Campaspe Primary Care Partnership

"Working together for healthy communities"

COMMUNITY HEALTH PLAN

2002

Murray Plains Division of General Practice

ECHUCA REGIONAL HEALTH

ROCHESTER & ELMORE DISTRICT HEALTH SERVICE

St Luke's

RESPECT | HOPE | FAIRNESS

KYABRAM & DISTRICT HEALTH SERVICES

TABLE OF CONTENTS

Introduction..... 1

Strategic Objectives..... 2

Key Achievements

Partnerships..... 6

Service Coordination..... 7

Integrated Service Planning..... 11

Hospital Demand Management..... 14

Operational Plan

Introduction..... 15

Priority Areas/Issues..... 16

Children & Young People..... 19

Older People..... 21

Mental Health..... 24

Alcohol & Drugs..... 26

Disability..... 27

Hospital Demand Management..... 28

Aboriginal Health..... 33

Information Communication Technology..... 35

Our Vision

"Through team work and leadership the Campaspe Primary Care Partnership will create an accessible and quality health care service system enhancing the quality of life of the community"

The 2002 Campaspe Primary Care Partnership Community Health Plan sets out to achieve a number of objectives.

Firstly the plan outlines the key achievements of the Campaspe PCP and highlights how these achievements impact on the consumer experience.

Through the plan the Campaspe PCP seeks to demonstrate how the key achievements and strategic objectives contribute to the overall reform process and builds a sustainable reform momentum within the catchment.

The document highlights the viability and readiness of the PCP. The basis of this readiness is the strength of partnerships and a common purpose within the Campaspe PCP. Sound partnerships exist both at an operational and management level and this is underpinned by an active community presence.

Finally this document outlines the priorities, gaps and emerging issues seen to be of most prominence in the Campaspe region and sets out a plan of how the elements of the PCP strategy are being integrated to address these priorities.

Strategic Objectives

In determining the following strategic objectives the Campaspe PCP took account of the momentum of the reform process currently underway in Campaspe, community and service provider expectations and the opportunities that exist to fulfil the vision of the Campaspe PCP.

1. Services and Program Coordination

Rationale: The agency initiated co-location of the HACC and ACAS assessment teams has led to the coordination of assessments for clients each service has in common. This has reduced client experience of assessment duplication and assisted in closer integration of the assessment teams. Agencies within the Campaspe PCP have agreed to develop further opportunities for service co-location building on this positive experience with an expected benefit of further service integration.

Key projects for 2002-2003 will focus on:

Co-location

- Linking a strong Initial Contact point with enhanced referral processes and GP Care Management by locating Carelink with a GP/Pharmacy Practice
- Linking Assessment to Care Planning by locating HACC and ACAS assessment teams with Care Management providers

Care Management

- Examining Care Management arrangements and building in more responsive and appropriate interventions

Chronic Illness

- Focussing on combining the Service Coordination elements with Health Promotion to implement a comprehensive and coordinated response to asthma management

Youth

- Building Service Coordination elements into the Youth Isolation Health Promotion initiative to support service integration

2. Delivering outcomes through implementation

Rationale: The Campaspe Primary Care Partnership has moved from describing service system change to an implementation stage where there is a clear focus on outcomes for the community. This strategic objective reflects the Campaspe PCPs commitment to ensure implementation is resourced and supported to achieve maximum effect and is underpinned by strong evaluative frameworks.

The key implementation areas include:

- Service Directory
- Initial Needs Identification Tool in Acute and Primary Care settings
- Campaspe Comprehensive Assessment Tool with HACC/ACAS
- Service Coordination Tool in Primary Care settings
- Workplace Cardiovascular Disease Risk Factors project
- Youth Isolation project
- Effective Follow Up of Suicidal Clients of Accident and Emergency Departments project
- Recommendations of the Seamless Care report
- Part implementation of Kyabram Aboriginal Community Needs Project

3. Building Sustainability into PCP activities

Rationale: The Campaspe PCP aims to build sustainability into the reform process through a combination of changes to agency practice, co-location of services, collaborative funding applications and agreements between agencies regarding residual PCP functions beyond 2002-2003.

Key focus areas identified for 2002-2003 include:

Health Promotion

- To stimulate practitioners and managers to shape the future directions of Health Promotion practice in Campaspe including structure/models with the development of a Health Promotion Strategic Plan

Partnerships

- Recognising that it is not one agencies core business to manage interaction between providers, government and the community and to seek opportunities to develop integrated activities.
- While current activity will be sustainable for twelve months the PCP will consider how this will occur beyond 2002-2003

Service Directory

- Recognising the need to support the uptake and utilisation of the service directory in line with individual agency capacity to resource directory maintenance and enhancements

Planning

- Formalising the links with Municipal Public Health Planning processes to progress future PCP Community Health Plans

Quality

- Formalising the role of the Campaspe Quality Committee and evaluation processes for collaborative agency projects

4. Investing in Workforce Development

Rationale: The primary focus for workforce development implementation is to support the Service Coordination and Health Promotion initiatives in the Campaspe PCP. Agencies in the Campaspe PCP also report of the difficulties in recruitment and

retention of qualified staff. Opportunities exist to share resources and positions to attract staff and there is potential to continue a multi-agency approach to training.

Key areas include:

- A workforce development program to support operational staff through the change management process generated by the implementation of service coordination initiatives
- A workforce development plan will address the practice, processes, protocols and systems (PPPS) to support Initial Contact, Initial Needs Identification, Assessment and Care Planning and will link to the Statewide DHS Workforce Development strategy
- Workforce development to advance Health Promotion initiatives in the areas of program planning, management and process, impact and outcome evaluation
- Support for primary care provider participation in the Department of Human Services Health Promotion Short Course and Leadership Program

5. Contributing to Regional, Cross Regional, Statewide and Cross Border Activity

Rationale: The Campaspe PCP considers itself to be part of the wider service system and will continue to contribute to regional and statewide activity.

Key activities include:

Loddon Mallee Region

- Information Communication and Technology Strategic Plan, Service Directory development, Loddon Mallee Aboriginal Reference Group and Loddon Mallee Regional PCP Group

Statewide

- Rural PCP Executive Officers, Statewide PCP Networks and statewide evaluation projects

Goulburn Valley/Hume

- Quality Language Services Project and Effective Followup of Suicidal Clients of Emergency Departments project

New South Wales

- Local government planning and Service Directory development

6. A continued focus on Aboriginal and Cultural and Linguistically Diverse communities

Rationale: The shared work of the Campaspe PCP and Aboriginal Communities in the Campaspe region has led to practical and tangible outcomes for the communities and has contributed to statewide learning. This work will continue to be a focus for the PCP as it strives to build a more responsive and relevant service system for Aboriginal people.

