

Home and Community Care (HACC) Program

Eastern Metropolitan Region Triennial Plan 2006-09



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1 Introduction

This document sets out how the Eastern Metropolitan Region (EMR) will implement the Victorian Aged Care Minister's Home and Community Care (HACC) priorities for 2006-09 (refer to 'Victorian HACC Program Expenditure Priorities Statement 2006-09'). The aim was to set goals for service expansion and achieve them progressively over the three-year period by expanding HACC services where the demand was greatest and in line with strategic HACC directions. This document provided the basis for consulting with service providers and other stakeholders about the expansion of HACC services during 2006-09. This document was adjusted as necessary in response to feedback and forms the basis of the Eastern Metropolitan Regional Triennial Plan 2006-09.

The Region has analysed funding per capita, service provision, demographic data and relevant reports to achieve funds equity across Local Government Areas (LGAs) and proposes a response to the Ministerial Priorities. In summary the HACC priorities for 2006-09 are:

- to accelerate progress towards inter-regional equity
- Priority 1 – to expand HACC Basic services and social support (planned activity groups) taking into account broader Victorian service development directions
- Priority 2 – to implement strategies to enhance access to HACC Basic services by people from Culturally and Linguistically Diverse Backgrounds (CALD) and to expand social support (planned activity groups)
- Priority 3 – to enhance access to services by Aboriginal people.

2 Consultation

In order to manage and support the HACC sector effectively, EMR engages in a number of strategies to develop and sustain partnerships and to enhance sharing of local knowledge. These strategies enable EMR and HACC Community Service Organisations to understand the needs of the HACC sector and to work together to develop services and implement changes that will better meet the needs of HACC clients.

2.1 General advisory and feedback mechanism already in place/and or planned

EMR works through a number of strategies to develop and maintain collaborative partnerships to share local knowledge with organisations. A range of forums and networks support and promote discussion, these include:

- HACC Planning Forums
- The Eastern Transport Access Network (ETAN)
- EMR HACC Training Advisory Committee
- State-wide HACC Training Committee
- Workforce Development Consultation Committee
- CSO networks including Councils, Community Health Services (CHS) and Planned Activity Group (PAG) providers
- HACC CALD Network - the key advisory and consultative body in EMR in relation to CALD issues
- EMR HACC CALD Strategic Plan Steering Group
- EMR Cultural Equitable Gateways Strategy (CEGS) Steering Committee
- State-wide CEGS Working Group Meeting
- EMR Equity and Access Steering Committee

- Koori Metropolitan HACC Network
- Regional Aboriginal Planning Group
- Primary Care Partnerships (PCPs)

Participation in all of the above forums provides the Region with an understanding of issues that arise for organisations. EMR provides information and promotes discussion on policy initiatives to respond to concerns raised by them. These networks have facilitated communication with organisations and assisted in strengthening relationships.

2.1.1 Processes undertaken to consult with the sector on the strategic intentions for the triennium

During July 2006, EMR presented a Draft Regional Triennial Plan Consultation Document to the sector to seek critical appraisal on the proposed strategic intentions. The aim was to test the proposed directions by EMR and change them where information had been overlooked or where a more sensible conclusion could be drawn from the available evidence.

Consultation sessions were held on the following dates:

Consultations	Date	Total number of attendees	Number of service providers	C'wealth representative in attendance
Waratah Room Nunawading	5 July 2006	42	27	1
Karralyka Centre Ringwood East	7 July 2006	32	22	1
ATSI, Healesville	13 July 2006	3	1	0
ATSI, Croydon	14 July 2006	1	1	0

2.2 Outcomes of consultation

The consultation sessions were attended by 78 people and there was much discussion on the proposed Triennial Plan. Written comments were encouraged and also received until 14 July 2006. The discussion centred on the planned state-wide initiatives that is, Assessment and Care Coordination, ASM, Respite, Social Support and Carers review and the likely outcomes from these. Concern was expressed that activities within the review would not receive growth until the process was finalised. Another area of concern was the unit prices and the problem resulting from this. Organisations were generally satisfied with the growth in core services and there was little change from the purpose and direction of the draft plan presented.

