Implementation of B-SW Regional Cultural Diversity Strategy

SERVICE PROVIDER: Southern Grampians & Glenelg Primary Care Partnership
YEAR END: JUNE 2001/2002/2003

REQUIREMENTS	TASKS	*Possible strategies*
KEY PRIORITY AREA 1. Service Providers shall undertake activities with their staff and communities to increase their awareness of all forms of cultural diversity.	o Increase awareness of cultural diversity in catchment beyond residents (attached census data 1996) o Increase awareness of tourism in the region and potential impact on services o Develop "mock disaster scenario" involving a tourist bus to identify effectiveness and implementation of current protocols and gaps to be addressed o Visit (April 2001) to Hamilton of group of Indonesian Health Service Managers. Presentation of maternity services. Visit to Community Centre and discussion of service provision and health promotion	?? *events for staff and/or the community - e.g.* ?? *social club activities* ?? *information sessions* ?? *seminars, conferences, forums* ?? *using current local festivals to showcase cultural diversity* ?? *information – e.g. posters/brochures in community languages, about lifestyle alternatives, about agencies and other languages, about other cultures* ?? *training for staff* ?? *liaison with the Geelong Migrant Resource Centre and other cultural groups.*
KEY PRIORITY AREA 2. Service Providers shall ensure that they are aware of all relevant information about the cultural background of each client by: 1. conducting training for all staff and managers 2. adapting existing tools and practices 3. accurately recording all relevant client details. DHS will disseminate information about relevant practices and processes to service providers.		?? *accessing training such as that provided by e.g.* ?? *ADEC (Action on Disability within Ethnic Communities)* ?? *the Migrant Resource Centre North-East (Achieving Cultural Competence)* ?? *Deakin University (Diverse Bodies, Diverse Entities)* ?? *implementing the HACC Cultural Planning Tool* ?? *incorporating cultural diversity strategies into the Community Health Plans developed by Primary Care Partnerships.*

REQUIREMENTS	TASKS	*Possible strategies*
KEY PRIORITY AREA 3. Service Providers shall ensure that all services provided by them are responsive to the differing cultural needs of their clients.	o	*1. training for staff in adapting their practices and processes to suit the individual needs of clients* *2. developing protocols within and between agencies* *3. incorporating a requirement for culturally responsive practice into existing service agreements, quality control processes and other mechanisms – e.g.* ?? *client feedback/surveys* ?? *agency Quality Improvement plans* ?? *the HACC Cultural Planning Tool*
KEY PRIORITY AREA 4. DHS shall coordinate access by service providers to regional information about cultural groups. DHS Direct Care and each Primary Care Partnership shall nominate a cultural diversity contact person.	o	?? *DHS convening an annual forum to update service providers on relevant resources.* ?? *Service providers considering training in electronic information retrieval In order to maximise effective use of information.*
KEY PRIORITY AREA 5. Service Providers shall undertake training and develop policies and practices to ensure more effective use of interpreting and translating services.		?? *Service Providers ensuring that they are aware of the range of interpreting and translating services available. This includes knowing the appropriate responsibility, procedures and costs involved in using these services. This could be done through developing strong links with the Migrant Resource Centre and other relevant agencies.* ?? *Service Providers and DHS investigating opportunities for increased use of technology.* ?? *DHS supporting initiatives in the region to improve access to language services.*

Appendix 3.1 Q

HealthWIZ data 1996 census (ABS) Southern Grampians and Glenelg shires

	Persons Males Numbers	Persons Females Numbers	Persons Total Numbers
"(1) Australia (Indigenous)"	119	165	284
"(2) Australia (non Indigenous)"	17094	17031	34125
"(3) Ireland"	18	22	40
"(4) United Kingdom"	518	561	1079
"(5) Canada"	6	12	18
"(6) New Zealand"	105	116	221
"(7) South Africa"	3	6	9
"(8) United States of America"	9	29	38
"(9) Hungary"	12	6	18
"(10) Poland"	9	3	12
"(11) Other USSR & Eastern Europe"	30	6	36
"(12) Croatia"	3	6	9
"(13) Greece"	13	12	25
"(14) Italy"	33	15	48
"(15) Macedonia, Former Yugoslav Rep. of"	0	0	0
"(16) Malta"	20	14	34
"(17) Serbia and Montenegro, Former Yug "	0	0	0
"(18) Other Southern Europe"	18	13	31
"(19) Germany, Fed. Republic of"	50	52	102
"(20) Netherlands"	112	87	199
"(21) Other Northern & Western Europe"	28	28	56
"(22) Lebanon"	0	3	3
"(23) Other Middle East"	3	6	9
"(24) Chile"	0	0	0
"(25) Other Latin America & Caribbean"	3	6	9
"(26) Vietnam"	0	0	0
"(27) Other Southeast Asia"	0	0	0
"(28) China (excl. Taiwan)"	3	3	6
"(29) Egypt"	3	0	3
"(30) Fiji"	3	6	9
"(31) Hong Kong"	3	6	9
"(32) India"	6	9	15
"(33) Indonesia"	3	3	6
"(34) Malaysia"	3	12	15
"(35) Philippines"	12	43	55
"(36) Singapore"	0	0	0
"(37) Sri Lanka"	6	6	12
"(38) Other Countries"	27	34	61
"(39) At Sea, Inadequately Described"	0	0	0
"(40) Not stated"	537	558	1095
"Total"	18812	18879	37691

Table: Language (20 groups): English, etc, Persons - Numbers Census 1996

	Persons Spoke English vry well or well Numbers	Persons Spoke English not well /at all Numbers	Persons Spoke English only & use n/a Numbers	Persons Total Numbers
"English"	0	0	36258	36258
"Australian Indigenous languages"	9	0	0	9
"Italian"	39	3	3	45
"Greek"	30	6	0	36
"Cantonese"	6	3	3	12
"Arabic (incl Lebanese)"	6	0	3	9
"Vietnamese"	3	0	0	3
"German"	89	3	6	98
"Mandarin"	9	3	3	15
"Spanish"	0	3	0	3
"Macedonian"	3	0	0	3
"Tagalog (Filipino)"	15	0	0	15
"Croatian"	9	3	0	12
"Polish"	12	3	0	15
"Turkish"	3	0	0	3
"Other Chinese languages "	0	3	0	3
"Other European languages"	160	12	0	172
"Other Asian languages"	33	3	0	36
"Other languages"	30	0	0	30
"Not stated, or Not Applicable"	77	6	841	924
"Total"	533	51	37117	37701

Appendix 3.1R

Southern Grampians Glenelg Primary Care Partnership

Access to Health and Community Services for People with Disabilities

Project Methodology

Aim:

To carry out a qualitative project to identify the specific issues faced by people with disabilities in accessing the primary care system.

Activities:

Through contact with agencies and groups who currently provide specific services for those with a disability.

1. Check service details are correct (use SWAN directory, Carelink database and the developing Community Services Directory as starting point)
2. Add or update any additional information in accordance with the fields required by the Department of Human Services BATS project.
3. Collect anecdotal and qualitative data on the current situation: barriers

   to access, key services not provided, best practice examples, options

   for partnership arrangements and/or project responses.
4. Develop an "access checklist" for people with physical, psychiatric, intellectual and other disabilities for primary care system and community service agencies to consider;
5. Develop project, research or other options aimed at improving access to services for those with a disability, in response to issues raised.

METHODOLOGY

Variables:

In order to provide a representative cross section of the demographic, the following variables will be taken in account:

?? Nature of disability: mental illness/psychiatric, intellectual/developmental, sensory, physical;

?? Age Group;

?? Location and delivery area of service including regional and rural/isolated services.

Cohort:

Rounds of face to face interviews will be held across these variables with:

?? Health Service users with a disability themselves – where this is feasible and/or in conjunction with other service user consultations (Eg. Rural Mental Health Consultations undertaken by VMIAC (May) HAAC consultations being undertaken by South West Healthcare (June – July), Rural Health Line consultations – June/July)

?? Regional advocacy and support services for people with disabilities;

- People with a disability
- Disability service providers;
- Carers of people with a disability;

Each round of interviews undertaken will be drawn from across the demographic and the cohort.

Control group:

Macarthur – technically outside the region this service combines services in mental health, aged care, disability, maternal and child health in a rural/isolated context across all age groups. The service also has many practice examples to inform both this project and the Better Access to Services aspects of the Community Health Plan.

Timeframe:

Each round of interviews will contain a representative sample of the cohort and the variables. A comprehensive report will be available at the end of each month detailing current programs and services offered by each provider, key contact people in the organization, the issues or barriers raised, examples of best practice, possible project options, and strategies for improving services across the Southern Grampians Glenelg region for the consideration of the PCP.

Jill Warne

May 2001

Appendix 3.1S

SOUTH WEST SUB REGION ACTION MAP

Mapping the preferred future of respite provision

JULY 2001 to JUNE 2004

This document describes activities developed during the Barwon South Western Respite Service Development Project. The South West Respite Network is responsible for identifying the priority projects and initiating the actions outlined. The purpose of both the Network and this Action Map is to support the efforts of agencies in the South West to continuously improve the accessibility, diversity and quality of respite services.

Contents:

Projects:	*Page #:*	*Commenced:*	*Completed:*
Best Ever Carer Consultation	1.		
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Marketing Strategies	7.		
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This documents is one component of the *Direction Statement* – a strategic plan for the development and co-ordination of respite services in the Barwon South Western Region for the period July 2001 to June 2004.

PROJECT TITLE:

BEST EVER CARER CONSULTATION

BACKGROUND:
Consulting with carers is an important stage in the process of planning for respite services. Sound consultation with carers provides planners and service delivery agencies with valuable information regarding unmet needs, quality of services and new ways of delivering services. The Network is concerned that undertaking sound carer consultation is surprisingly complex and that poorly conceived consultation will fail to provide useful information and frustrate carers, who have given their time in the hope that their situation would improve.

PROJECT OBJECTIVE:
The objective of this project is to publish a document that highlights the key elements of sound carer consultation by developing a list of 'dos' and 'don'ts' that can be used by any agency when consulting with carers.

PROCESS:
1. Identify a small group of network members with experience in carer consultation
2. Group to seek advice from peak bodies regarding previous publications on this topic – refer to the Primary Care Partnerships documents - "Consumer / Carer / Community Participation Strategy"
3. Group to review previous / recent consultations and discuss / document strengths and weaknesses of these activities
4. Group to publish a draft discussion paper on the intranet for all network members
5. Group to present / discuss / alter / refine the discussion paper at a full network meeting
6. Group to publish the final paper and distribute to all key agencies
7. Group to distribute the paper to other respite forums / networks in the State
8. Group to identify at least four forums and present the paper to each forum.

ANTICIPATED OUTCOME:
The publication of a practical guide that will improve the carer consultation processes by local agencies within the sub region, whist providing widely accepted guidelines when external groups seek to conduct carer consultation in the sub region.

TIMELINES:

1.	Identify group	
2.	Seek previous / other publications	
3.	Review other publications and processes	
4.	Publish draft	
5.	Discuss at full network meeting	
6.	Publish final paper	
7.	Complete distribution to other networks	
8.	Complete presentations to other forums	

GROUP MEMBERSHIP:

NAME:	*AGENCY:*
	(Convenor)

TITLE:

CENTRALISED INTAKE SYSTEMS

BACKGROUND:
At present there are three services in the South West that perform some of the functions of centralised intake for respite, usually through a '1800' phone number. The idea of these services is to ensure that members of the community are not given the 'run around'. Centralised systems are also helpful to generic agencies seeking to make effective referrals. This project involves exploring some of the principles and aspirations of centralised systems and to look for positive linkages between the existing centralised intake systems.

PROJECT OBJECTIVE:
The objective of this project is to complete and document a planning process that will make best use of the resources that are available for centralised intake for respite.

PROCESS:
1. Identify a small group of network members (including those people from the three systems involved) with a broad understanding and a range of perspectives on centralised intake systems
2. Group to compare the aspirations, strengths and constraints of the existing three 1800 phone number centralised intake systems – group to seek clear commonalities and differences
3. Group to develop a broad discussion paper, including recommendations for future development / enhancement of centralised intake
4. Group to present this paper to the whole network with a view to developing a clear network position and a future focussed direction
5. Group to implement strategies and activities determined by the network.

ANTICIPATED OUTCOME:
A number of outcomes relating to centralised intake are possible, depending on the findings of the group – the most desirable outcome is that this project develops the strongest, most logical links between services.

