Campaspe Health Needs Analysis Project

Echuca Regional Health

KYABRAM HEALTH

redhs

SHIRE OF CAMPASPE
Lifestyle & Opportunity

phn MURRAY
An Australian Government Initiative

Campaspe Primary Care Partnership

BENDIGO HEALTH

Njernda Aboriginal Corporation

GV Health

Implementation Plan

2016 – 2020

Contents

Prepared by the Campaspe Health Needs Analysis Reference Group, May 2016.

Glossary

ADIS	Alcohol Drug Information Service
AOD	Alcohol and other drugs
ATSI	Aboriginal and Torres Strait Islander
BH	Bendigo Health Care Group
BMI	Body Mass Index
CH/CHS	Community Health/Community Health Service
CPCP/PCP	Campaspe Primary Care Partnership
DHHS	Department of Health and Human Services
ERH	Echuca Regional Health
ECAT	Enhanced Crisis Assessment Team
GVH	Goulburn Valley Health
GP	General Practitioners
HPLG	Health Promotion Leadership Group
HPO	Health Promotion Officer
HTV	Healthy Together Victoria
IHP	Integrated Health Promotion
KDHS	Kyabram District Health Service
LMICS	Loddon Mallee Integrated Cancer Service
Murray PHN	Murray Primary Health Network
MH	Mental Health
MPHWP	Municipal Public Health and Wellbeing Plan
Njernda	Njernda Aboriginal Corporation
OCP	Optimal Care Pathway
REDHS	Rochester and Elmore District Health Service
SoC	Shire of Campaspe
VPHS	Victorian Population Health Survey

Introduction

Health services within the Campaspe local government area have established a partnership approach to look at ways to address the issues that have the most impact on their services collectively. The structure used to support this approach was developed in 2015 by the Victorian Department of Health and Human Services and referred to as the Service Planning Logic model.

The key partners sought to use the planning logic to develop a combined service plan/implementation plan that considers system needs and capabilities; innovation; investment priorities; area needs and capabilities; and technical guidelines.

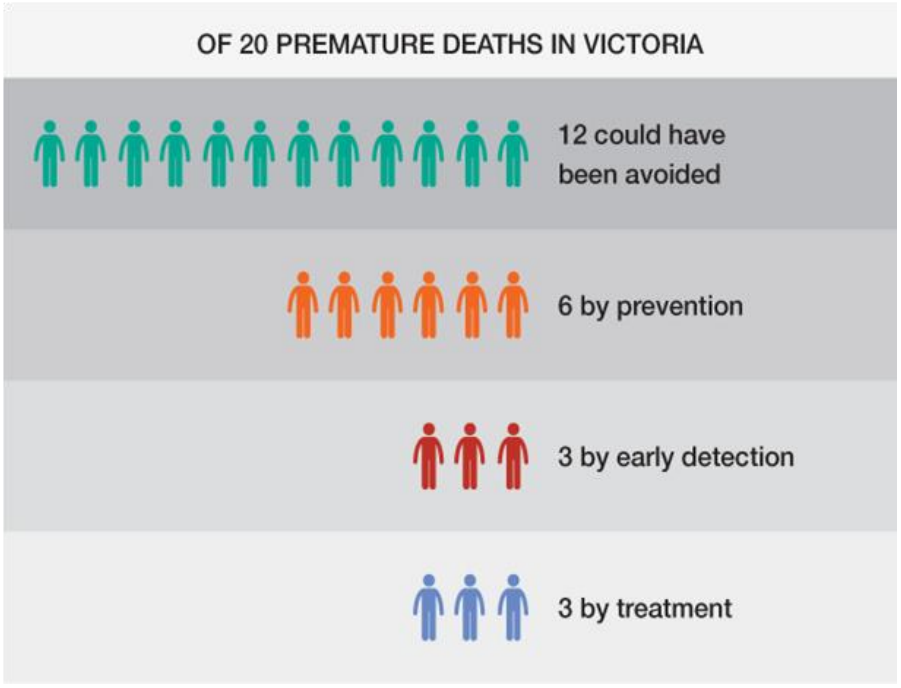
Project partners

Echuca Regional Health, Rochester and Elmore District Health Service and Kyabram District Health Service initiated this project. Each represents significant health services within the Shire of Campaspe. This group was broadened in recognition of additional significant partners to include the following as the Campaspe Health Needs Analysis Project Reference Group;

- Echuca Regional Health
- Rochester and Elmore District Health Service
- Kyabram District Health Service
- Murray Primary Health Network
- Shire of Campaspe
- Bendigo Health
- Goulburn Valley Health
- Njernda Aboriginal Corporation
- Department of Health and Human Services, and
- Campaspe Primary Care Partnership

The project also has the support of neighbouring state local government of Murray Shire Council in New South Wales.

Victorian data



Burden of disease due to risk factors (Australia 2010)

- 10.5 per cent dietary risks
- 8.5 per cent high body mass (excess weight for height)
- 8.3 per cent smoking
- 7.0 per cent high blood pressure
- 4.6 per cent physical inactivity
- 4.0 per cent high fasting plasma glucose (diabetes and pre-diabetes)
- 2.9 per cent high total cholesterol
- 2.8 per cent alcohol use
- 2.6 per cent drug use
- 2.2 per cent occupational risks (Institute for Health Metrics and Evaluation 2013)

Priority issues

Five key health priorities were identified by the Campaspe Health Needs Analysis Project Reference Group based on local health and wellbeing data and as having the most significant impact on health services and communities in the Campaspe local government area. The priority issues include;

- Drug & Alcohol
- Mental Health
- Obesity
- Cancer and
- Diabetes

Individually, each health service has varied capacity and capability to address these key issues within their catchment community. However to address many of the related system and area issues, a more collective approach would provide a more robust response. Integration of services that support these key priorities is limited at present with each health service providing variation of services generally based on historical service specific funding.

