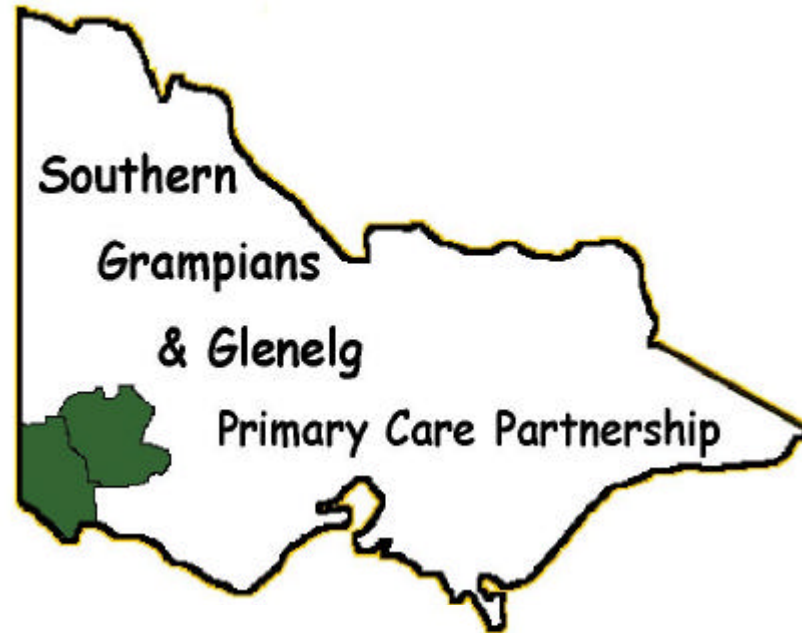


**SOUTHERN GRAMPIANS & GLENELG
PRIMARY CARE PARTNERSHIP**



COMMUNITY HEALTH PLAN

2003 - 2004

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Introduction

Since 2000, the Primary Care Partnership (PCP) strategy has been the mechanism for primary care reform in Victoria. Agencies have formed partnerships, prepared Community Health Plans and implemented these plans through a series of projects, programs and changes in the way they do their business.

A recent Southern Grampians and Glenelg PCP internal evaluation reported on progress to date and noted common themes including the recognition of the importance of the PCP in assisting agencies to maximise their outcomes, the need for agencies to be strategic in their involvement with PCPs, and that the PCP is seen as 'an important vehicle' to facilitate collaboration and coordination of activities. Overall comments showed that the PCP is responsive and supportive, works well and has brought agencies together.

A clear concept of the Social Model of Health now exists and is referred to as the framework for service delivery and strategic planning by many agencies.

Key priorities for the coming year, in order to continue to realise our vision, include furthering the development and implementation of service coordination tools, ongoing integration of health promotion and consumer engagement. A community report will be written as a follow up to the July 2001 'Working Together' report to inform community members regarding progress to date and next steps.

The Community Health Plan will report under the key framework areas of Partnerships, Integrated Health Promotion, Service Coordination, Consumer and Community Participation, Integrated Services Planning and the PCP Quality Framework/Internal Review.

The plan will then focus on operational issues under key population groups including youth, older people and aboriginal health. The operational plan will outline community and service profiles, linkages, local priorities, strategies and outcomes for consumers. The plan will also identify resource requirements and evaluation methods.

The Community Health Plan identifies the priority health and well being needs of the community and describes how providers are working together with input from consumers and carers to:

- Improve health and well being in their communities.
- Improve people's experience of primary care services.
- Strengthen health promotion and service coordination.

Partnerships

The Southern Grampians & Glenelg Primary Care Partnership has continued to consolidate relationships with agencies in the catchment area. Examples include a Memorandum of Understanding with the Winda-Mara Aboriginal Corporation which was launched in July 2002, the development of a constructive working relationship with the Dhauwurd Wurrung Elderly Citizens Association, and a Memorandum of Understanding with the Women's Resource Service located at Portland & District Community Health Centre which was launched in December 2002.

Service providers and consumers collaborated in the development of the Consumer Charter, which was finalised in July 2002 and is now displayed by all member agencies in public areas.

There are many agency initiatives that show case true partnership development – working closely with community health centres, housing agencies, local government, police, hospitals, GPs and schools.

Consumer and Community Participation in Planning

The PCP Internal Review highlighted that a range of consumer participation frameworks are in place across the agencies. Agencies reported various consumer committees, consultation with consumers in service planning and setting strategic direction and formal, confidential feedback mechanisms for consumers.

The Southern Grampians and Glenelg PCP recognises that community engagement is more than just consumer consultation and participation and that service planning must consider the needs of the wider community, not just the needs of the current service users. It has developed a strategy to develop the capacity both with primary care organisations and in the broader community to provide a real opportunity to influence outcomes. The primary focus is to share the experience of existing strategies within agencies and develop improved consumer and community participation within primary care agencies through funding support to demonstration projects.

