

**Northern Mallee
Primary Care
Partnership**

OUR VISION:
"Better Partnerships...
Quality Services...
Healthier Community"



What is the NMPCP?

Northern Mallee Primary Care Partnership



Strategic and Community Health Plan 2006-2009



Northern Mallee Primary Care Partnership

Strategic & Community Health Plan 2006- 2009

Deliverable 1: Partnership

October 2006

Primary Care Partnerships
Community Health Plan

Endorsed by PCP Chair:

Name: **MARTIN HAWSON**

Signature:

Date:

1. PARTNERSHIP VISION

VISION:

Better **partnerships**...quality **services**...healthier **community**.

MISSION:

The Northern Mallee PCP builds stronger partnerships to support and enhance primary care services in our region through leadership and collaboration to achieve quality services which will enable better community health and wellbeing.

2. ACHIEVING THE VISION: *priority setting and problem definition*

Active Community

A healthier community is an active community. Our member organisations will work together in a collaborative approach to promote physical activity through capacity building and promotion of local sporting clubs and organisations.

Mental Health

A healthier community is one of good mental health. Working together organisations will have the capacity to promote mental health, create awareness of mental health issues and provide mental health services for a healthier community.

Access to Services

Organisations actively participate in service coordination initiatives, (Identification, Planning, Implementation and Resources) for the benefit of the consumers and wider service sector.

Partnership Development

Greater engagement and active participation of members to create a strong network to progress the PCPs initiatives.

3. ACHIEVING THE VISION: *Capacity Building Plan*

Element: Partnerships (if using capacity building elements)

Goal	Objective	Strategies/Interventions	Estimated Impact
Greater engagement and involvement by member organisations and staff.	Develop membership engagement strategy.	<ul style="list-style-type: none"> Promotion of relevance of PCP. Engage current PCP inactive members. Identify issues of relevance to organisations – Survey. Active participation of Divisions of General Practice. Dissemination of relevant information; meetings, newsletters, DHS bulletins. Advocacy on behalf of organisations. 	<p>Protocols are adopted to formalise and guide collaboration between relevant organisations in the PCP.</p> <p>Contribution of partners to core PCP work.</p> <p>Attendance of the full range of partners at PCP meetings and other key activities.</p>

Element: Partnerships

Goal	Objective	Strategies/Interventions	Estimated Impact
Flexible and effective partnerships with relevant and inclusive memberships.	Develop community consultation & engagement strategy.	<ul style="list-style-type: none"> Map existing consultation programs. Support Positive Ageing Forum. Consumer Survey – Service System access. 	<p>PCP member organisations support a variety of formal and informal mechanisms for involving consumers and community groups.</p> <p>PCP supports a variety of mechanisms for communicating with consumers and community groups.</p> <p>Involvement of a range of non-PCP organisations and community groups in consultations.</p>

Element: Leadership

Goal	Objective	Strategies/Interventions	Estimated Impact
Greater engagement and involvement by member organisations and staff.	Develop a relevant forum program. Bi monthly Executive Committee Meetings.	<ul style="list-style-type: none"> • Bi-monthly networking forums. • Survey member organisations – what do they want. • Attend Loddon Mallee Regional Meetings & Statewide Meetings. 	<p>PCP member organisations staff report enhanced access to information and engagement with the PCP network.</p> <p>Attendance of the full range of member organisations staff.</p>

Element: Workforce Development

Goal	Objective	Strategies/Interventions	Estimated Impact
Effective representation of PCP issues.	Develop key relevant projects.	<ul style="list-style-type: none"> • Workforce development. • Single entry service system. • Chronic Disease Management. 	<p>Develop and implementation of service development projects in partnership.</p> <p>Establish Steering Committees which act as the basic decision-making body of the project.</p>

Element: Organisational Development

Goal	Objective	Strategies/Interventions	Estimated Impact
Effective governance structures.	Review of the PCP Memorandum of Understanding.	<ul style="list-style-type: none"> • Ensure MOU reflects current progress of PCP. • Develop a clear reporting framework Bi-monthly reporting of activity against CHP activity to Executive Committee. 	<p>MOU remains reflective of PCP priorities</p> <p>Adhere to consistent reporting framework</p> <p>Reporting enables progress to be monitored.</p>