TIMELINES:

1.	Identify group members	
2.	Compare existing services	
3.	Publish a discussion paper for the network	
4.	Network discussion / consideration	
5.	Implementation process to begin	
6.	Implementation process to be completed	

GROUP MEMBERSHIP:

NAME:	*AGENCY:*
	(Convenor)

TITLE:

THE INITIATIVE BANK

BACKGROUND:
A wide range of agencies and a diverse group of workers deliver respite. There are times when ‘some one’ has a ‘brainwave’ about a great way to expand or refine the available services. All too often these ‘brainwaves’ amount to nothing because there has been no mechanism to capture, consider and act on really great ideas. An Initiative Bank would provide a focal point for creativity and fresh thinking.

PROJECT OBJECTIVE:
The objective of this process is to initiate and widely promote a mechanism to capture the great ideas of workers that will improve services and accessibility and to convert these ideas into new forms of thinking and operating.

PROCESS:
1. Identify a small group of network members willing to design and conduct the project
2. Group to develop an Initiative Bank Kit – a document that outlines the purpose of the Initiative Bank and has lots of blank spaces for people to scribble down good ideas
3. Group to promote and convene a forum (perhaps tying in with a network meeting or another meeting where a large group of workers come together) – the forum would involve asking workers to discuss and ‘sell’ their ideas to the forum
4. Group to collate ideas from the forum and publish a simple document outlining initiatives
5. Group to present document to the whole network for consideration – network to consider the action required to convert the ideas to action
6. Group and network to support agencies willing to pick up ideas from the Initiative Bank
7. Group to report outcomes and activities over time
8. Review, evaluate and, if viable, repeat the process in 2 years time.

ANTICIPATED OUTCOME:
Fresh approaches to improving the accessibility, quality and availability of a broad range of respite services in the sub region.

TIMELINES:

1.	Identify small group	
2.	Develop a simple kit	
3.	Promote and conduct a forum	
4.	Collate ideas into a brief document	
5.	Present ideas to network	
6.	Support initiatives in early stages	
7.	Report on outcomes	
8.	Review, evaluate	
9.	Repeat the process, if successful	

GROUP MEMBERSHIP:

NAME:	*AGENCY:*
	(Convenor)

TITLE:

CARER SUPPORT GROUPS

BACKGROUND:
Carer support groups are widely regarded as a sound means for links to develop between people with a common interest and / or need. It is also understood that carer support groups will come and go, according to the needs and social dynamics of the people involved. This project involves considering new ways for carer support groups to thrive and extend their activities to meet the diverse needs of carers.

PROJECT OBJECTIVE:
The objective of this project is to examine the structures and dynamics of carer support groups and to implement strategies that broaden the possible range of activities that any carer support group can undertake.

PROCESS:
1. Identify a small group of network members with a role in assisting carer support groups – consider recruiting workers from non respite agencies who may have a health / community development role
2. Group to map the existing carer support groups, resources involved in maintaining these groups and their strengths and weaknesses.
3. Group to consult with a number of carer support groups to establish the key issues
4. Group to publish and present a document outlining the issues / ideas and options to the whole network
5. Network to determine a course of action that would best build on the strengths of carer support groups, within existing / available resources
6. Group to conduct a series of activities that will create opportunities for improved carer support groups
7. Group to report back to whole network on the success of activities.

ANTICIPATED OUTCOME:
Improved carer support groups across the sub region that create opportunities for improved information, support and activities.

TIMELINES:

1.	Identify a small group	
2.	Map existing groups and issues	
3.	Consult with groups	
4.	Publish and present a paper	
5.	Network develops course of action	
6.	Group conducts activities	
7.	Report back to whole network.	

GROUP MEMBERSHIP:

NAME:	*AGENCY:*
	(Convenor)

TITLE:

STAFF TRAINING

BACKGROUND:
Respite is delivered in a broad range of formats by a diverse range of agencies. Training for individual direct service delivery staff is a matter addressed by every agency. This project is about considering the common issues regarding training across all agencies. The network is seeking to enhance relationships with training providers that will best meet the training needs of workers. Sharing the responsibility for training will reduce costs to agencies, increase opportunities for cross agency familiarisation and establish a generic training 'base line'.

PROJECT OBJECTIVE:
The objective of this project is to improve the availability and breadth of training to workers by pooling training resources and developing enhanced relationships with training providers.

PROCESS:
1. Identify a small group of network members with a responsibility for training – identify key contacts within the training provider sector
2. Group to identify the agencies with the best structures and systems for training and compare these with the range of training responses
3. Group to prepare and publish a plan to share the responsibility for training
4. Group to present the plan to the network and seek broad agreement to a structured approach to training – network to identify the resources and processes to activate the system
5. Group to gather the resources and systems to initiate the process and implement trial shared training events
6. Group to evaluate and report back to network.

ANTICIPATED OUTCOME:
Improved levels of training across agencies and improved use of training resources.

TIMELINES:

1.	Identify group and training providers	
2.	Identify sound structures and systems	
3.	Prepare and publish a plan for the network	
4.	Present plan to network and identify resources	
5.	Gather resources and initiate trial processes	
6.	Evaluate and report to network.	

GROUP MEMBERSHIP:

NAME:	*AGENCY:*
	(Convenor)

TITLE:

RECOGNISING SERVICE DELIVERY STAFF

BACKGROUND:
Respite service delivery staff have a challenging job maintaining a focus on individual need, the broad range of family / social issues involved and the demands of making the best use of time and resources. The network feels that the diverse (often part time) service delivery workforce should be recognised for the important role provided. This project involves conducting a one off 'celebrate and pamper' event to be attended by workers from a broad range of agencies. The event would involve sharing stories and ideas as well as social interaction.

PROJECT OBJECTIVE:
The objective of this project is to conduct a one off event that will celebrate the achievements of direct service delivery staff.

PROCESS:
1. Identify a small group of network members who have the capacity to plan and conduct the event
2. Group to identify the agencies to be included in the event and to approach all agencies seeking support and endorsement of the idea
3. Group to plan, promote and conduct the event
4. Group to evaluate the event and report back to the network
5. Network to consider other means by which staff can be supported and recognised.

ANTICIPATED OUTCOME:
A positive and engaging celebration of the challenges and joys of working in respite services.

TIMELINES:

1.	Identify the small group	
2.	Group to identify the agencies to be involved	
3.	Group to plan, promote and conduct the event	
4.	Group to present an evaluation to network	
5.	Network to consider other forms of support.	

GROUP MEMBERSHIP:

NAME:	*AGENCY:*
	(Convenor)

TITLE:

MARKETING STRATEGIES

BACKGROUND:
The so-called ‘marketing’ of respite presents a dilemma. On the one hand agencies would like to encourage carers to understand the benefits of respite and access services… on the other hand marketing respite may increase waiting lists and frustrate demand for services. This project involves identifying groups in the community who have the most limited understanding of the benefits of respite. Once these groups are identified the project would involve ‘tailor making’ small scale marketing projects to improve an understanding of both the knowledge of services and the benefits of respite.

PROJECT OBJECTIVE:
The objective of this project is to develop and conduct sophisticated marketing activities that target key groups such as situations involving age related care, mental health issues and the presence of dementia.

PROCESS:
1. Network to determine one key target group – most at risk of ‘missing out’ on existing information and marketing strategies
2. Identify a small group of members from within the network with a detailed understanding of the needs of the identified group and the current / previous marketing processes in the region
3. Group to identify a series of marketing activities and produce a plan including documented alternative strategies
4. Group to present plan to whole network for support
5. Group to conduct marketing strategies
6. Group to evaluate strategies and present a report back to the network
7. Network to consider the effectiveness of the process and decide on the need to develop further marketing activities with other target groups.

ANTICIPATED OUTCOME:
Improved marketing of both the availability and benefits of respite to particularly disadvantaged groups.

TIMELINES:

1.	Network determines a priority target population	
2.	Identify small group of network members	
3.	Group to develop a plan	
4.	Group to present plan to network for support	
5.	Group to conduct activities	
6.	Group to evaluate activities and reports	
7.	Network to make further plans.	

GROUP MEMBERSHIP:

NAME:	*AGENCY:*
	(Convenor)

TITLE:

IMPROVED INFORMATION FLOW

BACKGROUND:
The provision of information regarding the availability of respite services to both generic service providers and carers is a complex task that involves considering the broad range of information needs. This project involves 'mapping' the current range of information services available to key groups (general practitioners, district health staff and carers), drawing together information and developing new forms of information to meet specific needs.

PROJECT OBJECTIVE:
The objective of this project is to structure a series of activities that will improve information to specific groups and link with the Primary Care Partnerships "Service Information Strategy".

PROCESS:
1. Identify a small group of network members with a role in information provision
2. Group to map existing information processes and resources and develop a matrix outlining the suitability of each strategy to the needs of specific groups
3. Group to publish a draft plan outlining a series of information projects that can be implemented over an extended period
4. Group to present plan to the network
5. Group to support those agencies with a responsibility to conduct information projects
6. Group to evaluate responses to the information and prepare a report to the network
7. Group to provide feedback to the network, with recommendations for further activities
8. Network to identify subsequent plans.

ANTICIPATED OUTCOME:
Improved flow of targeted information.

TIMELINES:

1.	Identify small group of network members	
2.	Group to map existing processes and evaluate	
3.	Group to prepare long term plan	
4.	Group to present plan to network	
5.	Agencies to conduct activities	
6.	Group to evaluate and prepare report	
7.	Group to present report	
8.	Network to identify subsequent projects.	

GROUP MEMBERSHIP:

NAME:	*AGENCY:*
	(Convenor)

TITLE:

POSITIVE MEDIA ON CARING

BACKGROUND:
Usage of the media to promote the benefits of respite is limited for good reason. Any widespread media regarding services would create additional demand for services, which could not be satisfied. Media regarding the role of caring however, could play a useful role in the strengthening of positive community attitudes to caring. Some research indicates that carers would like to be more positively recognised for the role. This project involves exploring new ways to support and recognise carers by developing a quiet, positive media profile behind the role of caring. A media profile may include messages regarding the value of caring, the diversity of caring roles, support groups in the region and the role of the broader community in recognising the vital function of carers.

PROJECT OBJECTIVE:
The objective of this project is to establish a media profile around the themes of caring.

PROCESS:
1. Identify a group of network members with media skills and contacts
2. Group to consult with carers regarding possible advantages of the proposed media profile
3. Group to develop a long term media plan that would ensure that positive messages regarding caring are projected across media outlets within the South West
4. Group to present plan to network for support
5. Group to support agencies with an identified direct role in the promotion of caring
6. Group to report back to the network on the process and outcomes
7. Network to determine subsequent plans.

ANTICIPATED OUTCOME:
A positive media profile regarding the role of caring.

TIMELINES:

1.	Identify the group of network members	
2.	Consult with carers regarding the project	
3.	Group to prepare a long term plan	
4.	Group to present plan to network for support	
5.	Group to support agencies involved	
6.	Group to evaluate and report back to network	
7.	Network to identify subsequent plans.	

GROUP MEMBERSHIP:

NAME:	*AGENCY:*
	(Convenor)

TITLE:

TOOLS FOR QUALITY

BACKGROUND:
The diversity of respite services is both a strength and a weakness. The strength of diversity arises from the broad range of services that are available. The weakness inherent in diversity is the difficulty encountered by agencies when considering issues of quality. This project involves exploring the quality related tools that are available and adapting these to form a generic quality tool to be applied by all network agencies. Establishing and implementing a quality tool would:

- assist agencies to become more familiar with the broad range of services
- entrench shared principles of quality across the sub region
- ensure a minimum quality level of provision across the sub region
- pin point quality related projects for network consideration.

PROJECT OBJECTIVE:
The objective of this project is to identify a shared, generic quality related tool that could be used by all agencies.

PROCESS:
1. Identify a small group of network members with an interest and track record in quality assurance processes
2. Group to map application of quality tools across the region and other respite networks and identify the best elements of available tools
3. Group to draft a generic quality tool and present to the network for support
4. Group to trial the quality tool within a small number of agencies and refine where required
5. Group to publish a final version of the quality tool and present to the network
6. Network to identify at least three forums / networks and present the tool as a working model.

ANTICIPATED OUTCOME:
Improved quality of services via the application of a generic quality tool adapted for local agencies.

TIMELINES:

1.	Identify small group of network members	
2.	Group to map existing tools	
3.	Group to draft materials and present to network	
4.	Group to trial the tool	
5.	Group to present final tool to network	
6.	Network to promote tool to other networks.	