This is a key priority for the SG & G PCP and will be addressed through the 'Community Engagement' project including the documentation of current best-practice in consumer and community participation and the implementation and evaluation of the NRCCPH Primary Care Self-Assessment Tool for Community and Consumer Participation. Consumer engagement underpins all planning and strategies across all population groups

Engagement with General Practitioners

The PCP internal evaluation found that, whilst partnerships between GPs and other agencies have improved, there are opportunities for further improvement. There is a perception that the issue of engaging GPs is a difficult area and therefore a key priority for the next 12 months. Options to address this focus area include developing and implementing an expanded project plan including further analysis, the development of tangible and practical projects, assisting providers with how to set realistic expectations with GPs and exploring options to assist GPs to manage paperwork demands.

The Otway Division of General Practice (ODGP) will continue to be consulted regarding activities that impact on General Practice. The ODGP will determine whether the PCP activities have an alignment with the ODGP's Strategic & Business Plans and the resources available for collaboration. Where collaboration between the ODGP and PCP has been negotiated the ODGP will help facilitate GP engagement. Other strategies will need to be investigated for obtaining GP input where the Otway Division is not an active partner. The formation of medical panels providing input into projects will be considered as with more general GP input regarding PCP activities.

Integrated Health Promotion

The Integrated Health Promotion Plan takes an integrated approach to responding to the priority health and well being needs of the local communities. The PCP endorsed a health promotion strategy in July 2002 to be implemented under the management of a Health Promotion Reference Group, providing a collaborative focus for strategic health promotion planning, review, capacity building and investment across the Southern Grampians and Glenelg shires.

The PCP funds collaborative health promotion projects, enabling agencies/providers to participate and learn as they develop collaborative, evidence based projects. Guidelines have been agreed for use of the funding. The PCP has agreed to focus on lifestyle behaviours rather than specific diseases as the first level of decision- making and then define target groups as the second level of planning. In addition the PCP has made a commitment to target groups of consumers previously marginalised in service development such as people with mental health issues; those with disabilities; those living on low incomes; those with low literacy skills; people with chronic health conditions; indigenous people and those living in rural and remote areas.

Locally identified disease priorities ('Healthy Communities Report' - Halstead Management Services 2002) include cardiovascular disease, asthma, diabetes, drug and alcohol issues, mental health and family violence. Aboriginal communities were identified as a specific target group.

A range of Health Promotion activities are underway, including Exercising Safely, Beyond the Farm Gate, Making Cents with Food, Strength Training for Older Adults, Women on a Mission, Mental Health Promotion, Prevention and Early Intervention, and development of a life skills proposal.

The focus for the coming year is to further integrate Health Promotion, develop a quality improvement for HP strategy and review the funding guidelines.

Integrated Disease Management

Integrated disease management can reduce the burden of disease through a holistic approach. It encompasses the continuum of care - from prevention through to treatment, management and maintenance. Integrated disease management is consumer focused and is underpinned by evidence-based research.

The PCP has an Integrated Disease Management and Partnerships Strategy to develop improved linkages between primary care agencies providing services in Southern Grampians and Glenelg shires, General Practitioners and the acute sector through improved multidisciplinary teamwork and the management of chronic disease within the catchment area. The agreed health priorities for the PCP are cardiovascular disease, asthma, diabetes, mental health, drug and alcohol-related problems and family violence.

Service Coordination

Development of service coordination policies and practice across the South West has been co-ordinated through the Service Co-ordination Working Group managed through PCP-SW. This group reports to the Clinical Primary Care Sub-Committee of the South West Alliance of Rural Health (SWARH) and through this group to the SWARH Steering Committee.

Funding was made available to agencies (up to \$5000 per agency) in 2002/3 to support their internal work on service coordination and use of the service coordination tool templates. Agencies that have received funding are Western District Health Service, ASPIRE, South Western Aged Care Assessment Service, Balmoral Bush Nursing Centre, Dartmoor & District Bush Nursing Centre, Southern Grampians Shire Council, Glenelg Shire Council, Casterton Memorial Hospital, Portland & District Hospital, Portland & District Community Health Service and Heywood Rural Health. The PCP is currently considering further options for service co-ordination funding in 2003/4. It is proposed that funds be made available to support agencies in the development of demonstration and/or best practice projects.

Specific projects being undertaken across the South West include developing protocols across all agencies, workshops on privacy for a range of providers and the development of protocols, development of inter-agency multidisciplinary care coordination protocols and integration of the service coordination tools across acute, sub-acute and community health at Portland & District Hospital

Service Information

The Southern Grampians & Glenelg PCP maintains a local primary care service directory on behalf of all agencies in the district using the INFOCOM Data Manager, chosen for its flexibility and excellent export/printing facilities that can meet local needs and potentially interface with the statewide database once issues around ownership of data have been resolved centrally. The PCP provides a service to agencies and service providers through the provision of individual personalised directories in formats appropriate to their needs.

The SW Counselling Directory has been distributed to over 400 service providers, including all GPs in the sub-region and is now available on the PCP website. The SW Transport Database information has been included and updated. The PCP is developing a model delegating responsibility for updating various sections of the database to relevant organisations, allowing for sustainability of the database as an accurate and current repository of information.

