Lower Hume Primary Care Partnership

Strategic Plan

2013-2017

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Lower Hume Primary Care Partnership

The Lower Hume Primary Care Partnership (LHPCP) covers the two local government areas of Mitchell and Murrindindi. Established in 2000, and funded through the Victorian Department of Health (DH) there are 29 Primary Care Partnerships (PCP) in Victoria. The Victorian PCP program has two key aims:

- To improve the experience and outcomes for people who use primary health care services;
- To reduce the preventable use of hospital, medical and residential services through a greater emphasis on health promotion programs and by responding to the early signs of disease and/or people's need for support.

Vision:

Lower Hume Primary Care Partnership (LHPCP) envisages a healthy and resilient local community whose health and wellbeing outcomes are improved through the collaborative and cooperative relationship of its members.

Values:

To implement the changes that will be required to achieve its vision the LHPCP members share the following values:

- cooperation and inclusiveness
- excellence in all activities
- openness and transparency while respecting confidentialities where appropriate
- respect for partners and accommodation of diversity of views
- integrity and trust
- enthusiasm to promote and develop the partnership
- creativity and willingness to change where appropriate

Leadership Team

Seymour Health
Nexus Primary Health
Kilmore and District Hospital
FamilyCare
Yea and District Memorial Hospital
Alexandra District Hospital
Goulburn Valley Medicare Local
Mitchell Shire Council
Murrindindi Shire Council

Additional partners

Salvation Army
Berry Street Alexandra
Women's Health Goulburn North East
Public and Private Aged Care Facilities
Early Years Services in Mitchell Shire
Early Years Services in Murrindindi Shire
Neighbourhood and community houses
Closing the Health Gap Lower Hume Project
Valley Sport

Mitchell Shire

The 2011 Census identified that of the 35,092 people living in Mitchell Shire:

35% of Mitchell residents are aged below 25 and 17.6% are aged 60 years or over.

11.7% of people living in Mitchell were born overseas

Key industries include construction, manufacturing, retail, agriculture, transport, racing/equestrian, government and tourism

The rate of unemployment in Mitchell is 5%

The Victorian Population Health Survey 2011-2012 identified that:

35% of people in Mitchell do not meet physical activity guidelines

More than half of the Mitchell population, 56.3% are overweight /obese

48.4% of residents did not meet the dietary requirements for fruit and vegetable intake

5% of the population reported food insecurity (ran out of food in the last 12 months and could not afford to buy more)

11%of persons in Mitchell are at risk of short-term harm from alcohol consumption

20.6% of Mitchell residents over the age of 18 are smokers

10.6% of the population reported a high/very high degree of psychological distress

Female life expectancy in Mitchell is 83 years of age and male life expectancy is 78.7 year of age

In Mitchell admission rates for dental conditions in children 0-4 years have decreased from 6.4 in 2007-08 to 2.5 in 2011-12.

Mitchell Shire scores 996.1 on the SEIFA index of disadvantage

Murrindindi Shire

The 2011 Census identified that of the 13,057 people living in Murrindindi Shire:

3,460 of residents are aged below 25 and 3,645 are aged 60 years or over.

11.63% of people living in Murrindind were born overseas

Key industries include agriculture, construction services, food and beverage services, education, tourism and public administration

The rate of unemployment in Murrindindi is 5%

The Victorian Population Health Survey 2011-2012 identified that:

18.4% of people in Murrindindi do not meet physical activity guidelines

More than half of the Murrindindi population, 56.9% are overweight /obese

49.6% of residents did not meet the dietary requirements for fruit and vegetable intake

7.8% of the population reported food insecurity (ran out of food in the last 12 months and could not afford to buy more)

14%of persons in Murrindindi are at risk of short-term harm from alcohol consumption

20.2% of Murrindindi residents over the age of 18 are smokers

9.7% of the population reported a high/very high degree of psychological distress

Female life expectancy in Murrindindi is 83.4 years of age and male life expectancy is 79.2 year of age

In Murrindindi admission rates for dental conditions in children 0-4 years have increased from 2.4 in 2007-08 to 4.3 in 2011-12.

Murrindindi Shire scored 997.2 on the SEIFA index of disadvantage

Purpose of the Plan

The Lower Hume Primary Care Partnership Strategic Plan 2013-2017 reflects the Strategic Goal of the Victorian Department of Health, Primary Care Partnership Program Logic 2013-2017 which aims to *Strengthen collaboration and integration across sectors by 2017*, in order to:

- maximise health and wellbeing outcomes
- promote health equity and
- avoid unnecessary hospital presentations and admissions.

