to support and encourage peer educators to raise awareness of falls prevention in the Shire of Yarra

Ranges;

- Further development of links with public residential settings, public hospitals and ambulance services to strengthen collaboration and coordination of falls prevention endeavours;
- Strengthen capacity for improved falls prevention planning in key planning documents such as the Municipal Public Health Plan, Safety Plan and other related plans;
- Implement a comprehensive evaluation of the 'SAFEMoves 2' Project, enabling learning's from the project to guide future falls prevention planning and activity for the Outer East;
- Promote consumer, carer and community participation.

The 'SAFEMoves 2' Project has been structured to complement and build on other key initiatives being undertaken by the Outer East Alliance, as outlined below:

1. The original 'SAFEMoves' Project, including linkages with the area-based reference group and ongoing activities focusing on enhanced accessibility and sustainability of project initiatives
2. The Model of Collaboration in Integrated Health Promotion Project
3. The Area-based Funding Model Project
4. The Senior Connections Project, including the resources developed around social isolation of people over the age of 65 years.
5. Linkages with other 'Falls Prevention' initiatives being undertaken by individual agencies in the catchment, eg 'Preventing Falls in Residential Settings' initiative at Mondo Lodge in Healesville.

The Outer East Alliance member agencies have committed to work in collaboration to develop and implement the 'SAFEMoves 2' Project, and a steering group is being established, which will involve key stakeholders, including Ranges Community Health Service, Yarra Valley Community Health Service, the Shire of Yarra Ranges, Eastern Ranges GP Association, and consumer, carer and community representatives.

## Other Initiatives

### Consumer, Carer & Community Engagement

The Outer East PCP *'Consumer, Carer and Community (CCC) Engagement Strategy'* has been developed to identify, and support the implementation of mechanisms, which strengthen the engagement of consumers, carers, and the community in activities of the Outer East Alliance. The CCC Engagement Strategy focuses on providing and promoting opportunities for service users and interested community members to play a broader strategic role in the improvement of health care quality in the Outer East. The Strategy consists of a number of components, including the Outer East CCC Engagement Framework and Consumer Rights and Responsibilities Charter.

The *Outer East CCC Engagement Framework* acknowledges and builds on existing good practice in the area of consumer, carer and community participation, within member agencies of the Outer East Alliance.

The CCC Engagement Strategy is viewed as critically important to the Outer East Alliance in its effort to build healthy communities across the Outer East. Elements of the Strategy have already been put in place, with many Outer East Alliance members having adopted and refined processes that encourage greater community participation at the program development and delivery level.

A major focus to date has been on promoting consumer/community input at the strategic and systems level of the Outer East Alliance. This has involved having a consumer representative on the Outer East Alliance and other key Working Groups of the Outer East PCP, however it is clearly recognised that further efforts are now required to expand representation and facilitate effective implementation of all aspects of the Outer East Alliance CCC Engagement Strategy.

#### **Specific Directions for the 2004 – 2006 Period:**

- Undertake a review of the CCC Strategy and Framework
- Implement strategies (including facilitation of a second CCC Forum), which enhance networking amongst consumers, carers and community members, and promote opportunities for their participation at the strategic level of Outer East Alliance
- Implement a 'Community, Consumer and Carer Reference Group' for the Outer East Alliance, as recommended in the CCC Engagement Strategy
- Establish appropriate support mechanisms for this Reference Group, including a key liaison person within the PCP staff team, provision of secretariat support, allocation of resources, and the development of peer support and mentoring approaches for members of the group, which provide guidance and build confidence in strategic decision-making
- Continue to implement workforce and organisational development initiatives, which enhance capacity for effective consumer, carer and community engagement within member agencies of the Outer East Alliance
- Complete an evaluation of CCC Engagement Strategy and the outcomes achieved

## **Hospital Admission Risk Program**

The Hospital Admission Risk Program (HARP) aims to avoid unnecessary use of emergency departments and inpatient services in the hospitals targeted by the Hospital Demand Management Strategy. This is to be achieved by ensuring models of care are developed so that people have their health and medical conditions better managed both within the hospital and while at home (Hospital Demand Management Strategy Bulletin, December 2001)<sup>10</sup>.

HARP is seeking to focus on tertiary prevention, by targeting people who have manifest disease and often where their illness has become chronic. While hospitals will have a central role, collaboration with specialist services in the community and primary care providers is considered critical to ensuring the effectiveness of new approaches to care delivery.

Members of the Outer East Alliance have worked cooperatively with Eastern Health to identify the underlying causes of increase emergency demand for hospital services and to develop strategies to meet the changing needs of the community. This has involved collaboration on the HARP activity, especially in the areas of the Intensive Community Response Capacity project and Information Management and Business Systems project.

The Outer East Alliance will work with Eastern Health and other PCPs in the ongoing management of funded HARP activity to ensure the linkages between acute and primary care services. Considerable opportunity exists for further sharing and building on existing planning mechanisms and structures. For example, multi-agency Health Planning Networks already exist in each of the Outer East municipalities.

## **Information Communication Technology (ICT)**

An Eastern Metropolitan Region ICT Project Reference Group was established in late 2003 and is supporting and directing the implementation of the ICT project in the region. The group has representation from a wide range of providers and is chaired by a PCP manager. Eastern Health is the lead agency for the project, reporting to the Reference Group.