Purpose of the project

The key aim of this project is to coordinate and integrate the services provided at each health service primarily to provide evidence based interventions across the continuum of care for each of the priority issues for the Campaspe catchment. Each of the project partners recognise the importance to plan and invest in a way that:

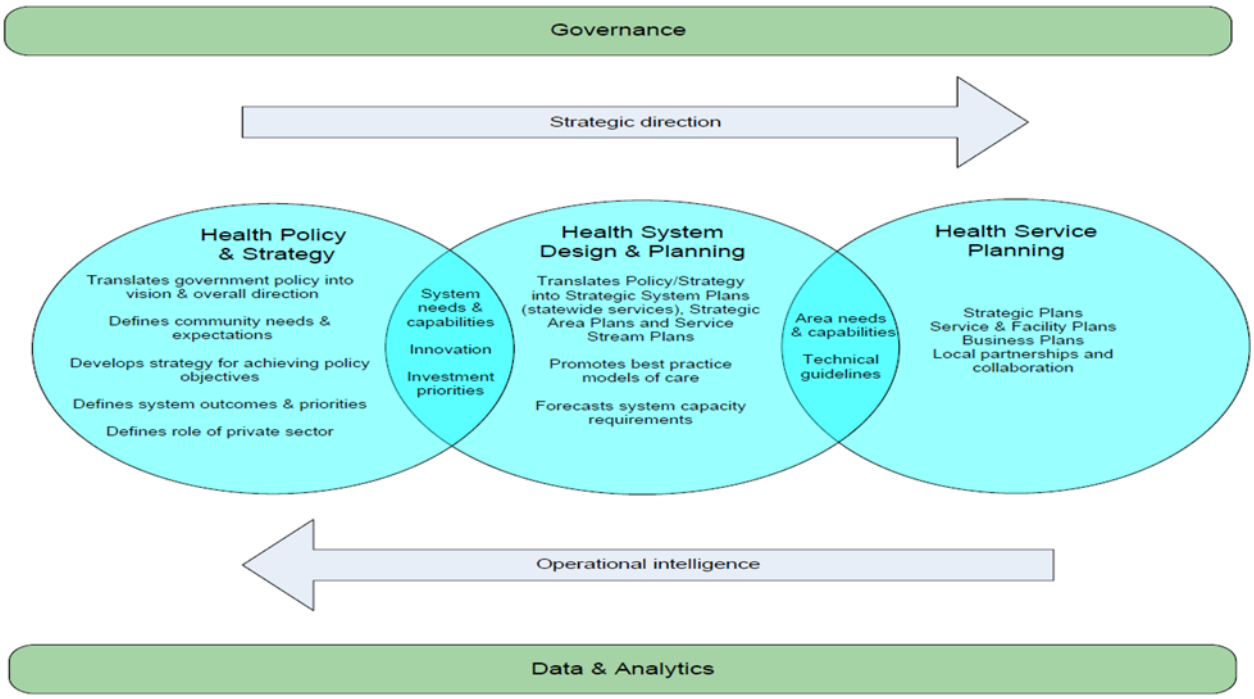
- Optimises the systematic connections and integration between its services;
- Aligns combined efforts to a shared understanding of health needs and priorities of people living within the Shire of Campaspe, and;
- Applies this understanding as the basis to explore opportunities to strengthen health service integration and to initiate strategies that target health needs and priorities for residents of the Shire of Campaspe.

The initial scope of work has been completed by Campaspe Primary Care Partnership on behalf of the project partners. It included three distinct areas of activity as follows:

1. Develop a clear and succinct summary of the agreed health priorities that impact people living in the Shire of Campaspe.
2. Develop and implement a robust engagement process with identified health services and other relevant stakeholders, and;
3. Drawing upon the previous steps, develop recommendations and draft an implementation plan to strengthen the integration and provision health services within the catchment area to address identified health priorities.

Service Planning Logic

The following diagram was developed by Adam Horsburgh and Bruce Prosser from the Department of Health and Human Services Health Service Performance & Programs Division (March, 2015). It describes the key principles and intent to guide health system service planning.



In using this model as a guide to develop this Implementation Plan; the following considerations were given to each of the specific elements in the Service Planning Logic and were used to inform and shape the processes applied;

Governance

- A reference group for this project was established in November 2015 to oversee development of a project that created a collective area based plan for the Campaspe area

Data and analytics

- The Campaspe Health and Wellbeing profile: http://www.campaspepcp.com.au/community-profile.php provided the majority of the base data for our catchment for the five key priority areas. Further to this evidence summaries were prepared for each of the priorities that considered specific policy context and any additional local data

Operational intelligence

- Consultation with partner organisations occurred via interviews with the project manager to review each organisations service profiles in relation to the priorities along with capacity and capabilities
- Consultative planning workshops were conducted to gain service provider knowledge and input to support a systems approach and rational for investment priorities

System needs and capabilities

- Systemic issues were identified in planning workshops with consideration given to the capabilities of services in Campaspe; gaps/issues and areas for improvement

Innovation

- Coordinated partnership approach – collective planning across multiple partners across the continuum of care

Investment priorities

- Project partners set priorities by determining the key objectives/strategies to be included in the implementation plan as recommended from the planning workshops
- Resourcing of the implementation plan – additional investment is being sought where possible, primarily through funding submissions and consideration of existing internal resourcing from project partners

Area needs and capabilities

- Campaspe priorities set are based on current impact on services and costs to the community
- Service and resource gaps considered in planning workshops specific to each priority issue

Technical guidelines

- Development of evidence summaries for each priority issue that detailed local data, policy context, best practice approaches/evidence based interventions; and clinical guidelines across the continuum of care from health protection; health promotion; illness prevention; primary care; secondary care; tertiary; quaternary care; rehabilitation and end of life.

Process applied for this project

The project was approached in three key stages to aid development of a catchment wide plan that considers the priority areas across the continuum of care.

Phase 1: Preparation of Evidence Summaries to inform planning

The evidence summaries provide for each priority

- A data profile of the health status information
- Policy reviews from state and national sources
- Clinical guidelines and intervention evidence across the continuum of care
- Local programs and services and service access

Evidence of relevant interventions that support the priority areas based on primary, secondary and tertiary care including systematic reviews, meta analysis, clinical guidelines and pathways were researched to develop each evidence summary. In addition, mapping of of current service delivery arrangements, service activity and service demand along with programs and services that respond/meet the relevant intervention/care provision was conducted to provide local context.

