



Outer East  
Health and Community Support  
Alliance

# Community Health Plan (2006-2009)

# Forward

The Outer East Health and Community Service Alliance (OEHCSA) was established prior to 1998. It was instigated as a result of a strong commitment by community and health care providers in the area to establish better ways of working together to improve health outcomes for people living and working in the Outer East.

This Community Health Plan provides a framework for guiding and building on that ongoing commitment to realising a shared vision of achieving “ actions that will deliver continuous improvements to the health and well being of individuals, families and communities across the Outer East”. The OEHCSA recognises that integral to achieving this vision, is the notion of ensuring effective engagement of community, consumers and carers in discussions, debate and decision making around the implementation of this Plan. Effective consumer and carer participation ensures that outcomes will be more effective and responsive to community needs.

Over the next three years the work of the OEHCSA will be focused on four key areas. They include:

- Partnerships
- Integrated Health Promotion
- Service Coordination and
- Chronic Disease Management.

These four key areas of activity are identified within the CHP 2006-2009 through individual plans, although it is important to recognise that each plan should not be considered in isolation. The outcomes achieved in any one area of the plan have an interactive effect - impacting significantly on the outcomes in other areas. In implementing this CHP the OEHCSA will seek to consolidate and coordinate efforts across all these activities to achieve maximum outcomes for the community.

This Plan has been developed through the collaborative efforts of the OEPCP secretariat, numerous staff across the member agencies of the OEHCSA and consumers who support the work of the OEHCSA. On behalf of the OEHCSA I would like to take this opportunity to thank those involved in developing this plan and to recognise your ongoing commitment to the OEHCSA. I would also like to welcome new members to the OEHCSA and to encourage their involvement in the implementation of the CHP (2006-2009).

As the Chair of the Alliance and the Executive Committees of the OEHCSA, I look forward to working with you all to achieve better health and well being outcomes for all people in the Outer East.

Peter Ruzyla  
Chair OEHCSA

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## **Background:**

The Outer East Health and Community Support Alliance (OEHCSA) is a voluntary alliance of agencies from the municipalities of Knox, Maroondah and Yarra Ranges, committed to collaborative thinking, planning and action. The OEHCSA was established prior to 1998 and continues to be based on a commitment to building partnerships that achieve better health outcomes for the people living and working in the Outer East.

Through their involvement in the OEHCSA, member agencies take up the opportunity to participate in the collaborative endeavours of the OEHCSA, which are articulated in the Community Health Plan (CHP). This may at times require giving up some autonomy if it is for the greater good of the OEHCSA and the achievement of desired service system and consumer outcomes.

Currently, the OEHCSA has a membership of eighteen organisations, including local government, community health services, acute health, district-nursing services, community support services, Divisions of General Practice, non-government services and a range of other key stakeholders (Appendix 1). All members are committed to supporting the strategic directions of the Primary Care Partnership (PCP) Strategy.

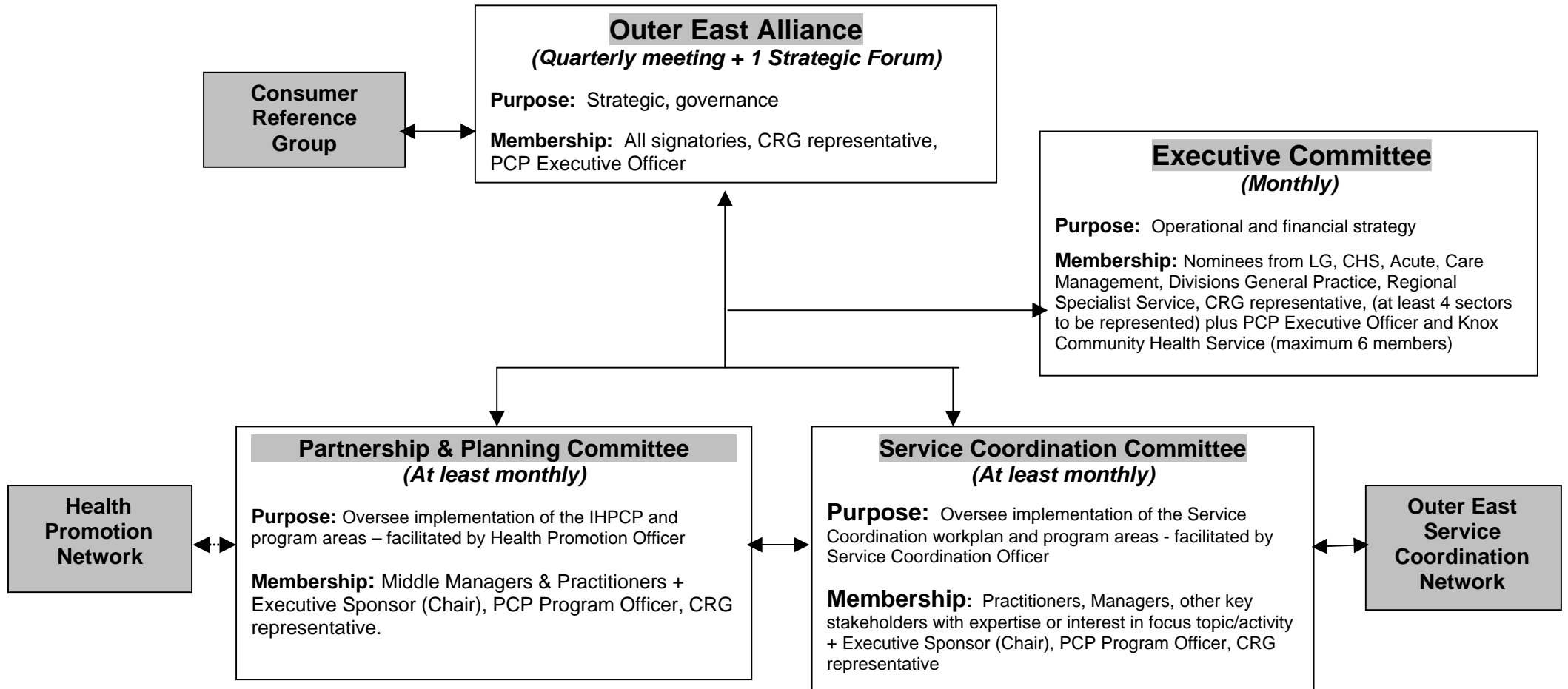
The PCP program for the Outer East is progressed by the OEHCSA through the CHP. The CHP is a partnership plan that outlines a range of key collaborative priorities and activities to be undertaken by member agencies, the PCP secretariat and the OEHCSA 'as a whole' over the next three years.

Broadly speaking, the Outer East CHP 2006-2009 priorities include:

- A focus on partnership development.
- Building the capacity of member agencies to undertake catchment focused integrated health promotion activities that reflect practices within a social model of health.
- Increased use of electronic referral systems and advanced implementation of service coordination activity which lead to enhanced care planning and care coordination practices and the creation of better health care outcomes for consumers.
- Early intervention in chronic disease management.
- Consumer, carer and community engagement and participation to ensure systems, services and programs are built around consumers, carers and community needs.

The diagram below illustrates the governance structure of the OEHCSA that supports the implementation of the CHP (2006-2009).

# Governance structure of the OEHCSA



Action groups/working groups/virtual teams with level of expertise or interest in 'focus topic' maybe established for– time limited, outcome focus work

## Policy Context:

The OEHCSA Community Health Plan (2006-2009) has been developed within the policy framework of “Growing Victoria Together”, a whole of government policy that integrates and shapes the policies and plans for the future of Victoria’s health services. Key priorities of the “Growing Victoria Together” policy are:

- High quality, accessible health and community services
- Building friendly, confident and safe communities
- A fairer society that reduces disadvantage and respects diversity
- Greater participation and more accountable government

The Victorian government policy “A Fairer Victoria” is also a key document in informing the strategic direction of the CHP. This policy provides a framework to address disadvantage by encouraging the development of innovative approaches to service delivery. It is based on the guiding principles of equal opportunity for all, reducing barriers, assistance to disadvantaged groups, targeted support to the highest risk areas and involving communities in decisions that affect their lives.

The state government strategy “Care in Your Community” is also integral to the development of this plan, it provides a framework for establishing a consistent approach to the development of a health care system that focuses on the needs of people, rather than service types, professional boundaries, organisational structures, funding and reporting requirements. Care in Your Community is particularly relevant to the development of this CHP, as the Outer East catchment of Melbourne was identified as one of three areas in Victoria to pilot this initiative in 2006-2007.

The Primary Care Partnerships Strategy is a key strategy in supporting the implementation of the CHP and guiding the work of the Primary Care Partnerships (PCP). A range of other specific policies and strategies listed in Appendix 2 also informed the development of the CHP and support and guide the implementation, review and evaluation of this plan.

The diagram below illustrates a higher level policy framework within this CHP should be considered.



State policy context for Victorian Primary Health Programs

*(Primary Health Branch Policy and Funding Guidelines-2006-07 to 2008-09)*

Integral to the work of the OEHCSA is the notion of engaging the community, consumers and carers as a valuable resource for guiding service system development to ensure it becomes more responsive to community need. It is essential therefore, that the community is effectively engaged and included in all aspects of OEHCSA activity.

The existing OEHCSA, Consumer, Carer and Community Engagement Strategy, recognises and values the participation and contribution of consumers, carers and the broader community in all aspects of OEHCSA activity.

Aligned with the OEHCSA Consumer Engagement Strategy is the state government policy “Doing it with us not for us”. This policy was developed from “the Victorian Government’s commitment to involving people in decision making about health care services and the need for a strategic policy to guide this process.” (DHS Primary Health Branch)

The policy has a primary focus on the acute and sub acute areas of the health service system, however it provides a valuable resource for assisting agencies to create better, more meaningful opportunities for consumer, carer and community to participate in planning for and developing a more responsive and coordinated health care system.

## **Vision:**

The OEHCSA is committed to actions that will deliver continuous improvements to the health and well being of individuals, families and communities across the Outer East.

Achieving the Vision:

This vision will be achieved through strong partnerships that facilitate an integrated, evidence base and consumer focused approach to planning for and responding to the health and wellbeing needs of the Outer East community.

## **Values:**

The core values identified by the members of the OEHCSA as integral to guiding the work of the OEHCSA in achieving this vision are:

- Integrity
- Trust
- Respect and
- Responsiveness

## **Strategic direction:**

The direction of the CHP (2006-2009) has been informed by input from member agencies, Department of Human Services (DHS), consumers and other relevant stakeholders through a series of consultation processes including Strategic Planning forums, planning sessions with various committees of the OEHCSEA and individual consultation meetings.

Through these consultation processes, members and other key stakeholders have developed specific goals and objectives to progress the work of the OEHCSEA over the next three years around four main areas of activity including:

- Partnerships
- Integrated Health Promotion
- Service Coordination
- Integrated Chronic Disease Management.

The CHP (2006-2009) consists of four individual plans which articulate a range of strategies that will be implemented across these four areas of activity. The plan also identifies the probable impacts the work of the OEHCSEA will have on achieving better health and well being outcomes for the people of the Outer East. Although each of the areas of activity is presented within the CHP as a unique plan, there is considerable overlap between work being undertaken in the individual plans. The success of the OEHCSEA in implementing the CHP as a whole, lies not only in evaluating outcomes for each individual plan, but also in creating opportunities to coordinate efforts across the all areas of activity.

Following is a summary of the broad strategic directions articulated in each of the four individual plans:

### **Partnership Plan:**

The Partnership Plan provides an opportunity to reflect on the partnerships of the OEHCSEA, in particular to identify how they support the work of the OEHCSEA, how to create opportunities to build on exiting partnerships strengths and to identify possibilities for establishing new partnerships. The development of the partnership section of the CHP 2006-2009 has been informed by the OEHCSEA Self- Evaluation Report which was completed in August 2006.

The broad strategic objectives, of the Partnership Plan include:

- Developing robust and flexible partnerships with diverse memberships
- Adoption of a quality improvement approach to assessing partnership strengths and weaknesses, and
- Greater engagement of and participation in of relevant stakeholders in PCP processes and activities.

## **Integrated Health Promotion Catchment Plan (IHPCP):**

The primary focus by the Outer East PCP in relation to health promotion over the next two to three years will be on the identified priority of “mental health and well being”. The Integrated Health Promotion Catchment Plan (IHPCP) has been developed within a capacity building framework, reflecting the role of the OEHCSEA and the PCP secretariat, in building the capacity of member agencies to deliver health promotion interventions that provide for better mental health and well being outcomes for people in the Outer East. The objectives in the IHPCP plan have been developed around the five key elements of capacity building which include leadership, partnership, organisational development, workforce development and resource allocation. Vulnerable populations/groups have been identified as a priority and within the context of this Plan, vulnerable populations are defined as including:

- indigenous communities
- newly arrived migrants
- young people
- older people

In implementing the IHPCP it is important to consider how gender impacts on an individual’s experience of mental health and well being. There has been a shift in health promotion thinking, which recognises it is important to consider how sex and gender interact with social determinants of health such as socio-economic status, indigenous status, disability, cultural and linguistic diversity, geographic location and sexual orientation. (Victorian Women’s Health and Wellbeing Strategy Stage Two: 2006-2010). The issue of gender should therefore be considered, when planning health promotion strategies and interventions to improve mental health and well being. It is important, for partners involved in the implementation of the IHPCP to apply a “gender lens” to their work, ensuring consideration is given to how gender impacts on the patterns of health and illness experienced by men and women in different community groups across the Outer East.

The broad strategic objectives of the IHPCP include:

- Developing systems and processes that support a better understanding of the needs of vulnerable individuals, populations and communities and which encourage sharing of knowledge.
- Improved access to services that provide for better mental health and well being outcomes for vulnerable individuals, populations and communities.
- Improving the mental health and wellbeing of vulnerable individuals, populations and communities by promoting and building social inclusion opportunities.
- To provide professional development in health promotion skills to members and the broader sector.
- The IHPCP also identifies a range of ongoing collaborative initiatives that focus on different health promotion areas including physical activity.

## **Service Coordination Plan:**

This section of the CHP focuses on a number of priority areas over the next two to three years, including:

- consolidation of existing effort with member agencies around increased use of e-referral and service coordination strategies.
- engagement of new agencies/sectors around use of e-referral and service coordination strategies.
- increased engagement of the Divisions of General Practice and GPs.
- investigation of enhanced service access models.
- movement towards the implementation of the assessment and care planning components of service coordination.
- further development of a regional approach in relation to service coordination.

### **Integrated Chronic Disease Management (ICDM) Plan:**

The ICDM component of the CHP is a new area of focus for the OEHCSA in 2006-2007. It is important to note however, that this section of the plan has strong links to a range of OEHCSA service coordination activities.

The guidelines provided by DHS for the development of the Chronic Disease Management section of the CHP identified fourteen specific objectives for PCPs to focus on over the next three years. Although all fourteen objectives have been identified within this plan, it is not anticipated that all these areas will be addressed within the first or possibly even the second year of implementing this plan. The OEHCSA has identified the following activities/interventions as priorities over the next 12 months:

- Support the work being undertaken by Knox Community Health Service (KCHS) in conducting an Outer East self-management mapping exercise.
- Extend the self-management mapping exercise (if required) to ensure it meets DHS requirements.
- Support KCHS in engaging the Divisions of General Practice in the Early Intervention in Chronic Disease (EliCD) project.
- Ensure that the learnings from the EliCD project are shared with member agencies.
- Support the development of partnerships between the acute sector and community health around chronic disease management.
- Support a regional approach to management of diabetes.

### **Ongoing collaborative initiatives:**

Following are a number of specific ongoing collaborative committees/initiatives that are supported by the OEPCP:

- Hospital Admission Risk Program (HARP)  
Members of the Outer East Alliance have been working with Eastern Health to identify the underlying causes of increased emergency demand for hospital services and to develop strategies to meet the changing needs of the community. Considerable opportunity exists to develop this partnership further by sharing and building on existing planning mechanisms and structures.