GROUP MEMBERSHIP:

NAME:	*AGENCY:*
	(Convenor)

TITLE:

RESOURCE POOLING AND SHARING

BACKGROUND:
Many reviews of respite have highlighted a fragmentation of funding. This issue has been canvassed effectively at a macro level but there has never been a structured, local approach to facilitating the sharing of resources. This project involves bringing local agencies together to swap ideas about sharing resources across geographical boundaries and respite target groups.

PROJECT OBJECTIVE:
The objective of this project is to create and formalise sharing structures that enable services to be delivered more effectively.

PROCESS:
1. Identify a small group of members willing to support a planning process around resource sharing
2. Group to consider the information available in the strategic plan – *Direction Statement*, regarding the distribution of services across the sub region
3. Group to facilitate forums and discussion around the sharing of resources within and across agencies, so-called silos and geographical boundaries
4. Group to present ideas for resources sharing, in draft form to the whole network for discussion and, if viable, expression of support
5. Group to assist agencies directly involved in resource sharing arrangements to formalise proposals prior to approaches of support being made to funding bodies – agencies directly involved would be responsible for formalising resource sharing arrangements
6. Group to report back to whole network.

ANTICIPATED OUTCOME:
New service provision configurations based on well constructed resource sharing arrangements.

TIMELINES:

1.	Identify small group	
2.	Group to collect information	
3.	Group to facilitate a series of forums and activities	
4.	Group to present ideas to network	
5.	Group to provide assistance to agencies	
6.	Group to report back to network.	

GROUP MEMBERSHIP:

NAME:	*AGENCY:*
	(Convenor)

TITLE:

CONNECTING WITH OTHER SECTORS

BACKGROUND:
The diversity of respite options has been a talking point within the development of this Action Map. The network has chosen to initiate mutually beneficial links with other sectors as a means of expanding respite / carer support options in the sub region. Creating connections with providers of recreation, education and employment services may support the development of completely new forms of respite – based on supporting friendships, social interaction and constructive engagement with the community.

PROJECT OBJECTIVE:
The objective of this project is to initiate and follow up contact with other sectors (recreation, education and employment) with a view to investigating, trialing, conducting and evaluating new forms of respite / carer support.

PROCESS:
1. Identify a small group of network members with key contacts in other sectors across the region
2. Group to prepare a list of possible contacts and to sort these contacts into priority order
3. Group members to initiate discussion with key contacts and report back to the network
4. Group to publish a brief paper outlining a broad range of options and present this to the network
5. Network members to initiate trial activities, evaluate outcomes and report back to the network
6. Network to support initiatives and consider further plans for interaction.

ANTICIPATED OUTCOME:
The development of new forms of respite / carer support delivered in partnership with a other sectors across the sub region.

TIMELINES:

1.	Group identified	
2.	Group to develop list of contacts	
3.	Group members to make individual contact	
4.	Group to present options paper	
5.	Members / agencies to act and evaluate outcomes	
6.	Network to consider outcomes and make plans.	

GROUP MEMBERSHIP:

NAME:	*AGENCY:*
	(Convenor)

TITLE:

MEETING CRISIS CARE NEEDS

BACKGROUND:
The network has identified that some groups within the broad target community are more inclined to present with crisis care needs than other groups. Situations affected by the presence of dementia, mental health issues and adolescence are more likely to reach some form of crisis than other groups. This project involves choosing one of these 'target groups' and becoming more familiar with the particular crisis care respite needs within that group. By exploring one group in detail it is hoped that valuable learning will assist the whole network to better co-ordinate and provide crisis care.

PROJECT OBJECTIVE:
The objective of this project is to improve the direct response to the need for crisis care by thoroughly understanding the crisis care needs of one 'target group'.

PROCESS:
1. Network to choose one 'target group' for initial consideration
2. Network to identify a small group of members with a clear connection to the target group in question
3. Group to develop information collecting processes to study the crisis care needs of the target group
4. Group to consider any data and other information available and present this to the whole network, with recommendations for further action
5. Network to consider recommendations and support the group to implement trial activities and structures
6. Group to evaluate outcomes and report back to the network
7. Network to develop long term plans to address crisis care needs.

.
ANTICIPATED OUTCOME:
Improve responses to crisis care needs.

TIMELINES:

1.	Network to identify 'target group'	
2.	Identify small group of network members	
3.	Group to collect information	
4.	Group to present information and options to network	
5.	Network to support group to implement activities	
6.	Group to evaluate outcomes	
7.	Network to consider long term plans.	

GROUP MEMBERSHIP:

NAME:	*AGENCY:*
	(Convenor)

TITLE:

CARER PARTICIPATION

BACKGROUND:
There are sound models carer and consumer participation in agencies across the South West. This project is about exploring the key attributes of carer / consumer participation and supporting agencies to develop, implement and evaluate participation strategies that work. The Primary Care Partnership is developing a broad 'Consumer, Carer and Community Participation Strategy", which will be a useful resource for this project.

PROJECT OBJECTIVE:
The objective of this project is to focus on new opportunities to increase the breadth of scope for participation in planning and governance by carers.

PROCESS:
1. Network to identify a small group of members with an interest in carer participation
2. Group to consider existing models in agencies, the Primary Care Partnership Strategy and models from other regions
3. Group to publish a discussion paper relating to the broad principles of participation
4. Group to convene a forum on the topic, with illustrations of the principles, existing models and further opportunities
5. Network to identify and support initiatives at an agency and cross agency level
6. Group to refine discussion paper and present the paper to at least three forums / networks outside of the region.

.
ANTICIPATED OUTCOME:
Initiatives that will develop, implement and evaluate new strategies to increase the level and effectiveness of carer / consumer participation in planning and governance.

TIMELINES:

1.	Network to identify a small group of members	
2.	Group to investigate models and strategies	
3.	Group to publish a discussion paper	
4.	Group to convene a forum	
5.	Network to support initiatives	
6.	Group to refine paper and present to other forums	

GROUP MEMBERSHIP:

NAME:	*AGENCY:*
	(Convenor)

TITLE:

ACTION MAP AND NETWORK EVALUATION

BACKGROUND:
This Action Map was developed in May 2001 for the period to June 2004. The purpose of the Action Map is to ensure that activities that enhance the co-ordination of respite services take place. The purpose of this project is to ensure that a sound evaluation process informs future planning. It is intended to evaluate the effectiveness of both the Action Map and the operation of the Network. The evaluation will involve:

- ?? Identifying all of the completed projects from the Action Map
- ?? Considering the operational effectiveness of the network
- ?? Developing a process to ensure that an Action Map for the period July 2004 to June 2007 is developed and published by the network
- ?? Develop a process to ensure that all documentation regarding the operation of the network is updated in keeping with the operational review of the network.

It is also assumed that the Department of Human Services will evaluate the effectiveness of the Network structure early in 2004.

PROJECT OBJECTIVE:
The objective of this project is to constructively reflect on the achievements of the network for the period 2001 to 2004 and to develop a further three year vision and plan that will ensure additional co-ordination projects continuously improve respite services.

PROCESS:
1. Network to identify a small group of members from a wide range of agencies to conduct the evaluation process
2. Small group to collect information regarding the outcomes of the Action Map 2001 / 4 and the operation of the network
3. Group to seek feedback from members, other sectors and funding bodies regarding the preferred future of the network and elements of a possible action plan
4. Group to facilitate two forums of all network members to ensure that the evaluation process is both thorough and inclusive
5. Network to publish an Action Map July 2004 to June 2007 and network documentation and provide this documentation to the Department of Human Services.

ANTICIPATED OUTCOME:
An updated Action Map (2004 to 2007) and revised / updated networking documentation.

TIMELINES:

1.	Identify a small group of members	February 2004
2.	Group to collect information	
3.	Group to seek further feedback	
4.	Group to facilitate two forums	March / April 2004
5.	Network to publish revised documentation.	April 2004

GROUP MEMBERSHIP:

NAME:	*AGENCY:*
	(Convenor)

Thursday , 28 June 2001

COMBINED SOUTH WEST and SOUTHERN GRAMPIANS/GLENELG PCP INTEGRATED DISEASE MANAGEMENT PROPOSAL

ASTHMA MANAGEMENT PROPOSAL for SOUTH WEST VICTORIA

Introduction

Asthma has been identified as a National Health Priority area and there is high potential for improved management to improve outcomes. The proposed program has been developed in line with the National Asthma Strategy Implementation Plan with a particular emphasis on its application to a rural region and will develop a skilled workforce in both the acute and community sectors and effective links with General Practitioners and pharmacists. The establishment of outreach asthma clinics throughout South West Victoria will improve consumer access to best practice asthma management.

A **diabetes** management proposal has also been developed by the South West PCP and the two proposals will form a single integrated disease management proposal for rural South West Victoria.

Catchment

This proposal will cover South West Victoria (the Shires of Southern Grampians, Glenelg, Moyne, Corangamite and City of Warrnambool). This takes in two PCP districts, the South West and the Southern Grampians/Glenelg.

Summary of Proposal

The hypothesis is that an integrated, coordinated and multidisciplinary approach to the management of asthma will deliver improved care for consumers with a decrease in the need for hospital and emergency care and a reduction in mortality and morbidity from asthma.

The goals of the integrated disease management approach are to:

1. ensure that those without asthma and who do not have a tendency to asthma remain so through general awareness of potentially harmful environments – primary prevention.
2. ensure that those without clinical asthma but who have the potential to do so do not develop the disease – secondary prevention.
3. reduce ill health among those who have clinical asthma – tertiary prevention.

Asthma Educators will be appointed around the region to work with GPs and health/community services and community pharmacists to develop integrated asthma care processes in the community through clinics established in a minimum of ten towns throughout the region. Priority will be given to people with moderate to severe persistent asthma. Consumer consultation will allow clinics to be targeted to meet specific needs; this may be culture (eg for Koori communities) or time (eg evening clinics for school children and working patients).

An increased number of health professionals within acute, emergency and community services will complete an accredited asthma education course, supported by their agencies, and will provide a skilled resource to complement the work of the asthma clinics. Such trained health professionals will also receive practical experience within the asthma clinics under the supervision of the appointed Asthma Educators.

A Coordinator will manage the project, linking with the PCP objectives of Better Access to Services, effective use of information technology, facilitating communication between service providers and achieving consensus as to best practice guidelines and their implementation and consumer consultation. Brokerage funding (client centred) will purchase resources or specialist services that would otherwise be unavailable, based on specific client need.

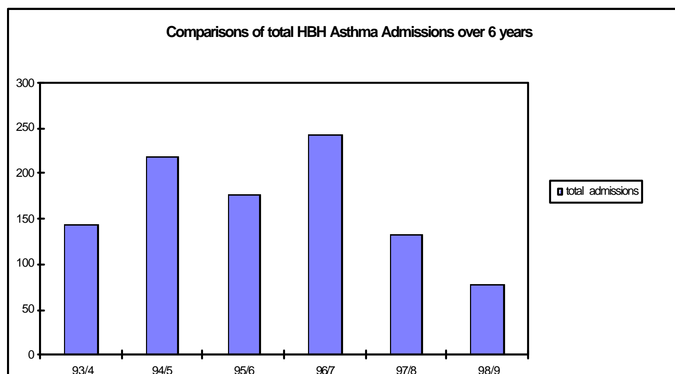
A specific focus of the first year of the project will be to work with acute and emergency services to develop protocols for appropriate interventions and facilitate successful recruitment of patients to the project. The asthma project will work with agencies to develop protocols for the successful liaison between acute and community services. Following years will focus more intensively on the community management of asthma.

Asthma in the South West

In the Barwon South Western region (1989/90 data) asthma occurs in 10.4% of males and 5.8% of females and is the leading reason for childhood admission to hospital. Admission rates in rural Victoria have been consistently higher than in metropolitan regions (1993 Separation data).

The geographical area of the Southern Grampians/Glenelg is 13,000 sq kms, with a population of 37,064. The South West PCP district has a population of approximately 59,000. At 1 in 4 children, 1 in 7 adolescents and 1 in 10 adults, there are an estimated total of 12,000 people with asthma. The number increases when other respiratory illnesses such as chronic obstructive airways disease and bronchiectasis (which are treated identically), are added to the total figure.

Information from questionnaires distributed to patients involved in the Otway Division of General Practice Shared Care in Asthma Education Project (1997/98) revealed alarming statistics in the total management of asthma and the need for continuing coordinated management of this chronic illness in the community. Findings included that 59% of clients have poor inhaler technique, that 50% are non-compliant with preventer medication and that 51% have never discussed emergency management with their doctor. Only 11% of people with asthma have a written management plan, although 69% are identified as high risk.