3 Joint Commonwealth/State commitment

Commonwealth/State matched growth in HACC service expansion is estimated to be \$55.9 million over the next three years, that is, \$17.4m in 2006-07, \$18.6m in 2007-08, and \$19.9m in 2008 -09. This is subject to annual confirmation.

The indicative growth funding will be allocated via the revised equity approach outlined in 'Victorian HACC Program Expenditure Priorities Statement 2006-09'. That is:

- All regions will receive funding to maintain existing per capita funding levels, responding to population growth during the triennium

- Additional funding will be provided to five under funded regions (North & West Metropolitan Region, Southern Metropolitan Region, Eastern Metropolitan Region, Barwon-South Western Region and Gippsland Region) to move them to defined funding benchmarks over the triennium, thus moving them closer to equity.

Indicative allocations for each region are listed below:

Indicative Growth Funding Based on Estimates

Region	Growth 2006-07	Growth 2007-08	Growth 2008-09
Barwon SW	\$1,656,000	\$1,534,000	\$1,583,000
Grampians	\$ 651,000	\$ 661,000	\$ 654,000
Loddon Mallee	\$ 877,000	\$ 829,000	\$ 862,000
Hume	\$ 747,000	\$ 881,000	\$ 879,000
Gippsland	\$1,719,000	\$1,706,000	\$1,765,000
North West Metro	\$6,035,000	\$6,580,000	\$6,785,000
Eastern Metro	\$2,622,000	\$2,663,000	\$2,489,000
Southern Metro	\$3,085,000	\$3,452,000	\$3,315,000
TOTAL	\$17,392,000	\$18,306,000	\$18,332,000

4 Strategic Needs Analysis

4.1 Program influences

In developing proposals for HACC service expansion, EMR Triennial Plan has taken into account that HACC operates in an environment influenced by services in the broader human services sector as well as initiatives within the HACC sector.

Factors considered in formulating the EMR Plan included the decline in pension level Supported Residential Services (SRS), expansion of flexible support options for people with disabilities, Commonwealth Community Care Packages, EMR HACC CALD Strategic Plan, ASM, Well for Life targeting Public Sector Residential Aged Care and PAGs and the draft Walking Together for the Future EMR Aboriginal Services Plan 2006-09.

EMR has also considered the DHS Plan 2006-07, program direction detailed in 'Community Health Services - creating a healthier Victoria' and 'Care in your Community – a planning framework for integrated ambulatory health care'. These policies provide for future direction, while focusing on improving the health and quality of life outcomes for people with chronic disease and/or complex needs. The policies aim to increase the capacity of individuals and support them to self manage and thereby enhance client responsiveness and broaden opportunities for alternative responses to hospital presentations and admissions.

These initiatives will enhance and improve integrated planning at a local level by strengthening and further fostering partnerships between organisations and Primary Care Partnerships more broadly. There will be an increasing focus on the development of care plans for individuals that respond to the client rather than care plans that consider the capacity of individual programs. The challenge for HACC and other programs areas will be to support these developments whilst preserving and improving program service delivery levels.

It is considered that the directions in the HACC Program complement these initiatives. Regional planning has taken account of where EMR anticipates the state-wide initiatives will focus future funding.

4.1.1 Victorian HACC Program strategic directions 2006-09

There are a number of HACC and Aged Care Assessment Service (ACAS) development projects that will be implemented during 2006-09 that will have a significant impact on local planning recommendations and developmental initiatives. These are briefly described below.

4.1.1.1 Decisions by Heads of Government and renegotiation of the HACC Agreement

(i) Implementing 'common arrangements'

On 10 February 2006, the Council of Australian Governments (COAG) met and agreed to a commitment to implement strategies to enhance and simplify access points to community based services and to rationalise assessment by December 2007. Community Care Officials have established a cross jurisdictional working group to guide research and development of this "common arrangement" in eligibility and assessment. The outcomes from this working group will further inform service development in Victoria over the triennium.

Victoria's assessment framework is consistent with this commitment and will be the vehicle for implementing it in Victoria.

