



Living  
and  
Working  
*Together*

*In*  
Our Community

**The Southern Mallee Community Health Plan**

Southern Mallee Primary Care Partnership

**2006 – 2009**



This plan was facilitated and prepared by Evolving Ways  
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## Introduction

The Southern Mallee Primary Care Partnership (SMPCP) is pleased to present the 2006 – 2009 Southern Mallee Community Health Plan.

The Southern Mallee Primary Care Partnership is committed to working collaboratively together across the Southern Mallee catchment and within each local government area of Buloke, Gannawarra and Swan Hill.

This plan has been developed by the SMPCP with assistance from the engaged consultant Evolving Ways. The process which was followed to develop this plan includes:

- Data analysis – local plans, burden of disease data etc
- Phone consultation with SMPCP Board Members – focusing on SMPCP governance and structure
- SMPCP Board Member half day workshop – further developing the governance and structure for the next three years and into the future
- Agency Workshop to further agree and progress the priority areas of integrated health promotion, service coordination and integrated chronic disease management

The Southern Mallee Community Health Plan has a strong emphasis on further developing and progressing the ‘partnership’ throughout the three years and into the future. SMPCP is dedicated to restructuring the partnership in terms of agencies collaborating together more efficiently and implementing structures and processes to support this.

The SMPCP has an overall agreed priority of ‘mental wellbeing and social connectedness’. Mental wellbeing and social connectedness is of critical importance for all people in all parts of the catchment. Attention to this priority can be seen throughout the plan within the integrated health promotion, service coordination and integrated chronic disease management deliverables. The plan has been developed in the context of the ongoing severe drought and has been influenced by the potential this situation has to impact negatively on chronic illness.

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## Summary of our plan

### Priority area: Strengthen the mental wellbeing and social connectedness of people living in the Southern Mallee

#### Enable effective involvement in SMPCP to achieve improved health and wellbeing outcomes for people living in Southern Mallee

Objectives	Strategies
Develop more effective governance processes and structures	Resource the <i>Partnership Sub-committee</i> to Year 1 <ul style="list-style-type: none"> <li>• Implement interim structures and processes</li> <li>• Agree upon the new structure and processes</li> <li>• Develop and implement a communications strategy to keep members up-to-date about the re-structure</li> <li>• Revise and/or develop MOU and other documentation to reflect the new processes and structures</li> </ul> Year 2 <ul style="list-style-type: none"> <li>• Develop and implement a plan to put into practice the new governance processes and structures, including any required resources and workforce development</li> </ul> Year 3 <ul style="list-style-type: none"> <li>• Conduct annual review of partnership using VicHealth’s Partnership Analysis Tool and implement action plan, as needed</li> </ul>
Ensure PCP members are effectively oriented to the partnership	Resource the <i>Partnership Sub-committee</i> to Year 1 <ul style="list-style-type: none"> <li>• Develop an orientation package and process for member agencies and Board members that is then implemented as new members join</li> </ul> Year 3 <ul style="list-style-type: none"> <li>• Review and refine the orientation package and process</li> </ul>

Objectives	Strategies
Foster leadership within SMPCP	<ul style="list-style-type: none"> <li>• Member agencies to provide leadership for all sub-committees, portfolios, working groups, networks, projects, and initiatives</li> <li>• Board members to provide leadership through actions to increase understanding of, and commitment to, PCP at all levels of own agency</li> </ul>
Ensure effective communication between SMPCP member organisations, particularly in relation to mental wellbeing and social connectedness	<p>Resource the <i>Integrated Health Promotion and Integrated Planning and Evaluation sub-committee</i> to Year 2, 3</p> <ul style="list-style-type: none"> <li>• Develop effective means of communication to complement face-to-face meetings, including videolinks, teleconferencing, use of web-based message boards</li> </ul>
Facilitate community involvement in PCP decision-making processes	<p>Resource the <i>Partnership Sub-committee</i> to Year 2</p> <ul style="list-style-type: none"> <li>• In collaboration with Aboriginal communities, develop strategies for their input and involvement in PCP</li> </ul> <p>Year 3</p> <ul style="list-style-type: none"> <li>• In collaboration with young people, develop strategies for their input and involvement in SMPCP</li> </ul>

**Strengthen planning, implementation and evaluation to achieve improved health and wellbeing outcomes for people living in Southern Mallee**

Objectives	Strategies
<p>Coordinate SMPCP planning processes with those of member agencies to ensure an integrated and complementary approach</p>	<p>Resource the <i>Integrated Health Promotion and Integrated Planning and Evaluation sub-committee</i> to</p> <p>Year 1</p> <ul style="list-style-type: none"> <li>• Develop an agreed SMPCP planning, monitoring and review process and cycle that involves:                             <ul style="list-style-type: none"> <li>– a workshop with member agencies to develop agreed principles and processes for alignment and integration of individual plans</li> <li>– a process for regularly updating health and wellbeing data as a basis for planning, and making this available to member agencies</li> <li>– a process for collating information from plans of member agencies within a common framework</li> <li>– a process for monitoring and reviewing the Community Health Plan</li> </ul> </li> </ul> <p>Year 2, 3</p> <ul style="list-style-type: none"> <li>• Provide support for the alignment and integration of plans</li> </ul> <p>Year 3</p> <ul style="list-style-type: none"> <li>• Evaluate progress with integration of plans</li> </ul>
<p>Promote and enable the application of best practice health promotion and evaluation across the SMPCP</p>	<p>Resource the <i>Integrated Health Promotion and Integrated Planning and Evaluation sub-committee</i> to</p> <ul style="list-style-type: none"> <li>• Develop a health promotion framework focusing on planning, priority setting, project development and evaluation</li> <li>• Support staff from member agencies to facilitate, as part of local <i>Healthy Networks</i>, forums focussed on themes within the health priority (for example, focussing on specific groups experiencing disadvantage, or specific age groups)</li> <li>• Conduct annual catchment-wide forums to showcase good practice in relation to the health priority, including presentation of evaluation findings to add to the body of evidence of effective strategies</li> <li>• Conduct a forum with each of the SMPCP's <i>Healthy Networks</i> to:                             <ul style="list-style-type: none"> <li>– define mental wellbeing</li> <li>– define social connectedness</li> <li>– identify existing social connectedness activities</li> </ul> </li> </ul>