Admissions to Western District Health Service have shown a significant decrease in the last two years with the involvement of an asthma educator.

Target Group

Priority will be given to patients with moderate to severe persistent asthma and specifically those where adherence to treatment programs is problematic. A minimum of 500 patients will be recruited with at least 50% with moderate to severe persistent asthma.

Patients will be recruited via GPs and hospitals; self-referral to the program will also be available. A register of patients enrolled with the asthma management program will be maintained to allow monitoring of interventions provided and outcomes. Informed consent will be obtained from enrolled patients to allow sharing of information between service providers to facilitate coordinated care.

A stratified approach will be developed to:

1. Identify the clients and assign them to risk/need categories
2. Intervene using agreed (best practice where developed) guidelines.
3. Monitor the results using objective measurements. This will feed back into the intervention program so that improvements are continuous.

Roles and Responsibilities of Key Service Providers

Otway Division of General Practitioners

- Chair the PCP Asthma Reference Group
- Development of endorsed best practice guidelines for asthma management in general practice and hospital setting
- Education of General Practitioners

General Practitioners

- Primary care provider, care coordinator
- Refer patients to the asthma clinics/education program
- Participation in the establishment and provision of asthma clinics
- Use best practice guidelines in practice

Acute services

- Refer patients to the asthma management program
- Develop protocols for the involvement of PHACS asthma educators in discharge planning, Accident and Emergency Departments
- Implement best practice protocols for the management of patients with acute asthma attacks in A&E and as in-patients
- Encourage and support appropriate staff to participate in asthma education training
- Incorporate best practice asthma clinical pathways into protocols developed for coordinated care, post-acute care and effective discharge planning and provide education to all staff
- Evaluation of patient care, outcomes and indicators
- Provision of accommodation, administration support and vehicle access for PCP Asthma Educators

Primary care services

- Refer patients to the asthma management program
- Provide resources (consulting space, transport, etc) and develop protocols to facilitate the involvement of the PCP asthma educators in the coordinated care of their patients
- Encourage and support appropriate staff to participate in asthma education training
- Evaluation of patient care, outcomes and indicators
- Provision of accommodation, administration support and vehicle access for PCP Asthma Educators

Pharmacists:

acute sector and community providers

- Contribute to asthma management through participation in asthma clinics and multidisciplinary teams
- Work within the National Guidelines to achieve the continuum of quality use of medicines in a rural area and between the hospital and community (Australian Pharmacy Advisory Council)
- Refer patients to the Asthma Management Program.
- Provide an access point for educational material
- Promote the work of the Asthma Educators and the Asthma Management program in the community

Allied health professionals

- Member of the asthma care team as appropriate
- Provision of specialist services on assessed need through a brokerage system

Statewide Agencies as Collaborative Partners

Collaborative work with statewide agencies will include:

- establishing access to specialist services for patients with complex medical needs, including establishing video links to reduce travel;
- accessing distance and interactive education to increase the numbers of trained asthma educators in the district;
- community education

Linkages will be established with:

- Specialist treatment centres such as the Alfred Hospital and Royal Children's Hospital.
- The Lung Health Promotion Centre at the Alfred responsible for the training of Asthma Educators through a 3-day course.
- Asthma Victoria produces patient and family information materials that are essential components of education programs. They are also responsible for the training of teachers, childcare workers, sporting club officials and other community groups who may be faced with providing bronchodilators or emergency first aid to a person with asthma.
- Pharmaceutical Society of Australia and individual pharmacists.
- Other key stakeholders as identified.

All agencies above will be invited to be members of the Steering Committee overseeing the implementation of the program.

Operational Model

A ***Reference Group*** will be formed to manage the Asthma Integrated Disease Management Project with representation from primary care agencies of South West Victoria. A representative of the Otway Division of General Practice will be invited to Chair the Reference Group, which will oversee the project and monitor progress and achievement of goals.

The Reference Group will call upon the expertise of local agencies, health professionals, State and National organisations as appropriate. Working parties of appropriate expertise will be formed to address specific tasks of the project.

The Reference Group will report to the Executive Committee of the Southern Grampians/Glenelg PCP who are responsible for financial management through the Western District Health Service.

A ***Coordinator*** (0.5 EFT) will be appointed to achieve the goals of the project. The Coordinator will have demonstrated skills in clinical practice and the development of policy and protocols in a clinical setting.

Asthma Educators (3 or 4 positions up to 1.5 EFT in total) will be employed around the South West to work in collaboration with GPs, pharmacists, health and community agencies and other health professionals to facilitate improved asthma management to establish asthma clinics in appropriate locations.

A ***Combined Steering Committee*** will be established by South West and the Southern Grampians/Glenelg PCP to manage the total Integrated Disease Management Proposal (asthma and diabetes components)

Data Collection and Program Evaluation

Recruitment of patients to the Asthma Management Program will allow monitoring of disease management and outcomes. The use of before/after measurements and quality of life indicators (*eg* use of the SF36) will allow improved analysis of the impact of programs and care plans.

Outcome goals for individuals with asthma include:

- Improved quality of life and ability to participate in activities that are routine for others.
- Decreased absences from work or school.
- Increased knowledge and ability to manage their own disease.
- Increased satisfaction with the health and community support system.

Outcome goals for the community include:

- Reduced numbers of hospital admissions and emergency situations.
- Development and use of common management protocols and increased compliance with treatment plans.
- Increased daily use of preventer medications and reduced reliance on reliever medication.
- Improved community management and support.
- Application of best practice guidelines to the management of asthma.

Evaluation of process will include:

- satisfaction of consumers with their involvement
- application of best practice guidelines
- a sustainable skilled network of service providers
- a sustainable model for the management of asthma in acute and community settings
- coordinated service delivery within the PHACS networks of South West Victoria

Specific indicators currently identified that will be used to measure performance in the South West Asthma management Program over the three year period include:

- % of general practitioners undertaking asthma education (increase)
- % of GPs using the 6-step asthma management protocols (increase)
- Number of health and community service providers undertaking an accredited asthma education program
- Number of written protocols developed and endorsed by professional groups
- Number of hospital admissions and visits to A&E throughout the district
- % of agencies and service providers using endorsed protocols (increase)
- % of patients using good inhaler techniques (increase)
- % of patients receiving written asthma management plans (increase)
- % of patients showing compliance with asthma management plans (increase)
- % of patients with productive, physically active lives (eg SF36) (increase)
- % of patients with chronic symptoms (decrease)
- % of patients using multiple delivery devices (decrease)

?? ASTHMA INTEGRATED DISEASE MANAGEMENT PROJECT for SW VICTORIA

Aim	Objective	Strategy	Intended Outcomes	Timeframe
Goal 1. Build Capacity for Implementation of the Integrated Disease Management Project.				
Establish Project Team	?? Appointment of staff to the project ?? Regular team meetings include ongoing evaluation of process ?? Establish communication processes between staff, Reference Group and clinicians	?? Andrea Sloane appointed to Coordinator position from April 30th 2001; based in Hamilton ?? Asthma Educators: Ev Thuma (0.6EFT - Hamilton); Michelle Evans (0.5EFT - Warrnambool); Una Cancian (0.2EFT - Portland) from May 1st 2001	?? Stability in staffing of project ?? Effective team work ?? Efficient communication	?? May 2001
Develop Sustainable Partnerships	?? Establish communication process with SW PCP diabetes IDM project ?? Identify the key partners in the South West Region to involve in project development and implementation ?? Involve key state wide organizations such as Asthma Victoria, Lung Health Promotion Centre, National Asthma Campaign and other services as relevant to the project. ?? Gain the support of the Otway Division of GP's ?? Gain the Support of local Pharmacists and the Pharmaceutical Society ?? Develop consumer interest to gain representation in relevant decision-making groups.	?? Consult regularly with Asthma Victoria ?? Consult regularly with Otway Division of General Practice ?? Consult with Pharmaceutical Society of Australia where appropriate ?? Meet with statewide agencies when appropriate ?? Work closely with SW Region PCP IDM Diabetes project ?? Form appropriate workgroups with relevant primary care service providers and consumers to develop project objectives and maintain initiatives within the region. ?? Involve all relevant individuals in the project at appropriate points to enable ownership and enthusiasm of project initiatives	?? Effective communication and contribution to statewide integrated disease management ?? Reference group and communication processes established ?? Understanding of roles and responsibilities ?? Involvement of GPs and pharmacists ?? Involvement of statewide stakeholders ?? Involvement of relevant partners in the project ?? Sustained partnerships over the duration of the project and beyond	?? June 2001 ?? Ongoing
Establish Local Steering Group	?? Identify key individuals to participate in project development and implementation	?? Identify relevant individuals whilst performing service mapping exercise ?? Invite participation via Delphi Questionnaire ?? Gain letters of support from PSA and Div GP's ?? Form work groups to enable special	?? Action plan endorsed by Reference Group ?? Intended outcomes reached in a timely manner ?? Active and enthusiastic involvement of Steering Group members	?? First meeting 20th of June 2001 ?? Ongoing

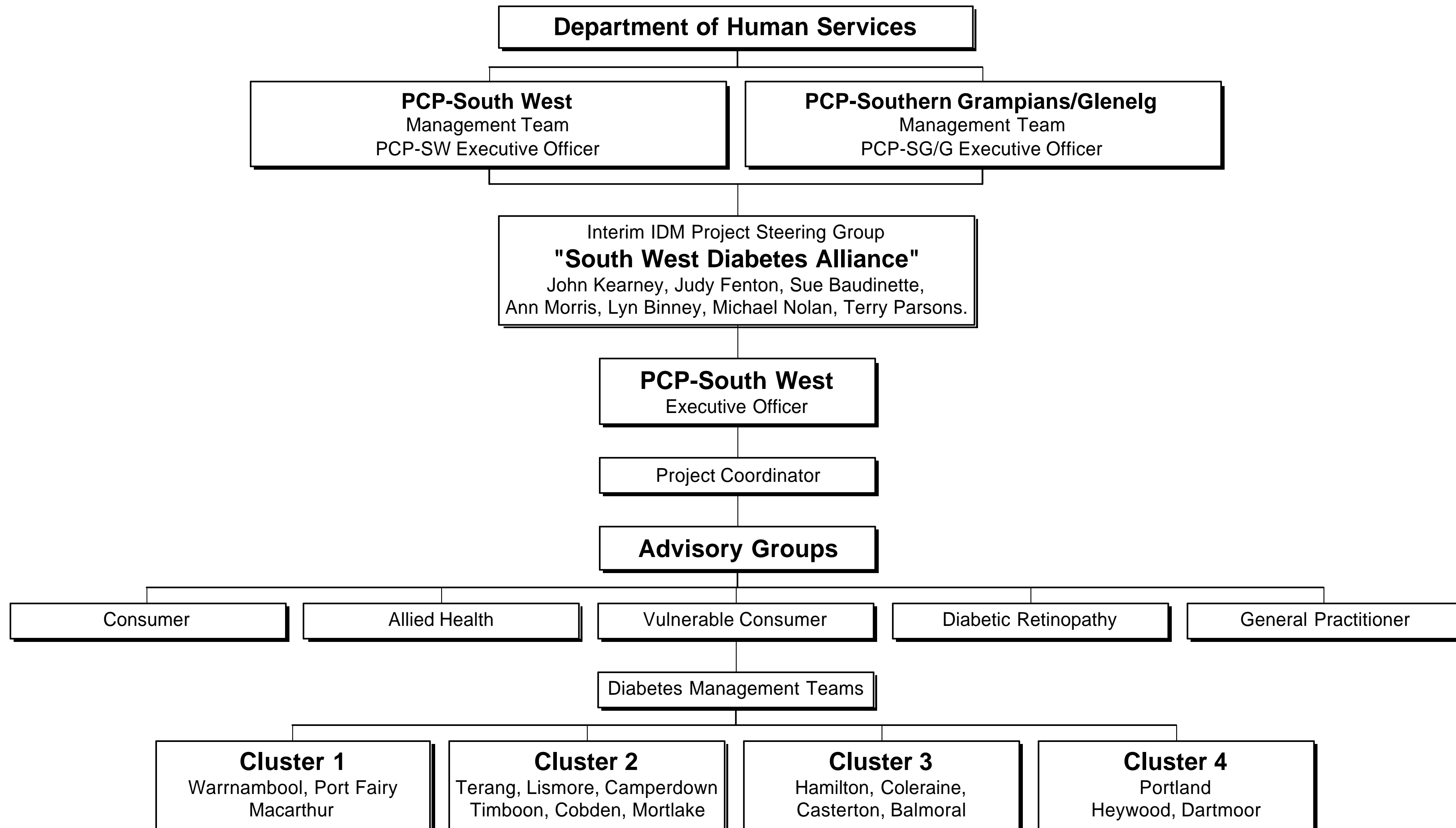
Aim	Objective	Strategy	Intended Outcomes	Timeframe
		interest and knowledge of individuals to be utilized for the benefit of the project		
Marketing of Project	?? Marketing of the Asthma IDM team and project	?? Coordinator to attend relevant Regional and state DHS meetings ?? Attend local service provider meetings, eg Division of GP's, Primary Care Nurses, ?? Promote project via relevant media and local newsletters.	?? Awareness and participation of key service providers in the asthma IDM project ?? Awareness and participation of the community in the project	?? August 2001
Identify Local Needs	?? Implement Project strategies around gaps in service provisions as identified by service providers and people with asthma and their carers.	?? Delphi Survey of Primary Care Service Providers in South West Region ?? Survey of People with Asthma in Local Pharmacies ?? Focus group consultations with people who have asthma and their carers ?? Apply local population data with morbidity and mortality stats from national statistic and Burden of Disease Data.	?? Identify perceived needs through service providers ?? Identify perceived needs through consumers ?? Attendance at focus group resulting in identification of existing and newly identified gaps in services. ?? Development of effective strategies to address needs and gaps in services	?? Delphi June 2001 ?? Consumer survey August 2001
Goal 2. Develop Better Access to Coordinated, Planned and Shared Asthma Management in South West Region				
Improve access to specialist asthma services BATS Better Access to Services	?? Increase access to information on services ?? Establish asthma management clinics (minimum of 10) across the South West staffed by Asthma Educators appointed to the IDM project. The Asthma Educators will work in collaboration with the patient's GP who will be the primary care provider. ?? Develop initial contact and risk screening protocols developed	✍ Map the existing asthma resources across the South West of Victoria ✍ Include information in service directory ✍ In consultation with the Otway Division of GP's, local health services and findings of mapping exercise set up asthma clinics to provide a service for local people ✍ Work in conjunction with GP's and Pharmacists for referrals ✍ Use existing screening protocols developed by the National Asthma Campaign.	?? Development of a visual representation of asthma services in South West Region. ?? Inclusion of all existing asthma services in directory ?? Increased services available for asthma management consultation ?? Ongoing referrals to asthma clinics from GP's and Pharmacists of existing and new clients ?? Adoption of	?? June 2001 ?? BATS ? ?? August and ongoing
Develop Clinical Pathways in Acute Settings	?? Develop clinical pathways for patients based on consensus and best practice guidelines ?? Integration of best practice guidelines into protocols and care pathways (management plans) for management at emergency, acute and community settings in a rural community	✍ Adoption of the current 6 steps for Asthma management endorsed by the National Asthma Campaign. ✍ Development of emergency department protocols for assessing and managing acute asthma	?? Hospital staff adherence to clinical pathway protocols ?? 100% of consumers referred from acute services receive follow up ?? Reduction in preventable asthma readmissions to hospital	?? Dec 2001