4. LIST OF PCP MEMBER ORGANISATIONS: *Explanation of Membership Types*

Organisation name	Type of membership	Deliverable/s involved in
Bendigo Healthcare Group	Management Advisory Forum Member	Integrated Health Promotion
Centacare	Management Advisory Forum Member	Inactive
Christie Centre	Management Advisory Forum Member	Inactive
Loddon Mallee Housing Service Ltd (LMHS)	Management Advisory Forum Member	Integrated Chronic Disease
Loddon Mallee Women's Health (LMWH)	Management Advisory Forum Member	Integrated Health Promotion
MADEC	Management Advisory Forum Member	Inactive
Mallee Accommodation Support Service (MASP)	Executive Committee Member	Chair, Service Coordination Reference Group
Mallee Division of General Practice (MDGP)	Executive Committee Member	Integrated Chronic Disease/Health Promotion /Service Coordination
Mallee Family Care (MFC)	Executive Committee Member	Chair, IHP working party
Mallee Sexual Assault Unit (MSAU)	Executive Committee Member	Partnership
Mallee Track Health & Community Service (MTHCS)	Executive Committee Member	Integrated Health Promotion/Partnerships
Mildura Aboriginal Corporation	Management Advisory Forum Member	Inactive
Mildura Base Hospital (MBH)	Executive Committee Member	Partnerships/Integrated Health Promotion/Service Coordination/Integrated Chronic Disease
Mildura Meals on Wheels (MMOW)	Management Advisory Forum Member	Partnerships
Mildura Private Hospital (MPH)	Management Advisory Forum Member	Partnerships
Mildura Rural City Council (MRCC)	Executive Committee Member	Partnerships/Integrated Health Promotion/Service Coordination/Integrated Chronic Disease
Murray Valley Aboriginal Co-operative	Management Advisory Forum Member	Inactive
Northern Mallee Migrant Service (NMMS)	Management Advisory Forum Member	Inactive
Oasis Aged Care	Management Advisory Forum Member	Inactive
Robinvale District Health Service (RDHS)	Executive Committee Member	Partnerships/Integrated Health Promotion/Service Coordination/Integrated Chronic Disease
SunAssist	Executive Committee Member	Partnerships/Integrated Health Promotion/Service Coordination
Sunraysia Community Health Services (SCHS)	Executive Committee Member	Integrated Health Promotion, Chronic Disease Management, PCP Administration, Service Coordination
Sunraysia Residential Services (SRS)	Management Advisory Forum	Partnerships
Vision Australia	Executive Committee Member	Partnerships/Integrated Health Promotion



Northern Mallee PCP

Strategic and Community Health Plan 2006-2009

Deliverable 2: Integrated Health Promotion

October 2006

Endorsed by PCP Chair:

Name: **MARTIN HAWSON**

Signature:

Date:

1. IHP Vision

The Northern Mallee Primary Carer Partnerships's (NMPCP) vision for health promotion is to increase physical activity levels and to enhance the mental wellbeing of people living within the Northern Mallee.

2. Priority Setting and Problem Definition

Following an extensive review of our priority issues from 2004 to 2006, the NMPCP has chosen to continue with the following two priority areas:

1. Physical activity and active communities; and
2. Promoting mental health and well being.

The priority setting process was reached after the following consultation:

- ➔ Vic Health – Health promotion priorities for Victoria.
- ➔ DHS - Victorian Burden of Disease Study.
- ➔ Vic Health – Evidence-based mental health promotion resource.
- ➔ Relevant local papers: Mallee Division of General Practice – Population health profile of the Mallee.
- ➔ Community consultation framework; Social indicators report MRCC.
- ➔ Local consultation: Workshop meetings with staff from member agencies, community consultation, PCP Executive consultation.
- ➔ National consultation: Members attendance to the National Health Promotion Conference in Alice Springs, Anti Cancer Council information sessions.

Priority setting process:

We believe these two priority areas have the greatest impact on the health of our community:

According to a report released by the Mallee Division of General Practice, compared against the Australian average our catchment area has:

1. A higher percentage of overweight males and females.
2. A higher percentage of smokers.
3. A higher percentage of physical inactivity.
4. Higher health risks due to alcohol consumption.
5. A higher percentage of arthritis.

Increasing physical activity has far reaching health benefits such as weight control, diabetes type 2 prevention, Cardio vascular disease prevention, blood pressure control and improved mental health. Promoting mental health and well being addresses alcohol and drug use, anxiety and depression and other mental health issues.

PROGRAM GOALS

Physical Activity Strategy:

Program goal: To increase physical activity levels of people living in the Northern Mallee region who do not currently exercise for at least 30 minutes per day, most days of the week.

