



**North Central
Metro PCP**

**NORTH CENTRAL METROPOLITAN PRIMARY
CARE PARTNERSHIP**

COMMUNITY HEALTH PLAN

2003-2004

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Appendix 1

Community Health Plan Review 2002 – 2003 (see accompanying document)

Section One – Context

Description of NCMPCP

The North Central Metropolitan Primary Care Partnership (NCMPCP) is an alliance of 60 health and community service agencies from the Cities of Whittlesea, Darebin and Yarra, with a core group of 14 member agencies involved in the management of the initiative, including Darebin, Plenty Valley, North Yarra and North Richmond Community Health Services, Darebin, Yarra and Whittlesea Councils, the Northern Division of General Practitioners, Royal District Nursing Service, Neami, Women’s Health in the North, Migrant Resource Centre North East, Northern Hospital, and the Department of Human Services (northern Metropolitan Region).

The catchment of the NCMPCP stretches north from inner urban City of Yarra through the traditional industrial suburbs which make up the City of Darebin, to the newer suburbs and semi-rural towns of the City of Whittlesea, which is bounded by the Great Dividing Range. The catchment area thus takes in a wide variety of communities and a broad base of health and community service providers.

The population across the PCP catchment in 2001 was estimated to be 315,996, growing to 342,673 by 2010, representing a percentage increase of 8.4%. The population included in the catchment for the NCMPCP is characterised by:

- ***cultural and linguistic diversity***, being home to a sizeable Aboriginal and Torres Strait Islander population as well as many newly arrived migrants and older more established migrant groups.
- ***significant levels of social disadvantage***, the factor which correlates strongly with poor health status and higher use of public health services.

The health conditions that contribute most to the burden of disease in the NCMPCP catchment include: diabetes, cardiovascular disease, asthma, and mental health.

- The catchment of the NCMPCP doesn’t define any health or community service system. The catchment is served by three hospitals (St Vincent’s, Northern, and the Austin), two area mental health services (Northern Area Mental Health service and St Vincent’s Mental Health Service), three Divisions of General Practice (Northern, Melbourne and North East Valley). The local government areas within the catchment include inner urban Yarra and semi-rural Whittlesea. The Primary Care Partnership Strategy has been challenging to implement in this complex catchment.
- The Partnership determined in 2002 that key primary care partnership activity should occur at a local government area level, and should include local government and community health in each local government area as the core of the primary care partnership in each local government area.
- The Partnership would strengthen Municipal Public Health Plans as the community health planning mechanism and driver for local primary care partnership activity, and use the strengths afforded by a perspective across a number of service systems to highlight broader systemic issues contributing to poor consumer experience of the health services system and develop strategies to improve that experience.

The Partnership has benefited from the considerable partnership experience within the catchment prior to the PCP Strategy and has been concerned to ensure that the PCP Strategy builds on existing strengths and contributes to sustainable improvements.

Vision and Values

The Partnership has strongly shared values which constitute the broad vision for the improvement of health care services to meet the needs of:

- the most disadvantaged in the community, who bear the poorest health status and are often the most marginalized people in our community, and
- the culturally and linguistically diverse community that makes up the NCMPCP catchment, including Aboriginal people and people from non-English speaking backgrounds, including newly arrived migrants and refugees.

Within a social model of health, the Partnership will address the health conditions that contribute most to the burden of disease in the NCMPCP catchment: diabetes, cardiovascular disease, asthma, and mental health, by:

- mediating the key risk factors for these conditions:
 - Social connectedness
 - Smoking
 - Nutrition
 - Alcohol
 - Physical activity
- early detection and optimal care and support for consumers in the community setting.

Objectives of NCMPCP

By working in partnership, we aim to:

- Plan cooperatively, to better understand the impact of socio-economic status and the social and physical environment upon the health and well-being of consumers
- Understand the experience of consumers and carers in using the health care services system and act where needed to improve the coordination of service system including intake, referral and assessment processes
- be more responsive and accountable to our consumers
- enable more equitable access to services, particularly the socially disadvantaged, people from non-English speaking backgrounds and the Aboriginal population
- provide services that are more culturally and gender sensitive, relevant and appropriate
- develop and promote service models that meet the diverse needs of consumers and communities across the sub-region

Brief history – What NCMPCP has achieved

Partnerships

- Hospital-community partnerships

The NCMPCP has brokered and facilitated partnerships across the interface of primary and acute care for three hospital catchments to the level each hospital has been prepared to engage in a sectoral approach. The NCMPCP has been instrumental in the development of a successful sectoral partnership approach to developing HARP submissions relevant to the Northern Health catchment, and in the development of the HARP Partnership Framework for Northern Health.