Aim	Objective	Strategy	Intended Outcomes	Timeframe
		✍ Involvement of health professionals and consumers in development process	?? Improved communication between acute and community sectors ?? Consumer adherence to clinical pathway	
Improve Education and resources for Health Professionals	?? Increase the number of health professionals who have completed an accredited Asthma Education program within health (including acute) and community agencies ?? Establish Respiratory Nurses Network for ongoing support and education in South West ?? Provide access to all existing useful resources on asthma and asthma management	✍ Access accredited distance education package for asthma educators ✍ Training of at least 10 asthma educators in region including staff of Koori agencies ✍ Distance education, in-service programs developed with specialist agencies, training institutions ✍ Provision of financial support to encourage uptake of specialist training	?? Increase in % of GPs who identify and manage asthma effectively ?? Increase in % of health professionals, hospitals, emergency departments and GPs who manage asthma using best practice guidelines ?? Increase in % of health professionals who are effectively trained in principles of asthma management/undertake ongoing community education ?? Increase in % of doctors and pharmacists who provide effective advice/ongoing care when prescribing/dispensing medication ??	?? January 2002
Promote Consumer Participation within the project	?? Invite interested consumers to attend relevant meetings to participate in decision making ?? Survey people with asthma and their carers to identify gaps in services and areas of need	✍ Recruit consumers via GP's and existing asthma educator contacts ✍ Advertise using local media and points of contact such as pharmacies ✍ Offer incentives such as payments, transport and acknowledgement for consumers to participate	?? Involvement of consumers in relevant groups and decision making roles ?? Program ability to adopt consumer identified service gaps ?? Consumer confidence to voice an opinion regarding services for the management of asthma	?? June 2001 and ongoing
Improve Communication Between Health Professionals	?? Identify best practice for asthma management and enable individuals with asthma to receive appropriate care and advice throughout the targeted regions	?? Adoption of appropriate software for the sharing of information between health professional	?? Improved care for people with asthma ?? Reduced morbidity and mortality	?? July 2002
Strengthen Communication between Health Professionals and people with asthma	?? Empower people with asthma to be informed about their asthma and gain the necessary information from their GP ?? Provide GP's with guidelines of best practice for the management of asthma	?? Promotion of the NAC six step asthma plan ?? Individual education via asthma clinics ?? Health Promotion Initiatives to promote communication and empowerment amongst consumers	?? Increased asthma management of people with asthma ?? Reduced morbidity and mortality within the SW region ?? Reduced emergency room utilization due to asthma exacerbations due to mis-management	?? Februar y 2002 and ongoing
Provide equitable access to medication and devices. cont..	?? Appropriate use of brokerage funding	✍ Establish guidelines for use of brokerage funding	?? Improved access to assistance for appropriate asthma management	?? Februar y 2002

Aim	Objective	Strategy	Intended Outcomes	Timeframe
Brokerage funding to assist clients to access vital resources		✍ Establish processes for use of brokerage funds ✍ Data from requests for brokerage funding will identify range of needs and barriers to access and inform future service provision ✍ Annual review of brokerage funding guidelines	?? Increased access of services by high risk groups including low-income groups ?? Increased use of flexible service responses to target highest risk consumers	
Goal 3. Identify and Reduce Risk Factors for People with Asthma				
Develop measures to advise high risk consumers/ families about risk factors	?? Identify at-risk groups ?? Develop local referral and follow-up protocols including pharmacists ?? Target priority at-risk groups, such as workplace environments .	✍ Use of information, screening tools by GPs and asthma clinics ✍ Ongoing monitoring of high-risk consumers ?? Development of appropriate Health Promotion activities in conjunction with existing programs, asthma clinics and community resources. ?? Inform local environmental organizations on the triggers of asthma to reduce likelihood of environmental allergens.	?? Prevention of acute episodes, complications and relapse ✍ Awareness amongst industry and relevant OHS workers to the risks of developing asthma due to allergen exposure ✍ Increase in number of families alerted to risk of sensitisation to allergens ✍ Increase in number of individuals informed of appropriate preventive measures	?? June 2002
Reduce asthma exacerbations due to identifiable trigger factors	✍ Increase awareness in the community of trigger factors and strategies to avoid asthma exacerbation due to exposure	?? Professional awareness of trigger factors, how to prevent and minimize them ?? Training of asthma educators and other health professionals to increase awareness of trigger factors ?? Develop links with industry and schools to improve workplace health and safety relating to asthma	?? Reduction in asthma exacerbations due to respiratory infections, allergens, additives ?? Reduction of environmental and workplace triggers ?? Reduction in risks of sensitisation to allergens and minimise disease	?? October 2002
Improve content and availability of information about asthma to consumer	?? Build on state and national media strategies to inform local consumers ?? Provide education for consumers and community on topical issues ?? Develop curriculum and policy to support good asthma management ?? Develop information resources for specific needs groups - eg disability, culturally diverse	?? Linkages with Asthma Victoria Schools program and community programs ✍ Liaise with occupational health and safety programs to target employees and reduce exposure to known risk factors ?? In-service and general education - eg school nurses to include best practice	?? Increased knowledge and ability to manage their own disease ?? Reduced emergency presentations ?? Reduced school absenteeism ?? Improved quality of information in media ?? Improved understanding of	?? March 2002 and ongoing

Aim	Objective	Strategy	Intended Outcomes	Timeframe
	groups	asthma management and prevention ?? Support initiatives of Asthma Victoria by promoting policy and curriculum change in community groups and schools.	preventer/reliever medications	
?? **Goal 4. Develop and Support Existing Early Intervention and Health Promotion Strategies**				
Support existing initiatives within the regions	?? Develop links with existing programs to support and help sustain objectives ?? Develop new health promotion initiatives that compliment existing programs	?? Waiting for service mapping to be complete (1st of June)	??	??
Adopt relative areas of the PCP Health Promotion Strategy	?? Develop objectives and intended outcomes in line with those of the PCP health promotion strategy around physical activity	?? Waiting for final draft of HP strategy 30th of June	??	??
Develop new and innovative Health Promotion initiatives for the target areas	?? Develop Health Promotion Initiatives to target specific age groups ?? Gain support of community in the implementation of the project ?? Promote the importance of asthma management and correct puffer technique and a positive relationship with GP asthma Educator.	?? See attached Health Promotion early Intervention strategy (June 10th)	??	??

DIABETES
INTEGRATED DISEASE MANAGEMENT PROJECT
Implementation Plan
Year 1 Organisation



Project Logic* Implementation Plan

?? Department of Human Services (Bronwyn Diffey/ Penny Mitchell)

<table>
<tr><th colspan="2">April –September 2001 Build Capacity for Implementation of IDM Process</th></tr>
<tr><td>Projecy Logic DHS Indicators
?? Plan clinical and non-clinical interventions based on evidence of best practice (including health promotion, early intervention and treatment);
?? Develop IDM strategies in collaboration with consumers, as part of Community Health Plans;
?? Identify specific strategies for ensuring that IDM models are appropriate for vulnerable populations;
?? Identify population sub-groups at highest risk of priority diseases/conditions to target for entry into IDM pathway, establish clear entry and prioritisation criteria, and develop recruitment strategies;
?? Plan and implement change management strategies including planned interagency partnership development, consumer participation strategies, communication protocols, resource allocation, peer leadership, education and training, monitoring and feedback.</td><td>Project Strategies
? ? Define consumer entry criteria to the IDM Project eg low, medium, high risk
? ? Develop recruitment strategies (according to risk, invitation, volunteer)
? ? Develop “plain english” consumer/carer information for IDM Project
? ? Define data and systems for collection

? ? Identify diabetes management team clusters across the South West
1. Warrnambool / Macarthur / Pt Fairy and
2. Portland/ Heywood/ Dartmoor and
3. Hamilton/ Coleraine/ Casterton/ Balmoral/ Penshurst
4. Terang / Lismore / Camperdown / Mortlake / Cobden / Timboon

? ? Identify members of the diabetes management team in each cluster
? ? Develop links with PCP Service Co-ordination, Health Promotion
? ? Describe local practice for each team
? ? Establish Steering and Advisory Groups
? ? Describe service utilisation / gaps /pressures
? ? Identify strategies to use IDM resources for “Adjustable Service Levels”
? ? Obtain consensus for the development of standardised evidence-based or best practice materials for use across the South West
? ? Document clear roles & responsibilities for GP’s</td></tr>
<tr><th colspan="2">September 2001 – March 2002 Implement IDM strategies consistent with evidence of best practice</th></tr>
<tr><td>DHS Indicators
?? Care is provided in a coordinated fashion by multidisciplinary teams in accordance with explicit care management plans developed in collaboration with consumers and carers, and includes regular follow-up and systematic assessment;
?? Basic clinical pathways for all IDM clients include the 3 stages of initial contact, comprehensive assessment, and care planning;
?? Implementation of care management plans is supported by the IDM project;
?? Management plans identify aspects of care that can be self managed by consumers and carers;
?? Consumers and carers are provided with ongoing education and training to support adoption and maintenance of self management strategies.</td><td>Standardised evidence-based or best practice for use across the South West (Foundation for comprehensive assessment and care planning)
? ? Consumer education material inc. consumer participation
? ? Management Guidelines
? ? Complications screening guidelines
? ? Community diabetes screening guidelines
? ? Management Guideline protocols
? ? Individual Care Plan Development inc. consumer participation
? ? Referral Protocols (Diab.Ed / GP/ Allied Health)
? ? Role & responsibility of Diab.Manag. Team
? ? Role & responsibility of consumer in consumer participation
? ? Information sessions and “Help Line” to encourage use of standardised materials
? ? Self management upskilling – consumer/carer
? ? Self management upskilling – diabetes management team
? ? Development of recall & reminder system
?? determinants ie time / biological /behavioural</td></tr>
</table>