Objectives:

1. To build the capacity of member agencies to facilitate exercise programs
2. To increase community knowledge towards the health benefits of physical activity
3. To promote and support local sporting and activity clubs that provides physical activity opportunities to the people of the Northern Mallee.
4. To increase levels of exercise in people who do not exercise for at least 30 minutes per day most days of the week.

Population target group: Inactive males and females.

Mental Health Strategy:

Program Goal: To enhance the mental wellbeing of people living in the Mildura Rural City council and Robinvale region.

Objectives:

To improve peoples knowledge of mental wellbeing and mental illness.

To build the capacity of member agencies in identifying and treating people with mental health issues.

3. Solution Generation

The Northern Mallee Primary Care Partnership has a vast and dedicated health promotion working party. Members represent agencies across a broad range of services that have an interest in improving the health of our community. Members meet monthly to drive the health promotion plan, share resources and information. The following Agencies are an active team in implementing the integrated health promotion plan. Most agencies have more than one representative from differing departments.

Sunraysia Community Health Services:

Mallee Division of General Practice

Mildura Rural City Council

Mallee Family Care

Mallee Sports Assembly

Robinvale District Hospital Services

Mallee track Community Health Services

Active After Schools Program

Mildura Base Hospital

Loddon Mallee Women's Health

Mental Health Services

Hospital Admissions Risk Program

Early Intervention in Chronic Disease in Community Health Services

Mildura Waves fitness Club

Commonwealth Carelink Centre & Carer Support Service

All agencies that formulate a Community Health Plan work with the NMPCP to ensure their goals and strategies are in line with our two priorities. Agencies are currently working on their community health plans (due end December 2006) and hyper linking to these plans can not be added at this time. (Oct 2006)

4. Capacity Building

Table 1: 2006-2009 Integrated Health Promotion Catchment Implementation Plan

Priority Goal:	To increase physical activity levels of people living in the Northern Mallee region.				
Objective (s):	<ol style="list-style-type: none"> 1. To build the capacity of member agencies to facilitate physical activity programs 2. To increase community knowledge towards the health benefits of physical activity 3. to promote and support local sporting and activity clubs that provide physical activity opportunities to the people of the Northern Mallee 4. To increase levels of exercise in people who do not exercise for at least 30 minutes per day most days of the week Population target group: Inactive males and females.				
Est. Impacts¹ (Qual/ Quant)	Reported increase of participation in physical activity Increased awareness of the benefits of physical activity				
Summary of mix of Interventions²	Lead Agency/s	Population Target Group/s: Estimated reach	Estimated timelines	Estimated intervention resources	Evaluation methods/expected outcomes
Workforce Development					
Support and subsidise the provision of certificate IV in fitness: individuals will be seen as qualified strength training instructors that meet fitness health training standards. Course via remote learning (fitnation). Ensures that the Northern Mallee communities can run their own programs/projects with qualified fitness instructors.	SCHS, MSA, MBH, MTHCS, MRCC, RDHS, MFC,	10 individuals from member agencies that run physical activity sessions	2007	PCP contribution \$15000 Individual contribution of 200 to 400 hours of study/written and practical assessments.	No of graduated participants. No of new physical activity programs commenced as a result of training. No of new participants in programs.
Support professional development and subsidise staff to attend the annual national health promotion conference.	All NMPCP member agencies	6 NMPCP members per year	May 2007 to June 2009	\$8000 PCP contribution being a 50% allowance for Accommodation and registration to member agency staff for next 3 annual conferences.	Report back to NMPCP with skills/information learnt and educate other members of NMPCP.

