



Hume Moreland Primary Care Partnership



**HUME MORELAND
PRIMARY CARE
PARTNERSHIP**

**STRATEGIC PLAN
2006 – 2009**



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Forward

The Hume Moreland PCP Strategic Plan 2006-2009 is the fourth such plan that the PCP has developed.

Since the first PCP Community Health Plans were produced in 2001, the overall strategic vision for PCPs has been revised and refined to reflect the combined experiences of the PCPs to date, as well as broader changes in the Victorian (and Australian) health systems. Likewise, as an individual PCP, we have developed a clearer (and perhaps more realistic) understanding over the past six years of the unique role that the Partnership can play in improving the service systems operating in Hume Moreland, and we have also adapted our objectives and strategies to respond to changing circumstances in our catchment.

In particular, the priorities set out in the Partnership section of the 2006-2009 Strategic Plan reflect our perception of the broader strategic context within which the PCP is now operating. These priorities relate to Integrated Chronic Disease Management, Area Based Planning for Ambulatory Care, and Child, Youth and Family Services. The Partnership objectives and strategies are designed to increase the collective capacity of member agencies to respond positively to developments in these three priority areas.

In developing the Integrated Health Promotion section of the Strategic Plan, we have sought to build upon our experiences over the past three years by continuing to work around the Physical Activity priority, with the goal of increasing the level of participation in physical activity among Hume Moreland residents. Our two specific objectives are to strengthen planning partnerships for more physically active communities, and to increase the opportunities for physical activity available to those groups of people less likely to exercise.

The Service Coordination section of the Plan has been developed jointly with the Moonee Valley Melbourne PCP. This is the outcome of a gradual process of working more closely on a number of service coordination initiatives over the past 12 months including the Melbourne Health Community Gateways Expo, the Refugee Health Service Coordination Project and the Connectingcare referral implementation process. Significant goals for service coordination over the next three years will be to engage a broader spectrum of program areas, and to develop multidisciplinary care planning systems especially for people with chronic diseases and complex conditions.

The PCP's experiences and achievements in Integrated Health Promotion and Service Coordination have provided the foundation for the Integrated Chronic Disease Management section of the Strategic Plan. This is an exciting new area of activity for the PCP, and we have sought to develop a plan which involves a broad spectrum of member agencies from the outset (especially in the area of chronic disease self management), while at the same time working closely with the Moreland Community Health Service and the North West Division of General Practice on the Early Intervention in Chronic

Disease Program to develop and implement an integrated model of care which can then be expanded to the entire catchment.

Many groups and individuals have been involved in the development of this Strategic Plan. They include:

Hume Moreland PCP Partnership Management Group
Hume Moreland PCP Health Promotion Implementation Group
Hume Moreland and Moonee Valley Melbourne PCPs Service Coordination
Implementation Groups
Hume Moreland PCP Integrated Chronic Disease Working Group
Hume Moreland PCP Staff (Alex Butler, Meg Henderson, Vicki Klapsinos, Clara Mandaletti)

We look forward to implementing the Plan over the coming triennium, and thus achieving our vision of a robust and flexible partnership which is able to plan, implement and evaluate not only initiatives that require collaboration between primary care services, but those that require collaboration between primary care services and other services or sectors, in order to achieve greater integration in health promotion, services and chronic disease management.



Roslyn Stevens

Chair
Hume Moreland Primary Care Partnership

Deliverable 1: Partnerships

1. Partnership Vision

Hume Moreland PCP seeks to be a robust and flexible partnership which is able to plan, implement and evaluate initiatives that require collaboration between primary care services, or between primary care services and other services or sectors, in order to achieve greater integration in health promotion, services and chronic disease management.

2. Achieving the Vision: Priority Setting and Problem Definition

Hume Moreland PCP has identified the following partnership priorities (and associated goals) which will be addressed during the period 2006-2009:

1. Embracing Integrated Chronic Disease Management

During its first six years of operation, Hume Moreland PCP has been oriented towards achieving objectives related to the three strategic directions of partnership development, integrated health promotion and service coordination. The addition of a fourth strategic direction – Integrated Chronic Disease Management (ICDM) – to the PCP’s range of responsibilities will have implications for every level and area of the PCP, from governance through to administrative support, and for both service coordination and integrated health promotion. A major challenge for the PCP over the next three years will be to ensure that rather than merely adopting an “add on” approach to ICDM, the PCP as a whole adapts and expands to encompass this new strategic direction.

Partnership Goal 1:

Ensure that the PCP’s membership, structure, governance, management and operations enable it to exercise appropriate leadership in the area of Integrated Chronic Disease Management.

2. Area Based Planning

Area based planning for ambulatory care (“Care in Your Community”) will be a major focus of activity for many PCP member agencies over the next three years, and will involve collaboration between primary care services, as well as between primary care services and Metropolitan Health Services. Adding value to the area based planning process and assisting our members agencies involved in area based planning will be a major challenge for the PCP over the next three years, particularly given that our catchment does not align with that of a single Metropolitan Health Service and that the role of PCPs in the planning process is not yet known. Given this situation, the PCP has decided that the most appropriate and useful approach we can take to planning at this stage is to take on a contained piece of planning work focused around a specific ambulatory care sensitive health condition. This work can then be shared with any area

based planning processes which include all or part of the Hume Moreland catchment. The condition which has been agreed upon by the PCP is diabetes.

Partnership Goal 2:

Build capacity and contribute to area based planning for ambulatory care through a focus on diabetes.

3. Child, Youth and Family Services

Much PCP activity to date has been oriented towards coordination and integration of services to meet the needs of older members of the Hume Moreland community, especially those with chronic disease. However, while both the Hume and Moreland catchments include large populations of older people, many of our member agencies also serve many young families. This is particularly true of Hume, which includes one of Melbourne's largest growth corridors. The regional implementation of the "Every Child, Every Chance" Strategic Framework for Family Services in early 2007 will offer the PCP an opportunity to begin to expand and balance its focus to encompass the needs of children and families, including their social needs. Catchment planning for services has been aligned with PCP catchments, with the planned North Central Catchment Planning Group covering Hume and Moreland. At this stage, it appears that contributing to the work of this Group may be the most effective way for the PCP to become involved in the field of child and family services.

Partnership Goal 3:

Develop the capacity of the PCP to promote collaboration between primary care services and other services and sectors in the Child, Youth and Family Services area.

3. Achieving the Vision: Capacity Building Plan

Objective 1: Ensure that the PCP's membership, governance, management, staffing and operational arrangements are adequate to the task of achieving our vision and the goals we have identified for the period 2006 to 2009.

Strategy: Partnership Review

The Partnership Management Group will undertake a substantive review of

- PCP membership
- Governance arrangements
- Structure, membership and Terms of Reference of existing and potential Implementation Groups, Working Groups etc.
- Management and staffing arrangements
- Communications

As a first step in this review, member agencies will be asked to complete the VicHealth Partnership Analysis Tool (PAT) in order to gain an understanding of the current strength of the partnership, and to identify aspects of the partnership which need to be addressed in order to achieve our vision.

Timeframe:

Early 2007

Relates to:

Partnership Vision, Goals 1, 2 and 3

Integrated Health Promotion, Service Coordination and Integrated Chronic Disease Management

Estimated impacts:

- Stronger commitment to the Partnership by member agencies. This will be measured by asking agencies to complete the VicHealth PAT again in early 2009, and comparing results with those obtained at baseline (early 2007).
- Changes to some or all of the PCP elements listed above. To be documented in annual PCP report.

Objective 2: Maximise the PCP's effectiveness and efficiency

Strategy: Collaboration with neighbouring PCPs

In recognition of the facts that:

- The “natural” catchments for some areas of activity in which Hume Moreland PCP is involved do not necessarily align with, or are not confined to, the Hume Moreland catchment boundaries; and
- Some activities are common to all PCPs and therefore lend themselves to economies of scale;

Hume Moreland PCP will seek to maximise its effectiveness and efficiency by collaborating with other PCPs. In particular:

- We will continue to develop our current collaborative arrangements with Moonee Valley Melbourne PCP in the area of service coordination and explore possibilities for collaboration in other areas
- We will investigate the possibility of establishing a closer relationship with North Central Metropolitan PCP, especially around activities involving Northern Health.

Timeframe:

Develop relationship with MVM PCP – Ongoing from July 2006

Investigate possibility of establishing a closer relationship with NCM PCP – Early 2007

Relates to:

Partnership Vision, Goal 2

Service Coordination, possibly Integrated Health Promotion and Integrated Chronic Disease Management

Estimated impact:

PCP is able to achieve objectives and goals in all four strategic areas within current resource limits.

Objective 3: Increase the level of resources available to the PCP and its member agencies to undertake activities in the four strategic areas

Strategy: Facilitate collaborative funding opportunities

The PCP will identify funding / resourcing opportunities around identified priorities in all four strategic areas of activity (partnership development, integrated health promotion, service coordination and integrated chronic disease management), and take the initiative in inviting agencies to come together to explore the possibilities of developing collaborative submissions or tenders.

Timeframe:

Ongoing

Relates to:

Partnership Vision, Goals 1, 2

Integrated Health Promotion, Service Coordination and Integrated Chronic Disease Management

Estimated impacts:

- The PCP and member agencies attract additional funding in one or more strategic areas of activity
- The PCP is able to point to achievements beyond those specified in this plan in one or more strategic areas of activity
- Stronger commitment to the PCP by member agencies (see Objective 1 above)

Objective 4: Raise the level of awareness and knowledge of PCP member agencies and staff around our priority areas

Strategy: Forums and Workshops

In addition to events organised by specific Implementation / Working Groups, the Partnership Management Group will host an annual forum focusing on an important issue relevant to all or most member agencies, and additional forums/workshops as required to build capacity around the priorities identified.

Timeframe:

Ongoing. First annual forum to be held in February 2007.