Implementation of the project has been underway since early 2004. Since that time Eastern Health has been finalising details and securing best value options on prices and level of service for participating agencies. A telecommunications provider will soon be advised. Following detailed consideration of options, the Reference Group determined ICT funding would be used to develop a virtual private network (VPN). The infrastructure has been designed to accommodate up to 100 primary care sites.

The first stage entails roll out to a total of 50 sites, commencing January 2005, with another 50 primary care sites to be targeted in the near future. Implementation and support of the new infrastructure is also reliant on the development of effective policy, procedures and mechanisms. This includes contractual arrangements, future governance, security policy and IT support arrangements that will be guided and endorsed by the Regional ICT Project Reference Group, in consultation with the key stakeholders.

<sup>10</sup> Hospital Demand Management Strategy Bulletin, December 2001.

## Conclusion

Outer East Alliance is very positive about the future directions, priorities and activities as described in the Community Health Plan 2004 – 2006.

Through effective engagement and participation of consumers, carers and the community at all levels of the Alliance activity, the Primary Care Partnership will move closer towards achieving its aim. This is to *"improve and sustain the quality of life of its residents and the health and wellbeing of the community as a whole"* and it will be in partnership with the community itself.

This Community Health Plan forms the blue print to guide and assist the Outer East Alliance in this collaborative endeavour, and it will be a 'true' partnership, with the community 'as a whole'.

## Appendix 1 Outer East Alliance members and service outlines

Name of Organisation (Outer East Alliance)	Brief Description (eg. Core business)
ACAS, Outer East	Comprehensive assessment services for aged.
Angliss Hospital	Acute medicine and surgery, acute rehabilitation, aged care and assessment services.
Care Connect	Case management and brokerage services (aged and disability)
Eastern Access Community Health	Community health (including, counselling, drug and alcohol, problem gambling, aged care, allied health and health promotion services), Psychiatric Disability Support, Disability Day Programs, and Child, Youth and Family Services.
Eastern Drug and Alcohol Service Consortium	Counselling to youth, adults and families, secondary consultation, training, education, community development.
Eastern Health	Provision of acute and sub-acute services in Eastern Metropolitan Region
Eastern Ranges GP Association	Co-ordination of education and training for GPs and provision of a mechanism for coordinated communication with relevant agencies and consumers.
Knox City Council	Local Government Authority responsible for planning, providing and purchasing of human services for aged and disabled, children, youth and families.
Knox Community Health Services	Community health service providing counselling, drug and alcohol, and health promotion services
Knox Division of General Practice	Co-ordination of education and training for GPs and provision of a mechanism for coordinated communication with relevant agencies and consumers.
Maroondah City Council	Local Government Authority responsible for planning, providing and purchasing of human services for aged and disabled, children, youth and families.
Maroondah Hospital	Acute medicine and surgery, mental health services and aged care services.
Ranges Community Health Service	Community health service providing allied health services and needle exchange.
Richmond Fellowship of Victoria	For people who experience psychiatric disability: residential rehabilitation services, long-term housing, outreach, respite and psychosocial rehabilitation day program.
Royal District Nursing Service - South and East Region	Provider of nursing services in the home to consumers.
Shire of Yarra Ranges	Local Government Authority responsible for planning, providing and purchasing of human services for aged and disabled, children, youth and families.
Villa Maria Society	Services and support for people with disabilities.
Whitehorse Division of General Practice	Co-ordination of education and training for GPs and provision of a mechanism for coordinated communication with relevant agencies and consumers.
Women's Health East	Services and support for women and service providers relating to women's health and well-being, including information, referrals, education and training, and medical services for sexual and reproductive health.
Yarra Valley Community Health Service	Community health service providing counselling, drug and alcohol, and health promotion services

## Appendix 2 Community Profile

### Demographics

The Outer East Alliance catchment area covers the local government areas (LGA) of Knox, Maroondah and Yarra Ranges.

The City of Maroondah is the smallest of the three LGAs covering 63 sq kms and having a population density of 1555.86 residents per sq km. The economy of Maroondah is mainly commercial and is anchored by the two main business centres at Croydon and Ringwood. There is also a significant concentration of industry in the south of the city.

The Shire of Yarra Ranges is the largest in area covering 2471.6 sq kms, with approximately 10% being urban, 35% rural and 55% parklands or reserves. The Shire of Yarra Ranges has a relatively low population density with 57.09 people per sq km. The fact that some of the residents live in fairly isolated areas, together with the topography of the Shire, has implications for service delivery and accessibility to services by residents.

The City of Knox covers 113.8 square kilometres and is far more densely populated with 1238.45 residents per sq km. While Knox has a large residential population base, it also has substantial local employment in business, retail and manufacturing.

### Population Growth

Table 1 shows the population of the Outer East at the 1996 Census of Population and Housing was estimated as being 369,877. By 2011, it is predicted that this will increase by 3.4% to 382,415 (*Victoria in Future*, 2000)<sup>11</sup>. This projected increase in population is significantly lower than the 13.6% increase predicted for Metropolitan Melbourne overall. Yarra Ranges had the lowest projected population growth with 1.4% and Knox had the highest with 5.0%.