Summary of mix of Interventions ²	Lead Agency/s	Population Target Group/s: Estimated reach	Estimated timelines	Estimated intervention resources	Evaluation methods/expected outcomes
Assist NMPCP agencies with supporting capacity building (sustainable skills, organisational structures, resources and commitment to PA Improvement. To be allocated as agreed by the NMPCP HP working party, as opportunities arise.	All NMPCP member agencies		September 2006 to June 2009	\$10,000 from PCP Agencies to cover staff time.	Report back to the NMPCP with outcomes via appropriate evaluation tool.
Organisational Development					
Support organisational development of NMPCP members in regards to physical activity. Allocation of funding to be agreeable when a request is put to the NMPCP HP working party.	All NMPCP member agencies		September 2006 to June 2009	\$10,000 PCP	Report back to NMPCP with skills/information learnt and educate other members of NMPCP.
Partnership Development					
Create and support a Diabetes health week committee to work together in planning and coordinating activities for the public awareness campaign over the week, with emphasis on exercise and diet for diabetes prevention.	SCHS, RDHS, MTHCS, MSA, MDGP, MRCC, MBH and other interested parties	General local community	July 07 July 08 July 09	PCP commitment \$3000 over 3 years	Committee established. Number of active agencies and projects implemented as a result of the actions.
Continue to promote the importance of agency representation in NMPCP HP working party. Staff to highlight this to managers and CEO's.	NMPCP working party representatives	Management of local health/community agencies	September 2006 to June 2009	\$0	No of agencies attending regular meetings. No of staff attending regular meetings.
Support Robinvale community in establishing local soccer team/competition and or other sports not yet available in Robinvale.	MSA, RDHS	Robinvale community	December 2006	\$3000 PCP	Established local community committee. Number of participants participating in Soccer or proposed new sports. No of new sports established.
Encourage and invite new members into the NMPCP HP working party for a balanced well represented committee. Hold monthly meetings for the working party to implement the HP plan.	All NMPCP member agencies	All agencies with a focus on community health	September 2006 to June 2009	\$1350 for catering/facilities September 2006 to June 2009	No. of new members. Evaluate working party members for effectiveness/value of the health promotion meetings.

Summary of mix of Interventions ²	Lead Agency/s	Population Target Group/s: Estimated reach	Estimated timelines	Estimated intervention resources	Evaluation methods/expected outcomes
Support community groups/clubs/recreational groups to raise the profile of their specific physical activity i.e./ walking groups, tennis, football, cricket, golf, lawn bowls.	MSA, MRCC, MTH&CS, RDHS, SCHS	Groups/recreation clubs	Jan 07 to June 09	\$6000	Reported increase by clubs and community groups of new members involved in sport.
Resources					
Walking campaign brochures and Physical Activity Directory hard copies.	MRCC, MTH&CS, RDHS, SCHS	General community members requiring information on walking tracks, & or physical activity opportunities in the Northern Mallee	Oct 07 to June 09	\$3500	No of resources generated and delivered to community members.
Health Education & Skill Development					
Support the implementation and running of the "Pit stop" programs to agencies at appropriate field days and events where men congregate to promote men's health/physical activity.	MTH&CS RDHS SCHS	Males of all ages	Oct 06 to June 09	\$4500	Number of Pit Stop programs being run per year. Number of men who have participated.
Support MSA with the girls get active program designed to introduce indigenous teenage girls into sport and exercise, as well as health education.	MSA	Indigenous teenage girls	annually	\$2000	Number of girls taking part in the program.
Support the east end project in promoting physical activity.	MSA, SCHS	The east end community		\$2000	Number of participants involved in projects.
Support Member Agency programs promotion in the monthly life style page of Sunraysia Daily. Promotion article to include 300 word editorial, supportive photo and flyer/advert.	All member agencies have access on application	Whole of community	July 06 to June 09	\$6650 Includes 36 months	Unable to accurately evaluate.
Estimated Total Budget per Goal⁵: \$75000 over 3 years					

Table 2: Mental Health Initiative - 2006-2009 Integrated Health Promotion Catchment Implementation Plan

Priority Goal:	To enhance the mental wellbeing of people living in the Northern Mallee region.				
Objective (s):	<ol style="list-style-type: none"> 1. To improve peoples knowledge of mental wellbeing and mental illness 2. To build the capacity of member agencies in identifying and treating people with mental health issues 				
Est. Impacts¹ (Qual/ Quant)	A reported increase in people's knowledge of mental health				
Summary of mix of Interventions²	Key implementation partners	Population Target Group/s:	Estimated timelines	Estimated intervention resources	Evaluation methods/expected outcomes
Workforce Development Support professional development and subsidise staff to attend the Annual National Health Promotion Conference.	All NMPCP member agencies	6 NMPCP members per year.	May 2007 to June 2009	\$8000 PCP contribution being a 50% allowance for accommodation and registration to member agency staff. next 3 annual conferences	Report back to NMPCP with skills/information learnt and educate other members of NMPCP.
Support Certificate IV in Work Place Training & Assessment.	All NMPCP member agencies	7 agency staff members.	June 2008	\$4500	No of graduates. No of work place training initiatives commenced as a result of training.
Support Dual Diagnosis training in the Northern Mallee	MFC, PMHS, Mental Health Services, SCHS, DD	All health professionals in the Northern Mallee.	Feb 2007	\$5000	No of attendees, survey results. No of agencies represented.