An agreement is being finalised with Southern Grampians Shire Council on integration of their recreational, sporting and community information within the PCP database; a key feature is negotiation of access by the Shire to the database for updating.

Integrated Service Planning

The 'Healthy Communities Integrated Planning Project'¹ 2002 commenced the integration of planning processes in South West Victoria and identified regional issues that required regional strategies, while recognising the continuing importance of local issues being tackled locally. The project resulted in Integrated Services plans for the PCPs, 5 Municipal Public Health Plans and a 5-shire Community Safety Plan and established links with a number of other plans and strategies such as Drug & Alcohol, Transport, and Mental Health.

A Management Group has been established for the 5 municipalities to ensure integrated implementation of the Healthy Communities Plan. Warrnambool City Council is the auspice agency to coordinate this work. The PCP has agreed to contribute \$25,000 to this process, including the development of a comprehensive planning database.

The PCP internal evaluation has shown that reports, including Healthy Communities and Burden of Disease, are clearly being referred to by agency members to use when undertaking planning. The weekly PCP Bulletin is seen as a useful tool to monitor service-planning activities and PCP meetings are also used as a tool for overall service planning. The Glenelg Shire is developing a document, which will report on the community well being for the shire addressing issues including crime, unemployment and health.

Following strategic planning for health services across the Southern Grampians and Glenelg shires², providing a strategic context for the five health services, the PCP contributed to the design of a viable sub-acute model of care for the Shires of Southern Grampians and Glenelg³. Sub acute care is understood to incorporate that level of care that is less intense and less diagnostically specific than acute care, incorporating the need for skilled medical and allied health interventions. Rehabilitation is the most clearly recognised form of sub acute care, but it also includes the assessment and management of multiple pathologies in older people, palliative care and aged mental health care. The challenge is to find a way of delivering an appropriate sub-acute service to smaller communities. It requires the development of new service models, and moving beyond the traditional sub-acute paradigms. The PCP will contribute to this development.

¹ *Healthy Communities Integrated Planning Report June 2002. Halstead Management Services*

² *Southern Grampians/Glenelg Public Sector Health Services Strategic Planning (2002-2007) April 2002 Tony Cull.*

³ *The Southern Grampians/Glenelg Rehabilitation Program: A Sub-Acute Model for Western District Rural Communities. Sach & Associates. December 2002*

PCP Quality Framework

The quality framework/internal review collected and collated information from participating PCP agencies in order to report on progress to date. The report was completed in May 2003. Steps taken by the review included contacting all participating agencies, sending background information, meeting with agencies, documenting and summarising interviews and preparation of a report with interview summaries as attachments.

A number of themes and opportunities emerged from the review including the recognition of the importance of the Primary Care Partnership in supporting agencies, improved collaboration, improved mentoring, sharing and learning and extremely positive feedback regarding the current management and leadership.

The Southern Grampians and Glenelg PCP has taken a strategic approach to primary care reform to ensure that activities are practical and that providers and the community can start to see tangible outcomes. Key targets for the coming year include:

- Improved integration of disability services into the PCP
- Implementation of a range of strategies to decentralise primary care reform and encourage all agencies to take lead roles in relevant activities
- Improve the use of information technology and communication to facilitate the effective participation of all providers without adding significant costs to the agencies in travel.
- Continue to develop workforce capacity and resources in the catchment, using people with expertise to nurture the development of others.
- To develop effective linkages with the acute health and medical services to ensure service coordination, health promotion and integrated planning activities have maximal outcomes for the community

OPERATIONAL PLAN

The operational plan addresses priorities and strategies for key population groups in the Southern Grampians and Glenelg PCP. The operational plan has been written in consultation with member agencies and will be supported by a CHPIA to ensure all strategies are implemented.

Priorities over the 2003/04 year include consumer engagement that crosses over all population groups together with progressing integrated disease management initiatives and continuing to integrate service coordination and health promotion activities across all providers.

Youth Issues

<p>Community and Service Profile</p>	<ul style="list-style-type: none"> • The loss of young people from country communities is seen as a major concern; as the Community and Service Profile population of young people declines, there are less social and recreational opportunities for those remaining as well as fewer support services and programs to assist this group. • Significant issues faced by young people in rural communities include a high unemployment rate, a high rate of teenage pregnancies, high levels of substance abuse (largely alcohol and cannabis), and a significant number of homeless youth. Koori youth were identified as demonstrating a higher risk of problems than for young people as a whole in the region (Healthy Community Report).
<p>Linkages</p>	<ul style="list-style-type: none"> • Koori health • Drug & Alcohol • Sexual Health • Asthma in schools project • Needle exchange • Access to Counselling • 10mmm • Freeza • Consumers
<p>Local priorities</p>	<ul style="list-style-type: none"> • The priority is to continue to bring together key agencies, providers and young people in a focussed planning process • Develop the context, policy framework and an action plan to agree on priority issues and strategies to address the health and well being of young people in a collaborative manner