Objectives	Strategies
<p>Promote the prevention of chronic illness and help address barriers to access and participation created by chronic illness</p>	<p>Resource <i>Integareded Health Promotion and Integrated Planning and Evaluation sub-committee</i> to                      Year 1, 2, 3</p> <ul style="list-style-type: none"> <li>• Include attention to chronic illness and associated barriers to participation in all integrated health promotion plans</li> </ul>
<p>Strengthen the capacity of providers to implement effective self-management interventions for people with chroinc disease</p>	<p>Resource the <i>Service Coordination and Chronic Disease sub-committeeto</i>:                      Year 1</p> <ul style="list-style-type: none"> <li>• Conduct self-management mapping survey</li> <li>• Develop plan for improving provider understanding of self-management and addressing identified gaps, based on the findings of the survey</li> </ul> <p>Year 2</p> <ul style="list-style-type: none"> <li>• Facilitate a collaborative process across SMPCP to determine:                             <ul style="list-style-type: none"> <li>– screening processes and practices for self-management</li> <li>– who provides self-management interventions</li> <li>– roles and responsibilities</li> </ul> </li> </ul> <p>Year 2 and 3</p> <ul style="list-style-type: none"> <li>• Implement the plan according to agreed timelines</li> </ul>

**Strengthen service coordination to achieve improved health and wellbeing outcomes for people living in Southern Mallee**

Objectives	Strategies
<p>Develop effective referral processes, systems and models of collaborative care between a selection of GPs across the catchment and other primary care providers for clients with chronic disease and complex needs</p>	<p>Resource the GP Divisions and the <i>Service Coordination and Chronic Disease sub committee</i> to: Year 1, 2, 3</p> <ul style="list-style-type: none"> <li>• Develop links with West Victoria Division of GP</li> <li>• Engage support of GPs to promote collaborative care</li> <li>• Showcase best practice referral and collaborative care via forums annually across the catchment</li> <li>• Keep GPs up-to-date about available services and programs via agreed information and communication strategy</li> <li>• Develop referral and feedback processes and protocols for trial between a selection of GPs and other primary care providers</li> <li>• Develop care planning processes and protocols for trial between a selection of GPs and other primary care providers</li> <li>• Conduct ongoing review and refinement of the processes and protocols trialled</li> <li>• Plan for further roll-out with other GPs including timelines, roles of GP Divisions and PCP, how roll-out will be supported, how to sustain initial trial and ongoing roll-out</li> </ul> <p>Year 1</p> <ul style="list-style-type: none"> <li>• Identify the service coordination training needs for member agencies (particularly reception staff, managers and service delivery staff) and develop a relevant training</li> <li>• Develop a plan to roll-out the Victorian Service Coordination Practice Manual and Service Coordination Tool Templates, including attention to workforce development activities</li> </ul> <p>Year 2, 3</p> <ul style="list-style-type: none"> <li>• Deliver the service coordination training package</li> <li>• Implement the plan to roll-out the Victorian Service Coordination Practice Manual and Service Coordination Tool Templates</li> </ul> <p>Year 3</p> <ul style="list-style-type: none"> <li>• Investigate the feasibility of a SMPCP-wide common assessment tool focused on mental wellbeing</li> <li>• Investigate feasibility of other sectors participating in SMPCP service coordination</li> </ul> <p>Year 1, 2, 3</p> <ul style="list-style-type: none"> <li>• Facilitate installation of public key infrastructure in all member agencies to enable interagency receipt of e-referrals via <a href="http://connectingcare.com">connectingcare.com</a></li> <li>• Conduct training to members to ensure capacity to implement e-referral</li> </ul>

Objectives	Strategies
<p>Maintain service information directories to help improve access to needed services</p>	<p>Resource the <i>Service Coordination and Chronic Disease sub-committee</i> to Year 1, 2, 3</p> <ul style="list-style-type: none"> <li>• Update Connectingcare in relation to mental health services and supports annually using either a member agency or contracted service</li> <li>• Raise awareness of Connectingcare amongst members and community</li> </ul>
<p>Support the coordination of drought relief strategies</p>	<p>Resource the <i>Integrated Health Promotion and Integrated Planning and Evaluation sub-committee</i> to</p> <ul style="list-style-type: none"> <li>• Facilitate agencies working in the Buloke Shire to work together with Shire personnel to ensure effective coordination of all strategies specifically directed to drought relief</li> <li>• Work in partnership with agencies to develop a drought-specific health promotion and service coordination plan across SMPCP</li> <li>• Convene the Mental Health First Aid training in each LGA, targeting those who work directly with drought-affected farmers</li> <li>• Convene one VicHealth Mental Health Promotion short course</li> </ul>

## Southern Mallee PCP

# Community Health Plan 2006 – 09

## Deliverable 1: Partnership January 2007

### Primary Care Partnerships Community Health Plan

**Endorsed by PCP Chair:**

Name:

Signature:

Date:

# 1. Partnership vision

*Living and Working Together in the Southern Mallee* – The Southern Mallee Primary Care Partnership will work together to improve the health and wellbeing of our communities.

