Community Health Plan

2002 – 2003

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Executive Summary

The MVM PCP Community Health Plan 2002-2003 is the revised working document of the partnership. Presented is an overview of the partnership, the catchment, strategic directions and key achievements for the past year, and the operational plan for 2002-2003.

The Key Achievements of the Partnership 2001-2002 include:

Partnerships

- Revised governance guidelines and structure of the partnership.
- Establishment of MVM PCP website.
- Development and use of Consumer and Carer Charter of Rights.
- Consumer participation in project activity eg Youth Access Program and Foothold on Safety.
- Consultation and involvement of consumers in PCP activities via agency consumer groups.
- Involvement of GP Division and GPs in PCP activities.
- Collaboration with GPs in submission developments aimed at a service improvements for the catchment.
- Successful EPC workshop with GPs in the catchment.
- Successful workshop on "Working with GP Divisions".

Service Coordination

- Development of whole of region model for service coordination supported by cross regional working group and local service coordination working groups.
- Development of consistent regional work practices, processes and protocols to support implementation of the statewide tool templates.
- Consumer input to tool templates and protocols implementation via field testing.
- Commenced development of regional service directory.
- Commenced regional E referral trial and interagency referral protocol trial.

Integrated Service Planning

- Reviewed health priorities across PCP catchment area.
- Progressed a number of projects from the 2001-2004 CHP including the Complex Care Needs in the CBD project.
- Actively participated in cross-alliance planning forum (Western Region).
- Collaborated with and linked PCP planning processes with Primary Mental Health team and Community Mental Health Plan 2002-2003 planning processes.
- Implemented integrated health promotion programs including the Youth Access Program and Foothold on Safety Programs.
- Successful collaborations with acute sector on HARP funding resulting in funding of five projects (4 with MH and 1 with RCH/Dianella Community Health).

The Operational Plan of the Partnership 2002-2003 focuses on strategies to:

- Maintain ongoing commitment of key partners including GPs.
- Ensure ongoing engagement with the acute/subacute sector.
- Ensure ongoing engagement and participation of consumers.
- Implement the statewide service coordination tool templates.
- Implement the use of the regional service directory and E referral.
- Integrate processes, practices and protocols into agency operations.
- Progress projects which will provide complementary information to service coordination work.
- Implement service planning processes and projects to address high priority health issues for the catchment.
- Continue to review data relevant to the needs of the catchment and integrated planning.
- Implement integrated Health Promotion programs.

Section 1 Introduction

Moonee Valley Melbourne PCP 2002-2003 Community Health Plan

This plan is the continuation of the Moonee Valley Melbourne (MVM) Primary Care Partnership (PCP) Plan 2001-2004 submitted to the Department of Human Services (DHS) in June 2001. Since that period the MVM PCP has continued to progress and refine its original strategies and objectives. The 2002-2003 Community Health Plan presents the significant achievements made within the Partnership in the last twelve months and outlines the directions required to continue building responsive and cohesive primary care system.

Achievements are spread across the key result areas of Partnerships, Service Coordination and Integrated Service Planning. The main challenge for the period 2002-2003 is for key partners to implement service coordination reforms that provide a seamless experience for consumers navigating the primary care system. We believe that the commitment of its member agencies places the MVM PCP in an excellent position to effectively do this. The MVM PCP's capacity is also strengthened by its alliance and coordinated work at all levels with Westbay and Melton/Brimbank PCPs in the Western Region.

Philosophy of the MVM Partnership

The MVM PCP is committed to developing structures and services that will support effective partnerships and relationships between service providers, consumers and carers. The partnership is committed to a social model of health and to developing a primary care system that involves people in their own health care. The partnership encourages active consumer and community participation in the design and evaluation of local services. It will:

- Develop planning and consultation processes that are genuinely inclusive of consumers and carers.
- Build effective working relationships between service providers that respect individual professional skills of the participants and their work with consumers and carers.
- Respond to the diversity of need through innovation and collaboration with 'communities of interest'.

The catchment area for this PCP is the cities of Moonee Valley and Melbourne.

MVM PCP Vision

The MVM PCP's vision is to improve the health and well-being 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. This applies within our catchment and beyond. Our relationship with other PCPs and other parts of the health system, as well as inter-sectorial relationships, are important to us.

Section 2 Catchment Profile

Population Overview
The characteristics of the population vary enormously across the catchment. The City of Melbourne 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 people. These people are unlikely to be reflected in the census data.

After decades of residential decline, the City of Melbourne has become one of the fastest growing municipalities in Australia In relative terms, Melbourne has low and static numbers of older people. The 70-84 year age group comprised 5.5% of the population in 1996 compared to 7.4 percent of all Victorians. Both the number and proportion of 70-84 year olds is expected to grow between 1996 and 2011. Melbourne has relatively low proportions of young children within its age profile but this is also likely to grow in future years.

The City of Moonee Valley by contrast, is one of the largest municipalities in the Melbourne metropolitan area, with an estimated total population of 112,000. Moonee Valley has an ageing population, with 14% of residents aged 65 plus, compared to a metropolitan average of 12%. It has a below average percentage of children and young teenagers. Over the next two decades substantial growth in the number of residents aged 65 plus is forecast. 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.

The population of the catchment was estimated to be 159,000 in 2001, increasing to 171,000 by 2011, with the majority of this growth occurring within the City of Melbourne *(Department of Infrastructure, Victoria In Future 2000)*.

Cultural Diversity
The populations of both municipalities are culturally diverse. Nearly 30% of residents in Moonee Valley were born in a non-English speaking country (NESC), including large numbers of residents from Italy, Greece and Asia (particularly China and Vietnam). Moonee Valley is also a key destination for new arrivals, many of them refugees.

The City of Melbourne is more multi-cultural in background than the Melbourne Statistical Division (MSD) with 31% of the City's population born overseas compared with 29% for the MSD. Residents in the municipality come from over 130 countries. While the most common overseas birthplace is the United Kingdom, six of the ten most common overseas birthplaces are Asian countries (Malaysia, Vietnam, China, Singapore, Indonesia and Hong Kong). In contrast, only two of the ten most common overseas birthplaces for the MSD are Asian (Vietnam and China).

Features of the Catchment's Health Profile 2001-2004
The population health data used to underpin the 2001-2004 Community Health Plan contained the following important features:

- Life expectancies of Melbourne and Moonee Valley residents broadly matched those of the Victorian population, although men living within the City of Melbourne have lower life expectancies than the state average and women have a higher life expectancy.
- The most common causes of death were cardiovascular disease and cancer.
- Sixty-five per cent of disability adjusted life years (DALYs) were accounted for by four conditions: cardiovascular disease, cancer, mental disorders and neurological and sensory disorders.

- Both local government authorities (LGAs) have lower rates of school age children currently smoking and ever having smoked than in the general Victorian community.
- There is some evidence that alcohol related health problems are higher within the MVM PCP than for Victoria.
- While heroin and marijuana use for school children is slightly below state averages, illicit drug use is a significant issue more generally and a direct and indirect cause of death and ill health.
- Conditions associated with illicit drug use include overdose, HIV/AIDS, Hepatitis C, low birthweight, poisoning, suicide and self-inflicted harm. There is strong growth in the numbers of Hepatitis C infections within the catchment.
- There are significant levels of unmet needs for people with disabilities and their carers.
- Mental disorders were the most common cause of years of healthy life lost across 5 – 44 year old age group and were still a significant influencing factor for young people, aged 18 – 30 years and people aged 45 years and older.
- High prevalence of homelessness and drug use in CBD. The CBD is an identified Drug Hot Spot.

The following conclusions were reached through the original planning process (as measured by years of life lost):

- For infants, neonatal conditions, congenital abnormalities and chronic respiratory disease constitute the main health issues.
- For adolescents and young adults, mental disorders, chronic respiratory diseases and injuries are prominent issues.
- For middle aged adults, cancer, cardiovascular diseases and mental disorders are prominent issues
- For older people, cardiovascular diseases, neurological and sensory disorders and cancer are the most prominent groups of problems.

Review of the Catchment's Health Profile

A review of the above data was conducted in 2001-2002 and conclusions indicate that:

- 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 particulary risk in the catchment.
- For adolescents and young adults, mental disorders, 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 disorders are prominent. As with other age groups those from disadvantaged backgrounds, CALD and new immigrants are at particular risk.
- For older people dominant health issues are respiratory illness, injuries such as falls, diabetes,cardiovascular disease and cancer. Older people are more at risk of admission to hospital when they have a medical episode due to the fact that carers are also elderly or that people are living alone.
- Male and female patterns of Years Lost to Disability are broadly similar although females have higher rates of musculo-skeletal problems, lower rates of injury and slightly higher rates of depression across the lifespan. Females have higher rates of admission to hospital then males (accounting for 53.6 per cent of admissions and 54.3 per cent of days in hospital).

Section 3 Key Strategic Objectives

MVM PCP recently reviewed the strategic directions contained in the 2001-2004 Community Health Plan to align with key deliverables in the 2002-2003 year. The focus of the MVM partnership for the next year is outlined below:

3.1 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.

3.2 Service Coordination

- MVM PCP will ensure the implementation of the statewide service coordination tool suite and strategy in a manner that supports consistent processes, practices and protocols across the Western Region.

- MVM PCP will continue to initiate and develop complementary information and strategies to the original statewide service coordination tool suite that support practitioners to operate a cohesive service system that is accessible to consumer, carer and community.

3.3 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.

Section 4 Summary of Key Achievements

4.1 Partnerships

4.1.1 Partners

Governance and Structure of MVM PCP
A new PCP structure recommended by the Steering Committee in January 2002 is designed to better integrate a number of functions across the partnership and ensure that the time spent by agency members in meetings is efficient and engaging the most appropriate agency staff. An Executive was formed to manage the operations of the PCP and the Steering Committee role has changed to one of overall governance, policy and planning. Two working groups which report through the Executive and Steering Committee were formed. An Integrated Service Planning (ISP) and Service Coordination (SC) working group were formed. The ISP working group takes carriage of health and service planning including integrated health promotion and the SC working group is responsible for the partnership's service coordination activities, consumer participation and general practitioner engagement strategy[#1].