Summary of mix of Interventions ²	Key implementation partners	Population Target Group/s:	Estimated timelines	Estimated intervention resources	Evaluation methods/expected outcomes
Support Quit training facilitator's course for 17 health professionals across the Northern Mallee region.	All NMPCP agencies	17 health professionals	November 2006	\$4000	Number of participants completed training. No of agencies represented. Number of community members quitting as a direct result of consulting local quit facilitators.
Support staff training on eating disorders.	MFC, PMHEIS, LMWH, SCHS, MBH,	All health professionals in the Northern Mallee	June 2007	\$5000	No of attendees, survey results.
Support Member Agency programs promotion in the monthly life style page of Sunraysia Daily. Promotion article to include 300 word editorial, supportive photo and flyer/advert.	All member agencies have access on application	Whole of community	July 06 to June 09	\$6650 Includes 36 months	Number of articles Community feed back recorded.
Partnership Development					
Support mental health week by actively taking part in the committee and organising events.	Mental health committee (MFC, SCHS, HPO, MDGP, Mildura Police, MRCC, MHS,	General community	October 2006, October 2007, October 2008	\$1500 \$1500 \$1500	Evaluation from mental health week committee.
Support and subsidise a regional forum for agencies to show case and promote health promotion strategies.	All NMPCP member agencies		March 2008	\$15,000	No of attendees, feed back from survey. No of agencies involved. No of presentations delivered.

Summary of mix of Interventions ²	Key implementation partners	Population Target Group/s:	Estimated timelines	Estimated intervention resources	Evaluation methods/expected outcomes
Encourage and invite new members into the NMPCP HP working party for a balanced well represented committed. Hold monthly meetings for the working party to implement the HP plan.	All NMPCP member agencies		September 2006 to June 2009	\$1350 for catering/facilities September 2006 to June 2009	No of new members.
Organisational Development					
Support organisational development of NMPCP members in regards to mental health. Allocation of funding to be agreeable when a request is put to the NMPCP HP working party.	All NMPCP member agencies		September 2006 to June 2009	\$6,000	Report back to NMPCP with skills/information learnt and educate other members of NMPCP.
Health Education & Skill Development					
Provide community education using the NMPCP Mental Health resource kit to community groups, schools, CALD communities and koori groups.	PMHEIS, MFC, SCHS	Community groups, Schools, CALD communities and Koori groups	On going	\$5000	Feed back from communication at the end of each session, using either verbal or written evaluation tools. No of attendees.
Support the East end project in the promotion of mental health & Chronic Disease Management programs.	MFC, MBH, SCHS	The east end community	On going	\$2000	
Support community education in Post Natal Depression.	LMWH, MFC, SCHS, PMHEIS	General Community	August 07	\$5000	Survey and number of people reached.
Resources					
Update and replacement of mental health resource kit as required.	HPPO	General community	Oct 06 to June 09	\$3000	No of new kits supplied.
Estimated Total Budget per Goal: \$75,000					

4.5 Resources – PCP IHP Catchment Resource Summary

Table 2 – Estimated IHP PCP resource allocation

Capacity building components	PCP IHP Funding/Resources
Partnership Development	34,200
Health education and skill development	27,150
Resources	6,500
Organisational development	16,000
Planning for evaluation & Dissemination	15,000 (PCP HPO)
Workforce development	66,150
Total PCP Resource/Budget Allocation	\$165,000

Provide information of other resources that will be used to support the IHP catchment work.

Table 3

Funding source/project	Links to Catchment Priority	Funding
Life scripts	Individuals are referred from GPs to SCHS for exercise programs and or smoking cessation.	\$20,000
*		
TOTALS		

**Note, at the current time we are unable to state what future funding opportunities will be available and successfully obtained in the Northern Mallee PCP*

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

The NMPCP will report on each intervention where appropriate, as described in the 2006-2009 Integrated Health Promotion Catchment Implementation Plan. This includes the number of agencies involved in PCP driven capacity building strategies, resulting in qualifications through education and projects/programs implemented as a result.

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

Chronic illness is predominantly a result of lifestyle related risk factors, these are:

- Hypertension eg stroke, heart disease.
- Smoking eg Cancer, heart disease, blood vessel disease.
- Poor Diet, inactivity & Obesity eg Diabetes type 2, heart disease, Atherosclerosis, cancer.
- Stress eg cancer, mental illness, bowel disease.
- Excess alcohol and/or drug use eg kidney disease, mental illness, liver disease.