Working within a social model of health, we will work together to:

- support service providers to better meet local needs.
- achieve an integrated approach to planning;
- coordinate services;
- strengthen the capacity of the community;
- promote healthy ways of living and help prevent ill health.

Our underpinning principles are:

- Participation – community participation in decision making processes is essential
- Empowerment – people must be provided with the information, education and supports needed for them to take responsibility for their own health and wellbeing
- Partnerships – health outcomes can only be achieved through collaborative efforts
- Health is a resource for everyday life and an aspect of quality of life
- Holistic – the promotion of health and wellbeing requires us to consider the context in which people live

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

Three key challenges have been identified:

- Current governance processes and structures:
  - do not easily allow for implementation of the PCP's objectives
  - result in vague reporting and accountability
  - do not allow for strategic operation
  - promote a view that the PCP is somehow separate from its members and everyday work
  - do not promote a shared involvement and responsibility
- Varying levels of ownership of, and involvement in, PCP by members because of:
  - perceived relevance of PCP
  - geography
  - capacity of members
  - poor orientation processes
- Poor planning processes:
  - no effective planning cycle or framework, including no effective monitoring and evaluation of Community Health Plan
  - no process for regular update of health and wellbeing data
  - no effective strategy for involving community in decision-making process
  - weak links with other key plans such as MPHP, Council Community Plans, agency plans

In 2007, we will undergo a review of our current governance structures and processes. This will include:

- the addition of an operational second tier of focused sub-committees or portfolios focused on service deliverables and/or outcomes. This operational second tier will take a catchment-wide approach;
- refocusing the Executive Officer's role to that of a facilitator of change;
- helping to operationalise the PCP's objectives and broaden participation in each municipality by refocusing and strengthening the *Healthy Networks* in the Shires of Gannawarra and Buloke, and identifying and supporting an appropriate network in Swan Hill;
- new processes for succession planning, board orientation, planning cycles, quality improvement, evaluation, and reporting systems; and
- developing stronger links between the local networks, the various sub-committees and the Board.

While we undertake this important review, an interim second tiered structure of three sub-committees will be put in place. These will focus on:

- partnerships;
- integrated health promotion and integrated planning and evaluation ; and
- service coordination and chronic disease

Each sub-committee will be accountable to the Board and be headed by a Board member. These sub-committees may draw upon the expertise of a range of personnel from member agencies as well as from the general community.

### 3. Achieving the vision: *Capacity Building Plan*

#### Governance processes and structures

Goal	Objective	Strategies/Interventions	Estimated Impact
Strengthen SMPCP governance processes and structures	Develop more effective governance processes and structures	<p>Resource the <i>Partnership Sub-committee</i> to</p> <p>Year 1</p> <ul style="list-style-type: none"> <li>• Implement interim structures and processes</li> <li>• Agree upon the new structure and processes</li> <li>• Develop and implement a communications strategy to keep members up-to-date about the re-structure</li> <li>• Revise and/or develop MOU and other documentation to reflect the new processes and structures</li> </ul> <p>Year 2</p> <ul style="list-style-type: none"> <li>• Develop and implement a plan to put into practice the new governance processes and structures, including any required resources and workforce development</li> </ul>	<p>Initially through a process implemented by the <i>Partnership sub-committee</i> and subsequently via annual review of partnership:</p> <ul style="list-style-type: none"> <li>• Clarification and documentation of: <ul style="list-style-type: none"> <li>– Roles and responsibilities of leaders of interim sub-committees</li> <li>– Roles, responsibilities and expectations of members</li> <li>– Roles and responsibilities of Executive Officer</li> <li>– Lines of accountability</li> </ul> </li> <li>• Links between Board, sub-committees, working groups, projects and networks established</li> <li>• Revised MOU in place and actively guiding the decision-making processes of SMPCP</li> <li>• PCPs objectives are effectively operationalised</li> </ul>

Goal	Objective	Strategies/Interventions	Estimated Impact
Strengthen SMPCP governance processes and structures [continued]	Develop more effective governance processes and structures [continued]	Year 3 <ul style="list-style-type: none"> <li>• Conduct annual review of partnership using VicHealth's Partnership Analysis Tool and implement action plan, as needed</li> </ul>	<ul style="list-style-type: none"> <li>• Members more active in SMPCP through sub-committees, portfolios, and networks,</li> <li>• PCP roles and responsibilities shared more equitably amongst member agencies</li> </ul>

**Effective involvement in PCP**

Goal	Objective	Strategies/Interventions	Estimated Impact
Enable effective involvement in SMPCP	Ensure PCP members are effectively oriented to the partnership	Resource the <i>Partnership Sub-committee</i> to  Year 1 <ul style="list-style-type: none"> <li>• Develop an orientation package and process for member agencies and Board members that is then implemented as new members join</li> </ul> Year 3 <ul style="list-style-type: none"> <li>• Review and refine the orientation package and process</li> </ul>	Initially through a process implemented by the <i>Partnership sub-committee</i> and subsequently via annual review of partnership: <ul style="list-style-type: none"> <li>• Member agencies have clear understanding of PCP, its purpose and objectives</li> <li>• Board members are confident in their role</li> </ul>
	Foster leadership within SMPCP	<ul style="list-style-type: none"> <li>• Member agencies to provide leadership for all sub-committees, portfolios, working groups, networks, projects, and initiatives</li> <li>• Board members to provide leadership through actions to increase understanding of, and commitment to, PCP at all levels of own agency</li> </ul>	Initially through a process implemented by the <i>Partnership sub-committee</i> and subsequently via annual review of partnership: <ul style="list-style-type: none"> <li>• Leadership more equitably shared amongst members</li> </ul>