- **Primary Care and Population Health Advisory Committee (PC &PHAC)**  
The PC&PHAC was established following changes to the Health Services Act arising from the Ministerial Review of Healthcare Networks in 2000. The role of the committee is to advise the board of Eastern Health and to ensure that community agencies and the residents of the Outer East participate in Eastern Health's policy development and planning and service delivery.
- **Municipal Public Health Plans (MPHPs):**  
Municipal Public Health Plans focus planning on local areas and empower local communities to work together on key health and wellbeing issues. MPHPs deal at a strategic level, focusing on the impacts of built, social, economic and natural environments on public health and the promotion of community health and wellbeing. MPHPs clearly link with, and it is essential that they feed into, the CHP planning process, to minimise duplication, identify opportunities for collaboration and to inform the identification of future planning priorities for the OEHCSA.
- **Aboriginal Health Promotion and Community Care (AHPACC):**  
The Aboriginal Health Promotion and Chronic Care (AHPACC) Partnership aims to increase the access Indigenous people have to culturally appropriate health care. The AHPACC Partnership supports Community Health Services (CHSs) and Aboriginal Community Controlled Health Organisations (ACCHOs) to work collaboratively to improve health outcomes for Aboriginal Victorians with, or at risk of, chronic disease.



# PARTNERSHIP PLAN

November 2006

## **Partnership vision:**

Achieve stronger partnerships that facilitate an integrated, evidence based and consumer focused approach to planning for and responding to the health and well being needs of the Outer East community.

## **Achieving the vision: priority setting and problem definition:**

The VicHealth Partnerships Analysis tool identifies “partnerships as an important way of bringing together skills and resources” to achieve more effective outcomes. “Collaborations, joint advocacy and action can be used to potentially have a bigger impact on policy-makers and government.” This partnership resource tool identifies three key elements in the development of strong partnership relationships. These include:

- an ability to establish a clear purpose for the partnership,
- being able to show how the partnership adds value to the work of the partners and
- ensuring that partnerships are carefully planned and monitored.

These three elements highlight what can become barriers to the development of strong partnerships. The aim of this plan is to identify strategies that provide a clear pathway forward for ensuring that the OEHCSA is able to continue to development robust and effective partnerships into the future.

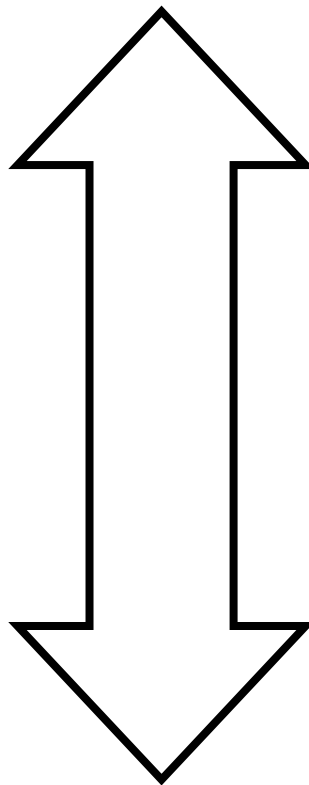
The VicHealth partnership tool also identifies four main concepts related to partnerships which it describes as existing on a continuum of partnership activity they are:

- Networking: exchange of information for mutual benefit.
- Coordinating: exchange of information for mutual benefit and altering activities for a common purpose.
- Cooperating: exchanging information, altering activities and sharing resources for mutual benefit and a common purpose.
- Collaborating: involves all of the above and a willingness to increase the capacity of another organisations for mutual benefit and a common purpose.

The diagram on the following page is taken from the “VicHealth Partnership Analysis” tool and provides an illustration of this concept of partnerships.

Continuum based on:

- Commitment
- Change required
- Risk involved
- Level of interdependence
- Power
- Trust
- Willingness to share turf



Networking

Coordination

Cooperation

Collaborating

This Partnership Plan seeks to consider the partnership activities of the OEHCSA within the context of this framework. Partnerships across the OEHCSA are formed at all levels along this continuum and the development of partnerships at each level provides its own challenges. It is interesting to note that research suggests partnerships are more likely to exist at the networking/coordinating end of the continuum and that true collaboration is difficult to achieve.

This Partnership Plan provides an opportunity to reflect on the partnership of the OEHCSA, to identify how they support the work of the OEHCSA and to create opportunities to build on existing partnership strengths and to identify possibilities for establishing new partnerships that will support the work of the OEHCSA. The OEHCSA Self-Evaluation Report completed in August 2006, provides specific recommendations about the future opportunities that exist to strengthen the partnership work of the OEHCSA.

It is clear from the Self-Evaluation Report, that the members of the OEHCSA are committed to maintaining and building partnerships that are supported by a common understanding about what the OEHCSA is aiming to achieve and a shared passion about working together to ensure that goals become a reality.

## Partnership Plan:

Goal (Identified by DHS)	Objective	Strategies/Interventions	Estimated Impact
<p>1. Develop robust and flexible partnerships with diverse memberships that are able to effectively pursue collaborative opportunities and also enable an integrated response to local needs</p>	<p>1.1 Increase the number of partners from different community settings (eg education, housing etc).</p> <p>Refer to Objective 2.1 IHP Plan</p>	<p>1.1.1 MOU reviewed to include agencies from other community sectors as potential members of the OEHCSA.</p> <p>1.1.2 Create opportunities to engage member agencies in partnerships with organisations outside the health sector.</p> <p>1.1.3 PCP to invite agencies from other settings to forums etc</p>	<p>New agencies and consumers not previously involved with the PCP engaged in projects that support the work of the OEHCSA.</p>

Goal (Identified by DHS)	Objective	Strategies/Interventions	Estimated Impact
<p><b>2.</b> Adopt a quality improvement approach to assessing partnership strengths and weaknesses and act on this information to progress the partnerships</p>	<p><b>2.1</b> Establish base line data around member satisfaction with partnerships activities supported by the OEPCP. Over the three years of the plan continue to assess satisfaction and identify opportunities to maintain and/or increase satisfaction.</p>	<p><b>2.1.1</b> Identification of an appropriate survey tool to measure member satisfaction with partnership opportunities provided through the OEPCP.</p> <p><b>2.1.2</b> Survey conducted to provide an initial baseline</p> <p><b>2.1.3</b> Annual survey conducted to provide a comparison against the baseline</p>	<p>Clarification of the expectations of member agencies and the Consumer Reference Group (CRG) in relation to partnerships opportunities and outcomes that they would like to achieve as a result of their participation in the OEPCP.</p> <p>Timeseries data collected that demonstrates the achievements of the PCP in establishing and maintaining effective partnerships.</p>
<p><b>3.</b> Facilitate change management through supporting leadership and capacity building within member organisations.</p>	<p><b>3.1</b> Increase the number of organisational plans (strategic and or operational plans) of member agencies that identify OEHCSA activities as priorities for their agency.</p>	<p><b>3.1.1</b> PCP Community Health Plan and individual operational plans agreed to by member agencies.</p> <p><b>3.1.2</b> Tasks associated with PCP workplans documented and assigned to member agencies.</p> <p><b>3.1.3</b> Tasks/activities reflected in relevant organisational plans.</p>	<p>Increased involvement by member agencies, CRG and consumers more broadly to participate in partnership activities.</p> <p>Clearer understanding by member agencies about how the goals and objectives of their agency link to the goals and objectives of the OEHCSA.</p>

Goal (Identified by DHS)	Objective	Strategies/Interventions	Estimated Impact
	<p><b>3.2</b> Support the work with KCHS and Shire of Yarra Ranges around the development of a partnership /relationship plans.</p>	<p><b>3.1.1</b> Share learning between agencies about processes for documenting partnership activities that enhance access to information about the history of key partnerships.</p> <p><b>3.1.2</b> Identify and establish processes /protocols/tools that assist in documenting knowledge/information about partnership activities.</p>	<p>Clear documentation around partnerships activity including who is involved, their purpose, what they have achieved.</p> <p>Partnerships will become more sustainable over time as knowledge will not be lost as people move in and out of partnership relationships.</p>
<p><b>4.</b> Develop greater engagement and active participation in PCP processes and activities with relevant stakeholders, in particular acute health services and Divisions of General Practice.</p>	<p><b>4.1</b> Support the engagement of the Divisions of General Practice in a range of OEHCSEA activities.</p>	<p><b>4.1.1</b> Work with KCHS and the KDGP to engage GP's in the implementation of the EliCD project.</p> <p><b>4.1.2</b> Support ERDGA in the implementation of the DGP Small Grant Project related to Lifescripts.</p> <p><b>4.1.3</b> Support DGP involvement in a range of service coordination initiatives (Refer to objective 4.1 Service Coordination Plan and the Regional PCP Activity Plan).</p>	<p>Strengthened relationships between the DGP and PCP resulting from working on projects of common interest.</p>

Goal (Identified by DHS)	Objective	Strategies/Interventions	Estimated Impact
	<p><b>4.2</b> Increase in the opportunities available for agencies (members and non members) to participate in networking and coordination partnership activities.</p>	<p><b>4.2.1</b> Facilitate opportunities that encourage a diverse range of agencies and consumers to participate in forums/workshops</p> <p><b>4.2.2</b> Identify potential partners cross all key areas of PCP activity including Health Promotion, Service Coordination and Chronic Disease</p>	<p>More agencies and consumers are provided with information about how they can be involved in OEHCSEA activities.</p> <p>A more diverse range of agencies and consumers are involved in OEHCSEA activities.</p>
	<p><b>4.3</b> Support the implementation of the Eastern Health HARP project especially in relation to its connection with the:</p> <ul style="list-style-type: none"> <li>▪ Regional PCP Activity Plan (see service coordination section of CHP)</li> <li>▪ EliCD project at KCHS.</li> </ul>	<p><b>4.2.1</b> Facilitate communications between Eastern Health, DHS and Community Health Services re HealthSmart and HMS.</p> <p><b>4.2.2</b> Facilitate communications between Eastern Health HARP Sector/Area managers and KCHS EliCD project.</p>	<p>Clear understanding about how to facilitate better IT communication (re sharing of client information) between the acute and community health sectors.</p> <p>Clearer link between the roles and responsibilities and referral pathways for each of the different programs.</p>

Goal (Identified by DHS)	Objective	Strategies/Interventions	Estimated Impact
	<p><b>4.4</b> Support the implementation of the Care in Your Community pilot project in the Outer East.</p>	<p><b>4.3.1</b> OEPCP to attend CinYC meetings and planning sessions.</p> <p><b>4.3.2</b> Ensure that the outcomes of the CinYC project are shared with partners and more broadly across the Eastern Region.</p>	<p>Increased understanding and engagement of members and IEPCP about the progress and outcomes of the CinYC project.</p> <p>Greater clarification around the links between the CinYC project with the work of the OEPCP in relation to CDM and the health promotion priority of mental health and wellbeing.</p>

## List of PCP member agencies/organisations and explanation of membership types

Agency name	Type of membership	Deliverable/s involved in
Eastern Access Community Health	Full member (Signatory of MOU)	All OEPCP committees and activities
Ranges Community Health Service	Full member (Signatory of MOU)	All OEPCP committees and activities
Knox Community Health Service	Full member (Signatory of MOU)	All OEPCP committees and activities
Women's Health East	Full member (Signatory of MOU)	OEPCP committees and activities (IHP, Executive and Alliance)
Shire of Yarra Ranges City Council	Full member (Signatory of MOU)	OEPCP committees and activities (IHP, SC, Alliance)
Knox City Council	Full member (Signatory of MOU)	OEPCP committees and activities (IHP, SC, Alliance)
Maroondah City Council	Full member (Signatory of MOU)	OEPCP committees and activities (IHP, SC, Alliance)
Eastern Ranges GP Association	Full member (Signatory of MOU)	OEPCP committees and activities (IHP, SC, Executive and Alliance)
Knox Division of General Practice	Full member (Signatory of MOU)	All OEPCP committees and activities (IHP and Alliance)
Whitehorse Division of General Practice	Full member (Signatory of MOU)	All OEPCP committees and activities
Eastern Health <ul style="list-style-type: none"> <li>• Angliss Hospital</li> <li>• Maroondah Hospital</li> <li>• Outer East Aged Care Assessment Service</li> <li>• Yarra Valley Community Health Service</li> </ul>	Full member (Signatory of MOU)	All OEPCP committees and activities
Care Connect	Full member (Signatory of MOU)	OEPCP committees and activities (SC, Executive and Alliance)
Royal District Nursing Service	Full member (Signatory of MOU)	All OEPCP committees and activities
Richmond Fellowship of Victoria		
Eastern Volunteers Resource Centre		OEPCP committees and activities (SC)

Agency name	Type of membership	Deliverable/s involved in
Villa Maria Society	Full member (Signatory of MOU)	OEPCP committees and activities (SC)
BaptCare	Full member (MOU to be signed)	To be determined
Uniting Care Community Options	Full member (MOU to be signed)	To be determined



# INTEGRATED HEALTH PROMOTION CATCHMENT PLAN

November 2006

## **Vision:**

To build the capacity of member organisations to improve the mental health and well being of vulnerable populations in the Outer East.

## **Priority setting and problem definition**

The World Health Organisation definition of mental health states that “Mental health is a state of wellbeing in which the individual realises his or her own abilities, can cope with normal stresses of life, can work productively and fruitfully and is able to make a contribution to his or her community.”

The VicHealth definition expands on this notion by describing mental health as the “embodiment of social, emotional and spiritual wellbeing...that provides individuals with the vitality necessary for active living, to achieve goals and to interact with one another in ways that are respectful and just.” (Vic Health,1989). Importantly, mental health is increasingly being seen to be fundamental to physical health and quality of life and needs to be addressed as an important component of improving overall health and wellbeing (Walker et al 2004 p.238).

The implementation of health promotion interventions are therefore, essential to encourage and facilitate the development of positive environments that create good mental health and wellbeing outcomes for populations, communities and individuals. “Mental health promotion requires action to influence determinants of mental health and address inequalities through the implementation of effective multi level interventions across a wide number of sectors policies programs settings and environments.”(Vichealth 2006 p13). Therefore, mental health promotion involves promoting the value of mental health and improving the coping capacities of individuals, populations and communities. It is not about focusing on the amelioration of symptoms and deficits. (WHO 2002 p9).

In identifying mental health and wellbeing as a priority of the IHPCP, the partners of the OEHCSA considered the needs of the local community in relation to the mental health and wellbeing needs of the wider community. Findings from the WHO suggest that one person in every four will be affected by a mental disorder at some stage of his or her life and it is estimated that by the year 2020, depression will become the second most prevalent burden of disease being responsible for 12 percent of the total burden of disease in Victoria. Mental health disorders (excluding dementia) affect more than 25 percent of the population with mental disorder rating third of the six highest illnesses that account for most of the health expenditure in Australia (AIHW, 2002).

The OEHCSA IHPCP is based on an understanding that changes in the health and wellbeing of individuals, populations and communities need to be focussed on interventions that affect the determinants of health (factor or characteristic that bring about a change in health). In relation to mental health and wellbeing the VicHealth Framework for Mental Health Promotion identifies the three overarching determinants for mental health as being:

Social inclusion:

- social and community connections
- stable and supportive environments
- a variety of social and physical activities

- access to networks and supportive relationships
- a valued social position

Freedom from violence and discrimination:

- the valuing of diversity
- physical security
- opportunity for self-determination

Access to economic resources

- access to work and meaningful engagement
- access to education
- access to adequate housing
- access to money

Overlaying these determinants is the evidence that suggests that mental ill health is more common amongst vulnerable populations, that is, people, populations or communities who experience social and economic disadvantage (Desjarlais & Kleinman, 1997). Within the context of this plan, vulnerable populations are identified as including:

- indigenous communities
- newly arrived migrants
- young people
- older people

This plan seeks to address inequity issues related to mental health and wellbeing by focussing on the goals of:

- developing a clear understanding of inequalities (social and economic) across the communities of the Outer East
- promoting equitable access to services across a range of community setting and
- creating opportunities for social inclusion and connectedness.

In implementing the IHPCP, it is also important for partners to consider the important difference between women and men's experiences of mental health and well being. Implementation of mental health promoting interventions as a response to this plan will incorporate a gender specific focus. It is recognised that sex and gender interact with social determinants of health such as socio-economic status, indigenous status, disability, cultural and linguistic diversity, geographic location and sexual orientation, therefore gender should be considered, when planning health promotion strategies and interventions. It is important, for partners involved in the implementation of this IHPCP to apply a "gender lens" to their work, ensuring that consideration is given to how gender impacts on the patterns of health and illness experienced by men and women in different community groups across the Outer East.