Key activities include:

Aboriginal Communities

- Njernda Aboriginal Corporation Koorine Women's Health and Wellbeing Project
- Kyabram Aboriginal Community Needs Project

Culturally & Linguistically Diverse Communities

- The Campaspe PCPs contribution to the Quality Language Services Project auspiced by Goulburn Valley PCP and Centre for Health Interpreter Services provides a basis to ensure Service Coordination initiatives are built around the needs of people from culturally and linguistically diverse communities

Increase the Participation of General Practitioners

What has changed as a result of PCP?

Co-location of Commonwealth Carelink with a GP/Pharmacy Practice

The PCP has negotiated the co-location of Commonwealth Carelink Centre at a major health facility incorporating general practice, pharmacy, massage, podiatry and pathology services. This will provide an opportunity to strengthen referral from Initial Contact and enhance links to Initial Needs Identification, Assessment and Care Planning.

Enhanced Primary Care Workshops

General Practitioners, Allied Health Workers, Nurses, Pharmacists and Primary Care Providers (total of 70 people) participated in a workshop to increase knowledge of the Enhanced Primary Care (EPC) items claimable through the Medical Benefits Scheme.

Murray Plains Division of General Practice

The Murray Plains Division of General Practice (MPDGP) is involved in Campaspe PCP Service Coordination initiatives to enhance linkages between the EPC Care Planning items. A Division staff member has been involved in the Service Coordination Development Project Team and the Campaspe PCP activities have also influenced the development of the MPDGP strategic plan.

Service Directory

GP Practice Managers and the Division of General Practice have had input into the development of the electronic service directory and will be involved in implementing the directory in GP Practices.

Benefits for clients/consumers

- Consumers who attend a GP practice will have access to more comprehensive service information and will be assisted in accessing these services
- A significant Initial Contact point will be strengthened
- Consumers will have greater access to Care Planning through the Enhanced Primary Care Medicare items
- GPs will be more aware of referral options and how to access a greater range of primary care services

Pilot Initial Needs Identification (INI) and Care Planning (CP) Tools

What has changed as a result of PCP?

The Campaspe PCP pilot followed an intensive consultation period involving the Campaspe Service Coordination Steering Committee, DHS and HDG Consulting Group.

The INI and CP tools were piloted for a minimum two week period (November 2001) and an evaluation was compiled in six MOU agencies and four non MOU agencies. Two agencies, Njernda Aboriginal Corporation and Rochester and Elmore District Health Service have integrated the tools into their practice and continue to use the INI and CP tools post the pilot period.

Benefits for clients/consumers

- Consumers were involved in the consultation sessions, Service Coordination Steering Committee meetings and in providing feedback directly to Department of Human Services regarding the tools
- Duplication of information collected from consumers was reduced
- Consistent consent practices and the availability of privacy information enabled consumers to increase their knowledge as to why information is collected
- Service providers had a common focus, for example utilising a standard tool to collect information, enabling providers to focus on outcomes for consumers

Implement Initial Needs Identification (INI) and Care Planning (CP) Tools

Service Coordination Development and Implementation

What has changed as a result of PCP?

The PCP identified the need to involve operational staff in the development of the service coordination initiatives. Increased operational staff involvement during the pilot period influenced the success of Service Coordination work.

A project team of eight practitioners was developed with a representative from each MOU agency in the PCP. The PCP acknowledged that workers "on the ground" have invaluable expertise and the potential to become change agents both at a systemic and individual agency level. The team members were seconded to the PCP one day a week for the period February to June 2002 with contractual arrangements between the PCP and the agencies.

Agency ownership of the change process has been enhanced due to the involvement of their staff and this has, in turn, strengthened long term viability and sustainability of service coordination reform. Project team members have had responsibility for the practice, processes, protocols and systems (PPPS) work for IC, INI and CP,

developing the way the model needs to work for them to achieve outcomes for consumers. The team have developed protocols for IC, INI and "funded" CP, a feedback sheet, flowchart and an agency education plan for implementation. The outcomes of this project have been presented at a statewide forum by the project team members themselves.

Benefits for clients/consumers

- Consumer developed Consumer Charter of Rights and Responsibilities integrated into Model implementation
- Consumer Steering Committee have reviewed draft protocols for IC, INI and CP and feedback sheet
- Consumers presenting at local and statewide forums on privacy issues

Integrated Assessment Platform (HACC/ACAS Co-location)

What has changed as a result of PCP?

To build on the physical co-location of these services a project team of five members was developed to drive the reform process. The Project team involved members from two MOU and two non-MOU agencies who were seconded to the PCP one day a week for the period February to June 2002 to develop an integrated assessment platform.

The HACC/ACAS team reviewed and analysed their current practices, processes, protocols and systems for the Service Coordination elements including referral processes to provide the foundation to the project and as a result found numerous commonalities. The project team has developed the Campaspe Comprehensive Assessment Tool (CCAT), which aims to provide a complimentary, comprehensive assessment form to use in conjunction with the INI and CP tools without duplicating consumer information. Guidelines, protocols and worker competencies to support practice and an evaluation template based on the program logic approach have been developed and endorsed by both services.

Broader assessment services such as District Nursing have been included in the project team and will incorporate learnings of the project into their practice. Staff within HACC/ACAS will coordinate their assessments for clients utilising the CCAT from July 2002. Progress of this project has been presented statewide by a project team member.

Benefits for clients/consumers

- Community representatives were involved in the project from the beginning and can see their input acted upon
- Less duplication of assessment
- More timely provision of services
- Less confusion for clients regarding who is assessing them for what
- Services seen to be cooperating and coordinating their activities
- Reduced time frame from receiving a referral to the actual assessment occurring
- Development of a common pathway for consumers ensuring smoother movement through the Primary Care System

Koorine Njernda Women's Health and Wellbeing

What has changed as a result of PCP?

Njernda Aboriginal Corporation has implemented the INI and CP Tools into their agency in conjunction with developing a Women's Health Service. Service Providers within Njernda responsible for coordinating care for aboriginal people with complex issues are using the Care Planning Tools to coordinate services for their community members.