Our two main priorities have been chosen to have the greatest impact in reducing lifestyle related risk factors. Our strategies are designed to build the capacity of our region to:

1. Increase access to physical activity programs and sport and recreation clubs.
2. Increase awareness of the impact both physical activity and good mental health have in chronic disease prevention and management.

Increased physical activity greatly assists reduction in; blood pressure, obesity, stress, depression and reduces the risk of diabetes type 2. An active person will be more motivated to eat a healthy diet, consume alcohol responsibly and reduce/quit smoking.

Mental Health promotion leads to increased awareness and uptake of mental health services, addressing mental health issues, substance abuse and excessive alcohol intake.

Through our local chronic disease management strategies, individuals who meet the criteria of becoming a hospital risk are placed on to a self management plan which incorporates exercise as a major intervention. The exercise plan requires in most cases close supervision by suitably qualified staff and management, at low or no cost (economic factors such as income can be a barrier to accessing physical activity programs). Our IHP enables community agencies to facilitate exercise programs by providing the ability for staff to be adequately trained and educated in exercise programs. This training has also been fundamental in providing access to our remote and rural towns, (that do not have gyms or sporting facilities due to environmental factors such as area residence) by training local staff to deliver exercise programs addressing local need in these regions.

Other examples of how our IHP aims to prevent chronic disease through exercise are:

1. Encouraging and supporting the Robinvale community to establish soccer teams. This will engage a significant number of teenage children to be part of a team, raising self esteem, increasing morale through sport, increasing opportunities.
2. Raising the profile of our local clubs and community groups that run sporting groups, through "Come and Try "sessions.



Northern Mallee PCP

Strategic and Community Health Plan 2006-2009

Deliverable 3: Service Coordination

October 2006

Primary Care Partnerships
Community Health Plan

Endorsed by PCP Chair:

Name: **MARTIN HAWSON**

Signature:

Date:

GOAL ONE:

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.

Objective	Strategies/Interventions	Estimated Impact	Project Partners
Support implementation of Better Access To Services (BATS) framework: <ul style="list-style-type: none"> • Organisations using BATS • Organisations new to BATS 	Development and implementation of Organisation Self Assessment Tool. Member organisations conduct self assessment annually. Formal Service Coordination partnership agreements between member organizations. Member organisations complete Snapshot Survey. Information used to identify gaps within the organisations and within the service sector. Member organisations incorporate commitment to service coordination into strategic plans, and departmental plans. Member organisations include BATS, PPPS, SCTT and e-referral into orientation and induction programs. Member organisations include provision for Service Coordination activities into yearly budgets. Member organisations have delegated service coordination representative on Service Coordination Reference Group. Development of Consumer Satisfaction survey. Implementation of Organisation Snapshot survey.	Increase number of organisations incorporated BATS/Service Coordination into planning and processes and induction. Organisations actively participate in service coordination initiatives (identification, planning, implementation and resources). Reported improved working relationships, levels of trust and confidence between primary care providers.	PCP Executive PCP Member Organisations Service Coordination Reference Group

GOAL TWO:

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.

Objective	Strategies/Interventions	Estimated Impact	Project Partners
Work with organisations and MDGPs to improve the level and quality of care plans designed for self management of chronic disease.	<p>Support and work with MDGP and health providers to identify and overcome barriers to service coordination and care planning.</p> <p>Work with Mallee Division of General Practice to progress GP engagement projects such as E-referral & Life Scripts and Chronic Disease Management.</p>	<p>MDGP Participates in Chronic Disease Management working party.</p> <p>Progression of joint referral and e-referral projects with Divisions of General Practice.</p> <p>MDGP participate in CDM working party information sessions for General Practice.</p>	<p>PCP Executive</p> <p>Chronic Disease Working party (HARP & EICDICHS)</p> <p>PCP Member Organisations</p> <p>Service Coordination Reference Group</p> <p>Mallee Division of General Practice</p>

GOAL THREE

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

Objective	Strategies/Interventions	Estimated Impact	Project Partners
Support organisations to adopt and implement local/regional or statewide PPPS and SCTT.	<p>Dissemination of Victorian Service Coordination Practice Manual.</p> <p>Local PPPS reflect progress of PCP programs and initiatives.</p> <p>Bi yearly training and update sessions offered to ground staff.</p> <p>Information session at one networking forum per year.</p> <p>Forum with presentations from Service Coordination Reference Group members on successes and experiences in their organisations.</p>	<p>Increased number of organisations incorporating Local/Victorian Service Coordination practice manuals into planning and processes and induction programs.</p> <p>Information sessions well attended by cross section of memberships.</p>	<p>PCP Executive</p> <p>PCP Member Organisations</p> <p>Service Coordination Reference Group</p> <p>Organisations involved in Service Coordination</p>

GOAL FOUR

Change management support for implementation of e-communication.