An Executive Officer/Project Manager for the PCP commenced mid-February along with a service coordination project officer. A part time project officer specifically focussed on an integrated health promotion project in the area of youth mental health also commenced in mid February. A part time administrative assistant commenced in late March as part of the MVM PCP project team.

Membership
In line with changes to its structure, MVM PCP has reviewed its memorandum of understanding separating this into two documents, one a Governance and Operations Guide and one a Partnership Memorandum of Understanding[#2].

Key agencies who are represented on the MVM PCP Steering Committee or one of the two working groups include:

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)	Doutta Galla, Macaulay Support Services, a nominated representative from the PDSSs that provide services in the catchment*
Women's health services	Women's Health West *
Sexual assault	CASA House, part of the Royal Women's Hospital (RWH) and Women's and Children's Health*
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*
Carers	Carers Victoria

Case Management – Aged & Disability	Care Connect
Hospital Services	Melbourne Health (MH) – Service Development, Discharge Planning, Post Acute Care Facilitation Unit (PACFU) Women's and Children's Health
Aged Care Assessment Services (ACAS)	Melbourne Extended Care and Rehabilitation Service (MECARS), Melbourne Health
Area Mental Health and Primary Mental Health	Inner West Area Mental Health Service – The Royal Melbourne Hospital*
Aged Psychiatry Assessment and Treatment teams	North West Aged Persons Mental Health Program - Melbourne Health*

* Denotes Steering Committee Representatives.

All agencies represented on the Steering Committee are signatories to the partnership agreement except the City of Melbourne and Women's Health West. Women's Health West will be a signatory to the new governance structure. Progress has continued with the City of Melbourne to ensure that it becomes a signatory to the partnership. The City of Melbourne have raised concerns of a legal nature over this issue, however this has not prevented ongoing staff involvement in service coordination, health promotion and integrated service planning activities within the PCP.

Communication
The minutes of Steering Committee and Executive Meetings are distributed to all member agencies. Working groups meet on a monthly basis and are convened by an Executive Member. Newsletters are distributed within the MVM PCP catchment area and in the Western region to inform a wider range of agencies on progress by the PCP. MVM PCP has its own website. The MVM website address is http://www.pcpmvm.infoxchange.net.au/ Newsletters, key documents and events are advertised on this site.

4.1.2 Consumer Participation

A particular strength across the PCP is consumer participation in project activities. Consumer participation is seen as integral to projects, rather than an additional process.

Key achievements include:

- Consultations with over 200 consumers in 14 consumer groups to inform the development of the charter and the consumer and carer participation strategy.
- Endorsement and promotion of the Consumer and Carer Charter of Rights within member agencies. (RDNS is considering adopting the Consumer and Carer Charter of rights service wide).
- Use of the resource "Development of a Consumer/Carer Participation Strategy: Some Tools"
- A data base of Consumer groups has been developed by the Service Coordination Project Officers for each PCP in the WMR. The groups listed represent the following primary care service sectors: aged care, carer support, children and family, disability, ethno specific, mental health, women's health and youth services.
- Field testing of the Consumer Outcomes section of the INI tools templates with consumers across the twelve consumer/carer groups older people, young people, children & families, women, men, carers, mental health, disability, CALD and generic cohorts.
- Consumers representation on project reference groups is an integral part of projects (for example the Youth Access Program (YAP), Foothold on Safety Project and the Complex Care Needs in the CBD project).

- Implementation of a PCP-wide policy to ensure consistency in payment/support to consumer and carer participants[#4]. This policy allows for flexibility in payment and reimbursement to meet the varying circumstances of consumers such as those of carers and younger people.
- Establishment of a working party 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.
- 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. Examples are included below.

Moonee Valley City Council Community Services Committee

The MVCC Community Services Community Committee has a membership drawn from the community. Ten community members, two councillors and three senior council officers form the Community Committee. A presentation to this group in June on PCP activities generated the following responses:

- Community members endorsed the directions of the PCP across the catchment.
- Members expressed surprise at the amount and complexity of work being completed.
- Members were excited at the prospect of service coordination changes.
- Members were particularly impressed with the service directory project and the prospect of community access to this.

Doutta Galla Community Health Service – African Women's Consultations

Doutta Galla runs a successful African Women's Exercise Program. This program was developed following a process of consultation with the African community in the MVM PCP catchment. Initially, DGCHS developed a walking group in response to the Africans Womens request for an exercise program. Participation in this group dropped off over time and was not achieving the results that were expected. A following consultation revealed that a walking group was not what the women wanted as they were currently walking a lot as part of their day to day activities. They specifically requested an exercise program with physiotherapy input. Given DGCHS's limited resources, an application to VicHealth's Active For Life Program was developed to allow for physiotherapy and an African Community Worker's input to an exercise program. This funding was successful and the result is a thriving and active program.

The African Womens' Exercise Program now has a consistent attendance of 13 to 15 women each week from the Kensington, Flemington, Ascot Vale and North Melbourne areas. The venue has been changed from the Kensington site of DGCHS to the North Melbourne Community Centre to accommodate the numbers. The venue also allows for the cultural privacy required for women from this Community group. The false start, and subsequent success of this program, demonstrates the importance of consumer ownership in determining program content and priorities as a means of achieving agreed outcomes.

4.1.3 GP Engagement

GPs in Partnerships and Health Service Planning

MVM PCP has GP representation or Divisional representation on various committees including the PCP Steering Committee, Integrated Service Planning Working Group and Service Coordination working group. A GP engagement strategy has been in operation with the Melbourne Division in 2001-2002 and has recently been revised. Its main aim is to ensure GP participation in service coordination activities, key PCP projects and in planning and development activities. This strategy

includes payment to GP participants and more details on the strategy are provided in the Operation Plan section below.

Key working groups that GPs participate in include; MVM PCP Complex Care Needs in the CBD Project, MVM PCP Service Coordination working group, Youth Mental Health Project and Integrated Health planning activities. Collaboration with the Melbourne Division of General Practice occurred in relation to a number of submissions including a Diabetes service development submission, Hospital Admissions Risk Program (HARP) asthma submission and an Allied Health and General Practice submission. Regardless of the success or otherwise of submissions ongoing, collaboration is expected in relation to the MVM PCP key health priority issues and collaboration with the acute care sector in preventing inappropriate use of acute and emergency services.

GPs in Service Coordination

MVM PCP Service Coordination held a successful workshop on Multidisciplinary Care Planning Using EPC Items on 29 May 2002 for General Practitioners, Health and Community Services staff and Service Coordination members. Forty-six practitioners participated in the workshop with representation from Community Health, Drug and Alcohol Services, Case Managers for Community Aged Care Programs, and Hospital Discharge Planning, Local Government, RDNS and GPs and GP practice staff. Twenty- two per cent of attendees were from General Practice and the remaining 78 per cent from the Health and Community Services sector.

Outcomes included:

- Increased GP and Community Provider awareness of Enhanced Primary Care(EPC) Items and Multidisciplinary Care Plans, increased awareness and understanding of the various services and resources available to practitioners.
- Networking between local service providers.
- Identification of local services that can contribute to care planning.
- Identification of opportunities and benefits of working together towards the best outcomes for consumers and their families particularly in relation to assessment and the implementation of care plans.
- Evaluations from the workshop indicated that community sector staff would like further opportunities to work out ways to better link GPs into care planning. The PCP will facilitate these in the next year.

The workshop included presentation of a best practice example of GP engagement and service coordination for multidisciplinary care planning within the PCP. The presentation by Ambi Kaur of Doutta Galla Community Health Service and Dr Marilyn Jones on the management of clients with diabetes highlighted collaboration and coordination across the primary care sector to achieve better outcomes for clients. The Doutta Galla diabetes service is characterised by flexibility and responsiveness for both the client and the referring general practitioner as well as delivering an holistic and outcome focused model of intervention.

Dr Marilyn Jones regularly refers her clients to the Doutta Galla Community Health Service Diabetes Service to receive a multidisciplinary and culturally sensitive service from a range of health care providers. This service is coordinated by a diabetes educator. Some of the benefits Dr Jones highlighted about this clinic included:

- Clients are responded to quickly and in a coordinated manner.
  - The GP can ring the clinic when the patient is in with them and initiate an appointment.
  - Initial appointments are timely.
- Information flows between the GP and the service to ensure ongoing care planning and quality services.

- Clients receive services that are culturally appropriate including the inclusion of spouse/carer education.
- Services are local and easily accessed by clients.

A further workshop was held in June 2002 for members of MVM PCP working groups on Working with Divisions of General Practice. This workshop was presented by the General Practice Division of Victoria and was an informative, interactive session which provided information on the background to Divisions of General Practice and provided an opportunity to identify areas of work for engaging GPs in PCP activities. Feedback from this workshop was overwhelmingly positive and indicated the need for ongoing discourse on key ways to present information on PCP progress to GPs.

4.2 Service Coordination

4.2.1 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. This was to ensure the achievement of two key objectives:

- To ensure that all consumers in the region regardless of where they enter the service system have the experience of co-ordinated and integrated care: and
- To ensure that in the future service providers, particularly those that cover the PCP catchments were not going to be required to implement three different practices/processes/protocols and systems, but rather that the PPPS work would be aligned across the West.

The Regional approach in the WMR to PCP Service Coordination strategy planning and implementation has had excellent commitment, resourcing and energy from agencies both at a management and practitioner level. Support to agencies has been provided by a Regional Coordinator, Project Consultants, Local Service Coordination Working Groups and Service Coordination Project Officers. This model has encouraged broad participation by key agencies, allowed for the benefits inherent in undertaking cross-sector work around practices, processes and protocol development; and encouraged a co-operative and sustainable approach to change management and system reform.