Youth Issues continued

Strategies		
Problem Definition/Solution Generation	Support and Resources	Review and Evaluation
Undertake consultations with youth workers and school nurses	PCP Project Officer	Consultation completed and evaluated by 30/12/03
Conduct a workshop for all key stakeholders (which will be an important first step)	PCP - SW and SG & G PCP	30/12/03
Relative roles of local government, PCPs and other initiatives such as the Southern Grampians & Glenelg Local Learning & Employment Network, Drug Treatment Services and schools, will be developed during the planning process.	All agencies/youth workers	Ongoing review
Life skills project	Drug and Alcohol Services	Complete project proposal by 30/12/03
Capacity building in the youth sector, establishing working relationships with key agencies and linkages (if granted).	Life Skills team	Improved capacity for consumers
Utilise the Youth Community Connections Grant that will form the model for developing a Youth Health Promotion Strategy.	Health Promotion Reference Group	Strategy to be developed by 31/10/03
Engage young people in the planning and development of strategies and initiatives for health promotion and capacity building	Community youth	Ongoing

Older People

Community and Service Profile	<ul style="list-style-type: none"> • Ageing of the population (Southern Grampians and Glenelg community profile⁴) is the most challenging issue facing the community. • By 2011 it is anticipated that 26.8% of the population will be over 60 years and 14% over 70 - the towns and townships have a higher proportion of older people as older people often move out of farm properties to towns as they reach more advanced years. • Ageing of the population will place pressure on health and community support services as they become more vulnerable to ill health, with cardiovascular disease, cancer and diabetes major problems. • Carers face a range of demands and young carers have been identified as extremely vulnerable and disadvantaged in our community.
Linkages	<ul style="list-style-type: none"> • Southern Grampians Aged and Disability plan • Sub-acute plan for Southern Grampians and Glenelg shires - rehabilitation • Carers support - Western District Health Service (WDHS); South West Respite Network • PCP projects - Exercising Safely, Active Penshurst • Dementia care • Consumers
Local Priorities	<ul style="list-style-type: none"> • The PCP to work across SW Victoria with PCP-SW, DHS and Local Governments to develop services and examine all available options for meeting any identified gaps. • Reduce the burden of illness in older people through development of a Healthy Ageing Planning Framework • Support for workforce development and training for carers and direct care staff about issues relevant to working with older people.

⁴ Southern Grampians & Glenelg Community Profile 2001. Prospero Consulting

Older People cont

Strategies		
Problem Definition/Solution Generation	Support and Resources	Review and Evaluation
<p>Implementation of the Healthy Ageing Strategy – under the HP umbrella.</p> <p>Develop a carers' service directory</p> <p>Address ageing parents – people with disabilities</p>	<p>Health Promotion Reference Group</p> <p>Service Co-ordination Project Workers</p> <p>Disability agencies</p>	<p>Reduction of risk factors</p> <p>Increased level of physical activity</p> <p>Improved access to service information</p>

Aboriginal People

Community and Service Profile	<ul style="list-style-type: none"> • While members of the Aboriginal community represent approximately 2% of the South West region, they are clearly shown to be the most disadvantaged group with regard to general health issues and particular attention should be given to their needs. Issues including diabetes and reduced average life span are of particular concern to the Indigenous community.
Linkages	<ul style="list-style-type: none"> • Projects – Making Cents with Food • Community Dreaming Project • Rot Gut poster (WDHS) • Towards a Healthy Heart • Glenelg Outreach Primary Health • HP funding will actively plan and encourage HP projects with Koori target groups • Building existent relationships with Dhauwurd Wurrung Elderly Citizens Association (DWES) and Winda Mara Aboriginal Corporation • An agreed framework on Aboriginal health issues has been developed between the Aboriginal community and primary care providers and a Memorandum of Understanding was signed in July 2002. • Consumers
Local Priorities	<ul style="list-style-type: none"> • Improved access to mainstream allied health, mental health and specialist services • Increased awareness of cultural and gender specific issues • The community has also requested additional services to address substance misuse and associated family violence.

Aboriginal People continued

Strategies		
Problem Definition/Solution Generation	Support and Resources	Review and Evaluation
<p>Ongoing implementation of the Memorandum of Understanding</p> <p>Develop brochure of Winda Mara's services, develop a directory of relevant services and a list of after hours services for use by Winda Mara Aboriginal Corporation</p> <p>Provide Winda Mara with information and training on use of hard copy and electronic service directories</p> <p>Job exchange program for skill development and to improve mainstream services to become more culturally aware</p> <p>Support the planning and development of gender specific initiatives including Mara Women's, Group and Men's Health Group</p> <p>Assist Indigenous groups in supporting, creating and promoting cultural heritage throughout the South West region</p>	<p>PCP Project Officer and Winda Mara Executive</p> <p>Winda Mara Aboriginal Corporation</p> <p>Glenelg Shire, Glenelg Southern Grampians Drug Treatment Service, Mara Women & Winda Mara</p> <p>Regional approach</p> <p>PCP project officer to facilitate</p>	<p>Identification of indigenous issues in relation to the provision of mainstream services, predominately in the area of health through the development of the MOU</p> <p>Improved access to information on Winda and Mara and mainstream services</p> <p>Improved access to mainstream services and job skills</p> <p>Improved collaborative and integrated planning and support</p> <p>Creation and maintenance of cultural heritage</p>