The NCMPCP has led and facilitated the development of a model for chronic disease management in the community to guide primary care system development in relation to the needs of those with chronic illnesses in the community, and as a guide to HARP investment in the primary care sector. Built on the learnings derived from the PCP Integrated Disease Management Projects, this model informed the development of primary care led HARP submissions for community care of COPD, Diabetes, and CHF in the Northern Health catchment, which were successful in attracting HARP funding. The model informed a similar proposal for the Austin Health catchment which was, unfortunately, not successful in attracting HARP funding in 2003.

HARP investment in the NCMPCP catchment amounted to around \$1.2 million in 2002 and a further \$1.2 million in 2003. The NCMPCP has been successful in aligning substantial investment to priority population health needs in the catchment.

- Health Promotion Partnerships

The NCMPCP has continued to support a Health Promotion Sub-Committee structure throughout 2002-2003 to improve integrated health promotion practice in the catchment.

The Partnership has developed tools to support Integrated Health Promotion Planning in the form of a Framework, and piloted the approach in developing health promotion projects to improve health promotion practice with transient housing populations in Yarra and Whittlesea.

The Partnership with Latrobe University and Boroondara PCP around the NH&MRC funded research project entitled the **Peer Led Self Management of Chronic Disease Project** has successfully continued.

A key outcome of this 2 year project will be the adaptation of a proven successful health promotion program within disease management, Lorig's model of Peer Led Self Management of Chronic Disease, for suitability to a local population that is culturally and linguistically diverse. The Project is developing the program for the Vietnamese, Chinese, Italian and Greek languages.

- Aboriginal Partnership

An important Partnership has been established over the last 12 months between the NCMPCP and the Darebin Aboriginal Services Network to progress a project to improve Aboriginal access to mainstream primary health services in the catchment. The NCMPCP catchment is home to the largest Aboriginal population in an urban area in Victoria who have the poorest health status of any group in our community. This newly forged Partnership will lead change in mainstream primary health care services to be more relevant and responsive to the particular needs of the Aboriginal population in the local community.

- Mental health services partnership

The NCMPCP continues to partner the Mental Health Services in the catchment (Northern Area Mental Health service and St Vincent's Mental health service) through the Primary Mental Health Early Intervention Team Initiative, Community Mental Health Planning, the Austin Child and Mental Health Services Improvement Initiative, and the HARP Mental Health projects that NCMPCP member agencies lead or are partners in including St Vincent's Holding it Together Project and the Northern Alliance Suicide and Self Harm Prevention Project.

- Regional Partnerships

The NCMPCP is an active participant in the Northern Region PCP Network, leading the development of a protocol between Women's Health in the North and the 3 PCPs in the Northern Metropolitan Region to collaborate to provide, amongst other things, a gendered community and service utilization profile as the basis for collaborative enterprise.

NCMPCP has represented regional PCPs on the Northern Health Population Health Advisory Committee throughout the 2002-2003 financial year.

Planning

NCMPCP has been strengthening existing statutory planning processes in the catchment, primarily the Municipal Public Health Planning Processes and hospital based Population Health and Advisory Committees, as the sustainable integrated population health planning mechanisms.

Particular achievements have included:

- A literature review of community health planning models to inform the development of Darebin Council's municipal health planning process, participation on the Steering Committee for *DarebinHealth* and presentation on chronic and complex care needs.
- Providing for the collection of life stage and gender disaggregated population health and service utilization data by local government area to inform municipal health planning as outlined in the NMR PCP protocol with Women's Health in the North.
- Collaborating with Northern Health to improve the focus and operations of the Population Health and Advisory Committee.
- Improving local government area level understanding about the needs of those with complex and chronic conditions.

The *Strengthening Community Action project* (described more fully in the next section) facilitates the participation of culturally diverse, Aboriginal and socially disadvantaged communities in municipal public health planning processes.

Consumer participation

NCMPCP has established and resourced a Consumer and Carer Advisory Sub-Committee as part of the governance structure of the Partnership. The Committee is made up of equal numbers of consumer representatives and service providers. The Committee has developed a project to build the capacity of consumer advocates and agency staff to strengthen community participation in processes of identifying, prioritising and developing solutions to address community health issues.

