



**Community Health Plan
Continued Operations
2003 – 2004**

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ATTACHMENT

A MVM PCP Integrated Health Promotion Plan 2002-2003

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Executive Summary

The MVM PCP Community Health Plan (CHP) 2003-2004 is the revised working document of the partnership. Presented is an overview of the key achievements for the past year, and the operational plan for 2003-2004.

The Key Achievements of the Partnership 2002-2003 include:

Partnerships

- Consumer forums in Moonee Valley and North Melbourne to report on CHP progress and engage with the community.
- Consumer focus groups to gain feedback and develop strategies for ongoing improvements in Service Coordination work.
- Consumer participation in project activity eg Youth Access Program, Carers Project, Foothold on Safety, Mental Health Care Coordination and CALD Needs Project.
- Consultation with consumers in the Western Metropolitan Region (WMR) in the development of the WMR Service Coordination Best Practice and Continuous Improvement Manual (WMR BPM) for Service Coordination implementation.
- Ongoing involvement of GPs in projects through focus groups (Mental Health, CBD Project, HARP Asthma) and involvement in PCP working groups.
- Partnership activities with Melbourne Health and Royal Children's Hospital (acute/subacute sector) resulting in improved project planning and trials of the Service Coordination Tool Templates (SCTT).
- Progression of ICT/IT issues with primary care agencies and acute care.

Integrated Service Planning

- Alignment of effort in relation to MPHP and CHP planning processes.
- Revision of future directions for Integrated Service Planning across the PCP catchment area.
- Completion of Complex Care Needs in the CBD project (Complex Care Needs Priority).
- Active participation in Western Region Cross-alliance planning forums.
- Ongoing collaboration with Primary Mental Health team development (Mental Health Priority).
- Ongoing collaborations with Melbourne Health on priority health issues and translation of these into active HARP projects. These included:
 - Diabetic Foot Project (Diabetes/Cardiovascular Health Priority)
 - COPD Project (Asthma/Respiratory Health Priority)
 - Falls Project (Falls/Injury Prevention Priority)
 - Frequent ED Attenders with Psychosocial Needs Project (Mental Health/Complex Needs Health Priority)
 - Mental Health Step Down Facility (Mental Health Priority)
- Ongoing collaborations with Royal Children's Hospital on priority health issues and translation of these into active HARP projects. This included a successful project in collaboration with Dianella Community Health on Children's Asthma (asthma health priority) and identification of children's injury as a primary health prevention need (Falls/Injury prevention health priority).
- Development of MVM PCP Health Promotion Network.
- Implemented integrated health promotion programs including the Youth Access Program (Mental Health Priority) and Foothold on Safety Programs (Falls/Injury Prevention Priority).
- Development of a Neighbourhood Project and submission to FACS focussing on consultation with people in the North Melbourne Housing Estate and improving access to services (Neighbourhood Planning – North Melbourne Priority).

- Participation in the RCH Platforms Project, which is focussed on increasing early identification of children's developmental needs (Disability Health Priority – Early Intervention 0-8).

Service Coordination

- Significant member agency contribution to the development and completion of the WMR BPM for Service Coordination for use by Western Region PCP agencies.
- Contribution to and implementation of WMR Do it Yourself Privacy Kit.
- Management of and completion of three specific Western Region service coordination projects to address Carers Needs (Disability Health Priority), CALD Needs and Mental Health Coordinated Care Planning (Mental Health Priority).
- Regional oversight and local implementation of WMR PCP E Business activities including establishment of WMR PCP Website, Service Directory, e Referral and online tools such as the WMR BPM.
- Commencement of a Training Project to support Ethno-specific and smaller agencies to implement the SCTT and the WMR BPM.
- Management and completion of WMR CALD Aged Care Strategic Plan.
- Implementation of the SCTT by mandated agencies across the MVM PCP catchment (Local Government, Community Health, ACAS and RDNS).
- Implementation of the WMR BPM by mandated agencies across the MVM PCP catchment.
- Ongoing support to non-mandated agencies (acute care, PDSS) to implement SCTT and the WMR BPM.
- Implementation of SCTT in Acute Care in HARP projects with Melbourne Health and Royal Children's Hospital.

The Operational Plan of the Partnership 2003-2004 focuses on:

Partnerships

- Maintain ongoing commitment of key partners including GPs.
- Ensure ongoing engagement with the acute/subacute sector.
- Ensure ongoing engagement and participation of consumers.

Integrated Service Planning

- Ongoing progress of project work to date in relation to identified priorities including HARP/Chronic Conditions, CBD project outcomes, CALD Aged Care Strategic Plan implementation, North Melbourne Neighbourhood planning and MVCC/RCH Platforms project.
- A further agreement of the partners to develop and implement integrated service plans that improve the current service system for consumers with a focus on:
 - Improved care planning and service delivery to Aged and Disability Clients across the catchment
 - Improved care planning and service delivery to clients with chronic care needs (HARP, Emergency Demand)
 - Improved Service Coordination for Children's Services.
- Ongoing progress with Integrated Health Promotion Priorities, Youth Mental Health and Foothold on Safety and facilitation of MVM PCP Health Promotion network.
- A further agreement of the partners to develop and implement an integrated health promotion plan for the catchment, that aligns current health promotion activities.

Service Coordination

- Expand and support the range of agencies implementing the statewide SCTT and WMR BPM.
- Ongoing implementation the use of the WMR Service Directory and E referral.
- Implementation of Regional CALD Competencies Project.
- Progression of the Carer Needs Profile in the statewide SCTT.

MVM PCP PROGRESS TEMPLATE

Priorities	Partners	ISP/Health Promotion	Service Coordination
Mental Health	<p>Moonee Valley City Council (MVCC) Boomerang Club & Youth Services, Doutta Galla Community Health Service (DGCHS) Macaulay and Youth Services, Melbourne City Council (MCC), NW Division of General Practice (NWDGP), Youth Services, Centre for Adolescent Health, Orygen Youth Services, Centrelink, young people.</p> <p>DGCHS Macaulay Program, MVCC Boomerang Club, Inner West Area Mental Health Services, Melbourne Health (MH) Acute Mental Health Services, Consumers.</p>	<ul style="list-style-type: none"> ➤ Youth Access Project, Youth Mental Health Promotion Project. ➤ Mental Health Step down (HARP). 	<p>Mental Health Care Service Coordination Project which development draft mental health care coordination protocols for WMR BPM.</p>
Falls/injury prevention	<p>DGCHS, MVCC, MCC, RDNS, NARI, GP Division.</p> <p>MH, DGCHS, Moreland CHS, RDNS.</p> <p>MVCC, MCC, RCH.</p>	<ul style="list-style-type: none"> ➤ Foothold on Safety. ➤ HARP Falls Project. ➤ Analysis of children's injuries data. 	<ul style="list-style-type: none"> ➤ Commenced use of the Service Coordination Tool Templates (SCTT). ➤ Identified need for significant change management strategy in Acute care as part of HARP.

MVM PCP PROGRESS TEMPLATE

Priorities	Partners	ISP/Health Promotion	Service Coordination
Complex Care Coordination	<p>MVCC, MCC, RDNS, DGCHS, IWRMRC, ACAS.</p> <p>MCC, DGCHS, RDNS Homelessness Services and other homeless and drug and alcohol service providers.</p>	<ul style="list-style-type: none"> ➤ Complex Care CBD – <i>Better Health Care for People with Complex Needs in the CBD project.</i> ➤ MH HARP ED Frequent Attenders project. 	<ul style="list-style-type: none"> ➤ Implementation of SCTT ➤ Development and implementation of WMR BPM ➤ WMR PCP’s E Referral and Service Directory ➤ WMR PCP’s Do it Yourself Privacy Kit ➤ CALD Needs Service Coordination project ➤ CARERS Needs Service Coordination project ➤ CALD Aged Care Strategic Plan ➤ Training small & Ethno-specific agencies project. ➤ MVM PCP Consumer focus groups/forums. ➤ Commenced use of SCTT. ➤ Identified need for significant change management strategy in Acute care as part of HARP.
Neighbourhood – North Melbourne	<p>MVCC, MCC, DGCHS, IWRMRC, Women’s Health West, Consumers.</p>	<p>North Melbourne Neighbourhood Project.</p>	
Emergency Demand /Chronic Conditions Diabetes/ Cardiovascular	<p>DGCHS, RDNS, MH, MVCC, MCC, Melbourne GP Division and Hume Moreland PCP Partner Agencies.</p>	<p>HARP Diabetic Foot Project.</p>	<ul style="list-style-type: none"> ➤ Commenced use of SCTT. ➤ Identified need for significant change management strategy in Acute care as part of HARP.

MVM PCP PROGRESS TEMPLATE

Priorities	Partners	ISP/Health Promotion	Service Coordination
Emergency Demand /Chronic Conditions Asthma/Respiratory	DGCHS, RDNS, MH, MVCC, MCC, Melbourne GP Division and Hume Moreland PCP Partner Agencies. DGCHS, RCH, Dianella CHS, GP Divisions.	HARP COPD Project. Community Asthma Project.	<ul style="list-style-type: none"> ➤ Commenced use of SCTT. ➤ Identified need for significant change management strategy in Acute care as part of HARP. ➤ Commenced use of SCTT.
Drug & Alcohol	MVCC, MCC, DAS West, Legal, Police, Justice, Ambulance, General Practice, Pharmacy, Acute, D&A, DHS, Business, Primary Care, Community.	Drugs Action Plan Review.	Voyage commenced trial of the SCTT on behalf of D&A services in the West.
Disability / Early Intervention	MVCC, RCH, Consumers.	RCH/MVCC Platforms Project.	Identified need for use of SCTT with addition of profile for children.





Section 1 Context

1.1 Moonee Valley Melbourne PCP 2003 -2004

Partnerships

This plan is the continuation of the Moonee Valley Melbourne (MVM) Primary Care Partnership (PCP) Plan 2002-2003 submitted to the Department of Human Services (DHS) in June 2002. It is predominantly an operational plan outlining the directions required to continue building a responsive and cohesive primary care system that links well with acute care and promotes health and wellbeing through integrated health promotion.

Achievements of the MVM partnership are summarised across the key result areas of Partnerships, Integrated Service Planning and Service Coordination. Some of the major challenges for MVM primary care partners in 2003-2004 include:

- i) Expansion of the service coordination reforms to a wider range of non mandated agencies such as acute care, mental health services and children's services
- ii) Gaining agreement for integrated service planning and health promotion planning that realign current services of agencies and,
- iii) Implementation of these plans.

MVM PCP's capacity to meet these challenges is strengthened by its alliance and coordinated work at all levels with Westbay and Brimbank/Melton PCPs in the Western Region.

1.2 MVM PCP Vision

The MVM PCP's vision is to improve the health and wellbeing of our population through developing a high quality, responsive, integrated and co-ordinated primary health care service system. The service system will ensure easy access to the range of services, involve consumers and carers in their own care, and focus on developing and maintaining effective partnerships between service providers. Our relationship with other PCPs, other parts of the health system and other sectors are important to us, and will be actively developed to improve outcomes for our clients.

1.3 Key Strategic Directions

Partnerships

- MVM PCP will operate in a robust partnership with key primary health providers from Community Health Services, Home and Community Care (HACC), Aged Care Assessment Services (ACAS), General Practice (GP) services, Primary Mental Health and primary drug treatment services. In particular MVM PCP will continue to operate with a GP engagement strategy that ensures participation of GPs in key aspects of the PCP strategy.
- MVM PCP will ensure strong service coordination and program development between the primary care sector and acute/subacute services to reduce hospital demand and promote a preventative focus on health care provision.



- MVM PCP will engage with consumers, carers and the community in relation to the implementation and ongoing developments in service coordination activities and integrated service planning, as well as health promotion program development and implementation.

Integrated Service Planning and Health Promotion

- MVM PCP will complete integrated health planning and service development activities with key primary care agencies via the agreed Western Region Planning Framework.
- MVM PCP will continue to develop and implement an integrated health promotion program across the catchment that is informed by the integrated planning process.

Service Coordination

- MVM PCP will ensure the implementation of the statewide Service Coordination Tool Templates (SCTT)¹ and strategy in a manner that supports consistent processes, practices, protocols and systems (PPPS) across the Western Region.
- MVM PCP will continue to initiate and develop complementary information and strategies to the original statewide Service Coordination Tool Templates that support practitioners to operate a cohesive service system that is accessible to consumers, carers and the community.

1.4 Partnership with DHS

Progression of work at all levels of the PCP is dependent on a strong partnership with DHS and ongoing commitment across a wide range of issues including:

- Continued improvements to the Statewide Service Directory such as comprehensiveness, capacity for data extraction, auto uploads and flexible formats for information distribution.
- Continued support for IT infrastructure to the Primary Care Sector including alignment of Information Communication Technology guidelines with the business requirements of PCP Agencies.
- Support for development of electronic versions of the Service Coordination Tool Templates (SCTT) that meet a range of providers needs, particularly GPs.
- Continued commitment from senior management of DHS WMR to the PCP effort including regional governance structures such as the Regional Chairs meeting.
- Ongoing recognition of the primary care platform in the Emergency Demand/HARP funding guidelines.
- Provision of regular opportunities for statewide forums to share best practice and to align PCP activities and DHS policy development across program areas.
- Commitment to ongoing consumer engagement.
- Cross program and divisional coordination within DHS including alignment of relevant planning activities.
- Commitment to improved data analysis and reporting to support ongoing planning.
- Continued DHS dialogue with Commonwealth areas particularly in relation to work with GPs.
- Continued access to innovation funds for pilot and demonstration projects.
- Development of a State Primary Health Policy.
- Recognition of partnership activities in agency funding and service agreements.
- Clarification of Primary Health Care reform directions by the end October 2003.

1.5 Catchment Profile

Population Overview

The characteristics of the population vary enormously across the catchment. The population of the catchment is estimated to be 163,167 in 2001², and expected to increase to 171,000 by 2011³. The majority of this growth is expected to occur within the City of Melbourne.

The City of Melbourne has an estimated total population of 52,117². It is characterised by relatively low numbers of residents but a high daily population in the Central Business District (CBD), estimated to be 400,000 per day. While the majority of these people are city workers, there are also high numbers of people who travel to the city for recreation and other purposes. The City of Melbourne attracts high numbers of people who are homeless. These people are unlikely to be reflected in the census data⁴.

The City of Melbourne continues to be one of the fastest growing municipalities in Australia. In relative terms, Melbourne has low and static numbers of older people. The 70-85+ year age group comprised 5.9% of the population in 2001 compared to 9.4% of all Victorians. Both the number and proportion of 70-84 year olds is expected to grow by 2011. Melbourne has relatively low proportions of young children within its age profile but this is also likely to grow in future years⁴.