The Regional approach has raised the profile of the PCP Reform Strategy across the service sector and in particular to services outside PCP member agencies. This is evidenced through the support of key regional provider networks (for example the Aged Services Network) and increased awareness of the PCP strategy focusing on improved outcomes for consumers.

A Western Region PCP Cross Alliance Whole of Region Service Coordination Workplan for the period January to September 2002 identifies key deliverables for WMR funded projects and the work of Local Service Coordination Project Officers. The three primary goals, along with key achievements to date, are outlined below:

Goal 1. **Development of a Western Metropolitan Region Best Practice and Continuous Improvement Framework for Service Coordination that encompasses agreed and shared best Practices, Processes and Protocols (PPPs) for Initial Contact (IC), Initial Needs Identification (INI) & Care Planning (CP).**

Key achievements to date:

- Development of a Whole of Region Model For Service Coordination[#5].
- Completion of an agreed WMR PCP Cross Alliance Service Coordination Protocol Template for use by all consultants, project officers and agencies working on projects in the Western Region[#6].
- Completion of a WMR PCP Cross Alliance Quality Practices Audit for Service Coordination[#7].

- Development of a Draft Initial Contact Protocol - Protocol for Operationalising the IC Element of the WMR Consolidated Service Coordination Model which details Introduction & Rationale, Goals, Objectives, Scope, Definitions, Protocol Participants (for each PCP in the West)[#8].
- Documentation of Consumer Outcomes For Initial Contact and Consumer Outcomes For Initial Needs Identification as developed by Service Providers[#9].
- Development of the first draft for the Interagency Multidisciplinary Care Coordination Meeting Protocol [#10].
- Completed "Do It Yourself Privacy Resource" has been developed and successfully trialed within the Western Region and is now being distributed statewide. Train the Trainer sessions were provided to PCP member agencies.
- Work in progress on developing Standards for Initial Contact and Initial Needs Identification.

Goal 2 Improved community (consumers & providers) access to information about services available, support and referral by development of an electronic Comprehensive Services Information Facility (CSIF Stage 1).

Key achievements to date:

- A Project Plan has been established and agreed for development of the Electronic Service Directory and development and implementation of an e-Referral trial between six Phase 1 agencies (eight sites). This includes three Phase 1 agencies in the MVM catchment – Moonee Valley City Council, RDNS and North West ACAS.
- An assessment of service directory and electronic referral capabilities of three systems has been completed with Connectingcare.com selected as the most appropriate option to meet business requirements.
- An implementation plan has been agreed to with Connectingcare.com.
- CSIF contacts have been established for each PCP in the Western Region.
- Service information for the Service Directory is currently being confirmed with agency contacts.
- Phase 1 e-Referral agencies have undertaken training with Project staff.
- Phase 1 e-Referral participants have commenced obtaining Public Key Infrastructure (PKI) certification, documented processes for broader implementation within nominated agencies, documented business processes to support progressive implementation and using Connectingcare for some of their referrals.
- Outcomes for this project are being used to inform the development of the Interagency Referral Protocols for use across the WMR PCP member agencies.
- MVM PCP is continuing to collate local service information through the service coordination project officer in anticipation of regional and statewide progress in relation to service directory development.
- Project completed on the need for 24 hour access to service information and referral[#17].

Goal 3 Further develop the evolving PPPS for IC, INI and CP with specific cohort groups (Stage 2).

Key achievements to date:

- MVM PCP has commenced the three Stage 2 Cross Alliance Regional Service Coordination projects. These projects will build on the current regional and local Service Coordination work, particularly in relation to the development of IC, INI and CP tools and practices that are inclusive of and sensitive to carer needs, culturally and linguistically diverse communities and care coordination for people with a chronic mental illness at the point of hospital discharge. Project briefs have been completed and recruitment for two of the projects has been finalised.

- Consumer input is integral to these projects. Consumers will be represented on the reference group and provide feedback on the service coordination tools.

- An independent evaluation of WMR Cross Alliance Service Coordination work has been completed[#16]. This report details the key achievements of the service coordination activities in the Region and contains consumer examples. Refer to Attachment C for the Executive Summary of this report.
- MVM PCP Service Coordination member agencies have participated in forums and workshops held both across the region and locally to progress the work of the Cross Alliance Service Coordination Workplan and build sustainability in the sector.

4.2.2 Local Service Coordination

The MVM Service Coordination Working Group has broadened its membership to include Carers Victoria, PACFU, Melbourne Health Discharge Planning, a GP and Drug and Alcohol services. Representation on the group strongly reflects the providers identified in the PCP Strategy. Its aim is to ensure translation of regional work into reality at a local and operational level.

Developmental work in changing service system practice is progressing in the MVM catchment. All work is reflective of a social model of health. Member agencies trialed the Initial Needs Identification and Care Planning tools in November 2001. The trial was supported by the development and signing of a Protocol for the Trial of the Initial Needs Identification by Moonee Valley City Council, North West ACAS and Doutta Galla Community Health Services. This protocol has been used to inform further cross regional protocol development.

The City of Moonee Valley and City of Melbourne HACC services have continued to use the Statewide Service Coordination Tool Templates since the trial period in late 2001. Feedback from the Cities of Melbourne and Moonee Valley on their use of the tool templates is outlined below.

Feedback from the Cities of Melbourne and Moonee Valley

The Assessment and Case management teams decided at the completion of the trial in November 2001 to continue using these tools for the following reasons:

- That after the six week trial, the initial problem of the time taken to complete the forms with each client had diminished.
- The INI tool suite is more user friendly than the existing Consumer Information and Referral Record (CIARR) form, and once familiar with the tool staff become very proficient.
- The INI tool suite offers a more streamlined assessment tool and incorporates a number of previously separate forms including referral forms, priority of access and Care Planning tools.
- The INI tool suite is more comprehensive than the previous forms used.
- The INI tool suite enables staff to collect more specific information regarding consumer needs, therefore enhancing the quality of service provided to clients and their carers. For example the Activities for Daily Living Profile provides comprehensive information on consumer needs, leading to care plans and service delivery which is better tailored to consumer needs.
- With consumer permission, information gathered can be shared with other agencies and need only be recorded once, thereby reducing the need for multiple assessments as previously experienced by consumers.
- The information gathered using the INI tool suite makes it easier to refer to other agencies. This is also enhanced by the commitment given by agencies working within the PCP to the Service Coordination Implementation Plan.

- Many examples can be cited where the identification and recognition by all agencies involved in the care and service provision for individual consumers has resulted in more timely assistance and greater safety for consumers.

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 strategies put in place by Moonee Valley City Council's Community Care Unit to incorporate changing practices and processes.

Changes implemented by Moonee Valley City Council's Community Care Unit

- A staffing restructure was undertaken in response to a recognition that the Service Coordination work would create efficiencies for staff in relation to the use of the Statewide Service Coordination Tool Templates, electronic referral and the development of a Service Directory.
- Work groups were formed to review what the Tool Templates and changing relationships with other Primary care providers would mean. The groups also considered current team positions and reviewed position descriptions and related tasks.
- Outcomes from these work groups included the development of new position descriptions and new positions to reflect the changing work practices. These positions include dedicated Intake Assessment Officers and Service Support Administration Officers. The Service Support Officer positions allow for more time dedicated to consumer intake and assessment.
- Intake Assessment Officers have participated in intensive training through Regional consultative workshops and in-house training.
- As a follow-up to Train the Trainer programs on Privacy and Confidentiality new processes have been put in place including a dedicated Community Care fax for receipt of consumer information and referral.
- The City of Moonee Valley Community Care Team is well placed to participate in the Validation Phase for the WMR PCP Cross Alliance Best Practice and Continuous Improvement Project from October to December 2002.

4.3 Integrated Service Planning

The restructure of the Partnership Scheme referred to under partnership achievements has resulted in a broader portfolio for the Integrated Service Planning working group to include integrated health promotion.

4.3.1 Review of Health Data and Priorities

Planning Framework 2001-2004

A key focus over the past year has been a review of the Community Health Profile and the data supporting this information. A consultant was employed to complete data collection, synthesis and analysis with a focus on:

- Reviewing data already gathered with a focus on data gaps and health planning implications including information about hospital separation data/emergency demand data and the uptake of enhanced medicare billing items.
- Reviewing any other local data relevant to the review of MVM PCP Community Health Plan priorities[#11].

In addition to the information presented by the consultant a number of member agencies provided information which informed the planning process. The best practice work on "A Gender Agenda" by Women's Health West was presented to the ISP working group with an agreement to analyse data according to gender in ongoing planning sessions. This led to a slight change to the framework, which

underpins the ISP, to include an adequate gender analysis[#11]. Women's Health West also provided the results of "Beyond Symptoms" and this information was considered in the community health plan review process. Information was provided by the City of Moonee Valley and City of Melbourne from their municipal health planning processes, the Melbourne Division of General Practice from their Strategic Planning process and from the Inner West Primary Mental Health team.

Following a review of the data and utilisation of the Planning Framework the following key health priorities/issues were confirmed as high priority issues for MVM PCP:

- Mental Health
- Falls/Injury Prevention
- Complex Care Needs/Coordination
- Neighbourhood Planning

A further four issues were identified as priorities with the view that these issues would be pursued if funding applications in these areas were successful and, to some extent, as part of work already being undertaken by member agencies. These priorities included:

- Asthma
- Diabetes and Cardiovascular Conditions
- Drug and Alcohol Issues
- Disability Issues

4.3.2 Regional Integrated Service Planning

MVM PCP has continued to be an active participant in the Cross Alliance PCP Planning forums. This group has made a commitment to:

- The ongoing use of the Western Region Planning Framework and to continued efforts to progress mental health as a cross regional health priority.
- The inclusion of Primary Mental Health Teams within PCP processes
- Support the development of a Primary Care Institute at Western Hospital to assist integrated data collection across the primary care sector and offer expertise in the analysis and utilisation of such data.