Relates to:

Partnership Goals 1,2 and 3
Integrated Chronic Disease Management

Estimated impacts:

More PCP member agencies, managers and staff will be actively involved in (and supportive of) developments in the designated priority areas. Measures will include numbers of participants in forums and workshops, feedback from participants, and success in achieving stated objectives around priorities.

Objective 5: Make a tangible contribution to area based planning processes for ambulatory care occurring in the Hume Moreland catchment

Strategy: Diabetes Planning Exercise

Undertake a contained planning exercise focused around the ambulatory care needs of people with diabetes, pre-diabetes or at risk of diabetes living in the Hume Moreland catchment. The scope of this exercise could include:

- Identification of potential care needs of people at different stages of disease progression;
- Identification of service models;
- Collation and dissemination of available health status data;
- Mapping of existing services and service usage rates and patterns; and
- Documentation of service gaps.

Agencies will be requested to contribute EFT or other resources to this project.

Timeframe:

Diabetes planning exercise to be undertaken during first half of 2007

Further strategy or strategies to be included in PCP annual report when area based planning arrangements involving the Hume Moreland catchment have been clarified by DHS

Relates to:

Partnership Vision, Goals 1,2

Integrated Health Promotion, Service Coordination, Integrated Chronic Disease Management

Objective 6: Create a shared knowledge base around child and family services among PCP member agencies through participation in the Family Services North Central Catchment Planning Group and other relevant networks, alliances and collaborations.

Strategies: Information sharing, networking and alliance building

Specific activities to be undertaken will include:

- Engaging existing member agencies active in the area of child, youth and family services
- Engaging other agencies in the Hume Moreland catchment which specialise in child, youth and/or family services
- Raising awareness and knowledge of PCP member agencies of developments in child, youth and/or family services including the Strategic Framework for Family Services
- Exploring with DHS Regional Office the potential opportunities for PCPs to contribute to the establishment and work of the North Central Catchment Planning Group

Timeframe:

Begin implementing strategy in 2007-2008

Relates to:

Partnership Vision, Goal 3
Service Coordination

4. Hume Moreland Primary Care Partnership Member Agencies, 2006

Agency ¹	Partnership Management Group	Health Promotion Implementation Group	Service Coordination Implementation Group ²	Integrated Chronic Disease Management Working Group ³
Anglicare Victoria			*	
Australian Greek Welfare Society			*	
Broadmeadows Disability Service			*	
Brotherhood of St Laurence			√	
Brunswick Neighbourhood House				
Carinya Society	√		*	
Church Nursing Service (Baptist Community Care)			√	
Dianella Community Health	√	√	√	√
Distinctive Options Ltd.				
Hume City Council	√	√	√	
Interchange North West	√		*	
Kurdish Association of Victoria				
Link Community Transport			√	
Melbourne Citymission	√		*	

*= involved in service coordination but not represented on Service Coordination Implementation Group

+ = have been involved in initial ICDM discussions, and anticipate involvement in 2007

¹ All member agencies are invited to participate in general partnership activities such as forums and contributing to the electronic newsletter

² Meets jointly with Moonee Valley Melbourne PCP Service Coordination Implementation Group

³ Short term working group set up to prepare Early Intervention in Chronic Disease Implementation Plan and ICDM section of this plan. PCP will establish ongoing structures for planning and implementing ICDM as part of its Partnership Review in early 2007, and it is anticipated that a larger number of agencies will become actively involved at that point.

Melbourne Health	√		√	+
Moreland City Council	√	√	√	√
Moreland Community Health Service	√	√	√	√
Moreland Hall	√			
North West Melbourne Division of General Practice	√	√	√	√
Northern Health (Broadmeadows Health Service)	√	√	√	+
Royal District Nursing Service	√		√	+
Sunbury Community Health Centre	√	√	√	+
Vision Australia Foundation		√		
Women's Health in the North	√	√		

Deliverable 2: Integrated Health Promotion

1. Vision

Health promotion practices in the Hume Moreland catchment will be more cohesive and more targeted with agencies working towards complementary goals around agreed health promotion priorities.

2. Priority Setting and Problem Definition

Catchment priority for 2006-2009: Physical Activity

Goal:

To increase the level of participation in physical activity among residents of the Hume Moreland catchment

Objectives:

1. To strengthen planning partnerships for more physically active communities
2. To increase the opportunities for physical activity available to those groups of people less likely to exercise

Rationale

Physical activity is one of the statewide health promotion priorities. It has been chosen with due consideration for the evidence available about the needs in the catchment, builds on the PCP's previous IHP work around this priority (including a Falls Prevention project) and complements the plans of the the two local governments (Moreland and Hume) and the three community health services (Dianella, Moreland and Sunbury) in the Hume Moreland catchment.

The available evidence about the importance of physical activity is clear. According to VicHealth :¹

- Physical inactivity accounts for 7% of the total burden of disease in Australia, second only to tobacco smoking.
- Physical inactivity has been linked to coronary heart disease, stroke, type 2 diabetes, high blood pressure, osteoporosis, some cancers and a slower recovery from depression.
- 54% of adults are not doing enough physical activity to reap health benefits and this percentage is increasing steadily
- Together with a healthy diet and not smoking, regular physical activity plays an important role in helping prevent chronic disease

According to the National Heart Foundation, the direct healthcare costs of inactivity in Australia are about \$400 million and more than 8000 deaths per annum.²

¹ VicHealth, Physical Activity Fact Sheet, February 2006.

² Bauman A, Bellew B, Vita P, Brown W, Owen N, 2002 'Getting Australia Active: towards better practice for the promotion of physical activity', March 2002.

There is abundant research evidence demonstrating that physical activity levels are influenced by a wide range of environmental, economic, financial, social and cultural factors^{3 4}. Data for the North West Metropolitan Region of Melbourne (in which the Hume Moreland catchment falls) show lower levels of participation in sufficient physical activity than the Victorian average, although not at a level deemed to be statistically significant⁵. The reasons for low levels of physical activity are likely to include socio economic disadvantage, underdeveloped physical infrastructure, and social and cultural factors.⁶

Many of the macro factors that influence physical activity levels are beyond the PCP's scope of activity and influence. The two objectives associated with the physical activity priority and goal have therefore been selected to reflect the PCP's potential to bring about a positive improvement in this area.

Objective 1

The first objective relates to the PCP's capacity to encourage and support partnerships. There are many players in the catchment with an interest and involvement in physical activity. Some of these players approach the issue from a health perspective, whereas others have a focus on sport and recreation, or infrastructure planning. Local government is a particularly important player because it encompasses all three dimensions of physical activity. Given that most of the key players in this area, including local government, are PCP members, the PCP is in an ideal position to work on bringing together and supporting cross-agency and cross-professional partnerships around the development of physically active communities in the broadest sense of the term.

Objective 2

The second objective derives from the fact that PCP member agencies already work with, and have a strong commitment to, disadvantaged groups in the catchment population. In many cases, these agencies already encourage and/or provide physical activity programs for these groups. The PCP goal envisages the development of a more integrated approach in this area and the creation of capacity to engage and involve larger numbers of people from those groups who are less likely to take part in physical activity.

³ Department of Human Services, 'Environments for Health: Promoting Health and Wellbeing through Built, Social, Economic and Natural Environments, September 2001

⁴ National Heart Foundation of Australia 'Promoting Physical Activity: Ten Recommendations from the Heart Foundation' May 2001.

⁵ Department of Human Services, 'Physical Activity, healthy eating and overweight/obesity', 2003

⁶ Maslen, G, 'Postcodes with Paunches', The Age, 17 April 2006.

Scope and Focus

In developing this IHP plan, the PCP has considered what the scope and focus of its work around the physical activity priority should be.

There are four main domains of physical activity in our society. These are:

1. As a form of transport (walking or cycling to destinations or combining with public transport)
2. During leisure time (participating in sport or active recreational activities)
3. At home (domestic duties, maintenance and gardening)
4. At work (manual labour)⁷

A possible fifth domain is physical activity undertaken as part of a structured rehabilitation and/or self management program under the guidance of a health professional.

The major focus of the PCP's IHP activities will be on the maximization of opportunities for, and involvement in, physical activity as a form of transport and as a leisure activity. In addition, we will seek to improve the links between exercise programs run by health agencies and mainstream physical activity opportunities

Within these parameters, the PCP's activities will have a particular emphasis on walking.

Walking has been selected due to its almost universal accessibility and its flexibility. Walking can be practiced in many different situations, alone or in groups, at almost no extra cost to the walker. Walking can be a multi-purpose activity, combining one or more of transport, physical exercise and social interaction. Walking offers benefits to the whole community as well as the individuals who undertake it, including increased social connectedness, community safety and energy saving. Walking is a valuable form of transport in that it can replace car journeys over shorter trips or can be combined with public transport. With over 45% of car trips in metropolitan Melbourne being shorter than 2km there is plenty of scope for encouraging more walking and less car use.⁸

⁷ VicHealth, Victorian Health Promotion Foundation, Fact Sheet: Physical Health, February 2006

⁸ Department for Victorian Communities, Go For Your Life, A State of Walking, 2006.

