Campaspe Primary Care Partnership

Community Health Plan 2004—2006

Index

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Glossary of Terms

BATS	Better Access to Services
BoD	Burden of Disease Study
BHCG	Bendigo Health Care Group
CAG	Community Advisory Group
CCC	ConnectingCare service directory
CHP	Community Health Plan
CMHP	Community Mental Health Plan
DALY	Disability Adjusted Life Year
DHS	Department of Human Services
ERH	Echuca Regional Health
GP	General Practitioner
HP	Health Promotion
IT	Information Technology
ICT	Information Communications and Technology
IHP	Integrated Health Promotion
KDHS	Kyabram and District Health Service
LG	Local Government
LMHA	Loddon Mallee Health Alliance
LMR	Loddon Mallee Region
LMWH	Loddon Mallee Women's Health
MCHN	Maternal and Child Health Nurse
MoU	Memorandum of Understanding
MPDGP	Murray Plains Division of General Practice
MPHP	Municipal Public Health Plan
NSW	New South Wales
PA	Physical Activity
PAC	Physical Activity Consortium
PCP	Primary Care Partnership
PKI	Public Key Infrastructure
PPPS	Practices, Processes, Protocols and Systems
REDHS	Rochester and Elmore District Health Service
SC	Service Coordination
SoC	Shire of Campaspe
SCTT	Service Coordination Tool Template

Foreword

This Community Health Plan for 2004 – 2006 captures the operational plans for the Partnership with particular emphasis on Service Coordination and Catchment wide Integrated Health Promotion. In addition to these key activities are other collaborative initiatives that capture the broader work that occurs locally, regionally and statewide for Campaspe PCP.

These plans are the product of the strength of our Partnership and it's new governance structure which has provided for us a platform for sustainability and agency ownership. Without this platform, our capacity to respond to the DHS Strategic Directions for PCPs and the DHS PCP Implementation Plan would be limited. With our current portfolio structure we are well positioned to implement new goals for this period from 2004 – 2006.

We undertook a new priority setting process this year to ensure a transparent and collaborative approach to determining our key goals. This process has been adopted by the Campaspe PCP and will support all future decision making processes for priority determination.

The key goals for Service Coordination include developing a standard benchmark to ensure all agencies attain a consistently high standard, and we plan to expand the Service Coordination system further through disability and early childhood services in the area.

Our catchment wide Integrated Health Promotion priority area for 2004 – 2006 is physical activity which comprehensively allows us to address the high incidence of heart disease, diabetes complications, angina and high blood pressure as well as address identified community need areas for increased physical activity opportunities.

The role ahead for us lies in maintaining sustainable leadership for Campaspe PCP which we will endeavour to continue through the PCP Management Group and Portfolio structure as well as the continued commitment by our member agencies.

Cathie Halliday
Chairperson
Campaspe PCP Management Group

Context

Vision of Campaspe Primary Care Partnership

The vision of the Campaspe Primary Care Partnership voluntary alliance is:

'Through teamwork, leadership and agency commitment for a sustainable partnership, the Campaspe Primary Care Partnership will create an accessible and quality health care service system enhancing the quality of life of the community'.

The Campaspe Primary Care Partnership continues to believe there are four integral, interdependent principles in achieving primary care reform;

- community involvement with a focus on improved outcomes
- strong partnerships
- a coordinated approach to the service system and
- an integrated approach to health promotion.

These factors have underpinned the Campaspe Primary Care Partnership since inception and continue to inform the work of the partnership.

Member Agencies

Campaspe Primary Care Partnership introduced in March 2004 a second level of membership for acknowledgement of agencies that display commitment to the principles of the Partnership but may not be able to fully participate in all areas.

Full Memorandum Of Understanding member agencies continue to be those that demonstrate commitment to the principles of the Partnership with active contribution to activities across Service Coordination and Health Promotion.

Memorandum of Understanding member agencies;
Bendigo Health Care Group
Echuca Regional Health
Goulburn Valley Health – Waranga Campus
Kyabram and District Health Service
Murray Plains Division of General Practice
Rochester and Elmore District Health Service
Shire of Campaspe
St Lukes Anglicare

Affiliate member agencies;
Bendigo Regional BreastScreen
Community Living and Respite Services
Greater Murray Area Health Service (NSW)
Interchange
Kyabram Community and Learning Centre
Lockington Bush Nursing Centre
Loddon Mallee Housing
Loddon Mallee Women's Health
Murray Human Services
Murray Shire Council (NSW)
Njernda Aboriginal Corporation
Sports Focus
Tongala Aged Care
Waranga Aged Care
YMCA – Echuca and District

A new Model of Governance

The Campaspe Primary Care Partnership Management Group have adopted a new governance structure (see table 1 below) and are in phase 1 of implementation. The Governance Structure consists of Portfolio areas which designated agencies have committed to being responsible portfolio holders for. The portfolio holder agencies responsibilities include promotion, advocacy and leadership within their portfolio area.

The model is supported by a revised Campaspe Primary Care Partnership Memorandum of Understanding (MoU) agreement, Rights and Responsibilities of MoU Agencies agreement and MoU Service Agreement documents. These documents detail the various roles and responsibilities of portfolio holder agencies, partnering agencies and PCP staff members.

The Portfolio areas agreed for this new model include Planning; Finance; Service Coordination; Service Directory; Integrated Health Promotion and Information Communications Technology.

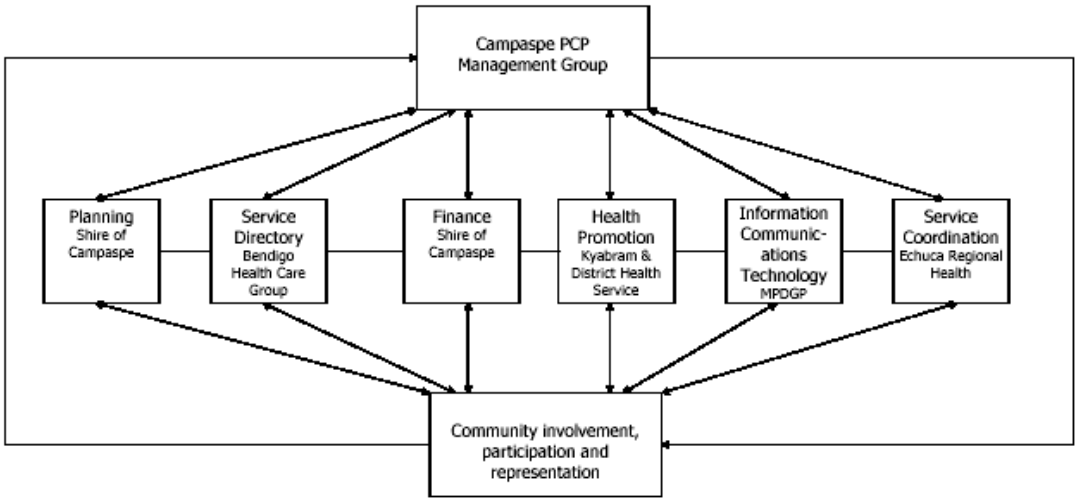

Table 1: Campaspe PCP Governance Structure

Achieving Planning Integration

Integrating planning processes has been a focus of Campaspe PCP primarily over the last two years. The key aim of this direction is to utilise local government's Municipal Public Health Plan as the strategic focus and the PCP Community Health Plan for the operational support of partnership work. From this framework, member agencies define their collaborative and agency specific work.

