Strategic plan 2019-2022

CHIRF- Mallacoota Community Health Infrastructure and Resilience Fund

PO Box 368
Mallacoota Vic 3892
ABN 4259 864 5477
@chirf.org

p. +0417 271 852

secretary@chirf.org
https://chirf.org.au

Table of Contents

Abbreviations

ABS-RA	Australian Bureau of Statistics Remoteness Areas
CHIRF	Community Health, Infrastructure and Resilience Fund Inc
COPHE	Community-Owned Primary Health Enterprises
DHHS	Department of Health and Human Services (State)
DoH	Department of Health (Federal)
ED	Emergency Department
FEG	Far East Gippsland
GPs	General practitioner(s)
GPHN	Gippsland Primary Health Network
MDHSS	Mallacoota District Health and Support Service
MIAC	Mallacoota Inlet Aged Care
MMC	Mallacoota Medical Centre
MMM	Modified Monash Model
MPSS	Multi-Purpose Service Program (Joint Federal and States/territories Program)
PHC	Primary Health Care
RVTS	Remote Vocational Training Scheme
RWAV	Rural Workforce Agency Victoria

Executive Summary

The strategic plan for Community Health, Infrastructure and Resilience Fund Inc (CHIRF) plan covers three- years July 2019 – June 2022.

Our purpose is: To ensure innovative, integrated, patient-centered, primary health care services and appropriate resources, infrastructure and workforce are available locally to the residents of the Mallacoota district

Our Vision is: 1) That the residents of Mallacoota District enjoy optimal health and wellbeing so they can grow, live, work and age well, while continuing to live locally; and 2) Research evidence is built to support other geographically remote small rural communities to help strengthen locally primary health care services.

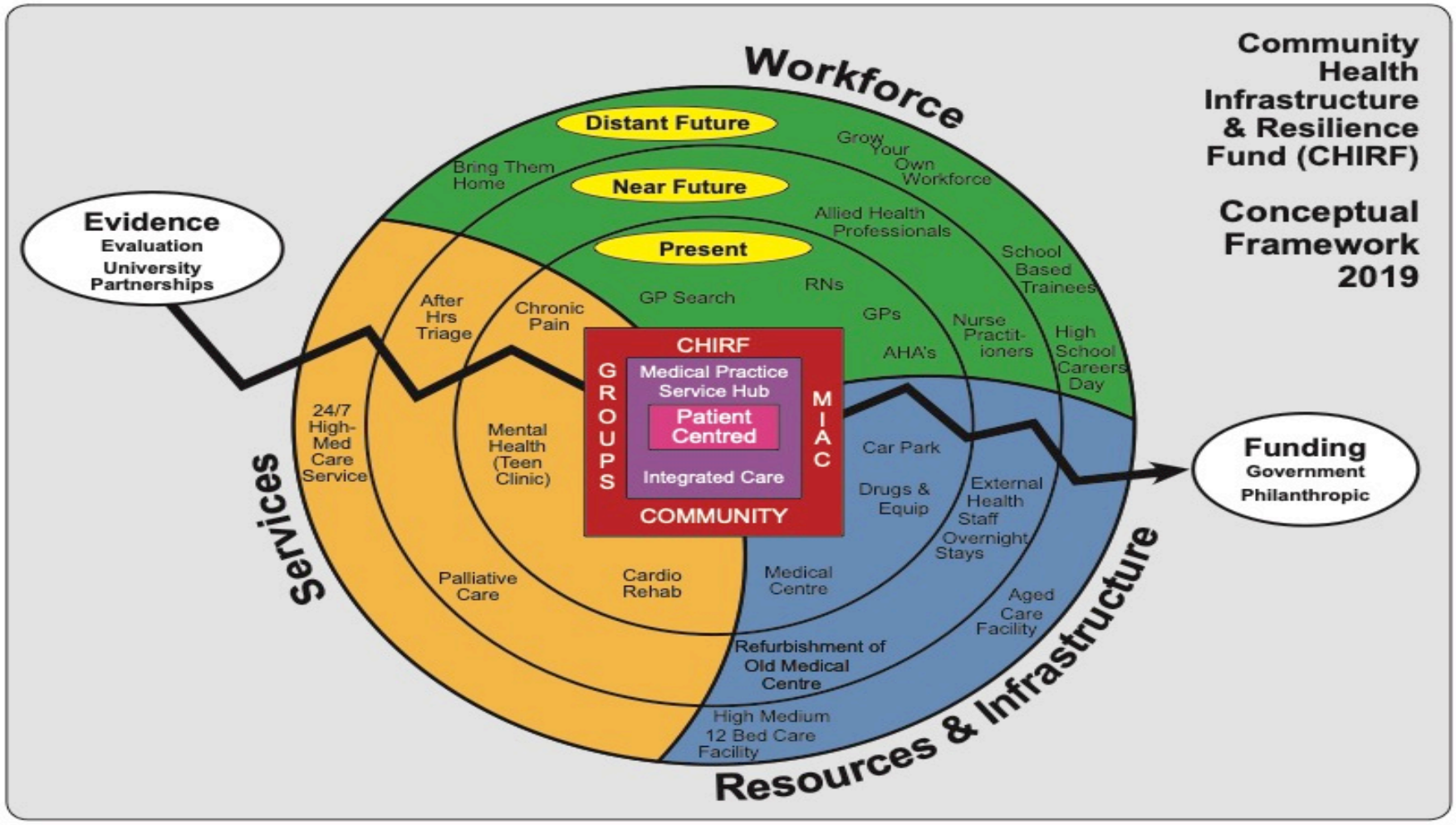
Our Values are:

- Community-engaged/led – Collaboration
- Integrity
- Innovative and credible
- Professional excellence

Our strategic priorities are:

1. Place-based health and wellbeing services
2. Quality services
3. Community-owned/managed resources and infrastructure
4. Local professional workforce

CHIRF Strategic Plan 2019-2022 – Conceptual Framework



Who are we?

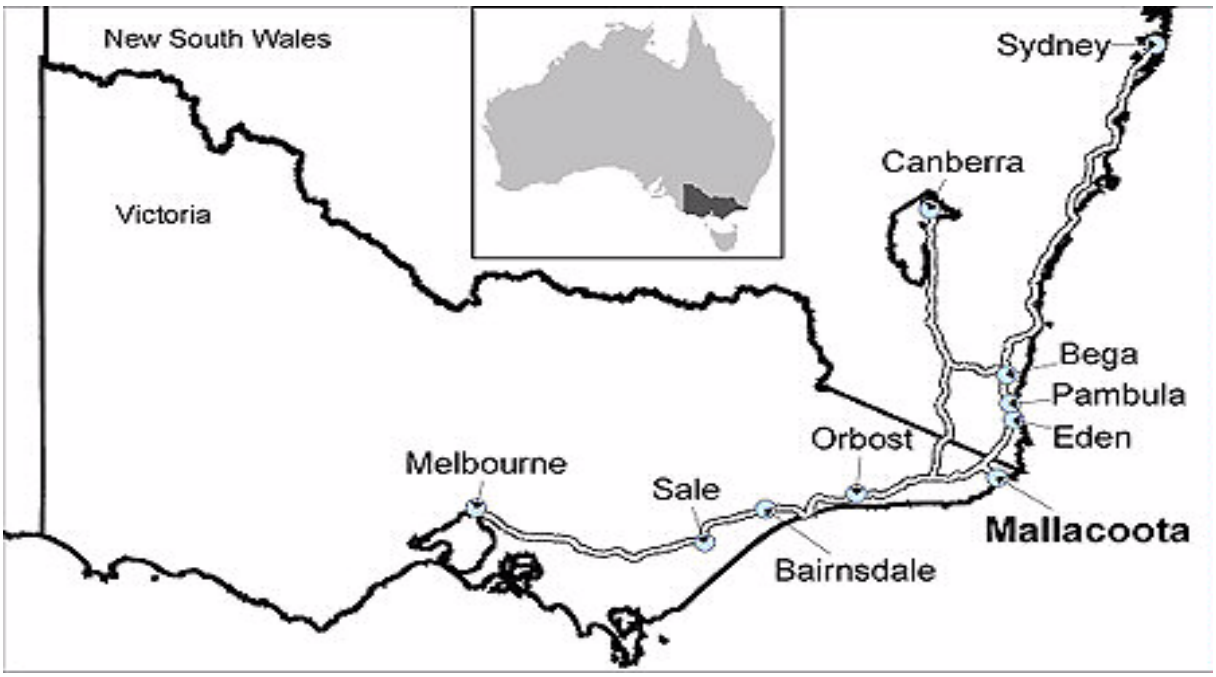
The Community Health, Infrastructure and Resilience Fund Inc (CHIRF) is a deductible gift recipient Health Promotion Charity. CHIRF is governed by a board of skilled volunteer community members. CHIRF was originally formed in May 2016 by a group of Mallacoota residents when it became clear that the sole medical practice in the town, the Mallacoota Medical Centre (MMC), which at that time was operating with one general practitioner (GP) would collapse without solid community support; leaving the community without the services of GPs. CHIRF's purpose is to ensure innovative, integrated, patient-centered primary health care (PHC) services and appropriate infrastructure is available locally to the residents of the Mallacoota district.

The environment we operate in

In setting strategic directions for the next three years, it is important to look at the external and internal factors influencing and impacting CHIRF and local PHC services and providers. Considering the strengths, opportunities, challenges and risks these environmental factors pose is critical to CHIRF's and its medical practice partners future success. With little knowledge of the medical industry or the community's health gaps, CHIRF has been on a very rapid learning curve to enable it to both strategise and find ways to respond quickly to identified health service needs.