The City of Moonee Valley by contrast, is one of the largest municipalities in the Melbourne metropolitan area, with an estimated total population of 111,050². Moonee Valley has an ageing population, with 14.4% of residents aged 65 plus (15,991 people), compared to a metropolitan average of 8.2%. It has a lower percentage of children and young teenagers than Melbourne (8.5% compared to 17.3%). Over the next two decades substantial growth in the number of residents aged 65 plus is forecast⁴. Population ageing is likely to be particularly pronounced in the Essendon statistical local area, which already includes the majority of Moonee Valley's older residents.

Cultural Diversity

The populations of both municipalities are culturally diverse.

The City of Melbourne is more multi-cultural in background than the City of Moonee Valley, with 28.6% of the residents in the City of Melbourne (31,631) born overseas, with 27,108 of the residents born in non-English speaking countries (NESC)⁵. Residents in the municipality come from over 143 countries. The top ten most common overseas birthplaces, in order of magnitude include Malaysia, United Kingdom, New Zealand, China, Hong Kong, Vietnam, Italy, India, Scotland and Germany².

In comparison, 24% of Moonee Valley residents (29,407) born overseas, with 24,953 born in a non-English speaking country. A large number of residents originated from Italy, Greece and Asia, particularly China and Vietnam. Moonee Valley is also a key destination for new arrivals, many of them refugees⁵. When comparing the top 5 countries in 2001, the City of Moonee Valley has a higher share of the population born in Italy and a lower share of the population born in the United Kingdom⁵, than the City of Melbourne.



Features of the Catchment's Health Profile

- For infants and children key health issues include asthma, injuries, obesity and disability. Dental issues also feature prominently as a major health issue for children across the catchment. Children from culturally and linguistically diverse (CALD) backgrounds, disadvantaged backgrounds and new immigrants are at particular risk in the catchment in terms of health needs.
- For adolescents and young adults, mental health, drug and alcohol issues, homelessness, injuries and respiratory conditions (particularly asthma) are key health issues. Those groups particularly at risk are young adults from disadvantaged backgrounds.
- For middle-aged adults, cardiovascular diseases and diabetes, respiratory disease (particularly asthma), cancer and mental health are prominent. As with other age groups those from disadvantaged backgrounds, CALD and new immigrants are at particular risk. Females have higher rates of musculo-skeletal problems, lower rates of injury and slightly higher rates of depression across the lifespan.
- For older people dominant health issues include respiratory illness, injuries such as falls, diabetes, cardiovascular disease and cancer. Older people are more at risk of hospital admission when they have a medical episode due to the fact that people are living alone or their carers are also elderly. Females have higher rates of admission to hospital than males (accounting for 53.6 per cent of admissions and 54.3 per cent of days in hospital).



Section 2 Summary of Key Achievements

2.1 Partnerships

2.1.1 Partners

Membership

In 2002/2003 MVM PCP reviewed its memorandum of understanding separating this into two documents, one is a Governance and Operations Guide, and one a Partnership Memorandum of Understanding (MOU)⁶. A deed of agreement to the *WMR Service Coordination Best Practice and Continuous Improvement Manual* is an attachment to the partnership MOU.

Current membership of MVM PCP includes:

Community health services	Doutta Galla Community Health Service*
Primary care services funded and delivered by local government	City of Moonee Valley* City of Melbourne*
HACC, including district nursing	Royal District Nursing Service (RDNS) Essendon Centre*
General practice	Divisions of General Practice: North Western Division of General Practice (NWDGP), Western Division of General Practice (WDGP) and Melbourne Division of General Practice (MDGP), represented by the Melbourne Division of General Practice*
Psychiatric disability support services (PDSS)	DGCHS - Macaulay Program, a nominated representative from PDSS that provide services in the catchment* MVCC Boomerang Club
Women's health services	Women's Health West * Royal Women's Hospital, CASA House*
Dental health services	Represented by Doutta Galla Community Health Service*
Community drug treatment services	Drug and Alcohol Services West*
Local ethno-specific health services	Inner Western Region Migrant Resource Centre* (new service to be advised by DIMIA)
Carers	Carers Victoria
Hospital Services	Melbourne Health (MH) – Service Development, Discharge Planning, Post Acute Care Facilitation Unit (PACFU) Women's and Children's Health (WCH)
Aged Care Assessment Services (ACAS)	Melbourne Health (MH), Melbourne Extended Care and Rehabilitation Service (MECRS)
Area Mental Health and Primary Mental Health	Melbourne Health (MH), Inner West Area Mental Health Service *



Aged Psychiatry Assessment and Treatment teams	Melbourne Health (MH), North West Aged Persons Mental Health Program *
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* Denotes Steering Committee Representatives.

2.1.2 GP Engagement

MVM PCP continues to have GP or Divisional representation on various committees including the PCP Steering Committee, Integrated Service Planning Working Group and Service Coordination Implementation Group.

Some GPs in the catchment are utilising the SCTT to initiate referrals to the local councils and to North West ACAS. Some GPs and practice staff have also expressed interest in the online Connecting Care Services Directory. At this stage many GPs are waiting for more primary care agencies to become involved before they proceed further.

2.1.3 Acute Care Engagement

MVM PCP has continued to collaborate effectively with acute care in the development and implementation of HARP projects and in work conducted in population and primary health care committees. The identification of key contacts for Melbourne Health, Royal Children's Hospital and Women's Hospital has increased communication between acute and primary care. Melbourne Health has continued to participate in a range of MVM PCP committees and working groups and has been particularly active in the implementation of SCTT in HARP projects.

2.1.4 Consumer Participation

A particular strength across the PCP in the past 12 months has been engagement with consumers.

Key achievements include:

- Consumer representation on project reference groups. These have included the Youth Access Program (YAP), Foothold on Safety Project, Carers Needs Service Coordination Project, CALD Needs Service Coordination Project, CALD Aged Care Strategic Plan, and the Complex Care Needs in the CBD project.
- Continuation of the Consumer, Carer and Community Working Group to progress consumer participation within the PCP, particularly in engaging consumers in achieving the objectives of the revised Community Health Plan. Strategies are included in the Operational Plan Section.
- Organisation of two Community Forum's to provide feedback to consumers on PCP achievements and directions, and to collect consumer feedback about how services can be more easily accessible. One forum was held for the local residents in the city of Moonee Valley, and another held for the local residents in the City of Melbourne.
- Establishment of two consumer focus groups - one representative of the Moonee Valley catchment profile, and the other representative of the Melbourne catchment.
- Facilitation of consumer focus group meetings to address consumer issues that have been identified, and to provide feedback and input into the development of appropriate solutions.
- Facilitation of an agency workshop, for the exchange of information between agencies on consumer consultation practices and processes.



- Successful consumer activities of member agencies, which promote the work being achieved through the PCP strategy or provide best practice examples to build on across the catchment.
- Ongoing implementation of a PCP -wide policy to ensure consistency in payment/support to consumer and carer participants⁸. This policy allows for flexibility in payment and reimbursement to meet the varying circumstances of consumers such as those of carers and younger people.

Moonee Valley Melbourne PCP Community Forums

MVM PCP has held two Community Forums - one in October 2002 with the local community in Moonee Valley and one in April 2003 with the local community in Melbourne.

The Community Forums provided a great opportunity to promote the work completed by the partnership to consumers. It also gave consumers the opportunity to have their say about:

1. How consumers find out about services
2. How we can make services easier to find
3. How consumers would like to be involved and have a say about the way services are provided.

The forums were well attended by both the local residents and local service providers, and many consumers were extremely enthusiastic about the opportunity to be consulted and express their concerns at these forums and in smaller focus group settings.

The issues raised by the local community, as well as their ideas on possible solutions have been communicated to the MVM PCP Steering Committee and Service Coordination Implementation Group for action. Ongoing consultation with this group of consumers takes place in the smaller Focus Group meetings.

Moonee Valley Melbourne PCP Focus Groups

MVM PCP has commenced quarterly Focus Groups with the local residents of Melbourne and Moonee Valley. From expressions of interest received at the two Community Forums, there are now 18 members involved in the Focus Groups. The Focus Groups and Community Forums have raised some important issues about how the primary care service system is "a maze" and access to services is very difficult, particularly for residents from non-English speaking backgrounds. As a result our consumers have suggested some ways this can be made easier, such as having a Poster in GP practices, shopping centres, schools etc which explains the health service system and how the agencies work together across the community. The Consumer Carer and Community Working Group is progressing work on a poster with ongoing consumer input.

2.2 Integrated Service Planning & Health Promotion

2.2.1 Integrated Service Planning

Work has continued with local government to ensure alignment of effort in relation to the development of Municipal Public Health Plans and Community Health Planning processes.

MVM PCP has revised future directions for Integrated Service Planning across the catchment area with a view to gaining;

- A further agreement of the partners to develop and implement integrated service plans that improve the current service system for consumers with a focus on:
 - Improved care planning and service delivery to Aged and Disability Clients across the catchment
 - Improved care planning and service delivery to clients with chronic care needs (HARP, Emergency Demand)
 - Improved Service Coordination for Children's Services.
- A further agreement of the partners to develop and implement an integrated health promotion plan for the catchment that aligns current health promotion activities.

The following issues continue to be high priority health or planning needs for the MVM PCP in 2003-2004:

- Mental Health.
- Falls/Injury Prevention.
- Complex Care Needs/Coordination.
- Neighbourhood Planning.
- Asthma/Respiratory Conditions (Emergency demand, chronic care conditions).
- Diabetes and Cardiovascular Conditions (Emergency demand, chronic care conditions).
- Drug and Alcohol Issues.
- Disability Issues/Early Intervention.

MVM PCP has continued to be an active participant in the Cross Alliance PCP Planning forums. This group has focussed on the delivery of quarterly education forums to progress the issue of integrated service planning processes. The PCP has continued to support the development of the Western Region Primary Care Institute.

2.2.2 Mental Health

Mental Health Youth Project - YAP

The Youth Access Project was a mental health initiative of the MVM PCP and managed in conjunction with the Project Steering Committee the MVM Mental Health Promotion Group. The MVM Mental Health Promotion Group included representation from: CAH, Centrelink, DHS, DGCHS, MCC, MVCC, MVMPCP, ORYGEN, VicHealth, Consumer Rep, Victorian Survivors of Torture, WHW and NWDGP.

Key achievements of this project include:

- Recruitment and training of 19 young people aged 12-24 years as youth consultants.
- Training of young people in the area of mental health promotion using a peer education model.
- Youth participation model that valued and acknowledged active youth participation and engagement throughout the project.



- Development of a Youth Friendly Tool.
- Youth consultancy provided to 16 services, utilising the Youth Friendly Tool.
- Provision of feedback and recommendations to agencies/services, which led to many services implementing change as a consequence of youth recommendations.
- A series of mental health promotion workforce development workshops conducted by CAH and developed and facilitated in conjunction with the Youth Access Project.
- Final report documenting project processes and outcomes⁹.
- The MVCC Youth Access and Participation Group was formed to support the enthusiasm of the YAP participants to continue to represent and advocate on behalf of young people on community and youth issues.
- Continued commitment from the MVM Mental Health Promotion group to progress on identified priority issues.

Mental Health Enhanced Discharge and Care Planning Project

The Mental Health Enhanced Care Planning and Discharge Project was one of nine projects initiated by the three Western Metropolitan Region Primary Care Partnerships (Moonee Valley-Melbourne, Westbay and Brimbank-Melton). All nine projects were built on the earlier cross-regional work undertaken by Deb Warren and reported in the *Better Access to Services (BATS) Mapping Report (February 2001)*¹⁰.

Warren's work involved extensive consultations with primary care providers across the WMR with respect to assessment and referral practices. In this context, three issues related to discharge of patients from acute mental health inpatient units were identified:

- Insufficient reporting and referral to community services.
- Insufficient or inaccurate provision of information to community services.
- Insufficient participation by community services in discharge planning.

This MVM PCP managed project sought to strengthen the relationship between the primary care sector and the acute mental health sector in order to promote a coordinated approach to care planning and to improve referral to primary care services at point of discharge for people with chronic mental illness. Draft care planning protocols and processes from this project form part of the WMR BPM for Service Coordination. Recommendations from the project include the need to trial the protocols and encourage the use of the SCTT in the mental health sector.

HARP: Melbourne Health Consortium - Mental Health Step Down Project

Progress on this project, focussed on the provision of step down accommodation for patients requiring ongoing clinical supervision following an acute psychiatric admission, has been slow due to the difficulties securing premises from which the services can operate. It is likely that this will be progressed in the near future with the capacity to direct unspent funds towards the appropriate refurbishment of a Step Down Facility.

2.2.3 Falls/Injury Prevention

Foothold on Safety 2 Project

The *Foothold on Safety 2* project is a three-year falls prevention project funded by DHS with a focus on older people in the MVM PCP catchment. A range of PCP member agencies are represented on the reference group and include, the City of Moonee Valley, City of Melbourne, RDNS Essendon, National Ageing Research Institute (NARI), MDGP, MECRS and DGCHS Community Health Service.

Key achievements to date include:

- Development, collation and distribution of falls prevention resources including ‘community presentation manual’ that highlights CALD and non-CALD resources such as a multi-lingual checklist.
- Awareness raising campaign using multimedia, festivals, performance art, workshops, networks and presentation to local community groups.
- Training in falls prevention has been conducted with allied health staff and multi-lingual aged care service providers, as a strategy to address local community demand for falls prevention information. There has been much interest for similar training, especially from CALD community groups.
- Development and implementation of training using the NARI-developed Train the Trainer manual. This training has been conducted with HACC workers at MVCC, with similar training planned for MCC.
- Review and trial of screening tool by service providers with older people at risk of falling.

HARP: Melbourne Health Consortium - Falls Project

This project is identifying patients presenting to Melbourne Health ED who have had a fall and implementing community based interventions to prevent subsequent falls and injury. Up until May 2003 the project had identified 356 patients as potential participants. Of these, 76 patients were assessed as eligible for the program and referred on to the project coordinator. 76 patients (21%) were assessed as eligible but excluded because they were not interested, were transferred to another hospital or had other complications. 204 patients (57%) were assessed as ineligible because they were in residential or other care or were outside the catchment area for the project.

Staffing for the program includes a 0.5 EFT coordinator at RMH for identification and recruitment and a 1.0 EFT Falls Prevention Coordinator at DGCHS. Community based services being utilised include occupational therapy, physiotherapy, Tai Chi, Falls and Balance clinics, optometry, Vision Australia, Council Services, Archicentre and home modifications.

Children’s Injuries

In 2002-2003 MVM PCP has collated and analysed children’s injury data which has identified children’s injury as a key primary prevention issue for the catchment. Preliminary meetings with RCH indicate children’s injury as a hospital priority and work will be progressed to develop a joint project to trial intervention strategies.

2.2.4 Complex Care Needs/Coordination

Better Health Care for People with Complex Care Needs in the CBD Project.