This Community Health Plan for 2004 – 2006 is the first stage in achieving implementation of this framework. The second stage involves aligning Campaspe's strategic needs into the Municipal Public Health Plan. Collectively, both plans will be developed again in 2006 allowing consolidation of this framework.

Operational Plan

In support of the development of this Community Health Plan, the Partnership introduced a Priority Setting Protocol to assist in the determination of both Service Coordination key areas and Integrated Health Promotion key health and well being issues. This approach has greatly enhanced priority setting to be supportive of the need areas and transparent in why particular areas have been chosen.

This involved development of a two staged process to define particular decision criteria for each area. The first step involved weighted decision criteria being developed for both Service Coordination (see appendix 1) and Health Promotion (see appendix 3) with key considerations relevant to achieving the respective goals. On completion of this process, the nominated priorities were then workshopped to complete a Prioritisation Matrix (see table below) by the relevant committee for Health Promotion and Service Coordination. Committee's discussed the nominated issues in relation to their strategic impact and their urgency for action.

Strategic Impact The relevance of this opportunity to the future direction		Urgency The need for action on this opportunity to improve current action/performance	
High	Critical to our future performance. Without it, the organisation cannot succeed.	High	Obvious need for improvement. Negative consequences are apparent. Requires immediate action (response to Tool)
Medium	Supportive of future performance, complements the critical activities of the organisation	Medium	Growing need for improvement. Negative consequences are beginning to show. Action required within 6 months
Low	Limited influence on future performance	Low	Need for improvement is not apparent. Action not required within a year.

Table 2: Prioritisation Matrix

For the completed prioritisation table for Service Coordination please refer to Appendix 2; and for the completed table for Health Promotion priorities please refer to Appendix 4.

Service Coordination

The Service Coordination planning requirements for 2004 – 2006 involves three mandatory areas of activity:

1. To support priority Human Services agencies, which are new to Service Coordination, implement the Service Coordination operational framework
2. To support priority General Practices to improve the quality of referral and care planning and in particular implement the General Practice Statewide Referral form
3. To continue support for agencies that have already successfully implemented the Service Coordination framework for initial contact and initial needs identification, and to support those agencies to move on to implement the Better Access to Services operational framework for assessment and care planning.

Vision of Campaspe Primary Care Partnership Service Coordination Steering Committee

That agencies within the Shire of Campaspe commit to providing a seamless service system, enabling the consumer to navigate with greater ease.

Goal of the Service Coordination Steering Committee

To facilitate functional integration between key primary health care agencies in the Campaspe Shire enabling consumers to experience a seamless service.

Objectives

- To enable services to improve coordination and therefore be more easily accessible to local communities
- To provide a tangible basis for agencies to work collaboratively to reduce service duplication
- To make recommendations about approval of projects and resource allocation.
- To guide process and the development of models.
- To evaluate service coordination initiatives to support shared learning across the State
- To identify mechanisms for facilitating change in practice and culture of stakeholders
- To involve consumers in all phases of service coordination development

Priority Setting Process

Campaspe Primary Care Partnership has developed a comprehensive priority setting process that for Service Coordination involved three stages;

1. Development of a Priority Setting Matrix (refer to Appendix 1) for Service Coordination that includes consideration of:
    a. DHS Strategic Directions 2004-2006
    b. Regional DHS Plan
    c. Campaspe Municipal Public Health Plan
    d. Local indicators of readiness for involvement and gaps in service areas
    e. Recommendations from PCP Management Group and steering committees
    f. Capacity of agencies to respond

2. Creation of a Prioritisation Matrix (refer to Appendix 2) according to:
    a. Strategic Impact
    b. Urgency

3. Development of a Service Coordination Plan for the next two years using the table provided by DHS and addressing:
    a. Goals
    b. Strategies
    c. Timelines
    d. Measures

Key Identified Areas

This process highlighted the new program areas for implementation of the Service Coordination strategy as Disability Services and Early Childhood Services based on the knowledge that of the key internal DHS services targeted for implementation, Loddon Mallee Region has committed to work with these two program areas in the next two years.

In addition, we have a number of new affiliate member agencies providing services in these areas and who are interested in exploring the possibility of implementation. With Early Childhood Services there are strong Campaspe and regional networks who have indicated an interest in pursuing development of this system alongside the DHS internal Specialist Children's Services to strengthen the process through collaborative planning and developing a consistent system to the benefit of all.

Drug & Alcohol and Mental Health Services were also considered a medium priority in Campaspe and the steering committee felt it would be better to align with DHS timelines.

The key areas identified and prioritised for existing agencies are:

- Auditing work already done
- Developing benchmark standards
- Evaluate e-referral pilot and roll out to the broader sector

It is considered a matter of urgency that at this point in time we evaluate the work already completed around service coordination systems and make necessary modifications. This process will include developing a set of benchmark standards to ensure a consistently high standard across all participating agencies. Those agencies who have reached this standard will then be in a position to mentor/support other agencies to attain this standard. This includes new agencies/program areas committing to the system. A similar process will be undertaken for the e-referral pilot prior to rolling it out to others in Campaspe.

Campaspe Primary Care Partnership will continue to support general practice engagement through improved quality of referral and care planning through use of the Service Coordination referral form (Victorian Statewide Referral Form in Medical Director). All GPs in Campaspe operate Medical Director software.