3. Integrated Health Promotion Catchment Implementation Plan 2006–09

Priority: Physical Activity

Objective(s):	<ol style="list-style-type: none"> 1. Strengthening planning partnerships for more physically active communities 2. Increasing the opportunities for physical activity available to those groups of people less likely to exercise 					
Estimated impacts (qual/quant)	<ol style="list-style-type: none"> 1. More opportunities available for physical activity in Hume Moreland catchment, especially for those population groups less likely to exercise. 2. More people in Hume Moreland taking part in physical activity, especially walking for transport and/or exercise. 					
Summary of mix of interventions	Key implementation partners	Population target group/s:	Estimated timelines (optional)	Estimated reach	Estimated intervention resources per member⁹	Estimated impacts
MULTI-AGENCY INITIATIVES¹⁰ - HUME						
Hume agencies participate in Hume City Council Leisure Services strategic approach: <i>plan, provide, partner and advocate</i> ¹¹	Hume City Council Dianella CH Sunbury CH Broadmeadows Neighbourhood Renewal Community groups and sporting clubs State Government departments	All Hume residents and workers. Priority Groups as identified within Hume Leisure Strategy: sporting club members; lower socio-economic groups; women /young women/new mothers; seniors; people with	Strategies listed are active documents with ongoing strategic planning and related actions identified	Population of Hume – 148,200 (ABS estimate, 2004)		Increased participation in physical activity, especially among priority groups. Higher levels of walking and cycling for commuting and recreation purposes

⁹ Established resources allocated to physical activity priority by Community Health Services have been included as sub-totals under agency specific initiatives. It has not been possible to estimate resource allocation for other agencies.

¹⁰ Includes interventions which involve two or more key PCP member agencies but which are not part of the formal PCP Capacity Building Plan. Lead agency or agencies listed first.

¹¹ Includes Hume City Leisure Strategy Plan 2006-2010, Development Principles Recreation and Community Facilities 2006, Play Space Strategy (in draft) and Open Space Strategy.

		disabilities; ATSI groups; CALD groups / newly arrived young people at risk; young people in urban growth areas				
Development of Hume Municipal Public and Primary Health Strategic Plan 2006-2011	Hume City Council Dianella CH Sunbury CHC Northern Health DHS North West Melbourne Division of General Practice Hume Moreland PCP	All Hume residents and workers	Plan to be finalised by end 2006	As above		Integrated approach to health promotion across Hume, including focus on physical activity
Hume Healthy Youth Development Framework	Hume City Council Dianella CH Sunbury CHC Royal Children's Hospital Local youth providers	Young people	Ongoing			
Hume Supportive Environments for Physical Activity ¹²	Hume City Council Dianella CH Sunbury CHC Vision Australia	Pedestrians / walkers (including walking groups)				More opportunities for walking as transport and leisure
Hume Walking School Bus	Hume City Council Dianella CH Local primary schools VicRoads / RoadSafe North Western	Primary school children and their parents and carers		Ten routes operational by end 2006		More children (and parents and carers) walking to and from school

¹² Includes footpath maintenance and linking and improving walking / cycling paths

Physical Activity and self management bridging programs ¹³	Broadmeadows Health Service Dianella CH Sunbury CHC Hume City Council Leisure Centre	New mothers Seniors People with diabetes & other chronic diseases People wanting to lose weight People in chronic pain	Ongoing			More people from specified groups participating in mainstream physical activity programs
MULTI-AGENCY INITIATIVES - MORELAND						
Participation in Active Fawkner Network to increase physical activity options in Fawkner	Moreland City Council Moreland CHS Sports clubs covering lawn bowls, table tennis, soccer, tennis, little athletics, folk dance group, football, bocce, basketball, Taekwando etc	Fawkner residents	Ongoing			Improve physical activity capacity and options in Fawkner
Continuing development of the pedometer loans scheme through Moreland Libraries.	Moreland City Council Moreland CHS	Moreland community	ongoing	10 pedometers in each of the 5 Moreland Libraries		Community members more motivated to achieve desirable physical activity levels
Participate in 2 Community Festivals in relation to physical activity (one in Brunswick/ Coburg area and one in Fawkner).	Moreland CHS Moreland City Council Active Fawkner Network	Moreland residents		500		Greater awareness of benefits of physical activity

¹³ Refers to programs that include introduction to community physical activity facilities. Includes new mothers' *Well Women's Workout*, Seniors' *Living Longer, Living Stronger* programs, *One Step Ahead* diabetes self management program, weight management programs, *Getting On With It* chronic pain management program, Broadmeadows Neighborhood Renewal *Well for Life* program, *Back to Exercise* program, Planned Activity Groups which incorporate physical activity, such as chair aerobics or tai chi.

Produce a brochure 'free stuff to do in Moreland' for young people, focusing on Physical Activity	Cocare – MCHS Moreland City Council Youth Services	12 – 18 years	2007	1000		Higher levels of participation in local physical activity options among young people
Increase physical activity options for older people – Establish an 8 week 'Come and Try' Program for older population groups in Fawkner and Glenroy introducing a range of new physical activity options such as table tennis, dancing etc and promote membership and sustainability of new physical activity options	Moreland Council Moreland CHS Active Fawkner Network Fawkner Leisure Centre Broadmeadows Leisure Centre	Older people in Glenroy/ Fawkner	2007	60 older people	Full implementation dependent on 'Go for Your Life' Services funding (submission pending)	Higher levels of physical activity among older people in Fawkner and Glenroy Bridging program into existing Physical Activity options
Support peer leadership model by recruiting volunteers to attend Get Active Walking Group training and facilitate 6 new community walking groups.	Moreland CHS Womensport and Recreation Moreland City Council Glenroy Neighborhood Learning Centre	ATSI community Mums with young children	2007	6 community volunteers 60 new walking group members		Higher number of trained walking group leaders and walking groups
Work with young women to provide new physical activity options, including	Moreland CHS Moreland City Council Sporting clubs Leisure centres	Young women aged 16-25 from Fawkner / Glenroy		30 young women		More physical activity options for young women. More young

identifying existing physical activity opportunities available in their local communities						women taking part in physical activity
Work with Coburg Leisure Centre to develop a range of strategies to increase access for young people to the leisure centre.	Moreland CHS Coburg Leisure Centre	Young people	ongoing			Increased numbers of young people using Coburg Leisure Centre
Participate in Glenroy Neighbourhood House 'Go for Your Life' steering committee to implement 2 new physical activity options for English as a Second Language participants and provide exercise sessions for African womens group	Glenroy Neighbourhood Learning Centre Moreland City Council Moreland CHS Dianella CH	Glenroy residents	Ongoing			Increased numbers of Glenroy residents taking part in physical activity
Investigate possibility of Moreland City Council and other agencies signing up to International Charter for Walking	Moreland Health Safety & Wellbeing Leadership Group					Greater commitment to walking & walkability across Moreland municipality
DIANELLA COMMUNITY HEALTH – AGENCY SPECIFIC INITIATIVES						
Support	Broadmeadows Leisure Centre	Partner agencies		150		Increased

establishment of women's only swimming program	Hume City Council Broadmeadows Community Neighborhood Renewal Victorian Arabic Social Services Migrant Resource Centre	Women				participation in water based physical activity among women in Hume.
Dianella Physical Wellbeing Working Group to support implementation of nutrition and physical activity strategies		Dianella staff	Ongoing			Increased internal capacity around physical activity
Weight Management Program	Broadmeadows Leisure Centre	Dianella CH clients /local community members experiencing weight management issues	6 week program delivered 4 times per year	70 people per year		Participants become more physically active
Vietnamese walking group		Elderly Vietnamese	Ongoing	20		Participants more physically active, aware of benefits of physical activity.
Support bilingual Arabic and Turkish peer leaders in running diabetes prevention and education programs	University of Melbourne	Arabic and Turkish speaking residents at risk of diabetes	Ongoing. Will act as sessional leaders for diabetes and cardiac rehabilitation groups	100		Increased level of understanding among Turkish and Arabic speaking residents of role of physical exercise in preventing diabetes

Work with Broadmeadows Community Neighbourhood Renewal (BCNR) Health and Wellbeing Working Group	BCNR and their project partners	Residents living in BCNR area	Ongoing	Walking group has approximately 6 members. Some other residents participate in walking group		Working Group members more aware of benefits of physical activity Working Group members provide information to residents on benefits of physical activity, opportunities for physical activity BCNR walking group is supported
Improve levels of physical activity among Psychiatric Disability Support Service clients	Finchley Psychiatric Service (part of Dianella Community Health)	Finchley clients	Ongoing	20 – 30 clients		Finchley clients more physically active, aware of psychological & physical benefits of physical activity
Run exercise group for Aboriginal Elders	Broadmeadows Leisure Centre	Dianella Staff Broadmeadows Uniting Care Wondarra Group	Completed Oct 06	6 Aboriginal Elders		Participants more aware of benefits of physical activity
Continue to support Dianella volunteer aqua aerobics leaders	Broadmeadows Leisure Centre Craigieburn Centre	Hume CC	Ongoing	Target 60 clients		Aqua aerobics leaders feel supported and continue in their role
Implement 8 week 'No Falls' program 3 times a year and identify opportunities		Older people at risk of falls		60 – 120 people		Reduced number of falls, higher levels of physical activity among

to reduce risk of falls in older population						participants
Resource sub-total for Dianella CS					\$235,472	
MORELAND COMMUNITY HEALTH SERVICE – AGENCY SPECIFIC INITIATIVES						
Convene an internal working party for physical activity and active communities.		Moreland CHS staff	Ongoing			Increased internal capacity around physical activity
Contribute 10 hours a year staff time to health weeks/ days relating to physical activity		Moreland residents	Ongoing			Greater awareness of benefits of physical activity
Provide 3 articles to local newspaper on Physical Activity and MCHS programs and services	Moreland Leader	Moreland Leader readership	Ongoing			Greater awareness of benefits of physical activity
<i>Foot Health Week</i> ‘Feet at work’ Activities <ul style="list-style-type: none"> ▪ Media release ▪ Liaison with local Trade Associations ▪ Local radio interview ▪ FHW displays across 4 sites ▪ Information for GP Division weekly fax bulletin ▪ Promotional emails/daily competition for MCHS staff 	Australian Podiatry Association	Moreland residents and workers	August 2006			Raise awareness of foot care at work and how increased walking can be included into work environments
Support fun ‘n healthy in Moreland project to link project activities to local sporting clubs and activities	24 participating primary schools	‘fun n healthy’ primary schools in Moreland	2007	3000 children over 24 schools		Ensure sustainability of project activities past the life of the project