Geography

The township of Mallacoota (postcode 3892) is part of the East Gippsland Shire and is located on the coast on the eastern tip of Victoria. It is 1,063 km west of Melbourne and is the last major township on Victoria's east coast before the border with New South Wales.



Source: (O'Meara, Kendall, & Kendall, 2004)

At the 2016 census, Mallacoota had a population of 1,036 http://www.censusdata.abs.gov.au/census_services/getproduct/census/2016/quickstat/SSC21574. At holiday times, particularly at Easter and Christmas, the population increases to around 8,000. In the 2016 census, the median age of Mallacoota residents (State Suburbs) was 58 years. Children aged 0-14 years make up 11.8% of the population and people aged 60-years and over make up 49% of the population. There were also 85 people over 80.

Due to the limited range of health care services and the absence of a residential aged care facility, a recent survey undertaken by Members of the Mallacoota Inlet and Aged Care Inc (MIAC) local charity indicated that from 2012-2018, 164 residents left Mallacoota in the to move closer to aged care services; with 64 departures occurring in the last two-years.

In terms of rurality, Mallacoota, is one of Victoria's most geographically isolated communities. While there are many definitions of remote communities in use; most commonly they are communities with small populations, are located a considerable distance from larger centres and located in sparsely populated regions. The Mallacoota district is an island in a sea of forest, some 200,000 hectares. The nearest community, Cann River, is 1-hour away has a population of 194. Mallacoota is classified under the 2016 Australian Bureau of Statistics Remoteness Areas (ABS-RA) five classification scale as 'ABS-RA4 – Remote Australia' and under the Modified Monash Model's [1] (MMM) seven geographical classification scale, as MMM6.

Primary Health Care services

PHC services are the first level of basic health services that individuals' access when making initial contact with a health system. There are a range of Federal and State government policies that impact on the provision of PHC services in rural and remote areas. The Federal Government has the key responsibility through its Department of Health (DoH)for the provision and sustainability of PHC services through funding of Medicare Benefit Scheme (MBS) for general practitioners and the operation of the Primary Health Network which is responsible for supporting both medical practices and PHC provision. However, in practice, State Governments are also a large contributor and funder of PHC services. In Victoria, the State Government supports PHC services through its Department of Health and Human Services (DHHS) which funds the operation of public hospitals, bush nursing hospitals or centres as well as a range of community health services/centres. DHHS has organised regional Victoria into five regional areas and Mallacoota is situated in the Gippsland area . There is also a jointly government initiative the Multi-Purpose Services Program (MPSP) funded between the Federal and state and territory governments for small regional and remote communities to support the provision of integrated health and aged care services. Its aim is to support the provision of health and aged care services to exist in regions that could not viably support stand-alone hospitals or aged care residential facilities.

In their PHC study, Thomas et al (2015) argued that there should be equity of access of PHC services for all Australians. The authors argued that a core group of primary health care services should be available locally to all Australians living in rural and remote communities. These PHC

[1] The Modified Monash Model was developed by the Australian government, Department of Health in 2015 it was developed on the work by Humphreys and McGrail from Monash University, it uses the ASGS-RA as a base, and further differentiates areas in Inner and Outer Regional Australia based on local town size. It was developed to help the Australian Government to address medical workforce shortages. The definitions of MMM categories 4-7 are: MMM-4 Medium rural towns, > 5K and < 15K, MMM-5 Small rural towns, < 5K, MMM-6 + 7 Remote and very remote communities.

services cover: care of the sick and injured, mental health and social and emotional wellbeing, allied health, sexual and reproductive health, rehabilitation, oral/dental health and public health and illness prevention. The authors argued that there are inherent challenges in providing these PHC services to Australians living in rural and remote communities, these are :

- Difficulties in recruiting and retaining a skilled workforce,
- Maintaining and extending health infrastructure,
- Ensuring service quality and safety, and
- Ensuring affordability.

There are currently four principal providers of PHC services in the Mallacoota district

- A privately-owned medical practice, the Mallacoota Medical Centre (MMC) providing family medicine and a pathology service.
- A state-operated ambulance service (Ambulance Victoria) covering both Mallacoota and Cann River populations, with two ambulances and staffed by one full-time paramedic and supported by a team of local volunteers.
- A private charity community health service - Mallacoota District Health and Support Service (MDHSS) providing a range of services five days a week 9 - 5 covering: home support and care, community nursing, post-acute and respite care, allied health, dental, volunteer transport and community-based wellbeing groups and planned activity groups), and
- A privately-owned community pharmacy.
- Hammond Care in 2019 introduced services to Mallacoota offering support for NDIS and access to Home Care Package support 24-7, 365 days.