(ii) HACC Renegotiation

The revised HACC Agreement is likely to include a commitment by jurisdictions to develop and implement a more consistent approach to planning, quality assurance and financial accountability. Community Care Officials have established cross jurisdictional working groups to guide development of planning, accountability, information technology and management. The outcomes from these working groups will further inform service development in Victoria over the triennium.

(iii) HACC triennial planning

It is likely that the revised HACC Agreement will incorporate the concept of a triennial plan. Victoria's existing triennial planning process is consistent with these arrangements but there is likely to be a timing constraint as the national triennial process is likely to be implemented in year 2 of Victoria's triennial timeframe. Victoria will implement a transition timeframe to align with national ones.

4.1.1.2 Active Service Model (ASM)

The aim of the ASM Project is to work collaboratively with HACC organisations to develop strategies to increase the Victorian HACC Program's effectiveness in maximising client independence through person centred and capacity building approaches to service delivery. The outcomes sought are:

- changes in the community's, workforce's and clients' perceptions of frail older people's functional capacity and the capacity of people with disabilities
- clients' functional capacity is improved or maintained such that their need for recurrent services is delayed or reduced.

The challenge for the HACC Program is to move from a 'dependency' model of service delivery where tasks are largely done for clients, to a restorative care and capacity

building approach to meet clients' basic maintenance and support needs. Instead of assuming constant decline, the aim is to retain or improve clients' independence and self-efficacy thereby minimising the impact of functional decline on the person's capacity to live at home and participate in everyday social interactions. This might mean assisting a client to shower themselves rather than doing it for them, or introducing clients to lighter and easy to use cleaning equipment in preference to doing all the cleaning for the person, or making minor modifications to the home environment.

The HACC ASM initiative is a developmental service enhancement project to occur over a number of years. The approach will have implications for the full suite of HACC activities. During 2006-07, the Department's focus is on gathering information through research, pilot projects and consultation. This will inform an implementation plan which will come into effect for the 2007-09 period. One important direction for regions is to foster more coordinated and integrated practice between HACC funded In Home Support and Health Services (refer to section 5.3), particularly within the context of the implementation of the HACC Assessment Framework.

4.1.1.3 Assessment and Care Coordination in HACC

'The Strategic Directions in Assessment in HACC: Final Report' (December 2005) set the key policy directions for the development of the Assessment and Care Coordination Framework in the HACC program. These include:

- splitting assessment and care coordination into two separately funded activities
- using care coordination to assist CALD and Aboriginal organisations to carry out a key support, monitoring and bridging role to large mainstream assessment and service delivery organisations
- consolidating HACC assessment funds to designated organisations that have the appropriate workforce and infrastructure.

Over 2006-09 the HACC Program will:

- develop the HACC Assessment and Care Coordination Framework, including consultation with the funded sector
- ensure that the Framework incorporates the agreed 'common arrangements' that are part of the Commonwealth's community care reforms
- develop a funding formula for assessment, client care co-ordination and case management as three separate HACC activities
- define the function, roles and expertise required for client care co-ordination, incorporating the Culturally Equitable Gateways Strategy (CEGS) evaluation findings
- develop a process for formally designating organisations as assessment or care coordination organisations
- implement the Framework by working with organisations to promote an active and independent approach.

Regional planning will respond to the progressive implementation of the framework.

4.1.1.4 Review of respite, social support and carers

The community care sector has expressed the view that the HACC Program should allocate growth funding to social support and respite in the coming triennium. Ethno-specific organisations have stressed the role of social support as an entry-point into HACC services.

A department wide policy on recognising and supporting care relationships is being finalised and will provide a framework for a coordinated and integrated approach to meet

the needs of carers and the people for whom they care. The policy will be supported by action plans from relevant program areas. The carer policy and action plans are scheduled for completion in 2006. Equally, it will be important for the HACC Program to put into effect the principles in the DHS framework on recognising and supporting care relationships.