Implementation of consistent consent processes has supported previous good practice for gaining consumer consent. An indigenous Womens' Health Worker has facilitated the practice, processes, protocols and systems (PPPS) work to develop a culturally sensitive cervical screening service. Two registered nurses have completed the theoretical component of the cervical screening training to provide on site pap smears for aboriginal women. An interim pap test service has been established with 30 women screened February to June 2002, which indicates a significant increase on the previous statistic of only one aboriginal woman being screened within the service in the previous two years.

Progress of this project has been presented at a seminar organised by the Centre for the Study of Health and Society at the University of Melbourne.

Benefits for clients/consumers

- Stronger internal referral pathways for services and better coordination of those services for aboriginal consumers with complex needs
- Better access to a range of services including cervical screening
- Implementation of tool templates has led to improved outcomes for Aboriginal people accessing Njernda Health House by improving coordination of care and early identification of needs
- Increased access to cervical screening (it had been identified that Aboriginal women would engage with workers "accepted" by their community)

Develop Service Directories

What has changed as a result of PCP?

Campaspe PCP has adopted the "Connecting Care" model for Service Directory development and implementation building on strong relationships with the Loddon Mallee PCP Consortium. This ensures the PCPs Local Service Information Strategy progresses in a uniform way across the region.

Service provider and program information has been collected by service coordination project teams, community representatives and the Loddon Mallee Region Commonwealth Carelink Centre. Data is currently being entered into a database with an estimated date of completion of August 2002.

Joint data collection arrangements have been instigated collaboratively with the Regional Carelink Centre which will be further developed to enhance long term sustainability for data maintenance.

Benefits for clients/consumers

- Consumer identified the need for a wider range of Primary Care Service Providers to be included on the Service Directory
- Consumer involvement with data collection and advertising to have information included in the Directory
- Consumer request for various formats of the Service Directory

Kyabram Aboriginal Community Needs Project

What has changed as a result of PCP?

A needs project has been completed with the Kyabram Aboriginal Community which has provided the basis for ongoing work. A steering committee was established to oversee this project will continue to facilitate the recommendations of the project report. More importantly, the completed document has credence with not only the mainstream service providers but with the Aboriginal Community itself due to the nature of the processes engaged to consult with them about their needs.

Outcomes for clients/consumers

- Additional social support funding has been provided by the Shire of Campaspe to support Koori Elders as a result of the needs articulated by the Kyabram Aboriginal Community Needs Project
- A Steering Committee has been formed and commitment from eight agencies gained to support the continuation of the group to progress the recommendations of the report

Implement Integrated Health Promotion Programs

What has changed as a result of PCP?

Interagency planning and strategy development has occurred by conducting workshops with service providers and community members on each of the Health Promotion projects. From these discussions the projects have been analysed utilising a program logic approach to ensure effective and quality planning.

The Health Promotion Steering Committee has played the key role for responsibility in this process. Establishment of a health promotion network (the Health Promotion Steering Committee) twelve months ago has brought together agencies with the aim to foster and strengthen relationships between providers for a more coordinated approach to health promotion initiatives.

Giving practitioners the opportunity to respond and address local health and wellbeing issues in collaboration rather than in isolation has added value to practitioners roles in decision making and setting strategic directions for preventative action in their community.

Outcomes for clients/consumers

- The development of the 2001 Community Health Plan provided services and the community with a document to base ongoing collaborative activity that responds to local community health and well being issues

INTEGRATED SERVICE PLANNING

Youth and Isolation project (YIPEE)

What has changed as a result of PCP?

The development of a leadership and mentoring project that targets isolated young people in the Campaspe Shire has brought together youth programs that cover a range of sectors with Campaspe primary care services. This project has also investigated opportunities for youth participation within the existing structures of our agencies and will implement these strategies over the course of the next twelve months.

This project has provided training into the issues for young people and youth friendliness for service providers by the Centre for Adolescent Health. The training was part of the project's service accessibility strategy.

Outcomes for clients/consumers

- Enhancing young people's connectedness to their community (contributes to a reduction in risk factors for suicide, depression and drug abuse)
- Development of young people as community leaders
- Progression towards a more coordinated approach to youth services
- Capacity of agencies to deliver responsive health promotion programs for young people has been enhanced
- Priority determination completed in partnership with the community and reflects their concerns

CVD Workplace Project

What has changed as a result of PCP?

Development of an evidence based practice model for Health Promotion in the Workplace has ensured that effective strategies have been employed in working to address cardiovascular disease risk factors with employees (who are predominantly male). The project has allowed for the development of strong links with two Workplaces to ensure its sustainability and effectiveness and has benefited from peak body advice provided by the Heart Foundation.

The Health Promotion Steering Committee members and sub committee/working group members have been involved in the program management of this project which contributes to enhancing practitioner capacity in Health Promotion. The establishment of the Health Promotion Steering Committee has also enhanced links with PCP Management Group and with consumers through the Community Steering Committee.

Outcomes for clients/consumers

- The Workplaces involved are taking an increased responsibility for their employees' health and wellbeing
- The employees are more aware of risks that contribute to cardiovascular disease and are more able to make informed choices
- Application of the recommendations will ensure the workplaces continue to improve and work towards better health for their employees over the next twelve months with liaison and support of agencies

INTEGRATED SERVICE PLANNING

- Participation of community members has occurred in the planning and management of the project through the Health Promotion and Community Steering Committees
- Nomination of the project for Victorian Healthy Workplace awards 2002

Reference:
Rural Health Promotion Program Report June 2002.
Integrated Health Promotion Program Report June 2002.

HOSPITAL DEMAND MANAGEMENT

Reducing Avoidable Hospital Admissions and Hospital Demand Management

Seamless Care

What has changed as a result of PCP?

The Seamless Care Report developed a framework for the integration of services implemented on discharge following an acute episode of care in an acute public or private hospital. Programs considered as part of this project included Home and Community Care, Post Acute Care, Hospital in the Home, Hospital to Home, District Nursing and the Victorian Aids and Equipment Program. The Seamless Care Project was a joint strategy between acute and primary care agencies.

The report identifies service enhancements to reduce hospital admissions and makes recommendations to provide agencies within this catchment and DHS a workplan for implementation. The implementation of the INI tool into acute settings through discharge planning is recommended as an opportunity for acute facilities to integrate acute and primary care and reduce hospital admissions.