Mallacoota is the is currently the only community in regional Victoria without a Victorian government funded hospital, bush nursing hospital/centre or a community health centre or Federally funded residential aged care services or jointly funded MPS. The closest Victorian public hospital is located at Orbost Regional Health (147km away with a travel time of 1hr 45 minutes each way). The nearest hospital in terms of distance is in NSW, is South East Regional Hospital in Bega (144km away and 1 hr. 45-minute travel time each way). It is tertiary hospital operating a 24/7 emergency department (ED). In Victoria, the closest ED is in Bairnsdale (235km away and with a travel time of nearly 3 hours each way). Ambulance Victoria noted in regard to its Mallacoota and Cann River service that 65% of patient transport for ED presentations went to NSW and 35% to Victoria over a 24-month period in 2014-2016. This data also indicates an above average attendance to EDs, and patients admitted (60% of presentations) compared 52.6% for Victoria. Data provided from Ambulance Victoria shows that over the period July 2014 – June 2017 Mallacoota's use of ambulance was 3.5 times that of Bairnsdale.

In July 2017 the Federal Government under the Rural General Practice Grants program announced a $300,000 matched capital grant to rebuild the MMC on a property on Maurice Avenue containing the existing MMC. The matched funding of $300,000 was provided by the local charity group MIAC which own the Maurice Avenue property. For this funding application MIAC formed a collaboration with CHIRF and the MMC. Additional matched community funding was also being provided by the Bendigo Bank by way of mortgage.

In 2017, the Gippsland Primary Health Network (GPHN) and DHHS commissioned Community-Owned Primary Health Enterprises (COPHE) to undertake an environmental scan and community consultation in Far East Gippsland (FEG). The FEG population was estimated at 5,300 and included the towns and surrounding areas of Orbost and district (3,714), Mallacoota and district (1,187) Cann River (169), Bemm River (287) and Nowa Nowa (341). The aim of the consultancy project was to develop and recommend a sustainable model of PHC service delivery for FEG, with the possibility of the model being replicable for other rural/remote Australian towns, where GP access is also at risk.

The key project findings/recommendations made by COPHE in their in confidence report (2017) with regard to PHC service provision for the Mallacoota community (and neighboring Cann River) were:

- Greater clarity as to roles and intersection of Commonwealth and State Government in PHC service provision in particular relating to:
    - Lack of clarity regarding the eligibility criteria for Multi-Purpose Service Program funding.
    - Which tier of Government is responsible for providing an after-hours service? Should it be the responsibility of GPs and funded by the Commonwealth through MBS, or is it a Victorian State government responsibility? And how would an after-hour service intersect with Ambulance Victoria? .
    - Whether Mallacoota is eligible for funding under Commonwealth or State programs to establish and operate a residential aged care facility?
- Given scarce PHC resources, the need for the development of integrated care models between the local providers especially for complex and chronic conditions to help ensure barriers to team care are removed and investigating where telehealth can be expanded.
- Increased collaboration and cooperation between PHC providers to support the development of effective integrated care models and development of joint approaches to workforce recruitment, funding applications and advocacy efforts to governments for PHC service improvement.
- Given the significant flow of primary health and acute services users into NSW from Mallacoota, further research is needed to better understand patient flows and referral patterns.

Over the project period, COPHE undertook a community engagement process with the Mallacoota residents which involved holding an open day and included a community consultation with 88 residents, as well as distributing a survey completed by 199 respondents. The majority of people (73%) did not agree that the services locally available are what you must expect living in a country area and 93% considered the Governments needed to act to improve the situation.

The data collected identified a strong need for more GP services in Mallacoota; some of the key arguments for this included:

- Lack of urgent care services,
- Lack of after-hours medical and nursing services,
- Given reliance on very small number of GPs:
    - risk of burnout of existing GPs and loss of local medical services, and
    - lack of choice of GP,

- Need to meet the seasonal increased demand for local medical services in peak holiday periods, and
- No access to bulk billing.

Other key PHC issues identified by Mallacoota residents were:

- No residential aged care services and elderly and frail resident having to leave town to access increased medical services and /or residential aged care services,
- Need for more locally available mental health services, especially for young people
- Lack of transport back to Mallacoota after ambulance transport to hospitals for ED presentations,
- Need for more paramedics, and
- Poor internet connectivity as a barrier for using technology to access health services

The local health workforce

COPHE reported that access to an adequate health workforce is a significant barrier to sustainable PHC service provision in FEG. In respect to GP services in FEG, they argued that it is widely acknowledged that Australia's MBS funding model, which is market driven, does not work well in small rural towns where a robust market does not exist and/or is subject to seasonal changes; both being the case in Mallacoota. As a result, the mostly small medical practices operating in the FEG have found it very difficult to attract and retain GPs as they are unable to guarantee a certain level of income through the MBS funding model. The COPHE report also suggests that there is likely is to be an additional negative impact on workforce in small rural towns as the Australian Government rolls out its market-related funding models for disability (National Disability Insurance Scheme-NDIS) and for aged care (My Aged Care). As well challenges recruiting GPs, Mallacoota is also affected by the same allied health[2] workforce challenges commonly experienced in rural and remote Australia. Until CHIRF funded services commenced in 2019 the allied health services being provided by MDHSS or MMC were either a drive in- drive out or fly-in -fly out services.