Implement 8 week 'No Falls' program 3 times a year		Older people at risk of falls	2007-2009	60 people		Reduced number of falls, higher levels of physical activity among participants
Explore funding opportunities to support 2 peer leaders to be trained as tai chi for arthritis leaders in Moreland, with the aim of these leaders supporting existing groups	Arthritis Foundation	Moreland residents with arthritis	2007	6 community volunteers 30 Tai Chi participants		More people with arthritis taking part in tai chi. Better understanding of positive benefits of gentle physical activity for people with arthritis
Consult with residents from Stewart Lodge SRS in Brunswick to explore and introduce 2 new physical activity options for residents such as Tai Chi or swimming	Stewart Lodge managers Avalon Exchange program	Residents of Stewart Lodge have chronic mental health problems and/or intellectual disability		Up to 70 residents		Most Stewart Lodge residents taking part in physical activity.
Incorporate physical activity participation into all counselling care plans for young people. Evaluate the impact of this strategy on levels of physical activity and analyse for barriers to participation		Young counselling clients	2007			Greater understanding of barriers, incentives to physical activity among young people. More clients taking part in physical activity
Resource sub-total for Moreland CHS					\$120,602	

SUNBURY COMMUNITY HEALTH SERVICE – AGENCY SPECIFIC INITIATIVES						
Establish 6 new walking groups per year from different locations in Sunbury	Community Groups Neighbourhood houses	First time mums and general Sunbury population	06-09	500		More sunbury residents taking part in regular physical activity in group setting
Increase the opportunities and access to physical activity options for people at risk of developing chronic condition by establishing graded exercise programs in different community locations	Community Groups Neighbourhood houses Retirement villages	People at risk of developing chronic conditions Older people living in independent accommodation	06-09	6000 contacts over 3 years		More Sunbury residents at risk of chronic disease taking part in regular physical activity in group setting
Improve the health and wellbeing of children with special needs in the Sunbury area, through participation in pilot swimming program and swim instructor training	Sunbury Early Intervention team (CHC) Aus Swim Local swim instructors	Special needs children, especially children with autism	06-07	20		Special needs children in Sunbury taking part in water based activity
Resource sub-total for Sunbury CHS					\$45,000	
WOMENS HEALTH IN THE NORTH						
Provide gender specific data in relation to women	WHIN	Women PCP member agencies	2006 - 2007	PCP member agencies in the catchemnt		Support a gendered approach to

and physical activity to inform the planning and implementation of programs in the Hume Moreland catchment in line with the advocacy role of WHIN in the region and sector				Community agencies in the catchment		program planning benefitting both men and women through programs and services that target their specific needs
Publish and disseminate the WHIN Health Behaviours Research Paper – Women and Physical Activity	WHIN PCP member agencies	PCP member agencies	2006 - 2007			Support a gendered approach to program planning benefitting both men and women through programs and services that target their specific needs
HUME CITY COUNCIL – COUNCIL SPECIFIC INITIATIVES						
Hume Leisure Centres – direct service delivery including subsidisation of gym memberships for	Local residents, schools and community groups	Hume residents and people who work in Hume	Ongoing			Enhanced levels of participation in physical activity at Hume Leisure facilities
Support for organised sports via provision of local facilities and grounds	Local sporting clubs / associations Local disability services / Access for All Abilities partners	Sporting club members	Ongoing	31 sports reserves currently provided and maintained		Organised sports in Hume continues to increase
Support for physical activity via	Local community groups Sporting clubs	Community group members	Ongoing			Number of people taking part in

Community Grants funding	Groups using Neighbourhood Houses					physical activity through community groups continues to increase
Hume Community Dance Program	Neighbourhood Houses	Young people	Ongoing	Over 2,000 participants weekly		People who might not take part in traditional sports undertaking regular physical activity
MORELAND CITY COUNCIL – SPECIFIC INITIATIVES						
Link new walkability indicators across Moreland City Council Departments	Moreland City Council departments, including: Social Development City Infrastructure City Development	People who live, work or study in Moreland	2007			Greater focus on making Moreland more walkable
Provide opportunities for residents to link to sporting clubs, recreation centres and neighbourhood houses using Moreland Community Directory and Moreland Council Webside	Moreland City Council Social Development Department	People who live, work or study in Moreland	Ongoing			More people involved in physical activity through sporting clubs, recreation centres and neighbourhood houses
Support the implementation of transport initiatives, including:	Moreland City Council Transport Unit	Primary school	Ongoing			More people walking / cycling to school, work for shopping in

<ul style="list-style-type: none"> Walking school bus Riding school bus Behaviour change programs to decrease car use for short trips Travelsmart 		<p>aged children</p> <p>People who live, work or study in Moreland</p> <p>Moreland City Council staff</p>				Moreland
Identify opportunities and provide programs and support for increased physical activity among different population groups	Moreland City Council Social Development Department	<p>Youth</p> <p>Families</p> <p>Aged</p> <p>Women</p> <p>People from CALD backgrounds</p> <p>Aboriginal people</p> <p>People with a disability</p>	Ongoing			More people involved in physical activity
Increase opportunities for Physical Activity and Walkability into urban planning, especially via the structure plans for Coburg, Brunswick and Glenroy	<p>Moreland City Council:</p> <ul style="list-style-type: none"> Strategic Planning Unit Activity Centres Unit 	People who live, work or study in Moreland	2007-2009			Greater focus on making Moreland more walkable
Provide opportunities for increased physical activity for Council	Moreland City Council Human Resources Unit	Council staff	ongoing			More staff involved in physical activity

staff as an OH & S initiative						
Develop a Women in Recreation Policy	Moreland City Council: Community Development - Social Policy unit Youth and Leisure	Females in Moreland	2007			More women involved in physical activity
NORTH WEST MELBOURNE DIVISION OF GENERAL PRACTICE						
Lifescrpts initiative	North West Melbourne Division of General Practice	General Practitioners in north west Melbourne	Ongoing	Approximately 265 GPs have been offered these resources so far	NWMDGP staff time at 0.5 days per week	More GPs in Hume Moreland actively encouraging consumers to take part in physical exercise
NORTHERN HEALTH – BROADMEADOWS HEALTH SERVICE						
Falls – Multi disciplinary management in individual and group situation	Northern Health – BHS Community Therapy Service (CTS)	Clients who have fallen or who have fear of falling	Ongoing			Maintenance of mobility within community – reduction in falls
Better Health Self Management	Northern Health – BHS Community Therapy Service (CTS)	Residents of Hume and Moreland	Groups run when referral numbers sufficient (8 or more referrals)			Participants able to self manage and more physically active

4. Capacity Building

1.1 Organisational Development

Objectives:

1. Increase the commitment of the PCP and its member agencies to the concept and implementation of integrated health promotion.
2. Support agencies to participate effectively in integrated health promotion.

PCP Structure

Key Activities	Timeline	Estimated Impact
Ensure that PCP Partnership Management Group (PMG) is aware of and committed to IHP priorities and workplans.	2006-07	PMG is able to provide high quality feedback to Health Promotion Implementation Group (HPIG). PMG members actively support and encourage IHP within their agencies.
Review membership of HPIG to ensure that all agencies committed to physical activity priority are appropriately represented.	2006-07	HPIG is able to make decisions and implement strategies effectively and efficiently.
Employ a PCP Health Promotion Officer (HPO) with appropriate skills and experience in an ongoing capacity.	2006-07	PCP member agencies are provided with expert advice on IHP relevant to their specific situation and experience.

PCP organisational facilitation role

Key Activities	Timeline	Estimated Impact
Ensure that HPIG and HPO are aware of organisational health promotion planning requirements and timelines of all member agencies (eg local government, community health, women's health, Divisions of General Practice) and that processes are in place to promote integration between these plans and the PCP plan with respect to physical activity.	2006-07	Interventions around physical activity are maximised and integrated.
Provide evidence based information and resources relevant to physical activity to member agencies.	2006-09	Physical activity interventions are evidence based.
Develop relationships and provide links with relevant local, regional, statewide organisations.	2006-09	Member agencies have access to broad range of knowledge and contact around physical activity.

4.2 Partnerships

Objectives:

1. Develop and strengthen the relationships between the PCP member agencies involved in Integrated Health Promotion in order to increase the level of integration and responsiveness around physical activity.
2. Develop new partnerships with agencies primarily involved with walking as a form of transport in order to maximise the opportunities for walking.

Key Activities	Timeline	Estimated Impact
Organise an initial planning forum around physical activity involving existing and potential participants in IHP activities. Repeat annually to review progress and identify opportunities and priorities.	2006-09	Participants increase knowledge and understanding of role and activities of other agencies / organizations involved in physical activity. Creation of shared knowledge base and understanding around physical activity priority.
Provide opportunities for staff from participating agencies to report back to the broader PCP membership on their experiences, achievements and difficulties in addressing the physical activity priority.	2006-09	Knowledge of IHP activities around physical activity in all member agencies is improved.
Disseminate information about funding opportunities related to physical activity to member agencies (and if relevant other potential partners) and encourage the development of PCP wide submissions where the grants provide opportunities to respond to identified local needs and strengthen local partnerships, and where the size of the grants is commensurate with the resources involved in preparing the submission	2006-09	Resource base for integrated physical activity promotion is increased. Partners gain experience in planning and working together.
Use the VicHealth Partnership Analysis Tool to assess current level of commitment to IHP among member agencies, and to identify barriers and constraints that need to be addressed as a precondition to further integration. Repeat in 2009 as part of the evaluation process.	2006-07	HPIG is comfortable and committed to the role it is required to perform.
Ensure that the PCP is represented on appropriate committees and networks relevant to physical activity.	2006-09	PCP member agencies are aware of broader developments in physical activity area. PCP influences initiatives in physical activity beyond those undertaken by member agencies.
Identify agencies involved in encouraging walking as transport, develop links and identify opportunities for joint activities.	2006-07	Opportunities and resources available for walking initiatives are maximized. Greater knowledge and

		understanding between health and transport sectors around promotion of walking.
Audit a range of organisations that have impact on walking and walkability and identify strategies to promote walking reduce the hindrances to walkability	2006-07	As above

4.3 Leadership

Objective:

Increase the capacity of members of the HPIG to play a leadership role with respect to IHP around physical activity both within their own agencies and across the PCP catchment.