The Quality Language Services Project was trialed with Kyabram and District Health Service within the framework of the Seamless Care Model.

Outcomes for clients/consumers

- This model was developed to ensure clients move through the service system safely, effectively in a coordinated manner and are empowered with knowledge about their care details
- Client risk of admission will be significantly reduced
- Referral processes from regional acute facilities have been streamlined

Effective Follow-up of Suicidal Clients of Emergency Departments

What has changed as a result of PCP?

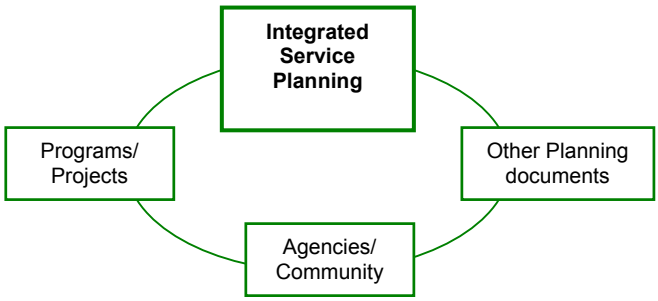
Loddon Mallee Regional PCPs were successful in obtaining Commonwealth funding to develop common practices, processes and protocols and systems for effective follow up of suicidal clients of hospital emergency departments.
Acute hospitals will be working together with primary care providers and the Primary Mental Health and Early Intervention team to progress this initiative.

Outcomes for clients/consumers

- Involvement of consumers in project submission development and future Loddon Mallee Region Steering Committee

Introduction to the Operational Plan

Integrated Service Planning processes for the Campaspe Primary Care Partnership have continued to include population and service data, regional and statewide planning documents and activities, feedback from agencies and communities and evaluation of strategies that the Campaspe PCP have been implementing over the last twelve months (refer to diagram below[1]).



The priority areas for the Campaspe PCP for 2002-2003 have been identified in consultation with Campaspe PCPs community and service profile data[2] and agreed to by the Management Group. Refer to the Priority Areas/Issues table for a snapshot of Campaspe PCP community and service profile and priority areas for 2002-2003[3]. A more comprehensive description of community and service data can be evidenced in the Primary Care Community and Service Profile for Campaspe, June 2002. Strategies to respond to these priority areas are evidenced in the Operational Plan section of this document.

[1] Campaspe Primary Care Partnership, *Community Health Plan 2001*
[2] Campaspe Primary Care Partnership, *Primary Care Community and Service Profile for Campaspe, June 2002*
[3] Documents contributing to the priorities as described below;
Campaspe Primary Care Partnership, Nikkelson, L. *Kyabram Aboriginal Community Needs Project Report, February 2002*
Campaspe Primary Care Partnership, Turner, L. *Seamless Care Report*
Rural Health Promotion Program Plan Report, June 2002
Integrated Health Promotion Program Plan Report, June 2002

PRIORITY AREAS/ISSUES

PRIORITIES/ PROGRAM AREAS	Children & Young people	Older people	Mental Health issues	Alcohol & Drug issues	DisAbility issues	Hospital Demand Management	Aboriginal Health
Population Data[4]	Children 0-9 years = 15.7% Young people 10-24 years = 20% 'Couples with children' account for 56.6% of the total (88.8%) family households.	Older people 60-99 years = 18.7% Higher than state average growth rate for older persons (13.3%)	Dementia is Campaspe's highest cause for YLD Depression is ranked 2nd for YLD	A&D Service utilisation for primary drug use 41.9% for alcohol use, 19.4% for cannabis use Lung cancer is Campaspe's 3rd highest cause of death Alcohol abuse/dependency is ranked 10th as YLD	Total of 7,149 people in Campaspe with disability Disability support pension rate is 12.9% of total Centrelink payments	1999/00 Campaspe has the highest asthma admission rate in Victoria (4.03/1000) Angina admission rates are the 2nd highest in Vic. (5.18/1000) BoD (1996) highest cause of DALY & YLL= Ischaemic Heart Disease (25% of total deaths also) Hospital admission rates 1997/98 for circulatory diseases were highest in Vic	451 Indigenous people in Campaspe Reduced life expectancy for males and females A&D Service utilisation for primary drug use 39.5% for alcohol use, 39.5% for cannabis use
Key Services	GPs, M&CH, Child Care, Pre schools, Youth Outreach Program Community Health, Allied Health, Public Dental, CAMHS, Family support, SAAP, Foster care, Intensive Family Support Early Intervention, Parent Resource, Health Promotion, Womens' Health	GPs, HACC, ACAS, ADASS, respite Community Health, Allied Health, Aged Care, Acute, Aged Persons Psychiatric Service, Attended care, Nursing, Carer Support services, Care Management Housing support, Womens' Health	GPs, Community Mental Health Service, Psychiatric Disability Support Service, Nursing, Carer support, care packages, Triage Housing support	GPs, Counselling, casework and continuing care, Drug withdrawal, Methadone maintenance treatment, Drink driver program, Drug Diversion program, Needle Syringe Program, promotion and prevention, housing support	GPs, Attended care, Nursing, HACC, ADASS, Aged care, ABI programs Carer support, Care Management Specialist primary school	GPs, Acute hospitals, Post Acute Care, HACC, Hospital in the Home, Hospital to Home, Victorian Aids & Equipment program, District Nursing Allied Health, Community health/ primary care services	GPs, HACC, Nursing, Child care, Housing support, Family support, Emergency relief, A&D counselling, Womens' Health,

[4] Sourced from Campaspe Primary Care Partnership *Primary Care Community and Service Profile for Campaspe June 2002*
Campaspe Primary Care Partnership, *Community Health Plan 2001*