The *Better Health Care for People with Complex Needs in the CBD*¹¹ project was initiated by the Moonee Valley Melbourne Primary Care Partnership to facilitate a more informed and coordinated primary care response to people in the CBD who are homeless and have complex needs. Melbourne, like most capital cities worldwide, attracts a large number of homeless people to the central city area. The City of Melbourne has sought to address this issue over the last decade or so through a number of submissions and research projects. This project has built on this earlier work, as well as the recent work of the Victorian Homelessness Strategy and other related research.

The project was implemented in two stages. The first stage involved a literature review and preliminary consultations to scope the issues. Stage two, examined existing services in and around the CBD in order to better understand service pathways and linkages, identify barriers and service gaps, identify and/or develop practical opportunities to improve service coordination, and identify and promote appropriate



service approaches and models. A variety of methods was used including interviews, forums, focus groups, and a service provider survey.

The project identified a number of service improvements and recommendations to be implemented or promoted by member agencies. The key suggested strategies are:

- A cross sectorial approach, recognising that the health needs of the target population cannot be successfully addressed in isolation to other needs such as housing, income, employment and recreation. These “other” needs will often be a higher priority than health for the person.
- A common approach to intake, assessment and referral that is sensitive to a cross-sectorial environment, and which builds on the PCP SCTT and the SAAP Common Assessment and a Referral Project.
- Adoption of a CALD-like framework, which recognises that for homeless people flexible appointment systems, outreach and after-hours services are the equivalent of language assistance services for people with poor fluency in English.
- Development of a highly visible and comprehensive primary health care centre in the CBD, targeting homeless and disadvantaged people with complex needs. Emphasis would be placed on seeking to link people back to their usual community where this is not the CBD.
- Consolidation and coordination of assertive outreach services, including consideration of increased capacity for extended hours.
- Increased resources and/or service flexibility to meet other priority shortfalls and service gaps identified by the project. Further investment in services should seek to build on existing services in order to avoid fragmentation and increase the viability of small services.

HARP: Melbourne Health Consortium – ED Care Program

The ED Care Program is focussed on improving access to community support services (including Drug and Alcohol Services) for frequent attenders with complex psychosocial problems. The program has analysed ED data and identified frequent attenders as those people with more than six attendances in a 12-month period. The program commenced flagging and recruitment of clients in February 2003 and currently has 6 clients enrolled in the program. Staffing consists of 0.5 EFT Coordinator at Melbourne Health and a 0.5 Community Service worker at Macaulay Program (DGCHS). This program is progressing well, and some of the other program outcomes to date include:

- Regular data analysis of frequent ED presenters.
- Mental health profiles of frequent attenders.
- Improved referral pathways between the ED & community.
- Improved co-operation and collaboration between services involved.

2.2.5 North Melbourne Neighbourhood Project

The North Melbourne Neighbourhood Project recognises the disadvantage experienced by Office of Public Housing clients in the neighbourhood of North Melbourne. The project seeks to build community capacity, enhance community engagement and improve service access and coordination. The project has a steering committee with representation from the City of Melbourne, City of Moonee Valley, Dousta Galla Community Health Service, Inner West Region Migrant Resource Centre (Past), MVM PCP, and Women’s Health West. This group will expand to include wider community representation. Strategies for community building will be developed in partnership with the community. Additional services and community members will be engaged to inform the project direction through the process of consultation and service mapping.



Key achievements to date include:

- Project development identifying objectives and strategies.
- Funding application submitted to the Victorian Multicultural Commission.
- Funding proposal submitted to Stronger Families & Communities.
- Service mapping and consultation with community leaders and representatives.

2.2.6 Emergency Demand/Chronic Conditions

Melbourne Health HARP Consortium - Diabetes Related Foot Condition Service

This project, focussed on reducing the amputation rate of people with diabetes, is an integrated model for the management and prevention of chronic and severe diabetes-related foot complications. The project aims to:

- Improve the health status and independence of the target group by providing:
 - specialist podiatry services to prevent and manage severe, chronic diabetes-related foot problems in the community
 - improved links with existing community services (health and support services, including general practitioners, diabetes management, nutrition and health promotion)
 - training and support for community health service providers and general practitioners in management of diabetes related foot problems.
- Prevent the incidence or deterioration of chronic complications arising from diabetic foot problems in order to:
 - improve quality of life for target population
 - reduce the likelihood of hospitalisation (reduced admissions and shortened length of stay among target group)
 - reduce amputation rates among target group over the next 3 years.

The project team was established in October 2002 and consists of 1.00 EFT of podiatry (0.5 EFT at DGCHS and 0.5 EFT at Moreland CHS) and 1.0 EFT – Royal District Nursing Service -Nurse Wound Consultant.

Client service commenced in the first week of November 2002. Initial assessments are conducted either within the podiatry clinic setting, or alternatively in the client's home by the Nurse Wound Consultant (NWC). Clinical services include; intensive care of the feet and wounds to reduce healing time, diabetes and foot education, biomechanical assessment, pressure redistribution, and the modification/initiation of appropriate footwear if required. Referrals are made to specialist vascular units for surgical review, General Practitioners, Physiotherapy, Occupational Therapy, Royal District Nursing Service (RDNS), Dieticians, Diabetes Educators, and Prosthetists and Orthotists. Referral sources are from RMH Podiatry, RDNS and local GPs.

Current waiting times are approximately one week to see podiatrists, and/or two days to see the nurse wound consultant. Commonly the NWC will jointly consult with both specialist podiatrists in their clinics, in order to assess any problematic wounds a client may have. If clients are housebound, the podiatrist may visit them in the home with the NWC. If the wound care required is ongoing and frequent, the NWC attends the care in the client's home. This has proven to be beneficial to the client as this has reduced the need to attend clinics for redressing. In May 2003 the service had 68 current clients, 10 referrals awaiting service, 2 discharges to date, comprehensive communication with all client's GPs (approx 70 across both municipalities) and 25 clients had received NWC/Podiatry collaborative care.



The HARP foot project team has potentially prevented the hospital admission of the entire project client group, given their ongoing high risk foot status. More specifically, this team has dealt with approximately 50 active limb or digit threatening ulcerations.

Melbourne Health HARP Consortium - COPD Program

The Melbourne Easy Breathers Pulmonary Rehabilitation Program is a 6-week program for patients with chronic lung disease. The projects aims to:

- Develop and implement a model for better management of people with COPD and their family/carers based on collaboration between acute and community health service providers.
- Enhance quality of life and reduce handicap for people with COPD.
- Reduce hospital admissions and readmissions, specifically total bed-days utilised, for the target group.
- Increase satisfaction of patients and their carers with their overall care.

The program operates at 3 different venues at any one time to increase accessibility for patients. There is an identified need for language specific groups. There is currently one group running for Italian speakers. There is an existing demand for a Greek-speaking group as well as another Italian group.

As of May 2003 a total of 116 patients had been referred to the Melbourne Easy Breathers Pulmonary Rehabilitation Program. 58 referrals had been addressed, 4 patients were assessed as inappropriate referrals, 5 patients refused services, 6 patients were referred on to other pulmonary rehabilitation programs, 42 patients had been assessed for the rehabilitation program, 25 patients had commenced the program, 19 had completed the full program, 18 patients were enrolled in the program and 58 patients remained on the waiting list.

Project staffing consists of 1.00 EFT nursing and 1.00 EFT physiotherapist employed and commenced November 2002, 0.2 EFT physician sessional from January 03 and an outreach staff member employed May 2003.

Additional services provided to those originally planned for the program have included; language specific groups, counselling for smoking cessation, rapid access to oxygen clinic and specialist respiratory medicine services (facilitation), and home rehabilitation.

Community Asthma Project Consortium

This project has been developed collaboratively by Moonee Valley Melbourne Primary Care Partnership, DGCHS, Dianella Community Health Services, Melbourne and North West Melbourne Divisions of General Practice and Royal Children's Hospital. It is funded through the Department of Human Services as part of the Hospital Admission Risk Program (HARP). The project aims to improve the health outcomes for children with asthma and their families who present at the Royal Children's Hospital and live in the Moonee Valley Melbourne Primary Care Partnership and Dianella Community Health Service catchments.

The program is developing a best practice education, support and collaborative program to enhance the knowledge of asthma management including the importance of written asthma action plans to reduce the numbers of children with asthma presenting to Royal Children's Hospital (RCH) Emergency Department. GPs are linked into the program through the nurse educator and participate in care planning. The program aims to be effective in reaching those communities that are particularly represented through the RCH ED including socioeconomically disadvantaged and CALD families through a community development approach. Currently the program has enrolled over 70 clients. Of these clients, 67% are from the MVM PCP catchment area and are receiving services through Dousta Galla Community Health Service. Staffing



includes 1.00 EFT Program Coordinator/Community Development, 1.00 EFT Clinical Coordinator, 0.6 EFT nursing (DGCHS and Dianella CHS) and 0.2 EFT data RCH.

The program model of care that has been developed is transferable to other catchment areas and the consortium through Dianella CHS proposed expansion of the model through the Northern and Western regions in the latest HARP funding round.

2.2.7 Drug and Alcohol

The City of Melbourne and the City of Moonee Valley have taken a lead on strategies to address drug and alcohol issues for the catchment. The City of Melbourne is currently reviewing their Drugs Action Plan 2001-2003¹², using a multi-agency partnership approach. Members of the Drugs Action Plan Review/Steering Committee include: COM, law enforcement, justice system, ambulance, doctors, pharmacies, hospitals, DHS, D&A agencies, business, expert & peak agencies, MVM PCP, licensed premises and community representatives. The Drugs Action Plan compliments Councils key safety and health policy frameworks, specifically the Strategy for a Safe City, City Health 2002 and the Syringe Management Plan.

Moonee Valley City Council have developed Drug and Alcohol Policy/Action Plan 2003. Strategies are also being implemented through partnerships within Council and in conjunction with the community. MVCC in partnership with the WMRMRC (past) delivered a Victoria University of Technology (VUT) accredited Bilingual Drug Information Educator Course to 16 participants representative of seven different CALD groups.

Both Councils incorporate service mapping as well as service and community consultation to inform their policies and action plans.

2.2.8 Disability – Early Intervention

Platforms Project

MVM PCP has been working with the Platforms Project¹³ which is a feasibility study to develop a model of service coordination for young children (0-8) and their families. This project is Commonwealth funded through the Department of Family & Community Services and is led by Professor Frank Oberklaid from the Centre for Community and Child Health in partnership with Moonee Valley City Council. There is national and international interest in the project. The goal of the project is to improve the early identification and response to health, developmental and behavioural concerns in young children in the City of Moonee Valley. The project is centred in two communities in Moonee Valley, being Avondale Heights, East Keilor in the north and North Melbourne, Kensington and Flemington in the south.

The project aims to map local services for families with young children, review the contact families have with services, ensure family-centred principles are shared (transition to school is of particular importance), ensure services are trained in the use of a standardised approach to screening children for developmental needs (the “Platforms” approach) and work with services to implement changes to link early childhood nursing and preschool services with a range of primary and secondary services.

Community Advisory Groups with members from community groups, parents, primary service providers and Platforms representatives have met monthly this year to identify resources and training needs for their respective communities. The services that have been identified will be included in the WMR PCP Service Directory (www.wmrpcp.org.au). Each group has come together to discuss general issues of



concern for the community. Strategies to address these concerns have been documented for the project. Some general issues across both groups that have been raised are:

- Many children are missing out on services they require.
- Waiting lists are getting longer for early intervention services.
- Concern about cost of services.
- Culturally and linguistically diverse families may not be accessing services due to language and financial issues.

The next phase of the Platforms project will involve training for the primary services staff from Occasional Care, Long Day Care, Maternal Child Health, Preschool, Schools and Family Day Care. The training will involve the use of the PEDS (Parent Evaluation of Developmental Status) questionnaire and family centred practise for use in these services.

Moonee Valley City Council will review and redevelop the Disability Policy and Action Plan during 2003. Building on achievements and issues emerging from the previous and current Disability Policy and Action Plan. The redevelopment will occur in partnership with stakeholders including the community and service representatives.

Carers Needs Project

The carers needs service coordination project was one of nine projects initiated by the three Western Metropolitan Region Primary Care Partnerships (Moonee Valley-Melbourne, Westbay and Brimbank-Melton). Carers Victoria, in a submission to DHS as part of the 2001 trial of the SCTT, identified that the templates failed to include a clear framework to encourage a holistic focus on the needs of the 'care giving unit,' at both the practice and planning levels. Extensive work both in Victoria and nationally had also identified the need for greater carer focus and this view was supported by PCP Agencies in the WMR.

The major focus of this MVM PCP managed project was the development of a Carer Profile¹⁴ to supplement the statewide SCTT with supporting guidelines. The process used to develop the Carer Profile included a comprehensive review of Australian literature and available assessment tools, consideration of information from the 2001 trial of the SCTT and Profiles, development of a draft Carer Profile in consultation with carers (trialed with the six WMR Local Government HACC Services and five other PCP agencies), evaluation of the trial, and further development of the Carer Profile.

The purpose of the Carer Profile is to focus on the caring role, as the carer understands his/her role during the processes of Initial Contact (IC) and Initial Needs Identification (INI). The intention is that use of the Profile will assist the carer in conjunction with the practitioner to determine initial needs and to decide on further actions.

Overall 69% of agencies and 79% of Local Government HACC Services felt that the Profile improved the focus on carer needs and assisted carers to better identify their needs. Carers who were involved in the trial were invited to provide feedback on the Carer Profile and expressed enthusiasm for the Carer Profile and the focus it provides on the carer role.

The major recommendations from the project was for statewide adoption of the Profile into the SCTT following further trailing and refinement of the profile. This would ensure that the role of carers and discussions of their needs become an integrated part of IC, INI and CP through a formal process and care outcomes for both consumers and carers are improved¹⁴.

2.3 Service Coordination

2.3.1 Regional Service Coordination

From the outset of the Reform Strategy the three Western Region PCPs agreed on a cross alliance approach to service coordination developments and implementation plans.