The *Strengthening Community Action project* is developing and delivering training in action research methods, community leadership and advocacy skills to consumer representatives involved in health planning and governance in the catchment. There is also a training program for staff in supporting consumer participation. The project involves consumers who have traditionally been under-involved in consumer participation opportunities, actively recruiting people from culturally and linguistically diverse communities, including Aboriginal people, and people representing the experience of socially disadvantaged consumers and carers in the community.

A consumer participation framework to assist agencies, and networks of agencies, to plan for consumer participation has been developed as a resource. Individual NCMPCP member agencies have been supported to develop and implement sustainable strategies for consumer participation.

Additional resources were provided to Service Coordination Improvement Projects to support consumer involvement in developing responses to identified service system issues.

Health promotion

Within a social model of health, the Partnership continues to address the health conditions that contribute most to the burden of disease in the NCMPCP catchment: diabetes, cardiovascular disease, asthma, and mental health by mediating the key risk factors for these conditions:

- Social connectedness
- Smoking
- Nutrition
- Alcohol
- Physical activity

Over the past 12 months we have aligned the activities and health promotion efforts of multiple stakeholders around this S-SNAP framework.

We have elected our targets for health promotion as those with the poorest access to health promoting experience: the homeless, those on low incomes, newly arrived communities, those with few language skills, and Aboriginal people. We are building the capacity of the sector to develop health promotion programs relevant to these target groups through promoting effective models of practice, encouraging the testing of successful models in new settings, and documenting and disseminating the learnings within the broader membership through showcasing forums, newsletters and web site updates.

We have built on the considerable expertise within the member base of the NCMPCP in working with diverse communities and we have been fortunate in being able to use this expertise to considerably extend the reach of innovative responsive practice.

Yarra is a gentrifying café society and remains home to many people on low incomes in transient housing. It is often not possible for people in transient housing in Yarra to prepare nutritious and inexpensive meals and there are fewer and fewer opportunities for people on low incomes to participate in community life. The Yarra Food Insecurity Project aims to provide nutrition support to people in transient housing in a way that allows them to be included and participate as citizens in social and community life in Yarra, through providing subsidised café meals, and other innovative approaches including the development of kitchen gardens as part of rooming houses. The Partnership has supported the extension of the Yarra Food Insecurity Project to testing the success of the approach in a different rooming house setting- refining our knowledge about what works and why.

We have undertaken collaborative health promotion project planning in response to funding opportunities arising around key population health priorities as they arose throughout the year, developing a framework to capture the information about current projects, existing knowledge and circles of cooperation, coordination and collaboration that we gather in the process of developing submissions and this becomes the starting point for actions and activities in the Partnership around these priority issues. Examples include:

- A CALD and Koori responsive approach to developing services for children and families
- Life Scripts- a coordinated Community Health Centre Based health promotion package to complement medical management of chronic illnesses

Service Coordination

Groups of NCMPCP member agencies implemented six local service coordination projects during 2002/3 to address local priorities for service system development.

The service coordination improvement projects have developed:

- A centralised CACPS waiting list for residents of Yarra and protocols to streamline communication with consumers and between services
- An aged care services network in Whittlesea
- Protocols to improve client centered communication between clinical and community mental health services in Yarra
- Intake and referral systems between primary care providers in Darebin
- Culturally relevant information translated into six languages explaining a web based needs register to enable informed consent for information sharing by people with disabilities seeking case management.
- Options for developing the role of 'Living Options' a service providing a central intake point and housing register for people with a psychiatric disability seeking supported accommodation.

NCMPCP member agencies have actively participated in developing a set of inter agency protocols that outline agreed practices, processes, protocols and systems for the provision of primary care services and the use of the Service Coordination Tool Templates (SCTT). Agency staff have been trained in the use of the SCTT and implementation is proceeding.

In collaboration with other PCPs in the region, a regional service coordination plan to inform ICT (Information, Communications, Technology) investment was developed.

Information Management

The NCMPCP has established and provided administrative support to the ICT Regional Governance Group for the last 12 months. NCMPCP member agencies were actively engaged, along with other members of the regional ICT Governance Group, in the process of developing regional ICT plans. The Governance Group brought together hospitals and primary care agencies in a discussion of information technology status, needs and options. The group explored inter-agency connectivity options and electronic referral systems but progress has been impeded by a lack of DHS funding commitment to implement regional vision and priorities.

PKI (Public Key Infrastructure) encryption that enables secure electronic referrals by email is being promoted to GPs and other primary care providers. NCMPCP is leading a group of providers in Whittlesea with the support of the Northern Division of GP and the BECC GP Liaison Unit in developing capacity to trial electronic referrals between Northern Hospital – Care Coordination, BECC, Plenty Valley Community Health and Whittlesea City Council – Home care.