PRIORITY AREAS/ISSUES

PRIORITIES/ PROGRAM AREAS	Children & Young people	Older people	Mental Health issues	Alcohol & Drug issues	DisAbility issues	Hospital Demand Management	Aboriginal Health
Key Health & Wellbeing Issues	Isolated young people (physical, social and emotional) Unemployment Road traffic accidents Abuse of drugs and alcohol	Challenges associated with an ageing community Access and knowledge of services	High prevalence of Dementia High disease burden for Depression Cross border barriers	Illicit drug use (eg amphetamines, cannabis) Safety issues relating to road trauma etc. Abuse of drugs and alcohol by young people Family violence Alcohol and tobacco use	Universal access Inclusiveness of people with a disability	High levels of Asthma hospital admissions High admission rates for Angina Incidence of Ischaemic heart disease	Alcohol and drug use (particularly injecting drug use) Family violence Young peoples issues (eg unemployment, education)
Service Gaps	Lack of Health Promotion resources						
	Recruitment and retention of staff working with children and young people (particularly specialist services, such as early intervention eg Speech Pathology) Access for young people (eg transport, & services) Lack of supports for family services such as early intervention, youth outreach, family violence, specialist services and generalist counselling	Need for enhanced Service Coordination to assist access, assessment and care coordination Demand on aged care services and the relationship of this demand with GPs Recruitment and retention of staff for aged care Lack of Respite Demand on Allied Health services	Cross border issues creating barriers Increasing demand on Mental Health services Limited access to generalist counselling	Lack of appropriate supports (as per priority for Children and Young People such as access to generalist counselling) Lack of Family Support regarding violence services Lack of youth oriented A&D counselling services	Lack of availability of age appropriate respite Need for advocacy training for service providers Providing appropriate services for people with disabilities Increased need for care coordination Infrastructure costs to implement universal access Demand on Allied Health services	Better access to primary care services Lack of research into hospital admissions for Campaspe Lack of accessible and available respite	Lack of Koori Health Workers Need workforce development in relation to cultural sensitivity for mainstream service providers Kyabram Aboriginal Community Needs Project recommendations (priority to have a liaison position) Need for extra Family Support services
	Equitable distribution of information communication technology systems (eg compatible software and hardware systems)						

PRIORITY AREAS/ISSUES

PRIORITIES/ PROGRAM AREAS	Children & Young people	Older people	Mental Health issues	Alcohol & Drug issues	DisAbility issues	Hospital Demand Management	Aboriginal Health
Campaspe PCP Priorities/ Areas of work **Refer to Operational Plan**	Isolated young people project (YIPEE) to reduce the issues of isolation Youth inclusiveness in Service Coordination Model (including Services Directory) to improve access	Implementation of integrated assessment platform (HACC/ACAS) Implementation of recommendations from Seamless Care Model (refer to Hospital Demand Management) Consolidating Service Provider Meetings across the PCP Single access telephone point development	Effective follow- up of suicidal clients presenting at emergency departments Support for PMHEIT Priorities: Better access to effective treatment, Service integration and collaboration, Mental health promotion and prevention, Education for providers and GPs Support Campaspe Advocacy and support groups in planning for implementation	Support implementation of Campaspe's Drug & Alcohol Action Plan Engagement/training of Alcohol and Drug service providers for INI and CP tools uptake and implementation	Support the development and implementation of the Campaspe Access and Inclusion Plan Opportunities for implementation of INI and CP tools to support Service Coordination Model	Effective follow- up of suicidal clients presenting at emergency departments (refer to Mental Health) Implementation of recommendations from Seamless Care Model Cardiovasular disease in workplace project Develop coordinated approach to Asthma Management inclusive of Health Promotion and Service Coordination initiatives	Strengthen relationships between mainstream agencies and the Kyabram Aboriginal Community Support Njernda Women's Health and Wellbeing Project Formalising PPPS work.
	Information Management and Information Communication Technology strategy implementation						

Isolated Young People

Background: Campaspe PCPs Health Promotion Steering Committee prioritised the issue of isolated young people to apply the Integrated Health Promotion Funding over three years and aims to integrate with service coordination initiatives to improve young people's access to services, increase and develop community leadership skills and provide opportunities for young people to have a voice.

Priority Area(s)	Youth Isolation Young peoples access to services, eg transport Youth inclusiveness in Service Coordination Model		
OUTCOME GOAL: To reduce isolation in Young People	STRATEGIES	CONSUMER IMPACTS AND PROCESS AIMS	TIMELINES
Partnership Arrangements	Undertake Health Promotion Strategic Directions planning to develop sustainable HP partnerships Continue stakeholder sub committee Encourage smaller agencies to adopt youth participation strategy Create opportunities for other youth sector agencies to be involved Encourage networking of youth service providers	Increase young people's social connectedness Increase young people's community leadership skills	2002
Consumer/Carer/Community Engagement	Involve community members in project steering committees Participation of community members in training for Youth Friendly Services Recruit young people and adult leaders to participate in leadership & mentoring program Recruit community 'youth' advocates in each community/township	Increased participation of young people in agencies 'Youth Friendly' agencies developed	Ongoing
GP Engagement/participation	Involve GPs in youth participation, Mentor and Leadership program Identify youth friendly GP practices		2002
Service Coordination Model (INI & CP tools) & Service directory	Trial INI tool with Youth Workers and Maternal and Child Health Nurses Implement service coordination model to support health promotion opportunities eg – referral to Mentoring/Leadership program Involve young people in development of service directory web page Improve service accessibility for young people eg increased confidence with improved information management systems	Enhanced sustainability to support implementation of project	2002 - 2003

CHILDREN & YOUNG PEOPLE

Service Planning / IHP programs	Foster interagency planning through planning workshops, HPSC and sub committee Develop & implement Mentor and Leadership program Link with other Campaspe mentor projects to establish a bank of skilled/trained mentors Strengthen Campaspe's youth voice by supporting youth participation in agencies Develop youth friendly services and enhance service provider skills in working with young people Develop sustainable structures to maintain the Youth Isolation project as agency core business Encourage workforce development for youth related service providers *Refer also to 2000/2001, 2001/2002 & 2002/2003 Health Promotion Program Plans*	Increase service providers skills for working with young people Increase knowledge of isolation issues for young people	2002 - 2003

OLDER PEOPLE

Build on Integrated Assessment Platform to strengthen Service Coordination Model

- **HACC/ACAS Assessment, Case Management and Carer Support Services co-location**
- **General Practice and Carelink co-location**

Background: Building on the successful co-location of the HACC and ACAS assessment services the PCP will further develop this model by pursuing co-location of Care Management and Carer Support Services with the Assessment Services. The PCP will also progress the co-location of Loddon Mallee Region Commonwealth Carelink with the Rich River Health Group inclusive of General Practice, pharmacy, pathology, masseur and podiatry services. This will strengthen the initial contact points, enhance links to the broader primary care service system and facilitate increased MBS, EPC items