In addition, when we reflect on the determinant of mental health and well being, it is clear that the influencing factors on social inclusion, freedom from violence and discrimination and access to economic resources are very different for women than men.

In implementing this plan, partners recognise that over time it may be necessary to review the current focus on the determinant of social inclusion and connectedness to address objectives related to freedom from discrimination and violence and/or access to economic resources.

Factors that influenced the decision by partners to focus on mental health and well-being as a priority for the Outer East included the fact that depression is considered to be the second most prevalent burden of disease by 2020 (WHO 2002), and will be responsible for 12 percent of the total burden of disease in Victoria.

At the local level the data for depression in the Outer East region strongly reflects world-wide and national trends. The DALY (Disability adjusted life years) rates in the Outer East for depression are ranked second behind heart disease and in terms of YLD (Years of life living with a disability) depression was ranked number one (DHS, 2006). Even when disaggregated for gender the outcomes were the same.

## Capacity building in relation to identified priority of mental health and wellbeing:

**Goal 1:** Develop systems and processes that support a better understanding of the needs of vulnerable individuals, populations and communities and which encourage sharing of knowledge.

Theme	Objectives	Strategies/Interventions	Impacts
<b>Workforce development</b>	<p><b>1.1</b> By December 2007, identify gaps in the skill sets of key staff within member agencies in relation to the provision of culturally appropriate services and programs for newly arrived and indigenous communities. .</p>	<p><b>Year 1:</b></p> <p><b>1.1.1</b> OEPCP and partners to facilitate information gathering exercise of targeted staff within member agencies to identify workforce development needs re provision of culturally appropriate practices.</p> <p><b>1.1.2.</b>OEPCP to facilitate meetings with key stakeholders and consumers to build a shared understanding of the skills required by key staff in the provision of culturally appropriate services and programs.</p> <p><b>1.1.3</b> Identify opportunities to disseminate learning's (eg regular meeting updates and reports, website, written information, newsletters, trainings, mentoring etc).</p>	<p>1.1.1 Gaps are identified and Documented.</p> <p>1.1.2 Baseline data establishing what staff currently know about culturally appropriate practices (needs analysis).</p> <p>1.1.3 Practitioners will have identified work force development needs in relation to the provision of culturally appropriate practices.</p> <p>1.1.4 Key organisations will have identified skills required to demonstrate culturally appropriate work practices.</p>
<b>Workforce development</b>	<p><b>1.2</b> To support the implementation of cultural training activities that assist key staff in 75% of member agencies to provide services and programs that respond to the needs of newly arrived migrants and indigenous communities.</p>	<p><b>Year 2:</b></p> <p><b>1.2.1</b> OEPCP to facilitate meetings with key stakeholders and consumers to identify what training opportunities are already provided within the</p>	<p>1.2.1 Record number of staff within agencies who have/have not completed prior cultural awareness training.</p> <p>1.2.2 Training opportunities in the</p>

Theme	Objectives	Strategies/Interventions	Impacts
		<p>Eastern Region and what training exists that would enhance practice.</p> <p><b>Year 2/3</b>  <b>1.2.2</b> Meet with key stakeholder agencies and consumers to identify and develop opportunities to provide cultural training for key agency staff.</p>	<p>Eastern region identified and recorded.</p> <p>1.2.3 Cultural training activities completed in 75% of member agencies.</p>
<b>Organisational development</b>	<p><b>1.3</b> By 2008 develop a protocol between member agencies around implementing culturally appropriate work practices for working with vulnerable populations.</p>	<p><b>Year 2</b>  <b>1.3.1</b> Utilise the work and outcomes from objectives 2.2</p>	<p>1.3.1 Protocol developed</p>
<b>Organisational development</b>	<p><b>1.4</b> By 2008 50% of member agencies will have implemented policies and practices that increase the use of culturally appropriate work practices</p>	<p><b>Year 2/3</b>  <b>1.4.1</b> Establish/audit and record current implementation of culturally appropriate strategies, policies and practices in agencies.</p> <p><b>1.4.2</b> Meet with key agencies and consumers to identify appropriate strategies, policies and practices.</p> <p><b>1.4.3</b> Identify other relevant strategies, policies and practices (eg Commonwealth processes).</p> <p><b>1.4.4</b> Disseminate protocols and learnings to member agencies via written information, website,</p>	<ul style="list-style-type: none"> <li>• Established baseline data of the number of agencies that currently have policies and protocols in place.</li> <li>• Evidence of culturally sensitive practices and policies in place.</li> <li>• A future impact will be to identify the number of member agencies who have reviewed their practices to ensure they are culturally appropriate for the people/communities they support.</li> </ul>

Theme	Objectives	Strategies/Interventions	Impacts
<b>Resource Allocation</b>	<b>1.5</b> To identify and link in with work being undertaken around collation and dissemination of local level health data (eg Community Indicators project) and support member agencies to access and use this data for service planning and development.	<p>newsletter, forums/trainings.</p> <p><b>Year 1:</b></p> <p><b>1.5.1</b> Work with key agencies including local government to gain a clear understanding of the data resources available through the Community Indicators Project.</p> <p><b>1.5.2</b> Disseminate learning's information to member agencies.</p> <p><b>Year 2:</b></p> <p><b>1.5.3</b> Meet with member agencies to identify gaps in local level health data and to review what data they are gathering and how it is being collected.</p>	<p>Increased understanding across member agencies about what data is available in relation to the health and well being of the Outer East community and how they are able to access it.</p> <p>Clearer understanding across member agencies about local level data/information requirements and gaps.</p> <p>Evidence of the provision of local level data to the Community Indicators Project</p>

**Goal 2:** Improved access to a broad range of community services that will facilitate better mental health and well being outcomes for vulnerable individuals, populations and communities.

Theme	Objectives	Interventions	Impacts
<b>Partnerships</b>	<p><b>2.1</b> By 2008 the OEPCP will have broadened its partnership collaborations around health promotion activities to include working with a range of agencies/organisations in other settings including neighbourhood houses, education, housing, universities and mental health organisations etc.</p>	<p><b>Year 1</b></p> <p><b>2.1.1</b> Identify and document inter-sector partnership opportunities and activities.</p> <p><b>2.1.2</b> Whee appropriate agencies from other community settings will be encouraged to participate in committees and working groups bringing new expertise and knowledge to the work of the OEPCP.</p> <p><b>2.1.3</b> Share partnership stories/ etc via newsletters, OEPCP, DHS websites.</p> <p><b>Year 1/2:</b></p> <p><b>2.1.3</b> Conduct a partnership forum that highlights/celebrates achievements around across setting partnerships that have improved mental health and well being outcomes for vulnerable populations.</p>	<p>Evidence of three new members to the PCP.</p> <p>The OEPCP will have supported at least three agencies from other community settings as members and/or associate members.</p>
<b>Partnerships</b>	<p><b>2.2</b> By 2007 document protocols and practices to be used by partners and member agencies that support better access to services fro newly arrived migrants and indigenous populations..</p>	<p><b>Year 1:</b></p> <p><b>2.2.1</b> Establish a working group.</p>	<p>Establish clearly defined sets of protocols and practices that assist agencies to make services more accessible to vulnerable individuals, populations and communities in the Outer East.</p>

Theme	Objectives	Interventions	Impacts
		<p><b>2.2.2</b> Working group to:</p> <ul style="list-style-type: none"> <li>• scope breadth of project (eg access to which services).</li> <li>• Identify current proposals for research/work being undertaken within member agencies regarding implementation of practices and protocols to make their services more accessible to vulnerable populations.</li> </ul> <p><b>2.2.3</b> Capitalise on and support work being undertaken especially in relation to member agency Integrated Health Promotion Plans and Municipal Public Health Plans.</p>	<p>Document developed that states an agreed set of practices and standards for agencies to implement.</p> <p>Memorandum of understanding developed to consolidate a shared understanding and commitment by member agencies to implement processes and practices that make their services more accessible to vulnerable individuals, populations and communities in the Outer East.</p>

**Goal 3:** Improve the mental health and wellbeing of vulnerable individuals, populations and communities by promoting and building social inclusion opportunities.

Theme	Objectives	Interventions	Impacts
<b>Partnerships</b>	<p><b>3.1</b> To create a range of opportunities by September 2008 for member agencies to link in with existing programs such as Metro Access, Access for All Abilities and Eastern Recreation Leisure Services to share inclusive models of practice.</p>	<p><b>Year 2:</b>  <b>3.1.1</b> Identify knowledge sharing/mentoring opportunities for member agencies in relation to these programs.</p> <p><b>Year 2:</b>  <b>3.1.2</b> Support member agencies to participate in at least two projects developed in partnership with these program areas.</p>	<p>Member agencies have had exposure to an opportunity to link in with workers in these programs to share knowledge and learnings around models of inclusive practice.</p> <p>Member agencies will have developed partnership relationships around specific project with one or more of these particular program areas.</p>
	<p><b>3.2</b> To contribute to the enhancement of the regional volunteer strategy in the Outer East with the aim of facilitating opportunities for individuals and groups to participate in activities of their choice.</p>	<p><b>Year 2:</b>  <b>3.2.1</b> Engage volunteer resource agencies.</p> <p><b>3.2.2</b> Work with local volunteer resource agencies and member agencies to identify opportunities for establishing partnerships around volunteering initiatives that promote social inclusion opportunities for vulnerable populations.</p> <p><b>3.2.3</b> Facilitate an information sharing/discussion session to consider opportunities to build upon the work being done on the Regional Volunteer Strategy.</p>	<p>Strengthening partnership relationships with local government as the key agencies involved in this initiative – evidence of partnership work with local government.</p> <p>Initiation of activities around one of the key determinants (social inclusion) for improving mental health and well being outcomes of the community.</p> <p>Creation of opportunities between member agencies to share knowledge around supporting and managing volunteers.</p>

Theme	Objectives	Interventions	Impacts
			Increasing opportunities for people and communities across the Outer East to participate in their local community through volunteering.
<b>Leadership</b>	<b>3.3</b> Identify and promote examples of good practice opportunities for people to engage with others and become partners in building social and community life.	<p><b>Year 1:</b></p> <p><b>3.3.1</b> Identify and liaise with organisations that support civic citizenship, leadership, mentoring programs that provide people/communities with structured opportunities for participation.</p> <p><b>3.3.2</b> Undertake mapping exercise and disseminate results.</p> <p><b>3.3.3</b> Support and promote the work being undertaken by Community Health Services related to active community participation (eg Community Health and Drama (CHAD) and community peer research projects).</p> <p><b>Year 2:</b></p> <p><b>3.3.4</b> Identify gaps in opportunities for specific individuals/populations/communities to participate in community activities of their choice.</p> <p><b>Year 3:</b></p> <p><b>3.3.5</b> Support member agencies to engage individuals/populations/communities in</p>	<p>Good practice examples of structured opportunities for participation in the Outer East documented</p> <p>Shared understanding amongst member agencies about the current activities available and the gaps that exist in relation to local opportunities for participation.</p> <p>Creation of new opportunities for participation through the programs such as CHAD and local community peer programs.</p>

Theme	Objectives	Interventions	Impacts
		identifying the types of activities they would like to be involved in.	

Goal 4 - To build the capacity of member agencies and practitioners in health promotion skills

Theme	Objectives	Interventions	Impacts	Links/Partners
<b>Workforce development</b>	<b>Year 1/2</b> <b>4.1</b> To conduct a training needs analysis for 50% of member agencies by June 2007 to establish skills gap.	<b>4.1.1</b> Health promotion skills assessment tool-  <a href="http://www.health.vic.gov.au/healthpromotion/downloads/hp_skills_asses_tool.pdf">www.health.vic.gov.au/healthpromotion/downloads/hp_skills_asses_tool.pdf</a>	<p>A better understanding across the catchment about the health promotion skill needs of staff within member agencies.</p> <p>Clarification about what types of training, mentoring etc opportunities should be sourced and/or developed.</p>	<ul style="list-style-type: none"> <li>▪ OEPCP</li> <li>▪ Encourage all member agency participation.</li> </ul> <p>Link with IHPP (Goal 1 Objective 1.1)</p>
	<b>Year 2/3</b> <b>4.2</b> To organise and deliver workforce development forums to 80% of member agencies and two external sectors, to increase understanding of advocacy, leadership, partnerships and settings based approaches in a health promotion context.	<b>4.2.1</b> Target group – LGA/Maternal Child health nurses, member agencies, education sector, housing sector	<p>Workforce development forums will have been delivered</p> <p>Participants will report that they have a better understanding about leadership, partnerships and settings based approaches</p>	
	<b>Year 1/2</b> <b>4.3</b> To deliver the “Introduction to Health Promotion” training package to five organisations by Dec 2007 to increase awareness of health promotion.	<b>4.3.1</b> PCP health promotion officer to deliver training in partnership with appropriate agencies /organisations.	<p>Staff in agencies where the training is delivered report they have a better understanding about health promotion.</p>	<ul style="list-style-type: none"> <li>▪ WHE,</li> <li>▪ EACH,</li> <li>▪ IEPCP</li> </ul>

Theme	Objectives	Interventions	Impacts	Links/Partners
	<p><b>Year 2/3</b>  <b>4.4</b> To seek opportunities for/support training for 50% of practitioners in member agencies and community houses by Dec 2008, in group facilitation skills, chairing meetings, social marketing and mentoring to increase skills.</p>	<p><b>4.4.1</b> PCP health promotion officer to source and support agency involvement in training programs.  <b>4.4.2</b> If training appropriate training opportunities are not available, work with key agencies/organisations to develop a training opportunities.</p>	<p>Practitioners are provided with opportunities to develop skills around group facilitation, managing meetings, social marketing and mentoring.</p>	<ul style="list-style-type: none"> <li>▪ OEPCP</li> <li>▪ Key agencies /organisations with relevant skills</li> <li>▪ Member agencies as participants.</li> </ul>
	<p><b>Year 1</b>  <b>4.5</b> To deliver one PCP awareness raising forum involving the Outer East Community House Network by June 2007</p>	<p><b>4.5.1</b> PCP health promotion officer to collaborate with the community house network.</p>	<p>Community houses in the Outer East are more aware of the work of the PCP and it partners.  Opportunities for developing partnerships with community houses are developed.</p>	<ul style="list-style-type: none"> <li>▪ Outer East</li> <li>▪ Community House Network</li> <li>▪ OEPCP</li> </ul> <p>Link with IHPP (Goal 2 Objective 2.1) and Partnership Plan Objective 1.1).</p>
	<p><b>Year 1/2</b>  <b>4.6</b> To encourage/support member agency involvement in forums/activities that increase understanding of the connections /links between community development and health promotion.</p>	<p><b>4.6.1</b> Facilitate guest speaker to Partnership and Planning meeting.  <b>4.6.2</b> Identify opportunities available and advertise to member agencies.</p>	<p>Increased awareness amongst health promotion practitioners in member agencies about how their work relates/links in with community development practice. Health promotion and community development practitioners in the Outer East working together on projects</p>	<ul style="list-style-type: none"> <li>▪ OEPCP health promotion officer</li> <li>▪ DHS</li> <li>▪ IEPCP</li> <li>▪ Local government</li> <li>▪ CHS</li> </ul> <p>Link with IHPP (Goal 3 Objective 3.1)</p>

Theme	Objectives	Interventions	Impacts	Links/Partners
	<p><b>Year 1- ongoing</b></p> <p><b>4.7</b> To participate and support partnership with other organisations with a capacity building responsibility in the Eastern Region. Through these partnerships support workforce development initiatives for health promotion.</p>	<p><b>4.7.1</b> Participate in the EMR Health Promotion Capacity Building Collaborative</p> <p><b>4.7.2</b> Participate in developing strategic plan and action plan.</p>	<p>Strategic plan and action plan developed</p>	<ul style="list-style-type: none"> <li>▪ OEPCP</li> <li>▪ IEPCP,</li> <li>▪ WHE</li> <li>▪ Eastern Health</li> </ul>