**Table 1 : Population Projections 1996–2011**

	1996	2001	2006	2011	% Change 1996-2011
Knox	136,825	142,589	143,480	143,657	5.0%
Maroondah	95,879	98,784	99,306	99,677	4.0%
Yarra Ranges	137,173	141,450	141,362	139,081	1.4%
<b>Outer East</b>	<b>369,877</b>	<b>382,823</b>	<b>383,148</b>	<b>382,415</b>	<b>3.4%</b>
<b>Metropolitan Melbourne</b>	<b>3,284,007</b>	<b>3,454,339</b>	<b>3,604,537</b>	<b>3,731,319</b>	<b>13.6%</b>

Source: Department of Infrastructure – *Victoria in Future* (2000)

<sup>11</sup> *Victoria in Future*, 2000.

## Age Structure

In terms of planning for primary care services, two age groups are of particular interest—the youngest (persons aged under 18) and oldest members of the community (persons aged 70 and over). Between 1996 and 2011 each municipality will experience a decline in the number of residents in the younger age groups and an increase in people aged 70 years and older. However, the population profile of the three LGAs will remain younger than Victoria overall.

**Table 2: Outer East Population Projection Changes 1996–2011**  
% of population by age group

Age group	Knox		Maroondah		Yarra Ranges		Victoria	
	1996	2011	1996	2011	1996	2011	1996	2011
0–4	7.9	5.7	7.4	5.6	7.6	5.7	6.9	5.4
5–17	20.9	17.3	18.4	16.3	21.9	17.4	18.0	15.4
70–84	4.8	6.7	6.6	8.1	5.0	6.5	7.4	8.3
<b>85+</b>	<b>0.9</b>	<b>1.4</b>	<b>1.0</b>	<b>1.8</b>	<b>0.8</b>	<b>1.4</b>	<b>1.2</b>	<b>1.9</b>

Source: Department of Infrastructure – Victoria in Future (2000)

More recent data sets drawn from the ABS 2001 data reinforces this trend which is important to future planning processes for health priorities in Outer East.

Age Goup	Knox	Maroondah	Yarra Ranges	Victoria
2001	2001	2001	2001	2001
0-4	6.9	6.8	7.0	6.4
5-19	22.9	20.6	23.8	20.4
70-84	5.3	7.4	5.5	7.9
85+	1.1	1.5	1.0	1.5

Source Community Health Plan Data Sets 2003

## **Gender**

The proportions of male to female ratio is consistent across all LGAs located within the Outer East, with a slightly higher percentage of females living in the three LGAs (50.7%) than males (49.3%). These figures are consistent with the Victorian average.

## **Indigenous People**

Only 0.3% of people living in the Outer East were recorded as being Aboriginals or Torres Strait Islanders at the 1996 census. This is fewer than for all of Victoria (0.5%). However, it is possible that the numbers of recorded indigenous people in the catchment area under-represent the actual level. In addition, there is a higher percentage of indigenous people in the Healesville area.

## **Ethnicity**

In 1996, the Outer East had a relatively high proportion of residents who are Australian born. Just under one quarter of residents (24.2%) were born outside Australia. This compares to the rate of 27.4% for Victoria as a whole and 29.2% for the Eastern Metropolitan Region. The proportion of UK migrants in the catchment area was significantly higher (8.2%) when compared to the Eastern Metropolitan Region (6%) and Victoria (4.9%). There is some recent evidence at the local level to suggest migration patterns have changed with increased representation of people from South East Asia.

## **Employment**

The unemployment rate for the Outer East for the September 2000 quarter (4.5%) was considerably lower than for both the Eastern Metropolitan Region (6.7%) and for all Victoria (7.6%).

Of those employed in the Outer East almost 70% were employed on a full time basis. Most people within the Outer East were employed in the areas of clerical work, trade related work and as professionals.

## **Income**

The 1996 Census data showed a somewhat different pattern of income distribution for each of the three LGAs in the Outer East. Knox had the highest proportion of households earning \$700 or more per week –higher than the other two LGAs and the Eastern Metropolitan Region and Victorian averages. Maroondah on the other hand, had the highest proportion of the three LGAs of households earning between \$120 and \$299 per week, which are regarded as low-income earners.

## **Concession Card Holders**

Another useful indicator of socio-economic disadvantage is the use of a Commonwealth concession card. As at March 1999, there were 44,448 holders of Pension Concession Cards and 29,289 Health Care Card holders in the Outer East. Yarra Ranges had the highest percentage of cardholders and Maroondah the lowest.

## **Socio-economic Disadvantage**

The Index of Relative Socio-Economic Disadvantage (IRSD), which is calculated by the Australian Bureau of Statistics, summarises census information on education, occupation, income, family structure, race (the proportion of indigenous people), ethnicity (poor proficiency in the English language) and housing to arrive at a single index score for each local government area in Australia.

The average score for Australia is set at 1000, with lower scores reflecting greater disadvantage. On this basis, the Outer East was one of the least disadvantaged municipalities in Victoria with a score of 1053.75 compared to 1015.96 for all Victoria. Of the three local government areas in the Outer East, Yarra Ranges had the highest level of disadvantage with a score of 1046.88, compared to Knox (1056.72) and Maroondah (1059.33).

A picture of the socio-economic status of the catchment was also provided in a study conducted by Professor Tony Vinson in August 1999, titled *Unequal in Life*<sup>12</sup> as part of the research program of The Ignatius Centre, the policy and research arm of Jesuit Social Services. This study of social disadvantage drew on information available from a range of different sources, but rarely collated.