Goal	Objective	Strategies/Interventions	Estimated Impact
Enable effective involvement in SMPCP [continued]	Facilitate community involvement in PCP decision-making processes	Resource the <i>Partnership Sub-committee</i> to  Year 2  <ul style="list-style-type: none"> <li>• In collaboration with Aboriginal communities, develop strategies for their input and involvement in PCP</li> </ul> Year 3  <ul style="list-style-type: none"> <li>• In collaboration with young people, develop strategies for their input and involvement in SMPCP</li> </ul>	<ul style="list-style-type: none"> <li>• SMPCP processes more culturally sensitive for aboriginal people</li>   <li>• SMPCP processes more responsive to the needs of young people</li> </ul>

## Integrated planning

Goal	Objective	Strategies/Interventions	Estimated Impact
<p>Strengthen planning to achieve improved health and wellbeing outcomes for people living in Southern Mallee</p>	<p>Coordinate SMPCP planning processes with those of member agencies to ensure an integrated and complementary approach</p>	<p>Resource the <i>Integrated health Promotion and Integrated Planning and Evaluation sub-committee</i> to</p> <p>Year 1</p> <ul style="list-style-type: none"> <li>• Develop an agreed SMPCP planning, monitoring and review process and cycle that involves:               <ul style="list-style-type: none"> <li>– a workshop with member agencies to develop agreed principles and processes for alignment and integration of individual plans</li> <li>– a process for regularly updating health and wellbeing data as a basis for planning, and making this available to member agencies</li> <li>– a process for collating information from plans of member agencies within a common framework</li> <li>– a process for monitoring and reviewing the Community Health Plan</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Member agencies committed to, and participate in, an integrated planning process</li> <li>• Relevant and current health data (including data from agencies' community consultations) inform planning</li> </ul>

Goal	Objective	Strategies/Interventions	Estimated Impact
	Coordinate SMPCP planning processes with those of member agencies to ensure an integrated and complementary approach [continued]	Year 2, 3 <ul style="list-style-type: none"> <li>• Provide support for the alignment and integration of plans</li> </ul> Year 3 <ul style="list-style-type: none"> <li>• Evaluate progress with integration of plans</li> </ul>	<ul style="list-style-type: none"> <li>• Plans of member agencies more integrated, based on catchment priorities</li> </ul>

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

**KEY:** Deliverables: Partnerships: 1, Integrated Health Promotion: 2, Service Coordination: 3, Integrated Chronic Disease Management: 4

Agency name	Type of membership	Deliverable/s involved in
Bendigo Health Care Group	Board Member	1,2,3,4
Buloke Shire Council	Board Member	1,2,3
Cohuna Distirct Hospital	Board Member	1,2,3,4
East Wimmera Health Service	Board Member	1,2,3,4
Gannawarra Shire Council	Board Member	1,2,3
Kerang & Distirct Hopspital	Board Member	1,2,3,4
Mallee Division General Practice	Board Member	1,2,3,4
Mallee Family Care	Board Member	1,2,3,4
Manangatang District Hosptial	Board Member	1,2,3,4
Murray Plains Division General Practice	Board Member	1,2,3,4
Northern District Community Health Service	Board Member	1,2,3,4
Sea Lake & District Health Service	Board Member	1,2,3,4
Swan Hill District Hosptial	Board Member	1,2,3,4
Swan Hill Rural City Council	Board Member	1,2,3
Women's Health Loddon Mallee	Board Member	1,2,
Monash University – Bendigo Regional Clinical School	Associate Member	1

<b>Agency name</b>	<b>Type of membership</b>	<b>Deliverable/s involved in</b>
Community Connections	Associate Member	1,2
Employability	Associate Member	1
Interchange	Associate Member	1
Mallee Sexual Assault	Associate Member	1,3
Mallee Sports Assembly	Associate Member	1,2
School Nurse Program	Associate Member	1,2,3

Southern Mallee PCP

# Community Health Plan 2006 – 09

Deliverable 2: Integrated Health Promotion  
January 2007

**Primary Care Partnerships**  
Community Health Plan

**Endorsed by PCP Chair:**

Name:

Signature:

Date:

# 1. IHP vision

***People in the Southern Mallee live in a healthy community.***

***People are empowered to take responsibility for their own health and well-being.***

***The social, physical and emotional health of our community is mirrored in the health of individuals***

Our underpinning principles are:

- Participation – community participation in decision making processes is essential
- Empowerment – people must be provided with the information, education and supports needed for them to take responsibility for their own health and wellbeing
- Partnerships – health outcomes can only be achieved through collaborative efforts
- Health is a resource for everyday life and an aspect of quality of life
- Holistic – the promotion of health and wellbeing requires us to consider the context in which people live

## 2. Priority setting and problem definition

The development of Health Promotion Plans for each of the LGAs within the SMPCP catchment included community consultation, attention to public health data and consideration of DHS health priorities. The SMPCP held a planning workshop with Board members and agency representatives early in 2006. Further consultation with member agencies resulted in refinement of the single priority:

We have set a single priority: **Mental wellbeing and social connectedness**

Mental wellbeing and social connectedness is a statewide health priority. Good mental health is a prerequisite for good physical health. They uptake of behaviours to improve physical health, including effective self-management of chronic illness, is strongly linked to an individual's mental health and wellbeing.