Theme	Objectives	Interventions	Impacts	Links/Partners
<p><b>Resource Allocation</b></p>	<p><b>Year 1- ongoing</b></p> <p><b>4.8</b> To provide support to member agencies applying for grants/funding submissions</p>	<p><b>4.8.1</b> Disseminate funding opportunities.</p> <p><b>4.8.2</b> Take a leadership role in facilitating and supporting agencies to work in partnerships when applying for grants.</p>	<p>Agencies feel that they have been supported and engaged in applying for grants/funding submissions.</p> <p>Increase in the number of funding applications submitted through the OEPCP that are supported by a range of local agencies.</p>	<ul style="list-style-type: none"> <li>▪ OEPCP</li> <li>▪ CHS</li> <li>▪ Community Houses</li> <li>▪ Local government</li> <li>▪ All members as relevant to the funding opportunities.</li> </ul>

Theme	Objectives	Interventions	Impacts	Links/Partners
	<p><b>Year 1- ongoing</b></p> <p><b>4.9</b> To provide relevant health information/ research to member agencies that supports work in the field of health promotion relating to the Outer east community health plan (mental health promotion)</p>	<p><b>4.9.1</b> Establish criteria for selecting information and articles to be placed on the website.</p> <p><b>4.9.2</b> List relevant journal articles on website as a resource (mental health promotion)</p> <p><b>4.9.3</b> Develop a collection of evidence based models of mental health promotion interventions in community settings</p> <p><b>4.9.4</b> Maintain information regarding the population health data for the Outer East catchment (localised issues)</p>	<p>Member agencies will have better access to relevant up to date local level health information and data to inform planning, service development and grant applications.</p>	<ul style="list-style-type: none"> <li>▪ OEPCP</li> <li>▪ All member agencies for input of relevant information they have access to.</li> <li>▪ Local government expert support.</li> </ul> <p>Link to IHPP (Goal 1 Objective 1.5)</p>
	<p><b>Year 1- ongoing</b></p> <p><b>4.10</b> To develop and support a health promotion directory of projects in the Outer East catchment on the OEPCP website</p>	<p><b>4.10.1</b> Create links to community houses and U3A.</p> <p><b>4.10.2</b> Create link to QIPPS that access their record of projects.</p> <p><b>4.10.3</b> Record current and ongoing health promotion projects in the Outer East and link in with the EMR DHS site.</p> <p><b>4.10.4</b> Create a page for PCP members to highlight events or resources.</p>	<p>Increase awareness of projects in the Outer east</p> <p>Number of projects listed</p> <p>Number of events listed</p>	<ul style="list-style-type: none"> <li>▪ OEPCP</li> <li>▪ Community Houses</li> <li>▪ U3A</li> <li>▪ CHS</li> <li>▪ All member agencies to provide information about health promotion activities</li> <li>▪ EMR DHS</li> </ul>

## Related organisational plans:

Member Agency	Organisational Plan
Eastern Access Community Health	<ul style="list-style-type: none"> <li>▪ EACH Integrated Health Promotion Plan</li> <li>▪ EACH Strategic Plan</li> </ul>
Ranges Community Health Service	<ul style="list-style-type: none"> <li>▪ Ranges Community Health Service Integrated Health Promotion Plan</li> <li>▪ Ranges Community Health Service Strategic Plan <a href="http://www.rangeschs.org.au/docs/strategicplan2003.doc">http://www.rangeschs.org.au/docs/strategicplan2003.doc</a></li> </ul>
Knox Community Health Service	<ul style="list-style-type: none"> <li>▪ KCHS Integrated Health Promotion Plan</li> <li>▪ KCHS Strategic Plan</li> </ul>
Yarra Valley Community Health	<ul style="list-style-type: none"> <li>▪ Eastern Health Promotion Plan</li> </ul>
Women's Health East	<ul style="list-style-type: none"> <li>▪ WHE Health Promotion Plan</li> <li>▪ Strategic Plan <a href="http://www.whe.org.au/strategic.html">http://www.whe.org.au/strategic.html</a></li> </ul>
Shire of Yarra Ranges	<ul style="list-style-type: none"> <li>▪ Vision 2020 Community Plan <a href="http://www.yarraranges.vic.gov.au/page/Page.asp?Page_Id=371&amp;h=0">http://www.yarraranges.vic.gov.au/page/Page.asp?Page_Id=371&amp;h=0</a></li> <li>▪ Community Well Being Plan 2006-2009 <a href="http://www.yarraranges.vic.gov.au/page/page.asp?Page_Id=235&amp;h=0">http://www.yarraranges.vic.gov.au/page/page.asp?Page_Id=235&amp;h=0</a></li> </ul>
Knox City Council	<ul style="list-style-type: none"> <li>▪ Knox Vision 2020 <a href="http://www.knox.vic.gov.au/Page/Download.asp?name=Vision_2020_Magazine_v10c_WEB.pdf&amp;size=1533951&amp;link=../Files/Vision_2020_Magazine_v10c_WEB.pdf">http://www.knox.vic.gov.au/Page/Download.asp?name=Vision_2020_Magazine_v10c_WEB.pdf&amp;size=1533951&amp;link=../Files/Vision_2020_Magazine_v10c_WEB.pdf</a></li> <li>▪ Community Health and Wellbeing Strategy 2002-2006 <a href="http://www.knox.vic.gov.au/Page/Page.asp?Page_Id=426&amp;h=1">http://www.knox.vic.gov.au/Page/Page.asp?Page_Id=426&amp;h=1</a></li> </ul>
Maroondah City Council	<ul style="list-style-type: none"> <li>▪ Maroondah a Community Planning together <a href="http://www.maroondah.vic.gov.au/CA256B88001F8356/OrigDoc/~19057FBFD1DF9A454A256B8E00833B39?OpenDocument&amp;1=05-About+Council~&amp;2=20-Long+Term+Vision~&amp;3=~">http://www.maroondah.vic.gov.au/CA256B88001F8356/OrigDoc/~19057FBFD1DF9A454A256B8E00833B39?OpenDocument&amp;1=05-About+Council~&amp;2=20-Long+Term+Vision~&amp;3=~</a></li> <li>▪ Municipal Public Health Plan</li> </ul>
Eastern Ranges GP Association	<ul style="list-style-type: none"> <li>▪ Strategic Plan</li> </ul>
Knox Division of General Practice	<ul style="list-style-type: none"> <li>▪ Strategic Plan</li> </ul>
Whitehorse Division of General Practice	<ul style="list-style-type: none"> <li>▪ Whitehorse Division of General Practice Strategic Plan (2007-2011)</li> </ul>
Eastern Health ▪ Angliss Hospital	<ul style="list-style-type: none"> <li>▪ Eastern Health is in the process of developing a Strategic Plan updates of this planning process can be accessed at <a href="http://www.easternhealth.org.au/eastern/strategic-plan.html">http://www.easternhealth.org.au/eastern/strategic-plan.html</a></li> </ul>

<ul style="list-style-type: none"> <li>▪ Box Hill Hospital</li> <li>▪ Maroondah Hospital</li> </ul>	<ul style="list-style-type: none"> <li>▪ Eastern Health: Health Promotion Plan (2006-2009)</li> </ul>
Care Connect	
Outer East Aged Care Assessment Service	

## Non member agency role in implementation of the IHPP

Agency	Potential partnership role
Neighbourhood Houses:	<ul style="list-style-type: none"> <li>▪ social and community connections</li> <li>▪ a variety of social and physical activities</li> <li>▪ access to networks and supportive relationships</li> <li>▪ access to work and meaningful engagement</li> <li>▪ access to education</li> </ul>
Housing support organisations:	<ul style="list-style-type: none"> <li>▪ access to adequate housing</li> <li>▪ stable and supportive environments</li> <li>▪ physical security</li> </ul>
Indigenous focussed agencies:	<ul style="list-style-type: none"> <li>▪ social and community connections</li> <li>▪ stable and supportive environments</li> <li>▪ a valued social position</li> <li>▪ the valuing of diversity</li> <li>▪ opportunity for self-determination</li> </ul>
Migrant Resource Centre	<ul style="list-style-type: none"> <li>▪ social and community connections</li> <li>▪ stable and supportive environments</li> <li>▪ access to networks and supportive relationships</li> <li>▪ the valuing of diversity</li> </ul>
Volunteer resource/support organisations:	<ul style="list-style-type: none"> <li>▪ a valued social position</li> <li>▪ opportunity for self-determination</li> <li>▪ the valuing of diversity</li> <li>▪ access to networks and supportive relationships</li> </ul>
Schools, TAFES, colleges etc	<ul style="list-style-type: none"> <li>▪ social and community connections</li> <li>▪ access to education opportunity for self-determination</li> </ul>
Businesses and Centres of Commerce	<ul style="list-style-type: none"> <li>▪ access to money</li> </ul>

Agency	Potential partnership role
Transport Services	<ul style="list-style-type: none"> <li>▪ access to education opportunity for self-determination</li> <li>▪ social and community connections</li> <li>▪ access to networks and supportive relationships</li> <li>▪ physical security</li> <li>▪ access to work and meaningful engagement</li> <li>▪ access to money</li> </ul>
Sport and Recreation Services	<ul style="list-style-type: none"> <li>▪ access to networks and supportive relationships</li> <li>▪ social and community connections</li> <li>▪ a variety of social and physical activities</li> </ul>

Resources – PCP IHP Catchment Resource Summary:

Capacity building component	DHS funded IHP activities for the PCP	Member contributions
Workforce development	<p>Staffing costs associated with:</p> <ul style="list-style-type: none"> <li>▪ identifying workforce development needs and supporting partnerships around, or the provision of, workforce development activities.</li> </ul> <p>Costs associated with activities:</p> <ul style="list-style-type: none"> <li>▪ Forums/workshops</li> <li>▪ Website</li> <li>▪ Newsletter</li> <li>▪ Individual consultations</li> <li>▪ Research</li> <li>▪ Resource development</li> <li>▪ Coordination of regional initiatives</li> </ul>	<ul style="list-style-type: none"> <li>▪ Staffing costs (2006/07) associated with: identifying workforce development needs</li> <li>▪ Presenting/facilitating/mentoring in relation to share knowledge with other members around specific workforce development needs</li> <li>▪ Participation in workforce development workshops, meetings and activities.</li> </ul>
<b>Proposed funding expended on workforce development 06/07</b>	<b>\$26,215</b>	
Partnership development	<p>Staffing costs associated with:</p> <ul style="list-style-type: none"> <li>▪ Facilitation of, executive support for and participation in regular OEHCSA committees and working groups</li> <li>▪ Coordination of a range of funding opportunities with and for partners</li> <li>▪ Resourcing knowledge sharing activities (eg newsletter, research, website updates)</li> <li>▪ Regional and subregional network activities</li> <li>▪ Administrative support</li> <li>▪ Evaluation of partnership outcomes.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Participation in regular OEHCSA health promotion meetings and working groups</li> <li>▪ Participation in regional and sub regional networks</li> <li>▪ Working with partners on the implementation of interventions related to the mental health and well being priority.</li> </ul>
<b>Proposed funding expended on partnership development 06/07</b>	<b>\$13,107</b>	

<b>Capacity building component</b>	<b>DHS funded IHP activities for the PCP</b>	<b>Member contributions</b>
Leadership	Staffing costs associated with: <ul style="list-style-type: none"> <li>▪ Implementation, monitoring and review of the CHP 2006-2009.\</li> <li>▪ Resourcing and supporting opportunities to build the capacity of member agencies around the identified health priority and more general health promotion work</li> <li>▪ Seeking resources</li> <li>▪ Support around community engagement</li> <li>▪ Evaluation of project outcomes.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Support learning/mentoring opportunities to share knowledge with partners</li> <li>▪ Undertaking key roles in OEPCP committees</li> </ul>
<b>Proposed funding expended on leadership 06/07</b>	<b>\$13,107</b>	
Organisational development	In the initial year of this plan it is anticipated that the costs associated with organisational development will be minimal. Objective 1.3 of the IHP plan suggests that there will be a need to allocate some OEPCP staff resources towards organisational development in 2006/07.	<ul style="list-style-type: none"> <li>▪ Participation in working groups</li> <li>▪ Individual meeting times</li> <li>▪ Sharing of resources</li> </ul>
Resource allocation	One of the key projects for the IHPCP (ie the local level data project) has been listed under the capacity building activity of resource allocation	<ul style="list-style-type: none"> <li>▪</li> </ul>
<b>Proposed funding expended on org development and resource allocation 06/07</b>	<b>\$13,107</b>	
<b>Organisational and administrative costs</b>	<b>\$11,565</b>	
<b>Total expenditure 06/07</b>	<b>\$77,103</b>	

Additional Integrated Health Promotion resources:

Funding sources/project	Links to catchment priorities	Funding
<b>HALS funding</b> Shire of Yarra Ranges lead	Focuses on older people who are identified within this plan as a vulnerable population group. The program supports social inclusion particularly in relation to: <ul style="list-style-type: none"> <li>▪ development of social and community connections</li> <li>▪ establishing a variety of social and physical activities and</li> <li>▪ access to networks and supportive relationships.</li> </ul>	\$20,000 (2005-2006)
<b>Footholds on Safety</b> PCP lead	Focuses on older people who are identified within this plan as a vulnerable population group. <ul style="list-style-type: none"> <li>▪ stable and supportive environments</li> <li>▪ a variety of social and physical activities</li> <li>▪ physical security</li> <li>▪ opportunity for self-determination.</li> </ul>	\$50,000 (2005-2006)
<b>PARE</b> (Physical activity referral and information exchange program) Eastern Ranges General Practice Association lead	Focuses on promotion of healthy living through the use of Lifescritps. <ul style="list-style-type: none"> <li>▪ development of social and community connections</li> <li>▪ establishing a variety of social and physical activities and</li> <li>▪ access to networks and supportive relationships.</li> </ul>	\$20,000 (2005-2006)
<b>Walking Grant (DVC)</b> PCP lead	Forum to raise awareness about walking groups and opportunities to participate. <ul style="list-style-type: none"> <li>▪ Support to local working groups through a walking group establishment grant program.</li> <li>▪ Adopt a walker day to encourage the social as well as a physical benefits of walking.</li> </ul>	\$10,000
<b>Total additional funding</b>		<b>\$100,000</b>

## Planning for quality health promotion practices (Evaluation of mix of interventions)

The PCP will support evaluation processes undertaken by agencies by:

- Identifying and facilitating opportunities to share knowledge and learnings amongst partner agencies around evaluation.
- Support mentoring training opportunities around evaluation
- Seek opportunities to engage tertiary institutions to provide expertise and to assist in developing effective evaluation processes for projects and programs linked to the priority.
- Facilitate access to local level baseline data to support the development of evidence-based interventions.
- Consider opportunities for developing an evaluation working group with member agencies.

The PCP will also seek to coordinate the results of evaluations completed by member agencies in relation to work around mental health and well being. In collating the results of agency evaluations, the PCP will be able to present a picture of what has been achieved in relation to improving mental health and wellbeing for individuals and communities across the whole PCP catchment.

## Evaluation and dissemination (Evaluation of capacity building strategies)

The PCP will use the tool developed by Hawe, King and Noort to evaluate and measure the capacity building efforts of the OEPCP. This tool provides a check list of nine different areas of assessment which can be used for impact evaluation of capacity building. For example:

Effective partnerships development can be evaluated against

1. The strength of the coalition using KPI's such as:
  - Number and type of agencies or sectors participating in work on catchments priorities and their role;
  - State of the IHP partnerships demonstrated through the annual application of the VicHealth partnership audit tool
2. Community/consumer involvement and capacity to be involved and address the issue using KPIs such as:
  - Community/ consumer engagement in policy/program development and implementation

Effective workforce development can be evaluated against:

3. Opportunities to promote incidental learning
4. Opportunities to promote informal learnings using KPI's such as:
  - Range and diversity of learning opportunities created
  - Satisfaction of partners with incidental and formal learning opportunities created (eg forums, mentoring, trainings, website information, presentations etc)
  - Partners are proactively proactive in being involved in OEHCSA activities.

Effective organisational change management can be evaluated against:

5. The capacity for organisational learning
6. The capacity of a particular organisation to tackle a health issue using KPI's such as

- Numbers and types of agencies in which organisational IHP plans (or equivalent) reflect IHP catchments priorities
- Number of agencies planning and implementing IHP related capacity building activity to foster change management skills.

Effective resource allocation can be evaluated against:

7. Program sustainability using KPI's such as:

- People with a stake in the program are involved
- Effects of the program are visible
- Prospects of the program to acquire or generate some additional funds/resources.