The key project findings/recommendations made by COPHE in their in confidence report (2017) with regard to PHC service provision for the Mallacoota community (and neighboring Cann River) were:

- To investigate options for joint recruitment of staff between organisations
- Address financial disincentives such as cost of recruitment, cost of relocation, cost of retention

Organisational factors

CHIRF's initial focus was to address Mallacoota's GP shortage and it developed in partnership with the MMC it began a 'Dr Search' initiative in May 2016. This involved attending major medical conferences and operating a stand to attract potential GPs and raise the profile of Mallacoota district and the PHC needs of remote communities more generally. Key outcomes from the Dr Search strategy include:

[2] No universally accepted definition of allied health workforce but commonly agreed that it includes health professions that are NOT medical, dental or nursing professions and includes professionals involved in prevention and management of chronic and acute health conditions such as physiotherapists, social workers, occupational therapists, dieticians, medical imagers and pharmacists etc.

- The successful recruitment in March 2018 of Dr Mubasher on a three-year contract to work at MMC. Dr Mubasher is an overseas trained doctor who has relocated from Canada with his family.
- Arising from the negotiations for the accreditation of Dr Mubasher, the development of a strong partnership has developed between CHIRF and the Remote Vocational Training Scheme[3] (RVTS). CHIRF negotiated with RVTS for the provision of a scholarship for Dr Mubashar.
- Upgrade of Dr Renwick-Lau qualifications to enable the MMC to be a remote medical training facility to enable it to take GP registrars. In February 2018 , Dr Butlin, became MMC's first resident undertaking a one-year placement under the supervision of Dr Renwick-Lau.
- Ensuring the Cann River community has access to medical services through the commencement in August 2018 of an outreach medical service, one day a fortnight provided by Dr Renwick-Lau from the MMC provided and operating from the Cann River Bush Nursing Centre.

Upon the successful recruitment in early 2018 of Dr Mubashar and the placement of Dr Butlin as a GP registrar at the MMC, CHIRF began broadening its mission, to address the Mallacoota's and Cann River communities' other significant unmet PHC needs (including allied health services, resources, infrastructure and health workforce- medical, nursing and allied health).

In the short term the focus has been on improving mental health services and support in community for people living with chronic health conditions. In the longer-term, CHIRF is working to secure the provision of extended aged care services in Mallacoota including a residential aged care facility and high care nursing services.

All CHIRF's PHC strategies place the MMC as the service hub for coordination and delivery of services. CHIRF believes that for a small geographically remote rural towns like Mallacoota, a medical practice hub model is the most economically efficient approach for delivering PHC services.

Research conducted by CHIRF has found that access to general GPs in remote areas is not guaranteed even by the state-funded Community Health Services. The issue of attracting and retaining GPs to remote communities is endemic. Given this, CHIRF has focused on ensuring the MMC is financially viable and that all the operations are directed at giving the GPs an expanded scope of operations. To that end, CHIRF's efforts include ensuring the MMC has up-to-date equipment to support both the resident GPs scope of operations and to encourage visiting

[3] An Australian Government funded agency providing a vocational general practice three to four-year training program through structured distance education and supervision for medical practitioners. The training provided meets the requirements for Fellowship of both Australian College of Rural and Remote Medicine (ACRRM) and the Royal Australia College of General Practitioners (RACGP). The program is designed to allow doctors to continue working in remote and isolated communities in rural Australia (MMM 4-7).

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specialists and allied health services. CHIRF as a DGR charity is able to access funding sources and funding streams that are not readily accessible to private medical practices like the MMC.

To achieve CHIRF's expanded mission, in 2018 it increased its range of activities to include:

- Collaborating and partnering with other Mallacoota community members/groups in particular MIAC,
- Expanding its geographical focus to include the Wilderness Sapphire Coast region[4],
- Lobbying Mallacoota's Federal and State elected representatives, the GPHN, and the Victorian Workforce agency – Rural Workforce Agency Victoria (RWAV), and
- Writing grant applications to philanthropic and government departments.