4.3.3 Primary Mental Health and Community Mental Health Plan

Mental Health is a top priority issue for the catchment and the Region. The Inner West Primary Mental Health team is represented on the MVM ISP working group and collaboration with the PCP and member agencies has occurred in the development of the Primary Mental Health Team and the Community Mental Health Plan. These linkages have provided opportunities for reciprocal arrangements and information sharing in the development of the Inner West Community Mental Health Plan 2002-2003(CMHP)[#12] and MVM CHP 2002-2003. Ongoing work with the primary mental health team will focus on service coordination activities and the development of a more detailed CMHP for 2003-2004.

4.3.4 Progress on Specific Projects from the Community Health Plan 2001-2004

Only one project identified as a priority in the 2001-2004 Community Health Plan has received funding. This project is the *Complex Care Needs in the CBD Project*. However there has been an ongoing commitment and incremental progress on the other projects.

Primary Health Service in CBD

- Selected PCP partners have continued to pursue the provision of a Primary Care Service in the CBD, primarily by way of seeking funding for drug and alcohol services.
- Doutta Galla and Youth Projects have been funded to provide a primary care service with a drug and alcohol focus in the CBD.

- A program coordinator is currently being recruited for the service which is planned to commence operation in July.
- Additional funds were provided direct to Youth Substance Abuse Service (YSAS) for a nurse educator and to the Centre for Adolescent Health to increase youth capacity.

It is expected that a number of projects that the PCP is currently managing or involved with, such as the Complex Care Needs in the CBD, Mental Health Discharge Service Coordination Project and HARP projects, will continue to inform the partnership about particular needs of people in the CBD.

Integrated Health Service for Older Women
This project proposes a holistic model of care for older women by co-location of a number of services/clinics for women, such as Breast Screen, Continence, Gynaecology and a Well Women's clinic, combined with a health promotion focus. Progress is dependent on negotiations over the development of the former Essendon Hospital site. Interested parties will know whether the project will go ahead by August 2002.

Improved Coordination of Flexible Community Care and Support Services
Moonee Valley City Council (MVCC) have identified that the availability of residential care services for frail older residents and residents with a disability has improved in the municipality. This is the result of an additional 170 residential care places announced by the Commonwealth Government in January 2001 and January 2002. Supply is however still below the benchmarks established by the Commonwealth Government.

MVCC has also identified that the provision of Community Care Packages, which are services aimed at supporting frail older people and people with a disability to remain in their own homes, is significantly below the established benchmarks, with extensive waiting lists for these services. Council is considering strategies to address this issue as part of the HACC and Aged Care funding rounds. MVCC has employed a consultant to assess the best practice services across the PCP, statistical information and preparation of the application for the Aged Care Funding Round later this year[#13].

The Aged Services Network in the Western Region has also identified access to residential and flexible care packages as a high priority issue in the region. Future work in this area will link with efforts of the Aged Services Network particularly around issues of coordination.

Complex Care Needs in the CBD
This project was funded as part of the 2001-2004 Community Health Plan and has progressed through a number of phases. Progression to date includes:

- Scope of the project defined with key stakeholders from a range of specialist agencies from the CBD[#14]
- Completion of a literature review of work already undertaken in this area[#14].
- Recruitment of GP with CBD practice to the project reference group.
- Recruitment of project officer with a strong background in service provision in the primary health and mental health sector.
- Inclusion of MH-RMH Emergency Department (ED) representative to reference group.

This project is due for completion in October and will be linked with other projects as mentioned above.

4.3.5 MVM PCP Collaboration with the Acute/Subacute Care Sector
MVM PCP has been active in its involvement with the acute/subacute care sector including representation from Melbourne Health and Women's and Children's Health at the Steering Committee or Working Group level.

MVM PCP commenced discussions with the acute/acute care sector in relation to HARP funding by hosting a forum for interested MVM PCP agencies and other agencies from the North Western Metropolitan Region with a connection with Melbourne Health or Women's and Children's Health. From these initial discussions, priority emergency demand issues were determined and further meetings were convened by Melbourne Health or by MVM PCP to progress submissions. These collaborations resulted in four full joint proposals to the HARP funding round with Melbourne Health and one full proposal in collaboration with Dianella Community Health and the Royal Children's Hospital. Full project submissions were submitted in relation to the management of Chronic Obstructive Pulmonary Disease (COPD), Falls prevention for high risk clients, Diabetic Foot, ED Department Frequent Attenders (Mental Health Step Down and Frequent Attenders) and Asthma prevention. All of these projects were successful in receiving funding and will form part of the work with the sector in the coming year. This work has provided a substantial basis for continuing to develop processes and practices for collaboration between the sectors.

Other developments in the acute care sector such as the Population and Primary Care Health Committees in hospitals have also provided a forum for collaboration between the acute/subacute sector and the primary care sector. These committees vary in their structure but are designed to consider and review population based health data. MVM has participated in two committees with representation at the Women's and Children's and the Western Hospital's Population and Primary Health Committees.

The Women's and Children's Population and Primary Care Committee has committed to a process of improving engagement with the primary care sector. An outcome of this commitment is the completion of an audit of current interfaces with the primary care sector across the organisation. This will provide the framework for recommendations to the Board about organisational expectations of ongoing relationships with the primary care sector. In addition, this committee has commenced a review of population data on the needs of Women and Children. "Beyond Symptoms" will form a significant part of the evidence base of the review of women's health needs.

MVM PCP has representation from Melbourne Health on the Service Coordination working group. This is particularly important in relation to the implementation of the service coordination tool suite and the regional service directory. Discussion around the future use of the tools and the service directory by hospital staff has been positive and should provide a good opportunity to continue to improve service continuity for clients. In particular post acute care and discharge planning staff are committed to increasing use of the service coordination tool suite.

In 2002 Melbourne Health reviewed its strategy for engagement with community health service providers. This has resulted in the establishment of a framework for regular meetings of senior community agency and Melbourne Health staff for strategic planing purposes, a forum for discussions related to service integration and coordination issues, and improved processes within Melbourne Health for internal communication and liaison regarding community health service and interface issues.

4.3.6 Integrated Health Promotion Programs

In addition to the progression of two specific health promotion programs, the PCP has continued to review the best way of achieving integration of limited health promotion resources across the catchment area. This is detailed below. The plan for 2002-20033 is to create a joint project position across the PCP with the two local governments to continue to promote this integration. The MVM PCP planning and health promotion functions sit with the same working group (ISP working group). The rationale behind this is that all key health issues and priorities agreed to by the planning group

should have a health promotion focus. Therefore, work undertaken by agencies on any of these issues will integrate the cross agency health promotion strategy. More agencies will be invited to contribute to this position and its resources over the next twelve months. The goal is for a sustainable health promotion strategy focussing on the identified priority health issues across the catchment.

Mental Health Youth Project - YAP
The Youth Access Project is a mental health promotion project focussing on young people and their access to a range of services in Mooney Valley and Melbourne. The YAP project commenced in February 2002 and will continue through until October 2002. The two main objectives of the Youth Access Project are:

- To increase the capacity of local services and agencies to provide appropriate services to young people.
- To involve young people in an integral role in the development and implementation of the project.

Recommendations from the project will inform future work in the area of youth mental health. Further funds will be sought from suitable funding rounds to continue to progress the outcomes of the project, particularly the *Youth Friendliness Tool* developed by the young people, and to support the young people to promote their learnings in the community.

Key achievements to date include:

- Consumer recruitment to reference group/advisory committee.
- 20 young people recruited to program - regular attendance and enthusiastic participation and training.
- 14 community organisations are involved in testing the youth friendliness tool. Agencies include community health, mental health, sexual health, income, housing, drug and alcohol, generalist youth, ethnic and general practice settings.

Feedback from young consumers in the YAP Project.

Reasons why young participants wanted to be involved in the project:

"because I'd like to be more involved in the services and the wellbeing of the youths of today"

"I want to reach out to people and maybe be of some use to the community"

"to make services more accessible to young people"

"because I think youth, health and community services are very important and I'm interested in helping them improve and develop"

Young participant's feedback as to what stops young people from accessing services:

"not knowing information about services"

"embarrassment, feel services are not approachable"

"I think many young people are unaware of available services and are reluctant to approach adults for help"

"don't understand their rights"

Feedback from young participants after mental health education - how has your understanding changed?:

> "that it is a common problem"
>
> "have a better definition of mental health problems"
>
> "they like to be viewed as normal people"
>
> "because I thought a mental illness was someone like I mean a spastic"
>
> "In a positive way. I used to think mental health is about mental illness"

Foothold on Safety Project
The *Foothold on Safety* project is a three-year falls prevention project funded by DHS. A range of PCP member agencies are represented on the reference group and include, the City of Moonee Valley, the City of Melbourne, RDNS Essendon, National Ageing Research Institute (NARI), MDGP, MECARS, Melbourne Health's PACFU and Doutta Galla Community Health Service.

Key achievements to date include:

- Development of falls prevention resources that are relevant to local community.
- Distribution of falls prevention resources and awareness raising about falls in the local community at local community festivals.
- Conducted "Better Balance Workshops" at festivals.
- Provision of information to local community groups in relation to falls prevention.
- Community consultations with a variety of local community groups to develop a clearer understanding of what older people want and how to effectively encourage broad community participation around falls prevention.
- Review and trial of screening tool by service providers with older people at risk of falling.

Section 5 Operational Plan 2002 – 2003

5.1 Partnerships

5.1.1 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:

- Need for PCP agencies to focus on implementation of clearly defined and achievable objectives.
- Ongoing need for support to agencies to implement service coordination changes and integrated health promotion activities.
- Ongoing need for communication at various levels to ensure systemic response to primary care reform.
- Ongoing need for a collaborative approach to achieving functional integration across the primary care sector, specifically General Practice.

Three clear messages are coming from GPs regarding the ongoing engagement in PCP activities:

- General Practice engagement in the use of the service coordination tools will be significantly enhanced if the tools and Service Directory are available electronically.
- General Practice Division members engagement in PCP activities is to occur via the Divisions of General Practice.
- The MDGP has issues with the Service Coordination Tool Template in its current format. Strategies are in place to work through these issues and to gain GP participation in the trial of Tool Templates and related WMR protocols, practices and processes to support implementation.