Phase 2: Engagement, consultation and collaborative planning

Current impacts on services for each of the priority areas were discussed in consultation with key partners. This included

- the significance of the issues/priority areas on the organisation, and
- determining current funded programs in the organisation that relate to the priority areas.

This information was added to the evidence summaries including current accessibility, responsiveness, utilisation and location of services/travel requirements.

A series of workshops were then delivered with participation from 82 health and community service providers in total (between 14-18 attendees at each of the 5 workshops) ranging from police, disability, local government, health practitioners, primary care networks, medical services and community health. The purpose of these workshops was to review clinical guidelines and evidence based interventions across the continuum of care from health protection; health promotion; illness prevention; primary care; secondary care; tertiary, quaternary care, rehabilitation and end of life; service access and resources gaps and determine service planning priorities for the four year implementation plan.

Phase 3: Recommendations and implementation needs planning

Recommendations for each priority area were then prioritised by the project reference group. The criteria considered in this prioritisation process included

- strategic impact
- urgency to address
- capacity to respond and address the strategy, and
- potential for collective impact.

Draft implementation plans were provided to the reference group for feedback and modifications prior to producing the final plan. Each priority area has nominated an executive sponsor organisation to support sharing of the workload required to implement the plan.

Expected outcomes

There are two distinct areas that these expected outcomes are based on;

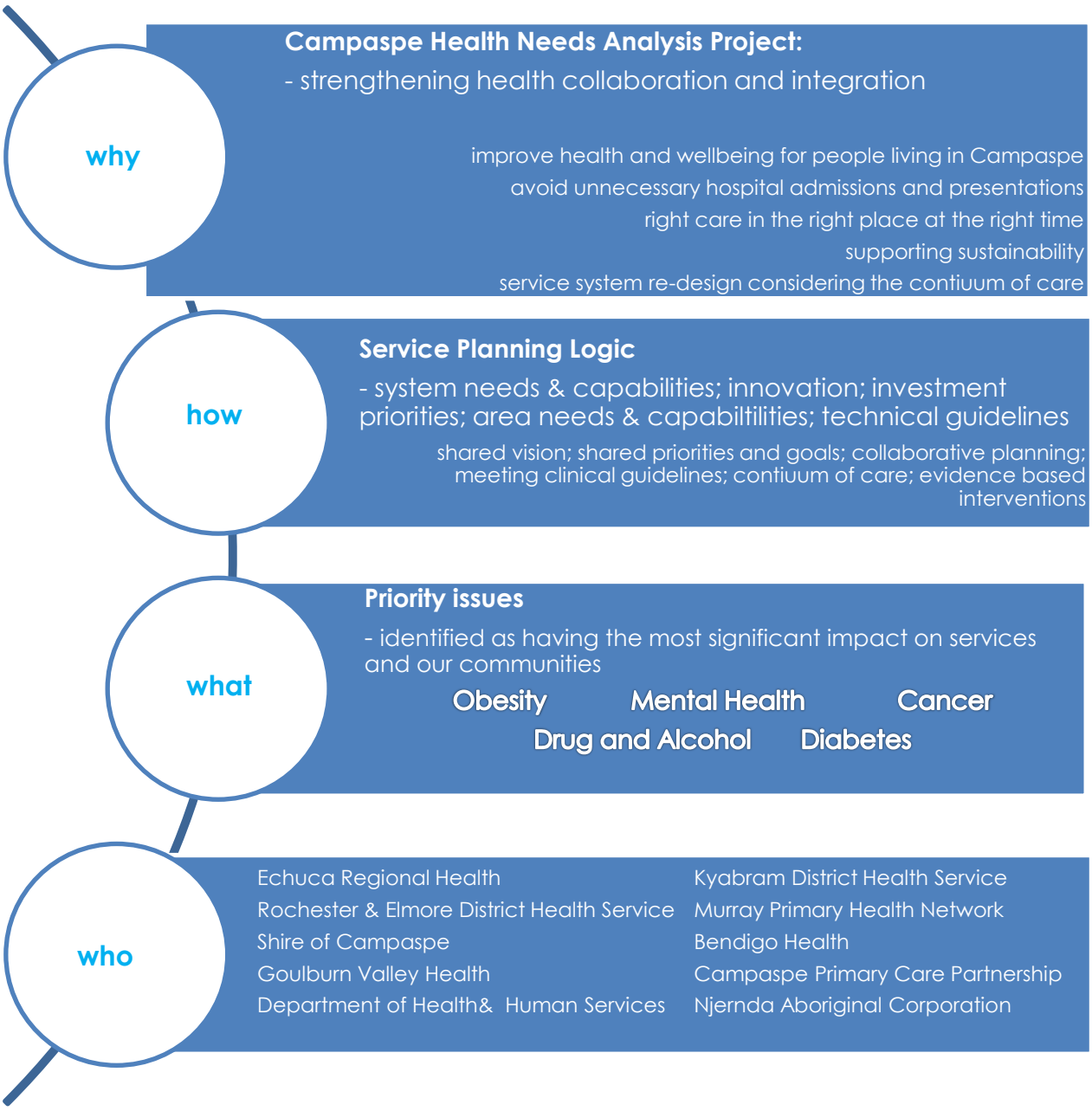
a. The achievements anticipated by working in partnership on the service planning logic model
b. The impacts and outcomes specific to each of the priority areas.

An overview of these outcomes are as follows;

Key focus area	Expected outcomes
Partnerships, collaboration and integration	Increased levels of integration and collaboration between services and planning structures - Linkages to partner organisations – Echuca Regional Health, Kyabram District Health Service, Rochester & Elmore District Health Service - Statement of Priorities, strategic plans and health plans notably Murray PHN, Campaspe Shire Municipal Public Health and Wellbeing Plan and Campaspe Primary Care Partnership strategic plan Evaluation of the application of the Service Planning Logic in creating health service performance improvements
Priority area 1: Obesity	Increased organisation adoption of systems approach and implementation of clinical guidelines
Priority area 2: Mental Health	Improved after hours access for mental health patients
Priority area 3: Cancer	Improvements in optimal care pathway adherence Increase in relevant screening rates by Campaspe residents
Priority area 4: Drug and Alcohol	Increase in alcohol and drugs services and accessibility for Campaspe communities
Priority area 5: Diabetes	Reduction in avoidable hospital admissions

Overall it is anticipated that over the four year period of this plan that a reduction in avoidable hospital admissions occur and to also see a reduction in the pressure that is in turn created on regional partners such as Bendigo Health and Goulburn Valley Health.