Objective	Strategies/Interventions	Estimated Impact	Project Partners
Support organisations currently implementing e-referral and support organisations wanting to implement e-referral.	<p>Assist organisations to apply for and obtain HeSA keys.</p> <p>Provide e-referral training when required.</p> <p>Assist organisations to explore Integrated IT systems.</p> <p>Assist organisations to incorporate local PPS in relation to e-referral.</p> <p>Organisations perform self assessment on readiness and capabilities to implement e-referral.</p> <p>Continue to encourage participation of member organisations in bi-monthly Service Coordination Reference Group meetings.</p>	<p>Organisations actively participate in e-referral initiatives.</p> <p>Increase in number of members using e-referral.</p> <p>Snapshot Survey reflects improvements to operations by the use of e-referral and feedback.</p>	<p>PCP Executive</p> <p>PCP Member Organisations</p> <p>Service Coordination Reference Group</p>

GOAL FIVE

Improved amount and accuracy of information to support referral through the electronic service directories.

Objective	Strategies/Interventions	Estimated Impact	Project Partners
Assist organisations to improve amount and accuracy of information available to support referral through the electronic referral systems.	<p>Develop protocols for updating organisations information on connectingcare.com.</p> <p>Training for organisation representatives to maintain own data on service directory.</p>	<p>Connectingcare data updates at least annually.</p> <p>Increased number of services available on electronic referral system.</p>	<p>PCP Executive</p> <p>PCP Member Organisations</p> <p>Service Coordination Reference Group</p>



Northern Mallee PCP

Strategic and Community Health Plan 2006-2009

Deliverable 4: Integrated Chronic Disease Management

October 2006

Endorsed by PCP Chair:

Name: **MARTIN HAWSON**

Signature:

Date:

All PCPs

Goal	Objective	Strategy	Planned Impact
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.	To facilitate a mapping survey into self management interventions, to be completed by relevant local member agencies, using the DHS survey template. Collect and summarise the findings detailing service gap identification in a report by March 2007.	Survey member agencies to determine current self management practices. Identify service gaps and work with agencies to address short falls in services.	Satisfactory completion of survey. Summary of findings from self mapping exercise identifying service gaps.
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.	The PCP will ensure ICDM works through facilitating working party and executive meetings for all key agencies, through a signed agreed memorandum of understanding.	PCP facilitate monthly meetings for a working party made up of key member agencies to meet, plan and discuss chronic disease management interventions.	Structured and well attended meetings to drive the CDM projects.
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.	Support implementation of Better Access To Services (BATS) framework: <ul style="list-style-type: none"> Organisations using BATS. Organisations new to BATS. State-wide Practices Processes, Protocols and Systems (PPPS). Subsequent versions of Service Coordination Tool Templates. Support organisations with implementation of e-referral.	Development and implementation of Organisation Self Assessment Tool . Member organisations conduct self assessment annually. Formal Service Coordination partnership agreements between member organisations. Member organisations complete Snapshot Survey. Information used to identify gaps within the organisations and within the service sector. Member organisations incorporate commitment to service coordination into strategic plans, and departmental plans. Member organisations include BATS, PPPS, SCTT and e-referral into orientation and induction programs. Member organisations include provision for Service Coordination activities into yearly budgets.	Increase number of organisations incorporated BATS/Service Coordination into planning and processes and induction. Organisations actively participate in service coordination initiatives (identification, planning, implementation and resources). Reported improved working relationships, levels of trust and confidence between primary care providers.