Effective leadership can be evaluated against:

8. Learning environment of a the team or project group using KPI's such as:

- Team goals are well defined
- Everyone knows their job and how it relates to the overall work of the team
- Expectations are clear

9. Quality of program planning using KPI's such as

- Program planning contains all the key elements (evidence based, consumer focused, and targeted, clear objectives and strategies, resource allocation, evaluation)

The OEPCP will use a range of tools and activities to ensure that agencies have access to learnings about outcomes achieved around mental health and wellbeing across the Outer East catchment. Tools that will be used will include newsletters, OEHCSA website, forums, trainings, mentoring opportunities, regular meetings and networks. The OEPCP will work towards developing a communication strategy that articulates effective method and processes for disseminating information and learnings to agencies.

## Applying an Integrated Disease management 'lens' to IHP planning

- The OEPCP has strong links with the AHPACC project which has a focus on the effects of diabetes on Indigenous people in the Outer East. Through the IHP the OEHCSA will be supporting interventions that encourage local indigenous people to become more physically active to help reduce the risk of getting diabetes and to assist in regulating the symptoms in those people who are living with the condition.
- The IHP acknowledges that positive mental health and well being outcomes for communities are enhanced by ensuring that people are able to access a range of community services that are provided outside the health care sector (eg education, housing etc). The IHP articulates specific strategies which encourage partnerships with agencies operating outside the health care sector.
- The health promotion work of the OEPCP also includes working with the Divisions of General Practice (DGP) to facilitate a project around the use of "Lifescrpts". The aim of this project is to encourage GPs to refer people, with a range of conditions including chronic disease to services that can provide them with "upstream" activities (eg physical activity, social connections etc) which can help in moderating the effects of their CD.

- The Healthy Active living for Seniors (HALS) project is also an important initiative that will provide a link between chronic disease management and health promotion. The program encourages older people in the Yarra Ranges area to become more active. Participants have reported significant benefits in regulating the symptoms of their chronic disease (eg asthma) as a result of being involved in this program. The project officer will collate this qualitative information providing direct evidence that health promotion interventions are effective strategies for supporting the management of chronic disease.



# SERVICE COORDINATION PLAN

November 2006

Goal		
<p><b>1. Implement 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 organisations.</b></p>		
Objective	Strategies/Interventions	Estimated Impact
<p>1.1 Achieve a consistent uptake and use of the SCTT, PPPS and E-SCS by PCP member agencies and support new sector involvement including AOD and PDRSS services.</p>	<p><b>Year 1</b></p> <p><b>1.1.1</b> Map the usage of E-SCS across member agencies engaged in using E-SCS in the Outer East.</p> <p>1.1.2 Strengthen the links between the SCC and the SCN to enhance the flow of knowledge and expertise and ensure that E-SCS is supported across organisations by practitioners and managers</p> <p>1.1.3 Work at a regional level with the IEPCC to engage the Alcohol and Drug and PDRSS sectors in information and training sessions around E-SCS, post implementation assistance and integration with regional and statewide PPPS manual.</p> <p><b>1.1.4</b> Support the work being undertaken as part of the Regional E-SCS project to develop systems and support activities that promote effective care planning and care coordination outcomes.</p>	<p>A clear benchmark of e referral usage, issues related to non-usage and an understanding of competencies related to service coordination.</p> <p>More consistent uptake of the SCTT, PPPS and E-SCS due to greater practitioner engagement in project activities and increased management support.</p> <p>Alcohol and Drug and PDRSS across the Eastern Region will have access to information and training re E-SCS and the PCP's will have a clearer understanding of the specific issues for these sectors in relation to E-SCS.</p> <p>Increased number of agencies using the care palanning/care coordination tools in the E-SCS</p>

	<b>(Refer to “Regional Service Coordination Plan”-Section 3 below for further detail)</b>	
	<b>Year 2/3</b> <b>1.1.4</b> Identify opportunities to undertake mentoring and leadership activities that encourage, more effective uptake of E-ESC amongst member agencies through shared experiences and knowledge.	
<b>1.2</b> Implement a service access model for the Outer East, which promotes common and streamlined access to services for customers.	<b>Year 1</b> <b>1.2.1</b> Finalise the Common Service Access Project report and seek resources to conduct a pilot within the Outer East.	Agreement amongst members agencies about the model to be adopted for the pilot  Applications for resources to support the project will have been sought.
	<b>Year 2</b> <b>1.2.2</b> Undertake the pilot and share learnings from pilot and identify opportunities for extending the model across member agencies and across the EMR. ( <i>Actions in Year 2 are dependent on outcome of 1.2.1</i> )	

**Goal**

**2. Successful implementation of the Victorian Service Coordination Practice Manual and subsequent versions of the Service Coordination Tool Templates.**

Objective	Strategies/Interventions	Estimated Impact
<p><b>2.1</b> To increase the knowledge and understanding of service coordination across member agencies in the Outer East and ensure that practice is informed by the Statewide and Regional PPPS manuals.</p>	<p><b>Year 1</b></p> <ul style="list-style-type: none"> <li>▪ Identify the skills required by practitioners to assess and facilitate referrals and access other services.</li> <li>▪ Identify opportunities to support practitioners to gain the skills required.</li> </ul>	<p>Regional communication strategy developed to support the distribution and implementation of the VSCPC.</p> <p>Victorian Service coordination Practice Manual distributed to all member agencies in the Outer East.</p>
	<p><b>Year 1 and 2</b></p> <ul style="list-style-type: none"> <li>▪ Work with the IEPCP to coordinate activities between the two PCP's to deliver regional forums and support the roll out of the Statewide Regional Service Coordination Manual.</li> </ul> <p><b>(Refer to “Regional Service Coordination Plan - Section 2 ” below for further detail)</b></p>	<p>Regular meetings between both PCP's</p> <p>Regional forums (one per year) to coordinate the sharing of learnings and knowledge across the eastern region.</p> <p>Regional approach to implantation of the Statewide Service coordination Manual.</p>

**Goal**

**3: Change management support for implementation of e-referral (if relevant)**

Objective	Strategies/Interventions	Estimated Impact
<p><b>3.1</b> To ensure that service coordination practices are embedded at an operational and strategic level within member organisations and are supported by effective systems and governance processes.</p>	<p><b>3.1.1</b> Undertake an audit of member agency workplans and relevant organisational plans to determine if the agency is strategically focused on encouraging/supporting service coordination and care planning practices.</p>	<p>Evidence that service coordination practices and care planning are embedded in the activities of member agencies.</p>
	<p><b>3.1.2</b> Develop opportunities for member agencies to take on a leadership role in promoting, engaging and supporting other agencies in enhancing service coordination practices and care planning within their organisation.</p>	<p>Further opportunities to celebrate successes in service coordination and care planning outcomes at a practical level and the creation of opportunities for agencies to share local knowledge and provided mentoring support.</p>
	<p><b>3.1.3</b> Work with the IEPCP and the project manager to support the implementation of the Regional Service Coordination Project.</p> <p><b>(Refer to “Regional Service Coordination Plan - Section 1 ” below for further detail)</b></p>	<p>Refer to Action Plan Appendix 1 of “Regional Service Coordination Plan”</p>

Goal		
<p><b>4. 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. (DHS)</b></p>		
Objective	Strategies/Interventions	Estimated Impact
<p><b>4.1</b> Develop improved communication and referral practices between by GP’s and other local health care providers by supporting an increase in the usage of the Statewide Referral form and the E-SCS</p>	<p><b>4.1.1</b> Work in partnership with the three Outer East Divisions of General Practice to support the engagement of GPs in service coordination.</p> <p><b>4.1.2</b> The IE &amp; OE PCPs will work together on the dissemination of current approaches and early learning’s of the Community Health Chronic Disease management programs.</p> <p><b>4.1.3</b> Support the work being undertaken to create a better interface between medical software and the Statewide Referral Form.</p>	<p>Increased engagement of DGP’s and GP’s in the use of E-SCS.</p>

Goal		
<p><b>5 Improved amount and accuracy of information to support referral through the Human Services Directory.</b></p>		
Objective	Strategies/Interventions	Estimated Impact
<p><b>5.1</b> Improve the amount accuracy of information available to support referral through all relevant Electronic Service Directories.</p>	<p><b>5.1.1</b> Work with IEPCP on strategies for ensuring that member agencies are updating Electronic Referral Directories.</p> <p><b>(Refer to “Regional Service Coordination Plan - Section 2 ” below for further detail)</b></p>	<p>Greater certainty that the information in the directories related to the member agencies of the Inner and Outer PCP is accurate.</p>

**Regional PCP Activity  
between  
Inner and Outer East PCPs.  
(2006-2009)**

**Identified areas of focus:**

1. Electronic Service Coordination System
2. Joint Regional service coordination work
3. New Sectors/agency engagement in Service Coordination
4. Integrated Chronic Disease Management Program
5. Care in Your Community Regional plan
6. Care Planning

## Preamble:

The Inner East Primary Care Partnership (IEPCP) and the Outer East Health and Community Support Alliance (OEHCSA) have been working closely on PCP (Service Coordination) activity for the past 5 years. The Regional Service Coordination manual and the success of the Regional E- Referral system are evidence of the close working relationship. This document provides for the first time the agreed parameters for the joint activity that is viewed as requiring a regional approach by both PCPs. This document also provides the reference point for the yearly review that will be conducted by the EMR Service Co-ordination Group (SCG). This will be synchronized with the Community Health Plan Implementation Agreement (CHPIA) that happens with each PCP individually.

The key area of work that the two PCPs are jointly collaborating on is the rollout and ongoing development of the Electronic Referral System (hence a budget is attached to this project). The other important areas that do not have joint budgets are the regional Service Coordination work, the engagement of new sectors, and a regional approach to the Integrated Chronic Disease Management Program.

## 1. Electronic Service Coordination System

### A. Context:

The Eastern Region's Electronic Service Coordination System was developed to improve the service / care coordination beyond the initial referral and strengthen the tools supporting service/ care coordination across the health (acute, sub-acute and primary health) and community service sectors.

The E-SCS was developed over a number of years through the original work of the Maroondah City Council in the late 1990s and later in conjunction with the Outer East Health and Community Support Alliance (OEHCSA) and the Inner East Primary Care Partnership (IEPCP). The system was based on the development of business processes and protocols between primary care and acute service agencies in the IEPCP and OEHCSA.

As a result of extensive consultation and a review/ feasibility study undertaken in the second half of 2004, the Eastern Metropolitan Region PCPs decided to move to a common system across the whole of the Region with the development of an enhanced ERS to improve the user interface and to strengthen the tools that support service/ care coordination across the health (acute, sub-acute and primary health) and community service sectors.

In 2005/6 the Eastern Region E-SCS Steering Committee, with funding from Department of Human Services, enhanced the electronic product and is now implementing the full system across the Eastern Region. The E-SCS enables agencies with client consent to send and receive patient information and view the client referral history/service summary via a secure web based system. This system supports agencies to work effectively and efficiently together (care coordination) for the client's benefit.

### B. Identified Problem: (Broadly speaking)

1. Appropriate governance arrangements are needed to ensure the ongoing development, effective uptake and use of the E-SCS, protect the "integrity of the system" through effective risk management and support good practice.

2. A critical mass of users in terms of range of agencies involved (breadth) and numbers of users within agencies (depth) is needed to have significant impact in terms in the effectiveness and efficiency of service coordination.

3. Developing and using the E-SCS for care co-ordination and “system of care” monitoring is predicated on the clinical/ care coordination practices and systems being implemented.

4. Service “System” performance has been difficult to assess and describe in quantifiable terms.

### **C. Program Assumptions: (principles and beliefs guiding the program)**

Trends in Health and community care are emphasising the development of “systems of care” - coordinated care, integrated disease management, chronic and complex care, and more recently “integrated ambulatory care”. The implication of these trends is the increasing emphasis on coordination of care not only within a health/human service sector, but also across sectors- from or between hospitals, community based services local government, home care services, community health centres, drug and alcohol services, youth support, juvenile justice services, PDRSS, GPs etc

Central to this process is for a range of relevant service providers involved in the care/support process to have timely information about client care across the spectrum of services the client may be involved with, particularly for those with chronic and complex care.

### **D. Program Goal:**

To support improved service and care coordination for clients within and across agencies and sectors through effective use of E-SCS for client and service history information transmission and access.

### **E. Program Objectives**

#### **Objective 1:**

Development of effective governance and contract management processes

KPI:

- Establishment and operation of Eastern Region Governance Process
- Adaptation of current or development of new governance processes to enable use with agencies located outside EMR

**Objective 2:**

Substantial increase in number of referrals using E-SCS compared with June 2006

KPI:

- Total numbers of staff trained
- Increase the critical mass of users in terms of range of agencies involved (breadth) and numbers of users within agencies (depth).
  - Proportion Agencies using compared to total number of publicly funded Human Service provider agencies
  - Range of sectors, Agencies and service types
  - Increased GP uptake
  - Outpatients and Inpatient use

**Objective 3:**

Increase use of E-SCS for shared care/ co-ordination of care for clients

KPI:

- Number of case review and care co-ordinations processes that use the E-SCS
- Range of service types using this ESCS for care co-ordination

**Objective 4:**

To conduct an independent evaluation that highlights impacts and outcomes (future efficiencies) of the E-SCS.

KPI:

- Evaluation conducted from February to March and final report completed by 1 June 2007

**Examples of benefits of the Electronic Service Coordination System to member agencies and consumers:****Consumers will have:**

1. Improved quality of care due to agencies having access to more comprehensive service histories
2. More positive experiences resulting from their needs being addressed more efficiently, and
3. Greater likelihood of being able to enjoy the general benefits of service coordination such as improved quality of life while living in the community and reduced likelihood of hospitalisation.

**Member agencies will have:**

1. A much better overview of client service provision histories
2. Ability to engage in improved care planning and care coordination
3. Much closer links and improved information exchange between health sector agencies and with other sectors providing social services
4. Improved cost-benefit performance in client service.

**Involvement of General Practice:**

The E-SCS project has a significant component of its work related to General Practice engagement. These include:

1. Extensive and regular consultation with the EMR Divisions of General practice.
2. GPs have participated in some of the forums held by the E-SCS Project.

3. The EMR GP Divisions have formal representation on E-SCS Project Steering Committee and now E-SCS Management Committee.
4. The E-SCS Project has established a General Practice subcommittee (comprising representatives of the EMR GP Divisions) with the following Terms of Reference:
  - To develop a recommend strategies to increase General Practice use of E-SCS.
  - To develop and maintain a system of support for GPs using the E-SCS.
  - Develop and implement a communication strategy about E-SCS with General Practice.
5. A small group of GPs used the system and an evaluation of it was conducted.
6. The E-SCS General Practice Subcommittee examined the barriers/facilitators to effective use of the E-SCS and has developed a strategy to support effective and efficient use on a more significant scale.
7. The Subcommittee has examined technical solutions to overcoming some of the barriers to use, and have developed a funding submission for Broadband for Health and are awaiting the outcome. They are also pursuing other avenues of funding.
8. Agencies are currently using the fax facility on E-SCS to send referrals to GP practices.
9. E-SCS Project has liaised with the PCP Care Planning Tools being developed in close consultation with the GP Division.
10. The GP division have actively supported, are actively participating in and are an integral part of the E-SCS Project.