CHIRF's successful funding applications from government and philanthropic organisations over the two-year period from July 2017 to May 2019 are detailed in the following table:

Funder	Program	Purpose	Fundees	Amount	Duration
Australian Government, Department of Health, Capital works	The Rural General Practice Grants program	The design, development and construction and fit-out on the property of a new medical centre, supported by MIAC funding and property ownership and a capacity to raise a mortgage.	CHIRF,	300,000	1year & 9mths (July 2017 – April 2019)
Foundation for Rural and Regional Renewal (FRRR)	Enhancing Community health outcomes (ECHO)	Funding to appoint a program manager to implement additional PHC services through the MMC and supporting the development of: • a coordinated mental health service • sustainable funding models for PHC services, and • an expansion of the Dr Search workforce recruitment program	CHIRF	$136,864	2 years (Dec 2018-Dec 2020)
GPHN	After-hours program-Nurse-led models pf care and coordination	Provide proactive health and logistic support to MMC patients to link to broader medical, health and community services. The target patient groups are: high-school aged young people and people living with chronic health conditions. Funding is specifically to support: the establishment of a nurse-led weekly "Teen Clinic" at the MMC	CHIRF	$78,800 (Teen Clinic $53,000, Chronic disease $25,000	1 year (Dec 2018-Dec 2019)

[4] The Wilderness Coast includes the townships of Mallacoota and Cann River and the Sapphire Coast situated in the southern-most region of NSW includes the townships of Bega, Narooma, Eden, and Merimbula

		run by an appropriately trained registered nurse; and Establish a nurse-led chronic disease rehabilitation management clinic at the MMC			
GPHN	After-hours primary care program	GP recruitment Participation in GPHN- led Mallacoota health service planning and development for mental health and after-hours care Participation in GPHN led meetings for expansion of primary health services to Cann river from Orbost Regional Health	CHIRF	$20,000	<1 year (Aug 2018- June 2019)

Some of the key programs and developments that have arisen as a result of this this funding as at May 2019 include:

- The commencement of a *Cardio Rehabilitation Program* in January 2019. The 9-week community based exercise and education program is being offered through the MMC to support its patients, their families or carers to assist in achieving heart and lung health. The program is being coordinated, and the exercise rehabilitation sessions are run by a newly recruited allied health assistant (an exercise specialist) who lives locally and work under the instruction of Dr. Renwick-Lau and a registered nurse. As part of the program, selected patients also have access to support for chronic pain. The program is interprofessional and includes inputs from a cardiologist (a visiting specialist), the local GP (Dr. Renwick-Lau), a registered nurse), occupational therapist, psychologist/metal health worker, local pharmacist and dietician/nutritionist. The program has addressed a significant PHC gap and demand is for places high, attendance strong and feedback very positive. CHIRF and the MMC are currently actively searching for ways of expanding the service to respond to address currently unmet community need.
- Through the FRRR Grant a visiting psychologist has been secured for 1.5 days a fortnight operating from the MMC. This replaces the telehealth service that was previously operating and was found to not be adequately meeting community needs. The service began in X and demand for the service is high. The ability to provide a psychology service has arose from CHIRF deciding to adopt a regional approach to addressing allied health workforce needs. In the case pf the psychologist this was secured through the new partnership with the Bega Valley Medical Practice. The securing of regular visiting psychologist through an outreach model has additional unfunded costs including transport and accommodation.
- By utilising limited community funds, CHIRF has also secured a visiting Mental Health Social Worker who works 1.5 days a fortnight. Demand for the service is similarly high. The provision of this service from a visiting health professional also has additional costs attached including transport and accommodation.

- The commencement in January 2019 of the training of a newly employed registered nurse who lives locally to support the running of a nurse-led Teen Clinic to operate out of the MMC starting by mid-2109. The clinic's purpose is to support the mental and general health and wellbeing needs of Mallacoota's school-aged young people (12-18yrs). The Teen Clinic involves a regional partnership between CHIRF, MMC and the Bega Valley Medical Practice and its owner Dr Duncan Mackinnon who developed the Teen Clinic model in 2016. Mallacoota is the fifth site to operate a Teen Clinic.
- Building of the new Medical Centre commenced in August 2017 and became operational on July 1 2019.
- Refurbishing the old Medical Centre during July – Sep 2019 to use as a base for MMC chronic disease rehab program.
- Recruitment of a Senior Project Manager (consultant) who is a leading academic in rural health workforce recruitment and retention research. The Project Manager's role is to support CHIRF to develop sustainable funding models for PHC services, develop processes to ensure data is collected and external evaluation undertaken of new activities to assess their effectiveness and efficiency and to support the possible development of a PHC service delivery framework for other small geographically remote rural communities to use.