Progression with GP engagement is also dependent on DHS resolution of Information Technology matters and Commonwealth/State issues.

Partnership Strategies

Strategies	Expected Outcomes
1. Review of PCP vision statements to ensure contemporary governing vision of partnership.	Reviewed vision statements for MVM PCP.
2. Ongoing facilitation of PCP structure and working groups to ensure participation of key players.	PCP Structure supports and facilitates participation of agencies.
3. Working Groups to focus on identification of implementation barriers and develop actions for resolution of these.	Key PCP agencies (Community Health, HACC, drug and alcohol, ACAS, Primary Mental Health, General Practice) implementing service coordination tool suite and progressing integrated health promotion programs. Additional agencies participating.

Strategies	Expected Outcomes
4. Ongoing implementation of communication strategy for agencies and consumers about PCP including newsletter, promotion and development of website and media events.	Communication strategy documented and implemented. Improved Website layout and content. Evidence of increased knowledge across sector and of consumers.

General Practice Engagement Strategies

Strategies	Expected Outcomes
1. A GP to be an active member of the Service Coordination Working group and communicate the outcomes and processes to other GPs.	Active GP involvement in Service Coordination. Outcomes and processes communicated to other GPs.
2. Staff member of the MDGP to be actively involved in the following groups and communicate the outcomes and processes to GPs and the other Divisions of General Practice: ⇒Steering Committee ⇒Integrated Service Planning Group	Active GP Division involvement in ⇒Steering Committee (Division Chief Executive Officer) ⇒ISP (Division Representative)
3. Information regarding Partnership to be forwarded to GPs regularly through the MDGP, NWDGP and WDGP weekly faxes to GPs.	Increased knowledge of GPs on PCP activities.
4. GPs to be actively involved in specific projects such as the Complex Care Needs in the CBD project and Youth Mental Health Project.	Active GPs involvement in specific projects.
5. Implementation of outcomes from Service Coordination Workshops on Multidisciplinary Care Planning Using EPC Items and Working with Divisions of General Practice.	Increased Multidisciplinary Care Planning to enhance consumer/patient outcomes.

Progress:

- GP achievements noted in key achievements section including involvement in service co-ordination activities and workshops.
- The GP issue of electronic access to the service coordination tools is a significant one and requires support from DHS.
- A draft communication strategy has been developed for the MVM PCP.
- A Communication Strategy has been developed for the Western Region PCP Chairs group to support the significant Cross Alliance activities these PCP's have undertaken.

5.1.2 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:

- Need for identified initial contact points between acute care and primary care sector for planning and service coordination.
- Some limitations in the capacity of community services to respond to acute care because of lack of resources.
- Lack of focus on health promotion and prevention and limited access to evidenced based data to support programs.
- Lack of knowledge within acute care setting about PCP activities and strategies.
- Difference in IT capabilities between the sectors.

Acute/Subacute Interface Strategies

Strategies	Expected Outcomes
1. Establishing a clear point of contact with acute care partners for planning and service co-ordination.	PCP is the contact point for the MVM Primary Care Sector. There is a clearly identified contact point for MH and Royal Children's Hospital (RCH).
2. PCP participation in HARP projects with Melbourne Health and Royal Children's Hospital. Projects to encourage the development of community services response to acute care needs, thereby preventing hospital admission and reducing demand.	HARP projects with acute sector promote development of community services and primary care service system responses.
3. Collaborative projects include health promotion component or are linked with current health promotion activities in primary care sector.	Projects identify health promotion component of program and this is evaluated.
4. Continued collaboration and data analysis with acute partners in preparation for the next HARP and hospital demand management funding round.	Further projects funded in second round funding.
5. 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.
6. Ongoing encouragement of Acute care involvement in ongoing service coordination activities across MVM PCP and the Western Region.	Acute care representatives on Service Coordination Working Group. Implementation of toolsuite and use of service directory with parts of acute care sector in addition to ACAS.
7. Development of strategies with acute partners for improved information flow within Acute Care settings see.	Increased knowledge of primary care partnership activities within acute care settings.

Strategies	Expected Outcomes
8. 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.
9. Implementation of Mental Health Discharge Service Coordination Project	Improved care planning and referral from acute mental health services to primary care services.

5.1.3 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 have indicated frustration with being consulted by numerous providers (over-consultation).
- Consumers find it particularly frustrating to be consulted and then receive no further feedback on how this consultation has helped or changed practice.
- There is a need to share best consumer and carer practice examples across the catchment.
- There is a need for facilitation of consumer participation at Steering Committee level

Consumer and Carer Participation Strategies

Strategies	Expected Outcomes
1. Seeking feedback on consumer experience with Service Coordination activities.	Gain feedback on the implementation of the Service Coordination Tool Suite at a local level and make recommendations based on this consumer feedback.
2. Provide feedback to consumers who have participated in the development of PCP Consumer Participation Strategy and Consumer Charter. This will provide an opportunity for consumers to hear about the progress and development of the Community Health Plan and Service Coordination work. It will also be an opportunity for consumers and carers to provide feedback to ongoing planning and on the level of involvement they may wish to have in further activities eg Steering Group involvement.	Promotion of work completed by the partnership to consumers. Ongoing feedback from consumers on ongoing health needs and processes required by the partnership to support this. Opportunities for consumers to continue to be involved at all levels of partnership activity.
3. Work with existing agencies practice and processes so that consumers and carers are not over-consulted about the same issues.	Coordination of activity with member agencies.
4. Facilitation of a service provider forum to share experiences of consumer/carer participation and promote best practice.	Skill development and support for ongoing best practice.

Progress

- As outlined in key achievements a strength of the partnership has been consumer participation in projects and activities by member agencies.
- These activities will continue to be built on over the next 12 months to ensure the growth of consumer and carer participation.

5.2 Service Coordination

5.2.1 Service Coordination Strategic Objective 1 - Service Coordination Implementation

MVM PCP will ensure the implementation of the statewide service coordination tool suite and strategy in a manner that supports consistent processes, practices and protocols across the Western Region.

Priorities/Gaps/Emerging Issues

- Need for DHS Regional funding resources to finalise the Best Practice and Continuous Improvement Framework Manual and CSIF work.
- Need to build on commitment from key agencies to the implementation of the Statewide Service Coordination tool templates.
- Of critical importance is the development of Capacity Building/Training Plans for Service Coordination activities which are complementary and aligned at a State, Regional and local level.
- Links with General Practitioners.
- Ongoing support at a local level to facilitate and drive Service Coordination strategies.

Service Coordination Implementation Strategies

Strategies	Expected Outcomes
1. Ongoing liaison with DHS regarding information updates and support for implementation of Statewide Service Coordination Implementation Plan.	Phased approach over the next 12 –18 months to implementation of Service Coordination Tool Templates in HACC, Community Health, ACAS and Drug Policy & Services. DHS documentation on issues regarding implementation of Tool Templates. Development of a Statewide Capacity Building/Training and Development Plan (alignment with & complementary to Regional & Local Plans). Region wide PCP Telecommunications strategic plan implemented. Statewide Service Directory available to PCPs.
2. MVM PCP will implement the WMR PCP Cross Alliance Best Practice and Continuous Improvement Framework for Service Coordination including agreed: ⇒ Best Practice standards for Initial Contact, Initial Needs Identification and Care Planning; ⇒Protocols for Initial Contact, Initial Needs Identification and Care Planning which will	Finalisation of a Best Practice and Continuous Improvement Manual for Service Coordination and associated training. Completion of validation phase of Best Practice Project manual.

Strategies	Expected Outcomes
include implementation of Statewide Service Coordination Tool Templates and support functional integration in the primary care sector.	
3 MVM PCP will facilitate the change management process for Service Coordination both within and across member agencies. This will include development and implementation of a Capacity Building/Training and Development Plan to support service coordination as a sustainable and continuous improvement process.	Incremental implementation of Best Practice and Continuous Improvement Manual across member agencies.
4 MVM PCP will actively support PCP member agencies in change management to facilitate the implementation of the CSIF Project. This will include facilitating the establishment of: ⇒A regional website for PCP agencies, other health and community service agencies and general community access, ⇒A local service directory tailored to meet the needs of PCP agencies and the community, ⇒Electronic referral capability, specifically extended to Western Health and to include general practitioners in formal referral processes, ⇒System enhancements to support and streamline service delivery – eg, waiting list management tools, online booking systems and hard copy service directory production.	Establishment of a regional website for PCP agencies, other health and community service agencies and general community access. Establishment of a local service directory tailored to meet the needs of PCP agencies and the community. Development of electronic referral capabilities and supporting business processes for use by the three WMR PCP agencies.
5. MVM PCP will implement the Regional Cross Alliance Service Coordination Consumer, Carer and Community Participation.	Consultations with consumer groups undertaken and feedback incorporated into Best Practice and Continuous Improvement Manual.
6. Targeted support to local PCP agencies to implement the Statewide Tool Templates and WMR Best Practice and Continuous Improvement Framework.	PCP resources facilitate and support agency development of Action/Implementation Plans.

Progress

- A Regional approach to meeting key deliverables has enhanced service coordination work and contributed to developing effective and incremental strategies for building sustainability to sector reform and change management processes.
- An independent evaluation of the Western Region Primary Care Partnerships Cross Alliance Whole of Region Service Coordination Project has been completed. *Please refer to Executive Summary, Cross Regional Service Coordination Evaluation Report, Attachment C.*
- The next 12 months is a critical time for service coordination work. Objectives outlined in the Regional Cross Alliance Service Coordination workplan January 2002 to September 2002 will be completed.