Achievements have been significant and include:

- Revision of Western Metropolitan Region PCP Cross Alliance Whole of Region Service Coordination Workplan in December 2002¹⁵.
- Significant agency contribution to the development of the *Western Metropolitan Region Service Coordination Best Practice and Continuous Improvement Manual*⁷. Pam Regan (MVCC) conducted a keynote presentation at the 'Better Health – Stronger Communities Forum' in February 2002 to show case the application of the WMR BPM in the Western Metropolitan Region.
- Contribution to development and implementation of *WMR Do It Yourself Privacy for Primary Care Agencies (2002)* kit¹⁶.
- Contribution to development, regional oversight and local implementation of *WMR PCP's E-Business* activities - including development of WMR PCP Website, Service Directory, e-Referral system¹⁷, and support tools such as the WMR BPM. Liz Cashill (Western Health) and Simon d'Orsogna (Western Region PCPs eBusiness Manager) presented at the 'Better Health – Stronger Communities Forum' on the WMR e-referral trial and implementation.
- *Completion of WMR CALD Needs Project*¹⁸ which developed guide lines for the implementation of Initial Contact and Initial Needs Identification with people from a CALD background. Recommendations from this report are being progressed with DHS, particularly the ongoing access by agencies to language services and training of providers in culturally sensitive practices. These guidelines form part of the WMR BPM. Hazel Ingram (MVCC) presented at the 'Better Health – Stronger Communities Forum' on the key findings from the CALD Needs Project.
- *Completion of WMR Carers Needs Project*¹⁴, which developed a Carers Profile to compliment the statewide SCTT. Recommendations from this report are being progressed with DHS including a statewide trial of the Carer Profile and inclusion of a Carer Profile with the revised SCTT. This profile forms part of the WMR BPM. Hazel Ingram (MVCC) presented at the 'Better Health – Stronger Communities Forum' on the development of the Carer Profile.
- *Completion of Mental Health Care Coordination Project*, which developed detailed draft protocols for care planning with community providers of people with a mental illness on discharge from hospital. These guidelines form part of the WMR BPM.
- *Commencement of WMR CALD Aged Care Strategic Plan*¹⁹ to inform the region on service provision needs over the next 5 years. This project has reviewed the data on the ageing CALD community in the West reviewing existing communities needs and projected need. This plan is due for completion in July. Implementation of this plan will be pursued in partnership with DHS in the next year.



- *Commencement of WMR Service Coordination Training for Ethno-specific and Smaller Agencies Project.* This project is supporting Ethno-specific and smaller agencies to understand the service coordination reform and implement the SCTT using the WMR BPM. Recommendations from this project will inform ongoing provider training needs across the region.

CALD Needs Project

The carers needs service coordination project was one of nine projects initiated by the three Western Metropolitan Region Primary Care Partnerships (Moonee Valley-Melbourne, Westbay and Brimbank-Melton). This MVM PCP managed project built on the earlier cross-regional work undertaken by Deb Warren including a cross alliance workshop conducted in March 2001 with ethno-specific agencies to identify BATS issues for ethno-specific agencies and CALD communities and was reported in *Better Access to Services (BATS) Mapping Report (February 2001)*¹⁰.

The work undertaken revealed that larger agencies were lacking in appropriate language and cultural sensitivities. In addition smaller ethno-specific agencies, while having cultural knowledge, language skills and consumer confidence were often under resourced, under trained and usually not funded to perform tasks related to Initial Contact and Initial Needs Identification as mandated. The project ran over six months and aimed to improve the focus on CALD needs in Initial Contact and Initial Needs Identification by:

- Enhancing culturally sensitive work practices.
- Strengthening relationships between ethno-specific agencies and mainstream service providers by encouraging shared and agreed Processes, Practices and Protocol Systems (PPPS).

The methodology of the project was to undertake face-to-face interviews with mainstream service providers, ethno-specific agencies and CALD consumers. A literature review of publications relating to PCPs/service coordination and CALD-sensitive best practice was also completed.

Specific outcomes of this project include CALD Best Practice Guidelines for IC and INI which form part of the *WMR Best Practice and Continuous Improvement Manual (WMR BPM)*⁷ and nine recommendations that address workforce development/training opportunities for both mainstream service providers and ethno-specific agencies, support for ethno-specific agencies, resource levels, and the use of translation and interpreter services.

2.3.2 Local Service Coordination

Local agencies that are implementing Service Coordination Tool Templates (SCTT)¹ include

- Doutta Galla Community Health Service
- Moonee Valley City Council
- Melbourne City Council
- Royal District Nursing Service – Essendon
- North West Aged Care Assessment Service
- Melbourne Health HARP Projects
- Essendon Day Centre
- Individual GPs.

Managing the changes that the service coordination work brings within an agency is critical to the success of the PCP Reform Strategy. The following outlines some successful strategies put in place by Doutta Galla Community Health Service to incorporate changing practices and processes for service coordination implementation.



Changes implemented by Doutta Galla Community Health Service (DGCHS)

- DGCHS participated in the trial of the Service Coordination Tool Templates (SCTT) in 2001-2002.
- Megan Davis, nominated Change Leader for Service Coordination reform, has undertaken comprehensive Train the Trainer Orientation in Service Coordination and the WMR Best Practice and Continuous Improvement Manual (WMR BM).
- An audit has been undertaken to assess DGCHS against the standards in the WMR BPM. An action plan was then developed outlining the steps for incremental implementation of the SCTT and WMR BPM by June 2003.
- Intake Workers have been appointed to undertake the Initial Contact function for all services at reception.
- Training has been provided organisation wide to approx. 80 staff on Service Coordination reform, use of the SCTT, and WMR BPM.
- DGCHS staff have commenced using the SCTT in a paper-based format, pending the relevant upgrades to their client management system SWITCH.
- DGCHS has been involved in the trial and implementation of the WMR Service Directory and e-referral project, and is now one of the 15 WMR agencies registered to receive electronic referrals via ConnectingCare.com. Staff have also commenced sending e-referrals on ConnectingCare.com.

Section 3	Operational Plan 2003 – 2004
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3.1 Partnerships

3.1.1 Partnerships Strategic Objective 1 – Partnerships and GP Engagement

MVM PCP will operate in a robust partnership with key primary health providers from Community Health services, Home and Community Care, Aged Care Assessment, General Practice services, Primary Mental Health and primary drug treatment services. In particular MVM PCP will continue to operate with a GP engagement strategy that ensures participation of GPs in key aspects of the PCP strategy.

Priorities/Gaps/Emerging Issues:

- Progression of work between agencies to improve service coordination and quality to consumers.
- Ongoing need for a collaborative approach to achieving functional integration across the primary care sector, particularly with General Practice.

Partnership Strategies

Strategies	Expected Outcomes
1. Ongoing facilitation of PCP structure and working groups to ensure participation of key stakeholders.	PCP structure and working groups support and facilitates participation of agencies.
2. Ongoing implementation of communication strategy for agencies and consumers about PCP including newsletters, forums and consolidation to WMR PCP's website.	<ul style="list-style-type: none"> ➤ Communication strategies documented and implemented. ➤ Progression of options for consolidated WMR PCP's website.
3. Ongoing coordination with the three WMR PCPs including sustainability of future activities.	Coordinated and sustained WMR PCP outcomes.

General Practice Engagement Strategies

Strategies	Expected Outcomes
1. GP or Divisional involvement in PCP Steering Committee, Service Coordination Implementation Group, Health Promotion Projects and ISP processes.	<ul style="list-style-type: none"> ➤ Active GP/ Divisional involvement in Service Coordination and other projects/groups. ➤ Outcomes and processes communicated through to other GPs
2. Ongoing work with GPs on SCTT implementation and care planning.	GPs using SCTT inclusive of WMR Service Directory and e-Referral system.
3. Support Melbourne Health on enhancing GP engagement and involvement in the Surgical Discharge Planning process (including the EPC items).	<ul style="list-style-type: none"> ➤ Enhanced GP engagement. ➤ Improved transition of patients from acute to the community.



3.1.2 Partnerships Strategic Objective 2 - Acute/Subacute Interface

MVM PCP will ensure strong service coordination and program development between the primary care sector and acute/subacute services to reduce hospital demand and promote a preventative focus on health care provision.

Priorities/Gaps/Emerging Issues:

- Ongoing need for collaboration to improve continuum of care for clients
- Difference in IT capabilities between the sectors.

Acute/Subacute Interface Strategies

Strategies	Expected Outcomes
1. Maintenance of partnership activities with acute care including identified contact points for hospital liaison, ongoing HARP projects and committee work.	<ul style="list-style-type: none"> ➤ PCP is the initial contact point for the MVM Primary Care Sector. ➤ Continued clearly identified contacts for MH and W&CH.
2. Engagement with acute sector in relation to Information Technology infrastructure (via PCP Telecommunications planning and funding).	Planning for IT in primary care sector ensures interface between acute and primary care sector.

3.1.3 Partnerships Strategic Objective 3 - Consumer and Carer Participation

MVM PCP will engage with consumers, carers and the community in relation to the implementation and ongoing developments in service coordination activities and integrated service planning and health promotion program development and implementation.

Priorities/Gaps/Emerging Issues:

- Consumer groups continue to comment on need for service coordination but also quality and access to services.
- There is a need for facilitation of consumer participation at Steering Committee level.



Consumer and Carer Participation Strategies

Strategies	Expected Outcomes
1. Seek feedback on consumer experience with Service Coordination activities, Health Promotion and PCP Projects.	Gain feedback on the implementation of the SCTT at a local level and make recommendations based on this consumer feedback.
2. Provide ongoing feedback to consumers within the catchment and those who have participated in PCP activities.	<ul style="list-style-type: none"> ➤ Promotion of work completed by the partnership to consumers. ➤ Opportunities for consumers to continue to be involved at all levels of partnership activity.
3. Ongoing work with and support to agencies to implement consumer participation strategies.	Increased agency engagement with consumers. Agencies collect and respond to consumer feedback through implementation of WMR BPM.
4. Facilitation of forums as appropriate to support workforce development in relation to consumer participation strategies.	<ul style="list-style-type: none"> ➤ Skill development and support for ongoing best practice. ➤ Annual review and reporting of agency progress against consumer participation standards in the WMR BPM.
5. Ongoing work with and support to agencies to respond to consumer feedback on Service Coordination, Health Promotion and PCP projects.	Consumers have improved experiences in accessing services and moving through the Primary Care service system.

3.2 Integrated Service Planning

3.2.1 Integrated Service Planning Strategic Objective 1 - ISP

MVM PCP will complete integrated community health planning and service development activities with key primary care agencies via the agreed Western Region Planning Framework.

The following generic strategies are required to support ongoing integrated service planning.

Integrated Service Planning Strategies

Strategies	Outcomes
1. Development of future directions paper in relation to Integrated Service Planning and Implementation and Integrated Health Promotion for partner agencies.	CEO sign off on ongoing agency/PCP activities to ensure coordination of effort.
2. Ongoing participation in Western Region Planning Activities including support to a Primary Care Institute to support the data requirements for integrated service planning.	Coordinated Western Region activities and sharing of resources where appropriate.
3. PCP participation in committees and forums such as Population and Primary Health Committees to encourage a collaborative approach to data analysis and planning.	PCP representation at committees and forums. Exchange of data and collaborative planning activities.

3.2.2 Key Health Priorities/Issues

The ongoing high priority groups for the MVM PCP are as follows.

- Mental Health – with a continued focus on Youth Mental Health Promotion, Emergency Demand and SCTT implementation.
- Complex Care/Coordination – with a continued focus on Complex Care Needs in the CBD and Care Coordination for older people (Care Planning, CALD Aged Care Strategic Plan Implementation, Carer Needs).
- Falls/Injury Prevention – with a continued focus on falls health promotion for older people, prevention of Children’s Injuries and Emergency Demand.
- Neighbourhood Planning in area of high need – with a focus on office of housing clients in North Melbourne.
- Diabetes/Cardiovascular Disorders with a focus on Emergency Demand and SCTT implementation.
- Asthma /Respiratory with a focus on Emergency Demand and SCTT implementation.
- Drug and Alcohol – with a focus on coordination of services and health promotion with local government as the lead agency.
- Disability Issues – with a focus on early intervention (0-8 years).

1. Mental Health

Community and Service Profile

Community Profile

The MVM PCP Community Health Plan 2001-2004 profile identified mental health as a significant area of need within the catchment across most age groups from people aged 13 and above²⁰. This data is also supported by City of Moonee Valley and City of Melbourne Municipal Health Plans, the Inner West Community Mental Health Plan²¹ and Dousta Galla Community Health Service Plan.

Mental health problems and mental illness are a major cause of poor health in Australia. Almost one in five (18%) experience a mental disorder at some time in their lives. Depression is the number one cause of the burden of disease in Victoria and the fourth cause Australia-wide². Hence there is a growing need to support people with high prevalence disorders, such as depression and anxiety.

Depression accounts for 5.68 per 1000 of all DALYs for females in the catchment and 3.87 per 1000 DALYs for males, ranking only behind COPD, diabetes, stroke, dementia and breast and lung cancer. Depression was the most common specific mental disorder reported by Victorian adults, with 3.0% of men and 6.2% of women reporting the condition⁴.

Depression frequently occurs in combination with anxiety disorders, substance-related disorders, conduct disorders, eating disorders, attention deficit/hyperactivity disorder and chronic conditions such as heart disease, cancer and diabetes. People with depression may also indulge in more risky health behaviours. There is evidence that 35% of people with mental disorders smoke; the effect is age specific, being more prevalent in younger adults⁴.

The 1999 Adolescent Health and Well-Being Survey found that there was a marked trend among Victorian secondary school students for depressive symptomatology to increase from a prevalence of 13% in Year 7 students to 20% in Year 9, and to 22% in Year 11. Girls (23%) were twice as likely as boys (12%) to report high levels of depressive symptoms. The prevalence of deliberate self-harm was similar for both males and females. Less than 4% of Year 7 students reported an episode of deliberate self-harm, rising to 6% for students in Years 9 and back to 5% for Year 11 (Bond et al, 2000)⁴.

Moonee Valley had an above average level of hospital admissions for a range of mental disorders, due in part to an above average level of admissions of East Keilor residents. East Keilor had an above average level of admissions for:

- Schizophrenic disorders, across a range of age groups (15-54 year olds).
- Alcohol dependence syndrome (35-44 year olds and 55-64 year olds).
- Depressive disorders (35-44 year olds).
- Non-dependent drug abuse (15-24 year olds and 35-44 year olds).
- Other non-psychotic disorders – across all age cohorts in the range 5-64.

The level of admissions for these conditions was significantly above average for both non-English Speaking Background and Australian-born residents. There was an above average level of admissions for affective psychoses in both Essendon and East Keilor²².

The City of Melbourne, which includes the CBD, has the bulk of crisis accommodation agencies and high rates of homelessness. The homeless population experiences above average rates of chronic mental illness, depression and substance abuse.



Of particular note across the catchment is the high level of need in the area of non-psychotic mental health problems. The Inner West Community Mental Health Plan indicates that there is clear evidence that the burden of disability from non-psychotic mental disorders is greater in the Western region for both males and females than anywhere else in Victoria. Groups across the catchment at risk of high prevalence mental health disorders include homeless people, socially disadvantaged people in office of public housing accommodation, people from non-English speaking countries of birth, refugees and carers²¹.