Almost one million Australian adults and 100, 000 young people live with depression each year (Beyond Blue 2005). Depression will be experienced by one in five people during their lifetime. Due to lack of understanding of the illness many will also experience stigma and discrimination (Commonwealth Department of Health and Aged Care, 2001). Among women depression is the third most common cause of illness and the tenth common cause for men. Physical illnesses such as heart disease, diabetes and cancer can work in combination with this illness. (Commonwealth Department of Health and Aged Care, 2001).

Farming is now recognised as an industry associated with high rates of injury, illness, (NOHSC, 1998) disability and death (Franklin et al, 2001), stress (Booth and Lloyd, 1999) and depression (Sanne et al, 2004). Communities in the Southern Mallee are concerned about the impacts of the current drought and weather conditions. The drought, in its sixth year, is never far from the minds of not only farmers, but also local businesses and general community members. The emotional stress of lingering drought is impacting not only on farmers but also their families, communities and associated businesses.

People in the Southern Mallee have lower incomes compared with other regional areas of Victoria. Those living in low income households are 1.5-2 times more likely to get depression (Astbury, 2001. cited Health Promotion Priorities for Victoria: A discussion paper. 2006). Likewise, areas experiencing greatest social disadvantage are 2 – 2.5 times more likely to have adverse mental health outcomes than those more fortunate.

Effective promotion and prevention in the area of mental health generally requires long-term sustained effort across multiple sectors of the community.

Our key goal is: **Strengthen the mental wellbeing and social connectedness of people living in the Southern Mallee**

### 3. Solution generation

#### Mix of interventions

The key partner organisations funded by DHS to provide health promotion activities have identified priorities for their individual catchment areas and developed health promotion plans on the basis of these priorities. In addition a number of other organisations provide significant health promotion activities.

Priorities and goals of member agencies are shown in the table below. Details of plans can be accessed via the hyperlinks provided

Provider	Coverage within SMPCP	Priorities	Goals
Swan Hill District Hospital	Swan Hill Rural City (except for Robinvale)	Physical activity	<ul style="list-style-type: none"> <li>• Increase participation in physical activity by members of the Swan Hill &amp; District community.</li> </ul>
		Food and nutrition	<ul style="list-style-type: none"> <li>• Promote health through good nutrition and healthy eating habits</li> </ul>
		Sexual and reproductive health	<ul style="list-style-type: none"> <li>• Improve sexual and reproductive health and wellbeing in Women, Men and Young People</li> </ul>
		Mental wellbeing and social connectedness	<ul style="list-style-type: none"> <li>• Improve mental wellbeing and social connectedness in members of the Swan Hill and District community through a range of targeted strategies</li> </ul>
Northern District Community Health Service	Gannawarra Shire	Strengthening mental health through a focus on social inclusion, freedom from violence and discrimination, and access to economic resources and participation	<ul style="list-style-type: none"> <li>• Strengthen the mental wellbeing and social connectedness of the communities of Gannawarra and Northern Loddon</li> </ul>

Provider	Coverage within SMPCP	Priorities	Goals
East Wimmera Health Service	Buloke Shire	Improving physical health	<ul style="list-style-type: none"> <li>• Increase physical activity levels within the communities serviced by East Wimmera Health Service.</li> <li>• Encourage healthy lifestyle behaviours</li> <li>• Improve farm family health</li> <li>• Decrease the risk of injury from bucketing water</li> <li>• Promote injury free communities</li> <li>• Increase awareness of sexual and reproductive health issues</li> <li>• Increase the number of women using early detection services for breast and cervical cancer</li> </ul>
		Strengthening social connectedness and mental wellbeing	<ul style="list-style-type: none"> <li>• Strengthen social connections and mental wellbeing during the drought in local communities</li> <li>• Support and connect individuals who have experienced grief and loss</li> <li>• Encourage social interaction and increase support</li> </ul>
		Building Organisational Capacity Partnership Development	<ul style="list-style-type: none"> <li>• Minimise the effects of the current drought conditions on local communities</li> <li>• Plan more effectively in health promotion</li> <li>• Ensure that East Wimmera Health Service provides food consistent with good health and nutrition practice</li> <li>• Improve communication between organisation</li> <li>• Provide new graduates with mentoring opportunities</li> </ul>

Other SMPCP members involved in significant health promotion activities:

<b>Provider</b>	<b>Coverage within SMPCP</b>	<b>Priorities</b>	<b>Goals</b>
Swan Hill Rural City Council	Swan Hill Rural City	Building community capacity	<ul style="list-style-type: none"> <li>Connect members of our community, provide opportunities for the expression of aspirations, facilitate bringing aspirations to fruition, and support the ability to influence the use of community assets and facilities</li> </ul>
		Facilitate and provide services for health and wellbeing	<ul style="list-style-type: none"> <li>Provide or facilitate a range of services that maintain community health, and provide opportunities and infrastructure that contribute to the educational, recreational, cultural and leisure needs of our community</li> </ul>
Mallee Division of General Practice		Service integration	<ul style="list-style-type: none"> <li>Support GP participation in community health activities identified in the Southern Mallee PCP community health plans</li> </ul>
			<ul style="list-style-type: none"> <li>Support GP engagement with local primary care service providers</li> </ul>
SMPCP Strong Steps Project	Swan Hill	Falls prevention	<ul style="list-style-type: none"> <li>Ensure residents living in Swan Hill region are using long-term protective factors to reduce the risk of falls</li> </ul>