Integrated Disease Management

NCMPCP contributed to the development of IDM models for diabetes, COPD and CHF in HARP submissions. Titled *Chronic Disease Management in the Community*, key model elements for the community end of the continuum of care were articulated.

Where the partnership is at now

The Partnership developed a shared vision and strategy in 2001. It was a grand vision and much of that strategy was unfunded. We are still working towards that vision and, within a resource constrained and dynamic environment the Partnership has adapted to progress the Partnership's vision in various ways.

HARP has emerged as a key opportunity to progress integrated disease management approaches in the catchment around diabetes, respiratory illnesses and cardiac problems, as well as increasing primary care sector awareness of the need to organise as a system to provide comprehensive community care for people with complex and chronic conditions who can experience the service system as fragmented and untimely or unresponsive to their needs.

HARP has highlighted systems issues, particularly that primary health care services are not currently organized as a "system" as such, that is capable of "intake" and community care management as part of a care continuum that crosses primary and acute care systems.

Whilst the right service mix at the right service levels are not currently available in the primary health care sector to impact upon hospital demand in a significant way, HARP is a means of investing in the development of the systems service capacity as well as driving systems improvements and coordination, in much the same way as has been achieved with funding to drive Service Coordination Improvement Projects in the PCP Strategy.

The NCMPCP accepts that the target populations for HARP, those with complex and chronic conditions, are high users of multiple services and can often experience the services system as fragmented. The NCMPCP progresses the Service Coordination aims, including the Service Coordination Tools implementation. The care planning and coordination associated with patients with complex and chronic conditions being cared for in the community will make sense of the investment in the PCP Strategy for many agencies.

It has also been highlighted that access to quality community care for low income people depends on their access to the required service mix in the community.

Costs associated with service use are a significant barrier to access. The bulk billing GP is a critical primary health care resource in the NCMPCP catchment. Affordable allied health services are another critical component. They exist within the Community Health Services in the NCMPCP but the supply is far outstripped by demand and waiting lists for podiatry, physiotherapy and occupational therapy extend to months. Post acute care services report that they want to purchase allied health services within Community Health to connect patients with the ongoing social support system that Community Health services with their considerable platform of innovative, responsive social and recreational support programs can provide, however Community Health services have not proved responsive to the brokerage model of post acute care.

The Partnership is gaining awareness of systemic problems and experience in developing systemic solutions, again largely as a result of the challenges and opportunities presented by HARP. This is particularly so for the municipality of Darebin, whose population of patients with complex and chronic conditions is amongst the highest of any local government area in the State, involving multiple providers across Commonwealth and State funded programs, including three hospitals.

The work that has been occurring around the development of acute-primary care systems at St Vincent's, Northern and the Austin is driving a need for a proactive response from the primary care sector in Darebin to ensure the system does not become more complex and fragmented as a result of HARP initiatives, and that investments through HARP are strategic and result in the required mix of services at the needed levels in the community to serve the target groups.

There is a growing readiness to take up opportunities to develop systems of care for people with complex care needs in the community and potentially to pool funds to ensure access to the right care at the right time in the community setting. Models such as the Primary Care Trust model could be of interest to the Partnership, building on the strong collaboration that has been developed between the Northern Division of GPs and the NCMPCP.

The Partnership is well able to inform strategic investment to strengthen primary health care and impact upon key population health issues in the catchment. There is also a readiness to develop municipal wide integrated health promotion plans to inform pooled health promotion resources and/or resource investment from VicHealth, the Commonwealth etc. That is, linking Municipal Public Health Plans to health promotion funding allocations.

The Partnership is capable of progressing these innovations should the opportunities through incentive or innovations funding arise.

In summary, the NCMPCP has been developing well as a Partnership around core values to do with social justice and access to quality services for those with the poorest health in our community.

The local implementation of Partnership activity is around local government areas or hospital catchments, which makes the task resource intensive and time consuming as the NCMPCP catchment includes 3 local government areas, 3 Divisions of General Practice, 2 Area Mental Health Services and 3 hospital catchments.