Service Profile to date:

(All profiles will continue to be populated to inform ongoing planning)

Life Stages		Family/Chn	Youth	Adults	Older
Service Continuum	Public Health Participative	Playgroups, parenting programs.	Council Youth Services and Centres.	Neighbourhood houses and other community venues.	Neighbourhood houses and other community venues.
	Preventative	Child and Maternal Health, Parenting programs, Inner West Primary Mental Health Team.	YAP – Youth Access Program MVM PCP, Living Room, DGCHS, Inner West Primary Mental Health Team.	MH HARP project - Frequent Attenders with psychosocial needs, Living Room, DGCHS, Inner West Primary Mental Health Team.	Living Room, DGCHS, Inner West Primary Mental Health Team.
	Early Intervention	DGCHS, Inner West Primary Mental Health Team.	Inner West Primary Mental Health Team DGCHS – Rocket, ORYGEN-EPPIC, Women’s Health West.	DGCHS, Waratah CCT, Inner West Primary Mental Health Team.	DGCHS, Waratah CCT, Inner West Primary Mental Health Team.
	Intensive	ORYGEN Child & Adolescent Services.	ORYGEN - Youth.	IWAMHS – MH, Salvation Army Intensive Support Services, DGCHS Homelessness Program.	General Practitioners North West Aged Persons Mental Health Program.

Life Stages		Family/Chn	Youth	Adults	Older
	Maintenance in Community	Inner West Primary Mental Health Team.	Inner West Primary Mental Health Team.	MVCC - Boomerang Club, DGCHS Macaulay MH HARP ED project, DGCHS Homelessness Program, Inner West Primary Mental Health Team.	Inner West Primary Mental Health Team.

Priorities/Gaps/Emerging Issues

One reason that mental illness significantly contributes to the overall burden of disease is that the first incidence of chronic mental illness tends to occur in early adulthood, with subsequent disability experienced for many years in the future. This characteristic of mental illness points to the need for early intervention if the burden is to be reduced. The 2001-2004 Community Health Plan²⁰ identified youth mental health problems as a priority group and this continues to be a focus for the 2003-2004 operational plan. The MVM PCP Youth Access Project (YAP)⁹ focussed on youth mental health. The project will be repeated in the 2003-2004 year.

The Inner West Community Mental Health Plan identifies key deficits in the availability of services for high prevalence disorders. High priority mental health issues are further complicated by the following characteristics,

- The highest level of disability from non-psychotic disorders in the state,
- High levels of migrant and refugee settlement,
- High levels of aged persons and people from CALD backgrounds,
- A high percentage of homeless population,
- A large transitional and public housing sector with high needs residents, and
- High rates of unemployment and social disadvantage²¹.

The high prevalence of depression across the catchment is being addressed by a focus on Youth Mental Health and implementation of the Primary Mental Health Team. It is expected that future work of the Primary Mental Health team and the implementation of the 2002-2003 Community Mental Health Plan will assist the PCP in continuing to define priorities around the high prevalence disorders such as depression and the development of models of prevention and early intervention. Future Inner West Community Mental Health Plans will give more prominence to strategic objectives specifically with regards to the promotion of the overall mental health and wellbeing needs of the Moonee Valley / Melbourne community through a partnership between specialist mental health services and primary care.

There is the ongoing issue of access to inpatient psychiatric beds. Access is limited due to reduced availability of supported accommodation, short stay crisis accommodation and long term psychiatric rehabilitation beds. As a result, people assessed within the ED as requiring a psychiatric bed often wait for extended periods within the ED. This is inappropriate and blocks an ED bed for extended periods (days). Admission to the ED often subjects the patient to a high stimulus environment which may exacerbate presenting behaviour. This may require chemical or mechanical restraint which may not be needed if direct admission to the psychiatric unit was more readily available. It is estimated that approximately six people per week who attend the ED require acute psychiatric admission or psychiatric follow-up.

Mental Health Strategies

Strategies	Outcomes
<p>1. Seek funding opportunities to continue to run the Youth Access Project. Ongoing facilitation of a Youth Access Project which focuses on young peoples' mental health and wellbeing.</p>	<p>Repeat Youth Access Project to provide:</p> <ul style="list-style-type: none"> ➤ increased awareness of mental health issues by young people in the community ➤ peer education and leadership by young people ➤ increased awareness by service providers of youth issues and implementation of strategies to become "youth friendly" ➤ continued focus on youth mental health issues across the catchment.
<p>2. Support the trial and ongoing use of the SCTT by Macaulay Program, Boomerang Club Psyche Disability Support Services, HARP Step Down project, Inner West Area Mental Health Services, and Melbourne Health (MH) Acute Mental Health Services.</p> <p>Trial the draft Mental Health Coordinated Care Planning protocol in the WMR BPM.</p> <p>PDSS to investigate establishing a common referral and intake process for residential and housing and support services.</p>	<ul style="list-style-type: none"> ➤ Implementation of the SCTT with PDSS, Community Mental Health Services and Acute Mental Health Services. ➤ Implementation of WMR PCP's E-Referral and Service Directory. ➤ Implementation of the draft Mental Health Coordinated Care Planning protocol with IWAMHS. ➤ Improved referral between mental health and primary care sector.
<p>3. Progression of HARP Step Down facility which is focussed on a high level of support for clients with a mental illness being discharged from hospital. DGCHS and MH are lead agencies of this project.</p>	<ul style="list-style-type: none"> ➤ Improved capacity for people with mental illness to be managed successfully in the community. ➤ Improved capacity of acute care sector to manage demand for beds by developing alternative options.
<p>4. Support ongoing workforce development opportunities for primary mental health care workers in conjunction with Primary Care Mental Health Training Project (Beyond Blue funded).</p>	<p>Primary care agency staff trained in current primary mental health best practice approaches.</p>

2. Falls/Injury Prevention

Community and Service Profile

Community Profile

Information from the 2001-2004 Community Plan identified injuries within the top five issues across most age groups. Particularly significant is the issue of injuries in the young and older population.

1. Children's Injuries.

A presentation in 2002 to the Women's and Children's Primary Care and Population Health Committee indicated that injuries were in the top five health issues affecting children across Victoria. RCH admission data indicates injuries in the top 20 reasons for emergency presentations and in the top 10 high volume separations²³.

An analysis of children's accident information from the Victorian Emergency Minimum Data Set (VEMD) (July 2001-June 2002)²⁴ indicates an average accident rate of 10% for children between the ages of 0-8 years across the Moonee Valley Melbourne Primary Care catchment (MVCC rate 11%, MCC rate 9%). In terms of numbers, 1310 children from Moonee Valley and 244 children from Melbourne presented to an Emergency Department in Victoria for an accident related injury.

An analysis of children's accident presentations 0 – 8 years at the Emergency Department of the Royal Children's Hospital (RCH) (July 2001 – June 2002)²⁵ indicates that at least 15% of all children presenting at RCH are from the Moonee Valley Melbourne catchment. The total number of presentations for accident related injuries (0-8 years) to RCH was 6077. This presentation number is at least 2.3 more presentations than for Asthma (2631 - refer HARP Background Paper March 2002) and represents a significant amount of Emergency Department time devoted to children's injuries (number for accidents only includes 0-8 years).

RCH data along with the VEMD data indicates that 44.% of accidents for the MVM PCP catchment were fall related incidents, 17% were collision accidents, and 4% poisons related incidents. A majority of these incidents took place in the home (57.6%), at school (10.8%), in a recreational/sports area (8%) or on a road (3.7%). Presentations to Emergency Departments occurs across all ages from 0 – 8 but is elevated at age 1 and 2. This corresponds with the developmental stage of increased mobility through walking and running.

2. Older People's Injuries.

Australian and overseas studies of community dwelling older people have identified that approximately 1 in 3 people aged 65 years and over fall each year, with 10% having multiple falls and over 30% experiencing injuries requiring medical attention. The rates of falls and associated injuries are higher for older people in residential aged care and hospital settings. Most recent figures from the National Injury Surveillance Unit indicate no clear upward or downward trends in age standardised falls related mortality or hospitalisation data. However, case numbers are rising because of the increase in the proportion of the population at the ages of higher risk²³.

An analysis of data for the MVM catchment highlights that the majority of falls occur within the home²⁶. In those who fall, approximately 65% of women and 44% of men fall inside their home and about 25% of men and 11% of women fall in their garden. In the home most falls occur in the most frequently used rooms-bedrooms, kitchen and dining room. People aged below 75 years are more likely to fall outdoors



than those aged 75 years and over, and indoor falls are associated with compromised health status in more active people. Most falls in the community occur during the day with only 20% occurring during the night. Colder days and the winter season increase the rate of falls in women and the incidence of fractures²³. Within the catchment, falls related ED presentations for females are at least double that of males²⁶.

A review of attendances at the Royal Melbourne Hospital Emergency Department (March 2000 – February 2002)²⁷ which had the word “falls” in the initial triage description revealed that over 1000 older people (average age 80) attend the ED annually, of whom almost half are admitted to either RMH or another hospital²⁸. An Emergency Demand Falls Project has been funded and is discussed under Emergency Demand.

Service Profile to date:

(All profiles will continue to be populated to inform ongoing planning)

Life Stages		Family/Chn	Youth	Adults	Older
Service Continuum	Public Health Participative	Playgroups, childcare centres, parenting programs.	Council youth services.	Community Venues and Activities.	PCP Foothold on Safety.
	Preventative	Parenting programs.		DGCHS - OT & variety of exercise programs MVCC/MCC community services various exercise programs wellness programs RDNS – screening, pharmacies & optometrists.	PCP Foothold on Safety DGCHS - OT & variety of exercise programs MVCC/MCC community services various exercise programs wellness programs, RDNS - screening pharmacies & optometrists.
	Early Intervention	MVCC & MCC Child and Maternal Nursing and Children’s Services, GPs.		DGCHS - physiotherapy, GPs, pharmacies & optometrists.	DGCHS - physiotherapy and exercise programs, GPs, pharmacies & optometrists, MECRS – falls and balance MH HARP project in collaboration with DGCHS and PCP (high risk).
	Intensive	Royal Children’s Hospital, PACFU.	RCH, MH – MECRS, PACFU.	MH -RMH, MECRS, NARI, PACFU.	MH –RMH, MECRS, NARI, PACFU.



Life Stages		Family/Chn	Youth	Adults	Older
	Maintenance in Community			MVCC & MCC Community Services, RDNS.	MVCC & MCC Community Services, RDNS.

Priorities/Gaps/Emerging Issues

- Falls prevention in the elderly is an ongoing priority in the catchment
- Need for additional falls prevention CALD resources with an emphasis on enhancing the quality of existing resources.
- Children’s injuries have been identified as a primary prevention need in the catchment and will be pursued with RCH.

Falls/Injury Strategies

Strategies	Expected Outcomes
<p>1. Ongoing implementation of Foothold on Safety Health Promotion Project.</p> <p>Encourage use of consistent falls prevention information and resources across agencies – with an emphasis on CALD resources.</p> <p>Work with agencies to collate information on physical activity, and include on the WMR Service Directory.</p>	<ul style="list-style-type: none"> ➤ Integrated health promotion program across MVM PCP catchment with a strong consumer focus. ➤ Integrated service planning and development as a result of information gained in the project. ➤ Implementation of SCTT in falls prevention service delivery activities. ➤ Use of consistent consumer information and resources for falls prevention across agencies. ➤ Physical activity information available on WMR Service Directory.
<p>2. Progression with RCH funding for project focussing on children’s injury prevention.</p>	<p>Integrated service planning and development across acute care and primary care sector.</p>

3. Complex Care Needs/Coordination

Community and Service Profile

Community Profile

Specific groups in the catchment who are a priority under the heading Complex Care/Care Coordination include older people/people with disabilities with complex care needs and people with a range of complex care needs in the CBD (particularly the homeless or those at risk of being homeless).

1. Complex Care Needs of Older People/People with Disabilities.

There is a significant burden of disease for older people in the catchment with conditions that require long term health and community support services. Hospital admission data indicates that people over the age of 65 years of age has increased to approximately 40% of hospital separations and nearly 55% of days stayed in hospital for the City of Melbourne and Moonee Valley in 200-2002².

According to the 1998 ABS Survey, 56.0% of Victorians with a disability living in households needed assistance to move around or go out, shower or dress, prepare meals, do housework, perform light property maintenance or paperwork, or communicate. Assuming that disability levels in the MVM PCP catchment area are equivalent to those for Victoria as a whole, some 15,092 people need assistance with at least one activity, ranging from an estimated 1,132 needing assistance with communication to around 9,190 needing assistance with property maintenance.

Carers have been defined as being those who provide some assistance to those who need help because of disability or ageing (ABS, 1998). In Victoria in 1998, about 13% of the population were defined as carers. Both males and females were represented as carers, although a majority of these people (80%) were female. Of those providing some assistance, 36% were in the 35-54 age range – a part of the life cycle when caring responsibilities may involve children, partners and ageing parents.

Primary carers are those who provide most informal assistance with personal activities to a person with a disability and therefore caring plays a major part in their lives. For Victoria in 1998, 18% of all people providing assistance were primary carers and most of these were female (62%). Most primary carers cared for a person in the same household. It can be reasonably estimated that there are just over 18,000 carers (in Victoria), including more than 3,300 primary carers in the MVM PCP catchment area²⁹.

Elderly people of culturally diverse backgrounds in the WMR are continuing to increase in numbers and diversity. At the 2001 census, people over the age of 65 years who were born in a non-English speaking country (NESC) accounted for 44% of the over 65+ population. This is a regional increase of 28% from the previous census count in 1996. Moonee Valley has one of the highest concentrations of CALD elderly in the WMR representing 41% of the 65+ population, compared to a lower concentration in Melbourne representing 27%. A more significant increase (64%) was recorded for the 70+ CALD population in the WMR from 1996 to 2001¹⁹.

Difficulties with communicating in English are continually reported as a significant obstacle for elderly people of CALD backgrounds in participating in the Australian community. In Moonee Valley 41% of the 65+ population speak a language other than English (LOTE) at home. In addition, 19% of the 65+ population who cannot English very well or at all. In Melbourne a slightly lower percentage of the 65+ population (30%) speak a language other than English (LOTE) at home, with nearly 14% that cannot speak English very well or at all.

The language proficiency data gives a clear indication of the communication difficulties experienced by people of CALD backgrounds. It also highlights the growing need for the development of language services such as interpreters and translation services, and CALD resources¹⁹.

Between 1996 and 2001 the number of older people from CALD backgrounds living in Victoria is projected to increase by 71% reaching 30.8% of the total older Victorian population. For the population aged 80+, by 2011 there is a projected growth increase rate of 171%¹⁹.

2. Complex Care Needs in the CBD.

There are specific areas of need in the MVM PCP catchment in the CBD. This includes high levels of people with psychiatric disability, people with drug and alcohol issues and people with complex social and health needs, e.g. homeless people with a chronic illness. There were 3,900 homeless people in inner Melbourne on Census night in 1996. This was 22% of the homeless population of Victoria. Many of the homeless in inner Melbourne are turned away from Supported Accommodation and Assistance Program(SAAP) Services, with boarding houses playing an important role in providing emergency accommodation. Gambling was also identified as an issue. Of 10 SAAP services in inner Melbourne surveyed, 40 percent indicated that gambling was the most common presenting issue, ranking it as high as sexual assault and domestic violence. Ninety percent of respondents in this survey felt that gambling had led to, or maintained homelessness for some people²⁰.