This task needs to be tackled in collaboration with other programs and other levels of government. For example, understanding the consequences of shifts in the demography and workforce structure of Australian society is important. These shifts seem to have an impact on women aged

40–65, who currently constitute a significant proportion of carers. An increasing proportion of women in this age group are in the paid workforce; it is also apparent that in many cases, they continue to take a caring role in relation to older relatives and/or disabled children. We need to identify and understand these and other trends and what they mean for a suite of services that have been in existence, relatively unchanged, for many years.

It is proposed to undertake a research and development project during the first 18 months of the triennium, leading to a funding strategy for respite and social support that will further inform regional developments in the out years of the Triennium.

4.1.1.5 Culturally Equitable Gateways Strategy CEGS

The objective of CEGS is to achieve a greater representation of people aged 65+ from CALD backgrounds among those using core HACC services primarily provided by Councils. Services targeted are domestic assistance, personal care, delivered meals, respite, property maintenance, and assessment.

To assess whether CEGS has been successful in achieving the above aim, an evaluation framework was developed to assist CEGS funded organisations to collect data that will facilitate the evaluation of CEGS. The evaluation of the Strategy is due to be completed in late 2006. The evaluation will inform decisions on the future of the Strategy. Regional planning will take account of CEGS developments and regional priorities to enhance access to core services by CALD groups.

4.1.2.6 Indigenous HACC Viability Funding Models Project

As part of a broader strategy aimed at developing HACC Program responses to the needs of Victorian Aboriginal communities, a consultancy project has commenced to consider the impact of small budgets and broad service provision expectations on Aboriginal specific organisations and examine a number of existing and proposed models of service provision that will provide options for funding services for Aboriginal communities that are more sustainable in the long term.

4.1.2 Regional response to address program developments

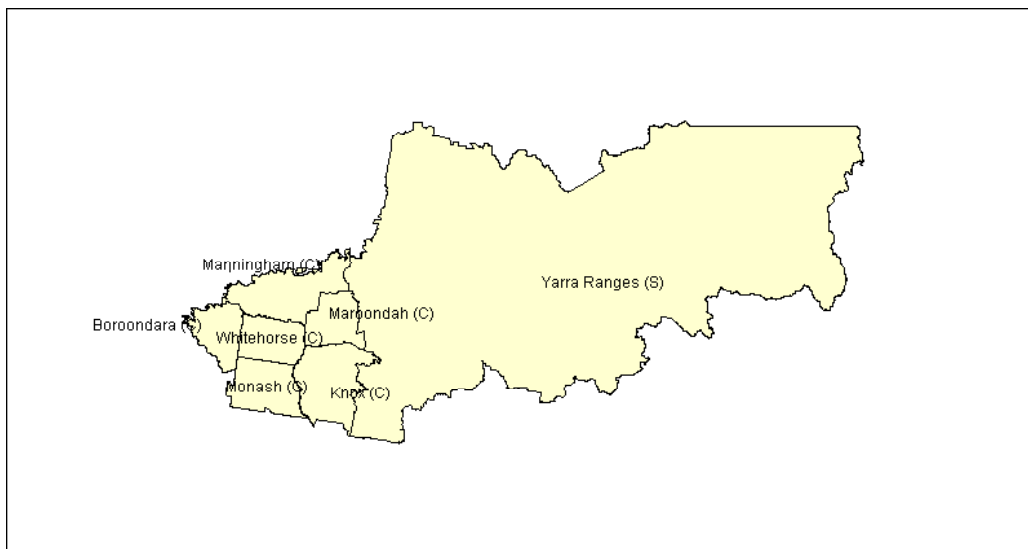
EMR will take into account implementation of a number of inter-connected service development initiatives including the HACC Assessment Framework and ASM. Key learnings from pilot projects and outcomes of the research phase of the ASM, outcomes from the respite, social support and carers initiative, and outcomes from the CEGS evaluation. EMR has planned additional strategic targeting of resources to meet the implementation of these service development projects for 2007-08 and 2008-09.