Women's Health

<p>Community and Service Profile</p>	<ul style="list-style-type: none"> • The Barwon South West Women's Health (BSWWH- A3) Women's Health Resource Worker sought the establishment of this Service Linkages Protocol with the Southern Grampians & Glenelg PCP to enhance the engagement between BSWWH -A3 and PCP member agencies by identifying their respective roles, responsibilities and commitments with respect to improved health and well being for women. • A Service Linkage Protocol was negotiated between the PCP and the SW Women's Health Resource Worker based at Portland & District Community Health Centre. It was signed in December 2002 • BSWWH-A3 is a small, specialist, multi-catchment community-based organisation that is managed by women for women. It is funded by the State Government, under the Victorian Women's Health Program, to facilitate the delivery of quality health services to women. BSWWH -A3 is located within the Portland & District Community Health Centre and provides an accessible resource service to workers in a variety of agencies; and promotes and facilitates women's health policy, planning and program development in the shires of Glenelg, Southern Grampians, Moyne and the City of Warrnambool. • BSWWH-A3 operates to achieve the following outcomes: <ul style="list-style-type: none"> • Equality of access • Equity in service delivery – recognition of the different health needs of women • Representation to enable equal participation in decision making
<p>Linkages</p>	<ul style="list-style-type: none"> • Coleraine Hospital Women's Health • PCP Health Promotion Reference Group • Women on a Mission • Portland and Casterton Neighbourhood House • Portland and District Community Health Centre • WDHS Womens Health Program • BreastScreen • WISP (Wholewoman Information Sharing Protocol) • Consumers
<p>Local Priorities</p>	<ul style="list-style-type: none"> • Improve responsiveness of PCP planning, analysis and strategies to the needs of women • Improve responsiveness of PCP member agencies services for women

Women's Health continued

Strategies		
Problem Definition/Solution Generation	Support and Resources	Review and Evaluation
<p>Analyse 2001 census/health data and link to the priorities to be identified in the BSW Women's Health Plan.</p> <p>Women's health and gender issues will be linked to the development of the mental health promotion, prevention and early intervention plan.</p> <p>Family violence has been identified as a PCP priority and will be addressed in a coordinated way with other networks at a regional level.</p> <p>Provision of education and training programs that highlight the impact of gender on community health and wellbeing to PCP member agencies;</p> <p>Development of a gender analysis framework that can be applied to the work of the PCP and member agencies;</p>	<p>PCP to co-ordinate Health Promotion Coordinator</p> <p>Aspire</p> <p>Women's Health Resource Worker</p> <p>Women's Health Resource Worker</p> <p>Aspire</p>	<p>Plan due 15/7/03</p> <p>Improved access to relevant service information</p> <p>Develop indicators for evaluation to be included in a gender framework above.</p>

People with Disabilities

Community and Service Profile	<ul style="list-style-type: none"> • Centrelink data recorded 4,217 people receiving the aged pension in the Southern Grampians Glenelg region in 2001. During the first quarter of 2001, 576 people were receiving a carer allowance, with 1,238 people receiving a Disability Support Pension. The report "Moving the Mountain"⁵ was received by the PCP Executive in February 2002 and the identified issues were integrated into the Healthy Communities report
Linkages	<ul style="list-style-type: none"> • Life skills project • Exercising safely • The Rural Access Worker is actively linked with PCP activities and disability action plans • Consumer engagement project • Consumers
Local Priorities	<ul style="list-style-type: none"> • Equity of access to primary care services • Improvements in transport • Address attitudinal and other barriers that often prevent people with disabilities receiving appropriate and holistic health and community care.

Strategies		
Problem Definition/Solution Generation	Support and Resources	Review and Evaluation
<p>Develop a carers' service directory and work with Glenelg Disability Action Group to coordinate production of service directory information.</p> <p>Ongoing support and participation in Disability Action Groups</p> <p>Continue to encourage and support agencies such as Mulleraterong to gain health promotion funding</p> <p>Support program workers in disability services – eg staff supervision, debrief, education, learning and development</p>	<p>Service Co-ordination Project Workers</p> <p>Health Promotion Reference Group</p>	<p>Improved access to information</p> <p>Enhanced staff well being – improved retention, reduced 'burnout'</p>

⁵ *Moving the Mountain. April 2002. Jill Warne*

Continue to support and encourage the use of dual diagnosis and acquired brain injury services	SWHC (dual diagnosis), ABI clinicians	Improved outcomes for clients
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Drug and Alcohol Issues