The 622 postcodes in Victoria were ranked according to how they scored against the selected criteria with one being the most disadvantaged postcode. The data demonstrated that while the Outer East municipalities are considered to be relatively well off in socio economic terms, there are pockets of disadvantage. The postcodes of Healesville, Yarra Junction and Warburton in particular, showed significant disadvantage.

<sup>12</sup> Unequal in Life, Professor Tony Vinson, The Ignatius Centre, Jesuit Social Services, August 1999.

## **Appendix 3 Service Profile**

### **Overview**

The information used for the development of the PBP service profile was obtained from the Outer East Alliance partners and supplemented by a service utilisation questionnaire. The questionnaire was designed to collect information on characteristics of service users, types of services provided, service models, service utilisation levels, service gaps and access issues, and current priorities for service development. All Outer East Alliance partners were asked to complete the questionnaire, with the total sample size being 21. Outer East Alliance partners represent a range of agencies including Local Councils, Community Health Services, Women's Health Services, community based Nursing Services and the Divisions of General Practice that operate within the three municipalities.

### **Types of service**

A mapping of the types of service provided by the Outer East Alliance partners within the Outer East was completed within the framework of the Services Needs and Service Mapping Template. The information used in this service type mapping exercise was provided by the Alliance partners and was supplemented by data gathered through the service utilisation questionnaire.

### Appendix 3 / Table 1 Outer East Alliance – Service Mapping & Service Needs Planning Template

Population Characteristics	Definitions and Descriptions	Children and families (0-12 yrs)	Young People (13-24 yrs)	Adults (25-64 yrs)	Older people (65 yrs and over)
	<b>Demographic characteristics</b>	<ul style="list-style-type: none"> <li>The number of children in all LGAs is higher than the state average,</li> <li>Over the next decade the numbers will decline in all LGAs.</li> </ul>	<ul style="list-style-type: none"> <li>The number of young people in all LGAs is higher than the state average principally because of low numbers in Melbourne.</li> <li>Over the next decade the numbers will decline or be static in all LGAs.</li> </ul>	<ul style="list-style-type: none"> <li>The number of adults in all LGAs is consistent with state data.</li> <li>Over the next decade the numbers will increase modestly in all LGAs.</li> </ul>	<ul style="list-style-type: none"> <li>The number of older people in all LGAs is lower than the state average.</li> <li>Over the next decade the numbers will increase modestly in all LGAs.</li> </ul>
	<b>Social characteristics</b>	<ul style="list-style-type: none"> <li>There are lower rates of people from NESB in Outer East.</li> </ul>	<ul style="list-style-type: none"> <li>There are lower rates of people from NESB in Outer East.</li> </ul>	<ul style="list-style-type: none"> <li>The unemployment rate across Outer East is substantially lower than for Victoria.</li> <li>There are lower rates of people from NESB.</li> </ul>	<ul style="list-style-type: none"> <li>There are lower rates of people from NESB in Outer East.</li> </ul>
	<b>Health characteristics</b>	<ul style="list-style-type: none"> <li>Chronic respiratory disease / Asthma is the major cause of disease burden for children in Outer East.</li> </ul>	<ul style="list-style-type: none"> <li>Asthma, mental disorders and injuries are the major causes of burden of disease for young people in Outer East.</li> </ul>	<ul style="list-style-type: none"> <li>Mental disorders, asthma, cancer and cardiovascular disease are the major causes of burden of disease for this age group in Outer East.</li> </ul>	<ul style="list-style-type: none"> <li>Neurological and sensory disorders, mental disorders, asthma, cancer and cardiovascular disease are the major causes of burden of disease for this age group in Outer East.</li> </ul>
	<b>Special needs</b>	<ul style="list-style-type: none"> <li>Asthma related programs for children and families.</li> </ul>	<ul style="list-style-type: none"> <li>Young adults with complex needs, including mental health problems.</li> </ul>	<ul style="list-style-type: none"> <li>Adults with complex needs, including homelessness and mental health problems.</li> </ul>	<ul style="list-style-type: none"> <li>Health promotion activities for older people.</li> </ul>
	<b>Special issues</b>	<ul style="list-style-type: none"> <li>Asthma</li> </ul>	<ul style="list-style-type: none"> <li>Mental health</li> <li>Injury</li> </ul>	<ul style="list-style-type: none"> <li>Mental Health, Cancer, Cardiovascular disease, diabetes.</li> </ul>	<ul style="list-style-type: none"> <li>Mental Health, Cancer, Cardiovascular disease, diabetes, neurological and sensory disorders.</li> </ul>