Nonetheless the Partnership:

- Commenced to develop Municipal Public Health Planning as a sustainable Community Health Planning mechanism, capable of informing health promotion investment
- Developed integrated disease management approaches for diabetes, respiratory illnesses and cardiac problems relevant to the catchment population
- Progressed primary care system developments relating to chronic and complex conditions
- Progressed primary prevention through integrated health promotion planning between local government and Community Health at the local government level, and secondary and tertiary health promotion through improved planning between GPs and Community Health at the catchment level
- Progressed hospital-community interface projects in three hospital catchments
- Developed plans for impacting upon CALD and Aboriginal access to appropriate health care in the catchment, and
- Supports the membership in implementing key planks of the PCP Strategy as they are developed eg. SCTT.

The coming year promises to continue the work of the past year and prepare the Partnership for the next phase of primary care reform.

Section Two - Operational Plan

Priority health and well being needs

The health conditions contributing most to the burden of disease in the NCMPCP catchment are diabetes, cardiovascular disease, asthma, and mental health.

The priority population groups are:

- People who are economically and socially disadvantaged
- Aboriginal people
- People from culturally and linguistically diverse backgrounds,

Within a social model of health, the Partnership will address the health conditions that contribute most to the burden of disease in the NCMPCP catchment by :

- mediating the key risk factors for these conditions:
 - Social connectedness
 - Smoking
 - Nutrition
 - Alcohol
 - Physical activity
- early detection and optimal care and support for consumers in the community setting.

Community and Service Profile

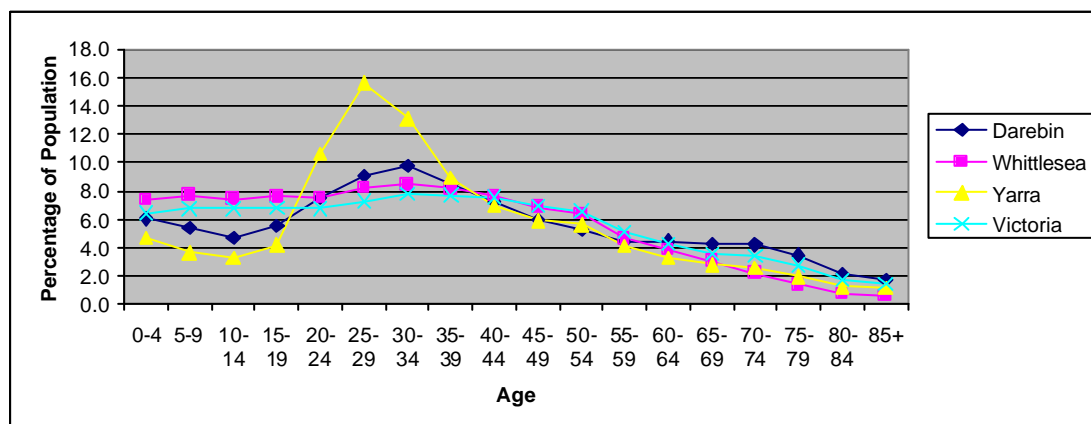
This section provides an updated community and service profile of selected characteristics of the North Central Metro Primary Care Partnership catchment, drawing on 2001 Census data and updated service utilization data provided in the DHS Community Health Plan dataset 2003.

COMMUNITY PROFILE

The population

In 2001 the population of the NCMPCP catchment (316,258) was 9.1 % of the metropolitan population and 6.6 % of the total Victorian population. The populations of the Local Government Areas in 2001 were: Darebin: 128,402, Whittlesea: 118,292 and Yarra: 69,564

Chart 1: Age profile 2001 population



Data source: Estimated Resident Population, ABS. Data reference period: 2001.

The age profile chart above shows that compared to the rest of the catchment, and the State, Whittlesea has a relatively young population with fewer older residents and a higher percentage of younger people. Yarra's age profile is distinct with fewer residents aged under 20 and a peak in the 20 to 40 age group. Darebin has the highest proportions, and numbers of people aged 60 and over.

Households

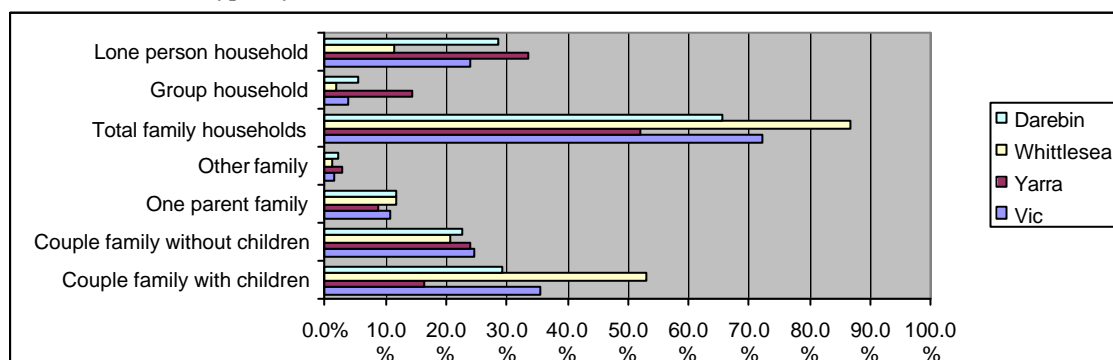
There were a total of 110,127 households in the NCMPCP catchment in 2001. There are over 12,000 more households in Darebin than Whittlesea although the population of Darebin is only about 10,000 more than the population of Whittlesea due to differences in household size and structure. Yarra has the smallest household size and a third of households in Yarra are single people.