## Eastern Region Electronic Service Coordination System

### Draft Project Tasks and Activities July 2006 to June 2007 v 3

Objective	Estimated Impacts	Key Tasks	Activities	Responsible	Other Involved	Time
1. Development of effective governance and contract management processes for EMR	Establishment and operation of Eastern Region Governance Process	Establish and Consolidate EMR Governance Process	Establish E-SCS management committee	Project Manager	OEHCSA	August 06
			Finalise documents detailing operational processes- System Governance, use obligations, dispute resolution processes.	Project Manager	OE, IEPCP and Maroondah Council	October 2006
			Signoff on system upgrade with Infoxchange Australia	Project Manager	OEHCSA/ Maroondah Council	November 2006
			Review Master Contract with software developer Infoxchange Australia	Project Manager	OEHCSA/ Maroondah CC	April 2007
	Adaptation of current or development of new processes to enable use of common client database with agencies located outside EMR	Resolve "cross border issue"- Develop systems and processes to preserve the "integrity of system" when system used with agencies outside EMR	Adapt /develop and document new processes to enable use with agencies located outside EMR In conjunction with relevant organizations. <ul style="list-style-type: none"> <li>➤ Resolve who can use system, adherence to common practices/ protocols, audit of use, software improvements and a complaints mechanism</li> </ul>	Project Manager	In conjunction with relevant organizations	April 2007

Objective	Estimated Impacts	Key Tasks	Activities	Responsible	Other Involved	Time
2. Substantial increase in number of referrals using E-SCS compared with June 2006	20% of total referrals by Dec 06 and 40% by June 07	<p>Increase the critical mass of users in terms of range of agencies involved (breadth) and numbers of users within agencies (depth) including working with the GP Divisions to increase usage by GP's</p> <p>Consolidation of E-SCS use in Agencies as the primary mode of sending and receiving referrals from other service providers</p> <ul style="list-style-type: none"> <li>➤ Establish the use of the E-SCS the normal mode of information transmission and obviate staff having to use different methods to send information to different agencies.</li> </ul>	<p>Increase staff and agencies that participate- Register agencies and users on system</p> <p>Provide training, support and action that is necessary to turn knowledge into actual usage.</p> <p>Identify and address barriers to increased usage of E-SCS at agency level through onsite agency visits and consultation forums with users.</p>	Project Manager/	Implementation Working Group. (Note this group involves a range of key stakeholders including the GP Divisions).	June 07

Objective	Estimated Impacts	Key Tasks	Activities	Responsible	Other Involved	Time
		<p>Work with GP Divisions in developing submission for funding of software development to enable GP to efficiently access E-SCS and to pilot with 10 Practices.</p> <p>Work with the GP Divisions to identify strategies for supporting and sustaining GP use of E-SCS.</p>	<p>Establish GP E-SCS working Party and explore:</p> <ul style="list-style-type: none"> <li>▪ funding options and develop relevant submissions.</li> </ul> <p>Establish GP E-SCS Working Party and explore:</p> <ul style="list-style-type: none"> <li>▪ recommendations for strategies to increase GP use of E-SCS.</li> <li>▪ recommendations for developing and maintaining a system of support for GPs using E-SCS.</li> <li>▪ the development and implement of a communication strategy about E-SCS with GPs.</li> </ul>	Project Manager	GP Divisions	June 07
		Induct St Vincent's HARP	<p>Resolve cross border issues and relevant processes to preserve integrity of system</p> <p>Develop and implement rollout in St Vincent's HARP</p>	<p>Project Manager</p> <p>Project Manager</p>	St Vincent's HARP (JH) and relevant PCPs	<p>April 07</p> <p>Oct 2006 to February 2007</p>

Objective	Estimated Impacts	Key Tasks	Activities	Responsible	Other Involved	Time
3. Increase use of E-SCS for shared care/ co-ordination of care for clients	<p>Increased number of case review and care co-ordinations processes that use the E-SCS</p> <p>Increased range of service types using E-SCS for care co-ordination</p>	Develop staff and agency skills in use of system for care co-ordination and "system of care" monitoring.	<p>Conduct at least two specific forums/workshops about use of E-SCS for this purpose. Work with the GP Divisions to engage GP's in these sessions.</p> <p>Support practitioner clusters in using care coordination support features within E-SCS.</p>	Project Manager,	<ul style="list-style-type: none"> <li>• IE/OE PCP Service Coordination managers</li> <li>• GP Divisions</li> </ul>	September 06 to June 07
4. Evaluation of the impact of use of E-SCS	<p>Quarterly Project Evaluation Reports.</p> <p>Impact Evaluation conducted from February to March and final report completed by 1 May 2007</p>	<p>Project Evaluation</p> <p>System impact evaluation.</p> <ul style="list-style-type: none"> <li>➤ Conducted by a body that has expertise in IT, client care and economic evaluation.</li> </ul>	<p>Analysis of usage patterns across agencies and service sectors.</p> <p>Develop Project Brief including clear purpose.</p> <p>Conduct Evaluation</p>	<p>Project Manager</p> <p>Independent Evaluation</p>		<p>October 06 and February 07, April 07 and final June 2007</p> <p>October 2006</p> <p>February-March 2007</p>

## Eastern Region Electronic Service Coordination System

Project Budget July 2006 to June 2007 v3

<b>Income</b>		<b>Amount</b>	<b>Comments</b>
DHS EMR		\$100,000	PCP Merger
DHS EMR		18,000	Special Purpose grant
Agency Contributions		35,000	
Brought Forward		\$36,000	
Brought Forward St Vincent's HARP Direct*		10,000	
<b>Total Income</b>		<b>\$199,000</b>	
<b>Expenditure</b>			
Relevant Objectives*			
<b>1,2,3,4</b>	Project Management	42,600	Management, coordination and action on all Segments of Project Plan Objectives
<b>1,2,3,4</b>	Operating on-costs inc travel/ forums etc	10,000	
<b>1.</b>	Contract Management contribution	8,000	For legal advice and contract management
<b>2.</b>	Project Support worker	8,000	Individual agency/on site support and problem solving
<b>2</b>	Additional Software enhancement costs	8,000	A number of small enhancements to improve user interface and operations
<b>2</b>	Training	12,000	For new users
<b>2</b>	St Vincent's Harp Direct*	10,000	Allocation to support induction of St Vincent's/ HARP Service, training and onsite support
<b>2.</b>	Electronic System support. Help desk, data maintenance and audit trail. OE and IE July 06- June 07	60,000	
<b>2</b>	GP engagement /resourcing	0	Need to get different funding source for this (\$100,000- includes software, network, hardware, implementation resourcing for pilot and support/ maintenance)
<b>3.</b>	Electronic Care Coordination projects resource	10,400	Specialist training in E-SCS, specific enhancement, modifications to support electronic care coordination,

			documentation
4.	Impact Evaluation of – ESCS	30,000	Conducted by a body that has expertise in IT, client care and economic evaluation.
<b>Total</b>		<b>\$199,000</b>	

### Project Objectives

- Development of effective governance and contract management processes for EMR
  - Substantial increase in number of referrals using E-SCS compared with June 2006
- Increase use of E-SCS for shared care/ co-ordination of care for clients
- Evaluation of the impact of use of E-SCS

## 2. Joint regional service coordination work

- Support the roll out of the Victorian Service Coordination Manual throughout 2007 as per Statewide Implementation plan
- This will be achieved through regular meetings of both PCPs and will include one regional forum annually. The regional forum will highlight similarities and differences that will require change in local practice.
- Conduct one regional practitioner forum in 2007 that facilitates ongoing uptake of the Victorian Service Coordination Manual.
- Develop a local policy on use of all relevant Electronic Service Directories ensuring that member agencies are updating and have the latest information on their service provision information listed on the directories.
- IEPCP CHP has an annual campaign to keep Service Directories up to date. The two PCPs will work together on this to ensure no overlap or duplication of effort where they have common member agencies.

## 3. New sectors/agency engagement in Service Coordination

Current status of engagement for the Psychiatric Disability Rehabilitation Support Services (PDRSS) and the Alcohol and other drug (AOD) sectors:

Both the PDRSS sector and the AOD sector are characterised by having a few large, dominant agencies and a large number of small to very small agencies (a couple of staff only). It was decided that the spearhead approach (focusing on those agencies most ready) should be used with the larger agencies being the trailblazers. The initial group of new sector agencies targeted for service coordination/e-referral implementation since December 2005 was:

- Mental Illness Fellowship
- IEMHS (Terra Firma/Keystone/Glenreach)
- ARAFEMI
- EACH Community Mental Health Support Services
- Eastern Drug and Alcohol Service (EDAS)
- Eastern Health Alcohol and Drug Service
- Anglicare Greater Eastern Drug and Alcohol Service (AGEnDAS)

Over the past 6 months work has focused on

- EACH Community Mental Health Support Services
- Eastern Drug and Alcohol Service (EDAS)
- Eastern Health Alcohol and Drug Service
- Anglicare Greater Eastern Drug and Alcohol Service (AGEnDAS)

Some agencies like ARAFEMI did not progress to full e-referral implementation as analysis of their procedures and operations showed that their client turnover and referral rates did not justify this.

Integrating the remaining four agencies into service coordination/e-referral has required a lot of on ground assistance to fully convey the principles of service coordination. The three AOD agencies and EACH CMHSS were scheduled to begin using the e-referral system in July. However, agency readiness has led to rescheduling in September 2006.

The second group of agencies to be engaged before the end of 2006 is aimed to comprise:

#### AOD

- EastCare (including Aurora)
- Knox Community Health Service – AOD service
- Maroondah Addictions Recovery Program
- New Life Program
- The Basin Rehabilitation Centre
- Ngwala Willumbong (depending on preparedness)
- Youth Substance Abuse Service (including Birribi and Eastern Youth Residential Withdrawal Unit).

There are four other agencies that are outside the region but from which the EMR buys beds/services. They have a reasonably high level of interaction with EMR agencies and therefore might usefully be involved and are:

- Odyssey House
- Depaul House
- Windana
- TRANX

#### PDRSS

- Mental Illness Fellowship
- IEMHS (Terra Firma/Keystone/Glenreach)
- Prahran Mission

Both the AOD and PDRSS sectors operate very much within their own silo and make formal, assisted written referrals at a very low rate. Service coordination in general and e-referral in particular offer a means of integrating these sectors better into the wider health care service sector. One essential element in fully implementing both service coordination PPRS and e-referral in the new sectors is the need firstly for greater interaction with the broader Mental Health sector - this should be given some priority in order to create a meaningful referral/interactive cluster.

Some updated computers were obtained through the Technology Refresh process so that a number of new sector agencies will now be able to participate electronically in service coordination and e-referral. This was a considerable barrier.

One measure that will be investigated is developing referral screening tools for the AOD and PDRSS sectors. These tools will be used for making referrals both within the respective sectors and for agencies outside the AOD and PDRSS sectors to make referrals.

Six tiers of engagement have been identified. These are:

1. Participation in an information session
2. Commitment to become involved (in engagement session)
3. Implementation of basic service coordination PPRS

4. Planning for e-referral PPPS
5. E-referral training and post-implementation follow-up
6. Supporting an organisation to use the e-referral system for care coordination.

The Inner East and Outer East PCP are committed to the integration of the PDRSS and AOD sectors over the next three years. Both the Inner East PCP and the Outer East PCP will aim to contribute between 0.5 of a day and a day per week to integrate these sectors. The Inner East PCP will achieve this through the Service Coordination Program Manager and the Outer East will have the Manager of the OE PCP oversee this work.

The Outer East will also combine this work with the 'Care in Community' pilot which has a focus on development of a new community based integrated health care system. This project provides opportunity to consolidate and build on regional service coordination and integrated chronic disease management work.

## 4. Integrated Chronic Disease Management Program

The IE & OE will work together on the dissemination of current approaches and early learning's of the Community Health Chronic Disease management programs. One to two forums will be held per year with a specific focus of engaging the Community Health Sector, Metropolitan Hospitals and the Divisions of General Practice.

The Inner East PCP will lead a service system redevelopment project focused on the management of Type 2 Diabetes. A regional committee will be established to oversee the work and representatives will be sought on commencement of the project (November 2006). See the IEPCP Partnership Plan for detail on project implementation and OEPCP Community Health Plan 2006-2009 for commitment to support this regional committee.

## 5. Care in Your Community

Care in Your Community (CinYC) provides a ten-year vision for a modern, integrated and person and family centred health system. It suggests a major change for health service delivery in Victoria, with consideration as to how some hospital services may be better delivered in the community so that they are more locally accessible and to improve the integration with and between other community based health services.

It means more care can be delivered outside hospitals, and services brought together (co-located and integrated) to improve convenience, accessibility, quality of care and efficiencies) – as well as providing a critical mass that can allow a wider range of services to be provided in non-hospital settings.

CinYC also provides a framework for conducting area based planning for the delivery of this new community based integrated health care system. The Outer East catchment of the Eastern Metropolitan Region has been chosen as one three trial sites to develop and implement a proposed methodology. Progress of this work will be reported on at the EMR Service Coordination Group and in that way will keep the IEPCP informed of progress.

## 7. Care Planning

Both PCPs will work together on developing a Regional Care Planning approach that will inform member agency activity in this important area. Currently there are numerous approaches, guidelines, projects and programs that all need to be integrated to create one informed approach to care planning for the Eastern Region. This work will also inform the State-wide approach that remains underdeveloped. The key pieces of work and policies that will provide an essential backdrop to this work are:

- The State-wide Practice Manual
- Local Inner East and Outer East service coordination work that has been completed
- The HARP guidelines- Eastern Health
- The three Chronic Disease programs that are operating from Community Health Services in EMR
- Client self management theory
- The Clinical Governance work that is being completed
- Local GP work to date
- Commonwealth GP items that focus on care planning, case conferencing and chronic disease

Both PCPs will work together on conducting a forum and developing a report/agreement that furthers the work on Care Planning over the next 12 months. The Inner East PCP will prepare a report for the forum highlighting current work, key concepts and important language.



# INTEGRATED CHRONIC DISEASE MANAGEMENT

November 2006

## All PCPs

Goal	Objective	Strategy	Planned Impact
<p>1. Completion of a mapping of self-management interventions (provided by agencies within the catchment).</p> <p><b>(Year 1 Priority)</b></p>	<p><b>Year 1:</b></p> <p><b>1.1</b> Support the work being undertaken by KCHS in conducting a self-management mapping exercise across the Outer East to inform the development of the EliCD project.</p>	<p><b>1.1.1</b> Engage the support of targeted member agencies to participate in the self-management mapping exercise.</p> <p><b>1.1.2</b> Work with KCHS to document the gaps in self-management interventions (as identified by the mapping exercise) and disseminate this information to members.</p>	<p>Agreed definition of what a self management program is and a better understanding by member agencies about self management programs.</p> <p>Better understanding of the self management programs available across the Outer East and the gaps that exist.</p>
<p>2. Facilitate planning processes to develop self-management interventions within member agencies that respond to gaps identified in the mapping process</p>	<p>To be developed in the review of the CHP in 2007-2008</p>		
<p>3. 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.</p> <p>(This work will be in Year 1 and continue into Year 2 and 3)</p>	<p><b>Year 1:</b></p> <p><b>3.1</b> Support the development of stronger partnership and networking opportunities between the acute and community sectors around management of chronic disease.</p> <p><b>Year 1:</b></p> <p><b>3.2</b> Support the Inner East lead Regional Diabetes initiative and identify how by focusing on a particular disease type it can become easier to clarify the roles and responsibilities of different organisations in relation to the provision of self-management interventions for people with chronic disease</p>	<p><b>3.1.1</b> Explore opportunities (eg Primary Health and Population Advisory Committee, Ambulatory Committee and HARP Chronic Disease Management Committee) to agenda discussions between the acute/community sector to define roles and responsibilities re management of chronic disease.</p> <p><b>3.1.2</b> OEPCP representation on the IEPCP Regional Diabetes Committee.</p>	<p>Access to structured opportunities for engaging the acute sector and community sector in ongoing discussions about the management of chronic disease in the EMR (eg via existing EH committees and a regional diabetes committee)</p>

Goal	Objective	Strategy	Planned Impact
	<p><b>3.3</b> Support the work of the KCHS EiiCD project in defining the roles and responsibilities of the acute sector and CHS in the provision of self management interventions for people with chronic disease.</p> <p>(Need to be considered further as the EiiCD project develops)</p>		
<p><b>4.</b> 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.</p> <p><b>(Year 1 priority particularly in relation to how it links in with the goals of the Service Coordination Plan)</b></p>	<p><b>Year 1:</b></p> <p><b>4.1</b> Create opportunities for discussion and work around the implementation of BATS practices to focus on client examples of chronic disease.</p>	<p><b>4.1.1</b> Work with the IEPCP to conduct a regional forum "From E-referral to Care Coordination" with a focus on creating a message about how service coordination practice can impact on the care coordination outcomes of people with chronic disease.</p>	<p>Opportunity for member agencies to consider the theory of service coordination/e-referral within the context of the real life experience of people living with a chronic disease.</p>
	<p><b>4.2</b> Continue to work with Eastern Health and the IEPCP (particularly in relation to the implementation of the HARP project) and link these activities to outcomes for the KCHS EiiCD project and Objective 3.1 in the Service Coordination Plan).</p>	<p><b>4.2.1</b> Identify and facilitate opportunities for both the HARP and the EiiCD initiatives to coordinate activities and share learnings about service coordination activities.</p>	
<p><b>5.</b> 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.</p>	<p><b>5.1</b> Support the development of the partnership between KDGP and KCHS in the implementation of the EiiCD project.</p>	<p><b>5.1.1</b> Provide some resources to KDGP to appoint a GP liaison officer to ensure GP's in Knox are informed and supportive of the EiiCD project.</p>	<p>GP's in Knox are informed about the KCHS EiiCD project and the model that has been developed by KCHS to provide services to local people with chronic disease.</p>