4.2 EMR HACC profile

4.2.1 Profile of EMR

EMR is a large and diverse metropolitan region in Melbourne. It includes the City of Boroondara with inner suburbs such as Kew, Camberwell and Hawthorn. While these suburbs are perceived as being relatively affluent there is the ongoing issue of 'asset rich' and 'income poor' elderly people residing in these areas. There is also the relative high number of boarding houses and supported residential services. Although the municipalities of Whitehorse, Manningham, Monash, Knox, and Maroondah have some affluent areas, they contain pockets of residents with a lower socio economic status i.e. the public housing estate in Ashburton and residents living in integrated Public Housing across all municipalities in the Region. In addition, there are clusters of low rental properties and caravan parks scattered across the Region. Geographically, the largest municipality is the Shire of Yarra Ranges. It has a mixture of urban and rural communities and over 40 townships. Within EMR, one third of the Aboriginal population lives in the Shire of Yarra Ranges.

Figure 3.1: Local government areas in Region



4.2.1.1 The HACC service sector

EMR provides funds to 85 (including Royal District Nursing Service). Of these, two are state-wide and eleven provide cross regional services. EMR has a diverse group of organisations providing services in the area including:

- Seven Councils
- Eight Community Health Services
- Two Hospitals/Networks - Eastern Health Care Network (Peter James Centre and Yarra Valley Community Health Service); and the Sisters of Charity Health Services (St George's Hospital)
- 54 organisations
- 14 CALD organisations

4.2.2 Preface to data considerations

To address the Strategic Ministerial Priorities, data has been gathered and analysed to provide an evidence-based approach to planning and funds allocation in anticipation of growth funds over the triennium, 2006-09. The focus of the examination has been on developing a picture of HACC services in the Region in terms of the relative funding levels per capita, population demographics, service supply and demand.

The Relative Resource Equity Formula (RREF) gives estimates of the target populations at regional and LGA levels, and has been combined with data on current resources to determine current per capita funding. The triennial HACC equity strategy, which aims to reach set funding levels in per capita terms, has been used to allocate regional growth funds in amounts which will enable regions to reach those levels by 2009, allowing for population growth over the period.

This information has been used to anticipate where the demand in HACC services will be greatest between 2006-09, and to assist where best to target resources in response to population growth.

The data included a number of data sets used by EMR to develop the Regional Plan, as well as additional data available locally. The primary data included population, funding, service provision data and the 'Cultural diversity, ageing and HACC: trends in Victoria in the next 15 years' Report.

4.2.3 Population profile

In developing data to determine the relative HACC population, DHS uses the RREF to identify the relative need for HACC services across the eight regions in Victoria. The RREF is then used to allocate the growth funds between the regions.

DHS uses RREF-LGA to indicate relative need for HACC services at LGA level within each region. The table below provides projected population growth over the triennium.

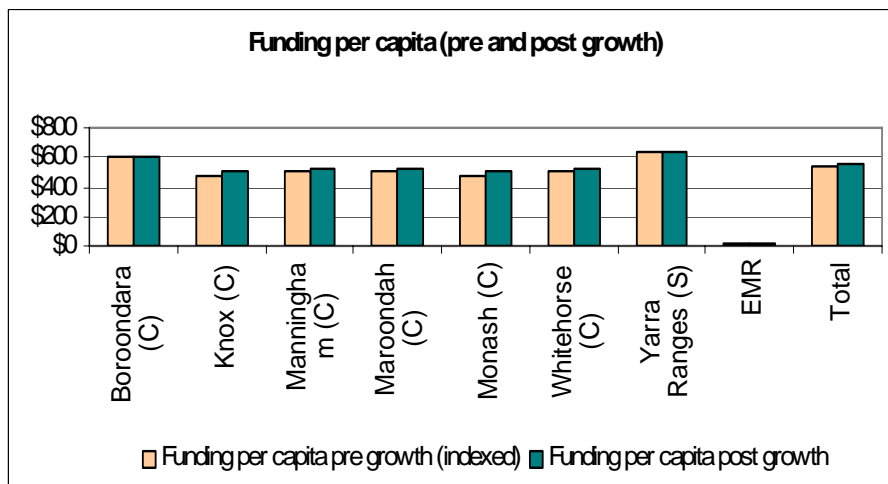
LGA	RREF-LGA pop 2006-07	RREF-LGA pop 2007-08	RREF-LGA pop 2008-09
Boroondara (C)	19,946	19,915	19,888
Knox (C)	18,269	18,791	19,315
Manningham (C)	17,710	18,295	18,882
Maroondah (C)	14,200	14,564	14,929
Monash (C)	26,323	26,788	27,256
Whitehorse (C)	22,872	23,106	23,341
Yarra Ranges (S)	17,142	17,523	17,904
Total	136,462	138,983	141,516

From the above table, EMR HACC population is estimated to increase by 5,054 people (3.6%) over the three years.