Community and Service Profile	<ul style="list-style-type: none"> • Key issues have been identified in the Glenelg & Southern Grampians Drug Action Plan and include underage drinking (particularly spirits and mixed drinks), binge drinking, use of cannabis and use of tobacco. • Quamby Glenelg and Southern Grampians Drug Treatment Services auspiced the development of the Drug Action Plan for the municipalities of Glenelg and Southern Grampians (November 2001) • The PCP conducted a priority setting exercise for Quamby to identify key tasks and strategies for implementation • PCP funded the collection of comprehensive information on drug and alcohol use, service provision and issues to further inform the development of effective strategies
Linkages	<ul style="list-style-type: none"> • Better Access to Counselling • Winda Mara Working Group – following on from the MOU • Life Skills project • Drug Action Plan • Community Strengthening Initiatives • Consumers
Local Priorities	<ul style="list-style-type: none"> • Develop initiatives and strategies that will promote and enhance early intervention and prevention in communities • Increase community awareness of the incidence of drug-related harms • To further enhance the engagement of consumers and increase consumer input in planning and implementation • Develop local structures and networks to support the carers and families of people with drug & alcohol issues • Support the development of appropriate drug and alcohol policies and practices in schools, local tertiary institutions and agencies

Drug and Alcohol Issues continued

Strategies		
Problem Definition/Solution Generation	Support and Resources	Review and Evaluation
Appoint a Drug and Alcohol reference group across the two Municipalities and a part-time coordinator to assist implementation of Drug Action Plan	Local Government Areas Glenelg Southern Grampians Drug Treatment Service Community agencies	Increased understanding of culturally specific issues re family
Support the Winda Mara approach to family based workshops and camps as a pilot project	Glenelg Southern Grampians Drug Treatment Service Portland District Health (formerly Portland District Hospital & Portland & District Community Health Centre)	Improve access to services
Annual update and distribution of information, leaflets and brochures; develop a directory of after hours referral services	Glenelg Southern Grampians Drug Treatment Service All agencies	
Extend the number of venues for the needle and syringe programs; develop a service directory which includes needle exchange programs and syringe disposal units	Western District Health Service Portland District Health Glenelg Southern Grampians Drug Treatment Service Drug Action Plan	Reduce harms associated with injecting drug use in communities
Increase awareness raising activities on issues such as binge drinking including use of Information Kits	Local Government Authorities	Improve capacity for informed choice
Promote Teacher education programs on drug and alcohol issues and involve students and relevant community agencies in the design of school programs	All agencies Drug Action Plan	Improve knowledge and support for teachers and students re use and misuse of substances
Provide education and treatment programs for tobacco users	Glenelg Southern Grampians Drug Treatment Service Drug Action Plan	Enhances collaborative and integrated approach to drug and alcohol issues
Offer training workshops to staff of relevant community agencies and networks on drug and alcohol issues	Schools Community agencies	Improve capacity of service providers
Work with Winda Mara to improve access to counselling		

services and appropriate use of funding	Glenelg Southern Grampians Drug Treatment Service Community Health Services	
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Drug and Alcohol Issues continued

Develop initiatives to raise awareness of misuse and abuse of prescribed medications	Glenelg Southern Grampians Drug Treatment Service GP's Pharmacists	Reduced misuse of prescribed medication
Promote safe use and management of medication within the general community		Improve safety of medication management

Mental Health Issues

Community and Service Profile	<ul style="list-style-type: none"> As reported in the 'Healthy Communities Report', it is calculated that over half of all people with mental illness do not receive services and treatment from the health system, with a resultant need to improve treatment and care for a broader range of people with high level needs while continuing service reform for existing client groups. Special high needs groups include Aboriginal people and rural and remote areas. It is well recorded and recognised that the suicidal death rate in rural communities is high. With the devastating consequences of drought and bushfires to farmers, the PCP has supported and assisted in the funding of the Applied Suicide Intervention Skills Training (ASIST), held in Hamilton in May 2003. The PCP has also participated in the development of the 1st Rural Mental Health Conference to be held in July 2003, the development of the SW Community Mental Health Plan that has endorsed as the mental health component of the PCP Community Health plan.
Linkages	<ul style="list-style-type: none"> Better Access to Counselling Services Women on a Mission - Portland Life Skills project - Portland Primary Mental Health Team Post Natal Depression group - WDHS Beyond Blue - PND information for GPs Consumers
Local Priorities	<ul style="list-style-type: none"> As identified in the SW Community Mental Health plan

Mental Health Issues continued

Strategies		
Problem Definition/Solution Generation	Support and Resources	Review and Evaluation
<p>The Southern Grampians and Glenelg Primary Care Partnership will continue to support the development of the South West (Rural) Primary Mental Health Team and is involved in the Stakeholders group.</p> <p>The PCP will continue to identify opportunities for mental health promotion in all strategies being developed.</p> <p>The PCP has been active within the Promotion/Prevention/Early Intervention Group auspiced by ASPIRE aiming to improve provider and community understanding and literacy regarding mental health and mental illness.</p> <p>PCP assisted in the facilitation of a Panel discussion at the Beyond Blue Post Natal Depression forum held in Warrnambool in February 2003.</p>	<p>Primary Mental Health Team (PMHT)</p> <p>Better Access to Counselling Project Worker</p> <p>PMHT Stakeholders Group</p> <p>ASPIRE, A Pathway to Mental Health</p> <p>Beyond Blue</p>	<p>Improved management of depression and anxiety</p>