Service Coordination Plan – 2004 – 2006

New Agency Implementation

MAJOR AREA OF SERVICE COORDINATION ACTIVITY	GOAL *(What is the projected outcome over 2 years?)*	STRATEGIES *(How will the projected outcomes be achieved and by whom?)*	TIMELINES *(When will each of the key tasks be completed?)*	MEASURES *(How will the PCP decide whether it has achieved it's goal?)*
Support priority human services agencies, which are **new** to service coordination, implement the Service Coordination operational framework	To implement the service coordination practice, processes, protocols & systems into new agencies in the two program areas of disability and early childhood services.	To identify agencies & key contact person within the Campaspe PCP area that provide services in disability and early childhood services (ie existing MOU agencies, new affiliate members). To invite membership to the Service Coordination Steering Committee To provide a Service Coordination Information Session to all new agencies To provide agency training, utilising the Service Coordination Train the Trainer system of internal workforce development	Jul – Sept 2004 Sept 2004 Sept – Dec 2004 Sept 2004 – Jun 2006	At least one agency in each program area working towards implementation of service coordination system Realistic implementation plan, including timelines, endorsed by Service Coordination Steering Committee. Agency representatives participating in Service Coordination Steering Committee

MAJOR AREA OF SERVICE COORDINATION ACTIVITY	GOAL *(What is the projected outcome over 2 years?)*	STRATEGIES *(How will the projected outcomes be achieved and by whom?)*	TIMELINES *(When will each of the key tasks be completed?)*	MEASURES *(How will the PCP decide whether it has achieved it's goal?)*
Continued….		To develop a peer support strategy to partner new agencies with those agencies who have already achieve agreed benchmark standards PCP staff to provide ongoing support to agencies throughout the implementation phase To encourage service providers to utilise the Connectingcare.com or statewide service directory as a resource for enhanced referrals and care planning	Ongoing Ongoing Ongoing	Information Sessions delivered to workers at each participating agency Pre & post testing at training sessions to ascertain level of knowledge/commitment gained Service Coordination practice regularly reviewed. Included in quality improvement processes

Support to General Practitioners

MAJOR AREA OF SERVICE COORDINATION ACTIVITY	GOAL *(What is the projected outcome over 2 years?)*	STRATEGIES *(How will the projected outcomes be achieved and by whom?)*	TIMELINES *(When will each of the key tasks be completed?)*	MEASURES *(How will the PCP decide whether it has achieved it's goal?)*
Support priority **General Practices** improve the quality of referral and care planning and in particular implement the General Practice Statewide Referral form	To improve quality of GP referral and care planning through use of statewide referral form	Encourage GPs to utilise the embedded statewide referral form in Medical Director for all referrals to primary care agencies/service providers in the Campaspe PCP area Those GPs without IT capability encouraged to use a paper form of the above referral form Murray Plains Division of General Practice continue to encourage GP participation in quality referrals through the statewide referrals form To encourage use of the Connectingcare.com service directory for referral resources knowledge	Ongoing Ongoing Ongoing Ongoing	Implementation plan endorsed by GPs , Division and practice manager GPs and other medical practice staff indicated an increased knowledge of service coordination including use of ConnectingCare, Statewide Service Directory & Better Health Channel and ability to populate the GP Statewide referral form (workshop evaluation) Increased number of staff able to refer electronically to partner agencies using the GP Statewide Referral form (training evaluation)

Agencies already utilising Service Coordination framework

MAJOR AREA OF SERVICE COORDINATION ACTIVITY	GOAL *(What is the projected outcome over 2 years?)*	STRATEGIES *(How will the projected outcomes be achieved and by whom?)*	TIMELINES *(When will each of the key tasks be completed?)*	MEASURES *(How will the PCP decide whether it has achieved it's goal?)*
Continued support for agencies that have **already successfully implemented** the services coordination framework	To develop a benchmark standard for PPPS	To develop/adopt benchmarking process (ie tools etc) and develop an agreed set of standards To internally audit agencies using the benchmark standards	Oct - Dec 2004 Feb 2005	Set of benchmark standards developed around the BATS framework All PCP agencies participate in an internal audit
	To work towards an agreed standard of practice for all participating agencies	Agencies to work together to achieve an agreed standard of practice Peer support of agencies with an acceptable standard of practice to those needing assistance SC Steering group to guide the above processes	Jan – Mar 2005 Jan – Mar 2005 Ongoing	All current agencies participate in the process Standards met by 80% agencies Agencies actively supporting each other to achieve acceptable practice standards

MAJOR AREA OF SERVICE COORDINATION ACTIVITY	GOAL *(What is the projected outcome over 2 years?)*	STRATEGIES *(How will the projected outcomes be achieved and by whom?)*	TIMELINES *(When will each of the key tasks be completed?)*	MEASURES *(How will the PCP decide whether it has achieved it's goal?)*
	Increased uptake of secure e-referrals within agencies and GP practices in Campaspe area	To evaluate current e-referral project To develop an information package to assist other agency uptake of e-referral To develop shared protocols to support e-referral development Support increase of agencies and GPs using secure e-referrals	Oct - Dec 2004 Jan – Mar 2005 Jan – Mar 2005 Dec 2004 – Jun 2006	Evaluation report completed E-Referral Information Package developed as resource for new agencies/service providers Common set of E-Business rules E-Referral process rolled out to other depts of agencies who participated in project
	To further develop assessment and care planning systems using the service coordination operational framework Support agencies to investigate existing assessment & care planning frameworks	Work together with SC Steering Committee to develop common assessment & care planning frameworks and standards for Campaspe agencies Support agencies to improve assessment & care planning processes July 2005 – Jun 2006	Review of existing frameworks and tools undertaken	2 agencies have improved their assessment & care planning processes and met the agreed standard

MAJOR AREA OF SERVICE COORDINATION ACTIVITY	GOAL *(What is the projected outcome over 2 years?)*	STRATEGIES *(How will the projected outcomes be achieved and by whom?)*	TIMELINES *(When will each of the key tasks be completed?)*	MEASURES *(How will the PCP decide whether it has achieved it's goal?)*
	Continue to utilize and expand current data on the ConnectingCare service directory across all primary care agencies	Agencies to maintain CCC data via online updates CCC training offered to new staff	Ongoing Jan – June 2005	All member agencies listed on CCC and staff utilising for resource info to ensure best referral options New staff familiar with CCC service directory

Integrated Health Promotion

Campaspe PCP vision for Health Promotion and supporting principles
In addition to the alliance goal is the Health Promotion Steering Committee's vision: 'That health promotion practices within the Shire of Campaspe are responsive to the health and well-being needs of the community' with their mission statement as 'The Health Promotion Steering Committee will provide opportunities to integrate and coordinate a range of health promotion activities in an environment which is supportive of continuous improvement and community involvement.'

Goal of the Health Promotion Steering Committee
To support a coordinated approach in the advancement and development of integrated health promotion initiatives between key stakeholders in the Campaspe Shire.