Framework – Summary



Priority Area: Obesity			
		Executive Sponsor	**Rochester & Elmore District Health Service**
Objective			Implementation Partners
1. To increase the organisational capacity of all partners to adopt the obesity clinical guidelines to support consistency across the Campaspe catchment			ERH, KDHS, REDHS, SoC, Campaspe PCP, BH, GVH, Njernda
Strategies	When/Timeframe	Resources Required	Measures/ Evaluation indicators
Organisational Development Working group to be formed to review strategies and timeframes; gather baseline data; develop meeting terms of reference and confirm evaluation measures	By August 2016	Project leader/representative required from each partner organisation Obesity steering group involving members from each partner organisation	Baseline data collected
Develop organisation policy and procedures to support application of clinical guidelines that are consistent across partner organisations	By December 2016		100% of PMT members adopt obesity clinical guidelines policy and procedure
Workforce Development Raise awareness of clinical guidelines with health professionals including definitions and management of obesity	January – March 2017		% improvement in application of clinical guidelines

Link to; advocate for and organise for government based campaigns to support social marketing and workforce training opportunities - 'Breaking the Silence: Talking to patients about weight loss' behaviour change training for health professionals	25 May 2016, Echuca Ongoing - ? online module access	Health and community service workers attendance in 2hr training	Number of attendees % of attendees that put into practice Standard measures recorded in patient records
Early intervention & Integrated Care Support and implement multidisciplinary teams [GPs, dietitians, nurses, exercise physiologists, behaviour therapists] for chronic and complex consumers to deliver effective diet and physical activity interventions	July 2017	Obesity steering group	% increase in number of chronic/complex consumers identified % increase in multidisciplinary teams care/case planning for chronic and complex consumers
Screening, risk assessment, intervention Screen for obesity during intake and reviews to ensure (i) data is collected to support organisational response (ii) appropriate measures are taken (ie. Waist measure; BMI calculation) to support early identification (iii) opportunities for interventions are implemented		Obesity steering group	% of all intake completed for each organisation
Early Intervention & Integrated Care Develop Campaspe specific obesity pathways that consider referral, feedback, care coordination, service accessibility/eligibility including psychosocial supports		Obesity steering group with Murray PHN Health Pathways	Pathway established Pathway useage (monitor)

Objective			Implementation Partners
2. To apply a systems approach with environment focus to reduce sedentary behaviours in communities across Campaspe			ERH, KDHS, REDHS, SoC, Campaspe PCP, BH, GVH, Njernda
Strategies	**When/Timeframe**	**Resources Required**	**Measures/ Evaluation indicators**
Social Marketing Challenge the culture of acceptance of obesity - Engage champions to talk about their weight loss /activity gains through local media - Press releases through local media and organisation newsletters raising obesity issues & prevention strategies	Every 2 months	HPO in each partner organisations to coordinate	VPHS Campaspe data – consumption of veg&fruit; sugar drinks; sedentary behaviours
Health Information Work with community groups and local media to inform community about physical activity guidelines across the lifespan and the Australian Dietary Guidelines focussing on messages of reduce portion sizes etc ie Livelighter campaign			Increased knowledge by community
Settings/Supportive Environments Local government to prioritise environmental supports that encourage physical activity, active transport, access to open spaces and public recreation ie. investment in Walking and Cycling strategy implementation and active seeking of resourcing; improvements and development of public recreation and open spaces	Ongoing	Shire of Campaspe – MPHWP implementation	Investment in infrastructure

Objective			Implementation Partners
3. Develop Campaspe specific obesity pathways that consider referral, feedback, care coordination, service accessibility/eligibility including psychosocial supports			ERH, KDHS, REDHS, SoC, Campaspe PCP, BH, GVH, Njernda
Strategies	**When/Timeframe**	**Resources Required**	**Measures/ Evaluation indicators**
Screening & Risk assessment Screen for obesity/collect data/measure appropriately to support early identification of high BMI	To be reviewed in 2018 for consideration as priority objective for implementation after initial 2 years of plan	Obesity steering group	Standard measures recorded in patient records
Early Intervention & Integrated Care Link with Murray PHN Health Pathways project and develop Campaspe specific pathway			Pathway developed
Ensure communication agreements exist and are implemented between local health services and GP practices to aid referral feedback and care coordination		Obesity steering group	Communication agreements in place

Objective			Implementation Partners
4. By June 2020, all partner organisations will set the benchmark for implementing healthy workplaces that enable staff to work in a healthy environment			ERH, KDHS, REDHS, SoC, Campaspe PCP, BH, GVH, Njernda
Strategies	**When/Timeframe**	**Resources Required**	**Measures/ Evaluation indicators**
Health Services Leadership – Organisational Development Health services to adopt health promoting workplaces principles and be actively implement the Healthy Together Achievement Program benchmarks for workplaces and health services - Implement workplace nutrition and physical activity policies	Linkage to Diabetes – objective 1 To be reviewed in 2018 for consideration as priority objective for implementation after initial 2 years of plan	Obesity steering group + working groups within each organisation	100% of partner organisations implementing policy
Offer employees access to workplace health programs, including risk assessment and risk modification programs			Participation in programs by staff
Support active transport and active behaviours at work ie standing desks, walking meetings, working/riding to work incentives			% increase in staff physical activity levels
Provision of walking and cycling tracks to support active transport		Local government	