**Appendix 3 / Table 1 continued**

	<b>Definitions and Descriptions</b>	<b>Children and families (0-12 yrs)</b>	<b>Young People (13-24 yrs)</b>	<b>Adults (25-64 yrs)</b>	<b>Older people (65 yrs and over)</b>
<b>Continuum of Care</b>	<b>Not at Risk</b> Describes population-based rather than individual strategies that may be universally or selectively targeted	Health promotion services (4, 6, 7, 11, 18, 19, 20) Maternal & Child Health (6, 15)	Drug & Alcohol training, education & community development (5) Health promotion services (4, 6, 7, 11, 18, 19, 20) Women's health education, information and training (18)	Drug & Alcohol training, education & Community development (5) Health promotion services (4, 6, 7, 11, 18, 19, 20) Women's health education, information and training (18)	Drug & Alcohol training, education & community development (5) Health promotion services (4, 6, 7, 11, 18, 19, 20)
	<b>At Risk</b> Describes strategies/services targeted at people who display the early signs of a disorder or who are considered at risk of experiencing a disorder (eg due to environmental or genetic factors)	Children Services (4, 6, 18) Services brokerage (6, 9, 15) Allied Health (4, 7, 10, 11, 17, 18, 19, 20) Immunisation (15) Medical (4, 18) Service brokerage (6, 9, 15) Social Welfare (7) Family Support (6, 7, 10)	Allied Health (4, 7, 10, 11, 17, 18, 19, 20) Counselling (4, 7, 15, 18, 20) Disability Services and Support (4, 16, 18) Drug & Alcohol Services (4, 5, 7, 10, 11, 20) Medical (4, 19, 18) Needle Exchange (11) Problem gambling (4) Service brokerage (6, 9, 15) Social Welfare (4, 7, 11, 5, 18, 20) Women's health referrals and information (18) Women's sexual and reproductive health services (18)	Allied Health (4, 7, 10, 11, 17, 18, 19, 20) Counselling (4, 7, 18, 20) Disability Services and Support (4, 16, 18) Drug & Alcohol Services (4, 5, 7, 10, 11, 20) Medical (4, 10, 18) Needle Exchange (11) Problem Gambling (4) Psychiatric Disability Support, Disability Day Programs (4) Service brokerage (6, 9, 15) Social Welfare (4, 7, 11, 5, 18, 20) Women's health referrals and information (18) Women's sexual and reproductive health services (18)	Aged care services (2, 4, 6, 9, 10, 19) Allied Health (2, 4, 7, 10, 11, 17, 18, 19, 20) Brokerage services (3, 6, 9, 15) Case management (3) Comprehensive assessment (1, 2) Counselling (4, 7, 10, 11, 18, 20) Medical (4, 10, 18) Problem gambling (4) Social Welfare (4, 7, 11, 5, 18, 20)
	<b>Symptomatic</b> Describes strategies/services targeted at people displaying the early onset of a particular condition/disorder	Allied Health (4, 7, 10, 11, 13, 17, 18, 19, 20) Children Services (4, 6, 7, 18) Dental Services (6, 7, 10, 11) Disability Case Management & Brokerage Services (3) Family Support (6, 7, 10) Medical (4, 18) Nursing Services (4, 6, 13) Psychiatric Services (4, 10) Service brokerage (6, 9, 15) Social Welfare (4, 7, 10, 11, 5, 18, 20)	Allied Health (4, 7, 10, 11, 13, 17, 18, 19, 20) Counselling (4, 7, 10, 11, 18, 20) Dental Services (6, 7, 10, 11) Disability Case Management & Brokerage Services (3) Disability Services and Support (4, 16, 18) Drug & Alcohol Services (4, 5, 7, 10, 11, 20) Financial Counselling (6) Medical (4, 18) Nursing Services (4, 13) Problem gambling services (4) Psychiatric Services (4, 10, 12) Service brokerage (6, 9, 15)	Allied Health (4, 7, 10, 11, 13, 17, 18, 19, 20) Counselling (4, 7, 10, 11, 18, 20) Dental Services (6, 7, 10, 11) Disability Case Management & Brokerage Services (3) Disability Services and Support (4, 16, 18) Drug & Alcohol Services (4, 16, 18) Drug & Alcohol Services (4, 5, 7, 10, 11, 20) Financial Counselling (6) Medical (4, 18) Nursing Services (4, 13) Problem gambling services (4) Psychiatric Services (4, 10, 12) Service brokerage (6, 9, 15)	Aged care services (2, 4, 6, 10, 13, 19) Allied Health (4, 7, 10, 11, 13, 17, 18, 19, 20) Assessment (1, 2) Brokerage services (3, 6, 9, 15) Case management (3) Counselling (4, 7, 10, 11, 18, 20) Dental Services (6, 7, 10, 11) Medical (4, 18) Nursing Services (4, 13, 20) Problem gambling (4) Social Welfare (4, 7, 10, 11, 5, 18, 20)