Table 1: Households by LGA

| | Darebin | Whittlesea | Yarra |
|--------------------------------|---------------|--------------|--------------|
| Couple family with children | 13,917 | 18,540 | 4,528 |
| Couple family without children | 10,678 | 7,168 | 6,636 |
| One parent family | 5,635 | 4,138 | 2,473 |
| Other family | 996 | 405 | 815 |
| Total family households | 31,226 | 30,251 | 14,452 |
| Group household | 2,632 | 630 | 3,988 |
| Lone person household | 13,631 | 4,028 | 9,289 |
| Total Households | 47,489 | 34,909 | 27,729 |
| Population | 128,402 | 118,292 | 69,564 |
| Ave. persons per household | 2.44 | 3.18 | 2.14 |

Source: Census 2001, Basic Community Profile

Chart 2: Household types by LGA



Source: Census 2001, Basic Community Profile

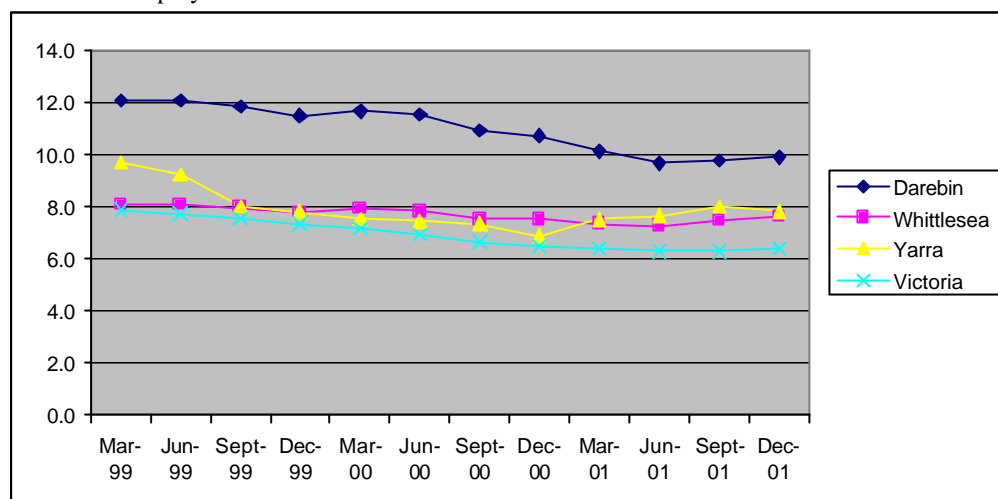
Within NCMPCP, Yarra and Darebin both have higher proportions of sole person households and group households than the state average.

The high proportion of families overall (86.7%), and two parent families (53.1%) is notable in Whittlesea. Almost two thirds of Darebin households are families however a third of these families are couples without children.

The proportion of families with children under 15 years is above the state average (32.9%) in Whittlesea (38.1%) and below in Darebin (27.5%) and Yarra (21.3%).

Unemployment

Chart 3: Unemployment Rate 1999 - 2001



Data Source: Department of Employment, Workplace Relations and Small Business (DEWRSB)

Unemployment rates in the NCMPCP catchment have remained above the Victorian average for this entire three-year period. Darebin had consistently higher levels of unemployment than the rest of the catchment however by the end of 2001 differences between LGAs diminished as Darebin's unemployment rate dropped and the rates in Whittlesea and Yarra increased.