Priority Area: Mental Health			
		Executive Sponsor	**Campaspe PCP**
Objective			Implementation Partners
1. To improve after hours access to specialist mental health services for Campaspe residents by June 2020			ERH, KDHS, REDHS, SoC, Campaspe PCP, BH, GVH, Njernda
Strategies	When/Timeframe	Resources Required	Measures/ Evaluation indicators
Organisational Development Working group to be formed to review strategies and timeframes; gather baseline data; develop meeting terms of reference and confirm evaluation measures	By August 2016	Project leader/representative required from each partner organisation Mental Health steering group involving members from each partner organisation	Baseline data collected
Integrated Care Review BH ECAT access for services within Campaspe for after hours access via telephone and videoconferencing - Establish working party to undertake review and recommend improvements - Look at current practice, barriers and enablers to	By December 2016	ERH and BH – time limited working party to review current practice	Recommendations report

achieving current access and referral pathways - Implement priority recommendations			
Investigate options to increase videoconferencing /telehealth access after hours - Ensure clinician competency in use of VC/telehealth – provide training to upskill where required; maintain skill/regular testing of use	2017 – 2018	Emergency dept; Urgent care centres	100% of emergency and urgent care clinicians competent in VC use % of relevant after hours presentations utilise VC
Advocacy & Leadership Advocacy to funders and politicians regarding impact of mental health crisis on emergency services - Prepare background document that refers to data impacts of MH patients for Campaspe	2016 - 2018	Victoria Police, Ambulance Victoria & ERH ED input	Document dissemination
Objective			Implementation Partners
2. Ensure local GPs are aware of local programs, services and related providers along with eligibility criteria to assist referral, feedback and care coordination pathways			ERH, KDHS, REDHS, SoC, Campaspe PCP, BH, GVH, Njernda
Strategies	When/Timeframe	Resources Required	Measures/ Evaluation indicators
Early Intervention & Integrated Care Link with Murray PHN Health Pathways and ensure Campaspe specific information is known; improve GP	2016	Murray PHN Murray Pathways project	% of GP and General Practice

practice knowledge on local services and access points			awareness of mental health services available Increased referrals from GPs to MH services Increase in coordinated care for MH consumers
Workforce Development Provide workforce training to GP practices about the pathways and referral options; also provide summary documents to aid GP awareness and linkages to relevant websites; newsletter communications	2017 - 2018		Communiqués to GP Attendance
Objective			Implementation Partners
3. Support communities and schools in implementing resilience programs for children/primary school aged that also address parenting supports			ERH, KDHS, REDHS, SoC, Campaspe PCP, BH, GVH, Njernda
Strategies	When/Timeframe	Resources Required	Measures/ Evaluation indicators
Health Education & Early Intervention Implement with primary schools resilience programs such as Kids matter, mindmatters to build resilience with children - Include parenting element to increase mental health literacy and parenting strategies	To be reviewed in 2018 for consideration as	Mental Health steering group	

Support communities to increase mental health literacy with programs ie. Mental Health First Aid, Suicide intervention skills etc	priority objective for implementation after initial 2 years of plan	Mental Health steering group	
Objective			Implementation Partners
4. To advocate for specialist/Psychiatrist access 5 days a week in Campaspe			ERH, KDHS, REDHS, SoC, Campaspe PCP, BH, GVH, Njernda
Strategies	When/Timeframe	Resources Required	Measures/ Evaluation indicators
Advocacy & Leadership Advocacy for specialist/Psychiatry access in Campaspe ie more visiting days required - support Health Services to have base information for business case proposals by gathering data and statistics report	To be reviewed in 2018 for consideration as priority objective for implementation after initial 2 years of plan	Mental Health steering group	Increased access to specialist care
Integrated Care Improve use of telehealth to support psychiatry accessibility - Improve knowledge and organisation readiness for telehealth connections with specialist services/providers - Review or develop if required telehealth processes and procedures for partner organisations			Increased capacity for telehealth Increased use of telehealth

Priority Area: Cancer			
		Executive Sponsor	**Echuca Regional Health**
Objective			Implementation Partners
1. To support LMICS to achieve optimal care pathways in Campaspe including expanded care coordination roles, supportive care and survivorship care			ERH, KDHS, REDHS, SoC, Campaspe PCP, BH, GVH, Njernda; LMICS
Strategies	When/Timeframe	Resources Required	Measures/ Evaluation indicators
Organisational Development Working group to be formed to review strategies and timeframes; gather baseline data; develop meeting terms of reference and confirm evaluation measures	By August 2016	Project leader/representative required from each partner organisation Cancer steering group involving members from each partner organisation	Baseline data collected
Integrated Care Establish a Campaspe specific working group/steering group recruited from health services to drive LMICS strategies towards achieving OCP for Campaspe including reviewing options for - Care coordination roles	2016 - 2018	Steering group with key representatives from organisations DHHS Survivorship	Terms of Reference Meeting participation/ attendance Resourcing to

- Supportive care - Survivorship care		funding – Murray PHN	achieve OCP
Advocacy & Leadership Work with potential funding sources and partners to resource local activities - LMICS - Cancer Council - Murray PHN - Universities - Philanthropic organisations			
Objective			Implementation Partners
2. To increase community awareness of the risk factors that contribute to cancer and the importance of screenings and increase screening rates			ERH, KDHS, REDHS, SoC, Campaspe PCP, BH, GVH, Njernda, LMICS
Strategies	When/Timeframe	Resources Required	Measures/ Evaluation indicators
Health Information & Education Develop clear messages (consistent with Cancer Council and Kyabram Cancer Screening project) for the community on the screenings relevant to undertake and local service access points	By December 2016	Cancer steering group	Campaspe messages developed; dissemination and marketing of messages
Consumer Engagement Engage with the community to recruit and train community advocates (consistent with LMICS) to relay the	2016 - 2018	Cancer steering group	Number of community advocates

messages to community groups and events		Cancer Council training for community advocates	Increased community knowledge of key messages Increased screening rates
Utilise existing fundraising events to promote clear messages regarding preventative risk factors, screening opportunities and optimal care timeframes		Cancer steering group	
Objective			Implementation Partners
3. Improve clinical handover and communication from specialists back to local GPs and services			ERH, KDHS, REDHS, SoC, Campaspe PCP, BH, GVH, Njernda
Strategies	When/Timeframe	Resources Required	Measures/ Evaluation indicators
Integrated Care Investigate options for care coordination planning between GPs, consumers, specialists and local oncology services to support multidisciplinary care - Develop local care coordination protocol - Gain input and agreement from disciplines involved - Implement protocol	To be reviewed in 2018 for consideration as priority objective for implementation after initial 2 years of plan	Cancer steering	OCP adherence Number of Multi-disciplinary care plans
Review processes that support more effective communication between practitioners involved in supporting people with cancer			