The largest HACC population growth will be in the municipalities of Manningham and Knox with an estimated increase of 1,172 (6.2%) and 1,046 (5.4%) respectively.

Followed by:

Monash	933 - 3.4%
Yarra Ranges	762 - 4.3%
Maroondah	729 - 4.9%
Whitehorse	469 - 2.0%
Boroondara	-58 - (0.3%)



4.2.3.1 Regional funding – per capita

LGA	Funding per capita pre growth (indexed)	Funding per capita post growth (2008-09)
Boroondara	\$ 568.71	\$ 609.41
Knox	\$ 413.99	\$ 503.50
Manningham	\$ 445.13	\$ 521.30
Maroondah	\$ 480.48	\$ 522.79
Monash	\$ 433.61	\$ 500.56
Whitehorse	\$ 455.06	\$ 522.77
Yarra Ranges	\$ 624.96	\$ 644.01
EMR	\$ 12.27	\$ 12.53
Total	\$ 497.00	\$ 555.71

4.2.3.2 Regional service provision profile

The relative levels of service delivery by activity were analysed using the available Minimum Data Set (MDS) for 2004-05 and 2005-06 pro rata. The analysis indicates that on a regional basis HACC basic service provision was broadly meeting performance targets, whilst acknowledging some variations exist. Issues contributing to this were staff recruitment and retention difficulties, reporting and software issues.

4.2.4 Regional strategic directions informing HACC planning

EMR has analysed quantitative data and information gained from contact with organisations that indicate that the LGAs are experiencing growth and demand for HACC services. Organisations have put in place demand management strategies to address the complexity, demand in growth and expectation of HACC service needs.

The recommendations of the 'EMR HACC CALD Strategic Plan' (completed 2005) are also being implemented in EMR. This includes funding a HACC Cultural Planning & Adviser position at the Migrant Information Centre (MIC) and a project focusing on the establishment of assessment and care coordination processes between ethno-specific organisations and Councils.

5.2 Funding priorities

Following analysis of the data available, provision and demand for HACC services, infrastructure and regional information available from organisations, EMR will allocate growth funds to address equity across the Region. The following strategies are proposed for the three priorities:

5.2.1 Priority 1

EMR proposes that overall 92.3% of growth funding will be targeted to Priority 1, to meet demand for HACC basic services and strengthen Allied Health in anticipation of demand flowing from the ASM project. Provision has been made in 2007-08 and 2008-09 within each LGA for Service Group 5 (Other) to assist with implementation of the ASM. Nursing services will also be grown within the relatively under resourced LGAs particularly in 2006-07 and 2007-08.

Whilst funding has not been specifically targeted towards CALD communities it is expected that access to mainstream services by CALD communities will increase. This should be reflected in MDS.

The LGAs of Knox and Monash will be grown to a lower per capita, primarily to enable these Councils time for planning to increase infrastructure capacity before larger injections of growth are allocated and at a higher rate in 2007-08, 2008-09 and the following Triennium.

Funding for assessment has not been provided in 2006-07 pending the outcomes of the HACC assessment and care co-ordination framework. However, provision has been made in 2007-08 and 2008-09 for these activities.

5.2.2 Priority 2

EMR proposes allocating 5% growth in 2006-07 under Priority 2. Funding will be targeted towards ethno-specific organisations to expand Social Support services for CALD communities.

Funding has been set aside in 2007-08 and 2008-09 for the expansion of social support services more broadly. Further consideration will be given at the time to determine how the funds will be specifically allocated.