Appendix 3.3N

Project Logic* Implementation Plan

?? Department of Human Services (Bronwyn Diffey/ Penny Mitchell)

September 2001 – June 2002	**Consumer satisfaction, Co-ordinated Services**
Consumers and carers experience enhanced access, engagement and satisfaction with services and programs and experience services as being provided in a seamless, coordinated fashion **Project Logic DHS Indicators** ?? Consumers have confidence in the advice, support, treatment, and care coordination they are receiving; ?? Clinical 'pathways' are appropriate to consumers' circumstances; ?? Increase utilisation of appropriate services, particularly by vulnerable populations; ?? Consumers are actively involved in the development of care management plans; ?? Consumers are able to adhere to care plans; ?? Consumers and carers report an ability to easily to navigate the service system; ?? Reduce overall consumption of health care resources. [Note: Progress against these Impact Indicators is dependent upon all components of the PCP Strategy, especially BATS/IM.]	**Data Collection and Analysis:** ? ? Define data for collection / Develop systems for collection / Define data collection intervals / Benchmark / Data collection and analysis / Feedback to participants ?? Processes approved by Ethics Committee relevant to teams and GP's ?? Completed initial comprehensive assessment on participants including complications screening , satisfaction, quality of life ?? Reviewed history of hospital admissions for consumer participants ?? Established and undertaken annual admissions and comprehensive assessment review for each participant Types of Data: **Health system utilisation & reorientation** Admissions/readmission's/referrals / no. care plans/ MBS no. utilisation **Consumer** Comprehensive Assessment A/ Diabetes Control – HbA1C B/ Complications – hypertension; dyslipidaemia; foot ulceration; retinopathy; nephropathy/ CVD Risk Factors C/ Quality of Life D/ Satisfaction **Health Professional** A/Re-orientation of services – referrals / individual care plans /case conferences B/Satisfaction ? ? Identification of the scope of behavioural change needs of consumers ? ? Identification of evidence based or best practice behaviour change strategies ? ? Development of a systematic approach to the identification of behavioural change needs ? ? Training for diabetes management team in effective behavioural change strategies ? ? Check the inclusion of behavioural change in the standardised education material, management guidelines, individual care plan, referral protocols, recall & reminder systems, consumer and professional training

EVALUATION PLAN I Evaluation of the stated Goals and Objectives of the Project

GOAL	STRATEGY & PROGRESS	PERFORMANCE CRITERIA
Improve capacity of the health system to deliver, manage and monitor services for the prevention of Diabetes and the care of people with or at risk of diabetes	**Access & Quality** ✍ Service mapping to identify existing resources & capacity to enhance co-ordination, quality and access, links with GP's, identification of consumer reps; recall & reminder systems Mapping tool developed, piloted, data being collected ✍ Identify diabetes management teams across the five municipalities of the South West – Hamilton; Warrnambool; Portland; Terang Teams agreed to by Diabetes Educators ?? Identify Allied Health Team members ✍ Identify GP "champions" Letter sent to all GP's n=130, 20 returns – Initial "champions" selected from this group ✍ Develop/adopt with the ODGP a step wise process to allow GP's to easily use the MBS Items for Case Draft process developed consultation with ODGP started ✍ Management Guidelines and Care Planning for people with diabetes ✍ Standardise educational materials, needs identification tools Agreement on standardisation of guidelines, care planing & education tools and across South West ?? Consensus on role & responsibility of key providers, ?? Increase access to education for key and non-key providers eg. Community services staff working with older people, the visually impaired and frail, Aboriginal Health Workers ✍ Support IT driven communication & information strategies eg: email, audio, video-conferencing, Internet **Self –Management** ✍ Inform and empower consumers to seek appropriate care including rights & responsibilities ✍ "Plain English" Consumer self management guidelines, pathways and Shared Care Plan or Booklet **Vulnerable Groups** ✍ Develop programs that meet the needs of specific groups eg. Indigenous Australian, people from culturally diverse backgrounds, older Australians	?? Establishment of Teams and Resourcing ✍ Document links with General Practitioners ?? Number of GP's engaged ?? Development & pilot of MBS Item process ?? Standardised guidelines, education material, individual care plans, role & responsibility ✍ Registration, Recall & Reminder System including consumer consent issues ✍ "Plain English" Consumer Information ✍ Demonstrated links with PCP "BATS" / IM development ✍ Demonstrated Links with PCP Local Information Strategy (Service Directory / Carelink) ✍ Consumer and Key Provider % utilisation and % satisfaction with consensus process and outcomes ✍ Utilisation of Diabetes Supply Scheme ✍ Referral rates ✍ Professional training provided, attended and valued ✍ Consumer information ✍ Demonstrated CALD sensitivity ✍ Consumer capacity to self-manage ✍ Consumer well-being (eg SF 36 Health Survey ✍ Consumer improved knowledge of and access to services ✍ GP improved knowledge of and access to services

GOAL	STRATEGY	PERFORMANCE CRITERIA
Prevent or delay the development of Type 2 Diabetes	✍ Link with PCP Integrated Health Promotion Strategy ✍ Establish links with national, state and local primary prevention strategies -see Appendix 1 Critical Resources ✍ Develop an evidence-based and coordinated approach to assessment and referral to dietary and exercise interventions in high-risk consumers with IGT ✍ Implement the Community Awareness Diabetes Strategy for early detection and intervention ✍ Promote opportunistic cost effective evidence-based screening ie targeting high risk consumers ✍ Adopt and promote guidelines for the standardised diagnosis of diabetes, specifically IGT and GDM ✍ Promote information for key providers and consumers on causes and prevention of diabetes ✍ Identify access barriers to lifestyle counseling ✍ Support key providers to be able to provide lifestyle counseling	✍ No. contacts with national, statewide organisations ✍ Increased no. of IGT referrals ✍ IGT Individual Care Plan development ✍ Screening guidelines ✍ Promotion of guidelines to key providers and consumers ✍ No. community awareness strategies undertaken regarding diabetes risk factors, symptoms, where/how to access information ✍ Targeted screening activity ✍ Lifestyle counseling activity ✍ No. coordinated primary prevention initiatives ✍ Links with PCP Health Promotion Strategy
Improve health related quality of life, reduced complications and premature mortality in people with Type 1 and 2 diabetes	✍ Develop a model for consumer registration, recall and reminder system ✍ Adopt complications screening guideline for A/ Diabetes Control – HbA1C B/ Complications – hypertension; dyslipidaemia; foot ulceration; retinopathy; nephropathy/ CVD Risk Factors C/ Quality of Life D/ Satisfaction ✍ Increase consumer awareness of guidelines ✍ Increase consumer access to care supported by guidelines ✍ Identify organisational and key provider support required to deliver services described by the guidelines ✍ Increase consumer self management capacity ✍ Increase access to peer support	✍ Implementation of the recall system ✍ Demonstrated utilisation of complications guidelines in key provider work practices ✍ Increased no. consumers receiving complications screening ✍ No. consumers with active individual care plans ✍ Consumer report confidence to self manage ✍ Shared care booklet utilisation & satisfaction ✍ Identification of barriers to best practice service delivery ✍ No. of organisational and workforce solutions to barriers to best practice service delivery
Achieve long term maternal and child outcomes for gestational diabetes and for women with pre -existing diabetes equivalent to those of non-diabetic pregnancies	✍ Adopt and promote Gestational Diabetes Management guidelines when available ✍ Encourage promotion of guidelines by General Practice, Allied Health, Maternal & Child Health Center's, Ante-natal clinics, Nursing Mothers, Pharmacists, Community Health Center's, Neighbourhood Houses ✍ Support key providers to report activity ✍ Provide "Plain English" consumer self management information, guidelines and pathways	✍ Screening guidelines / Increased no. referrals ✍ GDM Individual Care Plan development ✍ Promotion of guidelines No. community awareness strategies undertaken regarding diabetes risk factors, symptoms, where/how to access information ✍ Information and counseling received by women with diabetes (pre-conception & ante-natal)
Advance research knowledge and understanding about prevention, delay , detection, care and cure	✍ Develop links with National Diabetes Strategy including the Commonwealth-States Diabetes Forum ✍ Maintain & strengthen links with Statewide agencies	✍ No. of contacts with Statewide and National agencies ✍ Service Linkage Protocol with Diabetes Australia; International Diabetes Institute, National Heart Foundation

Appendix 3.3N

EVALUATION II KEY COMPONENT EVALUATION

Key Component	STRATEGY	Performance Indicator
Define target group	? ? Define consumer entry criteria to the IDM Project ? ? Develop recruitment strategies (according to risk, invitation, volunteer) ? ? Develop "plain english" consumer/carer information for IDM Project	?? Agreed criteria ?? Included criteria in "Plain English" consumer information ?? Recruited consumer participants to Project (eg Y1, 10 per team ?) ?? Obtained consumer consent ?? Recruited GP's to Project
Data Collection and Analysis: Types of Data: **Health system utilisation** Admissions/readmis sion's **Consumer**: A/ Diabetes Control – HbA1C B/ Complications – hypertension; dyslipidaemia; foot ulceration; retinopathy; nephropathy/ CVD Risk Factors C/ Quality of Life D/ Satisfaction **Health Professional** A/Re-orientation of services– referrals / individual care plans /case conferences B/Satisfaction	? ? Define data for collection ? ? Develop systems for collection ? ? Define data collection intervals ? ? Benchmark ? ? Data collection and analysis ? ? Feedback to participants ? ? Modify Project as needed	?? Processes approved by Ethics Committee relevant to teams and GP's ?? Completed initial comprehensive assessment on participants including complications screening , satisfaction, quality of life ?? Reviewed history of hospital admissions for consumer participants ?? Established and undertaken annual admissions and comprehensive assessment review for each participant
Multidisciplinary Teams Reorganisation of Consumer systems Reorganisation of provider roles	? ? Identified diabetes management team clusters across the South West 5. Warrnamb ool / Macarthur / Pt Fairy and 6. Portland/ Heywood/ Dartmoor and 7. Hamilton/ Coleraine/ Casterton/ Balmoral/ Penshurst 8. Terang / Lismore / Camperdown / Mortlake / Cobden / Timboon ? ? Identify members of the diabetes management team in each cluster ? ? Describe local practice for each team ? ? Describe service utilisation / gaps /pressures ? ? Identify strategies to use IDM resources for "Adjustable Service Levels" ? ? Obtain consensus for the development of standardised evidence-based or best practice materials for use across the South West	? ? Service Mapping Tool Analysis Tool –Appendix 1

Key Component	Strategy	Performance Indicator
Ready Access to Expertise Explicit Protocols & Plans	Service Mapping for ? ? Needs identification & documentation ? ? Care Planing practice ? ? Timely access to each member of the diabetes management team ? ? Waiting lists ? ? Role & responsibility of diabetes practitioners ? ? Identification of protocols between diabetes management team	? ? Service mapping analysis
Explicit Protocols & Plans **Systematic attention to information needs** **Improved Self Management** **Reorganisation of provider roles** **Reorganisation of Consumer systems**	Agreement to achieve the following: Standardised evidence-based or best practice for use across the South West ? ? Consumer education material ? ? Management Guidelines ? ? Complications screening guidelines ? ? Consumer diabetes screening guidelines ? ? Management Guideline protocols ? ? Individual Care Plan ? ? Referral Protocols (Diab.Ed / GP/ Allied Health) ? ? Role & responsibility of Diab.Manag. Team ? ? Role & responsibility of consumer ? ? Self management upskilling – consumer/carer ? ? Self management upskilling – diabetes management team ? ? Development of recall & reminder system ?? determinants ie time / biological /behavioural	* Routine audit of care co-ordination * Consumer access to complications screening *Utilisation of standardised materials ?? Consumer satisfaction ?? Service Provider satisfaction
Systematic attention to behavioural change needs Reorganisation of provider roles & consumer systems Use of Explicit Protocols & Plans Systematic attention to information needs	? ? Identification of the scope of behavioural change needs of consumers ? ? Identification of evidence based or best practice behaviour change strategies ? ? Development of a systematic approach to the identification of behavioural change needs ? ? Training for diabetes management team in effective behavioural change strategies ? ? Check the inclusion of behavioural change in the standardised education material, management guidelines, individual care plan, referral protocols, recall & reminder systems, consumer and professional training	? ? Evidence of best practice ? ? Consumer participation ? ? GP Engagement ? ? Inclusion of behavioural change strategies in materials ? ? Follow up with consumers
Well Co-ordinated Assessment Team Reorganisation of provider roles Reorganisation of Consumer systems	? ? Define the evidence based or best practice approach to diabetes assessment	? ? Routine audit of care

Budget

The Budget will be reviewed after the Service Mapping analysis.