Goal	Objective	Strategy	Planned Impact
		<p>Member organisations have delegated service coordination representative on Service Coordination. Reference Group</p> <p>Development of Consumer Satisfaction survey</p> <p>Implementation of organisation Snapshot survey</p>	
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.	To ensure our PCP had adequate criteria to identify potential clients, and provide education to appropriate health service providers and GPs for catchment within our population group.	<p>Information sessions of ICDM as a joint program between HARP and EliCD to GPs, Health Service providers and the general public.</p> <p>Assist in the development of criteria that meets the identification of clients that will benefit from assessment in a CDM program.</p>	Number of client referrals received for CDM assessment.
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.	To ensure our PCP had adequate criteria to identify potential client's and provide education to appropriate health service providers and GPs for catchment within our population group.	<p>Information sessions of ICDM as a joint program between HARP and EliCD to GP's Health Service providers and the general public.</p> <p>Assist in the development of criteria that meets the identification of clients that will benefit from cross-disciplinary/multi-agency care.</p>	Number of client referrals received for CDM assessment.
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.	To ensure our PCP has adequate criteria to identify potential clients, and provide education to appropriate health service providers and GPs for catchment within our population group.	<p>Information sessions of ICDM as a joint program between HARP and EliCD to GPs, Health Service providers and the general public.</p> <p>Assist in the development of criteria that meets the identification of clients that will benefit from cross-disciplinary/multi-agency care.</p>	Number of client referrals received for CDM assessment.
7. Strengthened approaches to address disadvantage and health equality in Integrated Health Promotion initiatives, including barriers to participation such as chronic disease.	Ensure through a partnership approach that the NMPCP Health Promotion Working Party address barriers to participation in physical activity.	<p>CDM key staff members take an active role in the NMPCP HP Plan.</p> <p>NMPCP HP Coordinator take an active role in ICDM.</p> <p>Development of programs designed to attract and supervise clients with chronic disease.</p>	Increased participation of people with chronic disease into physical activity and other relevant health promotion events.

PCPs working with CHSs funded under the EliCD initiative

Goal	Objective	Strategies/Interventions	Estimated Impact
8. Successful implementation of workforce development strategies for self-management, particularly for community health services and GPs.	To ensure availability and accessibility to self management education/training to all agencies involved in ICDM.	Facilitate workforce development opportunities for all agencies involved in ICDM, eg flinders model training.	All staff providing self management services through CDM specific funded programs to be trained in using the flinders model.
9. Successful implementation of communication and marketing strategies (developed in conjunction with the Divisions of General Practice) that promote the benefits and availability of local self-management interventions to GPs.	All GP's have information and knowledge on self management programs and interventions.	Develop and distribution of information brochures for clients and GPs. Presentations at GP meetings. Individual presentations to GP clinics targeting practice nurses. Regular updates to GPs on ICDM programs.	Increased awareness. Increased referrals to CDM programs. Increased use of medicare CDM items.
10. Improved communication and collaborative care planning (by working closely with the Divisions of General Practice) between GPs and community health services.	To promote communication to GPs & CDM programs to ensure increased utilization of collaborative care plans.	Bi monthly meetings of CDM executive group. Monthly meetings of CDM working party. GP engagement with clients enrolled on CDM programs.	Improved client outcomes.
11. Development and adoption of disease-specific care pathways to ensure that clients get the right care in the right place, regardless of where they enter the service system.	To develop selected care pathways for the top 5 chronic diseases recognised in the Northern Mallee region, and provide staff education for utilization in care plans.	Research and indentify through the CDM working party meetings the top 5 chronic conditions in the Northern Mallee. Support development of disease specif care pathways.	Developed specific care pathways with a high standard of evidenced based care.
12. Support for change management provided to agencies, particularly community health services, which are implementing new systems or strengthening existing systems to provide proactive care rather than reactive care for clients with chronic disease.	To ensure key stakeholders are involved in change management processes.	Facilitate CDM meetings through existing committee structures for discussion and implementation of change management.	Successful implementation of change management practices.
13. Facilitation of a process for agencies to develop and implement consistent approaches to the use of decision support tools to support ICDM.	ICDM will have an agreed universal decision support tool with adequate staff training in place to ensure best practice.	Provide assistance for the training in Flinders model as the agreed decision support tool in self management.	All ICDM to be trained in the Flinders model within 6 months of employment.

Goal	Objective	Strategies/Interventions	Estimated Impact
14. Dissemination of transferable change management lessons in relation to ICDM.	To accurately document change management outcomes for dissemination.	Attend relevant information sessions, conferences and seminars to maintain latest evidenced based best practices.	Shared and beneficial learned experiences.
15. Completion of the statewide evaluation tools for ELICD.	To accurately collect and complete state wide evaluation documents.	Familiarisation of the state wide evaluation tools. Attend state wide evaluation meetings.	Completion of the evaluation tools.