- If funding is continued, then the Regional Cross Alliance Best Practice Project will be completed from October to December 2002 for the proposed Validation and Train the Trainer phase of manual implementation.
- The eight Stage 1 DHS funded Service Coordination projects will be finalised and the outcomes of these projects will continue to build an integrated and coordinated primary care service system.
- The three Stage 2 Projects will complement and be aligned with the work undertaken so far in Stage 1.

5.2.2 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 suite that support practitioners to operate a consumer, carer and community accessible and cohesive service system.

Priorities/Gaps/Emerging Issues

- Engagement with acute care sector and mental health sector.
- Agency capacity to respond to Service Coordination Implementation Plan.

Complementary Service Coordination Strategies

Strategies	Expected Outcomes
1. Encouragement of acute care sector and mental health sector in use of tools.	Provision of information and support to acute care sector and mental health regarding use of Service Coordination Tool Templates and supporting protocols.
2. Management of three Stage 2 Regional Cross Alliance Service Coordination Projects.	1. Identification of CALD Needs to inform the development of protocols, guidelines and workforce development /training plan for IC, INI & CP. 2. Identification of Carer Needs to inform the development of protocols, guidelines and workforce development /training plan for IC, INI & CP 3. Completion of a protocol to support coordinated care planning and referral from acute mental health services to primary care services.
3. Management of CALD strategic plan and competencies project for Western Region.	Completed Western Region CALD Strategic Plan and competencies.

Progress

- Positive links are in place with the acute care sector. Representatives from Discharge Planning and PACFU are involved in the MVM PCP Service Coordination Working Group and participate in Regional Forums and workshops.
- Progress will be dependent on DHS progression with Acute and Mental Health Divisions
- The Stage 2 Projects will commence in July 2002 and be completed in December 2002.
- Recruitment for two projects has been finalised and recruitment for the third project is underway.
- A plan is in place to ensure the alignment of Stage 2 projects with Stage 1 Regional Cross Alliance Service Coordination work.

5.3 Integrated Service Planning

5.3.1 Integrated Service Planning Strategic Objective 1 - Integrated Service Planning

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. Ongoing focus on alignment of municipal health, community safety, community health and community mental health planning through ISP working group processes.	Shared data collection and analysis processes for completion of these plans across the primary care sector.
2.Ongoing exploration of links with acute care planning and data analysis processes.	Shared data analysis to inform future plans and developments in relation to the acute care and primary care interface.
3. 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.

Progress

- Discussion has already occurred in relation to a shared commitment to mental health as a leading health issue across the Western Region.
- Further work on promotion of the activities in the mental health area will be progressed through the Western Region Cross Alliance Planning Forum.
- Discussion has occurred with Melbourne Health in relation to data analysis and the need for collaboration between the sectors for HARP funding rounds.

MVM PCP will link the various planning processes to promote a coordinated approach to planning across the member agencies. A principle strategy is the shared funding of an integrated health promotion position across the catchment. This position will gain commitment from member agencies to a shared and integrated approach to health promotion. The information from this approach will assist in formulating ways to support a more coordinated approach to the various planning processes. This alignment of planning processes will be progressed through the ISP working group in the coming year.

5.3.2 Key Health Priorities/Issues

The high priority groups for the MVM PCP are as follows[#11].

- Mental Health – with a continued focus on Youth Mental Health Promotion.
- Complex Care/Coordination – with a continued focus on Complex Care Needs in the CBD and care coordination for older people.
- Falls/Injury Prevention – with a continued focus on falls health promotion for older people.
- Neighbourhood Planning in area of high need – with a focus on office of housing clients.

Other priority issues that are a priority but cannot be progressed without specific funding included:

- Diabetes/Cardiovascular Disorders
- Asthma

- Drug and Alcohol – particularly mapping and coordination of services, health promotion
- Disability Issues – with a focus on early intervention (0-6) and carers needs.

At least two of these additional issues, diabetes/cardiovascular disorders and asthma, are considered under PCP Emergency Demand activities. The other two will not be discussed in detail as further information is required to inform directions, although drug and alcohol issues will be progressed in part through the Complex Care Needs in the CBD project and the new Primary Health Drug and Alcohol Service in the CBD.

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 above. This data is also supported by City of Moonee Valley and City of Melbourne municipal health plans, the Inner West Community Mental Health Plan and Doutta Galla Community Health Service Plan.

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 Keilor. (*Moonee Valley Health Plan 2000-2003, August, 2000*).

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 prevalent across the catchment at risk for 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 carers.

Of the specific high prevalence conditions, depression is the biggest problem both nationally and within the Inner West catchment in terms of the burden of disease. 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 in the 1997 Survey of Mental Health and Wellbeing, with 3.0% of men and 6.2% of women reporting the condition.

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 adults.

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).

Service Profile to date:
(All profiles will continue to be populated to inform ongoing planning)

Life Stages		**Fam/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.	YAP – Youth Access Program MVM PCP.	MH HARP project: improved community outreach and management of ED frequent attenders with complex psycho social needs.	
	Early Intervention	Doutta Galla Community Health Services.	Inner West Primary Mental Health Team Doutta Galla – Rocket, MHSKY–EPPIC.	Doutta Galla Community Health Services, Inner West Primary Mental Health Team.	Doutta Galla Community Health Services.
	Intensive	MHSKY Child & Adolescent Services.	MHSKY - Youth.	Inner West Area Mental Health Service –MH, Salvation Army Intensive Support Services, Doutta Galla Homelessness Program.	General Practitioners North West Aged Persons Mental Health Program.

Life Stages		Fam/Chn	Youth	Adults	Older
	Maintenance in Community			MVCC - Boomerang Club, Doutta Galla PDSS, MH HARP ED project with Doutta Galla CHS, Doutta Galla mental health homelessness.	

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 Plan identified youth mental health problems as a priority group and this continues to be a focus for the 2002-2003 operational plan. The main project focussing on youth is the youth mental health promotion project. This project will come to a conclusion on October 2002 but will continue to inform further work and developments in this area.

The Inner West Community Mental Health Plan also suggests key deficits in the availability of services for high prevalence disorders, in combination with extreme need for service from a population with the highest level of disability from non-psychotic disorders in the state, high levels of migrant and refugee settlement, the bulk of homeless crisis accommodation agencies, a large transitional and public housing sector with high needs residents, and high rates of unemployment and social disadvantage.

This emerging issue of the high prevalence of depression across the catchment is to some degree 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 development of a more detailed 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.

Two other priority mental health issues emerged as part of the HARP funding round discussion between PCP agencies and Melbourne Health.

The first of these involves access to in-patient 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.

The second issue is the lack of coordination between ED and primary care providers. It also includes the limited capacity of current community providers to provide flexible intensive support to maintain people with complex psychosoial issues, often with mental health, drug and alcohol and chronic homelessness 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 services.
These issues will be progressed through the successful HARP projects.

Mental Health Strategies

Strategies	Outcomes
1. Ongoing Youth Mental Health Promotion Project and progression of outcomes of the project.	Increased awareness of mental health issues by young people in the community. Peer education and leadership by young people in the program. Increased awareness by service providers of youth issues and implementation of strategies to become "youth friendly" Outcomes of project lead to continued project focus on youth mental health issues across the catchment.
2. Implementation of the Mental Health Discharge Service Coordination Project.	Outcomes facilitate improved care planning and discharge referral between acute and primary care sector.
3. Implementation of Complex Needs in the CBD project. Although not specifically just focussed on mental health this project will overlap with the Mental Health Discharge project and funded HARP projects.	Service coordination model between specialist and mainstream primary care providers to improve outcomes for people with complex care needs in the CBD.
4. Progression of HARP projects that are focussing on improving access to flexible community support services and a step down facility for people with a mental illness. The step down project includes an innovative partnership between the acute and primary care sectors.	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.

Progress.

- Progress has been made on all of the identified strategies and will continue over the next twelve months.
- Progression on the youth mental health project is presented in more detail in the Health Promotion Progress Template.
- A project officer is commencing in June to complete the final stage of the Complex Care Needs in the CBD project and commence the Mental Health Discharge project.
- The PCP will be involved in the progression of the funded HARP projects.
- HARP projects will need to be linked to current projects to ensure that there is no duplication of effort and there is ongoing collaboration between the sectors to improve client outcomes.
- The PCP continues to be active in the work of the Primary Mental Health Team and the development of the Community Mental Health Plan.

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.

Hospital admission data indicates injury as a high category for admission to hospital and emergency demand for children and for older people. Moonee Valley's above average level of hospital admissions for injuries and poisonings was largely due to a high admission rate amongst 0-14 year olds and 35-54 year olds. Moonee Valley had a particularly high level of 'other' accidental injuries and poisonings, across a wide range of age groups. Within the age range 5-14, there was a high level of hospital admissions for accidental falls. Another area of particular concern for Moonee Valley is its high level of hospital admissions in the category assault or rape for females aged 20-29 and 35-39.

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 risk *(HARP Background Paper)*.

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 fractures *(HARP Background Paper)*.

A review of attendances at the Royal Melbourne Hospital Emergency Department (March 2000 – February 2002) 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 hospital (*RMH HARP proposal*). A recent presentation 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 separations *(HARP Background Paper)*.

Service Profile to date:

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

Life Stages		Fam/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.

Life Stages		Fam/Chn	Youth	Adults	Older
	Preventative	Parenting programs.		Doutta Galla CHS - OT & variety of exercise programs MVCC/MCC community services various exercise programs wellness programs, RDNS – screening, , pharmacies & optometrists.	PCP Foothold on Safety Doutta Galla CHS - 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.		Doutta Galla CHS - physiotherapy, GPs, pharmacies & optometrists.	Doutta Galla CHS - physiotherapy and exercise programs, GPs, pharmacies & optometrists, MECARS – falls and balance MH HARP project in collaboration with Doutta Galla CHS and PCP (high risk).
	Intensive	Royal Children's Hospital, PACFU.	RCH, MH – MECARS, PACFU.	MH -RMH, MECARS, NARI, PACFU.	MH – RMH, MECARS, NARI, PACFU.
	Maintenance in Community			MVCC & MCC Community Services, RDNS.	MVCC & MCC Community Services, RDNS.