Objectives

- To promote a collaborative approach between key health promotion agencies
- To continue to engage with agencies that have an interest in improving health and well being
- To foster and strengthen integrated health promotion approaches
- To act as a reference committee for health promotion agencies and consumers
- To involve consumers in all phases of health promotion development
- To influence policy development and resource allocation to improve health promotion outcomes within the Campaspe Shire
- To base health promotion activities on evidence-based practices
- To support the process, impact and outcome evaluation guide in achieving quality health promotion practice for Campaspe.
- To encourage resource sharing of state-wide good practice health promotion projects.

Priority Setting Process

The process for defining the catchment priority involved following the Planning & Priority Setting Protocol developed by the Campaspe PCP Planning Reference Group (described in Operational Plan - see page 3). For Health Promotion this step-by-step process involved developing and completing a weighted decision criteria (refer to Appendix 3) for each priority topic area. The categories in the weighted criteria include;

- *Evidence:* Ambulatory care sensitive conditions data; Burden of Disease data; Hospital admissions data or other

- *Capacity Building*: Community consultation/ identified need; Service system gaps/ lack of resources; Recommendations from PCP committees; MPHP identified needs; Intersectoral collaboration; Staffing capacity/ potential for action to be taken

- *Strategic:* Opportunity to link to other funding sources; Links to PCP strategic directions; Link to national, statewide and regional priorities; Links to local agency plans

This step narrowed down the priority areas to physical activity, food and nutrition and mental wellbeing and social connectedness purely because they gained the most responses to the set criteria.

Stage 2 of this process then discussed the nominated issues in relation to their potential for strategic impact and their urgency for action (refer to attachment 4). It was found that each of the nominated priorities had an equal 'urgency for action' however the strategic impact potential was greatest for **physical activity**.

Level of Integration for Campaspe PCP Summary

Campaspe Primary Care Partnership have achieved a high level of integration since the introduction of Integrated Health Promotion with the commencement of PCPs. This began with the initial integration level of networking and coordination and has progressed since 2003/2004 to cooperation. This year's catchment wide plan clearly indicates collaboration with demonstration indicators of this level being;

- Agency/organisation plans have like goals; objectives and target groups.
- Agency plans nominate implementation of the strategies outlined in the catchment wide plan
- All stakeholders involved in the primary care sector in Campaspe are included in the catchment wide plan plus additional sector representation
- The combined capacity of agencies has been planned to address a common goal/purpose

PCP catchment priority topic for health promotion activity and supporting rationale

Campaspe Primary Care Partnership have identified one catchment priority topic for 2004-2006 of Physical Activity. The basis for this priority relates to the high incidence of angina and diabetes complications from the Ambulatory Care Sensitive Conditions Study; burden of heart disease; physical inactivity; obesity and high blood pressure in reference to the Burden of Disease Study; strong community identified need; and strong potential for intersectoral collaboration and integration. In addition to physical activity as the priority, there were obvious connections to link this priority to work relating to mental wellbeing and social connectedness. The Health Promotion Steering Committee chose to include mental wellbeing and social connectedness by incorporating this key area as an objective for physical activity (refer to Summary Planning grid). Following the process outlined above, a literature review was completed to identify physically inactive target groups.

'There is compelling evidence that physical inactivity is responsible for a large proportion of coronary heart disease and type 2 diabetes (as well as some cancers, overweight and obesity, osteoporosis, falls in the elderly and mental health problems). Sedentary people have between 1.5 and 2 times higher risk of CVD compared with people who are active at moderate levels (such as brisk walking). Physical activity is also vital for the prevention and management of type 2 diabetes.'[1]

[1] Victorian Government Department of Human Services (2004) Planning for healthy communities, reducing the risk of cardiovascular disease and type 2 diabetes through healthy environments and lifestyles. Prepared by Deakin University in partnership with the National Heart Foundation of Australia

The recommended strategies to be adopted in the promotion of physical activity in Campaspe can be broadly classified as; population approaches and individual approaches. The main approach that has been adopted both in Australia and internationally to promote physical activity is a population approach (policy and environmental strategies, and mass media). Multi-level, multi-strategy approaches that emphasise combined environmental, policy and individual strategies are likely to be the most effective in promoting sustained increases in physical activity in the population (Deakin Uni, Dept of Health Sciences, 2000).

More than half of all Australian adults (57%) are not achieving sufficient levels of physical activity for a health benefit, and almost 15% are completely sedentary. There is evidence that physical activity rates in Australia are declining (Armstrong et al. 2000). The cost of physical inactivity is associated with high direct costs conservatively estimated at $400 million per year. About 8,000 preventable deaths each year are associated with physical inactivity, which ranks second only to tobacco as the largest contribution to the overall burden of disease (Bauman et al, 2002).

The greatest public health gains are to be achieved by encouraging even small increases in physical activity among the least active Australians - that is, those who are sedentary and engaging in low levels of activity. Current recommendations state individuals can gain health benefits from accumulating, on most days of the week, 30 minutes or more of moderate intensity physical activity in minimum bouts of around 10 minutes (Bauman et al, 2002).

The mental health benefits of physical activity have been recognised for many decades. Recent reviews have shown that aerobic exercise or strength training programs can reduce the symptoms of depression (Paluska and Schwenk 2000). Physical activity is as effective as meditation or relaxation in the treatment of anxiety. A recent controlled trial found that exercise training among older adults was as effective as antidepressant medication, although the onset of benefits was slower (Blumenthal 1999). [2]

Program Outline

Problem Definition:

Program Goal
To increase participation rates in physical activity

Program Objectives
1. To decrease barriers and increase availability of opportunities supporting physical activity
2. To coordinate and support sustainable implementation of older adults physical activity programs
3. To develop a localised supportive environments framework to increase children's participation rates
4. To increase social connectedness opportunities through physical activity

(Victorian Division) and Diabetes Australia – Victoria for the Victorian Department of Human Services, State of Victoria.
[2] Campaspe Primary Care Partnership (August 2004) Physical Activity Literature Review – completed by Helena Thorpe.

Population Target Groups
Children (5 – 12)
Young people (12 – 25)
Older Adults (55+)
30 – 55 year olds; (working women; middle aged men and women; mums with young children)

Solution Generation

A key stakeholder planning session was employed for goal, objective and strategy development. A combination of interventions have been adopted for this plan based on the literature review conducted; existing work plans (particularly for the Falls Prevention Project), and on the collective work completed at the strategies workshop by major stakeholders. Findings have informed the strategies as outlined in the Summary Planning Grid.