## 4. Capacity building

### Priority goal: Strengthen the mental wellbeing and social connectedness of people living in the Southern Mallee

Theme	Objectives	Interventions	Estimated impacts
Organisational development	Ensure effective communication between SMPCP member organisations, particularly in relation to mental wellbeing and social connectedness	Resource the <i>Integrated Health Promotion and Integrated Planning and Evaluation sub-committee</i> to Year 2, 3 <ul style="list-style-type: none"> <li>Develop effective means of communication to complement face-to-face meetings, including videolinks, teleconferencing, use of web-based message boards</li> </ul>	<ul style="list-style-type: none"> <li>Organisations have expanded knowledge base in relation to strategies to address mental wellbeing and social connectedness</li> </ul>
	Maintain service information directories to help improve access to needed services	Resource the <i>Service Coordination and Chronic Disease sub-committee</i> to Year 1, 2, 3 <ul style="list-style-type: none"> <li>Update Connectingcare in relation to mental health services and supports annually using either a member agency or contracted service</li> <li>Raise awareness of Connectingcare amongst members and community</li> </ul>	<ul style="list-style-type: none"> <li>Organisations, individual professionals and the community are better informed about services and supports, particularly those related to mental wellbeing and social connectedness</li> </ul>
Partnerships	Support the coordination of drought relief strategies	Resource the <i>Integrated Health Promotion and Integrated Planning and Evaluation sub-committee</i> to <ul style="list-style-type: none"> <li>Facilitate agencies working in the Buloke Shire to work together with Shire personnel to ensure effective coordination of all strategies specifically directed to drought relief</li> </ul>	<ul style="list-style-type: none"> <li>Increased effectiveness of drought relief support to the community</li> </ul>

Theme	Objectives	Interventions	Estimated impacts
	Support the coordination of drought relief strategies [continued]	<ul style="list-style-type: none"> <li>Work in partnership with agencies to develop a drought-specific health promotion and service coordination plan across SMPCP</li> </ul>	
Partnerships [continued]	Promote and enable the application of best practice health promotion and evaluation across the SMPCP	Resource the <i>Integrated Health Promotion and Integrated Planning and Evaluation sub-committee</i> to <ul style="list-style-type: none"> <li>Develop a health promotion framework focusing on planning, priority setting, project development and evaluation</li> </ul>	<ul style="list-style-type: none"> <li>An integrated approach to health promotion activities in SMPCP</li> </ul>
Leadership		<ul style="list-style-type: none"> <li>Support staff from member agencies to facilitate, as part of local <i>Healthy Networks</i>, forums focussed on themes within the health priority (for example, focussing on specific groups experiencing disadvantage, or specific age groups)</li> <li>Conduct annual catchment-wide forums to showcase good practice in relation to the health priority, including presentation of evaluation findings to add to the body of evidence of effective strategies</li> </ul>	<ul style="list-style-type: none"> <li>Increase in skills and knowledge required to address mental wellbeing and social connectedness within local communities</li> <li>Increased evidence base for promoting wellbeing and social connectedness within the community</li> </ul>
Workforce development	Promote and enable the application of best practice health promotion and evaluation across the SMPCP	<ul style="list-style-type: none"> <li>Conduct a forum with each of the SMPCP's <i>Healthy Networks</i> to:               <ul style="list-style-type: none"> <li>define mental wellbeing</li> <li>define social connectedness</li> <li>identify existing social connectedness activities</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li><i>Healthy Network</i> members have common understanding of mental wellbeing and social connectedness</li> </ul>

Theme	Objectives	Interventions	Estimated impacts
	Support the coordination of drought relief strategies	<ul style="list-style-type: none"> <li>• Convene the Mental Health First Aid training in each LGA, targeting those who work directly with drought-affected farmers</li> <li>• Convene one VicHealth Mental Health Promotion short course</li> </ul>	<ul style="list-style-type: none"> <li>• Staff working directly with drought-affected farmers have increased knowledge around mental wellbeing (assume 50 agency representatives)</li> <li>• Staff have increased knowledge about mental health promotion (assume 20 agency representatives)</li> </ul>

#### 4.5 Resources – PCP IHP Catchment Resource Summary

Please fill in the table below indicating the **estimated** resource allocation for the current funding period. Indicate either the \$ amount for funds made available directly to catchment partners or an approximate \$ amount where PCP health promotion staff time will be the primary resource.

##### Estimated Integrated Health Promotion (IHP) PCP resource allocation

Capacity building components	DHS funded PCP IHP	Member contributions
Partnership development		
Leadership		
Organisational development		
Planning for evaluation and dissemination		
Workforce development		
<b>Estimated Total PCP resource/budget allocation</b>	\$86,440.28	\$

##### Additional Integrated Health Promotion Resources

Funding source/project	Links to catchment priority	Funding
Go For Your Life: Being Active and Eating Well – funding application for consideration		
Go For Your Life: Fruit and vegetables for health – local action funding for consideration		
Go For Your Life: Seniors Active Living – funding application for consideration		
<b>Totals</b>		

## **5.1 Planning for quality health promotion practice (*Evaluation of mix of interventions*)**

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

SMPCP will facilitate and support evaluation processes through:

- the development of a common evaluation framework, within which member agencies will be able to evaluate individual projects to promote mental wellbeing and social connectedness;
- the provision of training, as needed, to enable managers and staff of member organisations to understand the link between planning, implementation and evaluation, and to identify and measure appropriate indicators of success; and
- collate findings from individual evaluations to add to the evidence base of effective strategies to address mental wellbeing and social connectedness in the community.