Goal	Objective	Strategy	Planned Impact
<p>6. 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.</p> <p>(Not a specific focus for Year 1)</p>	<p>6.1 Begin to work with partner agencies to identify clients with chronic disease who may require cross-disciplinary/multi agency care planning.</p>	<p>6.1.1 Document learnings from the EliCD project about clients with chronic disease who are likely to require cross-disciplinary care planning. Share this information with DGP's across the Outer East.</p>	<p>Begin to develop a dialogue and possible agreement between PCP members, particularly DGP, about which clients require cross-disciplinary/multi agency care planning.</p>
<p>7. 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.</p> <p>(Not a specific focus for Year 1)</p>	<p>Note: Links to Goal 3 above</p>	<p>7.1 Work with the IEPCP to conduct a regional forum "From E-referral to Care Coordination" with a focus on creating a message about how service coordination practice can impact on the care coordination outcomes of people with chronic disease.</p> <p>One of the proposed outcomes of this forum is to engage agencies across the EMR in discussions about how to progress a coordinated approach to care planning and care coordination.</p>	<p>Begin to engage IEPCP and OEPCP member agencies in discussions about a coordinated approach to care coordination and care planning.</p>
<p>8. Strengthened approaches to address disadvantage and health equality in Integrated Health Promotion initiatives, including barriers to participation such as chronic disease.</p> <p>(Year 1 Priority)</p>	<p><b>Year 1:</b></p> <p>8.1 Support the work of AHPACC particularly in relation to its focus on Diabetes in Indigenous communities.</p>	<p>8.1.1 Continue to work with Mullum Mullum Gathering Place to develop the programs/activities for indigenous women around walking groups for women and other physical activity opportunities.</p>	<p>Increase in the opportunities available in the Outer East for indigenous people and older people to participate in activities that could prevent the onset of or control the symptoms of certain chronic diseases.</p>
	<p><b>Year 1:</b></p> <ul style="list-style-type: none"> <li>▪ Continue to support the Footholds on Safety program which seeks to engage older people of all abilities to participate in physical activities that can help them manage their chronic illnesses.</li> <li>▪ Support the work being undertaken by ERGPA on LifeScripts through the Small Grant for DGP's funding round.</li> </ul>	<p>Support the opportunity for the OEPCP HP project officer to work on this project</p>	<p>Further development of the partnership relationship between the OEPCP and the Divisions of General Practice in the Outer East.</p> <p>Further development of the partnership/networking relationships between the DGP and CHS.</p>

Goal	Objective	Strategy	Planned Impact
	Support the "Go For Your Life" initiative (if successful). (This objective will need to be reconsidered if the application for funding by the OE is successful).		

### PCPs working with CHSs funded under the EliCD initiative

Goal	Objective	Strategies/Interventions	Estimated Impact
<p><b>9.</b> Successful implementation of workforce development strategies for self-management, particularly for community health services and GPs.</p> <p>(Not a specific priority for Year 1 however it would be possible to work with KCHS to determine workforce development needs and to begin planning for future training etc)</p>	<p><b>Year 1:</b></p> <p><b>9.1</b> Identify workforce development strategies required to build the skills of staff in CHS's around the development /implementation of self-management practices.</p>	<p><b>Year 1:</b></p> <p><b>9.1.1</b> Work with KCHS (and possibly agencies in the Inner East) to gather information from the self-management mapping exercise and the implementation of the EliCD projects that highlights staff skill requirements</p>	Clearer understanding of the skills required by staff in member agencies around the implementation of strategies for self management.
		<p><b>Year 2:</b></p> <p><b>9.1.2</b> Identify opportunities for supporting learning/information sharing sessions (eg forums, workshops, mentoring) that can provide GP's and staff in CHS with appropriate skill development</p>	
<p><b>10.</b> 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.</p> <p><b>(Year 1 Priority)</b></p>	<p><b>Year 1:</b></p> <p><b>10.1</b> Work with the Knox Divisions of GP's in partnership with KCHS to identify appropriate strategies for promoting local self-management interventions to GP's</p>	<p><b>10.1.1</b> Provide some resources to KDGP to appoint a GP liaison officer to ensure GP's in Knox are informed and supportive of the EliCD project.</p>	GP's in Knox are informed about the KCHS EliCD project and the self-management model that has been developed by KCHS to provide services to local people with chronic disease
<p><b>11.</b> Improved communication and collaborative care planning (by</p>	<p><b>11.1</b> Create opportunities for better communication between GP's and</p>	<p><b>11.1.1</b> Talk to Knox DGP's and other DGP's (eg Whitehorse DGP's)</p>	Clearer understanding of what the barriers are to facilitating coordinated care

Goal	Objective	Strategies/Interventions	Estimated Impact
<p>working closely with the Divisions of General Practice) between GPs and Community Health Services.</p> <p>(Not a priority focus for Year 1 but is closely linked to the above )</p>	<p>CHS's that lead to more coordinated approaches to care planning for people with chronic disease.</p>	<p>about their involvement in the EliCD projects to identify barriers/opportunities for improving communications between GP's and CHS about collaborative care planning.</p> <p>Identify strategies/actions that could be undertaken to begin to address barriers.</p>	<p>planning between GP's and CHS and how this could be addressed</p>
<p><b>12.</b> 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.</p> <p>(Not a priority focus for Year 1 however some strategies can begin to be implemented)</p>	<p><b>Year 1:</b>  <b>12.1</b> Support the Inner East lead Regional Diabetes initiative.</p> <p><b>Year 2/3:</b>  <b>12.2</b> Develop the links between the work being undertaken in the Care in the Community pilot project and this goal of the Chronic Disease Management Plan .  <b>12.3</b> Develop the links between <i>Strategy 1.2</i> (Common Referral Point project) in the Service Coordination Plan and this goal of the Chronic Disease Management Plan</p>	<p><b>12.1.1</b> OEPCP representation on the IEPCP Regional Diabetes Committee.</p> <p>To be further developed following the review of this plan in 2007-2008</p>	<p>Development of a process and opportunities for sharing learning and experience about diabetes across the EMR.</p>
<p><b>13.</b> 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.</p> <p>(Year 1 priority is around the KCHS EliCD project with a focus on</p>	<p><b>Year 1:</b>  <b>13.1</b> Support KCHS in identifying training needs around change management and sourcing opportunities/funding for the provision of the training required.</p>	<p><b>13.1.1</b> Meet with project manager of EliCD project at KCHS to analyse results/learnings from the first stage of the project to identify training/change management needs at KCHS re implementation of proactive rather than reactive care needs for clients with chronic disease.</p>	<p>A better understanding about what organisational processes need to be developed or changed and what staff training needs to be implemented to ensure agencies/staff (especially in CHS) are able to respond in a proactive way to caring for the needs of people with chronic disease.</p>

Goal	Objective	Strategies/Interventions	Estimated Impact
opportunities for sharing learnings with other OE agencies. The focus on other agencies will however be extended significantly in Year 2 and 3).	<b>Year 1/2</b> <b>13.2</b> Ensure that training opportunities are also provided (where appropriate to) to other agencies within the OE.	<b>13.2.1</b> Identify opportunities for resourcing appropriate training needs.	
<b>14.</b> Facilitation of a process for agencies to develop and implement consistent approaches to the use of decision support tools to support ICDM.  (Not a specific priority for Year 1)		<b>14.1.1</b> Work with KCHS and HARP on the implementation of the Statewide Service Coordination Manual specifically in relation to how the tools contained in the manual support the implementation of the EliCD project and HARP	
<b>15.</b> Dissemination of transferable change management lessons in relation to ICDM.  (This is a very broad goal but is also key to the role of the PCP over the next 3 years of this plan. Some work can be done in Year 1 but strategies will need to be further developed in 2007-2008).	<b>Year 1:</b> <b>15.1</b> Ensure that opportunities to share learnings, provide training and support lessons in change management in relation to CDM are fostered across the member agencies in the Outer East.	<b>15.1.1</b> Create opportunities through forums, trainings ,meetings, newsletters, websites etc to provide member agencies with learnings/information about issues related to ICDM and how agencies can effectively support people with chronic disease..	Member agencies are provided with a range of opportunities to receive information about effectively supporting people with chronic disease.
<b>16.</b> Completion of the statewide evaluation tools for EliCD.	<b>16.1</b> To learn from and build on the work being undertaken by the nine different EliCD projects across the state.	<b>16.1.1</b> Participate in CDM evaluation processes being undertaken by DHS.	Participants will have specific learnings about the EliCD that can be passed on to member agencies to inform them about how to build the capacity of their organisations to support people with chronic disease.

## Appendix 1

### OEHCSA membership:

1	BaptCare	
2	Care Connect	
3	Eastern Access Community Health	(EACH)
4	Eastern Health	
	• Angliss Hospital	
	• Maroondah Hospital	
	• Outer East Aged Care Assessment Service	(OEACAS)
	• Yarra Valley Community Health Service	(YVCHS)
5	Eastern Ranges GP Association	(ERGPA)
6	Eastern Volunteers Resource Centre	(EVRC)
7	Knox City Council	(KCC)
8	Knox Community Health Service	(KCHS)
9	Knox Division of General Practice	(KDGP)
10	Maroondah City Council	(MCC)
11	Ranges Community Health Service	(RCHS)
12	Royal District Nursing Service	(RDNS)
13	Richmond Fellowship of Victoria	
14	Shire of Yarra Ranges City Council	(SYRCC)
15	Villa Maria Society	
16	Whitehorse Division of General Practice	(WDGP)
17	Women's Health East	(WHE)
18	Uniting Care Community Options	(UCCO)

## Appendix 2

### Policies and Strategies relevant to the OEHCSA Community Health Plan (2006-2009)

- 1 Aboriginal Services Plan 2006-2009
- 2 A Fairer Victoria
- 3 Care in Your Community
- 4 Chronic Disease Management Program Guidelines for PCP's and CHS (October 2006).
- 5 Doing it with us not for us
- 6 Eastern HARP Chronic Disease Management Program Guidelines 2006/07
- 7 Eastern Region Service Coordination Practice Manual
- 8 Growing Victoria Together
- 9 Integrated Health Plans and key Strategic Plans of all member agencies.
- 10 Knox EliCD Implementation Plan (2006-2007)
- 11 Measuring health promotion impacts: A guide to impact evaluation in integrated health promotion
- 12 OEHCSA Community Health Plan (2004-2006)
- 13 OEHCSA Consumer, Carer and Community Engagement Strategy
- 14 Primary Care Partnership Strategy
- 15 Primary Health Branch Policy and Funding Guidelines 2006-07 to 2008-09
- 16 Victorian Service Coordination Practice Manual
- 17 Victorian Women's Health and Wellbeing Strategy
- 18 VicHealth Evidence-based mental health promotion resource
- 19 VicHealth Partnership Analysis Tool
- 20 Women's health matters-from policy to practice: 10 point plan for Victorian Women's Health 2006-2010.

## Appendix 3

### Anagrams:

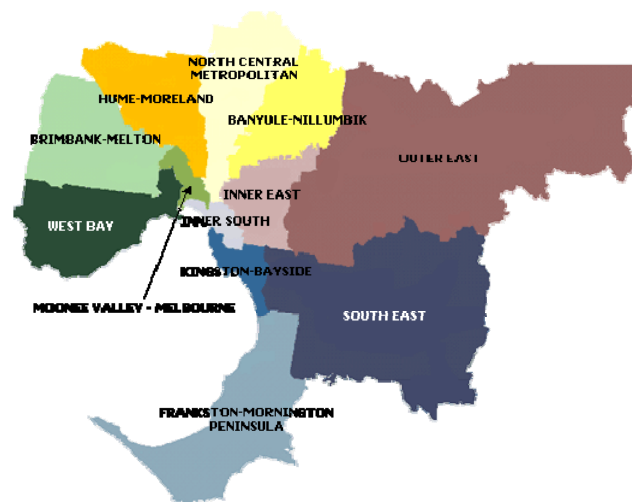
ACCHO:	Aboriginal Community Controlled Health Organisations
AHPACC:	Aboriginal Health Promotion and Chronic Care
AIHW:	Australian Institute of Health and Welfare
CHP:	Community Health Plan
CHS:	Community Health Service
CinYC:	Care in Your Community
DGP:	Divisions of General Practice
DHS:	Department of Human Services
DVC:	Department of Victorian Communities
EiICD:	Early Intervention in Chronic Disease
E-SCS:	Electronic Service Coordination System
HARP:	Hospital Admissions Risk Program
ICDM:	Integrated Chronic Disease Management
IHP:	Integrated Health Promotion
HALS:	Healthy Active Living for Seniors
IEPCP	Inner East Primary Care Partnership
LGA:	Local Government Area
MPHP:	Municipal Public Health Plan
OEHCSA:	Outer East Health and Community Support Alliance
PC&PHAC:	Primary Care and Population Care Advisory Committee
PCP:	Primary Care Partnership
SCTT:	Service Coordination Tool Template
WHO:	World Health Organisation

Note: This profile will be updated as new information becomes available. Contact the OEPCP for copies of the updated profile.

## Appendix 4:

### Demographic profile:

This Appendix provides a brief profile of the demographics and health status of people and communities within the local government areas (LGA) of Maroondah, Knox, and Yarra Ranges. Within the context of this profile this catchment area will be referred to as the Outer East.



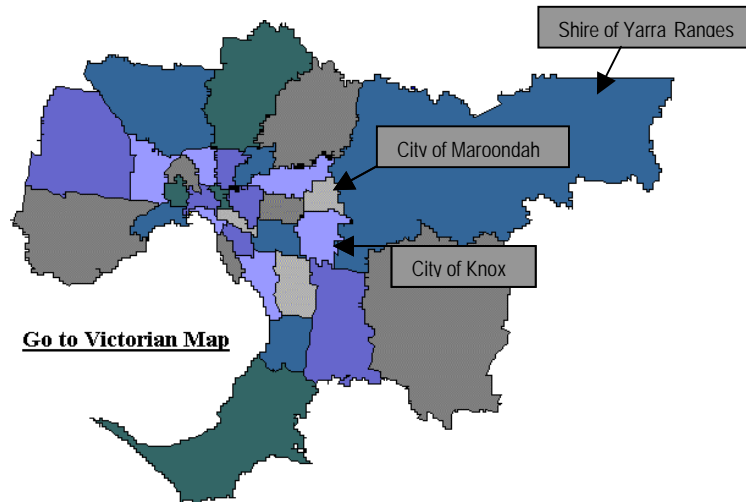
The information is provided to assist in identifying and describing priority areas for the OEPCP Community Health Plan and to inform decision-making for further planning initiatives.

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

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

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

The map below illustrates the relative sizes of the three different local government areas.



## Age Structure:

In planning for services and programs that provide for the health and well being of communities it is important to understand the age profile of the community.

Table 1 provides a picture of various age groupings as a percentage of the total population for each of the three local government areas (LGA) that make up the Outer East. Two age groups are of particular interest when planning for the health and well being of a community - the youngest (persons aged under 18) and oldest members of the community (persons aged 70 and over).

**Table 1:** Population profile for age groups 2001

Age Goup	Maroondah 2001	Knox 2001	Yarra Ranges 2001	Victoria 2001
0-4	7.0	6.9	7.0	6.4
5-14				
15-24				
70-84				
85+				

## Population projections

Table 2 shows the population projections for each LGA for the twenty year period between from 2001 to 2021. Looking forward from the 2001 Population and Housing Census to 2021, it is expected that Yarra Ranges will have the lowest projected population growth with an increase of 2.6%, while Maroondah will experience an increase of 18% over the same period, the highest of the three LGA's.