Priority Area(s)	Demand on aged care services and the relationship of this demand with GPs Need for enhanced Service Coordination to assist access to a range of services Implementation of integrated assessment platform (HACC/ACAS) Single access telephone point development		
OUTCOME GOAL Service co-location, supported by the development of agreed practice, process, protocol and systems to support service integration.	STRATEGIES	CONSUMER IMPACTS & PROCESS AIMS	TIMELINE
Partnership Arrangements	Develop an agreed co-location project outline Develop formal partnership protocols eg MOU Involve Department of Human Services and Department of Health and Aged Care Determine and conduct interagency training of service familiarisation Share learnings with BHCG HART project – eg peer review of work practices for integration	Increased ease of understanding of local service information for clients Better access to a wider range of services	2002 - 2003
Consumer/Carer/Community Engagement	Involve consumers in working groups/Steering Committees and report to Community Steering Committee Increase engagement of consumers via Carelink co-location with GP Practice		

OLDER PEOPLE

GP engagement/participation	Trial fax feedback sheet with GPs Locate Carelink worker with GP/Pharmacy Practice Link GP patients with Carelink including EPC Care Planning Involve Division of GPs to assist education and training of Practice Staff to create pathways to link consumers to Carelink Continue to link with GP Practice Nurse workforce	Less duplication of information collection for consumers Increase in clients utilising services	
Service Coordination Model (INI & CP tool) & Service directory	Implement co-location project team to develop PPPS Facilitate workforce development for implementation of INI and link with statewide activity eg HACC Implement Service Coordination model with MOU agencies, testing and refinement of developed PPPS work Identify opportunities for implementation of Service Coordination model with non MOU agencies, testing and refinement of developed PPPS work Trial Campaspe Comprehensive Assessment Tool guidelines and protocols and evaluate Further investigate care planning practices, processes, protocols and systems Investigate opportunities for pooling resources and equipment to support model implementation Recommend physical co-location options to support model implementation Investigate opportunities to link with Service Directory and Information Communication and Technology projects Provide service directory education and training to enhance uptake and utilisation of service directory Recommend Service Directory model enhancements such as electronic information management Investigate options for Campaspe single access telephone point linked to Carelink	More responsive and timely interventions Develop system to determine priority and eligibility for care coordination Coordinating a whole of system approach to aids and equipment purchase and equipment pools Increase knowledge and access to Brokerage funds Strengthening Initial Contact Point access to the broader Primary Care system via GP Practice	2002 - 2003 2002 - 2003 2002 - 2003

Service Planning / IHP programs	Use data from INI, CP tools and Service directory to match expressed need to level of service delivery to inform planning and project future service need Investigate opportunities for implementation of the INI Health Behaviours Profile Investigate and facilitate IT support for data entry Use Carelink data to compare contacts and further plan model development		2002 - 2003

Mental Health

Background: The Campaspe PCP will work in partnership with the Primary Mental Health & Early Intervention Team (PMHEIT) to provide a coordinated response to the PMHEIT priority activity areas of Service Integration and Collaboration, Mental Health Promotion and Prevention and Better Access to Effective Treatment.

The Effective Follow up of Suicidal Clients from Emergency Departments (EFSCED) project proposes to develop and implement locally produced models for effective follow up of suicidal clients in five PCPs in the Loddon Mallee Region building on the established multi agency service coordination committees in each PCP catchment. The Campaspe PCP project (Echuca Regional Health is the lead agency) will eventually expand to include all hospitals in the Campaspe region by year three and will be supported by a Loddon Mallee Regional Project Management Group.

Priority Area(s)	EFSCED Project – development and implementation of a framework across the PCP Support local mental health advocacy and support groups Support for PMHEIT Priorities		
OUTCOME GOAL To develop effective mental health pathways in Campaspe	STRATEGIES	CONSUMER IMPACTS & PROCESS AIMS	TIMELINE
Partnership arrangements	Continue to support PMHEIT with involvement in their reference committee Participate in regional EFSCED Project Management Group Facilitate local EFSCED Project implementation Create links with Shire of Campaspe's Critical Response Plan Develop stronger links between mental health and primary care agencies Create links with LMR Dual Diagnosis Service Develop Campaspe EFSCED operational working group	Development of coordinated service delivery for EFSCED	2002 - 2003
Consumer/Carer/Community Engagement	Ensure consumer representation on local and regional EFSCED Project steering committees Continue participation in Community Mental Health Working Group		
GP Engagement/participation	Involve GPs in EFSCED model development Engage GP as Project Supervisor Create links to Carelink and Services Directory for service information for consumers Recruit GP for participation in local EFSCED Project steering committee	Steady progression in the development, piloting and implementation of the EFSCED policies and protocols	

MENTAL HEALTH

Service Coordination Model (INI & CP tool) & Service directory	Recruit and second project worker from MOU agency to manage project Build on previous Service Coordination Model development Develop PPPS specific to emergency department presentations, year 1 based on Echuca Regional Health Look for opportunities to integrate INI and CP tools in EFSCED Implement workforce development to support implementation of EFSCED Project Implement Service Directory to support the model Ensure mental health services and supports are included in Service Directory Support uptake of EFSCED Project across Campaspe acute facilities	Acute ED facilities will have established procedures that enhance collaboration with mental health services Increased effective followup of suicide clients presenting at ED	2002 - 2005 2003 - 2005 By 2005
Service Planning / IHP programs	Continue involvement in PMHEIT plan development and implementation Link Youth Isolation project with PMHEIT activities and EFSCED Project Develop evaluation plan for local EFSCED Project Participate in and support external evaluation process for EFSCED Project		2002 - 2003

ALCOHOL & DRUGS

Alcohol and Drugs

Background: Alcohol and drug services are a DHS priority group for implementation of the INI and CP tools over the next eighteen months.
The Effective Follow-up of Suicidal Clients from Emergency Departments Project will have a strong relationship to the area of Alcohol and Drugs.
Campaspe PCP has been involved in the Shire's Alcohol and Drug Advisory Committee and will continue to assist in its Action Plan implementation.