Key Activities	Timeline	Estimated Impact
Provide HPIG members with information about and access to resources relevant to physical activity eg data, literature, workshops, forums, conferences, websites etc.	2006-09	HPIG members have the information and knowledge to play a leadership role around physical activity.
Provide HPIG members with opportunities to exercise leadership around IHP relevant to physical activity within and beyond the PCP eg presentations at forums and workshops, participation in IHP planning activities etc.	2006-09	HPIG members gain the experience needed to play a leadership role around physical activity.
Publicise membership, role and activities of HPIG to member agency staff through PCP newsletter, website, events etc.	2006-09	Member agency staff understand the role of HPIG and look to HPIG members as leaders in the field of IHP around physical activity.

4.4 Workforce development

Objectives:

1. Increase awareness of the importance of physical activity among all primary care workers in the Hume Moreland catchment, as well as knowledge of steps that they can take to direct clients towards appropriate physical activities.
2. Increase the number of staff (and where appropriate volunteers) of member agencies qualified to plan, organize, lead and evaluate physical activity programs targeted towards members of the Hume Moreland population identified as less likely to exercise.

Key Activities	Timeline	Estimated Impact
Use monthly electronic PCP newsletter and other available local media (including electronic service directories, websites etc.) to share information about physical activity opportunities in the community.	2006-09	Staff of member agencies are aware of physical activity opportunities available to their clients.
Publicise findings and resources resulting from PCP Foothold on Safety project to members agencies.	2006-07	Greater understanding among staff of how falls prevention interventions can facilitate physical activity among older clients.
Finalise and distribute GP information resource on group physical activity programs at Hume Moreland CHSs and update annually.	2006-09	GPs and other General Practice staff are aware of, and refer clients to, appropriate CHS physical activity programs.
Facilitate and/or provide training for existing and potential walking group leaders.	2006-07	Availability of more leaders facilitates creation of additional (and greater diversity of) walking groups.
Provide training to HPIG members and other relevant agency staff in evaluation of physical activity interventions.	2006-09	Increased evaluation skills leads to more effective physical activity interventions.
Identify and promote other training/workforce development opportunities relevant to physical activity	2006-07	More highly skilled workforce leads to creation of more physical activity initiatives and opportunities.
Encourage opportunities for participants in physical activities organized by PCP member agencies (especially but not only walking group members) to participate in decision making about infrastructure and program development eg. through Walkers Forums.	2006-09	Decisions relevant to physical activity take into account views of participants

4.5 Resources

Estimated Integrated Health Promotion (IHP) PCP resource allocation

Capacity building components	DHS funded PCP IHP (2006/07)	Member contributions
Partnership development		
Leadership		
Organisational development		
Planning for evaluation and dissemination		
Workforce development		
Estimated Total PCP resource/budget allocation	\$72,500 ¹⁴	\$

Additional Integrated Health Promotion Resources

Funding source/project	Links to catchment priority	Funding
Application submitted for 'Go for your life' Seniors Active Living grant.	Seniors have been identified as one of the groups less likely to exercise.	\$20,000 per year for 2 years.
Totals		

¹⁴ Funds yet to be allocated between individual capacity building components.

5.1 Planning for Quality Health Promotion Practice

(Evaluation of mix of interventions)

How will the PCP facilitate and support evaluation processes conducted by the agencies around the priority

The PCP will provide evaluation support and training to agency staff in order to strengthen evaluation skills at the agency level. This will increase the capacity of agencies to evaluate their health promotion activities, particularly around physical activity. As part of this process, the PCP will encourage the development and use of common indicators (where appropriate) in assessing the effectiveness of work around the physical activity priority.

What processes will the PCP use to obtain an evaluation of the work around this priority across the whole PCP catchment?

The PCP is not resourced at a level which would allow us to evaluate the effectiveness of health promotion work around physical activity across the whole PCP catchment. An evaluation of this scale would constitute quite a significant project in its own right, and would be best undertaken by a professional evaluator or group of evaluators.

5.2 Evaluation and Dissemination

(Evaluation of capacity building strategies)

In broad terms, the PCP will adopt a three tiered approach to evaluation and reporting over the triennium, as follows:

2006/2007	Process evaluation only
2007/2008	Process evaluation Impact evaluation around capacity building interventions
2008/2009	Process evaluation Impact evaluation around capacity building interventions Impact evaluation around capacity building objectives

The results of this evaluation work will be included in the relevant CHPIA.

Further details of how the evaluation of the capacity building elements of the IHP will be conducted will be developed at a half day evaluation workshop which the PCP will conduct for participating agencies in March 2007. If necessary, outside experts will be used to facilitate all or part of this workshop. The questions below will be the focus of the workshop:

- 1. What are the processes the PCP will employ to measure progress towards achieving the capacity building objectives detailed in the previous section?**
- 2. How will the PCP know when the capacity building objective(s) have been achieved?**
- 3. How will the PCP facilitate the dissemination of learning, including unexpected results?**

This workshop will also provide agencies with an opportunity to assess their needs for training and support around evaluation of their work around physical activity at the agency level (see 5.1)

In addition, The Health Promotion Implementation Group will implement an annual planning / review / evaluation cycle, which will include at least one meeting per year focusing on each of the four capacity building elements, one meeting per year focused on evaluation, and one meeting at which the Integrated Health Promotion plan is reviewed and amended in light of the results of the annual evaluation. The meeting schedule will also be planned to accommodate consideration of other health promotion plans (or plans bearing on health promotion) which may impact on the PCP IHP plan (and/or vice versa). Examples

include Municipal Public Health Plans and Council Plans related to physical activity and walking.

6. Applying an Integrated Disease Management ‘lens’ to IHP Planning

How are the IHP approaches and interventions in your IHP catchment being used to prevent and/or delay chronic illness within your catchment?

A major reason for the choice of physical activity as the PCP’s health promotion priority has been its importance in preventing a range of chronic diseases, including:

- [coronary heart disease](#)
- [stroke](#)
- [colorectal cancer](#)
- [depression](#)
- [type 2 diabetes](#)
- [osteoarthritis](#)
- [osteoporosis](#).

Of the seven diseases which cause the greatest Burden of Disease among the populations of Hume and Moreland, three (heart disease, diabetes and depression) are related to a lack of physical activity. In addition, insufficient physical activity also contributes to other factors related to chronic disease, including high blood pressure, excess weight and high blood cholesterol.

Our IHP goal of increasing participation in physical activity across the catchment is therefore directly relevant to the prevention of chronic disease, as are our two major objectives of improving infrastructure planning for physical activity and providing more opportunities for participation in physical activity among those groups identified as less likely to exercise.

Are there specific chronic conditions and underlying social determinants being addressed within priority approaches?

Although the IHP plan itself has not been developed with a specific chronic condition in mind, several other sections of the Hume Moreland Strategy Plan 2006-2009 reflect a particular emphasis on planning for the prevention and integrated management of diabetes, and the IHP plan is consistent with this priority.

Through its emphasis on facilitating participation in physical activity for groups less likely to exercise, the IHP plan recognises that there are a range of social determinants which can influence the ability of people to make behavioural changes associated with good health outcomes, and that deliberate interventions are required to at least offset some of these disadvantages.

How are the barriers to participation, inclusion and ‘whole of person’ optimal wellbeing created by chronic conditions being addressed within IHP planning and implementation?

Through the choice of walking as the our priority physical activity:

- most people with chronic conditions are able to walk (as opposed to taking part in more high energy activities), and people can calibrate their walking (in terms of distance, speed , frequency etc.) to fit their physical capacity over time
- walking can be inclusive and social (eg walking groups, walking with friends or family), thus contributing to social connectedness and wellbeing
- walking is inexpensive (people with chronic conditions often have low incomes)

The increasing role of CHSs (and other primary care providers) in early intervention in chronic disease and integrated chronic disease management will maximise opportunities to ensure that people with chronic disease (especially those newly diagnosed) are provided with information about the importance of physical activity and the availability of suitable groups and/or facilities.

The PCP and agencies partipating in the Integrated Health Promotion plan will investigate alternatives to walking for groups unable to participate eg frail older people.

What strategies are being used to encourage organisations with a ‘downstream’ focus on chronic illness to take a more ‘upstream’ approach?

The North West Melbourne Division of General Practice is an active member of the Hume Moreland PCP Health Promotion Implementation Group, and will actively support the IHP physical activity priority through the ActiveScript program. This year, the Division has distributed a resource listing all group activities run by the three Community Health Services (including physical activity groups) to all General Practices, and this will be updated and distributed annually.

The Broadmeadows Health Service, a sub acute service which is part of Northern Health, is also represented on the HPIG and has contributed to the IHP plan.

More generally, the PCP’s Integrated Chronic Disease Management activities over the next three years will have a very strong emphasis on publicising and supporting self management programs for people with chronic illness. Physical activity is a crucial element in all self management programs and this will create a natural link between the more ‘downstream’ approaches to chronic illness traditionally taken by, for example, GPs and acute and sub acute services and the ‘upstream’ focus of many health promotion interventions.

Deliverable 3: Service Co-ordination

Introduction

This section of the Community Health Plan focuses on strengthening the systems and capacity of primary care agencies across the PCP to coordinate and respond to the needs of the clients and community. For the first time the service coordination component is a joint plan across the Moonee Valley Melbourne and Hume Moreland Primary Care Partnerships, reflecting the commitment by both management groups to extend collaboration across the PCPs where common work is occurring.