The MVM PCP Better Health Care for People with Complex Needs in the CBD project¹¹ found that a disproportionately high percentage of Victoria's homeless population is located in the CBD and Inner Melbourne and that of these people there are strong indications that a disproportionately high number have complex needs comparative to the whole homeless population – 80% of the service provider survey respondents reported between 50% and 100% of service users had complex needs compared to 18% of SAAP users nationally.

Based on the Complex Needs project sample, the homeless service user population in the CBD appears to be predominately single, younger males from an English-speaking background. Only two CALD sub-groups were identified in the consultations – indigenous Australians and Vietnamese-born service users. Women and older people may be under-represented in the service user population due to a reluctance to use services that are dominated by younger males.

Substance abuse, mental health/stress, inadequate food/poor nutritional status, and poor general health/access to GPs were the most frequently reported health needs/issues. There was overlap between needs as identified by service providers and those identified by service users although service users placed greater emphasis on inadequate food, inadequate sleep, and lack of GP services in the CBD that bulk bill.

A wide range of barriers were identified through the consultations. These tended to be consistent with barriers reported in the literature and included:

- Lack of/short supply of some services.
- Service inflexibility (including lack of services that outreach or operate after hours).
- Cost of services, in particular the lack of GPs who bulk bill.
- Lack of coordination and impact of transience on continuity of care.
- Lack of services directly in the CBD.
- Client behaviours (for example, inability to remember appointments or unwillingness to use services).
- Dual diagnosis/disability continuing to fall through service system cracks.
- Lack of accessible information about services.



- Worker attitudes/lack of skills.

Mental health services (all types) were reported as being least accessible, partly due to lack of capacity and partly due to perceived inflexibility and restrictive entry criteria.

Service Profile

There are a number of services relevant to the provision of Complex Care/Care Coordination in relation to older persons/people with a disability with complex care needs and complex care needs in the CBD. These are set out below.

1. Complex Care Needs of Older People/People with Disabilities.

Services to older people with complex care needs are provided by a wide range of providers. Member agency providers include; DGCHS, Essendon RDNS, General Practice, North West Aged Psychiatry services, North West Aged Care Assessment Services, the Cities of Melbourne and Moonee Valley, and Melbourne Health through its various departments and services such as the ED department, Melbourne Extended Care and Rehabilitation and post acute care. MVCC and MCC also provide aged care packages. Some of the non PCP member agencies providing care packages to the MVM PCP catchment include; Anglican Aged Care Services Group, Australian Polish Community Services, Brotherhood of St Lawrence, Care Connect, CO-AS-IT, Dutch Care, Fronditha – Western, ISIS Primary Care, Maltese Community, Salvation Army – Melbourne, Moonee Valley Southern Cross, and Wintringham. A number of service providers provide residential care services across the catchment.

There are approximately 32 services involved in the Ethno-specific Services Network (ESN) that provide services to the CALD community in the WMR.

2. Complex Care Needs in the CBD.

Services provided to people with complex care needs in the CBD are again provided by a wide range of providers many of whom are not PCP member agencies. PCP member agencies providing services include; Dousta Galla Community Health via counselling services and community connections program, the City of Melbourne, Inner West Area Mental Health via specialist homeless persons program, the City of Moonee Valley via HACC Housing Advocacy Worker, Melbourne Health through its various departments and services particularly the ED and Area Mental Health Services, Essendon RDNS, General Practice, and Women's Health West. Some of the non PCP member agencies providing services to people with complex care needs i.e. homeless people in the CBD include; RDNS Homeless Persons Program, Hanover Outreach, Open Door, Flagstaff Crisis Accommodation, Ozanam day Program, Ozanam House, Salvation Army Intensive Support Services and Regina Coeli. A full service profile can be accessed in the Complex Care Needs Project in the CBD¹¹.

Eighty-eight (88) individual services were identified as important to people with complex care needs in the CBD in terms of referral pathways, and/or service linkages. Other agency, word-of-mouth and assertive outreach were the three most commonly reported ways in which consumers heard about services.

GPs were identified as a major point of entry to the primary care sector but referral from GPs to other primary care, housing and welfare services was found to be inhibited by their relative isolation from the broader service system and the lack of easy-to-access information about services. Commonwealth funding arrangements, including EPC items, were reported as not providing sufficient incentives for GPs to work with this complex client group. It was suggested to the project that salaried GPs in community



health services may be better positioned to work with the target group, however these services were also found to be under threat due to funding difficulties.

Hospital Emergency Departments were also identified as a key entry point where opportunities to link homeless people with complex needs to appropriate services are often not fully exploited. Some services, for example RDNS Homeless Persons Program and St Vincent's Hospital ALERT Program, are addressing this issue, as are the recently funded HARP projects targeting frequent attenders at the RMH and St Vincent's Hospital.

Priorities/Gaps/Emerging Issues

1. Complex Care Needs of Older People/People with Disabilities.

Following discussion of the above data, providers in the MVM PCP catchment have identified a number of other priorities for older people/people with complex care needs including;

- Improved Care Planning and coordination of current services.
- Implementation of the WMR CALD Aged Care Strategic Plan.
- Progression of Carers Needs as identified through the use of WMR BPM Carer Profile.

Other issues that emerge from CHP Data service utilisation data include;

- Reduced access to allied health services compared to other regions.
- Increased waiting times for Primary and Community Health Services compared to other regions.

2. Complex Care Needs in the CBD

What emerged through the CBD project was a picture of a service system that is very open, complex, and often reliant on informal processes and personal relationships. This complexity is partly a function of the wide range of needs experienced by the target group which cuts across the health, housing and welfare sectors.

Formal service networks focusing on homelessness in the CBD were found to be weak or organised around other targets such as youth. In particular, better coordination of *outreach* workers in the CBD was identified as an issue, with strong interest in developing a specific network or some other kind of forum for coordination and information sharing. The CBD Services Network, which was initiated by Urban Seed towards the end of the CBD project, may provide a vehicle for meeting this gap. However, while initial participation has been good, consideration will need to be given to strategies to ensure its longer-term sustainability.

The most frequently reported service shortfalls/gaps were:

- Assertive outreach.
- Affordable (bulk-billing) GP services.
- Suitable housing linked with long-term care packages and/or outreach support.
- Clinical mental health homeless outreach and psychiatric disability support.
- Flexible allied health and counselling services.
- Flexible meals and planned activity services.
- Dual diagnosis/disorder services.
- Drug rehabilitation beds.
- All services outside normal business hours.



The lack of a visible and comprehensive primary health care centre in the CBD was also reported as a major gap and formed the basis for one of the major recommendations of the Better Health Care for People with Complex Care Needs in the CBD project¹¹.

There is also a continued lack of coordination between ED and primary care providers. Part of this relates to a limited capacity of current community providers to provide flexible intensive support to maintain people with complex psychosocial issues in the community. Often these clients end up as frequent attenders through emergency departments when their accommodation and social environments break down. These clients are often behaviourally disturbed and require significant staff resources within the ED. It is acknowledged that treatment of physical symptoms, combined with referral to appropriate community services is often ineffective, as the ED is unable to provide sufficient community follow-up to ensure the effectiveness of referrals. Lack of out-of-hours capacity from community services (such as PDSS and Drug & Alcohol Services) has been identified as a critical shortcoming of current services¹¹.

Strategies identified to address these issues by the MVM PCP have been:

- Continued support for the development of a Primary Care Service in the CBD.
- Completion of the *Better Health Care for People with Complex Needs in the CBD* project.
- Development of an ED HARP Project with MH focussed on frequent attenders with complex psychosocial needs (2002).

Future work will continue to focus on the recommendations of the CBD Project including promotion of a Primary Care Service in the CBD and support to the MH HARP ED project (which will be coordinated under an integrated approach to chronic care conditions HARP 2003/2004).

Complex Care Needs/Coordination Strategies

Strategies	Expected Outcomes
1. Ongoing progression of needs of older people/people with disabilities with complex care needs including a focus on: <ul style="list-style-type: none"> ➤ Improved Care Planning & coordination of current services. ➤ Progression of recommendations of WMR CALD Aged Care Strategic Plan. ➤ Progression of Carers Needs. ➤ Redevelopment of Niddrie site by Partner Agencies with a focus on care coordination for older persons/people with disabilities. Progression by MVCC and DGCHS. ➤ Ongoing lobbying for increased allied health services in MVM PCP catchment. 	<ul style="list-style-type: none"> ➤ Care Planning processes for HACC clients identified and implemented between agencies. Review to include review of waiting times for services. ➤ Regional implementation of strategies to address Ageing CALD community needs. ➤ Use of Carer Profile across catchment. ➤ Increase coordination of aged and disability services for clients in Niddrie catchment. ➤ Increased access to allied health services for people in MVM PCP catchment.
2. Ongoing progression of needs of people with Complex Care Needs in CBD by follow up of recommendations from <i>Better Health Care for People with Complex Needs in the CBD</i> project. MCC will lead on support for Primary Health Care Service in the CBD.	<ul style="list-style-type: none"> ➤ Increased coordination of primary care services in CBD. ➤ Increased referrals and links between ED and community care providers in provision of care for complex care clients.

4. Neighbourhood Planning in High Area of Need

Community and Service Profile

Community Profile

Public housing communities were identified in our planning process as communities of high need. In order to qualify for Office of Housing accommodation support, applicant must satisfy stringent criteria. Therefore as a result of being eligible for such criteria, Office of Housing clients have a high proportion of people from low-income backgrounds frequently combined with a range of health and social problems. Research has consistently demonstrated the link between low income and poor health³⁰. Research undertaken by Shane Thomas and Associates (2001)²⁹ has shown that members of the public housing community experience significant disadvantage in health and wellbeing and have higher service needs relative to the general community. Postcode analysis demonstrated that hospital admissions were at a high level for the North Melbourne area, although some allowance should be made for proximity of the areas to the hospital.

The selection of the North Melbourne area for the project stems from a number of factors. An analysis of existing service provision arrangements showed that the other major area of high density housing client concentration, Kensington, was already the focus of a wide range of community development activities whereas North Melbourne was not in relative terms. The North Melbourne estates also represent a shared area of interest of key service providers of the MVM PCP. Thus our rationale for the selection was based upon a gap analysis of existing service provision and service need. This rationale draws upon Bradshaw's widely used typology of health service need²⁹.

North Melbourne is a culturally, linguistically and socio-economically diverse community. Approximately 40% of North Melbourne residents speak a language other than English at home. The public housing community eight main regions and includes many communities of interest. The eight regions include 31% Asia, 23% Africa, 22% Australia, and 5% South America. Information from "Beyond Symptoms" (2002)³¹ by WHW indicates there are more female than male public housing tenants in all Local Government areas across the Western Region. Female tenants are particularly prevalent in Moonee Valley, Melbourne and Maribyrnong.

People living in public housing experience a high level of disadvantage. This is reflected in the demographic data (Census 2001)² for the North Melbourne neighbourhood in relation to income and sole parent families. This report identified North Melbourne as significantly disadvantaged in the MVM PCP catchment area. Information from the Office of Housing in North Melbourne indicates that sole families comprise 23% of the family structures on the North Melbourne public housing estate. There are 284 public housing units providing accommodation for 1,657 residents. A high proportion of these residents are in receipt of Centrelink payments. Public housing residents in the area from low-income background experience a combined range of health and social problems. A report produced by the Jesuit Social Services, *Unequal in Life* (1999)³², ranked Hotham Hill (the location of high density public housing in North Melbourne as 88th out of 622 in its level of disadvantage.

The North Melbourne Neighbourhood project recognises the disadvantage experienced by Office of Housing clients and seeks to build community capacity and improve service access and coordination. Community capacity will be developed in conjunction with community leaders and representatives. Appropriate and sensitively designed outreach activities will link with existing activities delivered by the participating agencies within the MVM PCP.

Service Profile for North Melbourne to date

(All profiles will continue to be populated to inform ongoing planning)

Life Stages		Family/Chn	Youth	Adults	Older
Service Continuum	Public Health Participative	Libraries, Recreation facilities, North Melbourne Art House, North Melbourne & Flemington Community Centres, Hotham Hub Children's Centre.	Libraries, Recreation facilities, North Melbourne Art House, North Melbourne & Flemington Community Centres.	Libraries, Recreation facilities, North Melbourne Art House, North Melbourne & Flemington Community Centres.	Libraries, Recreation facilities, North Melbourne Art House, North Melbourne & Flemington Community Centres.
	Preventative	MCC North and West Melbourne Neighbourhood House – literacy, community arts. Jean Mc Kendry Neighbourhood Centre, Chinese & Vietnamese Neighbourhood Centre.	MCC North and West Melbourne Neighbourhood House – literacy, community arts, Jean Mc Kendry Neighbourhood Centre, Chinese & Vietnamese Neighbourhood Centre.	MCC North and West Melbourne Neighbourhood House, Jean Mc Kendry Neighbourhood Centre, Chinese & Vietnamese Neighbourhood Centre.	MVCC – wellness programs, Jean Mc Kendry Neighbourhood Centre, Chinese & Vietnamese Neighbourhood Centre.
	Early Intervention	DGCHS, MVCC – Hotham Hub Children's Centre, Maternal and Child Health Service Bunclre Street, Family Day Care, GPs.	GPs, DGCHS –Macaulay Program.	DGCHS–Macaulay Program, MVCC Community Care - home care, meals. GPs.	DGCHS–Macaulay Program, MVCC Community Care – home care, meals, GPs.
	Intensive	Post Acute Care, childcare & physiotherapy.		DGCHS - Community Connections.	

Life Stages		Family/Chn	Youth	Adults	Older
	Maintenance in Community	Office of Housing, North Melbourne Tenant's Association, North Melbourne Legal Service, Tenant's union Victoria, St Vincent de Paul, Vietnamese Welfare Association.	Office of Housing, Melbourne Tenant's Association, North Melbourne Legal Service, Tenant's union Victoria, Vincent de Paul – Ozanam House; Bailey House. Vietnamese Welfare Association.	DGCHS – Macaulay Program, Salvation Army – Melrose St Program, Office of Housing, Melbourne Tenant's Association, North Melbourne Legal Service, Tenant's Union Victoria, Vincent de Paul – Ozanam House; Bailey House. Vietnamese Welfare Association.	DGCHS – Macaulay Program, Salvation Army – Melrose St Program, Office of Housing, Melbourne Tenant's Association, North Melbourne Legal Service, Tenant's Union Victoria, Vincent de Paul – Ozanam House; Bailey House, Vietnamese Welfare Association.