**Appendix 3 / Table 1 - continued**

Continuum of Care	Definitions and Descriptions	Children and families (0-12 yrs)	Young People (13-24 yrs)	Adults (25-64 yrs)	Older people (65 yrs and over)
	<b>Symptomatic continued</b>			Social Welfare (4, 7, 10, 11, 5, 18, 20) Women's health referrals and information (18, 20) Women's sexual and reproductive health services (18)	Social Welfare (4, 7, 10, 11, 5, 18, 20) Women's health referrals and information (18, 20) Women's sexual and reproductive health services (18)
<b>Acute</b> Describes strategies/services targeted at treating the acute episode of a condition/disorder	Acute medicine and/or Surgery (4, 18, 10, 19) Allied Health (2, 4, 7, 10, 11, 13, 17, 18, 19, 20) Children Services (4, 18) Dental Services (6, 7, 10) Disability Case Management & Brokerage Services (3) Psychiatric Services (10) Disability Services and Support (4, 16, 18) Emergency Care (2, 4, 18, 10, 19) Family Support (6, 7, 10) Psychiatric Services including inpatient care (10) Social Welfare (4, 7, 11, 5, 18, 20)	Acute medicine and/or Surgery (10, 18, 19) Allied Health (2, 4, 7, 10, 11, 13, 17, 18, 19, 20) Counselling (4, 7, 10, 11, 20) Dental Services (6, 7, 10) Disability Services and Support (4, 16, 18) Drug & Alcohol Services (4, 5, 7, 10, 11, 20) Nursing Services (4, 10) Problem gambling (4) Psychiatric Services including inpatient care (10, 12) Service brokerage (6, 9, 15) Sexual Assault (10) Social Welfare (4, 6, 10, 11, 5, 18, 20) Women's health referrals and information (18)	Acute medicine and/or Surgery (10, 18, 19) Allied Health (2, 4, 7, 10, 11, 13, 17, 18, 19, 20) Counselling (4, 7, 10, 11, 18, 20) Dental Services (6, 7, 10) Disability Services and Support (4, 16, 18) Drug & Alcohol Services (4, 5, 7, 10, 11, 20) Nursing Services (4, 13) Problem gambling (4) Psychiatric Services including inpatient care (10, 12) Sexual Assault services (10) Social Welfare (4, 6, 10, 11, 5, 18, 20) Women's health referrals and information (18)	Acute medicine and/or surgery (10, 18, 19) Acute rehabilitation (2, 4, 10, 18, 19) Allied Health (2, 4, 7, 10, 11, 13, 17, 18, 19, 20) Aged Care services (2, 4, 10, 13, 19) Assessment (1, 2, 10) Care management (3, 10) Counselling (4, 7, 10, 11, 18, 20) Dental Services (6, 7, 10) Nursing Services (4, 13, 20) Problem gambling (4) Social Welfare (4, 6, 7, 11, 5, 18, 20)	

**LEGEND:**

1. ACAD, Outer East
2. Angliss Health Services
3. Care Connect
4. Eastern Access Community Health
5. Eastern Drug and Alcohol Service Consortium
6. Knox City Council
7. Knox Community Health Services
8. Knox division of General Practice
9. Maroondah City Council
10. Maroondah Hospital
11. Ranges Community Health Service

12. Richmond Fellowship of Victoria
13. Royal District Nursing Service – South & East Region
14. Sherbrooke & Pakenham Division of General Practice\*
15. Shire of Yarra Ranges
16. Villa Maria Society
17. Whitehorse Division of General Practice
18. Women's Health East
19. Yarra Ranges Health Service
20. Yarra Valley Community Health Service
21. Yarra Valley Division of General Practice

**Please note:**

Allied Health includes all or some of the following activities:

Physiotherapy, podiatry, occupational therapy, speech pathology and dietetics.

**Knox, Whitehorse and Yarra Valley** Divisions of General Practice offer co-ordination of education and training for GPs and provide mechanisms for coordinated communication with relevant agencies and consumers.

\* Not a member agency

**Appendix 4  
Outer East Health & Community Support Alliance  
Strategic Planning Forum Report  
30 March 2004**

**1. Introduction**

The forum was convened with the purpose of developing a future vision for the OEHCSA within the context of the recently released DHS PCP Strategic Directions Paper and consultation process.

The dual aims of the forum were to:

Undertake future planning for the OEHCSA, including vision and strategies

Use the discussion to inform and consolidate the written response to the DHS PCP draft Implementation Plan.

In doing so, participants wished to be progressive in their thinking and explore the potential strategies in relation to service system reform and coordination.

**2. Context**

A number of slides were presented highlighting key points from recently released DHS policy frameworks including: the PCP Strategic Direction and Implementation Plan documents; the Metropolitan Health Strategy; and the Draft Community Health Services Policy Framework.

During discussion regarding the current policy context, participants noted general themes as:

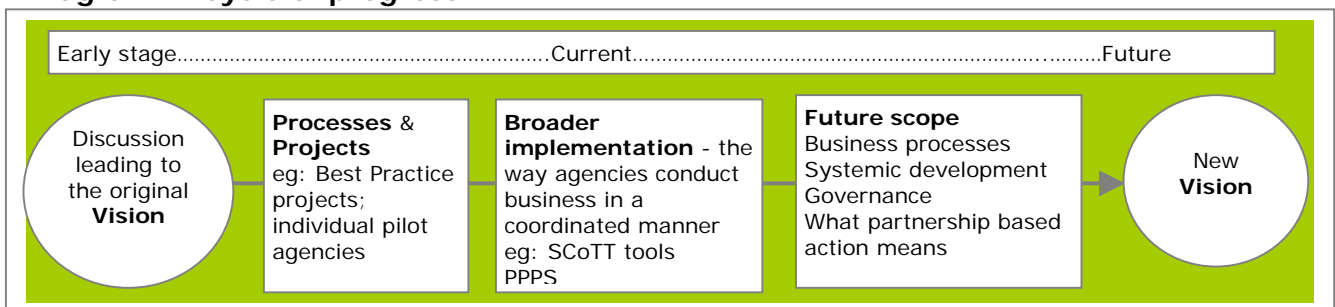
- Definitions focusing on Primary Health Care rather than just Primary Care
- A sense of greater alignment with the acute sector and hospital diversion
- Validation of the role and achievements of the primary care sector
- The importance of an integrated cross-divisional DHS focus
- Common themes across the three policies eg: integration and partnerships
- Acknowledgment that much planning still occurs in 'silos' resulting in fragmentation
- Acknowledgment of the gap between policy and planning and implementation detail and practice.

In relation to the future vision and planning for the OEHCSA the importance of setting realistic goals that were achievable within this broader policy context was noted.