Many of the components of the plan are ongoing activities that aim to consolidate the progress of implementation of the Better Access to Services framework that has formed much of the work of the PCP over the past 5 years. Over the next three years there will be further emphasis on supporting the expansion of the service coordination strategy into new program areas (see Goal 3.2) and facilitating systems development to coordinate care planning (see Goal 3.4). The Refugee Health Service Coordination project (see Goal 3.5) is a new Service Coordination initiative being implemented in 2006/07.

Whilst some projects have specific funding attached (as detailed in the plan) many of the activities are reliant on the small amount of core funding the PCPs receive for service coordination. This results in having to prioritise what is achievable with the given resources. Many of the activities are also contingent on deliverables by DHS and these have been detailed under each major goal.

DHS have requested that the service coordination plans address five major areas of activity, as detailed below.

Key to Service Coordination goals

1. Implement the BATS framework by progressing common practices, processes, protocols and systems for initial contact, initial needs identification, referral, assessment and care planning by member organisations;
2. Improve communication about clients (especially those with chronic disease and complex needs) with General Practice leading to more active GP participation with other service providers involved in the client's care;
3. Successful implementation of the Victorian Service Coordination Practice Manual and subsequent versions of the SCTT;
4. Change management support for implementation of e-referral (if relevant); and,
5. Better depth and accuracy of information available on the Human Services Directory to support referral.

Goal 3.1 Core Mandated Agencies

That the aged care assessment service, community health services and HACC funded organisations in the Hume Moreland and Moonee Valley Melbourne PCPs have fully implemented a sustainable level of service coordination by 2009.

Objectives

- 1.1 Adoption of the Statewide PPPS by the core service coordination agencies.
- 1.2 Core service coordination agencies have implemented high quality referral practices including timely referral acknowledgement adherent to privacy legislation, using secure electronic mediums.
- 1.3 Implementation of SCTT 2006 by core service coordination agencies.
- 1.4 Full implementation of initial contact and initial needs identification by core service coordination agencies.
- 1.5 Core service coordination agencies using DHS developed guidelines and tools for assessment.
- 1.6 Maintenance of a high level of cohesion between core service coordination agencies.

Strategies

Key Activities	Status	Funding*	Timeline
Disseminate and facilitate adoption of the Statewide PPPS.	New	SC	2006-07
Review Statewide PPPS to identify the need for specific supplementary protocols.	New	SC	2006-07
Provide information and forums for discussion to assist implementation of SCTT 2006.	New	SC	2006-07
Agency participation in annual interagency referral audit to establish patterns of referral traffic and baseline measures for assessing change over time and to provide information to assist in determining PCP priorities for engaging new program areas in service coordination activities (see Goal 3.2).	New	DHS	2006-07 and 2008-09
PCPs and agencies work to implement procedures to ensure that referral acknowledgements are completed and returned within the required time period to all referring agencies, including acute and sub acute.	Ongoing	SC	2006-09
Create ongoing opportunities for Connectingcare electronic referral training sessions for primary care workers.	Ongoing	SC	2006-09
Promote quality improvement in e-referral practices and processes through use of Plan Do Study Act (PDSA) cycles and implementation of resources such as self audit tools.	New	SC	2008-09
Ensure maintenance of updated service directory through Connectingcare.	Ongoing	SC	2006-09
Publicise the new agencies that sign on to be electronic referral recipients to all services.	New	SC	2006-09
Maintain awareness of service coordination development and promote resources through service coordination page in PCP newsletters, PCP website etc.	Ongoing	SC	2006-09
Facilitate the joint Moonee Valley Melbourne and Hume Moreland PCPs Service Coordination Implementation Group and regularly evaluate its effectiveness in assisting development and implementation of the Service Coordination Plan for the PCPs.	Ongoing	SC	2006-09
Support the development and trialing of tools for assessment within the context of the BATS framework.	New	SC	2006-09

*

* SC = core service coordination funding

Estimated Impacts

All core service coordination agencies are using the SCTT 2006 and have implemented the Statewide PPPS to undertake initial contact, initial needs identification, assessment and referral via secure electronic mediums. This can be measured by agency feedback and participation in the Interagency Referral Audit 2007 and 2009. Rates of use of electronic referral can also be measured and reported by Connectingcare.

Cohesiveness of the core service coordination agencies can be measured by the ongoing attendance at forums, workshops and training and the Service Coordination Implementation Group meetings and the implementation of the VicHealth Partnership Analysis Tool as described in Partnership Objective 1.

DHS Service Coordination goals*

1, 3, 4, 5

DHS Inputs

- Distribution of the Statewide PPPS kits.
- Ensure that software vendors incorporate SCTT 2006.
- Ensuring that new software developments can auto populate e-referral forms.
- Funding for staff with relevant expertise to monitor and assist agency implementation of electronic referral practice.
- Annual interagency audit.
- Development of guidelines and tools for assessment.

Goal 3.2 New Program Areas

That the Moonee Valley Melbourne and Hume Moreland PCPs engage mental health, palliative care, drug and alcohol, disability, and children's services programs in participating in service coordination by 2009.

Objectives

- 2.1 Increase understanding by all program areas of service coordination as set out in the Better Access to Services framework.
- 2.2 Encourage responsiveness to the needs of all program areas in ongoing development of the SCTT.
- 2.3 Adoption of service coordination and the Statewide PPPS within the specified program areas.
- 2.4 Expand use of e-referral to include services with high level of referral traffic to and/or from ACAS, CHS, and HACC funded organisations.

Strategies

Key Activities	Status	Funding	Timeline
Identify champions within organisations already implementing service coordination who can promote benefits of service coordination including improvement in client outcomes to specified new programs.	New	SC	2006-09
Facilitate input by children's services programs into the development of a profile for inclusion in SCTT v3.	New	SC	2007-08
Promote use of the Connectingcare service directory to new program areas.	Ongoing	SC	2006-09
Create opportunities for Connectingcare electronic referral training sessions for primary care workers, including those from new program areas.	Ongoing	SC	2006-09
Hume Moreland PCP to support implementation/enhancement of service coordination including e-referral in Psychiatric Disability Rehabilitation and Support Services operated by Dianella and Moreland CHSs.	New	SC	2007-08
Pilot approaches to service coordination with new program areas, such as mental health and drug and alcohol and disseminate outcomes to facilitate wider application in other program areas through the MVM PCP Melbourne CBD project.	New	Project specific	2006-07
Invite representatives from new program areas to participate on the Service Coordination Implementation Group to raise awareness of service coordination development and resources.	New	SC	2006-09

Estimated Impacts

That the specified program areas are using the SCTT 2006 and have implemented the Statewide PPS to undertake initial contact, initial needs identification, assessment and referral via secure electronic mediums to a level identified and supported by DHS. This can be measured by agency feedback and participation in the Interagency Referral Audit 2007 and 2009. Rates of use of electronic referral can also be measured and reported by Connectingcare.

Representation of the specified program areas at forums, workshops and training, and on the Service Coordination Implementation Group.

DHS Service Coordination goals*

1,3,4,5

DHS Inputs

- Provide leadership and direction at State and Regional program executive level.
- Resource and support implementation and training to facilitate adoption of PPS and e-referral from new program areas.
- Ongoing developments of the SCTT to meet the needs of all program areas.
- Funding for staff with relevant expertise to monitor and assist agency implementation of e-referral practice.

Goal 3.3 Acute and Sub-acute Services

That referral systems and practices between acute and sub acute services including ACAS, and primary care services, notably Community Health Services and HACC funded organisations within the Moonee Valley Melbourne and Hume Moreland PCPs be improved through the use of electronic referral and the service coordination tool templates.

Objectives

- 3.1 Increase acute and sub acute services understanding of service coordination as set out in the Better Access to Services framework.
- 3.2 Adoption of the service coordination and the Statewide PPS by relevant acute and sub acute services, in particular HARP, PACFU, community rehabilitation services and services involved in relevant DHS pilots and initiatives. For example, patient flow collaboratives.
- 3.3 Expand use of e-referral from acute/sub acute services to ACAS, CHS, and HACC funded organisations.
- 3.4 Increase the opportunity for acute, sub acute and primary agencies to interact and understand each other's business.

Strategies

Key Activities	Status	Funding	Timeline
Ensure ongoing participation of representatives from acute and sub acute areas on the Service Coordination Implementation Group to raise and maintain awareness of service coordination development and resources.	Ongoing	SC	2006-09
Invite acute and sub acute members to forums, workshops and presentations related to service coordination.	Ongoing	SC	2006-09
Create ongoing opportunities for Connectingcare electronic referral training sessions.	Ongoing	SC	2006-09
Publicise the new agencies that sign on to be electronic referral recipients to all services.	New	SC	2006-09
Promote use of the Connectingcare service directory.	Ongoing	SC	2006-09
PCP and agencies work to implement procedures to ensure that referral acknowledgements are completed and returned within the required time period to all referring organisations.	Ongoing	SC	2006-09
Facilitate primary care agencies participation in the Melbourne Health Community Gateways expo.	Ongoing	SC	2007
Encourage expos at other acute and sub acute sites.	Ongoing	SC	2006-09
Ensure PCP representation on relevant acute and sub acute committees and forums.	Ongoing	SC	2006-09

Estimated Impacts

Acute and sub acute programs are making secure electronic referrals using the SCTT 2006. The specified acute and sub acute programs are using the Statewide PPPS and SCTT 2006 for initial contact, initial needs identification, assessment and referral. This can be measured by agency feedback and participation in the Interagency Referral Audit 2007 and 2009. Rates of use of electronic referral can also be measured and reported by Connectingcare.

Agency participation can be recorded in the Melbourne Health Gateways Expo and any such events at other acute or sub acute sites.

DHS Service Coordination goals *

1, 3, 4, 5

DHS Inputs

- Metropolitan Health Services section of DHS to encourage acute, sub acute & primary care services to work together to develop more integrated service models and delivery across the care continuum.