Priority Area(s)	Support implementation of Campaspe's Drug & Alcohol Action Plan Engagement/training of Alcohol and Drug service providers for INI and care planning tool uptake and implementation		
OUTCOME GOAL Implement the INI tool with A &D services to enhance consumer links to the Service Coordination Model	STRATEGIES	CONSUMER IMPACTS & PROCESS AIMS	TIMELINE
Partnership arrangements	Increase involvement of A&D service providers in Service Coordination and Health Promotion initiatives Involve A&D Service in EFSCED Project Create links with Dual Diagnosis Service	Maintain consistent approach to Service Coordination Model implementation with A&D services.	2002 - 2004
Consumer/Carer/Community Engagement	Involve Consumer Steering Committee in endorsement of PPPS relating to A&D services		
GP Engagement/participation	Formalise existing referral arrangements using Service Coordination tools		
Service Coordination Model (INI & CP tool) & Service directory	Implement education and workforce development to support INI and CP tools for A&D service providers Implement INI and CP tools with A&D service providers Support uptake and utilisation of the Service Directory with A&D service providers		
Service Planning / IHP programs	Continue to assist in implementing the of Campaspe Drug & Alcohol Action Plan Enhance A&D service provider links to Health Promotion activities eg. workers refer to Youth Isolation Project Contribute to service coordination tools evaluation processes		

D I S A B I L I T Y

DisAbility

Background: Campaspe is adopting the philosophy of inclusiveness for people with disabilities as part of the Rural Access Program. This ensures that agencies advocate for their service to be inclusive of people with disabilities and considers them when planning service provision. This approach filters across all program areas, not just Disability Services.

Priority Area(s)	Support the development and implementation of the Campaspe Access and Inclusion Plan Opportunities for implementation of INI & CP tools to support Service Coordination Model		
OUTCOME GOAL Enhancing Service Coordination for people with disabilities	STRATEGIES	CONSUMER IMPACTS & PROCESS AIMS	TIMELINE
Partnership arrangements	Continue to support the Rural Access Project Facilitate co-location of assessment and care planning services	Encourage disability service providers in adopting Service Coordination model To support inclusive practice within the Service Coordination model	2002 - 2003
Consumer/Carer/Community Engagement	Involve Community Steering Committee in the development of inclusive practices as part of the Campaspe Access and Inclusion Plan		
GP Engagement/participation	Refer to co-location regarding Carelink (pg 21)		
Service Coordination Model (INI & CP tool) & Service directory	Investigate opportunities for implementation of INI & CP tools to support Service Coordination Model Implement Service Directory with disability services		2002 - 2004
Service Planning / IHP programs	Support the development of the Access and Inclusion Plan Create pathways for people with disabilities to access Health Promotion programs Contribute to Access and Inclusion Plan evaluation processes		2002 - 2003

Asthma

Background: Campaspe has the highest asthma hospital admission rate in Victoria (2000/01). Campaspe PCP recognise the opportunity to link Service Coordination and Health Promotion initiatives to reduce asthma related hospital admissions.

Priority Area	Develop a coordinated approach to asthma management within Campaspe agencies		
OUTCOME GOAL To reduce asthma related hospital admissions by developing a coordinated management approach between acute and primary care	**STRATEGIES**	**CONSUMER IMPACTS AND PROCESS AIMS**	**TIMELINES**
Partnership Arrangements	Identify PCP resources required to implement Develop and endorse project workplan Develop governance structure for project Identify ongoing workforce development and training issues Investigate options for pooling asthma program resources Link with peak bodies	Reduced asthma related hospital admissions Coordinated integrated response to managing consumers with asthma	2002 - 2004
Consumer/Carer/Community Engagement	Involve Community Steering Committee in planning and implementation of project	Development of asthma discharge kit for consumers	
GP Engagement/participation	Involve GPs in model and link to MBS items Involve Division of GP in PPPS development		
Service Coordination Model (INI & CP tool) & Service directory	Implement INI in appropriate agencies to support asthma model Implement an agreed approach to care planning arrangements for people with chronic asthma Develop PPPS specific to asthma model supported by service directory Develop PPPS for Emergency Department presentations to support acute/primary interface	Referral and feedback processes developed with GPs and primary care agencies	
Service Planning / IHP programs	Develop local asthma coordination plan with evaluation processes Develop an Integrated Health Promotion program for asthma		

Cardiovascular Disease

Background: Campaspe has a high level of disease burden relating to cardiovascular disease. As a result the Campaspe PCP prioritised the Rural Health Promotion funding to implement the Workplace cardiovascular risk factors project. This project aims to develop an evidence based model to facilitate more Health Promoting workplaces and to enhance the capacity of agencies to support workplace health promotion practice.

Priority Area	High levels of cardiovascular disease in Campaspe		
OUTCOME GOAL To reduce the incidence of CVD in the Workplace	STRATEGIES	CONSUMER IMPACTS AND PROCESS AIMS	TIMELINES
Partnership Arrangements	Continue liaison with peak body organisation - Heart Foundation Undertake Health Promotion Strategic Directions planning to develop sustainable Health Promotion partnership arrangements and implement recommendations Continue stakeholder sub committee Support workplaces in sustaining a supportive environment for Health Promotion practice	Model produced for uptake by other primary care practitioners Sustainable project model applied to other workplaces/employees	2002 - 2003
Consumer/Carer/Community Engagement	Continue to involve industry representatives in sub committee Continue Community Steering Committee involvement in Health Promotion Steering Committee to oversee project implementation Involve community in developing Healthy Workplace Awards Scheme	Workplaces continue with Health Promotion initiatives to reduce CVD risk factors	
GP Engagement/participation	Investigate engagement process with GPs Involve GP in risk assessments for workplace employees		
Service Coordination Model (INI & CP tool) & Service directory	Investigate links to implement INI Health Behaviours Profile for use with workplace employees Investigate links to Service Directory Health Promotion options	Involvement of more agencies in sub committee/ project facilitation	

Service Planning / IHP programs	Foster interagency planning through planning workshops, HPSC and sub committee Develop evidence based model for workplace health promotion Provide health education on CVD risk factors to workplace employees Support workplaces in making organisational changes eg policies in relation to CVD risk factors Develop and implement a local Healthy Awards Scheme for workplaces Enhance the capacity of primary care agencies to support workplace HP by providing workforce development Develop, implement and review evaluation plans for the project *Refer also to 2000/2001, 2001/2002 & 2002/2003 Program Plans*	Businesses/workplaces aware of Healthy Awards Scheme and take a proactive role in their employees health and wellbeing	2002 - 2003

Seamless Care

Background: Part implementation of the recommendations of the Seamless Care report will be core work of the Campaspe PCP. This report developed a framework for the integration of services implemented on discharge following an acute episode of care in an acute public or private hospital. Further implementation opportunities will occur with additional resources (marked in red).