The Plan is underpinned by the following PCP Guiding Principles

Tackling Health Inequalities	LHPCP will work at the system level to address health inequities within locally agreed and consolidated conditions by adopting social determinants of health approach to tackle health inequity across the full continuum of health and wellbeing, particularly for the most disadvantaged. LHPCP will advocate for change with cross sector partners on broader determinants.
Person and Family Centred	LHPCP will build relationships between service users and the community, sharing power and responsibility, meeting individual and community needs by being sensitive to values, preferences and expressed needs, coordinating and integrating care and support by service providers and an environment conducive to person-centred care for providers and service users
Evidenced-Based and Evidenced Informed decision making and action	Decision making will be evidenced based and founded on a shared understanding of community need and priorities and where possible the range of evidenced based or evidenced informed interventions that are available,
Cross - sector partnerships	LHPCP will strive for seamless service delivery throughout the consumer journey across health and relevant non health sectors.
Accountable Governance	Will be demonstrated by effective and accountable leadership and facilitation, being transparent, accountable and responsive and having a shared commitment to and participation in addressing health inequities in partnerships across health (public and private) and non health sectors.
Wellness Focus	An holistic focus on prevention, early intervention and wellness
Sustainability	An efficient and effective use of resources, including optimum use of technology where it is available and cost effective.

The LHPCP Strategic Plan 2013-2017 also supports the delivery of outcomes identified in the strategic priorities of the Hume Region Strategic Plans and Local Government Health and Wellbeing Plans.

Priority Areas

The Hume Region Primary Care Partnership integrated planning framework includes four regional priorities and regional strategic plans. The regional priorities are Aboriginal Health, Aged Care, Chronic Care and Health Promotion.

Prevention Priorities	**Target Group**	**Regional Strategic Plans**
Healthy Eating	Aboriginal and Torres Strait Islander Peoples Vulnerable Children 0-12	• Hume Region Health and Aged Care Plan 2013-2018 • Hume Region Integrated Health Promotion Strategy 2012-2017 • Koolin Balit 2012-2022
Alcohol	Aboriginal and Torres Strait Islander Peoples Young People 12 - 25	• Hume Region Health and Aged care Plan 2013-2018 • Hume Region Integrated Health Promotion Strategy 2012-2017 • Koolin Balit 2012-2022
Oral Health	Aboriginal and Torres Strait Islander Peoples Vulnerable Children 0-5	• Hume Region Oral Health Plan 2010-2013 • Koolin Balit 2012-2022

Early Intervention and Integrated Care Priorities	**Target Group**	**Regional Strategic Plans**
Diabetes	Aboriginal and Torres Strait Islander Peoples Older People	• Hume Region Health and Aged care Plan 2013-2018 • Hume Region Chronic Care Strategy 2012-2022 • Koolin Balit 2012-2022 • Hume Integrated Aged Care Plan 2010-2015
Improved Client Pathways	People diagnosed with Diabetes Older People Aboriginal and Torres Strait Islander Peoples	• Hume Region Health and Aged Care Plan 2013-2018 • Hume Region Chronic Care Strategy 2012-2022 • Hume Integrated Aged Care Plan 2010-2015
Promotion of innovative and flexible service models	People diagnosed with Diabetes Older People	• Hume Region Chronic Care Strategy 2012-2022 • Hume Integrated Aged Care Plan 2010-2015

Action Areas

The priorities areas provide strategic direction against six action areas to drive change and improve health outcomes for the population of Hume Region:

Governance	Workforce Capacity
Partnerships	Consumer and Community Engagement
Continuous quality Improvement	E-health

Lower Hume Primary Care Partnership Role

The Lower Hume Primary Care Partnership will support member agencies through enabling, facilitating, planning, coordinating and capacity building to create consistency in regional and sub-regional collaborative approaches to achieving outcomes. This will be achieved through:

- action orientated work;
- alignment of effort and reduction in duplication;
- coordinating communities of practice and peer networks;
- supporting continuous quality improvement initiatives;
- promoting and showcasing agency work;
- supporting staff to translate policy into practice and
- value-adding to support partners to broaden sector engagement.

Lower Hume Primary Care Partnership Strategic Direction 2013-2017

A number of consultation and planning workshops at both the regional and sub-regional levels have occurred with participation from funded and non–funded service providers. Workshops have encouraged participation, leadership and debate, supporting the collation of a plan which LHPCP staff will endeavour to support through the enablement, facilitation, planning and alignment of activities. Workshops have enabled the development of an Integrated Health Promotion Plan and encouraged leadership through consultation processes, which values an inclusive approach and process.