Community and Women's Health funded services have contributed greatly to the determination of the plan. Their contributions to the project primarily consist of being the key agencies for implementation of the interventions with some cross over into capacity building. The Women's Health funded service for Campaspe is Loddon Mallee Women's Health who plan to ensure that a gender focus is incorporated into relevant policy and practice objectives of our PCP and others in the Loddon Mallee Region.

Other agency involvement has been included in the plan where is fits under their core business. Many agencies have also nominated to take on extra responsibilities to ensure all activities outlined will be implemented.

Capacity Building-Support and Resources

Campaspe Primary Care Partnership is committed to supporting this priority area for 2004 – 2006 with project coordination to be provided by the PCP Health Promotion Project Manager. This will predominantly be through the continuation of a partnership approach and facilitation of cooperation between the partners/agencies.

In addition to this resource, Organisational Development will be supported with the continuation of the PCP Health Promotion Steering Committee and commencement of the Physical Activity Consortium which will act as a project reference and steering group. Agencies will also be supported to ensure there is a strong organisational focus on the project.

In terms of Workforce Development it is acknowledged that this is a major component of the projects needs. It is envisaged that a workforce development plan be developed which will then allow for prioritisation of professional development need areas. This is to be discussed and decided collaboratively to ensure all needs are met for each of the priority areas and target groups. It is also envisaged that this will evolve with the project's implementation to ensure it is reflective of issues and barriers that arise.

Information resources have been decided as key tools to support this project and therefore allocations have been made to support their production. Human resources/time has also been allocated to support evaluation planning for each of the components of the project also.

Evaluation and dissemination planning

A number of evaluation tools are already in existence and use in Australia for physical activity measures. The relevant tools will be incorporated into the evaluation plans developed for this project. It is envisaged that each area/objective of this plan will develop an Evaluation Plan. This will be completed with the relevant project working groups at their initial meetings to define for each strategy and action the relevant evaluation question; expected reach and impacts; the key performance indicators; the appropriate measuring tool; data source and the timing of the measurement. This process will follow Campaspe Primary Care Partnerships Evaluation Planning Procedure which adopts the Program Logic approach to evaluation.

Integrated Health Promotion Summary planning grid

Priority Goal:	To increase participation in physical activity
Objective 1:	To decrease barriers and increase availability of opportunities supporting physical activity
Est. Impacts (Qual/ Quant) for Objective 1	90% of agencies participating Physical Activity Consortium implement PA strategies into agency business 80% of attendees/participants of training opportunities improve their knowledge and skills in evidence based PA strategies 50% of attendees/participants implement evidence based PA strategies Increase in number of PA opportunities being provided in communities Barriers to participation addressed in strategic planning processes 30-50% of target groups report increase in participation 50% of target groups report knowledge of key project messages

PCP key stakeholders	Summary of mix of Interventions & CB strategies	Population Target Group/s:	Estimated timelines	Estimated Reach	Resources per key stakeholder for Obj1
Community Reps	Establish Physical Activity Consortium with community sector representation Involve community in working group level of PAC Increase community knowledge and perceptions of PA opportunities and benefits Promote community leaders as PA champions	Children (5 – 12) Young people (12 – 25) Older Adults (55+) 30 – 55 year olds; (working women; middle aged men and women; mums with young children)	October – January to commence	5-10 community representatives / identified community leaders	Involvement in local community action groups; Physical Activity Consortium; working groups
Community Health	Physical Activity Consortium/working group involvement Assist in leading working groups Participate in and develop workforce training/skill development plan Develop communication and social marketing plan Create a supportive community culture for PA		October – January to commence November – February November to March Ongoing	15-20 agencies	ERH HPO 1 day/ week (.2 EFT) KDHS HPO ½ day/week (.1 EfT) KDHS Coord 2 days/month (.1 EFT) REDHS Coord 2 days/month
Women's Health	Physical Activity Consortium/working group involvement to ensure inclusion of a gender focus		October – January to commence		LMWH

PCP key stakeholders	Summary of mix of Interventions & CB strategies	Population Target Group/s:	Estimated timelines	Estimated Reach	Resources per key stakeholder for Obj1
Local Government	Establish Physical Activity Consortium Drive older adults strategies via Falls Prevention project Support other sub target group strategies Create a supportive culture for PA – involvement in communication and social marketing plan Integration with related planning processes Support development of local brochures Investigate planning and development opportunities supporting PA Participate in Workforce development opportunities Investigate supportive transport options Participate in and develop workforce training/skill development plan Develop communication and social marketing plan Create a supportive culture for PA within organisation		October – January to commence (see above)	1 agency links to 10-15 community groups	Falls Prevention Project Officer Recreation Services Planning Children's Services: involvement in children's working party Youth Services: involvement in young peoples working party
GPs and Divisions	Physical Activity Consortium/working group involvement			Meeting attendance	Area manager

PCP key stakeholders	Summary of mix of Interventions & CB strategies	Population Target Group/s:	Estimated timelines	Estimated Reach	Resources per key stakeholder for Obj1
Sports Focus	Involvement in Physical Activity Consortium and related working/interest groups Investigate and define barriers to participation specific to related target groups			85% meeting attendance	Program coordinator
Community Houses	Physical Activity Consortium/working group involvement			2 agencies	Representatives
Education	Physical Activity Consortium/working group involvement			2 school reps	Representatives
Other	Involve Sport and Rec., YMCA and all other key stakeholders				Representatives
PCP HP Capacity	**Building**				
Organisational Development	Build partnerships and facilitate cooperation via the Physical Activity Consortium. Provide project/strategy coordination Develop Communication and social marketing plan for project messages Create a supportive culture for PA Re-structure the PCP Health Promotion Steering Committee to support commencement and participation in the Campaspe Physical Activity Consortium and reduce duplication Incorporate PA with other planning processes Develop performance management system/indicators to support implementation by all agencies/groups	Children (5 – 12) Young people (12 – 25) Older Adults (55+) 30 – 55 year olds; (working women; middle aged men and women; mums with young children)	Commencing October 2004 – June 2006 October and December 2004 meetings Ongoing via Planning Reference Group Incorporate into evaluation plan	15 – 20 agencies 8 – 10 member agencies	0.1EFT PCP staff $14,500 Meeting costs $4,800 $10,000 for marketing strategy Support to agencies $2,000