Objective			Implementation Partners
4. Establish support groups across Campaspe with Cancer Council Vic trained facilitators			ERH, KDHS, REDHS, SoC, Campaspe PCP, BH, GVH, Njernda
Strategies	**When/Timeframe**	**Resources Required**	**Measures/ Evaluation indicators**
Consumer Engagement Work with communities to establish cancer support groups across the Campaspe catchment that are facilitated by Cancer Council trained group leaders	To be reviewed in 2018 for consideration as priority objective for implementation after initial 2 years of plan	Cancer steering group	Number of support groups established

Priority Area: Drug & Alcohol		Executive Sponsor	Shire of Campaspe
Objective			Implementation Partners
1. To develop Campaspe specific access and referral pathway to improve service knowledge and referrals			ERH, KDHS, REDHS, SoC, Campaspe PCP, BH, GVH, Njernda
Strategies	When/Timeframe	Resources Required	Measures/ Evaluation indicators
Organisational Development Working group to be formed to review strategies and timeframes; gather baseline data; develop meeting terms of reference and confirm evaluation measures	By August 2016	Project leader/representative required from each partner organisation AOD steering group involving members from each partner organisation	Baseline data collected
Integrated Care Review current service access points for all AOD services; eligibility criteria and referral triggers; compare with existing referral pathways Prepare Campaspe specific referral pathway based on	2017 - 2018	AOD steering group to be including ERH, Njernda, REDHS, BH	Local pathway and access points disseminated to providers

current services available and MH reform system			Increased accessibility of AOD services Increased availability for AOD services
Link with Murray PHN HealthPathways projects to ensure consistency and appropriateness for Campaspe residents and services	2017 - 2018	AOD steering group	
Objective			Implementation Partners
2. To increase resourcing of AOD programs and services in Campaspe			ERH, KDHS, REDHS, SoC, Campaspe PCP, BH, GVH, Njernda
Strategies	When/Timeframe	Resources Required	Measures/ Evaluation indicators
Advocacy & Leadership Advocacy to improve/increase AOD service provision in Campaspe including counselling/casework; hospital based withdrawal; support groups; early intervention programs; rehab day model - Develop Campaspe specific data profile that includes ADIS/Turning Point data and local service data for use with potential funding opportunities - Develop draft business case	By December 2016	AOD steering group	Increased accessibility of AOD services Increased availability for AOD services
Meet with local politicians and local government council to advocate position	January – June 2017		Dissemination of local data report

Link to Murray PHN strategies related to AOD programs and services including Ice action plans and LM CHS AOD consortia	From July 2016		Implementation of initiatives in Campaspe/ additional resources for Campaspe
Organisational Development Establish a Campaspe AOD service provider network to support and monitor access and promote multidisciplinary approaches	January 2017 onwards		Netwok meeting ToR established and meetings held
Objective			Implementation Partners
3. Increase community knowledge and awareness of safe drinking levels and drug information			ERH, KDHS, REDHS, SoC, Campaspe PCP, BH, GVH, Njernda
Strategies	When/Timeframe	Resources Required	Measures/ Evaluation indicators
Organisational Development Link to Campaspe Shire MPHWP priority – to address culture of alcohol - Promote alcohol free events - Encourage sporting clubs to join Good Sports Program	2016 - 2018	AOD steering group Link with Healthy Workplace working groups	Number of alcohol free events held in Campaspe Number of 'Good Sports' accredited clubs
Review workplace culture and promotion of alcohol – create alcohol policy for organisations based on HTV Achievement program; consider screening dependent on			100% or organisations have adopted policies

risks within the workplace			and procedures
Community Education Work with community groups to provide community education sessions to improve knowledge, information and support linkages regarding AOD and local services - Expand ICE information projects from REDHS and KDHS across all communities in Campaspe - Work with local media to provide health information regarding alcohol and drugs and service access points			Number of community sessions held/Number of community groups engaged Number of media articles
Objective			Implementation Partners
4. Support resilience programs for young people			ERH, KDHS, REDHS, SoC, Campaspe PCP, BH, GVH, Njernda
Strategies	When/Timeframe	Resources Required	Measures/ Evaluation indicators
Review current program implementation across Campaspe schools and services - conduct mapping activity with schools and young people's services Review evidence base for relevant interventions/programs that address resilience	To be reviewed in 2018 for consideration as priority objective for implementation after initial 2 years of plan	Working group to be established involving Community Health, Schools, youth counsellors, CCLLEN	Mapping document Evidence based review completed

Work with schools to implement appropriate resilience programs and to develop policy that ensures maintenance of programs			

Priority Area: Diabetes			
		Executive Sponsor	**Kyabram District Health Service**
Objective			Implementation Partners
1. By June 2020, all partner organisations will adopt health promoting workplaces principles and be actively implementing the Healthy Together Achievement Program benchmarks for workplaces and health services *Support healthy food choices to be the easier choices for all by working across the entire food system* *Promote consumption of healthy foods consistent with the Australian Dietary Guidelines*			ERH, KDHS, REDHS, SoC, Campaspe PCP, BH, GVH, Njernda
Strategies	When/Timeframe	Resources Required	Measures/ Evaluation indicators
Organisational Development Working group to be formed to review strategies and timeframes; gather baseline data; develop meeting terms of reference and confirm evaluation measures	By August 2016	Project leader/representative required from each partner organisation Diabetes steering group involving members from each partner organisation	Baseline data collected
Health Services Leadership – Organisational Development Implement workplace nutrition, physical activity and smokefree policies using HTV Achievement program guides ○ Ensure consistency with Healthy Choices: healthy	2016 - 2018	Workplace HP committees to be established in each organisation (if not	Healthy Together benchmarks achieved for physical activity;