5.2.3 Priority 3

EMR intends to build on initiatives funded in 2004-05 and 2005-06 and proposes to allocate 2.7% of growth funding under Priority 3. This will further expand services to the Aboriginal population across the Region to improve access to HACC services. MDS has indicated that there is poor usage and uptake of In Home Support services by the Aboriginal community in EMR, particularly outside the Shire of Yarra Ranges.

5.3 Service group priorities

In 2006-09, Victoria is trialling the merit of clustering recommendations for indicative growth in the Triennial Plan into service groupings. We expect that this will make it easier to see the strategic impact of regional funding priorities over the triennium in response to strategic directions set centrally. It will still provide room for annual service mix adjustments in response to local changes.

The annual plan recommendations for growth, allocations to organisations and monitoring of performance will continue to be at activity level.

Within each priority, the region proposes the following proportionate allocation to specific Service Groupings (SG) where:

- **SG1** is **Assessment** and incorporates assessment and client care co-ordination
- **SG2** is **Health** and incorporates allied health and nursing
- **SG3** is **In home support** and incorporates domestic assistance, personal care, respite and property maintenance
- **SG4** is **Social support** and incorporates planned activity groups and volunteer co-ordination
- **SG5** is **Other** and incorporates delivered meals, flexible service response, service system resourcing

5.3.1 Proportionate allocation to specific service groupings

EMR	Year 1	Year 1	Year 1	Year 2	Year 2	Year 2	Year 3	Year 3	Year 3
Service Groups	Priority 1	Priority 2	Priority 3	Priority 1	Priority 2	Priority 3	Priority 1	Priority 2	Priority 3
SG 1 Assessment				15.4%			15.1%		
SG 2 Health	62.8%			46.5%			36.7%		
SG 3 In home support	36.1%			33.1%		23.8%	41.3%		100%
SG 4 Social Support		100%	100%		100%			100%	
SG 5 Other	1.1%			4.9%		76.2%	6.8%		
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%

EMR (DHS)	Year 1	Year 1	Year 1	Year 2	Year 2	Year 2	Year 3	Year 3	Year 3
Service Groups	Priority 1	Priority 2	Priority 3	Priority 1	Priority 2	Priority 3	Priority 1	Priority 2	Priority 3
SG 5 Other	100%								
Total	100%								

Boroondara	Year 1	Year 1	Year 1	Year 2	Year 2	Year 2	Year 3	Year 3	Year 3
Service Groups	Priority 1	Priority 2	Priority 3	Priority 1	Priority 2	Priority 3	Priority 1	Priority 2	Priority 3
SG 1 Assessment				29.6%					
SG 2 Health	65.9%								
SG 3 In home support	34.1%								
SG 4 Social Support			100%						
SG 5 Other				70.4%		100%			
Total	100%		100%	100%		100%			

Knox	Year 1	Year 1	Year 1	Year 2	Year 2	Year 2	Year 3	Year 3	Year 3
Service Groups	Priority 1	Priority 2	Priority 3	Priority 1	Priority 2	Priority 3	Priority 1	Priority 2	Priority 3
SG 1 Assessment				11.9%			8.6%		
SG 2 Health	100%			38.9%			21.3%		
SG 3 In home support				49.2%			63.6%		
SG 4 Social Support		100%	100%		100%			100%	
SG 5 Other						100%	6.5%		
Total	100%	100%	100%	100%	100%	100%	100%	100%	

Manningham	Year 1	Year 1	Year 1	Year 2	Year 2	Year 2	Year 3	Year 3	Year 3
Service Groups	Priority 1	Priority 2	Priority 3	Priority 1	Priority 2	Priority 3	Priority 1	Priority 2	Priority 3
SG 1 Assessment				11.1%			19.2%		
SG 2 Health	63.4%			57.4%			47.6%		
SG 3 In home support	36.6%			25.6%			33.2%		
SG 4 Social Support			100%						
SG 5 Other				5.9%		100%			
Total	100%		100%	100%		100%	100%		