Our Purpose, Vision, Values and Strategic Priorities

Purpose			
To ensure innovative, integrated, patient-centered, primary health care services and appropriate resources, infrastructure and workforce are available locally to the residents of the Mallacoota district.			
Vision			
The residents of Mallacoota District enjoy optimal health and wellbeing so they can grow, live, work and age well, while continuing to live locally. Research evidence is built to support other geographically remote small rural communities to help strengthen locally primary health care services.			
Values			
Community-engaged/led - Collaboration	**Integrity**	**Innovative and credible**	**Professional excellence**
We are inclusive and aim to represent and reflect the needs and viewpoints of the majority of the members of our community. We believe the best results arise from building strong, productive and mutually-beneficial partnerships with governments, businesses, not-for-profit organisations and individuals. As a health promotion charity, we actively engages in lobbying on health care issues on behalf of the community	We behave with honesty, accountability and reliability. We care for others and for ourselves. The decisions we make are transparent and we can be relied upon to follow through the agreements we make with others.	We are creative in the delivery of services to our community. The PHC services we support are patient-centered and delivered through the local medical practice which acts as a service hub. We believe local medical practices are the most efficient mode of delivery for local PHC services for geographically remote, small rural communities. Our priorities, decisions, policies and activities are always based on sound evidence and credible research and we actively seek,	People receiving our services are the driving force behind all decisions we make. We use resources in the most effective and efficient manner. We are dedicated to high standards of practice and promote opportunities for professional development for all our employees and staff working in local medical practices.

		support and encourage the evaluation and research needed to develop effective and efficient service models. We are active learners, see issues, identify the problems and seek to solve them the most efficient way possible. We believe that a financially viable, well-resourced work place and an environment that is conducive to workforce satisfaction is a critical element of our work.	
Strategic priorities and success measures			
Place-based health and wellbeing services	**Quality services**	**Community-owned/managed resources and infrastructure**	**Local professional workforce**
We will be a viable and effective organisation, ensuring high quality PHC services that people need, want and are provided locally.	We will continuously review and evaluate how we work to ensure the PHC services we fund are high-quality, effective and evidenced-based and our activities comply with all legal requirements and industry standards.	We will explore opportunities to purchase, build and expand community-owned assets to increase opportunities for people to receive PHC services locally and ensure their operational sustainability.	We will work to attract and retain suitably skilled and qualified staff who are valued for their contributions and care about the people they work with. We will work to attract and retain health professionals who are interested in living and working in the Wilderness Sapphire region

Our Plan

In order to achieve our priorities, we have set strategic objectives that will be achieved through a range of activities. Each objective has success measures that provide indicators of CHIRF's progress. Each activity has a date we are aiming to achieve this by and who or which organisation will lead these activities Our objectives may change over the life of this plan in response to external and internal events and decisions. Activities will be updated, as objectives change and/or specific activities are achieved, and new activities are identified. CHIRF's strategic plan will be available on its website and any updates will be posted.

Priority 1 (P1)	**Place-based health and wellbeing services** - *We will be a viable and effective organisation, ensuring high quality health and wellbeing services that people need, want and are provided locally.*		
Objective		**Activities**	***Success measure**
P1.1	Ensure CHIRF's stakeholders are informed about and engaged with changes to the organisation and the PHC sector	Write and distribute an electronic Newsletter and communicating CHIRF's developments and PHC sector news – produced three times a year Run a stall at local community markets operating in the Wilderness Sapphire region– conducted at least four times a year	Increase membership by 5%.

P1.2	Increase CHIRF's profile and explore new business opportunities.	Consult with medical practice partners on PHC service, resource and infrastructure and workforce needs in the present and near future (see examples Appendix 1)	Two new programs/ventures (potentially building on or redesigning an existing service or program).
P1.3	Understand the industry/ marketplace and look at growth opportunities for CHIRF, in a collaborative way with other service providers.	Research areas of interest for growth in the distant future considering demographics, service demand, existing providers (for examples see Appendix 1 Talk to current non-partnering local service providers about opportunities for collaboration.	Recommendations for growth priorities made and reviewed by the Board (i.e. geographic areas, target group/s, service type/s etc.) Minimum of one growth priorities decided upon.
P1.4	Aim to support other remote communities if requested to improve their locally provided PHC services through sharing our knowledge and skill sets	Work with organisations like RVTS to identify other communities and assist in workforce identification and retention	A cadre of remote communities working together to ensure workforce needs and health service requirements are met.

Priority 2 (P2)	**Quality services -** *We will continuously review and evaluate how we work to ensure our health services are high quality, effective and evidenced-based and our activities comply with legal requirements and industry standards.*		
Objective		**Activities**	***Success measure**
2.1	Establish a culture of evidenced-based practice informed by local research.	Develop partnerships with universities to undertake external evaluations of all new funded PHC services	100% of CHIRF funded new PHC services are externally evaluated by universities