Goal 3.4 Care Planning

To facilitate systems development to coordinate multi disciplinary care especially for people with chronic disease and complex conditions in the Hume Moreland and Moonee Valley Melbourne PCPs.

Objectives

- 4.1 Strengthen organisational and work force capacity to implement care planning, drawing on the learnings from the MVM PCP Interagency Care Planning Protocol Pilot, the HM PCP GPs and Community Health projects, and from HARP programs.
- 4.2 Engage general practitioners, community health services, aged care assessment service and HACC funded agencies in multi disciplinary care planning.
- 4.3 Development of strategies for testing and implementing the Protocol to achieve systematic multi disciplinary care for people with a range of chronic conditions and complex needs including dementia.

Strategies

Key Activities	Status	Funding	Timeline
Establish an Interagency Care Planning Protocol Working Group.	New	SC	2006-07
Participate in development of a staged whole of region change management strategy for the effective implementation of the inter agency care planning protocol.	New	SC	2006-09
Identify workforce development strategies for inter agency planning protocol implementation based on the MVM PCP pilot project.	New	SC	2006-09
Develop agreement between agencies about which clients are offered comprehensive assessment and which agencies complete and are involved in comprehensive assessment.	New	SC	2007
Review the Interagency Care Planning Protocol to ensure it supports GP and agency inclusion in care planning.	New	SC	2006-07
Seek opportunities for funding through GPDV and DHS for Community Health Services and GP Divisions to develop collaborative practice models for care planning.	New	SC	2007-09
Implement GP Small Grant project focusing on provision of information on Melbourne Health services, specifically outpatient services, on Melbourne Health and GP division websites.	New	Project specific	2006-07
Support the development of collaborative service models between acute and primary care sectors designed to implement evidence based best practice assessment and management for people with chronic disease. For example: diabetes and osteoarthritis.	New	SC	2007-09

Strategies

Key Activities	Status	Funding	Timeline
Implement the Transition Care project for people with dementia, funded by the State Government Aged Care Program.	New	Project specific	2006-07
Collaborate with the Divisions of General Practice to maximise GP involvement in care planning.	New	SC	2006-09
Collaborate with the Divisions of General Practice to ensure that GPs and agencies are aware of Medicare care items relevant to care planning.	New	SC	2006-09
Promote care pathways to other sectors including acute and sub acute, to facilitate client access to community based primary care.	New	SC	2007-09

Estimated Impacts

A sustainable and participatory care planning processes have been developed, and protocols and supporting materials disseminated to PCP member agency staff. Rates of participation in care planning training and working groups can be recorded, as well as specific measures as identified in supporting projects.

GPs and the Divisions of General practice will be fully involved and protocols and systems established to support their participation.

DHS Service Coordination goals *

1, 2, 3, 4, 5

DHS Inputs

- Address resourcing issues related to care planning.

Goal 3.5 Refugee Health

To strengthen the relationships between local general practice providers and other refugee service providers to deliver better health outcomes for refugees building on service coordination practices and processes that have been developed in the MVM and the Hume Moreland PCP catchments.

Objectives

- 5.1 Establish protocols between GP practices and other agencies providing services to refugees.
- 5.2 Develop care planning pathways to facilitate care coordination, monitoring and review of refugees who need this level of planning.

Strategies/key activities

- Implement the Refugee Health Service Coordination Project.

Timelines

October 2006- June 2007

DHS Service Coordination goals *

1, 2, 3

DHS Inputs

- Support networking between PCP refugee health projects and other relevant Statewide players.

Deliverable 4: Integrated Chronic Disease Management

Introduction

From 2006-07, Hume Moreland Primary Care Partnership will receive additional recurrent funding from the Department of Human Services Primary Care Branch for Integrated Chronic Disease Management. PCPs are expected to work with the broader service system to develop integrated systems across agencies to care for people with chronic disease.

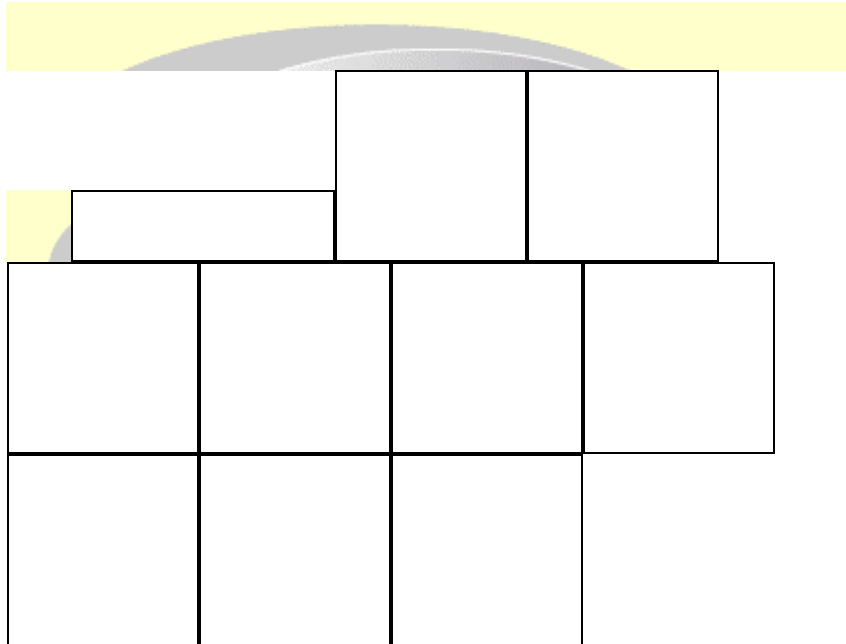
The stated objectives of chronic disease management are to:

- Slow the rate of disease progression (in the context of the person's clinical condition) whilst maximising their health and well being within the community;
- Improve access to quality integrated multidisciplinary care across the care continuum;
- Facilitate client and carer empowerment through self management programs;
- Promote and encourage protective behaviors;
- Actively engage GPs as part of a multidisciplinary coordinated approach, including the development of written care plans;
- Reduce inappropriate demands on the acute health care system; and,
- Demonstrate the contribution CHSs and PCPs (in particular, including Divisions of GP) can make to the care and management of people with chronic disease.

Chronic Disease Management encompasses the continuum of care from prevention through to treatment and care management for people with chronic disease.

It is a requirement that PCPs base their planning for integrated chronic disease management on Wagner's Chronic Care Model. This model, as pictured below, describes 6 main areas that require attention and systematic change in order to deliver improved outcomes in the management of chronic disease. These elements are:

- Community linkages;
- Organisational systems;
- Self management support;
- Delivery systems design;
- Decisions support; and,
- Clinical information systems.



Wagner's Chronic Care Model

This plan includes a list of these elements as they relate to each of the four main goals: planning self management; system redesign; GP engagement; and, support for the Early Intervention in Chronic Disease program to be implemented by Moreland Community Health Service.

DHS have requested that the integrated chronic disease management plan address fifteen major areas of activity, as detailed below. Items 9-15 are specifically for PCPs that have a community health service funded through the Early Intervention in Chronic Disease initiative and relate to supporting and building capacity of agencies providing services to people with a chronic disease primarily in that local government area. For Hume Moreland PCP this relates to the local government area of Moreland.

***Key to DHS Major Area of Activity**

1. Completion of a mapping of self-management interventions (provided by agencies within the catchment). Facilitate planning processes to develop self-management interventions within member agencies that respond to gaps identified in the mapping process.
2. Facilitation of a process for agencies to define their roles and responsibilities, especially acute and community health services, in relation to providing self-management interventions for people with chronic disease.
3. Successful implementation of the Better Access to Services (BATS) framework by progressing common practices, processes, protocols and systems for initial contact, initial needs identification, referral, assessment and care planning by member agencies, particularly as it relates to people with chronic disease.

4. Developed and defined local agreements and systems to identify clients with chronic disease who require comprehensive assessment, by working with PCP member agencies, particularly GPs.
5. Developed and defined local agreements and systems to identify clients with chronic disease who require cross-disciplinary/multi-agency (including GP) care planning, by working with PCP member agencies, particularly GPs.
6. Developed and defined local agreements and systems around initiating and coordinating care planning for people with chronic disease by working with PCP member agencies, particularly GPs.
7. Strengthened approaches to address disadvantage and health equality in Integrated Health Promotion initiatives, including barriers to participation such as chronic disease.
8. Successful implementation of workforce development strategies for self-management, particularly for community health services and GPs.
9. Successful implementation of communication and marketing strategies (developed in conjunction with the Divisions of General Practice) that promote the benefits and availability of local self-management interventions to GPs.
10. Improved communication and collaborative care planning (by working closely with the Divisions of General Practice) between GPs and community health services.
11. Development and adoption of disease-specific care pathways to ensure that clients get the right care in the right place, regardless of where they enter the service system.
12. Support for change management provided to agencies, particularly community health services, which are implementing new systems or strengthening existing systems to provide proactive care rather than reactive care for clients with chronic disease.
13. Facilitation of a process for agencies to develop and implement consistent approaches to the use of decision support tools to support ICDM.
14. Dissemination of transferable change management lessons in relation to ICDM.
15. Completion of the statewide evaluation tools for ELiCD.

Goal 4.1 Planning for Self Management

Clients with a chronic disease will have access to a collaboratively planned and robust primary care service system that promotes and supports self management.

Objectives

1. Identify current chronic disease management infrastructure and activities operating within Hume and Moreland.
2. Understand present and potential future demand for chronic disease management intervention within Hume and Moreland
3. Develop an interagency plan for chronic disease management in Hume and Moreland that includes the detailing of resource allocation.
4. Develop structures to support partnering and collaborative solutions.
5. Increase the number of staff in Hume and Moreland who are trained in self management.
6. Maximise staff understanding of self management and how it will benefit clients with a chronic disease.
7. Promote self management opportunities to clients with a chronic disease.
8. Facilitate involvement and minimise barriers to client participation in self management.