eating policy and catering guide for workplaces and Healthy choices: food and drink guidelines for Victorian public hospitals [HTV Achievement program] ○ Ensure vending machines within services/partner organisations eliminate unhealthy foods and high sugar drinks/ or provide healthy options ○ Review inpatient meal provision		already) to oversee Campaspe PCP HPLG to support collective approach	healthy eating, smoking 100% of vending machines in health services have no sugar&low fat options only 100% or organisations have adopted policies and procedures
Health Education & Early Intervention Provide employees with access to workplace health programs, including risk assessment and risk modification programs including of smoking cessation courses and supports for employees	From January 2017		Number of staff provided intervention/ engaged in programs
Supportive Environments Support active transport and active behaviours at work ie standing desks, walking meetings, walking groups			Reduction in sedentary behaviour in workplace
Walking and cycling tracks routes to workplaces to be audited to; - promote active transport - advocate with local government upgrades to infrastructure where needed - investigate innovative means to fund infrastructure upgrades ie fun runs/fundraising; funding submissions etc	By December 2016		Audits completed and findings disseminated to local government

Objective			Implementation Partners
2. To enhance/create physical environments that support active lifestyles/physical activity			ERH, KDHS, REDHS, SoC, Campaspe PCP, BH, GVH, Njernda
Strategies	**When/Timeframe**	**Resources Required**	**Measures/ Evaluation indicators**
Link with Shire of Campaspe MPHWP – improve, develop and promote safe walking and cycling tracks; develop and improve access to public recreation and open spaces Refer to Obesity Objective 2 also	2016 - 2018	HPO/Project Officer at local government	
Objective			**Implementation Partners**
3. To conduct screenings with key target groups to support early identification of diabetes			ERH, KDHS, REDHS, SoC, Campaspe PCP, BH, GVH, Njernda
Strategies	**When/Timeframe**	**Resources Required**	**Measures/ Evaluation indicators**
Early Intervention Engage with GPs to screen at risk target groups Workplace and community based screenings to raise awareness of seriousness of diabetes and need for early	To be reviewed in 2018 for consideration as priority objective for implementation after initial 2 years of	Diabetes steering group Murray PHN practice support Community Health Nurses to conduct	Number of screenings conducted % of those identified at risk have active referral to GPs

identification	plan	screenings	completed
Provide pre-diabetes programs and self-management programs ie Beat-It, Diabetes education and self-management program (Desmond) where scope to do so		Diabetes steering group	Number of programs available
Objective			Implementation Partners
4. To increase access to specialist diabetes services including Endocrinologists in Campaspe			ERH, KDHS, REDHS, SoC, Campaspe PCP, BH, GVH, Njernda
Strategies	When/Timeframe	Resources Required	Measures/ Evaluation indicators
Advocacy and Leadership Advocacy for Endocrinology access in Campaspe ie more visiting days required - support Health Services to have base information for business case proposals by gathering data and statistics report	To be reviewed in 2018 for consideration as priority objective for implementation after initial 2 years of plan	Diabetes steering group	
Increase use of telehealth options for specialist access - Improve knowledge and organisation readiness for telehealth connections with specialist services/providers - Review or develop if required telehealth processes and procedures for partner organisations			Increased capacity for telehealth Increased use of telehealth

Explore development of specialist diabetes services for access in Campaspe (including paediatrics, foot care, eye health etc)			
Organisational Development Support Kyabram Health to become National Association of Diabetes Centre (NAD Centre)	From May 2016	KyHealth Chronic Disease portfolio/Community Health team Campaspe Diabetes Network	Accreditation as NAD achieved
Ensure LMR Diabetes Pathways are implemented at each health service in Campaspe - identify current service gaps in relation to the pathways and service access for Campaspe; prepare report to aid resource opportunities as they arise	Ongoing	Campaspe Diabetes Network	Partner organisations apply regional diabetes pathways

Summary of Interventions

Key Strategy/ Intervention	Obesity	Mental Health	Cancer	Drug & Alcohol	Diabetes
Systems approach to healthy eating and physical activity					
Healthy workplace and Creating Healthier Hospitals and Health Services – Healthy Together Achievement program [healthy eating, physical activity, smoking, alcohol]					
Physical activity infrastructure					
Pathway development to support referral communication and care coordination					
Consumer health literacy – community knowledge and awareness					
Secure additional resourcing to improve access and availability					

Resourcing Plan

The project reference group are actively seeking additional funding to support implementation of the plan and will pursue options as they arise.

Key area to be resourced	Funding activity focus	Potential funding sources
Project partnership	Project leadership and management Evaluation of initiative against DHHS Service Planning Logic Implementation Plan Project teams for each priority area	Victorian government ○ Better Care Victoria ○ Department of Health and Human Services, Health Service Performance & Programs ○ Department of Health and Human Services, region Campaspe partners ○ in kind contributions
Priority area initiatives	Mental health, cancer, alcohol and drugs, diabetes, obesity – actions as detailed above in implementation plan Linkages to Victorian government ○ Ministerial Advisory group for former WorkHealth program ○ Improving Cancer Outcomes Act 2014 ○ Ice action plan 2015 ○ 10 year mental health plan	Victorian government ○ Cancer Survivorship program ○ Safer Cyclists and Pedestrian Fund ○ Community Ice Action grants ○ Worksafe Prevention fund ○ Prevention/health promotion funding Peak organisations ○ VicHealth ○ Cancer Council ○ Diabetes Australia ○ Turning Point

		Murray Primary Health Network ○ Primary Mental Health, Partners in Recovery, mental health stigma grants, Suicide Prevention ○ Alcohol and Drug Treatment services ○ HealthPathways ○ Other areas as available Shire of Campaspe ○ Community Grants program ○ District Community Planning groups Internal resourcing from project partners Philanthropic funding programs ie Helen Macpherson Smith Trust; Myer Foundation
Project communications including achievements & updates	Strategic communication plan to be developed Ensure key updates are provided to key stakeholders Communicate project achievements and key messages	Project reference group Priority area working groups

Additional definitions

Body mass index (BMI): A measure of body weight in relation to height that can be used to estimate levels of unhealthy weight in a population, calculated as weight in kilograms divided by height in metres squared. WHO classifies adult body weight status based on the following BMI scores.