Pensions and Benefits

Table 2: Pensions and Benefits

| | Aged Pension | | New Start | | Disability Support | | Total | |
|---------------|---------------|------------|---------------|------------|--------------------|------------|---------------|-------------|
| | Clients | % pop | Clients | % pop | Clients | % pop | Clients | % pop |
| Darebin | 17,238 | 13.4 | 5,300 | 4.1 | 6,343 | 4.9 | 28,881 | 22.5 |
| Whittlesea | 8,739 | 7.4 | 3,197 | 2.7 | 4,855 | 4.1 | 16,791 | 14.2 |
| Yarra | 5,300 | 7.6 | 3,682 | 5.3 | 2,676 | 3.8 | 11,658 | 16.8 |
| NCMPCP | 31,276 | 9.9 | 12,180 | 3.9 | 13,874 | 4.4 | 57,330 | 18.1 |
| NMR | 73,152 | 9.5 | 25,165 | 3.3 | 28,795 | 3.7 | 127,113 | 16.5 |
| Metro | 312,706 | 9.0 | 90,808 | 2.6 | 100,426 | 2.9 | 503,941 | 14.4 |
| Victoria | 458,529 | 9.5 | 129,779 | 2.7 | 149,167 | 3.1 | 737,475 | 15.3 |

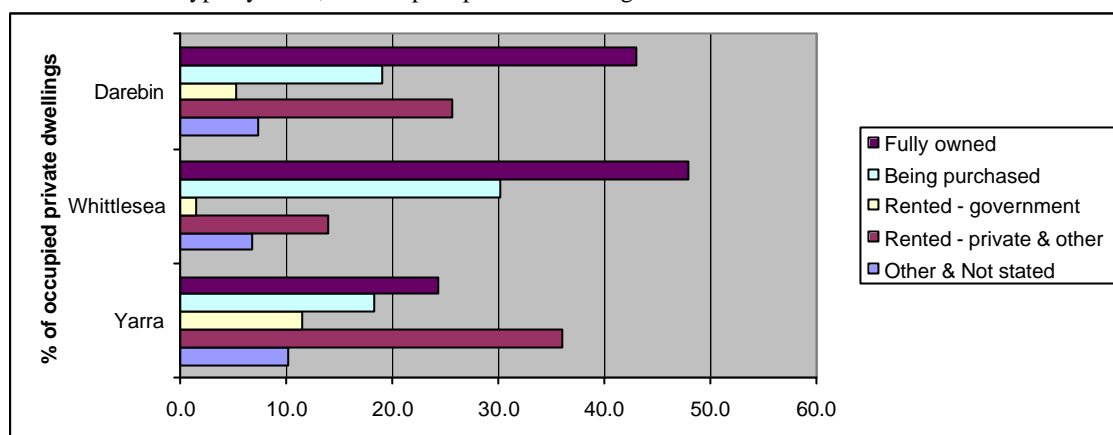
Data Source: Centrelink, Data Reference Period: September or November 2001

The NCMPCP catchment includes a greater proportion of people on pensions and benefits than that for the NMR as a whole, metropolitan Melbourne or Victoria.

Within that, one in five of the population of the City of Darebin receive pensions and benefits.

Housing

Chart 4: Tenure Type by LGA, Unoccupied private dwellings 2001



Source: ABS

Yarra has the highest level of public rental housing in Victoria. The low level of public housing available in Whittlesea is a key concern given the high rates of dependence on pensions and benefits.

Table 3: SEIFA Index, NCMPCP

| Municipality | Rating |
|-----------------|--------|
| Darebin | 944.4 |
| Whittlesea | 982.7 |
| Yarra | 984.0 |
| Northern Region | 994.0 |
| Melbourne Metro | 1018.7 |
| Victoria | 1016.0 |

Cultural and Linguistic diversity

As shown in the table below all LGAs in the NCMPCP catchment have higher proportions of people born overseas than is the average in Victoria. The percentage of the total population born overseas dropped by nine percent in Yarra and increased by six percent in Whittlesea between the 1996 and 2001 census collections.

The DIMIA settlement database provides information on the intended destination of new migrants on arrival by their migration category. There are relatively higher proportions of migrants in the humanitarian and family reunification categories settling in the NCMPCP catchment as compared to the rest of the state and fewer skilled migrants.