Position Statement

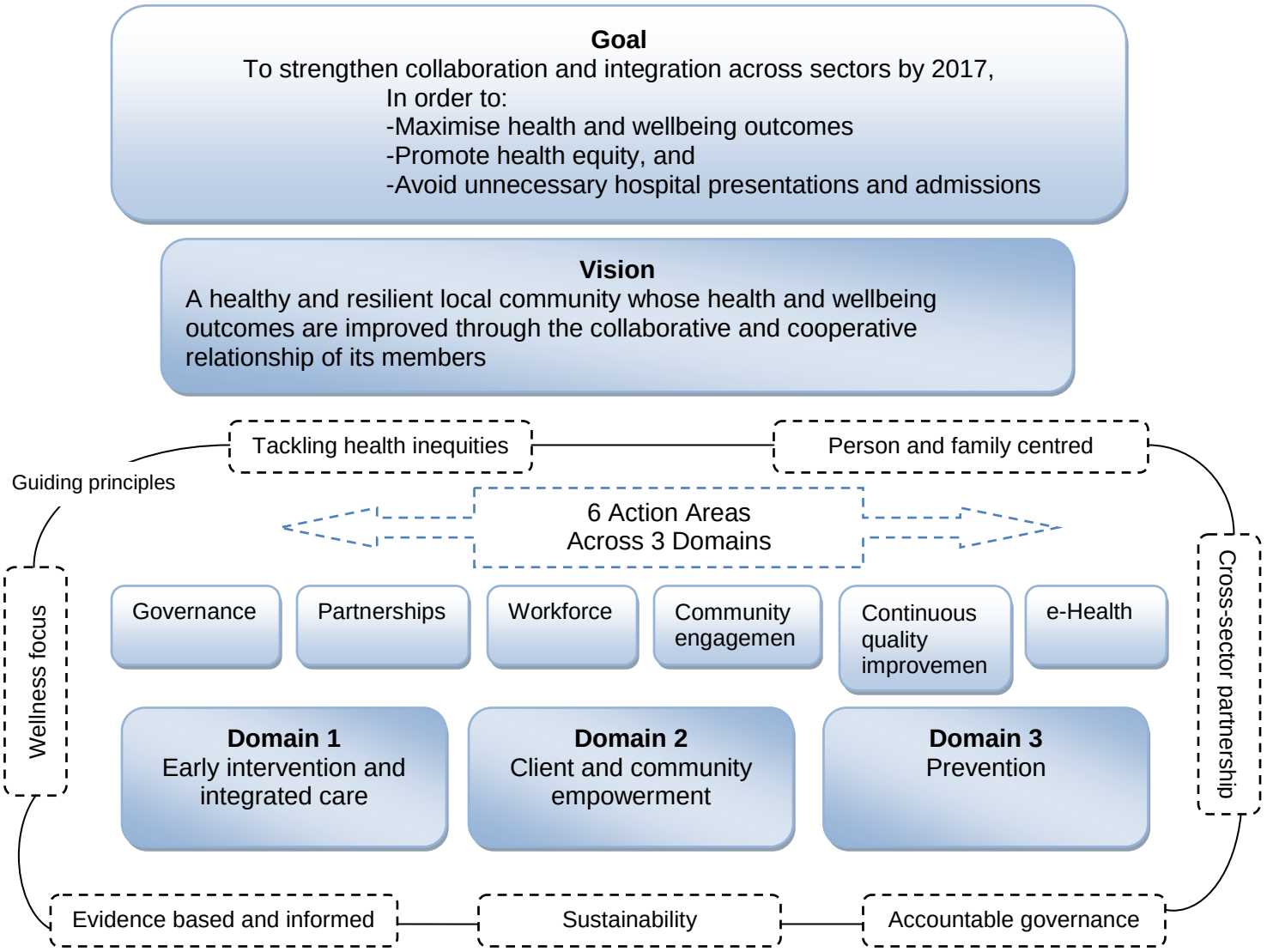
The four Primary Care Partnerships within the Hume Region will continue to act as a platform, to bring service providers together, in partnership to support the delivery of coordinated, integrated care and improved health literacy in four key regional priority areas. Many factors have contributed to a greater emphasis on the Hume Region Primary Care Partnerships working together to approach planning and facilitation of catchment based activities. Factors such as:

- Agencies having objectives in common, along with an emphasis on addressing the social determinants which impact on health;
- Greater emphasis on evidence based practice;
- A need to embed and connect technologies;
- Prevention of and impact of early interventions on disease prevalence;
- Greater emphasis to enable self-determination of community members through increased health literacy;
- Increase in the number of 'non-local' catchment wide services;
- Funders requesting greater efficiencies through partnership approaches and
- Limited resources with increasing service demand.