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

Through strategies outlined above, the SMPCP will support member organisations to evaluate and report on projects and strategies. The SMPCP will broker mentoring arrangements for those organisations that feel they need support to implement effective evaluation with the agreed common framework.

SMPCP will collate and disseminate findings of evaluations from across the catchment.

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

**What are the processes the PCP will employ to measure progress towards achieving the capacity building objectives detailed in the previous section?**

SMPCP will evaluate each of the capacity building objectives, using the common framework (see 5.1) and according with indicators and measurements agreed with the evaluation sub-committee and key member agencies.

**How will the PCP know when the capacity building objective(s) have been achieved?**

Measurement against agreed indicators.

**How will the PCP facilitate the dissemination of learning, including unexpected results?**

The SMPCP will develop reporting formats for the provision of findings to the Board, funding bodies, member organisations and the community. Content and means of dissemination will vary according to the audience.

## 6. Applying an Integrated Disease Management 'lens' to IHP planning

**Provide an overall summary or brief response to the questions set out in the guidelines about how prevention of chronic illness and addressing barriers to access and participation created by chronic illness are reflected within your IHP catchment plan.**

SMPCP has identified a single, overarching priority for its 2006 – 2009 Community Health Plan. This is mental wellbeing and social connectedness, seen as of critical importance for all people in all parts of the catchment. Attention to this priority is also linked to the affects of chronic illness, the two being interlinked in their potential of each to affect the other.

Each of the Health Promotion Plans from the key health promotion organisations within the SMPCP has included attention to chronic illness.

Current plans, including this Community Health Plan, have been developed in the context of ongoing severe drought and have been influenced by the potential this situation has to impact negatively on chronic illness.

Southern Mallee PCP

**Community Health Plan 2006 – 09**

Deliverable 3: Service Coordination  
January 2007

**Primary Care Partnerships**  
Community Health Plan

<b>Endorsed by PCP Chair:</b>		
Name:	Signature:	Date:

Goal	Objective	Strategies/Interventions	Estimated Impact	
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.	Develop effective referral processes, systems and models of collaborative care between a selection of GPs across the catchment and other primary care providers for clients with chronic disease and complex needs	Resource the GP Divisions and the <i>Service Coordination and Chronic Disease sub committee</i> to: <ul style="list-style-type: none"> <li>• Incorporate these objectives in the strategies outlined in the Integrated Chronic</li> </ul> PLUS	Using an agreed evaluation plan and data collection: <ul style="list-style-type: none"> <li>• Increased knowledge and understanding of service coordination principles and processes (assume 50 agency representatives)</li> <li>• Increase in awareness of, and referral to, a range of mental health services and supports</li> <li>• Increase in referrals and care planning</li> <li>• Changed approaches to practice</li> <li>• Improved outcomes for clients</li> <li>• Successful application of the manual and tools (measures to be determined each year)</li> </ul>	
2. Improve communication about clients (especially those with chronic disease and complex needs) with general practice, leading to more active GP participation with other service providers involved in the client's care.		Year 1 <ul style="list-style-type: none"> <li>• Identify the service coordination training needs for member agencies (particularly reception staff, managers and service delivery staff) and develop a relevant training</li> <li>• Develop a plan to roll-out the Victorian Service Coordination Practice Manual and Service Coordination Tool Templates, including attention to workforce development activities</li> </ul>		<ul style="list-style-type: none"> <li>• Increased knowledge and understanding of service coordination principles and processes (assume 50 agency representatives)</li> <li>• Increase in awareness of, and referral to, a range of mental health services and supports</li> <li>• Increase in referrals and care planning</li> <li>• Changed approaches to practice</li> <li>• Improved outcomes for clients</li> <li>• Successful application of the manual and tools (measures to be determined each year)</li> </ul>
3. Successful implementation of the Victorian Service Coordination Practice Manual and subsequent versions of the Service Coordination Tool Templates.		Year 2, 3 <ul style="list-style-type: none"> <li>• Deliver the service coordination training package</li> <li>• Implement the plan to roll-out the Victorian Service Coordination Practice Manual and Service Coordination Tool Templates</li> </ul> Year 3 <ul style="list-style-type: none"> <li>• Investigate the feasibility of a SMPCP-wide common assessment tool focused on mental wellbeing</li> <li>• Investigate feasibility of other sectors participating in SMPCP service coordination</li> </ul>		<ul style="list-style-type: none"> <li>• Decision made about the feasibility of a common assessment tool</li> <li>• Mental health services mapped and additional agencies identified (assume 3)</li> </ul>