PCP key stakeholders	Summary of mix of Interventions & CB strategies	Population Target Group/s:	Estimated timelines	Estimated Reach	Resources per key stakeholder for Obj1
Workforce Development	Participate in Evaluation Skills Development project Facilitate evaluation plan development and completion for the project Improve service provider knowledge of IHP/preventative strategies specific to PA – conduct forums/workshops with support of Peak Bodies addressing barriers to participation, evidence etc. Develop workforce training/skill development plan Provide support for HP and create networking opportunities for service providers Link local services providers closely with DHS Capacity Building initiatives Provide opportunities for professional development Continue to produce a quarterly HP newsletter for Campaspe region – working group reports to feed into newsletter		September to March 2005 January to March 2005	3 agencies 4 workshops (per objective)	$10,000 to implement training plan Catering/ meeting costs $1,000
Resources	Project coordination, facilitation Evaluation (including planning and report coordination) Develop PA brochures Participate in LMR Capacity Building working group Agencies to provide representation on the HPSC/network			500	0.1EFT PCP staff $14,500 $12,000 $4,200
Estimated Total Budget for Objective 1:					**PCP $73,000**

Priority Goal:	To increase participation in physical activity
Objective 2:	To coordinate and support sustainable implementation of older adults physical activity programs
Est. Impacts (Qual/ Quant) for Objective	80% of agencies participating in Falls Prevention Committee have older adults PA as organisational goal Increased awareness of PA opportunities by target group Number of sustainable PA programs being implemented across Campaspe

PCP key stakeholders	Summary of mix of Interventions & CB strategies	Population Target Group/s:	Estimated timelines	Estimated Reach	Resources per key stakeholder for Obj
Community Reps	Participation in working group (falls prevention committee) Participate in peer leader training Facilitate local PA programs under supervision of health/fitness professionals	Older adults (55+)	Ongoing bi-monthly meetings	10 community instructors trained	
Community Health	Develop community/peer education model utilising train the trainer for strength exercise program instruction & supervision Participate in Falls Prevention committee Provide education sessions to older adults on the benefits of PA Facilitate access to a range of programs across the Shire area – support community transition into fitness instructor model to ensure participants receive appropriate levels of strength training		October – June 2005 Bi – monthly meeting Ongoing – Safety week; Seniors week; Rural Health week Ongoing	100 participants in programs across 5 – 8 locations	KDHS CHN 2 days/ week (.4 EFT) KDHS Physio 0.16 EFT ERH CHN 1 day/month REDHS Physio 3 days/ month BHCG Physio 1 day/month
Local Government	Support a collaborative approach to sharing information, resources and planning via existing Falls Prevention committee		Bi-monthly meetings	6 – 10 agencies	Falls Prevention Project Officer
GPs and Divisions	Support Older adults exercise directory use and referral to programs (incorporating Active Script)		January- March	2 GP practices	Area manager

PCP key stakeholders	Summary of mix of Interventions & CB strategies	Population Target Group/s:	Estimated timelines	Estimated Reach	Resources per key stakeholder for Obj
Hospitals	Support Community Rehab Centre linking to access/provision of older adults exercise programs			No. of referrals	
Sports Focus	Support resource/directory development		January – June 2005	500 older adults	Program Coordinator
Community Houses	Support provision of older adults exercise programs		Ongoing weekly sessions	3-5 agencies 50 – 100 participants	Coordinators
PCP HP Capacity Building					
Organisational development	Support best practice model for strength training provision (community interface with COTA providers) Link in existing exercise programs to best practice model		January December 2005	80% of structured exercise programs	Falls Prevention working group Support to agencies $2,000
Workforce development	Up skill more health practitioners in strength training facilitation Evaluation planning		2005	3-5 practitioners	$3,000
Resources	Develop Older adults directory Project facilitation support		January – June 2005 ongoing		$3,000 0.1EFT PCP staff $14,500
Estimated Total Budget for Objective 2:					**$22,500**

Priority Goal:	To increase participation in physical activity
Objective 3:	To develop a localised supportive environments framework to increase children's participation rates
Est. Impacts (Qual/ Quant) for Objective	Schools endorse and implement framework (eg. schools implement policies and procedures; adopting PA goals; staff increase knowledge and skills in PA Health Promotion; allocate resources to support PA policy and procedures)

PCP key stakeholders	Summary of mix of Interventions & CB strategies	Population Target Group/s:	Estimated timelines	Estimated Reach	Resources per key stakeholder for Obj
Community Reps	Establish (and continue to implement where existing) Walking School Bus program	Children 5 – 12 years and the school community	February – December 2005	5 locations across Shire	
Community Health	Develop a framework/model from evidence based literature for adoption locally in Primary Schools Support schools adoption of the framework Provide education sessions for teachers Link diabetes & physiotherapy clients to volunteer system for Walking School Bus program		January – December 2005	4-8 Primary Schools 200 - 500 children 50 teachers 3 diabetes clinics	KDHS & ERH HPO 1 day/week (.2 EFT) ERH CHN 1 day/month REDHS 0.1 EFT
Local Government	Link to Transport Commissions after school program				
Schools/ Education	Implement Health Promoting schools framework with support from local community health services Gain involvement from Primary School Nursing program		June – December 2005	4 – 8 primary schools 200 - 400 children	
Sports Focus	Develop local brochure/resource guide specific to target group		January – June 2005	500 children	
Other					

PCP key stakeholders	Summary of mix of Interventions & CB strategies	Population Target Group/s:	Estimated timelines	Estimated Reach	Resources per key stakeholder for Obj
PCP HP Capacity Building					
Organisational development	Support framework development		January – March 2005	4 agencies	Support to agencies $2,000
Workforce development	Provide training seminar on effective strategies for working with children Evaluation Planning		Early 2005	15 HP practitioners 5 school teachers	$3,000
Resources	Project facilitation and support				PCP facilitation 0.05 EFT/1 day per month $7250
Estimated Total Budget for Objective 3:					**$12,250**

Priority Goal:	To increase participation in physical activity
Objective 4:	To increase social connectedness opportunities through physical activity
Est. Impacts (Qual/ Quant) for Objective	Increase in social connectedness opportunities for specific target groups (eg. isolated mothers) 70% of service providers attend mental health training and report improved knowledge and skills Number of agencies that incorporate mental health promotion into core work Number of programs that incorporate PA into programs Number of workplaces adopt PA programs and policies

PCP key stakeholders	Summary of mix of Interventions & CB strategies	Population Target Group/s:	Estimated timelines	Estimated Reach	Resources per key stakeholder for Obj
Community Reps	Involvement in Communities 'Get into it' Festival	All of community	June – October 2005	500	
Community Health	Develop and implement Workplace programs to support and encourage PA	30 – 55 year olds; (working women; middle aged men and women)	3workplaces per year	6 workplaces 10–15 people per workplace = 60 – 90	ERH HPO 1 day/week ERH CHN 1 day/month REDHS CHN 1 day/month
	Isolated mothers program development and implementation (KDHS)	Geographically isolated mums with young children	June to December 2005	8-15 participants	KDHS HPO .1 EFT
	Post natal depression program development (ERH)	First time mothers	January – December 2005	15 participants	ERH HPO .1 EFT