ITEM	Year 1	Year 2	Year 3
Salary & Wages			
Co-ordinator @ ZG7 Clinical Nurse Consultant / Snr. Allied Health 1EFT-> 0.5 EFT in on costs	$ 59,215	$61,583	$32,023
Service delivery - Key Providers of the Multi-disciplinary Diabetes Management Team 1EFT (av) = $ 56,350 (inc oncosts) Service delivery - Mobile Diabetic Retinopathy Screening Service 0.4 EFT	$10,825 $22,540	$19,123 $23,442	$47,425 $24,379
Administration 0.2 EFT in on costs **Registration, Recall & Reminder System Development**	$7,500	$7,800	$8,112
?? Development/ adaptation of existing software for a diabetes registration, recall and reminder system (South West Alliance of Rural Hospitals & suppliers of GP Software Medical Director) ?? Lead Agency –administration fee	$ 10,000 $2,400	$ 2,000 $2,400	- $2,400
Travel ?? Vehicle lease 1 EFT = $8,000 + .10 cents per km @ 400 km per week ?? Vehicles 1.4 EFT	$15,120	$15,724	$ 16,356
Equipment ?? Diabetes supplies (metres, strips, podiatry) ?? Diabetic Retinopathy photographic equipment ($1.50 per eye ie $3.00 per person @95 screening days per annum @20 people per day)= $5,700 **Office Accommodation** ?? rent inc utilities* / phone/fax/email/internet ?? computer / telecommunications, videoconferencing	$ 5,700 $ 5,200	$5,928 $3,500	$6,165 $3,640
Workforce Capacity Building* ?? Professional specific training in registration, recall & reminder system ?? Multi-disciplinary team work/change management ?? Diabetes Disease Management Model –professional information kit	$ 2,000	$5,000	$3,000
Community Development ?? Community Awareness Diabetes Strategy ?? Self-management & empowerment education resources	$1,500	$2,000	$2,500
Evaluation	$8,000	$1,500	$4,000
TOTAL	**$150,000**	**$150,000**	**$150,000**

Southern Grampians & Glenelg Primary Care Partnership

Improved Access to Counselling Services

Summary

The proposed project will identify service delivery needs, as identified by a range of stakeholders (professional and community). We will also assess the extent and appropriateness of current service provision and identify the existing skills, knowledge and qualification base of workers. Access will be developed to expert supervision and support for practitioners currently providing counselling through collaboration with RMIT University Flexible Learning Centre in Hamilton and the academic support of the School of Social Science and Planning.

This project will also pilot a model to increase the availability of qualified and specialist practitioners who can work in and/or with a range of community health services and agencies within the Southern Grampians and Glenelg Shires and will evaluate this.

Outcomes from this project will be strategies and opportunities to increase the skills and qualifications of the rural human services workers in response to identified priority needs. There will also be recommendations for innovative, flexible and 'rurally appropriate' service provision.

Aims and Objectives

The project has been developed by a work group of professionals providing counselling services in Southern Grampians and Glenelg Shires to address the identified need to improve quality and access to services in this rural area. The project aims to make a contribution to the improved recruitment and retention of counselling staff. It also pilots a brokerage funding model to extend the community access to counselling. The key objectives are:

- ?? Skill development for local professionals who include counselling in their work
- ?? Sustainable professional support and supervision processes for a broad range of professionals
- ?? Increased access to tertiary and specialist training in counselling
- ?? Increase community access to specialist counselling services through brokerage funding

Rationale

Needs assessments, agencies, professional networks and community groups have all identified counselling services as a need area. This includes availability (total services available), access to specialist counselling services, viability of (especially specialist) services given the small population scattered over a large geographic area, the cost of private psychology treatment, recruitment of appropriately skilled counselors and ongoing professional support. Detailed information as to the needs and resources/skills available is not currently available.

Referrals to the social work services provided by the community health services include the following priority issues: relationship counselling; parenting and family issues; anxiety and depression (referred from psychiatric services because clients do not demonstrate evidence of major psychiatric illness). A significant gap in services identified by agencies and palliative care services is bereavement and grief counselling. Skilled abortion counselling has also been identified as a need by the Family Planning Clinics. Specialist counselling services provided include drug & alcohol, domestic violence, sexual abuse, financial and rural. Many of these services are provided on a sub-regional basis across SW Victoria.

High levels of depression and suicide are reported in rural Victoria. It is suspected that there are many barriers that prevent people seeking support early; this may be partly due to the stoic attitude of country people but is also related to waiting lists at funded counselling services and the high costs of private practitioners. Residents of small townships and isolated farms face additional barriers in accessing services due to transport issues. Counselling providers able to meet the specific needs of people with a disability has also been highlighted by the disability agencies.

Concern has been expressed at the lack of specialist counselling to meet the needs of people with complex problems not able to be met by local generalist counsellors. A flexible response to provide access to appropriate services is required, given that there would not be enough demand to establish local services. A significant problem for a rural area is lack of privacy for clients in accessing appropriate services; this may include not wishing to see a local counsellor that they also meet with socially, or concerns at being seen visiting a service. Again a flexible response is required to provide expanded choice for the community.

Recruitment of experienced social workers and psychologists is reported as a major problem by agencies. For example, Western District Health Service received no applications from qualified social workers to a recent advertisement. There are skilled welfare workers in the district and many nurses and allied health workers provide counselling as a component of their services. The proposal has been developed to identify the existing skills and resources and to develop opportunities for upskilling and providing appropriate support and ongoing education to existing service providers within the district.

Isolation of social workers and counsellors in rural areas is perceived as a major problem in "burnout" and maintaining quality practice. The regional social work network covers a large area including Horsham, Portland and Warrnambool and aims to provides support through quarterly meetings, but these are often cancelled due to lack of time for workers to attend.

Many of the findings will be relevant to this larger area and other rural areas. Development of professional support networks and access to education will also apply over a larger area than the 2 shires and be available to any worker wishing to access them. This proposal has been developed in the context of the goals of the Primary Care Partnerships, to improve coordinated access to appropriate skilled services and to identify the full range of counselling needs in the community of Southern Grampians and Glenelg Shires. Community consultation is seen as vital to ensure services/processes are acceptable and will be used.

Action Plan

The Action Plan detailed below combines the strategies and actions required, with both process and outcome evaluation criteria built in to all stages of the project for all goals. It also allows for reporting on achievements against the identified tasks and will be used as a regular reporting tool for the Primary Care Partnership and DHS. The final report of the project will report on the achievement of all goals against the identified evaluation criteria.

The project will commence with a workshop for a broad range of professionals involved in providing counselling, who will be involved in establishing the key performance indicators of importance to them. A workshop at the end of the project will allow the same group to contribute to the final report and evaluation of the project against those key performance indicators.

The second major goal of the project is increased community access to specialist counselling services through the use of brokerage funding. Development of an evaluation tool will be a priority task at the start of the project. The tool will assess the extent to which the use of brokerage funding is able to develop a more client-focused service delivery, able to meet client defined needs and increase choice in available service.

Strategies and Timelines

Strategy	Tasks	Who	Time Line	Risk Management	Evaluation Criteria	Achievements
Implementation	?? Develop Service Linkage Protocol between RMIT and the PCP ?? Establish Steering Committee to oversee implementation, reporting to PCP Executive o Identify and invite key stakeholders o Include consumers in planning and implementation ?? Identify communication processes between PCP and RMIT ?? Appoint project staff ?? Liaise with DHS on statewide implementation and evaluation ?? Identify related planning processes	PCP staff	April 2001	Involvement of professionals and consumers ?? Involve other services early in project ?? Recognise the 'culture' that services work in and also their skills and expertise ?? Initially target service providers, known to be supportive of the project, to be involved and to spread the word ?? Work with PCP Community Participation Workgroup to identify ways of involving consumers Effective relationship between PCP and RMIT ?? Develop Service Linkage Protocol to clarify roles and responsibilities ?? Establish effective administrative processes ?? Membership of Steering Committee Avoid duplication, confusion and consultation burn-out ?? Link with implementation of Primary Mental Health and Early Intervention plan ?? Link with review of counselling services in community health	Process: ?? Involvement of broad range of providers and consumers ?? Steering Committee formed with terms of reference, broad membership ?? Service Linkage Protocol with RMIT ?? Integrated planning and coordinated counselling service development Outcomes: ?? Project objectives achieved	Dr Margaret Skene to be Project Manager Dr June Allan (RMIT) agreed to supervise research Draft Service Linkage Protocol developed with RMIT Core membership of Steering Committee identified; recruiting additional members PCP signatory to Memorandum of Understanding and membership on PMHEI Management Group; PMHEI membership on Steering Committee Community health membership of Steering Committee Workshop planned for July 27th 2001 to present overview of project to providers

Strategy	Tasks	Who	Time Line	Risk Management	Evaluation Criteria	Achievements
				centres		
1. Professional Skill Development						
1.1 Mapping of services and skills across Southern Grampians & Glenelg Shires	?? Undertake a service and skills audit in South West Victoria with focus on Southern Grampians and Glenelg shires	PCP	July 2001	Comprehensive information obtained ?? Link with collection of information for services database ?? Link with BATS strategy collection of data for assessment and care planning	Outcomes: ?? Counselling component of broad range of professionals identified ?? Includes private practitioners ?? Information contributes to comprehensive services database for the catchment area	Southern Grampians and Portland Health and Welfare Directories provide starting point for agencies and private practitioners to contact re audit
1.2 Needs Assessment	?? Identification of perceived gaps in generalist counselling skills and priority training needs ?? Identify perceived gaps in skills to meet the needs of specific target groups such as Koori people, people with disabilities. o Develop a research methodology to include survey of designated counselors, social workers, allied health, community nursing, private practitioners ?? Consultation/feedback with providers and consumers to test and expand the information collected above	RMIT	July - Oct 2001	Needs assessment not "wish list" ?? Effective research design ?? Draw on existing studies, which indicate areas of needs and service gaps. ?? Market project through appropriate communication channels to access broad range of providers Consumer participation ?? Target consumers of specialist agencies via PCP members	Process: ?? Provider feedback on process ?? Consensus on identified gaps, priorities and proposed strategies Outcomes: ?? Strategies for sills development	
1.3 Increase education and training options	?? Negotiation with tertiary institutions and use of local resources such as the RMIT Flexible Learning Centre	RMIT PCP	April 2002	Resistance to change ?? Match training with identified needs ?? Build time into team meetings	Process: ?? Feedback on education provided during project	

Strategy	Tasks	Who	Time Line	Risk Management	Evaluation Criteria	Achievements
	?? Provide a minimum of 3 specialist training sessions to meet priority needs of service providers locally ?? provide improved access for local service providers to undergraduate/postgraduate courses and specialist short courses within Victoria and by distance education ?? Long-term strategic plan for increased flexible provision of relevant RMIT courses in liaison with the RMIT Flexible Learning Centre ?? increase the number of social work and psychology students on placement in the district through development of innovative projects and support with accommodation, transport, etc ?? Alliances with other tertiary institutions: SW TAFE, Deakin and Monash Universities on improved coordination of relevant training opportunities		ongoing	for reflection and open discussion of successes (and failures) of the work. ?? Engage service providers in the steering committee and project development. Sustainable options developed ?? Effective working relationship with RMIT ?? Correlation between training and identified needs ?? Identify barriers to student placements and develop strategies to overcome ?? Recognition of need for cost effective options and to meet academic criteria	?? Guidelines to support non-local students (welfare, social work and psychology) on placement in the area; completed and distributed to universities and TAFE Outcomes: ?? Accessible and sustainable education options developed ?? Improved recruitment and retention of cousnellors	
2. Sustainable Professional Support Processes						
2.1 Development of innovative ideas	?? Undertake a literature review, particularly to explore innovative models of rural service delivery, support and skills training	RMIT	October 2001		Process: ?? Innovative ideas available	Graduate student to undertake literature review