**3. The Vision**

Peter Ruzyla presented a model on the whiteboard demonstrating the cycle of progress and achievements of the OEHCSA over the previous years. In noting that many of the original objectives of the Outer East Alliance had been achieved, he suggested that it was appropriate in thinking about the future to 'challenge ourselves with other things.' The cycle was represented diagrammatically illustrating how initial 'talk' and discussion about reform had led to a vision, that resulted in new processes and new projects, followed by the development of tools and business processes, all of which contributed to achieving the vision; and that there was now scope for further action to achieve a new vision.

**Diagram 1: Cycle of progress**



Discussion about the future centred around:

- Blurring boundaries between services to focus on consumer needs rather than agency needs

Whether agencies make a difference just by linking up

Member agencies progressively partnering in cooperative relationships and 'giving up' autonomy

- Recognition that agencies may need to lose some autonomy for the greater good of the Outer East Alliance and to achieve desired service system/consumer outcomes.

#### 4. Strategic Planning

Key areas were identified and discussed in relation to a potential future vision and the degree to which participants were open to change. The categories of 'safe,' 'stretchy' and 'provocative' were used to facilitate the thinking and discussion. The points underlined are those that were supported by those present as being desirable goals as part of the future vision.

**Table 1: Desirable goals (underlined)**

	<b>SAFE</b>	<b>STRETCHY</b>	<b>BOLD/PROVOCATIVE</b>
Resources	<ul style="list-style-type: none"> <li>• As is</li> <li>• Agencies use their own</li> </ul>	Sharing (a little bit)	<ul style="list-style-type: none"> <li>• Transfer of \$ resources between agencies</li> <li>• Give \$s to whoever does best practice</li> <li>• Development of virtual team</li> <li>• <u>Transfer of 'best' resources from agencies to new pool based on project monitored via short term work plans with KPIs.(Elite team not seen as long term or sustainable).</u></li> <li>• Example of short term project pool: <u>Community capacity building</u></li> </ul>
Service Coordination	<ul style="list-style-type: none"> <li>• SCTT</li> <li>• Electronic Referral</li> <li>• Individual agency implementation</li> </ul>	<ul style="list-style-type: none"> <li>• <u>All agencies/services/sectors – fully implemented</u></li> <li>• <u>All Eastern Health</u></li> <li>• Education, support</li> <li>• DHS programs</li> </ul>	<ul style="list-style-type: none"> <li>• <u>1300 number for Outer East</u> (leading to data for planning and evaluation)</li> <li>• Intake service (quality control)</li> <li>• <u>Intake across services (not service by service)</u></li> <li>• <u>Care planning/GPs</u> (data for planning and evaluation)</li> </ul> <p>NB: The need for caution in these bold initiatives was noted</p>
Governance	<ul style="list-style-type: none"> <li>• As is</li> </ul>	<ul style="list-style-type: none"> <li>• Broader sector involvement</li> <li>• <u>Regional level strategies</u></li> <li>• <u>Consumer involvement</u></li> </ul>	<ul style="list-style-type: none"> <li>• <u>Reducing key participants at a governance (not membership) level OR</u></li> <li>• More participants the better</li> <li>• Regional Health Board eg: Acute, Sub acute, Community, PCP, MPHP</li> <li>• <u>Developing a new governance paradigm</u></li> </ul>
Targeting / Consumer and Population Health Impact	<ul style="list-style-type: none"> <li>• Current statement</li> <li>• BATS</li> <li>• Service who comes through the door</li> </ul>	<ul style="list-style-type: none"> <li>• The too hard basket (those who don't come through the door) – be more specific about target groups</li> <li>• Hardest groups to engage</li> </ul>	<ul style="list-style-type: none"> <li>• <u>Focus x% of resources on agreed target groups. by all member agencies, consensus on activities. Use of DHS \$s to support; think big, x EFT per agency. Eg: SRS marginalised or specific population group such as chronic disease</u></li> <li>• Should we make a difference to all?</li> <li>• <u>Coordinated action/linking; specific actions</u></li> </ul>
Consumer Engagement	<ul style="list-style-type: none"> <li>• Make plans for them – presumptions made</li> </ul>	<ul style="list-style-type: none"> <li>• <u>Consumer development and capacity building and empowering</u></li> </ul>	<ul style="list-style-type: none"> <li>• <u>Sustainable services run by and for consumers ie. Consumer run services</u></li> <li>• <u>System built around consumers</u></li> <li>• <u>Consumers reduce stress for services – use consumers as a valued 'resource'</u></li> </ul>
Planning (3 tiers) 1. DHS & DHACS 2. Enhanced integration between agencies 3. Individual agency planning	<ul style="list-style-type: none"> <li>• Be broad</li> <li>• Non-measurable</li> <li>• More of the same/as is/treadmill</li> </ul>	<ul style="list-style-type: none"> <li>• <u>MPHP + CHP + CHPIA to extract agreed priorities for overlapping areas and specific strategies/multi-faceted and agencies and roles</u></li> </ul>	<ul style="list-style-type: none"> <li>• Test of true partnerships – put money where mouth is</li> <li>• <u>What was outcome/by postcode</u></li> <li>• <u>Being brave enough to stop what isn't achieving</u></li> </ul>

Broad strategies were then developed in relation to these goals, as shown in Table 2 below. Please note that the detail in some cells (eg: responsibility, timeframe) require completion.