PCP key stakeholders	Summary of mix of Interventions & CB strategies	Population Target Group/s:	Estimated timelines	Estimated Reach	Resources per key stakeholder for Obj
Women's Health	Women in Employment project implementation in Campaspe	30 – 55 year olds; (working women; middle aged men and women; mums with young children)	February – June 2005	100-150 working women	LMWH ERH REDHS Bendigo Regional Breastscreen
	Girls in a Whirl training program inclusion of PA module	service providers		20 participants	LMWH
	International Women's Day activities				
	Magazine focus on physical activity (Wealth)	women in the LMR	September 2005 edition	3000 LMR 300 Campaspe	
Local Government	Support Communities 'Get into it' festival				
St Luke's	Plan and implement community 'Get into it' Festival	General community	June – October 2005	2 festivals in Campaspe	St Luke's workers plus stakeholder working group
Sports Focus	Promote Junior sports – school holiday based activities Particip'action' day	Young people and children	2005, school holidays	100 young people	Sports Focus

PCP key stakeholders	Summary of mix of Interventions & CB strategies	Population Target Group/s:	Estimated timelines	Estimated Reach	Resources per key stakeholder for Obj
PCP HP Capacity Building					
Organisational development	Support sustainability of workplace initiatives	Working women	Ongoing	PCP staff	Support to agencies $2,000
Workforce development	Support Melbourne Uni with Mental Health training for all agencies (MAP) as scheduled Provide training for mental health promotion and social connectedness Evaluation planning		January – June 2005	50 service providers	$3,000
Resources	Project facilitation and support		July 2004 – July 2006		PCP facilitation 0.05 EFT/1 day per month $7250
Estimated Total Budget for Objective 4:					**$12,250**
Estimated Total Budget per Goal:					**$120,000**

Ongoing Collaborative Initiatives

The Effective Follow Up of Suicidal Patients in Hospital Emergency Departments Project

This project commenced in 2002 and will be complete by March 2005. The project is a collaborative one involving each of the five PCPs in the Loddon Mallee Region in order the develop regional pathways and protocols to assist hospitals to provide effective follow up to patients who present at emergency departments and are not accepted by the mental health service for treatment/therapy. This project is part of the National Suicide Prevention Strategy.

The lead agency for the Campaspe PCP area is Echuca Regional Health with the other three smaller hospitals (Kyabram, Rochester & Rushworth) also committed to this project. Each hospital has a working group to develop the necessary process and personnel around this initiative. We are currently in Stage 3 of the project which involves working toward implementation of the process in the three smaller hospitals.

Aboriginal Communities within Campaspe

Campaspe PCP will continue to link and support Campaspe's Aboriginal communities with the work of the Primary Care Partnership strategy. The PCP will continue to enhance the current relationships and seek additional support for extended work with the communities in Echuca and Kyabram.

In addition, Njernda Aboriginal Corporation have identified the need for consistent Service Coordination practices within their organisation. The PCP funded Women's Health project will be extended to enable other program areas to adopt the Service Coordination philosophies in a culturally specific way. Integrating Health Promotion into these approaches will also be a key goal.

Information Communications Technology

The ICT strategy is underpinned by our membership with the Loddon Mallee Health Alliance (LMHA) in which the five Loddon Mallee Region PCPs pooled their Growing Victoria funding to develop an equitable IT infrastructure across the region to improve communications for all primary care agencies who are PCP members. The LMHA is currently rolling out the communications physical connection through the primary care agencies who choose to connect. This will be beneficial to all agencies, whether large or small, in providing cheaper phone and internet costs, faster transfer of data, and with remote sites achieving benefits from improved connectivity.

In addition to this infrastructure enhancement, we continue to support the ConnectingCare electronic Service Directory both in providing up to date information for each agency and as a valuable resource for referral information.

We continue to be proactive in promoting electronic referrals as the most secure and efficient method of referral. We are currently engaged in a pilot project to encourage e-referrals between GPs and primary care service providers in Campaspe. This pilot has engaged two general practices and four primary care agencies. On completion of the pilot there will be further rollout to other agencies and GP practices

to implement this strategy as can be seen in the Service Coordination Plan. It also includes strategies and goals to further promote and support IT friendly Service Coordination strategies.

Consolidating Planning Processes

Supporting the Municipal Public Health Plan to become the key strategic planning document for Campaspe is another key area for PCP involvement. This will require consolidation of the priority needs determination process to include regular updating of community consultation information and statistical data analysis.

Incorporating these elements and roles into a collaborative planning framework will be supported by development and adoption of a planning policy, guidelines and protocols for the Campaspe region. This allows the incorporation of the Municipal Public Health Plan and Community Health Plan being able to inform not only agency planning processes but collaborative committee/action group plans as well. Development of this system will also include mechanisms for other plans to inform the Municipal Public Health Plan and Community Health Plan to make it an inclusive approach to planning.

Supporting Innovation and Service Developments

Campaspe PCP is committed to supporting innovation and will continue to foster potential developments that enhance our service system and gain better outcomes for our communities. Being proactive by utilising opportunities like funding rounds, partnerships with other state departments and sectors in supporting innovation and service developments will be concentrated on their potential to link to achieving Service Coordination and Integrated Health Promotion.

Regional Opportunities

Campaspe PCP will continue active membership in the Loddon Mallee Region PCP Network with key areas for involvement including the sharing of resources, regional representation and continued collaboration on relevant projects/tasks.

Appendix 1

Priority Setting Matrix for Service Coordination 2004 - 2006

Program Area	DHS Strategic Directions 2004-2006	Regional DHS Plan	MPHP identified needs	Other Data Indicators	IHP links	Service system gaps/ inconsistency	Recommendation from PCP Mgt Gp/ Steering Committee	Local Service Provider indicators incl carry over from last CHP	Urgency Level (1-not essential/ 2-essential/ 3-mandatory)	Capacity of Agencies To respond	Is there staffing capacity	
Disability services	Implement Internal services	Implement Internal services	Improved coordination		DHS / NGOs	Other than aged & Disability		New affiliate member	2	Funded/agreement	Not specified	
Early Childhood Services	Implement Internal services	Implement Internal services	Childcare services		DHS / NGOs				2	Funded/agreement	Not specified	
Drug & Alcohol	Targetted		More needed		Mental Health	Need more services		ERH	2	Funded/agreement	Not specified	
GPs	Targetted		Improved coordination with GPs			Not enough GPs		GP integral part of SC strategy E-referral project	3	Difficult	Not specified	
Sub-Acute	Targetted			Cardio/ cancer	Support chronic illness				2	Funded/agreement	Not specified	
Mental Health	Targetted			Suicide project	Support mental health			Suicide project to Mar 04	1		Not specified	
Outpatient Services				Improve GP engagement (DGPV)	Chronic illness				1		Not specified	
Existing Programs Further development	To be developed further		Improve assessment & coodination		Mental health/ chronic illness			Interagency protocols/ care planning	3		Not specified	