Priorities/Gaps/Emerging Issues

Service providers have reported an increasing shortage of childcare places as an issue for people living within the high rise. The unavailability of childcare limits people's opportunities to interact within the community. A number of families in need of English classes have found it difficult to attend classes as childcare is unavailable.

The North Melbourne Community Centre reported that there are significant difficulties for people living in the high rise, as most are very disadvantaged. Many residents are sole parents and/or single people who experience mental health and/or drug and alcohol issues. Moonee Valley City Council services indicated a high degree of isolation of clients (particularly older clients) in the North Melbourne estate. Many people are socially isolated and suffer high prevalence mental health issues such as depression and anxiety. Many clients have financial problems.

The North and West Neighbourhood House outlined the need for better public transport to enable residents to attend their services. The Neighbourhood House recognises a need to develop youth programs as there is a gap in services in this area, especially for youths living in the high-rise estates who may feel particularly isolated from the rest of the community in the area.

Moonee Valley City Council services indicated a high degree of isolation of clients (particularly older clients) in the North Melbourne estate.



Neighbourhood Planning Strategy

Aim: Progression of Neighbourhood Planning Project in North Melbourne housing estate.

Strategies	Expected Outcomes
1. Ongoing consultation with community in relation to needs including maintenance of links with community leaders and representatives.	Community consultation will provide information on service gaps, community needs and expectations. Consultation will enhance contact with individuals and empower community members to better identify with their neighbourhood and services available therein.
2. Hold community events at the North Melbourne estate.	Enhanced social connectedness and community engagement, leading to increased consultation opportunities.
3. Continued pursuit of funding for project work with community.	Funding is granted and funds can be allocated to commence project.

5. Emergency Demand/Chronic Conditions

Community and Service Profile

Community Profile.

The 2001-2004 Community Health Plan²⁰ indicated that the disease which results in the highest DALYs for both men and women aged 55 years and over in the City of Moonee Valley is cardiovascular disease, specifically, heart disease. For males in this municipality, lung cancer and chronic respiratory disease were the second and third highest. Diabetes and colon cancer were also high. For females in the City of Moonee Valley, breast cancer and musculo-skeletal diseases are second and third highest. Dementia and diabetes were also high.

In the City of Melbourne, the disease that caused the highest burden for males aged 55+ was also cardiovascular disease followed by chronic respiratory disease and musculo-skeletal disease. For women in this age group in the City of Melbourne, cardio-vascular disease was highest, followed by dementia, musculo-skeletal disease and depression.

Hospital emergency demand and admission data for the Royal Melbourne²⁷ and the Children's Hospital²⁵ are particularly relevant for MVM PCP catchment area. Royal Children's hospital indicates high levels of hospital emergency demand and admission for asthma and injuries²³. Data from the Royal Melbourne Hospital indicates high levels of emergency demand and admission for Chronic Obstructive Pulmonary Disease (COPD), falls of frail older people, diabetes complications and cardiovascular disorders. As indicated earlier, hospital admission data indicates that people over 65 account for 30% of admission to hospital and over 50% of bed days in the MVM catchment²³. Western Region diabetes complications admission rates were significantly above the Victorian average and chronic ACSC's were the PCP's top five causes of admission in 2001-2002³³.

Two other areas where high demand for RMH Emergency Department services could be reduced through the provision of alternative services were identified in the 2002 HARP process. These included;

- Frequent use of the ED by people with complex psychosocial needs including mental illness, chronic medical conditions, substance abuse, ABI and homelessness.
- People requiring access to inpatient psychiatric beds who wait for long periods in the ED for admission to an acute psychiatric unit.

These areas are included as ongoing strategies under Mental Health Issues and Emergency Demand.

Service Profile

All of the services represented in the MVM PCP have an interface with the acute and subacute care system. Those services most often referred to on discharge from Melbourne Health to the primary care sector include General Practice, Essendon RDNS, the Cities of Moonee Valley and Melbourne Community Care Services and Doutta Galla Community Health Service (including Macaulay Support Services).

Priorities/Gaps/Emerging Issues

Ongoing work on emergency demand issues has highlighted:

- Need to for ongoing evidence-based programs in the community in partnership with the acute sector to prevent hospital admission and improve client outcomes.
- A need to focus on integration across chronic care conditions as well as coordination across the care continuum
- Ongoing need for collaboration in analysis of information about preventable illnesses.



Emergency Demand/Chronic Conditions Strategies

Strategies	Expected Outcomes
<p>1. Ongoing MVM PCP collaboration with MH in the planning and implementation of projects in relation to high prevalence preventable conditions and illnesses such as;</p> <ul style="list-style-type: none"> ➤ Diabetes ➤ Falls ➤ Cardiovascular disease ➤ COPD ➤ Stroke ➤ ED frequent attenders with complex psychosocial needs <p>Ongoing progression of current projects by coordination into an integrated HARP project focussed on Comprehensive Services to People with Chronic Care Conditions. Expansion to other chronic care conditions as per success with submissions to HARP.</p>	<ul style="list-style-type: none"> ➤ Further projects funded through HARP funding round which aim to reduce emergency demand and preventable admissions for people with chronic care conditions. ➤ Successful implementation of HARP projects with acute and primary care partners. ➤ Standardised patient disease management information throughout projects and agencies. ➤ Improved care planning for people with chronic care conditions.
<p>2. Ongoing collaboration with MH and Western Health in relation to coordinated acute care response to service coordination implementation and training including support to E-Business activities of the WMR PCP's.</p>	<ul style="list-style-type: none"> ➤ MHs use of SCTT and WMR BPM. ➤ Improved service information about primary care sector within MH. ➤ MHs use of WMR Service Directory/Statewide Service Directory and E-Referral system.
<p>3. Ongoing implementation of community asthma project with partners across MVM PCP catchment and Dianella CHS catchment.</p> <p>Expansion of Community Asthma Project across Western and Northern region with new partners.</p>	<ul style="list-style-type: none"> ➤ Comprehensive management of children with asthma in the MVM PCP catchment. ➤ Comprehensive management of children with asthma in the current Western and Northern Region.

6. Drug and Alcohol

Community and Service Profile

Community Profile

The 2001-2004 Community Health Plan²⁰ identified drug and alcohol problems across the catchment. The Victorian Burden of Disease Study showed that alcohol abuse and dependency was responsible for 3.46 DALYs per 1000 males in the Melbourne/Moonee Valley PCP catchment area. This rate is slightly above the Victorian average. For females living in the PCP catchment area, alcohol abuse and dependency was responsible for only 1.21 DALYs per 1000 females. This rate is below the Victorian average.

Alcohol:

Alcohol is a risk factor for a large number of medical conditions and injuries, including stroke, cirrhosis and road traffic accidents. Furthermore excessive alcohol consumption has significant psycho-social and economic effects². Turning Point Alcohol and Drug Centre established a number of alcohol-related data sets in order to develop indicators of alcohol consumption and related harm at a regional and local level in Victoria. The figures for the PCP indicated considerable variation between Melbourne and Moonee Valley. Melbourne had a very high rate of 'alcoholness' indicating the need for alcohol services and prevention programs. During the period of 1999-2000 there were 46 alcohol related deaths among residents of Moonee Valley and 21 deaths recorded in the City of Melbourne³⁴.

Illicit Drugs:

There were large increases in the numbers of heroin overdoses in Metropolitan Melbourne during June 1998 and July 1999, with an average daily ambulance attendance at non-fatal heroin overdoses increasing in rate from 5.2 to 9.9. The MVM PCP catchment area accounted for 17.75 % of all non-fatal heroin overdose-related ambulance call-outs for this period. Illicit drug related death in Victoria and the Western metropolitan region continued to increase from 1999-2000. According to Turning Point Drug and Alcohol Centre, the effect of the heroin shortage has seen a reduction in the number of heroin overdose attendances in metropolitan LGAs, with a significant reduction apparent for the City of Melbourne³⁴.

The rate (per 100,000 population) of illicit drug related deaths among residents of the City of Moonee Valley was 7.76 in 2000. The City of Melbourne illicit drug related mortality for 2000 was 17.3. Between 1999-2000 there were 24 illicit drug related mortalities among residents of Moonee Valley and 16 deaths reported in the City of Melbourne. The majority of these deaths relate to the health consequences of heroin use, particularly overdose.

The 1999 Adolescent Health and Well-Being Survey found that the proportion of students in the MVM PCP catchment who had ever used marijuana and the number who have used marijuana in the last 30 days is slightly lower than the average for the Western Metropolitan Region. Rates for other drug use in the MV/M PCP catchment were consistent or slightly higher than overall rates in Victoria. However, the survey was confined to schools so the number is likely to be under-represented

Tobacco imposes the greatest burden on health for Victorians accounting for 9.8% of the total DALYs. The rate (per 100,000 population) of tobacco related mortality among residents from the City of Moonee Valley was 47.43 and 31.68 among City of Melbourne residents³⁴.

A substantial proportion of Victorian drug related harm occurs in the City of Melbourne this has important implications for the provision of services to minimise the harms associated with drug use³⁴.



Service Profile

Key local Drug and Alcohol agencies include: DAS West, Living Room Primary Health Service, Youth Projects including Foot Patrol, Ozanam House, Ozanam Community Centre, Odyssey House, Turning Point/Directline, CAH, De Paul House, Melbourne Sexual Health Centre, Salvation Army, RWH, Youth Substance Abuse Service.

Generalist Support Services include: Traveller Aid, Open family, YMCA, Carlton/Parkville Youth Services, Dousta Galla Community Health Service, Urban Seed, Hanover, Melbourne City Mission, Frontyard, Young People’s Health Service, Open Family, Action Centre, Melbourne Youth Support Service, CBD Housing Information and Referral Service.

Emergency Services: Police, Metropolitan Fire Brigade and Ambulance.

Other services include: pharmacists, GPs, hospitals and specialist and peak agencies.

Priorities/Gaps/Emerging Issues

- Lack of coordination between services.
- Need for coordination with new service developments in CBD.
- Lack of integration with mainstream services.
- Links with GPs.
- Emerging issues include chroming, poly-drug use, lack of recovery space, and the importance of maintaining syringe management strategies.
- Assisting business, newly arrived communities, and support for families.
- Life stage issues.

Drug and Alcohol Strategies

Strategies	Expected Outcomes
1.Link PCP activity with work being conducted by MVCC and MCC in relation to service mapping, consultation and Drug Action Strategies.	<ul style="list-style-type: none"> ➤ Drug Action Plans/Policies provide strategic framework for councils response and activities to address drug related harm. ➤ Drug & Alcohol Service Mapping and consultation informs service coordination activities.
2. Ongoing inclusion of new CBD Primary Health – Drug and Alcohol service in PCP activities.	Living Room part of Steering Committee mail list for MVM PCP.
3. Encourage use of SC tools and WMR BPM with local D&A Services.	Use of SC Tool Templates by D&A Services.

7. Disability/Early Intervention

Community and Service Profile

Community Profile

Functional disability information presented in the 2001-2004 Community Health Plan²⁰ was based on estimates at the LGA level from data on Victoria as a whole contained in the Disability, Ageing and Carers survey (1998)³⁵.

The rate of disability in the community has been found to increase with age. The 1998 Survey on Disability, Ageing and Carers showed that the disability rate rose, from 3% for children aged 0-4 to 52% of those aged 75-79, to 81% for those aged 85 and over, with the trend being similar for males and females. Overall, 18% of the population suffered from a disability, a higher rate than in previous such surveys, with 16% experiencing specific restrictions in the core activities of self-care, mobility and communication and/or in schooling or employment³⁵.

Early Intervention

There is now an understanding that investment in prenatal, postnatal infant and early childhood periods of life is necessary in order to facilitate the healthy development of children into adulthood especially for those who live in disadvantaged circumstances. Almost all adult diseases and causes of ill health have their antecedents in childhood. This includes cardiovascular disease, mental health and social functioning. Early childhood is thought to hold the key to many future outcomes. Brain research has shown us that this is a time of rapid brain development, during which time many sensory and intellectual pathways are laid down. This presents both a window of opportunity and a window of vulnerability –a time when exposure to appropriate stimuli and experiences in a nurturing environment can protect a child against life's hardships, or it can be a time when the devastating effects of neglect and abuse on brain development lead to emotional and behavioural problems that are life long³⁶.

One of the most powerful determinants, or risk factors, for poorer child outcomes is poverty. There is strong evidence that shows the link between socio-economic status and adverse outcomes for children in a range of domains including health and education. Long term research from the US has demonstrated that, for at risk families, intensive early intervention aimed at the needs of the child and the family produces improved outcomes. Almost 10% of all Australian children are thought to have some kind of learning difficulties or developmental problem. These children are at higher risk of a range of poor emotional and social outcomes. However, early identification and intervention particularly before grade 2, can improve outcomes³⁶.

The population of children and families in the 0-9 year old group in the MVM PCP catchment is 12,882 for MVCC and 3023 for MCC². We can conclude that at least 10 % of this population, 1289 children for MVCC and 302 children for MCC, may experience learning or developmental problems. MVM PCP has a number of identified areas of low socio-economic status. These are predominantly housing estates in the following suburbs; Carlton, North Melbourne, Flemington, Kensington, Ascot Vale, and Avondale Heights.

Service Profile

The Platforms project has progressed service profile information for Early Intervention. Services provided to children 0-8 years across the MVCC catchment will be added to the WMR PCP's Service Directory as well as published by the project for service providers in the area. Information from surveys to date



indicate that services families are most in contact with include GPs child and maternal health nurses, RCH ED, paediatricians and then a range of specialist providers such as speech pathologists.

Priorities/Gaps/Emerging Issues

- Need for increased coordination and collocation of services.
- Need for use of SCTT and development of profile for children.
- Need for comprehensive service information for providers and consumers.
- Access to a range of services particularly Speech Pathology services, specialist paediatric and women's health services in local areas.

Disability/Early Intervention Strategies

Strategies	Expected Outcomes
1. MVM PCP continued collaboration in the Platforms project with MVCC and RCH. This project is focussing on the needs of children from 0-8 years in disadvantaged communities.	<ul style="list-style-type: none"> ➤ Identification of service gaps for 0-8 year olds in disadvantaged communities. ➤ Community building and development. Increased links between services.
2. Review and redevelopment of MVCC Disability and Action Plan.	<ul style="list-style-type: none"> ➤ Increased access to service and the community. ➤ Partnership development. ➤ Knowledge and understanding.
3. Pilot SCTT within MVM PCP catchment Children's Services including the development of a profile suitable for children.	<ul style="list-style-type: none"> ➤ Implementation of trial of SCTT. ➤ Development of profile for use by Children's Services.

3.2.3 Integrated Service Planning Strategic Objective 2 - Health Promotion

MVM PCP will continue to develop and implement an integrated health promotion program across the catchment which is informed by the integrated planning process.