A Hume Region approach enables resources to be shared, combined or prioritised, such as staff training and new programs. Members can benefit from a greater collaborative approach rather than a historical competitive one. Member agencies of the Lower Hume Primary Care Partnership aim to improve the health and wellbeing of their communities**.** For an *individual* this means a variety of health prevention and wellbeing needs will be met as access to, and navigation of, the health system becomes simplified. For the *service system* it means creating a seamless pathway for people as they progress through the stages of life, and for our members, greater capacity, and opportunity, to work effectively with positive outcomes for the community and increased staff satisfaction, therefore retention.

The LHPCP Integrated Health Promotion Plan 2012-2017 has been updated as a separate but complementary document to the LHPCP Strategic Plan 2013-2017. Operational Plans will be developed for each of the priority areas. The plans will build upon the previous concentration of work with established agency partners to enhance service access, chronic disease management, and integrated health promotion initiatives.

Summary of Lower Hume Primary Care Partnership Strategic Plan 2013-2017



Domain 1. Early Intervention & Integrated Care

Objective:

To strengthen the primary health system to deliver person-centred and accessible early intervention and integrated care that aims to keep people as well as possible for as long as possible, particularly people with complex care needs.

Strategies
• Work with member organisations including Goulburn Valley Medicare Local to strengthen integration and communication practices among providers (including state, commonwealth and private providers) to improve consumer transitions within services and between services. • Facilitate the implementation of the Victorian Service Coordination Practice Manual 2012 by member agencies and the broader service system. • Work with member agencies to identify and address access barriers to services for Aboriginal and Torres Strait Islanders people and people diagnosed with Diabetes. • Facilitate the development and implementation of local agreements for care planning, care coordination and case conferencing to ensure systemic care planning (including e-care planning) within and across organisations. • Facilitate the development and implementation of local agreements and systematic interagency pathways for defined consumer cohorts using evidence-based guidelines. • Facilitate development and implementation of a robust identification and recall system for people with complex and multiple needs for review and quality control. • Facilitate continued system improvements for early identification and intervention for priority target groups. • Continue to strengthen e-health initiatives.
To achieve this we will
• Extend the care planning project to include guidelines and protocols for shared care plans including referral, monitoring, transition and identification of a care coordinator. • Promote and support member agencies to embed self-management approaches in all aspects of care. • In partnership with Goulburn Valley Medicare Local we will audit access and coordination of Chronic Care Services in Mitchell and Murrindindi Shires and produce a report with recommendations for improvement. • Improve care pathways for people with diabetes through the development of a region wide, coordinated model of care that aligns with the National Diabetes Service Improvement Framework. • Promote and facilitate agency uptake of the Victorian Service Coordination Manual, including supporting agencies to complete the State-wide Service Coordination Survey.

- Work with HACC Allied Health and Primary Care Allied Health providers to develop and implement intra and inter-agency agreements and protocols.
- Continue to support aged care service providers to work in collaboration to improve service access and coordination through the development of interagency protocols and agreements.
- Provide information to clinicians and intake workers on the new one page screening tool contained in SCTT 2012, and encourage continual use of this for Initial Needs Identification.
- Continue to promote and increase the number of e-referrals/ secure messaging amongst agencies.
- Promote and implement the use of e-health and telehealth in diabetes management and support in rural areas.
- Continue to advocate that agencies arrange for their staff to complete the online Service Coordination and SCTT 12 training modules.

Success Measures

- In 2017, 100% of member agencies including HACC funded programs and aged care providers complete the annual Service Coordination Survey.
- Development of and compliance with formalised agreements and protocols by agency members.
- Annual increase in the number of member organisations with guidelines and expectations for shared care plans including referral, monitoring, transition and identification of care coordinator.
- Annual increase in the number of member organisations that demonstrate evidence of communication with GPs regarding the shared care plan of clients with complex care needs.
- Increase in the number of clients whose issues (identified at the Initial Needs Identification) have all been responded to with appropriate action.
- Annual improvement against the key domains of the Assessment of Chronic Illness Care (ACIC) Survey.
- Annual increase in the number and type of agencies participating in e-referral/secure messaging
- Increase in the number of agency staff that complete the on-line Service Coordination and SCTT 12 Training modules.