Strategy	Tasks	Who	Time Line	Risk Management	Evaluation Criteria	Achievements
	?? Creative workshops with counselors and other professionals	RMIT	March 2002			
2.2 Develop support networks for professionals providing counselling services	?? Establish professional network(s) including ideas generated in 2.1 o Agree geographical area to be covered o Identify aims of network - support, supervision, training, etc o Agree processes, evaluation of effectiveness, etc ?? Collaboration between existing and new professional networks with the RMIT School of Social Science and Planning and other academic resources: o improve access to expert supervision and support, utilising on-line technology and the Flexible Learning Centre in Hamilton.	PCP RMIT	Sept 2001 April 2002	Project fully integrated into the development of other service initiatives. ?? Discussions with services and through the Management Committee ?? Consensus on use of appropriate 'best practice' guidelines ?? Consensus on assessment of quality and competence in counselling Effective negotiations with RMIT ?? Links with RMIT Hamilton ?? Links with School of Social Science and Planning	Process: ?? Providers support for professional networking and supervision Outcomes: ?? Professional support network with identified objectives and meeting schedule ?? Improvements in quality of counselling provided by broad range of providers as per agreed standards	Linda Briskman - Head of Social Work Department at RMIT and member of Programs Advisory Committee (RMIT School of Social Science and Planning) Margaret Skene Deputy Chair Community Advisory Committee at RMIT Hamilton and member of Programs Advisory Committee (RMIT School of Social Science and Planning)
2.3 Increase status of rural counselors	?? Increase the value of rural positions: generation of innovative strategies to develop higher status positions in rural areas through links with academic institutions.	RMIT	April 2002	Effective links with tertiary education ?? Identify other tertiary organisations in addition to RMIT	Process: ?? Innovative strategies tested Outcomes: ?? Improved recruitment and/or retention of counsellors	

Strategy	Tasks	Who	Time Line	Risk Management	Evaluation Criteria	Achievements
3. Increase community access to therapeutic counselling services						
3.1Community Needs Assessment	?? Identify gaps in services available or appropriate to meet the needs of the population in Southern Grampians and Glenelg Shires. Develop research methodology which may include: o Interviews with agency staff providing services to specific target groups such as Kooris and disabled people to identify perceived needs and issues around access to counselling services. o Discussion groups with consumers of above agencies and family members to identify issues around access, experiences with counselling services, needs and wants.	RMIT PCP	May 2001 to August 2001	See 1.2 Consumer involvement ?? Provide support and resources for consumers ?? Involve consumers and carers in the decision-making ?? Ensure consumers are equal partners. ?? Ensure consumers and carers are fully informed about plans and support options	Process: ?? Provider feedback on effectiveness of consultation process ?? Consumer feedback on effectiveness of consultation process Outcomes: ?? Needs, priorities and gaps identified; included in PCP service plan	
3.2 Pilot an innovative model of rural service delivery through use of Flexible Counselling Packages.	?? Develop pilot project - Flexible Counselling Packages o Development of management processes, guidelines and referral protocols for Flexible Counselling Packages. o Develop guidelines for assessment and identification of clients appropriate to receive Flexible Counselling	PCP PCP	June 2001 Sept 2001	Access throughout catchment area ?? Involvement of all primary care agencies ?? Issues such as transport, hours of service delivery, waiting times identified Effective linkages with PCP strategies ?? Effective referral via services database ?? Ensure Initial Needs Identification picks up	Process: ?? Integrated into PCP service coordination strategy ?? Guidelines address known barriers to access ?? Evaluation identifies additional obstacles to access Outcomes: ?? Consumer and provider feedback identifies clear	

Strategy	Tasks	Who	Time Line	Risk Management	Evaluation Criteria	Achievements
	Flexible Counselling Packages. o Promotion of the pilot program and referral processes to agencies throughout Southern Grampians and Glenelg shires. o Data collection will include numbers of clients, services purchased, presenting needs, involvement and roles of local service providers o Client feedback sought through a satisfaction survey and follow-up interviews of randomly selected clients (consent will be sought).	PCP	April 2002	Identification picks up counselling needs ?? Ensure service specific, specialist and comprehensive assessment processes link with program ?? Pilot care planning tool with specialist providers, GPs and referring agencies Sustainability ?? Ensure consumers and carers are fully informed about plans and support options ?? Project design reflects implementation of achievable and immediate impact activities	directions for future service delivery ??	
3.3 Develop client-focused service delivery better able to meet client defined needs and increase choice in available service	?? Evaluate pilot project - Flexible Counselling packages o Analysis of data to identify the gaps in local service availability and reasons for requiring the Flexible Counselling Packages o Monitoring of the relative roles of local services and other services used will provide insight into potential coordinating arrangements. o Identify key learning from	RMIT PCP	July 2001 June 2002	Development of a good evaluation design ?? Evaluation criteria specified at start of project ?? Define timelines and measurable outcomes ?? Best use of academic research experience ?? Define key measurable performance indicators ?? Ensure collection of data Effective provider feedback includes: ?? Involvement of private practitioners and GPs	Process: ?? Transferability to other rural areas clarified Outcomes: ?? Referral and care planning integrated into coordinated primary care service delivery for the catchment area ?? Consumers have access to appropriate counselling relevant to their need ?? Variations and specific needs groups identified with relevant	

Strategy	Tasks	Who	Time Line	Risk Management	Evaluation Criteria	Achievements
	the project to inform other PCP strategies including GP integration, consumer participation, Better Access To Services & Information Management ?? Act on client feedback and integrate into planning and future service development o Integrate identified priorities into the PCP service plan and Community Health Plan ?? Recommendations for future service delivery and strategic development o Sustainable changed work practices identified that can be incorporated into current services o Further funding proposals developed	PCP PCP RMIT /PCP	April 2002 June 2002 July 2002	?? Clarity and relevance of guidelines re referral to Flexible Counselling Packages ?? Broad service provider access to program ?? Options for future funding of program Effective consumer feedback includes: ?? Broad range of consumers ?? Feedback processes relevant to consumer groups ?? Clarify ethics and consent issues ?? Focus is access to services not the outcomes of the counselling itself; barriers to access identified Project fully integrated into the development of other service initiatives. ?? Consensus on use of appropriate 'best practice' guidelines	solutions ?? Sustainable program implemented	

Budget

Project support (WDHS and RMIT) - 650 hours @$50 per hour $32,500

Administration support - 200 hours @ $25 per hour $5,000

Counselling Funding Packages - (based on $600 per client and 50 clients) $30,000

Steering Committee (travel and administration) $1,000

Travel and accommodation costs (Project Worker) $8,000

Reports - printing and distribution $1,000

Consultation costs - venue, refreshments, etc $2,000

TOTAL $79,500

Management

Dr Margaret Skene will be Project manager.

Dr June Allan (School of Social Science and Planning - RMIT) will develop and supervise the research and skills audit. Professor Linda Briskman (RMIT) will provide research expertise and liaise re development of education and training options.

The project will be overseen by a Steering Committee chaired by Merrilyn Risk, Senior Social Worker with Portland & District Community Health Centre. The membership will include representatives of the collaborating agencies (listed below) and the Primary Care Partnership, agencies providing counselling services, private practitioners, GPs and/or the Otway Division of General Practice and consumers of counselling services. The Steering Committee will report to the Executive of the Southern Grampians & Glenelg Primary Care Partnership.

The Steering Committee will also be responsible for ensuring the Flexible Counselling Packages are used to provide access to counselling services not otherwise available or suitable to meet the client need, development of equitable access processes and the evaluation and reporting of the pilot program.

Collaborating agencies/providers are:

Portland & District Community Health Centre - Merrilyn Risk
Western District Health Service - Community Services - Margaret Skene
Southern Grampians & Glenelg Primary Care Partnership - ""
Community Connections (Vic) - Bruce de Vergier
RMIT University Counselling Services to be advised
RMIT University, School of Social Science and Planning - Linda Briskman, June Allan

DIABETIC RETINOAPTHY SCREENING - Southern Grampians & Glenelg Primary Care Partnership

The goal of the proposal is to increase the number of people screened for diabetic retinopathy on a sustainable basis in the Southern Grampians and Glenelg shires. It builds on a pilot program conducted through South West Healthcare (Warrnambool) using a non-mydriatic retinal camera. It will also be linked to the Diabetes Integrated Disease Management Program managed through PCP-South West. Specifically, the goals are to increase knowledge and awareness of the importance of retinal screening amongst people with diabetes and health professionals and to increase community access to an approved retinal screening program, especially of high risk groups - men and Kooris.

OBJECTIVE	TASKS	PERFORMANCE INDICATORS	RISK ANALYSIS	CONTINGENCY PLAN	TIME FRAME
To improve access to retinal screening in the Southern Grampians and Glenelg Shire	First priority is to establish an advisory group *-Develop list of relevant stakeholders ie-Local GPs, Otway Division of GPs, Ophthalmologists Optometrists Diabetes educators SW project coordinator.* *-Invitation mailout* *-Develop communication/decision making within the group*	Reference group established and meetings commenced Identity of trainees established	Lack of interest by key stakeholders	Involve from the outset Identify key spokespersons Link to SW Diabetes IDM Steering committee Identify roles and responsibilities of advisory members , *Liaise with colleagues*	ASAP July / August 2001
?? Training of two staff in the use of the retinal camera	Contact CERA/Vision Australia to arrange training program *Liaise with SW project manager*	Staff trained in use of retinal camera			ASAP

OBJECTIVE	TASKS	PERFORMANCE INDICATORS	RISK ANALYSIS	CONTINGENCY PLAN	TIME FRAME
?? Establish protocols with South West Healthcare	Liaise with Project Manager at SWH *Re pilot project* *Identify existing activities and resources* Develop timetable for screenings	Screening of 200 people with diabetes	Duplication of activities	Management through Diabetes IDM Steering Group	July 2001
?? Establish screening sessions based on the pilot program conducted by SW Healthcare	Liaise with Project Manager at SWH Selection of suitable venues *Review remote locations*	Timetable of sessions developed			Sept 2001
?? Raise community awareness of, - Diabetic Retinopathy - The project	Media release stating the significance of diabetic retinopathy and the objectives of the project Local Diabetes Support and Information Group involvement	Number of promotions	Not reaching target audience	Liaise with SW PCP project	

OBJECTIVE	TASKS	PERFORMANCE INDICATORS	RISK ANALYSIS	CONTINGENCY PLAN	TIME FRAME
To integrate screening for diabetic retinopathy into existing diabetes management pathways ?? Development of referral pathways	Develop a regional diabetic retinopathy screening pathway Reference group agenda item *Query: consumer registration and recall system* Review strategies of SW project	Referral pathways developed			
?? Define the role of the Optometrist	Discussion of the role played by the Optometrist in the team model	Optometrist included into management team	Discord in relation to the role of Optometrist	Policy issues with DHS And IDM groups	August 2001
?? Delineation of roles and responsibilities of health professionals within the multidisciplinary team	Reference group agenda item	Consensus on role and responsibilities within the multidisciplinary team	Lack of agreement		Feb 2002
?? Diabetes Educators educational programs to include information on the prevention of diabetic retinopathy	Liaise with SW Project IDM project	Standardized information			August 2001
?? Ensure adequate resources for ongoing retinal screening across South West Victoria	Develop data collection model to enable evaluation of project *Learn from SW project* 2002/2003 Budget item	Ongoing budget to support screening	Financial resources limited	Develop funding proposals	May 2002

OBJECTIVE	TASKS	PERFORMANCE INDICATORS	RISK ANALYSIS	CONTINGENCY PLAN	TIME FRAME
To target high risk population groups in the locality					
?? Develop appropriate screening for the Koori Community	Contact Winda-Mara Aboriginal Corporation	Minimum of 10 Koori persons screened	Difficulty engaging Koori groups	Representative on advisory group Engagement strategy developed with Koori Health Worker	
?? Increase the screening rate of men with diabetes	Liaise with Western District Health Service Men's Health coordinator	High percentage of screenings from "high risk" group	Miss target clients	Link with "care planning" development of IDM project	
Protocols Re access to screening ?? Newly diagnosed ?? Random identification ?? Existing diagnosed clients ?? Reviews	Links with initial needs identification assessment and care planning process being established for PCP service coordination IDM Project	Agreed protocols available			