Health Promotion Strategies

Strategies	Expected Outcomes
1. Facilitation of MVM PCP Health Promotion Network.	Enhanced networking and increased capacity of MVM PCP health promotion programs and strategies.
2. Development of integrated health promotion planning process for catchment.	Integrated health promotion planning leading to increased capacity and coordination of health promotion practice across catchment.
3. Continued progression of health promotion projects in identified health priority needs (see Mental Health and Falls Prevention).	Health promotion strategies address health priorities achieving meaningful outcomes for consumers.
4. Ongoing coordination with the three WMR PCPs to Integrated Health Promotion in identified priority areas.	Coordinated and sustained Integrated Health Promotion across the WMR.

For MVM PCP Integrated Health Promotion Plan 2003-2004, please refer to Attachment A.



3.3 Service Coordination

3.3.1 Service Coordination Strategic Objective 1 - Service Coordination Implementation

MVM PCP will ensure the implementation of the statewide Service Coordination Tool Templates and strategy in a manner that supports consistent processes, practices and protocols across the Western Region.

Priorities/Gaps/Emerging Issues

- Ongoing need to support the WMR Regional Services Directory and e-referral implementation.
- Ongoing engagement with Ethno-specific and smaller agencies.
- Ongoing engagement with acute care sector.

Service Coordination Implementation Strategies

Strategies	Expected Outcomes
1. Ensure the provision and maintenance of up to date information re agency services on the WMR Connecting Care (CC) Services Directory, to linked to the statewide directory (indicated for late 2003). The CC system enhancements include the ability for agencies to have access to update their own records online.	<ul style="list-style-type: none"> ➤ Accurate and up to date information on WMR agencies and services listed in the WMR Service Directory. ➤ Effective and streamlined linkages of local directory to statewide directory once developed. ➤ Regional directory linked to statewide (expected 2003).
2. Support additional WMR agencies and services to become listed on the WMR Connecting Care Services Directory.	<ul style="list-style-type: none"> ➤ Improved consumer and service provider access to information about WMR agencies and services. ➤ Effective and streamlined linkages of local directory to statewide directory once developed.
3. Ongoing encouragement and support for agencies to utilise the Connecting Care Services Directory / E-Referral system to <ul style="list-style-type: none"> ➤ Access up to date information on services in their catchment, and ➤ Participate in e-referral training and implementation 	<ul style="list-style-type: none"> ➤ Agency participation in E-Referral implementation through utilisation of the Connecting Care Services Directory / E-Referral system. ➤ Ongoing training is received by agencies on the Services Directory / E-Referral system.
4. Ongoing encouragement and support for agencies to register for PKI and utilise the Connecting Care Services E-Referral system as per project Workplan	More efficient and effective referral practices between practitioners particularly in terms of privacy requirements.
5. Ongoing management of the WMR PCP's Ethno-specific and Smaller Agency Training and Support project.	<ul style="list-style-type: none"> ➤ Ongoing engagement with Ethno-specific and smaller agencies. ➤ Agency training sessions are completed and recommendations are developed for ongoing support for Ethno-specific and smaller agencies.

Strategies	Expected Outcomes
6. Ongoing support and training to Ethno-specific, smaller and non-mandated Agencies in the implementation of the SCTT and WMR BPM.	Implementation of the SCTT and WMR BPM with smaller, Ethno-specific and non-mandated agencies.
7. Implementation of WMR Service Coordination Workplan <ul style="list-style-type: none"> ➤ Regional SC Meetings ➤ Change Leader Forums ➤ Workforce Development ➤ Local SC Meetings ➤ Review of WMR BPM ➤ Ongoing support to agencies in the implementation of the SCTT and WMR BPM that is consistent across the region. 	<ul style="list-style-type: none"> ➤ Ongoing workforce development and issue resolution related to the implementation of the SCTT and WMR BPM. ➤ Consistent implementation of the SCTT and WMR BPM across the region. ➤ Continuous improvement and maintenance of the WMR BPM.

3.3.2 Service Coordination Strategic Objective 2 - Complementary Service Coordination Activities

MVM PCP will continue to initiate and develop complementary information and strategies to the original statewide Service Coordination Tool Templates that support practitioners to operate a consumer, carer and community accessible and cohesive service system.

Priorities/Gaps/Emerging Issues

- Need for development and progression of care planning processes
- Need for workforce development to support access and equity for CALD communities.
- Ongoing engagement with acute care sector.
- Uptake with General Practitioners.

Complementary Service Coordination Strategies

Strategies	Expected Outcomes
1. Implementation of CALD Competencies project; <ul style="list-style-type: none"> ➤ Identify work practice competency standards for Primary Care Services in working with CALD Aged Care Communities. ➤ Develop accredited Training Program in line with SCTT and WMR BPM. ➤ Implement Training program with WMR Service Providers. 	<ul style="list-style-type: none"> ➤ Improved service delivery to ageing CALD communities. ➤ Enhanced training and skills of workers across WMR agencies. ➤ Strengthened relationships between the WMR PCPs and ethno-specific communities through improving staff capacity and shared practice.

Strategies	Expected Outcomes
<p>2. Progression of Carer Needs Profile in the Statewide SCTT;</p> <ul style="list-style-type: none"> ➤ Review the opportunity for a statewide trial. ➤ Advocate use of the Carer Profile by Agencies where appropriate. ➤ Support the introduction of the Carer Profile as part of the Service Coordination Tool Suite. 	<ul style="list-style-type: none"> ➤ Trial and implementation of the Carer Profile by Agencies where appropriate. ➤ Introduction of the Carer Profile as part of the Statewide Service Coordination Tool Suite.
<p>3. Encouragement and support for the use of the SCTT with Melbourne Health, in addition to HARP Projects, including</p> <ul style="list-style-type: none"> ➤ Pre-admission clinic ➤ Discharge Planning ➤ Allied Health 	<ul style="list-style-type: none"> ➤ Implementation of the SCTT within Melbourne Health. ➤ Improved referral between the acute and community.

MVM PCP PLANNED OUTCOMES – 2003 2004 TEMPLATE

Priorities	Partners	ISP/Health Promotion	Service Coordination
Mental Health	<p>MVCC Boomerang Club & Youth Services, DGCHS Macaulay and Youth Services, MCC Youth Services, Centre for Adolescent Health, Orygen Youth Services, Centrelink, NWDGP, young people, Western Schools Network.</p> <p>DGCHS Macaulay Program, MVCC Boomerang Club, Inner West Area Mental Health Services, Melbourne Health (MH) Acute Mental Health Services, Consumers.</p>	<ul style="list-style-type: none"> ➤ Repeat program of Youth Access Project, Youth Mental Health Promotion Project. ➤ Workforce development sessions for primary health care staff. ➤ Progression of Mental Health Step down (HARP). 	<ul style="list-style-type: none"> ➤ Service Information in WMR Service Directory. ➤ PDSS in WMR establish a common referral and intake process for residential and housing and support services. ➤ All partners to trial the SCTT and WMR BPM. ➤ Implementation of WMR PCP's E-Referral and Service Directory. ➤ Trial of draft Mental Health Coordinated Care Planning protocol.
Falls/injury prevention	<p>DGCHS, MVCC, MCC, RDNS, NARI, GP Division.</p> <p>MVCC, MCC, RCH.</p>	<ul style="list-style-type: none"> ➤ Foothold on Safety Project. ➤ Development of primary care prevention project focussed on Children's Injuries. 	<ul style="list-style-type: none"> ➤ Use of consistent consumer information for falls prevention across agencies. ➤ Physical activity information collated for catchment on WMR Service Directory.

MVM PCP PLANNED OUTCOMES – 2003 2004 TEMPLATE

Priorities	Partners	ISP/Health Promotion	Service Coordination
Complex Care Coordination	<p>MVCC, MCC, RDNS, DGCHS, IWRMRC, ACAS, GP Divisions, GPs.</p> <p>MCC, DGCHS, RDNS, GP Divisions, Living Room, Homelessness Services and other homeless and drug and alcohol service providers.</p>	<ul style="list-style-type: none"> ➤ Analysis of data and planning for improvement of existing services for Aged/Disability consumers in MVM PCP catchment with a focus on care planning. ➤ Redevelopment of Niddrie site by Partner Agencies. ➤ Ongoing lobbying for increased allied health services in MVM PCP catchment. ➤ Progress CBD Project Recommendations. 	<ul style="list-style-type: none"> ➤ Implementation of SCTT and WMR BPM. ➤ Implementation of WMR PCP's E Referral and Service Directory. ➤ Implementation of Regional CALD Aged Care Strategic Plan. ➤ Ongoing regional training small & Ethno-specific agencies project. ➤ MVM PCP Consumer focus groups/forums. ➤ Regional Care Planning Project Implementation. ➤ Increased coordination of aged and disability services for clients in Niddrie catchment. ➤ Increased access to allied health services for people in MVM PCP catchment. ➤ Implementation of SCTT and WMR BPM. ➤ Implementation of WMR PCP's E Referral and Service Directory.
Neighbourhood – North Melbourne	<p>MVCC, MCC, DGCHS, IWRMRC, Women's Health West, Consumers, GPs and other sector providers.</p>	<p>Implementation North Melbourne Neighbourhood Project.</p>	<ul style="list-style-type: none"> ➤ Increased community leadership. ➤ Enhanced coordination of services in the area.
Emergency Demand / Chronic Conditions: Diabetes/ Cardiovascular/ COPD/Falls/Complex Psychosocial Needs	<p>DGCHS, RDNS, MH, MVCC, MCC, Melbourne GP Division and Hume Moreland PCP Partner Agencies.</p>	<p>HARP Diabetes, Stroke, Falls, COPD, Chronic Heart Failure, and MH ED Frequent Attenders with complex psychosocial needs projects are part of an integrated approach to improving services across catchment for Chronic Care Conditions including care planning.</p>	<ul style="list-style-type: none"> ➤ Training and support project with Acute Care – MH and WH. ➤ Implementation of SCTT and WMR BPM. ➤ Implementation of WMR PCP's E Referral and Service Directory. ➤ Use of consistent consumer information on chronic care conditions across agencies.

MVM PCP PLANNED OUTCOMES – 2003 2004 TEMPLATE

Priorities	Partners	ISP/Health Promotion	Service Coordination
Emergency Demand / Chronic Conditions: Asthma	DGCHS, RCH, Dianella CHS, GP Divisions.	<ul style="list-style-type: none"> ➤ Ongoing Community Asthma Project in MVM PCP and Dianella CHS catchment. ➤ Expansion of Community Asthma Project across Western and Northern Region. 	<ul style="list-style-type: none"> ➤ Implementation of SCTT and WMR BPM. ➤ Implementation of WMR PCP's E Referral and Service Directory. ➤ Use of consistent consumer asthma information across agencies.
Drug & Alcohol	<p>MVCC.</p> <p>MCC, DAS West, Living Room, Legal, Police, Justice, Ambulance, General Practice, Pharmacy, Acute, D&A, DHS, Business, Primary Care, Community.</p>	<ul style="list-style-type: none"> ➤ Moonee Valley Drug and Alcohol Policy/Action Plan. ➤ Bilingual Drug Information Educator Course (illicit Drugs). ➤ Service Mapping and consultation. <p>Review of City of Melbourne Drugs Action Strategy 2001-2003, which compliments Councils key safety and health policy (eg. Strategy for a Safe City, City Health 2002 and the Syringe Management Plan).</p>	<ul style="list-style-type: none"> ➤ Implementation of the SCTT with D&A Agencies.
Disability / Early Intervention	MVCC, RCH, other Children's and Allied Health Services, Consumers.	RCH/MVCC Platforms Project	<ul style="list-style-type: none"> ➤ Development of profile for children. ➤ Trial of SCTT and WMR BPM with children's services. ➤ Children's Services Information on WMR Service Directory.



Acronyms/Glossary

#	Refers to a full copy of a document being available on request to the MVM PCP
ABS	Australian Bureau of Statistics
ACAS	Aged Care Assessment Services
ACSC	Ambulatory Care Sensitive Conditions
BATS	Better Access to Services
CAH	Centre of Adolescent Health
CALD	Culturally and Linguistically Diverse communities
CASA	Centre against Sexual Assault
CBD	Central Business District
WCCT	Waratah Continuing Team
CEO	Chief Executive Officer
CHP	Community Health Plan
CMHP	Community Mental Health Program
COPD	Chronic Obstructive Pulmonary Disease
CP	Care Planning
CROSS-ALLIANCE	Combined Western Metropolitan Region Primary Care Partnership Alliances. (Westbay, Brimbank-Melton and Moonee Valley/Melbourne)
DALY	Disability Adjusted Life years
DAS West	Drug and Alcohol Services
DHS	Department of Human Services
DIMIA	Department of Immigration & Multicultural & Indigenous Affairs
DGCHS	Doutta Galla Community Health Services
ED	Emergency Department



EPC	Enhanced Primary Care
FACS	Family and Commercially Services
GP	General Practitioner
HACC	Home and Community Care
HARP	Hospital Admissions Risk Program
IC	Initial Contact
ICT	Information and Communication Technology
INI	Initial Needs Identification
ISP	Integrated Service Planning
IWAMHS	Inner West Area Mental Health Service
IWRMRC	Inner West Region Migrant Centre
LGA	Local Government Authority
LOTE	Language other than English
MCC	Melbourne City Council
MDGP	Melbourne Division of General Practice
MECRS	Melbourne Extended Care and Rehabilitation Services
MH	Melbourne Health
MSD	Melbourne Statistical Division
MVCC	Moonee Valley City Council
MVM	Moonee Valley Melbourne Primary Care Partnership
NARI	National Ageing Research Institute
NWC	Nurse World Consultant
NESC	Non-English speaking Countries
NWDGP	North West Division of General Practice
PACFU	Post Acute Care Facilitation Unit
PCP	Primary Care Partnership



PDSS	Psychiatric Disability Support Services
PEDS	Parent Evaluation of development Status
PKI	Public Key Infrastructure
PPPS	Practices, Processes, Protocols and Systems for Service Coordination
RCH	Royal Children's Hospital
RDNS	Royal District Nursing Service
RWH	Royal Women's Hospital
SAAP	Supported Accommodation Assistance Program
SCTT	Service Coordination Tool Templates
VUT	Victorian University of Technology
WCH	Women's and Children's Health
WDGP	Western Division of General Practice
WHW	Women's Health West
WMDGP	Western Metropolitan Division of General Practise
WMR	Western Metropolitan Region of DHS
WMR BPM	Western Metropolitan Region Service Coordination Best Practice and Continuous Improvement Manual
YAP	Youth Access Program
VEMD	Victorian Emergency Department Data
VICSEG	Victorian Cooperative on Children's Services for Ethnic Groups
YSAS	Youth Substance Abuse Service

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