Prioritisation Matrix
Campaspe PCP Service Coordination Planning 2004-2006

Strategic Impact What strategies will deliver the greatest returns for consumers & carers		**Urgency** Greatest need for action to address gaps/inconsistencies in service coordination	
High Critical to future performance of service coordination impact	**Auditing** current policies & protocols and developing a benchmark standard **Develop PPPS** for Assessment & care planning of clients Progress work of **E-referral** pilot project and expand it into broader primary care sector Continue to **support GPs** to improve quality of referrals and care planning through use of the SCTT tools **Disability Services and Early Childhood Services** were identified for the best opportunity for service coordination impact in the next 2 years. This will build on the Regional DHS office targeted these 2 program areas for implementation by 2006. Also, of our new affiliate members, those providing disability and early childhood services are willing and have the capacity to move towards implementation in the near future. They are supported by DHS funding & service agreements.	**High** Obvious need for improvement. Immediate action required	Need to **assess** standard of existing protocols and develop a benchmark standard to adhere to Need to develop **PPPS around assessment & care planning** Need to maintain momentum from **e-referral** pilot project and roll out to broader sector to maximise impact of more efficient referral process. **GPs** are involved in most episodes of health care and as such must move toward the service coordination system to ensure the success of a well coordinated care system for clients. E-referrals are the most efficient means for GPs to embrace this system as they all operate from Medical Director software. HACC Aged & Disability services have already integrated the service coordination system and targeting other **disability services** will strengthen this approach. **Early Childhood Services** are also seen as being strongly influenced by DHS early childhood services, particularly MCHS and Early Intervention services.
Medium Supportive of future performance, compliments critical activities		**Medium** Growing need for improvement. Action required in 6 months	Campaspe has a shortage of **Drug & Alcohol Services**. Utilising the SC system will improve quality of care. ERH is the only service provider and has committed to implementation as part of the overall SC implementation strategy. **Mental Health Services** would greatly benefit from the SC approach, especially as they are already partially involved through the Effective follow up of Suicidal clients project.
Low Limited influence on future performance	Both **DHS Mental Health and Drug & Alcohol Services** remain difficult to engage due to conflicting requirements internally. Until this is resolved we cannot start work on implementation.	**Low** Need for improvement not apparent. Action not needed.	

Decision Criteria/Priority Setting Matrix for Integrated Health Promotion

ISSUE	Ambulatory Care Sensitive Conditions study	Burden of Disease	Other Data Eg hospital admissions etc	Community Consultation/ identified need	Service system gaps/ Lack of resources	Recommendation from PCP Mgt Gp/ Steering Committee	MPHP identified need	Involves intersectorial collaboration (including community)	Is there staffing capacity/potential? Can action be taken?	Opportunity to link to other funding sources	Links to PCP Strategic Directions	Link to national, statewide and regional priorities	Links to local agency plans/core business	Other
Physical Activity	✓ angina, diabetes complic.	✓ heart disease, physical inactivity, obesity, high bl. pressure	✓ diabetes, angina,	✓ identified in Kyabram consultation /community plan	✓ no walking strategy, min. access to fitness centres		✓ parks walking track, footpaths, public ex. areas	✓ LG town planning, recreation, CAGs, education, sport&rec. transport, environ.	✓ current work being done	✓ VicHealth, DHS Falls Prevention, C'wealth		✓	✓ KDHS, ERH, REDHS, St Lukes, Sports Focus, SoC	
Food & nutrition	✓ heart disease, dental, diabetes complic.	✓heart disease, colon cancer, phys. Inactivity, high bl. Pressure, obesity,	✓diabetes complic. Cardiac, angina	✓ identified in Kyabram consultation /community plan	✓dietetics services limited with waiting lists		✓food safety	✓LG, education, health services	✓ Community health	✓C'wealth funding (future)		✓	✓	low fruit & veg intake cholesterol
Mental wellbeing/ social connected-ness	See CMHP			✓	✓lack of/limited prevention services avail in Campaspe		✓suicide prevention, support services/ counselling, mental health, grief & loss	✓schools, mental health, community health, LG, commuity	✓St Lukes, CAMHS limited	✓ VicHealth		✓	✓ BHCG, St Lukes, SoC, Social Work services, drought strategy	
Tobacco, alcohol & other drugs	✓ angina, asthma, COPD	✓heart disease, lung cancer, stroke, tobacco, high blood pressure,	✓angina, road accidents	✓Ky plan yp smoking	✓lack of/limited prevention services		✓support services/ counselling, GP,	✓ schools, police, LG,	Limited	✓ limited, no state or C'wealth		✓	✓ ERH, SoC	alcohol harm
Healthy weight	As per Physical Activity and Food & Nutrition													
	A - evidence			**B – capacity building**						**C - strategic**				

Prioritisation Matrix Workshop/Discussion Tool – Catchment Wide Integrated Health Promotion Planning 2004

Strategic Impact [PCP performance relates to achieving Integrated Health Promotion; opportunity for range of stakeholders to be involved]		**Urgency** [need for action of this opportunity to improve the health and wellbeing status of the community]	
High [critical to our future performance/ achieving Integrated HP]	**Physical Activity** (high potential to achieve IHP and agency involvement; links to existing work areas; will contribute to PCP performance)	**High** [obvious need for improvement; negative consequences are apparent; require immediate action]	**Physical Activity** (see evidence section of Weighted Decision-making Criteria Tool) **Mental Wellbeing & Social Connectedness** (strong evidence links with social determinants of health) **Food & Nutrition** (see evidence section of Weighted Decision-making Criteria Tool)
Medium [supportive of future performance; complements the critical activities of the PCP]	**Mental Wellbeing & Social Connectedness** (lack of strong local data/evidence, limited capacity of agencies to respond) **Food & Nutrition** (limits agency involvement to Health services primarily – less inclusive of other agencies/sectors)	**Medium** [growing need for improvement; negative consequences are beginning to show; action reqd. within 6 mths]	
Low [limited influence on future performance]		**Low** [need for improvement not apparent; action not reqd. within a year]	