		Build a funding provision into all grant applications to ensure evaluation of all service activities and supporting the development of models. Build a funding provision into all grant applications sufficient to support the organisational requirements of both CHIRF and MMC.	80% of recommendations of from service evaluation are addressed within recommended timeframes Improved outcomes for clients. Development of sustainable funding models for providing PHC services to geographically remote, small rural communities
2.2	Establish a culture of continuous improvement with CHIRF's members, staff, partner medical practices, patients/clients and other stakeholders.	Collect, analyse and report quarterly to board and partner organisations on the data collected on service activities. Establish and manage client/patient feedback mechanisms Identify and act upon any improvement suggestions	95% quality improvement suggestions addressed within required timeframes 85% return and response rate to stakeholder feedback mechanisms Improved outcomes for clients/patients
2.3	Ensure CHIRF's operating systems are fit for purpose.	Conduct a review of CHIRF' policies and procedures (e.g. financial management, human resources, work health and safety, strategy and governance). Revise operating systems as necessary	100% of policies and procedures reviewed. 95% operating system is fit for purpose

Priority 3 (P3)	**Community-owned/managed resources and infrastructure -** *We will explore opportunities to purchase, build and expand community-owned assets to increase opportunities for people to receive health and wellbeing services and ensure their viability.*

Objective		Activities	*Success measure
3.1	Develop a concept for Mallacoota for it to become a residential aged village	Identify the resources other large aged villages have and replicate in Mallacoota Work with Council on the infrastructure issues, mobility pathways etc.	
3.2	Obtain access to sufficient space to successfully operate the Rehabilitation Program	Identify funding to support rental of a shop in the main street, Identify partners to ensure gym equipment and necessary support options for Occupational Therapy and Physiotherapy. Source funding for a hydrotherapy pool	
3.3	Work to secure the provision of high care nursing services on the same site as the new medical centre	Plans have been developed and an initial costing is $10m for a 12-bed high medium care nursing facility with Palliative, End of Life capabilities and rooms for high tech equipment	
3.4	Work to secure the provision of residential aged care facility and high care nursing services locally	Investigate partnerships to support land and property development (e.g. with developers) to provide residential aged care facility Identify opportunities for government funded infrastructure assets	Commitments made to the development of aged care facility in Mallacoota and health workforce plans developed to staff facility
3.5	Investigate the shortfall in activities for kids of all ages in Mallacoota and seek ways to address them. Consider the use of the old medical centre for supervised kid's activities.	Inventory of existing services Comparison with other active communities in supporting kids' services	

		Identification of ability to provide services Funding needs.	
3.6	Develop funding support for after hours services based on a nurse triage model staffed by Nurse Practitioners &/or Registered nurses		
3.7	Consider the issue of patients returning home from hospital and health services away from Mallacoota and develop solutions.		
3.8	Maintain and active attendance at the major medical conferences and ensure CHIRF/MMC's focus is constantly being updated to address current issues, beyond just Dr Search.		

Priority 4 (P4)	**Local professional workforce** - *We will attract and retain suitably skilled and qualified staff who are valued for their contributions and care about the people they work with*		
Objective		**Activities**	***Success measure**
4.1	Ensure CHIRF and/or health medical practice partners effectively manages and plans for its current and future workforces.	Develop an innovative flexible workforce plan including use of locums broadening scope of practice, student placements) to meet the regions PHC service needs in present and near future that supports retention(see examples Appendix 1) Develop an innovative evidenced-based grow your own workforce strategy that encourages health careers aspirations in local young people including holiday paid work for local people studying health	80% of new health positions are filled within 3 months Increased enrolment into health courses by local high school students after completion of school Increased student placement opportunities and summer vacation employment for students studying health courses.

		courses at University (see examples Appendix 1)	
4.2	Ensure any future staff employed by CHIRF and/or its medical practice partners are a good fit for rural practice	Develop and implement selection criteria and interview questions to investigate interest in rural practice and an interprofessional approach. Develop and implement a staff satisfaction / turnover intention survey – to be implemented every 6 months	Job satisfaction is high among the staff working for CHIRF and/or its partner medical practices
4.3	Ensure any newcomer staff employed by CHIRF and/or its medical practice partners moving to live in the region are warmly welcomed and well-supported to settle in well and develop social connections and a sense of belonging to the community within first 12months	Identify and train community mentors to provide social support to newcomer health professionals Develop and implement a staff satisfaction / turnover intention survey – to be implemented every 6 months	Retention of newcomer health professionals working and living locally is greater than 12-months
4.4	Ensure the staff of CHIRF and/or its medical practice partners are recognised for improved performance and high-quality performance, directly related to patient/client outcomes.	Develop an incentive- based staff recognition program. Implement the staff recognition program.	Job satisfaction is high among the staff working in partner medical practices
4.5	Ensure CHIRF's Board has the right mix of skills and knowledge and has open and effective communication	Develop a Board succession plan that documents current Directors' skills and	Board positions are fully occupied. Board receives consistent reports regarding operations, finances, assets. staff risk and quality.

	with lead-personnel in partner organisations.	service history and considers gaps and likely position successors. Document CEO-Board reporting processes, including templates for regular reporting, frequency and mechanisms for escalation of issues.	

References

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