Maroondah	Year 1	Year 1	Year 1	Year 2	Year 2	Year 2	Year 3	Year 3	Year 3
Service Groups	Priority 1	Priority 2	Priority 3	Priority 1	Priority 2	Priority 3	Priority 1	Priority 2	Priority 3
SG 1 Assessment				35.4%			14%		
SG 2 Health	69%						48%		
SG 3 In home support	31%			64.6%			24.9%		
SG 4 Social Support		100%	100%						
SG 5 Other						100%	13.1%		
Total	100%	100%	100%	100%		100%	100%		

Monash	Year 1	Year 1	Year 1	Year 2	Year 2	Year 2	Year 3	Year 3	Year 3
Service Groups	Priority 1	Priority 2	Priority 3	Priority 1	Priority 2	Priority 3	Priority 1	Priority 2	Priority 3
SG 1 Assessment				14.8%			11.5%		
SG 2 Health	56.9%			52.6%			44.7%		
SG 3 In home support	43.1%						38.2%		
SG 4 Social Support			100%	32.6%					
SG 5 Other						100%	5.7%		
Total	100%		100%	100%		100%	100%		

Whitehorse	Year 1	Year 1	Year 1	Year 2	Year 2	Year 2	Year 3	Year 3	Year 3
Service Groups	Priority 1	Priority 2	Priority 3	Priority 1	Priority 2	Priority 3	Priority 1	Priority 2	Priority 3
SG 1 Assessment				19.5%			32.1%		
SG 2 Health	56.2%			52.9%			24.5%		
SG 3 In home support	43.8%			27.6%			30.8%		
SG 4 Social Support			100%		100%				
SG 5 Other						100%	12.6%		
Total	100%		100%	100%	100%	100%	100%		

Yarra Ranges	Year 1	Year 1	Year 1	Year 2	Year 2	Year 2	Year 3	Year 3	Year 3
Service Groups	Priority 1	Priority 2	Priority 3	Priority 1	Priority 2	Priority 3	Priority 1	Priority 2	Priority 3
SG 1 Assessment									
SG 2 Health	59.9%								
SG 3 In home support	40.1%					47.2%			100%
SG 4 Social Support			100%						
SG 5 Other				100%		52.8%			
Total	100%		100%	100%		100%			100%

5.3.2 Priority 1 service focus

The data demonstrates that within Priority 1, the Region should focus on growing HACC services in Health (Service Group 2) and In home support (Service Group 3).

Over the triennium the allocation of 5% to social support has been maintained. It is anticipated that the outcomes of the review into social support and respite may refocus the target of these funds within Social Support (Service Group 4).

EMR has proposed 34.6% of funds allocation to In Home Support (Service Group 3) over the triennium. It is anticipated that as a result of the review of the ASM the distribution of these funds within activities may need to be reallocated to address anticipated growth within both respite and service coordination.

5.3.2 Priority 2 service focus

The key focus for Priority 2 will be on expanding Planned Activity Groups provided by ethno-specific organisations to CALD communities.

A review of respite, social support and carers will be undertaken within the first 18 months of the triennium. It is likely that this will impact on CALD communities. Once the outcomes of the Research and Development Project are known, some adjustments may be necessary to proposed allocations to resource outcomes.

5.3.3 Priority 3 service focus

EMR proposes to target In Home Support and Social Support to the Aboriginal community across the Region. Funding will be directed to the two Aboriginal specific service providers within EMR, located in the Shire of Yarra Ranges and the City of Maroondah.

PAGs are currently well attended by the Aboriginal community and will be expanded to service additional clients and act as a gateway to the broader HACC service system. Volunteer Coordination has also been identified as a need in the Shire of Yarra Ranges and will assist in promoting skills and capacity building within the Aboriginal community.

The increased funding to the Shire of Yarra Ranges In Home Support services will be targeted towards new clients in 2007-08 and 2008-09 following initiatives focusing on increased Aboriginal identification. The outcomes of a service development initiative in 2006-07 focusing on increasing the capacity of mainstream service providers to effectively deliver In Home Support services to Aboriginal HACC-eligible clients across the Region will inform future direction.

6 Service Development Grant (SDG)

Pending the outcomes of the state-wide initiatives on the HACC Assessment and Care Coordination Framework and the Active Service Model, EMR will use SDG funding in 2007-09 to work collaboratively with organisations to implement recommendations.