BMI score	Weight category
< 18.5	Underweight
18.5–24.9	Normal
25.0–29.9	Overweight
30.0–34.9	Obese class I
35.0–39.9	Obese class II
> 40.0	Obese class III

Burden of disease: Burden of disease studies measure and rank the contributions of diseases, health conditions and risk factors to premature deaths (years of life lost or 'YLL') and years lived with disability (YLD) and also calculate a combined measure, disability adjusted life years (DALYs). Together these provide an estimate of a society's total health loss and disease burden and provide an important basis for planning, policy development and priority setting.

Continuum of Care:

Protection	Whole population focus; ie. emergency preparedness, environmental health (food safety, clean water etc), protection from communicable diseases
Health Promotion	Services that help you make decisions about actions and behaviours that lead to good health ie. healthy workplaces, school based programs, social inclusion
Illness Prevention	Services that help you make decisions about actions and behaviour that prevent you from becoming ill ie. Lifestyle Modification Programs – Life!,
Primary Care	Primary Medical Care – service you receive at first point of contact with the medical system ie. GP
	Primary Health Care – service you receive at first point of contact with the health care system ie. allied health clinicians, community health, private providers
Secondary Care	Care required when primary care is not enough
Tertiary Care	Technical, intensive and/or complex care more than secondary care
Quaternary Care	Next step in intensiveness, technicality and complexity of care ie. Trauma care, organ transplants
Rehabilitation	Services you need to get you back on your feet/functional after ill health
End of Life	Care received when you are dying

Source: Department of Health, Victorian Health Priorities Framework 2012-2022, 2011.

The value of identifying categories of health need in a population along a continuum lies in promoting the principle of continuity of care. The continuum is not representative of a linear process; it is intended to represent stages of health need for people which may arise over time and at various stages of life and disability.

Food security: The World Food Summit of 1996 defined food security as existing when 'all people at all times have access to sufficient, safe, nutritious food to maintain a healthy and active life'. Commonly, the concept of food security is defined as including both physical and economic access to food that meets people's dietary needs as well as their food preferences. Food security is built on three pillars:

- food availability: sufficient quantities of food available on a consistent basis
- food access: having sufficient resources to obtain appropriate foods for a nutritious diet
- food use: appropriate use based on knowledge of basic nutrition and care, as well as adequate water and sanitation (World Health Organization 2015b).

Healthy Together Achievement Program fosters a whole –of-organisation approach to health and wellbeing by creating healthy environments in early childhood settings, schools and workplaces

Healthy Together Eating Advisory Service children's services, hospitals and workplaces access to information regarding healthy food and drink options

National physical activity guidelines for Australians: For health development in infants (birth to one year) physical activity, particularly supervised floor-based play in safe environments, should be encouraged from birth. Toddlers (aged one to three years) and pre-schoolers (three to five years) should be physically active every day for at least three hours, spread throughout the day.

Children aged five to 12 years should accumulate at least 60 minutes of moderate to vigorous intensity physical activity every day. Children's physical activity should include a variety of aerobic activities, including some vigorous intensity activity. On at least three days per week children should engage in activities that strengthen muscle and bone. To achieve additional health benefits, children should engage in more activity, up to several hours per day.

Young people aged 13–17 years should accumulate at least 60 minutes of moderate to vigorous intensity physical activity every day. Young peoples' physical activity should include a variety of aerobic activities, including some vigorous-intensity activity. On at least three days per week young people should engage in activities that strengthen muscle and bone. To achieve additional health benefits, young people should engage in more activity, up to several hours per day.

Adults aged 18–64 years should be active on most, preferably all, days every week and accumulate 150–300 minutes of moderate-intensity physical activity or 75–150 minutes of vigorous-intensity physical activity, or an equivalent combination of both moderate and vigorous activities, each week. Adults should do muscle-strengthening activities at least two days each week.

Adults aged 65 years and over should be physically active for 30 minutes every day. Even a slight increase in activity can make a difference to a person's health and wellbeing (Department of Health 2014a).

Chronic and complex conditions: A condition is considered chronic when it lasts for more than six months, has a significant impact on a person's life, and requires ongoing supervision by a health professional. Examples include asthma, cancer, cardiovascular disease, diabetes mellitus, mental health conditions, arthritis and musculoskeletal conditions. People with complex care needs have multiple health, functional and/or social issues and are at risk of functional decline and/or hospital admission.

Health inequality and inequity: Health inequalities can be defined as differences in health status or in the distribution of health determinants between different population groups – for example, differences in mobility between elderly people and younger populations or differences in mortality rates between people from different social classes. Some health inequalities are attributable to biological variations or free choice and others are attributable to the external environment and conditions mainly outside the control of the individuals concerned. In the first case it may be impossible or ethically or ideologically unacceptable to change the health determinants and so the health inequalities are unavoidable. In the second, the uneven distribution may be unnecessary and avoidable as well as unjust and unfair, so that the resulting health inequalities also lead to inequity in health (World Health Organization 2015a).

Social determinants of health: The social determinants of health are the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at the global, national and local levels. The social determinants of health are mostly responsible for health inequities – the unfair and avoidable differences in health status seen within and between countries.

Social gradient of health: Within countries, evidence shows that, in general, the lower an individual's socioeconomic position, the worse their health. There is a social gradient of health that runs from top to bottom of the socioeconomic spectrum. This is a global phenomenon seen in low, middle and high income countries.

Socioeconomic disadvantage: Refers to populations profiled using the ABS Index of Relative Socioeconomic Disadvantage. This index summarises information about the economic and social conditions of people and households within an area, with areas categorised into quintiles.

Wellbeing: There are two dimensions of wellbeing: subjective (or personal) wellbeing which includes considerations such as life satisfaction, resilience, feeling one's life has meaning; and objective wellbeing which includes more objective measures such as having adequate housing, physical health, education, sufficient resources, adequate food, appropriate care, and a healthy and safe environment (Department of Health England 2013). Wellbeing is therefore the outcome of many factors, both internal to an individual and of their wider social experience and conditions of living.