The projected increases in population for each LGA from 2001 to 2021 are predicted to be lower than the population increase for the Melbourne Statistical Division

**Table 2:** Population Projections 2001–2011

	2001	2006	2011	2021	% Change 2001-2021
Maroondah	100,279	103,165	108,162	118,457	18%
Knox	147,433	152,508	154,618	157,316	6.7%
Yarra Ranges	142,553	143,949	144,492	146,278	2.6%
Melbourne Statistical Division (MSD)	<b>3,471,625</b>	<b>3,681,262</b>	<b>3,874,958</b>	<b>4,236,156</b>	<b>22%</b>

If the population projection data is broken down into age groups it can be seen that between 2001 and 2021 the number of residents in the younger ages groups will decrease as a percent of the total population for each LGA. Accordingly, the percentage of residents in the 60 plus age bracket will continue to grow relative to the total population of each LGA (Table 3). This change in the age profile is particularly evident in the 60-84 age range, with all three LGA's showing a significantly greater increase over time in the relative numbers of residents of this age compared to the Melbourne Statistical Division.

**Table 3:** Population projections: Change in key age groups (% of total population)

Age group	Maroondah	Knox	Yarra Ranges	MSD
	2001 to 2021	2001 to 2021	2001 to 2021	2001 to 2021
0–4	-1.4%	-1.9%	-1.1%	-1.1%
5-14	-3.1%	-5.1%	-3.9%	-2.7%
15-24	-2.0%	-3.1%	-2.6%	-1.7%
60-84	8.4%	13.4%	11.3%	5.4%
85+	1.3%	0.8%	0.6%	1.1%

Source: Department of Sustainability and Environment– Victoria in Future (2004)

## Gender

The proportion of male to female ratio is consistent across all LGAs located within the Outer East, with a slightly higher percentage of females living in the three LGAs (50.9%) than males (49.1%). These figures are consistent with the Victorian average.

## Indigenous People

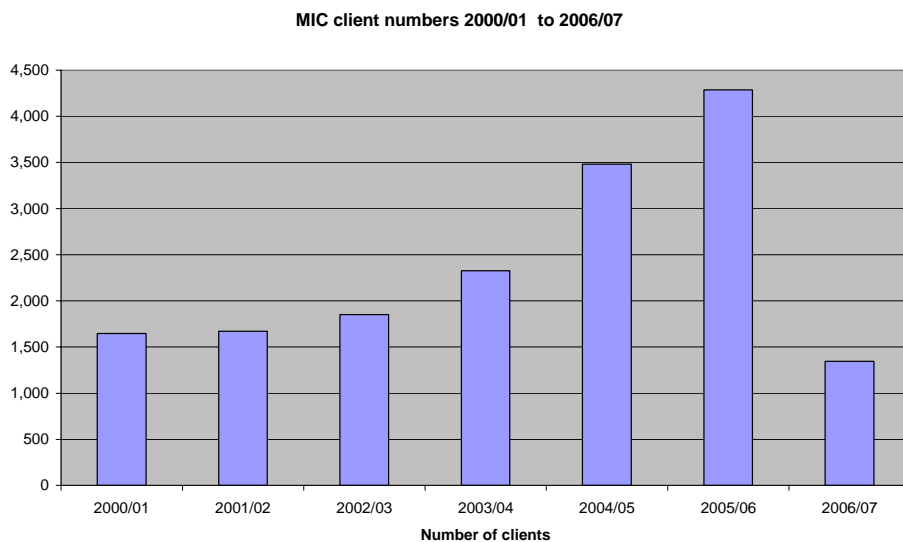
At the 2001 census 0.3% of the population living in the Outer East or 1,404 people were recorded as being Aboriginals or Torres Strait Islanders. Across the Outer East the highest proportion of Aboriginals or Torres Strait Islanders live in the Shire of Yarra Ranges, 748 people or 0.5% of the municipality's population (an equal percentage with the whole of Victoria), with the largest population of Indigenous people living in the Healesville area. It is important to note however, that the numbers of recorded indigenous people in the catchment area may well under-represent the true numbers.

## Ethnicity

In 2001, the Outer East had a relatively high proportion (75.5%) compared to 71.1% for Victoria of residents who were Australian born, suggesting that just under one quarter of residents (24.5%) in the Outer East were born outside Australia.

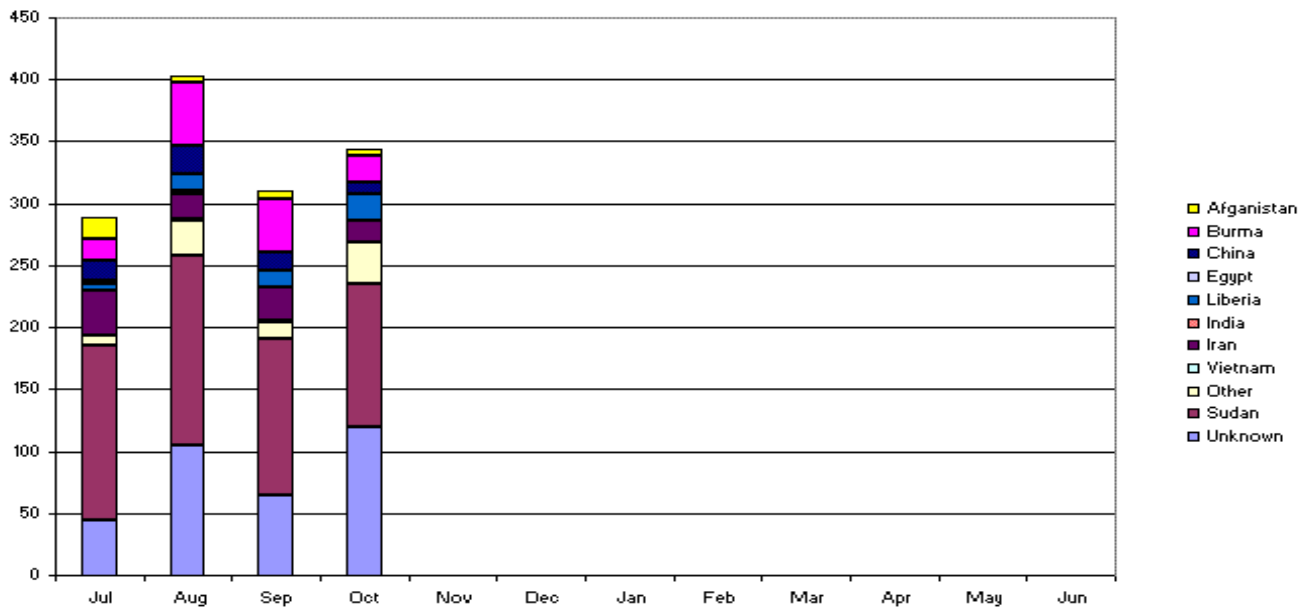
There is some recent evidence at the local level to suggest migration patterns are changing. The Maroondah City Community Profile states that a total of 214 overseas migrants settled in Maroondah between 1 July 2005 and 30 June 2006. Countries of origin such as Myanmar/Burma (22%), India (9.3%), Philippines (8.9%), China (7%) and Liberia (6.5%) feature among the main sources of countries for newly arrived migrants.

The Eastern Migrant Information Centre (MIC) provides services for migrants and refugees living in the local government areas of Boroondara, Knox, Manningham, Maroondah, Monash, Whitehorse and Yarra Ranges. Data collated by the MIC shows their client numbers have increased almost threefold over the last six years (see graph below).



The graph below illustrates recent MIC client data for the months of July, August and September 2006. The data shows that over this period of time people born in Sudan made up the greatest proportion of people using the services of MIC. The graph also provides details of other cultural groups accessing the MIC. The table below indicates that people from a range of different cultural background are attending the Eastern MIC.

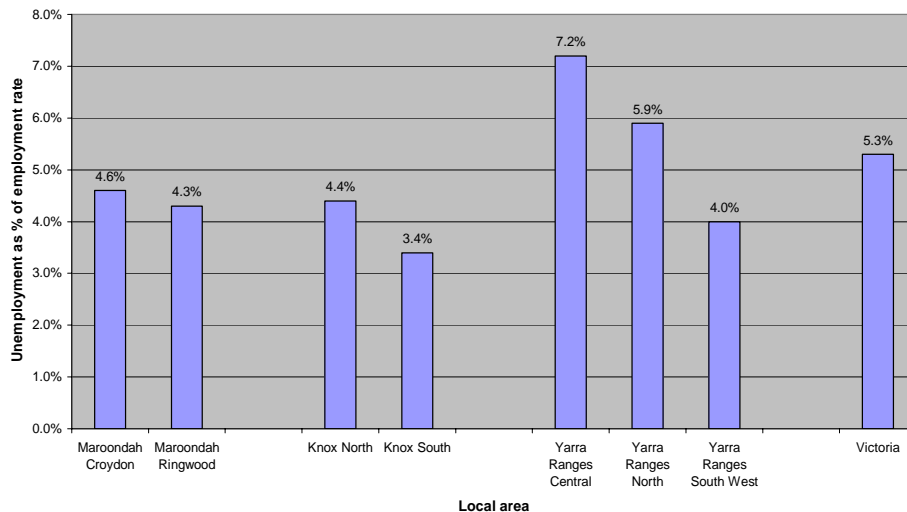
Country of Birth of Clients 2006-2007



## Labour force

Results from the 2001 Census suggest that of the working population within the Outer East, approximately 61% are employed on full time basis and 31% are employed part-time with the remainder not identifying their hours of employment. Most people within the Outer East were employed in the areas of clerical work, trade related work and as professionals.

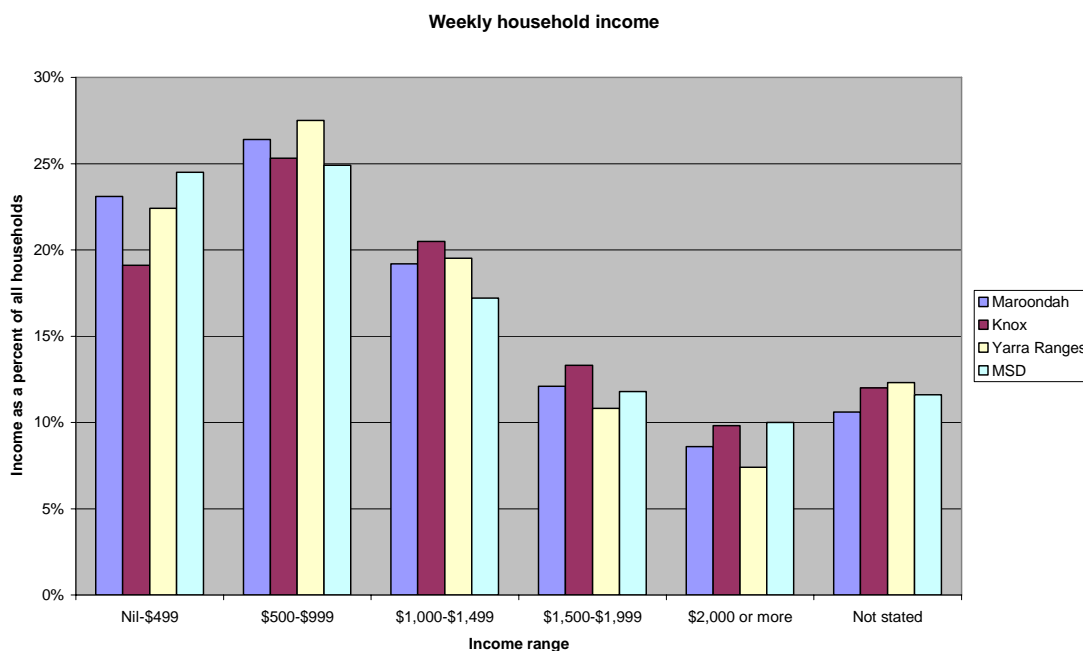
Unemployment rates June 2006



As the graph above illustrates unemployment rates vary across the Outer East with the highest rates of unemployment occurring in the Shire of Yarra Ranges. Higher than average unemployment rates are particularly evident in the northern and central part of Yarra Ranges with both of these areas showing significantly higher rates than for Victoria as a whole.

## Income

The 2001 Census data showed a somewhat different pattern of income distribution for each of the three LGAs in the Outer East. Knox had the highest proportion of households earning \$1,000 or more per week –higher than the other two LGAs and the Melbourne Statistical Division average. Maroondah on the other hand, had the highest proportion of the three LGAs of households earning between \$0 and \$499 per week, which are regarded as low-income earners, while Yarra Ranges has the highest proportion of households earning in the low to medium range and significantly lower number households with earning in the highest two salary brackets.



## Socio-economic Disadvantage

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

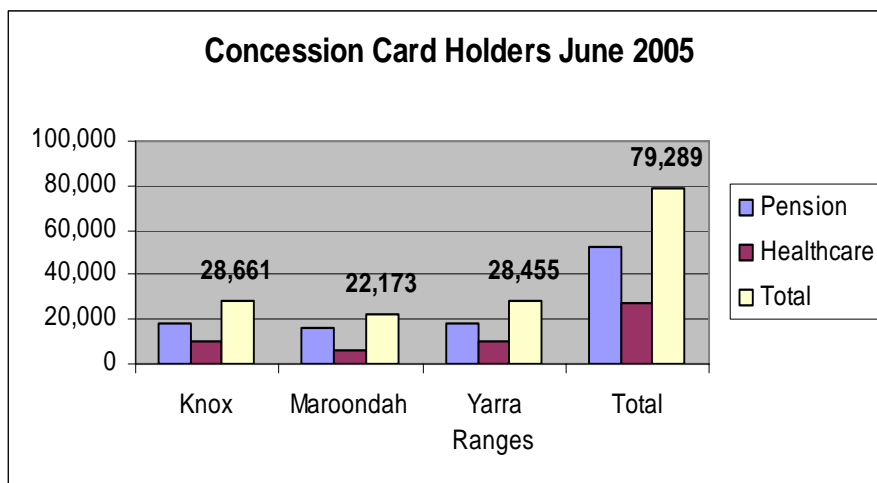
The average score for Australia is set at 1000, with lower scores reflecting greater disadvantage.. Of the three local government areas in the Outer East, Yarra Ranges had the highest level of disadvantage with a score of 1037.12, compared to Knox (1041.04) and Maroondah (1052.96).

A picture of the socio-economic status of the catchment was also provided in a study conducted by Professor Tony Vinson in August 1999, titled *Unequal in Life* as part of the research program of The Ignatius Centre, the policy and research arm of Jesuit Social Services. This study of social disadvantage drew on information available from a range of different sources, but rarely collated. The 622 postcodes in Victoria were ranked according to how they scored against the selected criteria with one being the most disadvantaged postcode. The data demonstrated that while the Outer East municipalities are considered to be relatively well off in socio economic terms, there

are pockets of disadvantage. The postcodes of Healesville, Yarra Junction and Warburton in particular, showed significant disadvantage.

### Concession Card Holders

Another useful indicator of socio-economic disadvantage is the use of a Commonwealth concession card. As at June 2005, there were 52,338 holders of Pension Concession Cards and 26,951 Health Care Card holders in the Outer East. Yarra Ranges had the highest number of cardholders and Maroondah the lowest.



### Outer East Service Profile:

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

## Outer East Health and Community Support Alliance – Service Mapping & Service Needs Planning Template

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

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

tinuum of Care

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

**LEGEND:**

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|--|--|
| 1. ACAD, Outer East                            | 12. Richmond Fellowship of Victoria                      |
| 2. Angliss Health Services                     | 13. Royal District Nursing Service – South & East Region |
| 3. Care Connect                                | 14. Sherbrooke & Pakenham Division of General Practice*  |
| 4. Eastern Access Community Health             | 15. Shire of Yarra Ranges                                |
| 5. Eastern Drug and Alcohol Service Consortium | 16. Villa Maria Society                                  |
| 6. Knox City Council                           | 17. Whitehorse Division of General Practice              |
| 7. Knox Community Health Services              | 18. Women’s Health East                                  |
| 8. Knox division of General Practice           | 19. Yarra Ranges Health Service                          |
| 9. Maroondah City Council                      | 20. Yarra Valley Community Health Service                |
| 10. Maroondah Hospital                         | 21. Yarra Valley Division of General Practice            |
| 11. Ranges Community Health Service            |  |

Allied Health includes all or some of the following activities:  
Physiotherapy, podiatry, occupational therapy, speech pathology and dietetics.

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

\* Not a member agency