Priorities/Gaps/Emerging Issues
Falls focussing on older people was reconfirmed as a priority issue for the MVM PCP. Given the ageing population of the catchment it is expected that this issue will continue to escalate. As can be seen by the service profile, falls in older people is the only area that has services across the care continuum. It is therefore important to ensure coordination of effort in relation to falls activities through alignment of primary care falls activities and acute sector falls activities and with broader community work such as that being progressed by local safety committees.

It is unclear from the available data what are the specific issues for children in relation to injuries in the catchment other than knowing that falls and poisoning are particularly prevalent. More information is required about the groups most affected and the preventative strategies which may assist.

Falls/Injury Strategies

Strategies	Expected Outcomes
1. Ongoing implementation of Foothold on Safety Health Promotion Project. ⇒Ensure services for falls prevention across	Integrated health promotion program across MVM PCP catchment with a strong consumer focus.

Strategies	Expected Outcomes
the MVM PCP catchment are mapped and documented for inclusion in service directory information.	Integrated service planning and development as a result of information gained in the project. Implementation of service coordination tools in falls prevention service delivery activities.
2. Progression service development proposals that pursue outcomes for older people at risk of falling via suitable funding rounds such as HARP. Participation in implementation ensuring links with PCP service coordination activities such as referral, care planning and service directory use and development.	Integrated service planning and development across acute care and primary care sector.
3. Further exploration of children's injury data with RCH to determine appropriateness of an injury prevention project.	Increased understanding of injury issues for children in MVM PCP catchment and development of appropriate strategies to address these.
4. PCP engagement with MVCC Safety Committee to progress emerging injury and safety issues in the catchment.	Increased PCP linkages with wider sector injury and prevention activities.

Progress

- Significant progress has been made in relation to the Foothold on Safety project and HARP funding applications, as outlined in the Key Achievements section.
- Information in relation to children's injury data is aggregated at state level and progress requires follow up in relation to the PCP catchment area.
- The PCP has initiated contact with the MVCC Safety Committee and will continue to ensure linkages with such groups to promote the integration of the falls strategy work but also consider other community safety issues as appropriate.

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 women, older people with disabilities and people with a range of complex care needs in the CBD (particularly the homeless or those at risk of being homeless).

1. The Community Health Plan 2001-2004 identified significant health needs for older women in relation to mental disorders, chronic respiratory disease, injuries, cancer and cardiovascular disease. While women have a higher life expectancy than men, they experience a greater burden of disease for many health conditions. Hospital admission data indicates that women in the MVM catchment area accounted for 53.6 % of admissions to hospital. The 2001-2004 Community Health Plan identified the need for coordination of services for older women in the catchment and recommended co-location of services at the former Essendon Hospital site.

2. The Community Health Plan also identified that there was 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 also indicates that people over the age of 65 years of age accounted for over 30% of hospital admissions and over 50% of days stayed in hospital for the City of Melbourne and

Moonee Valley. The 2001-2004 Community Health Plan identified the need for improved coordination of services for this group. The strategy identified was a review of residential and flexible service packages for this group of people. Issues in relation to residential and flexible services for older people with disabilities has been identified as a priority for the Aged Care Services Network in the Western Region. Further work on this issue should be progressed in conjunction with this group.

3. In addition, the 2001-2004 Community Health Plan identified that there were specific areas of need in the MVM PCP catchment in the CBD. This included 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 people[#14]. The strategies identified to address these issues were the development of a Primary Care Service in the CBD and the Complex Care Needs in the CBD project.

Service Profile

There are a number of services relevant to the provision of Complex Care/Care Coordination in relation to older women's health needs, older persons complex care needs and complex care needs in the CBD. These are set out below.

1. Older women's health services are provided by; Doutta Galla Community Health via general practice and counselling services and programs, the Royal Women's Hospital for various clinics, Essendon RDNS, Women's Health West through health promotion programs, general practice, North West Aged Psychiatry services, and the Cities of Melbourne and Moonee Valley through specific support programs for women from CALD backgrounds.

2. Services to older people with complex care needs are provided by a wide range of providers many of whom are not member agencies of the PCP. Member agency providers include; Doutta Galla Community Health, Essendon RDNS, General Practice, North West Aged Psychiatry services, the Cities of Melbourne and Moonee Valley and Melbourne Health and through its various departments and services such as the ED department, Melbourne Extended Care and Rehabilitation and post acute care. MVCC and MCC 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 also provide residential care services.

3. 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; Doutta 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. These services will be mapped more comprehensively as part of the Complex Care Needs Project in the CBD.

Priorities/Gaps/Emerging Issues
It is clear that various sectors of our community who have complex care needs receive services from a range of providers. These services may work on an informal basis and sometimes formal basis to form a coordinated service response, but there is no overall system that encourages services to work together for better client outcomes. Any project focussed on complex care needs requires an understanding of the current service system and the barriers for clients accessing theses services before solutions can be implemented. Further work is required in all of the above areas to progress service coordination developments. The Complex Care Needs Project in the CBD will provide a detailed map of services and opportunities for coordination.

Complex Care Needs/Coordination Strategies

Strategies	Expected Outcomes
1. Ongoing progression of coordinated Older Women's Health Service at the Essendon Hospital Site bringing together Breast Screen, Continence, Gynaecology and a Well Women's clinic.	Integrated services for older women in the catchment. Improved opportunity for cross referral and health promotion activities.
2. Ongoing review of Flexible Community Care and Support Services for older people in the MVM PCP catchment area to determine service coordination opportunities. Link with work being progressed by Aged Care Services Network (ASN) in the Western Region.	Progression of issues identified in relation to residential and flexible community care support for older people with disabilties.
3. Ongoing completion of Complex Care Needs in CBD.	Inform service coordination and client access issues for homeless people in the catchment.
4. Ongoing progression of the development of Primary Care Services in the CBD.	Accessible primary care services linked to a range of specialist services in the CBD.

Progress

- Progression of the above projects has been outlined in the Key Achievements section and further progress will occur in the coming year.

4. Neighbourhood Planning in High Area of Need

Community and Service Profile
Community Profile
Communities identified in our planning process as high need are those in public housing. In order to qualify for eligibility for Office of Housing accommodation support, the applicant must satisfy stringent criteria. The criteria result in Office of Housing clients having a high proportion of people from low-income backgrounds frequently combined with a range of health and social problems. Low income is strongly associated with higher rates of health problems. Graham's (2000) book on Understanding Health Inequalities and Turrell's chapter in Eckersley et al's (2001) book on The Social Origins of Health and Well Being both contain significant evidence concerning the strong link between low income and poor health status.

In addition, recent work by Shane Thomas and Associates in the Wyndham project conducted for the Department of Human Services has shown that Office of Housing clients have much higher service needs than those within the general community. Information from "Beyond Symptoms" 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.

The present 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. Appropriate and sensitively designed outreach activities will link with existing activities delivered by the participating agencies within the MVM PCP.

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 activities whereas North Melbourne was not in relative terms. Postcode analysis of the limited range of data we had at that level of aggregation, showed that hospital admissions were at a high level for the North Melbourne area. 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 need[#11].

Service Profile for North Melbourne to date
(All profiles will continue to be populated to inform ongoing planning)

Life Stages		Fam/Chn	Youth	Adults	Older
Service Continuum	**Public Health Participative**	Libraries, recreation facilitation, North Melbourne Art House.	Libraries, recreation facilitation, North Melbourne Art House.	Libraries, recreation facilitation, North Melbourne Art House.	Libraries, recreation facilitation, North Melbourne Art House.
	Preventative	City of Melbourne North and West Melbourne Neighbourhood House – literacy, community arts.	City of Melbourne North and West Melbourne Neighbourhood House – literacy, community arts.	City of Melbourne North and West Melbourne Neighbourhood.	MVCC – wellness programs.
	Early Intervention	Moonee Valley City Council – Hotham Hub Children's Centre, Maternal and Child health service Buncle Street, Family Day Care, GPs.	GPs.	MVCC Community Care, House, GPs.	MVCC Community Care – home care, meals, GPs.
	Intensive	Post Acute Care, child care & physiotherapy.		Doutta Galla Community Connections.	
	Maintenance in Community			Doutta Galla PDSS, Salvation Army – Melrose St Program.	Doutta Galla PDSS, Salvation Army – Melrose St Program.

Priorities/Gaps/Emerging Issues
An increasing shortage of childcare places is reported by service providers as an issue for people living within the high rise as unavailable childcare limits people's opportunities to interact within the community. There are a number of families in the high rises who are in need of English classes but are finding it difficult to attend classes as child care is unavailable.

The Buncle St Centre reported that there are significant difficulties for people living in the high rise, as most of them are very disadvantaged and many of them are single parents or single people with mental health and/or drug and alcohol issues. There are health concerns with depression and many people are isolated. 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 highrise 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: Development of a Neighbourhood Planning Project in North Melbourne housing estate.

Strategies	Expected Outcomes
1. Development of reference group with PCP member agencies and other key players to develop detailed project plan.	Clear project brief developed.
2. Network with community leaders to engage consumers and develop a process for community consultation.	Community leaders will provide information on service gaps, community needs and expectations to provide a starting point to contact individuals and empower them to identify their neighbourhood and services available.
3. Ensure project has focus on working with consumers to improve access to services.	Each individual living within the estate has clear or initial understanding of what services are available to them, how to get there, and feel comfortable attending and accessing services. Ensure that service has been developed to a point where it can be accessed by all.
4. Submission of project for funding through Neighbourhood Renewal processes or other suitable funding process.	Funding is granted and funds can be allocated to commence project.

Progress
- A small working group has progressed this project to the detail outlined above and is awaiting further neighbourhood data to develop further.
- A consumer representative has indicated interest in this project and will be asked to join the reference group.
- A submission will be forwarded to the Neighbourhood Renewal program.

5. Emergency Demand

Community and Service Profile

Community Profile.