Strategies

Key Activities	Status	Funding	Timeline
Support agencies to complete the self management mapping exercise.	New	ICDM	2006-07
Identify service gaps especially in the area of self management.	New	ICDM	2006-07
Analyse burden of disease and other health status data to better understand chronic disease management demand, especially diabetes, as per Partnerships Goal 1.	New	ICDM	2006-07
Incorporate chronic disease into integrated health promotion catchment planning.	New	IHP	2009
Identify strategies to bridge service gaps especially in the area of self management.	New	ICDM	2007
Define responsibilities/partnerships/opportunities/resources.	New	ICDM	2007-09
Support development of MOUs/partnering agreements.	New	ICDM	2007-09
Promote self management training opportunities to agencies.	New	ICDM	2009
Provide opportunities for referees to understand concepts, benefits and availability of self management.	New	ICDM	2007
Develop self management resources for referees.	New	ICDM	2007
Work with agencies to ensure that self management opportunities are detailed on electronic service directories.	New	ICDM	2009
Utilise the care planning process to promote and encourage client participation in self management activities.	New	ICDM	2009

Promote access to physical activity for the groups who are least likely to exercise, as per Integrated Health Promotion Objective 2.	New	IHP	2009
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Estimated Impacts

Agencies in Hume and Moreland will have undergone a process that assists them to better identify demand, service gaps and strategies to provide collaborative and robust services to people with a chronic illness.

This can be measured by the comprehensive documentation of self management programs operating in Hume and Moreland, evidence of participation in planning forums and the development of a sub regional plan to address service gaps and new developments.

A greater number of clients with a chronic disease are accessing and sustaining self management techniques. This can be measured by the client data detailing self management usage.

Relationship to Wagner’s Chronic Care Model

- Organisational systems
- Self management
- Community linkages
- Delivery systems design
- Clinical information systems

DHS Major Area of Activity*

1, 2, 7, 8, 9

DHS Inputs

- Web based self management mapping tool
- Sharing of learnings from other PCPs and ELiCD programs.
- Address resourcing issues related to care planning.

Goal 4.2 Service Integration

Clients with a chronic disease will experience a coordinated, seamless and multidisciplinary health care system that works alongside the client to achieve better health outcomes.

Objectives

1. Implement the BATS framework to support coordinated service delivery to people with a chronic disease.
2. Develop strategies for testing and implementing a care planning protocol to achieve systematic multi disciplinary care for people with a range of chronic conditions.
3. Strengthen organisational and work force capacity to implement care planning for people with a chronic disease.
4. Facilitate involvement in and minimise barriers to participation in physical activity for people with a chronic disease.
5. Drawing on the learnings of the ELiCD program and care planning initiatives, document suitable clinical pathways for clients with specific chronic diseases.
6. Develop and implement processes for referral and assessment for people with a chronic disease.

Strategies

Key Activities	Status	Funding	Timeline
Disseminate and facilitate adoption of the Statewide PPS.	New	SC	2006-07
Review Statewide PPS to identify the need for specific supplementary protocols.	New	SC	2006-07
Provide information and forums for discussion to assist implementation of SCTT 2006.	New	SC	2006-07
PCPs and agencies work to implement procedures to ensure that referral acknowledgements are completed and returned within the required time period to all referring agencies, including acute and sub acute.	Ongoing	SC	2006-09
Create ongoing opportunities for Connectingcare e referral training sessions for primary care workers.	Ongoing	SC	2006-09
Ensure maintenance of updated service directory through Connectingcare that details chronic disease management options.	Ongoing	SC	2006-09
Support the development and trialing of the BATS framework and tools for assessment in chronic disease management.	New	SC	2006-09

Strategies

Establish a Regional Interagency Care Planning Protocol Working Group.	New	SC	2006-07
Develop a staged whole of region change management	New	SC	2006-09

strategy for the effective implementation of the inter agency care planning protocol.			
Identify workforce development strategies for inter agency care planning protocol implementation based on the MVM PCP pilot project.	New	SC	2006-09
Maintain awareness of service coordination and chronic disease development and promote resources through service coordination and chronic disease management page in PCP newsletters, PCP website etc.	Ongoing	ICDM	2006-09
Develop agreement between agencies about who receives, completes and is involved in comprehensive assessment for people with a chronic disease.	New	ICDM	2007
Detail clinical pathways for people with diabetes.	New	ICDM	2007
Detail clinical pathways for other identified major chronic disease groups in Hume and Moreland.	New	ICDM	2007-09

Estimated Impacts

That clients in Hume and Moreland will be able to access a client centred, timely and robust service to support their goals in managing their chronic disease. This system will be supported by: clearly defined pathways; access points; practices, processes and protocols; timely referral; and care planning opportunities by health professionals who collaborate to provide optimal health outcomes with the client.

This can be measured by the volume of referrals and care plans implemented and the number of people accessing services to assist in managing their chronic disease.

Relationship to Wagner's Chronic Care Model

- Organisational systems
- Decision Support
- Clinical information systems
- Delivery systems design

DHS Major Area of Activity*

3, 4, 5, 6, 7, 10, 11

DHS Inputs

- Distribution of the Statewide PPS kits.
- Ensure that software vendors incorporate SCTT 2006.
- Ensuring that new software developments can auto populate e-referral forms.
- Funding for staff with relevant expertise to monitor and assist agency implementation of e-referral practice.
- Development of guidelines and tools for assessment.
- Address resourcing issues related to care planning.

Goal 4.3 General Practice Engagement

General Practices in Hume and Moreland are actively engaged with other primary care agencies to provide a multidisciplinary and coordinated approach to chronic disease management.

Objectives

1. Develop a GP engagement and workforce development plan in collaboration with the Division of General Practice.
2. Develop a marketing and promotion campaign to inform and engage GPs in chronic disease management.
3. Engage general practice in multidisciplinary care planning for clients with a chronic disease.
4. Develop care pathways and agreements with general practice for clients with a chronic disease.

Strategies

Key Activities	Status	Funding	Timeline
Collaborate with the Divisions of General Practice to maximise GP involvement in care planning.	New	SC	2006-09
Review the regional PCP Interagency Care Planning Protocol to ensure it supports GP and agency inclusion in care planning.	New	SC	2006-07
Identify workforce development strategies for interagency care planning protocol implementation.	New	SC	2006-09
Detail clinical pathways for people with diabetes.	New	ICDM	2007
Develop agreement between agencies about who receives, completes and is involved in comprehensive assessment.	New	ICDM, SC	2007
Develop self management resources for GPs.	New	ICDM	2007
Work with the Division of General Practice to promote self management opportunities through GPs.	New	ICDM	2009
Utilise the care planning process and other Medicare incentive schemes to promote and encourage client participation in self management activities.	New	ICDM	2009
Promote successes and positive client outcomes to GPs and the broader community.	New	ICDM	2009
Maintain awareness of service coordination and chronic disease development and promote resources in PCP newsletters, PCP website etc.	Ongoing	ICDM	2006-09
Work with the Divisions of General Practice to promote multidisciplinary care planning, relevant tools and Medicare Benefit Scheme incentive items.	New	ICDM	2006-09
Detail clinical pathways for other identified major chronic disease groups in Hume and Moreland.	New	ICDM	2007-09

Estimated Impacts

General Practitioners will participate in coordinated chronic disease management across Hume and Moreland. This will be measured by the number of care plans with GP

participation, the use of appropriate Medicare Benefit Scheme items, the number of referrals by GPs to chronic disease management programs, the provision of information and training sessions for GPs, and the development of clinical pathways.

Relationship to Wagner's Chronic Care Model

- Organisational systems
- Self management
- Decision support
- Clinical information systems
- Delivery systems design

DHS Major Area of Activity*

4, 5, 6, 8, 9, 10, 11

Goal 4.4 Early Intervention in Chronic Disease

Primary care agencies in Hume and Moreland will contribute to the successful implementation of an Early Intervention in Chronic Disease program and disseminate the learnings across the catchment.

Objectives

1. Contribute to the planning and implementation of the ELiCD program.
2. Support the workforce development and change management processes required to implement a proactive strategy to address chronic disease.
3. Develop tools and protocols to assist in the navigation and decision making processes.
4. Participate in the statewide evaluation.

Strategies

Key Activities	Status	Funding	Timeline
Participate in information sessions, forums and submit articles to the PCP newsletter that promote the ELiCD program.	New	ICDM	2009
Establish a PCP working group to support the development of the ELiCD program.	New	ICDM	2006
Facilitate and support partnerships between primary care agencies, the acute and sub acute sector, community groups and GPs to support ELiCD delivery.	New	ICDM	2009
Assessment protocols as described in goal 4.2	New	SC	2007
Care Planning as described in goal 4.2	New	SC	2009
Care Pathways as described in goal 4.2	New	ICDM	2007
Self management as described in goal 4.1	New	ICDM	2009
GP engagement as described in goal 4.3	New	ICDM	2009
Contribute to the completion of the statewide evaluation tools for ELiCD	New	ICDM	2009

Estimated Impacts

The ELiDC program in Moreland will be characterized by collaboration between agencies, GPs, other sectors and Moreland Community Health Service. The collaborators will have developed agreements and pathways in delivering services to people with a chronic disease. This will be measured by the documentation of partnerships, care pathways, protocols and as detailed in the statewide evaluation.

Relationship to Wagner's Chronic Care Model

- Organisational systems
- Self management
- Community linkages
- Delivery systems design
- Clinical information systems

DHS Major Area of Activity*

8, 9, 10, 11, 12, 13, 14, 15

DHS Inputs

- Statewide evaluation tools and process.
- Development of guidelines and tools for assessment.
- Address resourcing issues related to care planning.
- Sharing of learnings from other PCPs and ELiCD projects.