Access to Counselling Services/Regional Leadership Initiative

<p>Community and Service Profile</p>	<ul style="list-style-type: none"> • Community consultation for the Healthy Communities Project identified widespread concern about the level of provision of counseling services, particularly in the rural areas of the South West region. • Ideas developing from this program include better use of specialist providers as mentors to generalists and developing shared care options to both meet client needs and up skilling providers on an ongoing basis.
<p>Linkages</p>	<ul style="list-style-type: none"> • Primary Mental Health Team • Memorandum Of Understanding (MOU) developed between Winda Mara Aboriginal Corporation and PCP. MOU Working party developed implementing strategies to enhance engagement and relationships between the Indigenous population and the mainstream service providers. • Consumers
<p>Local Priorities</p>	<ul style="list-style-type: none"> • Professional support and supervision available. • To build the counselling capacity of practitioners by providing them with ready access to needed information, resources and services. • To determine the most appropriate counselling model to address the specific counselling needs of the community.

Access to Counselling/Regional Leadership Initiative continued

Strategies		
Problem Definition/Solution Generation	Support and Resources	Review and Evaluation
<p>To develop sustainable professional support and supervision processes.</p> <p>Maintain and enhance the South West Counselling Directory</p> <p>Provide required training opportunities locally and maintain provision of information on training</p> <p>Complete the evaluation of the Resource and Brokerage Program and make recommendations to DHS for future funding</p>	<p>PCP Project Officer</p> <p>Steering Committee</p> <p>RMIT - Melbourne campus</p>	<p>Improved referral processes through the database, enabling practitioners to refer more efficiently and effectively</p> <p>Enhanced skills through professional development opportunities</p> <p>Improved communication and relations between practitioners through increased opportunities to network</p> <p>More opportunity for specialised counseling to those who would not otherwise be able to receive it through Counseling Resource and Brokerage Program</p> <p>Increased opportunity for support and debriefing for practitioners, which ultimately impacts on the retention of practitioners</p> <p>Increased capacity and knowledge of GPs of high prevalence mental health disorders (anxiety, depression)</p> <p>Improved access to service information</p>

Chronic Disease Management

<p>Community and Service Profile</p>	<ul style="list-style-type: none"> • Cardiovascular disease, including heart diseases, stroke and related vascular diseases, remains the major public health problem for Australia responsible for 40% of all deaths in Australia. Indigenous communities are identified as particularly vulnerable with twice the rate of the non-indigenous population. People of lower economic status are also more likely to die from cardiovascular disease. • Asthma and Diabetes have been identified as local priorities and received Integrated Disease Management funding for 3 years from the Commonwealth; these projects are to be finalised by December 2003
<p>Linkages</p>	<ul style="list-style-type: none"> • Better access to counseling • Women on a mission • Making cents with food • Toward a Healthy Heart • Consumers
<p>Local Priorities</p>	<ul style="list-style-type: none"> • Work collaboratively with relevant agencies across SW Victoria to develop a comprehensive approach to cardiovascular disease • Complete the Asthma IDM project and involvement with the DHS Regional Respiratory Pathways project • Investigate options that continue work on asthma • Support completion of the Diabetes IDM project managed though PCP-SW • Increase the uptake of physical activity for all people

Chronic Disease Management continued

Strategies		
Problem Definition/Solution Generation	Support and Resources	Review and Evaluation
<p>To implement the Active Script Program with the local GPs in collaboration with the Greater Green Triangle Centre for Rural Health and PCP-SW</p> <p>To support South West Sports Assembly in increasing its focus on Health Promotion through the Vic Health Participation in Community Sports Scheme and the Older Adults Recreation Network Program</p> <p>Development of CVD proposal through Greater Green Triangle University Department of Rural health</p> <p>"Exercising Safely" Project Phase 2</p> <p>Develop awareness of chronic disease self-management models and implement agreed model in the catchment - linking in with asthma</p> <p>All relevant agencies will continue to be consulted at all stages of the project. Negotiations will occur with these agencies regarding respective roles to maximise collaboration and outcomes</p>		<p>Improve collaboration across all provider groups including GPs and pharmacists</p> <p>Increased awareness thru' HP activities (e.g. QUIT program for maternal and child health nurses). Improved asthma management for consumers in the rural area, improved skills through professional development for health professionals and increased opportunity to network</p> <p>Improved self management strategies through education and asthma management plan</p> <p>Improved access to service information re health and physical activities</p>

Family Violence Issues

<p>Community and Service Profile</p>	<ul style="list-style-type: none"> • Details of the level of family violence in Victoria and SW Victoria are included in the “Healthy Communities Report”¹. The term “family violence” is used rather than domestic violence as more than one family member may be involved. Women are usually the victims. Children are often traumatised either as witness or victims themselves of violence, and men are affected usually as the perpetrator of violence or, in a very small number of cases, as a victim. • Agencies with a specialist focus on family violence are Emma House, CASA, and DHS – child protection. Emma House and CASA have limited resources and are stretched in terms of service provision. All service agencies have clients dealing with family violence, including health and welfare, drug and alcohol, housing, local government, general practitioners, police. • The PCP coordinated a SW Workshop on Family Violence in April 2003 that developed strategies for implementation over the coming year
<p>Linkages</p>	<ul style="list-style-type: none"> • Better access to counseling • Women on a mission • Making cents with food • Toward a Healthy Heart • Consumers
<p>Local Priorities</p>	<ul style="list-style-type: none"> • Work collaboratively with relevant agencies across SW Victoria to develop a comprehensive approach to cardiovascular disease • Complete the Asthma IDM project and involvement with the DHS Regional Respiratory Pathways project • Investigate options that continue work on asthma • Support completion of the Diabetes IDM project managed though PCP-SW • Increase the uptake of physical activity for all people