Priority Area	Implementation of recommendations of the Seamless Care Model report		
OUTCOME GOAL To implement framework for the integration of services following an acute episode of care	STRATEGIES	CONSUMER IMPACTS & PROCESS AIMS	TIMELINE
Partnership arrangements	Dissemination of project recommendations to PCP, Loddon Mallee Region and statewide (available on DHS PHKB website) Implement project recommendations to support development of co-located services project (refer to pg 21) Reconvene multi agency Seamless Care Steering Committee Facilitate agencies agreement to ensure equitable and full geographic coverage of community services Implement recommendations with appropriate non MOU agencies	Consumers experience coordinated services on discharge from a public or private acute facility	July 2002 August 2002
Consumer/Carer/Community Engagement GP Engagement/participation	Continue to report progress to Community Steering Committee Educate GPs in the Effective Discharge Strategy Work with a GP practice and Division of GP to implement EPC care planning arrangements specific to the Seamless Care Model	Consumers experience reduced risk of acute hospital readmission indicated by a reduction in the PAC data for acute facility admissions	Ongoing

HOSPITAL DEMAND MANAGEMENT

Service Coordination Model (INI & CP tool) & Service directory	Develop protocols for formal feedback and referral mechanisms between acute and primary care providers Conduct training in use of service directory Provide training for Aboriginal workers in service directory Develop protocols to determine care planning responsibilities of service providers Implement common assessment tool inclusive of safety risk assessment developed as part of the integrated assessment project Trial use of INI form with General Practice/Carelink co-location Trial Service Directory for electronic information transfer from GP practice to acute facility pre -admission clinic Investigate opportunities to implement recommendations of the Quality Language Services Project	Service Directory implementation will allow consumers and the service providers with current information on services and eligibility	2002 2003
Service Planning / IHP programs	Evaluate project and review data analysis of VAED data after a period of implementation Ensure referral options to HP programs are promoted Undertake further analysis of gaps and duplications to inform agency plans and further funding submissions	Enhanced links between GPs and acute facilities will reduce duplication of information collection and streamline referrals	2002 - 2003

Aboriginal Health

Background: The focus of the Campaspe PCPs work with the Aboriginal Communities centres on two key areas:
Women's Health and Wellbeing Project at Njernda Aboriginal Corporation (Koorine) formalising the Practice, Process, Protocol and Systems work as part of a funded service coordination initiative (marked in black).
The Kyabram Aboriginal Needs Analysis. Part implementation of the recommendations will occur within the core business of the PCP (marked in yellow), other strategies will require additional resources (marked in red).

Priority Area(s)	Support Njernda Women's Health and Wellbeing – Koorine Project Support part implementation of Kyabram Aboriginal Needs Project To provide ongoing liaison between mainstream agencies and the Kyabram Aboriginal Community		
OUTCOME GOAL Enhancing Service Coordination for people from an aboriginal community within Campaspe	STRATEGIES	CONSUMER IMPACTS & PROCESS AIMS	TIMELINE
Partnership arrangements	Continue to enhance partnerships between Njernda and PCP agencies Strengthen role of internal and external working parties for Koorine Project Facilitate relationship between Mercy Womens' Hospital and Njernda Implement Aboriginal Liaison worker with mainstream agencies Continue to foster and strengthen relationships between mainstream agencies and the Kyabram Aboriginal Community	Increased access to culturally appropriate Womens' Health Service	2002-2003
Consumer/Carer/Community Engagement	Involve aboriginal community in PPPS work Involve community members in Kyabram Aboriginal Community Steering Committee and Cultural Awareness training implementation		
GP Engagement/participation	Continue involvement of the Division of GP and designated GPs in project Aboriginal Liaison Officer to promote links with GPs in Kyabram		

ABORIGINAL HEALTH

Service Coordination Model (INI & CP tool) & Service directory	Build on implementation of INI and SC tools and finalise protocols to support practice for Koori Health Workers Further develop Women's Health Model for Cervical Screening and Followup Procedure Service Provide staff education for practice, process, protocols and systems Develop and trial implementation of Service Directory with Njernda Develop and implement models for liaison and referral with mainstream agencies eg. hospital, police, schools, juvenile justice and employment sectors Strengthen community access to information and services by linking to the PCP service directory	Increased identification of health and wellbeing needs of Koori people Enhanced risk identification for Aboriginal women	2002-2003
Service Planning / IHP programs	Support the development of Njernda's Health Plan Further promote health promotion programs for women's health as part of the Koorine project Continue to investigate opportunities for the Kyabram Aboriginal Community to be involved in agency planning processes		2002 - 2003

Information Communication Technology

Background: The Loddon Mallee Region is progressing a "whole of health" approach to information communication and technology development. The Campaspe PCP is undertaking an active role in this initiative.

Priority Area	Information Management and Information Communication Technology strategy implementation		
OUTCOME GOAL Development of Information Technology solutions to enhance connectivity between acute and primary care services in the Loddon Mallee region	**STRATEGIES**	**CONSUMER IMPACTS & PROCESS AIMS**	**TIMELINE**
Partnership arrangements	Participation in Loddon Mallee "whole of health" governance arrangements Amend joint heads of agreement to reflect whole of health approach Develop arrangements for smaller Primary Care Agencies to participate Ensure agencies in the Campaspe PCP are informed and involved in the project	Coordinated whole of health approach to the investment in Information Technology and Communication leading to cost efficiency	2002 - 2004
Consumer/Carer/Community Engagement	Ensure Community Steering Committee is informed and involved in the development of the Strategic Plan		
GP Engagement/participation	Involve the Murray Plains Division of General Practice to facilitate GP involvement in Strategic Plan		
Service Coordination Model (INI & CP tool) & Service directory	Ensure PPPS work of the Service Coordination initiatives are taken into consideration in the development of the strategic plan Link the ongoing development of Connecting Care service directory to the ICT strategic plan	Consumers experience a wider range of service options in a more efficient manner.	
Service Planning / IHP programs	Continue to participate in the development of the Loddon Mallee Regional Information Technology and Communication Strategic Plan Participate in region wide evaluation process		