Goal	Objective	Strategies/Interventions	Estimated Impact
Change management support for implementation of e-referral.	Develop effective referral processes, systems and models of collaborative care between a selection of GPs across the catchment and other primary care providers for clients with chronic disease and complex needs [continued]	Resource the <i>Service Coordination and Chronic Disease sub-committee</i> to Year 1, 2, 3 <ul style="list-style-type: none"> <li>• Facilitate installation of public key infrastructure in all member agencies to enable interagency receipt of e-referrals via connectingcare.com</li> <li>• Conduct training to members to ensure capacity to implement e-referral</li> </ul>	<ul style="list-style-type: none"> <li>• PKI installation in an increased number of agencies (measures to be determined each year)</li> <li>• Increase in number of e-referrals (Baseline established in 2007 for comparison in 2008 and 2009)</li> </ul>
4. Improved amount and accuracy of information to support referral through the Human Services Directory.	Maintain service information directories to help improve access to needed services	Resource the <i>Service Coordination sub-committee and Chronic Disease</i> to Year 1, 2, 3 <ul style="list-style-type: none"> <li>• Update Connectingcare in relation to mental health services and supports annually using either a member agency or contracted service</li> <li>• Raise awareness of Connectingcare amongst members and community</li> </ul>	<ul style="list-style-type: none"> <li>• Increased awareness of, and referral to, a range of mental health services and supports, as determined by a process developed by the <i>Service Coordination sub-committee</i> (assume 40 member agency staff and 20 community members)</li> </ul>

## Southern Mallee PCP

# Community Health Plan 2006 – 09

## Deliverable 4: Integrated Chronic Disease Management January 2007

### Primary Care Partnerships Community Health Plan

**Endorsed by PCP Chair:**

Name:

Signature:

Date:

## All PCPs

Goal	Objective	Strategy	Planned Impact
<p>1. Completion of a mapping of self-management interventions (provided by agencies within the catchment). Facilitate planning processes to develop self-management interventions within member agencies that respond to gaps identified in the mapping process.</p>	Strengthen the capacity of providers to implement effective self-management interventions for people with chronic disease	<p>Resource the <i>Service Coordination and Chronic Disease sub-committee</i>:</p> <p>Year 1</p> <ul style="list-style-type: none"> <li>• Conduct self-management mapping survey</li> <li>• Develop plan for improving provider understanding of self-management and addressing identified gaps, based on the findings of the survey</li> </ul> <p>Year 2</p> <ul style="list-style-type: none"> <li>• Facilitate a collaborative process across SMPCP to determine:               <ul style="list-style-type: none"> <li>– screening processes and practices for self-management</li> <li>– who provides self-management interventions</li> <li>– roles and responsibilities</li> </ul> </li> </ul> <p>Year 2 and 3</p> <ul style="list-style-type: none"> <li>• Implement the plan according to agreed timelines</li> </ul>	<ul style="list-style-type: none"> <li>• Workforce development needs in relation to self-management interventions identified</li> </ul>
<p>2. Facilitation of a process for agencies to define their roles and responsibilities, especially acute and community health services, in relation to providing self-management interventions for people with chronic disease.</p>		<ul style="list-style-type: none"> <li>• Roles, responsibilities and screening practices clarified and documented</li> </ul>	
<p>3. Successful implementation of the Better Access to Services (BATS) framework by progressing common practices, processes, protocols and systems for initial contact, initial needs identification, referral, assessment and care planning by member agencies, particularly as it relates to people with chronic disease.</p>		<p>Year 1, 2, 3</p> <p>Resource GP Divisions to lead (in collaboration with <i>Services Coordination and Chronic Disease sub-committee</i>) the strategies associated with this objective:</p> <ul style="list-style-type: none"> <li>• Develop links with West Victoria Division of GP</li> <li>• Engage support of GPs to promote collaborative care</li> </ul>	<p>Using an agreed evaluation plan and data collection:</p> <ul style="list-style-type: none"> <li>• Increased GP awareness of, and referral to, a range of health services and supports</li> <li>• Increase in case planning</li> <li>• Changed approaches to clinical practice</li> <li>• Improved outcomes for clients</li> </ul>

Goal	Objective	Strategy	Planned Impact			
4. Developed and defined local agreements and systems to identify clients with chronic disease who require comprehensive assessment, by working with PCP member agencies, particularly GPs.	Develop effective referral processes, systems and models of collaborative care between a selection of GPs across the catchment and other primary care providers [continued]	<ul style="list-style-type: none"> <li>• Showcase best practice referral and collaborative care via forums annually across the catchment</li> <li>• Keep GPs up-to-date about available services and programs via agreed information and communication strategy</li> <li>• Develop referral and feedback processes and protocols for trial between a selection of GPs and other primary care providers</li> <li>• Develop care planning processes and protocols for trial between a selection of GPs and other primary care providers</li> <li>• Conduct ongoing review and refinement of the processes and protocols trialled</li> <li>• Plan for further roll-out with other GPs including timelines, roles of GP Divisions and PCP, how roll-out will be supported, how to sustain initial trial and ongoing roll-out</li> </ul>				
5. Developed and defined local agreements and systems to identify clients with chronic disease who require cross-disciplinary/multi-agency (including GP) care planning, by working with PCP member agencies, particularly GPs.						
6. Developed and defined local agreements and systems around initiating and coordinating care planning for people with chronic disease by working with PCP member agencies, particularly GPs.						
7. Strengthened approaches to address disadvantage and health equality in Integrated Health Promotion initiatives, including barriers to participation such as chronic disease.	Promote the prevention of chronic illness and help address barriers to access and participation created by chronic illness	<p>Resource <i>Integrated Health Promotion and Integrated Planning and Evaluation sub-committee</i> to Year 1, 2, 3</p> <ul style="list-style-type: none"> <li>• Include attention to chronic illness and associated barriers to participation in all integrated health promotion plans</li> </ul>	To be determined, based on an agreed evaluation process and data collection			