Domain 2. Consumer and community empowerment

Objective:

For consumers, carers and community members to be meaningfully involved in decision making about health planning, care and treatment and the wellbeing of themselves and the community.

Strategies
• Support implementation of person-centred models of care that incorporate self-management support and goal-directed shared care planning across the health and wellbeing continuum. • Support member organisations to implement strategies that build consumers capacity to engage with services (including health literacy). • Encourage regular updates of information in the National Services Directory by LHPCP member agencies and promote the use of the National Health Service Directory across the LHPCP catchment. • Action improvements identified to improve the consumer journey for people with diabetes. • Develop and/or investigate better ways to increase the knowledge of consumers and providers about services available and how to access them with a focus on oral health, aged care and diabetes.
To achieve this we will
• Complete a health literacy assessment of member organisations using the Enliven Health Literacy Assessment evaluation tool to assist in the development of individualised action plans. • Provide education to organisations on the Wagner Chronic Care Model, introducing the Assessment of Chronic Illness Care (ACIC) and Patient Assessment of Chronic Illness Care (PACIC), and work on improving practice in preparation for implementation of assessments in June 2014. • Using the PACIC evaluation tool, audit member organisations on community involvement and empowerment, and put strategies in place to increase consumer and community involvement in health planning, care and treatment. • Continue to promote client centred approaches to the key elements of service coordination (initial contact, initial needs identification, assessment, care planning and shared care plans). • Continue to promote the use and regular update of the National Human Services Directory. • Support aged care providers (HACC, Commonwealth and Residential) with the implementation of person centred and Goal Directed Care (CDC)

Success Measures

- The percentage of consumers with multiple or complex needs with a shared care plan.
- Increase in the number of organisations participating in the Patient Assessment of Chronic Illness Care (PACIC) Survey.
- Annual Improvement in the Patient Assessment of Chronic Illness Care (PACIC) Survey by participating organisations.
- PCP member organisation details in the National Health Service Directory (NHSD) are current and complete.
- Increase in the number of organisations participating in the Assessment of Chronic Illness Care (ACIC) Survey.
- Annual improvement in the Assessment of Chronic Illness Care (ACIC) by participating organisations

Domain 3. Prevention

Objective:

To work with Victorians, particularly with the most disadvantaged, to maximise their health and wellbeing, reduce the prevalence of risk factors and increase prevalence of protective factors through focusing on local partnership priority health and wellbeing issues.

Strategies
• Continue to support greater integrated health promotion planning and integration with local government and other key agencies funded and non-funded including Goulburn Valley Medicare Local. • Implement Collaborative practices that deliver evidence-based integrated health promotion. • Consolidate primary and secondary prevention activities in line with identified Victorian priorities and Mitchell and Murrindindi Municipal Public Health and Wellbeing Plans. • Systematic use of integrated health promotion indicators
What we will do
• Continue to strengthen partnerships with Mitchell and Murrindindi Shire Councils, Goulburn Valley Medicare Local and local community groups to create supportive environments for integrated health promotion. • Support member agencies work to improve access to food that is safe, nutritious and culturally valued. • Support member agencies to create supportive environments that promote responsible drinking amongst young people aged 12 to 25. • Build the capacity of member agencies to work collaboratively to plan, implement and evaluate primary prevention on regional and sub-regional priorities. • Evaluate health promotion initiatives to show impacts and add to evidence base. • Advocate for actions to improve the social determinants of health inequalities. • Implement the Street Harvest project in partnership with local neighbourhood houses to improve food access. • Implement an oral health promotion program that aims to improve the oral health of children 0 to 5 years. • Explore and implement opportunities for older people entering residential care to maintain social connections.

Success measures
• Demonstrated collaborative evaluation of activities for the Regional “Healthy Eating” and Sub-regional “Alcohol Related Harm” health promotion priorities within the LHPCP catchment. • Demonstrated partnership between LHPCP and GVML on agreed evidenced based interventions that target the regional priority of Healthy Eating. • A 10% increase annually in the number of early childhood services that provide environments supportive of oral health across Murrindindi and Mitchell Local Government Areas. • Demonstrated collaboration with Local Government on the implementation of Municipal Health and Wellbeing Plans and the PCP Integrated Health Promotion Plan.