Family Violence Issues continued

Strategies		
Problem Definition/Solution Generation	Support and Resources	Review and Evaluation
<p>PCPs in the SW to work with their member agencies and encourage them to develop workplace policies on family violence. A Forum of member agencies would be a first step in this process.</p> <p>Development of training and awareness programs to support agencies once they have developed family violence policies</p>		<p>Better utilise funding</p>

Transport Issues

<p>Community and Service Profile</p>	<ul style="list-style-type: none"> • The continuing gaps and limitations of transport options are continually identified and the impact is felt by all sectors in the community but special reference was made to the needs of older residents, those with disabilities and youth. It is recognized that while there have been significant achievements in the development of community transport options that affects the areas covered by all 3 Plans, serious limitations and difficulties remain. • Transport is an essential component in maintaining physical and mental health and involvement in the community. In particular, young people in small towns wish to access social/sporting activities in the larger centres and educational/vocational/employment opportunities. • The SW Community Transport Development project has been successful in initiating and supporting community transport services in Portland, Heywood, Merino, Coleraine, Balmoral, Hamilton, Peshurst, Macarthur, Mortlake, Camperdown, Warrnambool, Timboon/Cobden. Funding for community transport for Casterton and Port Fairy is being pursued. • Agreed volunteer policies and resources have been developed for use by all community transport services
<p>Linkages</p>	<ul style="list-style-type: none"> • Consumers • Shire Councils • Rural Access Worker/s • Volunteer Network • SouthWest Community Transport
<p>Local Priorities</p>	<p>The PCP will continue to support and work closely with the SW Community Transport Development Program as transport is identified as a key priority. This will include:</p> <ul style="list-style-type: none"> • Development of community transport responses for individual communities and groups. • Improved facilities for access to transport by people with special needs. • To provide continuing support for the South West Community Transport Development Project (auspice Western District Health Service) to improve, increase and extend transport options in the South West. • Improve the accessibility of existing public and/or community transport facilities for those with special needs (e.g.) frail aged, persons with disabilities, parents with prams/pushers etc.

Transport Issues continued

Strategies		
Problem Definition/Solution Generation	Support and Resources	Review and Evaluation
<p>Develop community transport services to meet areas of identified need in SW Victoria.</p> <p>Improve access to information on transport services - The South West Community Transport Directory was first produced in 2000 and information is regularly updated.</p> <p>Develop a Transport Planner linked to the PCP Services directory</p>	<p>PCP Information Management Project Officer</p>	<p>Improved access to transport service information</p> <p>Improved access to services</p> <p>Well supported volunteers</p>

Availability of Services

<p>Community and Service Profile</p>	<ul style="list-style-type: none"> Residents in South West Victoria are concerned by the limited availability of locally based health services. The professions identified during the consultation process as lacking in numbers and availability includes General Practitioners and the broad range of allied health professionals. Dental services were consistently identified as an issue¹. Portland and Hamilton have been unable to recruit a dentist to the Public Dental Health Services in those areas and there is a two to three year waiting list for non-emergency dental treatment. Alternative approaches to increasing high cost dental treatment need to be considered if dental health is to be managed.
<p>Linkages</p>	<ul style="list-style-type: none"> Consumers Barwon South West Regional Network Advisory Group (BSW RNAG)
<p>Local Priorities</p>	<ul style="list-style-type: none"> Recruitment and retention of a broad range of health and community support professionals. Promote succession training within organisations and agencies Strategies for shared and/or visiting positions, including outreach medical specialists that match local demand. Explore the potential for some health consultations, education and support to be provided through phone and video links. The Barwon South West Regional Network Advisory Group (managed by the PCP for the Victorian Healthcare Association) organized a regional conference on workforce issues May 21st 2003. The strategies developed by the conference will form the agenda for the next year

Availability of Services continued

Strategies		
Problem Definition/Solution Generation	Support and Resources	Review and Evaluation
<p>Develop training for leadership and organisational development, including for both staff and volunteers</p> <p>Develop opportunities for staff placements and rotations in a variety of sectors to broaden skills and experience</p> <p>Promote rural practice including lifestyle benefits</p> <p>Develop a coordinated approach for new and potential professionals including billeting, mentoring and support for the whole family</p> <p>Develop opportunities to acknowledge the work of the many workers often working in isolation and with difficult clients</p> <p>Develop a reliable and effective infrastructure to improve access to training and meetings and reduce the costs of travelling</p>	<p>BSW RNAG committee</p>	<p>BSW RNAG to develop over next 12 months</p>

CHIP1A - to be forwarded by 4/7/03