The 2001-2004 Community Health Plan 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 cardio-vascular 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 Melbourne and The Children's hospital are particularly relevant for MVM PCP catchment area. Royal Children's hospital indicates high levels of hospital emergency demand and admission for asthma and injuries *(HARP Background Paper).* 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 particularly diabetic foot and for Cardiovascular disorders *(HARP Background Paper and internal Melbourne Health analysis)*. 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 catchment.

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

- Frequent use of the ED by people with, including mental illness, chronic medical conditions, complicated by complex psychosocial problems which may include substance abuse, ABI and homelessness and
- 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 under Mental Health Issues.

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's Community Care Services and Doutta Galla Community Health (including Macaulay Support Services).

Priorities/Gaps/Emerging Issues

Ongoing work on emergency demand issues has highlighted:

- A reduced capacity of some parts of the community sector to respond to referrals from acute care due to limited infrastructure and resources.
- Need to develop evidence-based programs in the community in partnership with the acute sector to prevent hospital admission and improve client outcomes.
- Opportunities exist for greater collaboration in access to and analysis of information about preventable illnesses.

Emergency Demand Strategies

Strategies	Expected Outcomes
1. Ongoing MVM PCP collaboration with MH in developing and implementing projects in relation to high prevalence preventable conditions and illnesses such as diabetes, falls, respiratory conditions, cardiovascular disease and frequent ED attenders. Submission to funding rounds such as HARP.	No of projects funded through HARP funding round which aim to reduce emergency demand and preventable admissions. Successful implementation of projects.
2. Ongoing collaboration with MH in relation to service coordination activities and developments.	MH participation in service coordination activities such as use of Service Coordination tool suite by various hospital services. Improved service information about primary care sector within MH. MH's use of primary care service directory.
3. Ongoing collaboration with RCH in developing and implementing projects in relation to high prevalence preventable conditions and illnesses such as asthma and injuries. Submission to funding rounds such as HARP.	Project funded through HARP funding round which aims to reduce emergency demand and preventable admissions. Successful implementation of project.

Progress

- As indicated in the Key Achievements section, MVM PCP participated in collaborations with MH and RCH in relation to the HARP funding round.
- Full submissions with MH included projects focussing on Falls, COPD, Diabetic Foot and ED Demand management. All of these projects have been funded under HARP.
- One project was submitted in collaboration with Dianella Community Health and RCH on asthma management of children. This project has been funded under HARP.

6. Drug and Alcohol

Community and Service Profile

Community Profile

The 2001-2004 Community Health Plan 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.

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. There also appears to have been large increases in the numbers of heroin overdoses in Metropolitan Melbourne, with the average daily attendance by ambulances at non-fatal heroin overdoses increasing from 5.2 to 9.9 between June 1998 and July 1999. The MVM PCP catchment area accounted for 17.75 % of all non fatal heroin overdose-related ambulance call-outs for this period.

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. Usage rates for other drugs in the MV/M PCP catchment were around or slightly higher than those for the state overall. However, the survey was confined to schools so the number is likely to be under-represented

Service Profile
Limited work has been completed on a service profile for drug and alcohol services. Work in the coming year by MVCC and in the Complex Care Needs in the CBD will provide information for developing a comprehensive service profile of drug and alcohol providers.

Priorities/Gaps/Emerging Issues

- Lack of coordination between services.
- Lack of integration with mainstream services.
- Links with GPs.
- Need for coordination with new service developments in CBD.

Drug and Alcohol Strategies

Strategies	Expected Outcomes
1.Link PCP activity with work being completed by MVCC in relation to service mapping of D&A services for Municipal Health Planning purposes.	Drug &Alcohol Service Mapping informs service coordination activities.
2. Ensure information on new CBD Primary Health – Drug and Alcohol service development is included in PCP service directory information.	Information available in Regional Service Directory.

Progress

- Limited progress has been made with regard to Drug and Alcohol issues to date.
- Work on service mapping will assist in informing future directions in this area.

7. Disability

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

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 employment.

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. The largest client group in the MVM PCP catchment using formal disability services are those suffering from profound or severe intellectual disability. The number of DHS DisAbility clients in the Moonee Valley LGA and City of Melbourne at April, 2002 was 535 and 218 respectively.

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, including more than 3,300 primary carers in the MVM PCP catchment area.

Information from the DHS Best Start Program indicates that children who are exposed to poverty and low socioeconomic status are at risk of developmental problems. It is widely accepted that poverty has long lasting effects. Families living in poverty are more likely to be homeless, to experience family conflict, parental mental illness and parenting difficulties. Infants and children from families with low socioeconomic status are at risk of low birth weight, exposure to toxic substances, malnourishment, asthma and other chronic health problems and parenting difficulties. Such children are more likely to have poorer language and learning development, lower school achievement, poorer health and later psychiatric illness, more behavioural and emotional problems, delinquency and crime, teen pregnancy and unemployment *(Best Start for Children , Summary of the evidence base underlying investment in the early years, DHS, 2001).* MVM PCP has a number of identified areas of low socioeconomic status. These are predominantly housing estates in the following suburbs; Carlton, North Melbourne, Flemington, Kensington, Ascot Vale, and Avondale Heights.

Service Profile

Limited work has been completed on a service profile for Disability. A Strengthening Families project being undertaken by MVCC and RCH called *Platforms* will provide more detail on services provided to children 0-6 in specific catchments identified as high need. The PCP neighbourhood planning project should also provide further information on Disability services into the North Melbourne estate.

Priorities/Gaps/Emerging Issues

- Carers Needs were highlighted as an issue in the 2001-2004 Community Health Plan and continue to be a growing concern. Further information on the needs of Carers across the catchment is required before this issue can be progressed.
- Access to Speech Pathology services was raised as a major concern by MCC and MVCC Children's Services. Further information on the needs of disadvantaged groups within the catchment is likely to emerge in the Platforms project and in the Neighbourhood Planning project.

Disability Strategies

Strategies	**Expected Outcomes**
1. MVM PCP collaboration in the Platforms project with MVCC and RCH. This project is focussing on the needs of children from 0-6 years in disadvantaged communities.	Identification of service gaps for 0-6 year olds in disadvantaged communities. Community building and development.
2. Completion of Service Coordination Carers Needs Project.	Increased understanding of carers concerns in service provision by primary care sector.

Progress

- MVM PCP has commenced working with the Platforms project which is a joint project between MVCC and RCH on the needs of children 0-6 years and their families from disadvantaged communities[#15]. The MVCC communities identified as areas of high need include; North Melbourne, Kensington, Flemington, Ascot Vale and Avondale Heights.

- The project aims to build capacity of the community to improve the early identification of major risk factors known to be associated with poor health, development and behavioural outcomes in children.

- The PCP will ensure that this project interfaces with the neighbourhood planning project so that information from the two action research projects are shared. The Carers Needs Service Coordination project, whilst focussed on the implementation of the Service Coordination Tool Suite, will offer insights into the needs of carers through feedback with carers and focus groups.

5.3.2 Integrated Service Planning Strategic Objective 2 - Integrated 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.

For MVM PCP Integrated Health Promotion Activities Progress Report 2000-2002 please refer to Attachment A.

For MVM PCP Integrated Health Promotion Plan 2002-2003, please refer to Attachment B.

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
CALD	Culturally and Linguistically Diverse communities
CBD	Central Business District
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)
CSIF	Comprehensive Services Information Facility
DALY	Disability Adjusted Life years
DHS	Department of Human Services
EPC	Enhanced Primary Care
GP	General Practitioner
HACC	Home and Community Care
HARP	Hospital Admissions Risk Program
IC	Initial Contact
INI	Initial Needs Identification
ISP	Integrated Service Planning
LGA	Local Government Authority
MCC	Melbourne City Council
MDGP	Melbourne Division of General Practice
MECARS	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
NWDGP	North West Division of General Practice
PACFU	Post Acute Care Facilitation Unit
PDSS	Psychiatric Disability Support Services
PCP	Primary Care Partnership
PKI	Public Key Infrastructure
PPPs	Practices, Processes and Protocols for Service Coordination
RCH	Royal Children's Hospital
RDNS	Royal District Nursing Service
RWH	Royal Women's Hospital
SAAP	Supported Accommodation Assistance Program
WDGP	Western Division of General Practice
WMR	Western Metropolitan DHS Region
YAP	Youth Access Program
YSAS	Youth Substance Abuse Service

Documents Available on Request

1. MVM PCP Structure (2002)

2. MVM PCP Partnership Memorandum of Understanding and Operations Guide (2002)

3. WMR PCP Cross Alliance Service Coordination Consumer/Carer Consultation Plan (May 2002)

4. MVM Consumer, Carer and Community Participation Reimbursement Policy (June 2002)

5. WMR PCP Cross Alliance Whole of Region Consolidated Model for Service Coordination (June 2002)

6. WMR PCP Cross Alliance Protocol Template (February 2002)

7. WMR PCP Cross Alliance Quality Practices Audit for Service Coordination (February 2002)

8. WMR PCP Cross Alliance Draft Initial Contact Protocol – Protocol for Initialising the Initial Contact Element of the WMR Consolidated Service Coordination Model (April 2002)

9. WMR PCP Cross Alliance draft Consumer Outcomes for Initial Contact and Consumer Outcomes for Initial Needs Identification (April 2002)

10. WMR PCP Cross Alliance draft Interagency Multidisciplinary Care Coordination Meeting Protocol (May 2002)

11. MVM PCP Integrated Service Plan Priorities Project Report (2002)

12. Inner West Community Mental Health Plan (2002-2003)

13. Moonee Valley City Council Report – Community and Residential Care Issues for Older Residents (April 2002).

14. Complex Care Needs in the CBD – Project Report and Literature Review (2002)

15. MVCC & RCH Platforms Project Outline (2002)

16. Western Region Primary Care Partnerships Cross-Alliance Service Coordination Evaluation (June 2002)

17. 24 Hour Access Feasibility Study (2002)

Note: Any other references are available on request.