Table 2: Strategies

Goal/Key Result Area	Tasks	Responsibility	Timeframe
<p>Targeting</p> <p>Goal: To focus x% of resources on agreed target group/s</p>	<ul style="list-style-type: none"> <li>Decide on criteria – transparency (where can we make a difference)</li> <li>Identify target groups <ul style="list-style-type: none"> <li>x DHS – disease based (set)</li> <li>x local – social determinants</li> </ul> </li> <li>Link with stage of planning cycle – needs analysis/mapping/priorities – develop agency/target group matrix for this</li> <li>Ensure decision-making process with consumers</li> <li>Ensure skills and resources available across agencies and in community/consumers</li> <li>Develop action plan</li> </ul>		
<p>Planning</p> <p>Goal: To achieve a more congruent approach with integrated and agreed priorities and strategies across agencies</p>	<ul style="list-style-type: none"> <li>Identify all relevant planning documents</li> <li>Map/analyse</li> <li>Review what is already occurring with quality /scope of activity profile</li> <li>Ask each Local Government Area to advise of priority</li> <li>Recommendation priorities</li> <li>Contribution to PCP CHP for next two years</li> <li>Link with targeting matrix (see above)</li> </ul>	<ul style="list-style-type: none"> <li>Planning &amp; Partnerships Working Group to consider level and scope and what is achievable</li> <li>Use Social Determinants of Health matrix</li> <li>Use Health Promotion Framework</li> </ul>	Prior to September
<p>Consumer Engagement</p> <p>Goal: To use the community and consumers as a valued resource for a system built around consumers</p>	<ul style="list-style-type: none"> <li>Implement existing CCC Engagement strategy and clarify purpose</li> <li>Secure commitment to consumer engagement at: agency level and link to Outer East Alliance; and at community level</li> <li>Link to targeting priorities</li> <li>Consider strategies eg consumer action group; consumer representation on working groups and at Outer East Alliance level</li> <li>Address resource implications</li> <li>Share learning's and implications</li> </ul> <p>NB: It was acknowledged that consumers (CAGs) have been engaged in Integrated Health Promotion projects And that Health Issues Centre has identified training for region).</p>	<ul style="list-style-type: none"> <li>Advisory Committee to document achievements and move CCC Engagement draft to final document</li> <li>Start at next Partnerships &amp; Planning Working Group</li> <li>Establish a sub working group for consumer engagement</li> </ul>	Before September 2004
<p>Service Coordination</p> <p>Goal: To continue implementing service coordination and investigate a generic intake service model/concept</p>	<ul style="list-style-type: none"> <li>Use Key Practitioner Reference Group to request permission and commitment to revisit specialist and generic concept: form nucleus to develop the generic intake service idea further; consult and clarify the potential model and consider implications; prepare a Discussion Paper</li> <li>Stabilising and rollout current SCTT</li> <li>Support implementation with GPs</li> <li>Patient &amp; Client Information Management system</li> <li>Regionalising PPPS &amp; Electronic Referral</li> <li>Look for new opportunities - Consider Super Clinic opportunities</li> <li>Look at Statewide Patients &amp; Clients Information Management System</li> <li>Work towards regional electronic referral</li> </ul>	<ul style="list-style-type: none"> <li>Generic intake model - Discussion paper required. Needs resourcing – seek DHS feasibility study funding for scoping document via special initiatives</li> </ul>	

<p>Governance</p> <p>Goal: To review governance and potentially adopt a new governance model/paradigm</p>	<ul style="list-style-type: none"> <li>• Acknowledge need to reflect various strategies that may be different across the region</li> <li>• Develop a working party to consider models</li> <li>• Talk with other PCPs</li> <li>• Consider implications of reducing key partnerships (ie governance), but still able to increase membership</li> <li>• Ensure model facilitates moving from a coordination to true partnership within Outer East Alliance</li> <li>• Ensure the governance model is according to what needs to be done – layered structure where form follows function.</li> </ul>	<ul style="list-style-type: none"> <li>• Finance and Operations Committee</li> <li>• Working party to look at governance models</li> <li>• Have discussion with other PCPs around what they are doing</li> </ul>	<p>Consider at next meeting of Operations and Finance Committee</p>
<p>Resources</p> <p>Goal: To ensure resource usage reflects the vision and strategies and that maximum value is gained</p>	<ul style="list-style-type: none"> <li>• Identify who does what best practice (eg: electronic referral model, consumer engagement)</li> <li>• Scope and identify types of resources utilised (eg \$\$s, staff time, concepts)</li> <li>• Identify existing virtual teams</li> <li>• Increase permission / responsibility</li> <li>• Specify objectives and measures</li> <li>• Harness consumer resources (eg grants and knowledge - virtual team)</li> <li>• Respond to opportunities for submissions – ie. consumer groups are able to apply for grants</li> </ul>	<ul style="list-style-type: none"> <li>• Across PCP working groups – more discussion needed</li> </ul>	<p>Further discussion at Outer East Alliance meeting and further work up (link resources to activities)</p>

**Next steps:**

- Documentation of the strategic directions arising from the Forum
- Confirmation of goals
- Completion of details in Table 2
- Dialogue with the other PCPs in the region

In closing the forum it was noted that by moving towards the vision and goals discussed during the course of the forum that the “Outer East would be *better* placed to work together.”

Report compiled by HDG Consulting Group: Ro Saxon: 3 May 2004