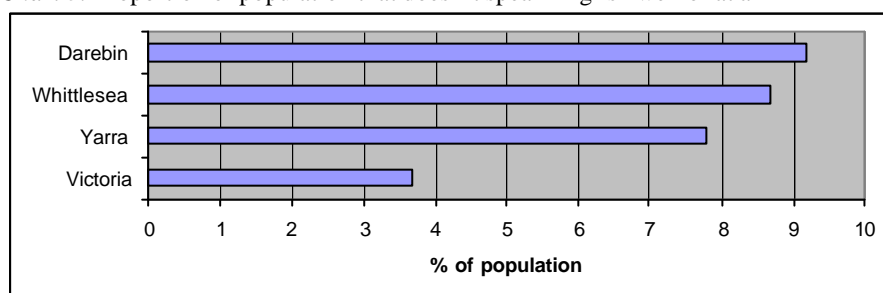
Table 4: Overseas Born Population

| Census Data | | | | DIMIA migration categories July 1997 to June 2002 | | | |
|----------------------|-----------|-----------------|--------------|--|-------------------------|---------------------|----------------|
| | 2001 | % ∇ 96 to 01 | % of pop. | Humanitaria n | Family reunification | Skilled Migrants | TOTAL |
| Yarra | 19,426 | -9% | 27.9 | 149 | 930 | 438 | 1517 |
| Whittlesea | 38,203 | 6% | 32.3 | 289 | 853 | 445 | 1587 |
| Darebin | 41,188 | -2% | 32.1 | 861 | 1386 | 588 | 2835 |
| NCMPCP (% of Vic) | 98,817 | -1% | 31.2 | 1299 (9.7%) | 3169 (9.7%) | 1471 (4.3%) | 5939 (7.4%) |
| VICTORIA | 1,080,344 | 4% | 22.4 | 13,369 | 32,824 | 34,162 | 80,753 |

Sources: ABS Census 2001, DIMIA Settlement Database

The cultural diversity of the catchment is reflected in the proportion of the population that doesn't speak English well or at all. In all LGAs in the NCMPCP catchment there is more than double the percentage of people who do not speak English well as compared to Victoria.

Chart 5: Proportion of population that doesn't speak English well or at all



Sources: ABS Census 2001

The established migrant communities in the NCMPCP catchment include the Italian, Greek, Macedonian, Chinese, Vietnamese, and Arabic speaking communities.

Table 5: Top Ten Emerging Communities

| Darebin | 2001 | % ∇ 96-01 | Whittlesea | 2001 | % ∇ 96 - 01 | Yarra | 2001 | % ∇ 96 - 01 |
|----------------------------|---------------|--------------|----------------------------|---------------|----------------|----------------------------|---------------|----------------|
| IRAQ | 519 | 8% | YUGOSLAVIA, F. R | 624 | 391% | MALAYSIA | 451 | 9% |
| BOSNIA &HERZ. | 337 | 54% | IRAQ | 502 | 356% | INDIA | 317 | 22% |
| SOMALIA | 289 | 66% | BOSNIA AND HERZ. | 298 | 161% | YUGOSLAVIA, F.R. | 267 | 305% |
| PAKISTAN | 170 | 183% | SAMOA | 268 | 121% | JAPAN | 165 | 59% |
| JAPAN | 146 | 66% | PAKISTAN | 97 | 90% | SINGAPORE | 142 | 26% |
| AFGHANISTAN | 106 | 23% | AFGHANISTAN | 82 | 86% | ETHIOPIA | 98 | 78% |
| BANGLADESH | 97 | 194% | KUWAIT | 61 | 97% | PAPUA NEW GUINEA | 79 | 34% |
| ALBANIA | 69 | 53% | G. STRIP & W. BANK | 46 | 100% | KOREA, (SOUTH) | 66 | 32% |
| KUWAIT | 55 | 104% | SOMALIA | 38 | 171% | SOMALIA | 58 | 57% |
| SUDAN | 39 | 50% | SAUDI ARABIA | 30 | 233% | IRAN | 43 | 153% |
| Grand Total | 8,996 | 49% | Grand Total | 7902 | 53% | Grand Total | 7451 | 72% |
| OVERSEAS TOTAL | 41,188 | -2% | OVERSEAS TOTAL | 38203 | 6% | OVERSEAS TOTAL | 19426 | -9% |
| NOT STATED (% of total) | 7169 (17%) | | NOT STATED (% of total) | 5856 (15%) | | NOT STATED (% of total) | 5765 (30%) | |

Source: ABS Census 2001

The Countries of origin with the highest increase in the rate of new arrivals between 1996 and 2001 were:
 Darebin – Bangladesh, Pakistan, and Kuwait
 Whittlesea – Federated Republic of Yugoslavia, Iraq, and Saudi Arabia
 Yarra - Federated Republic of Yugoslavia, Iran and Japan

Summary of key health issues arising out of the migrant and refugee profile of the catchment:

New arrivals

- Lack of understanding about the Australian health system, used to a different system, for example used to accessing specialists directly
- Language difficulties for some communities
- Health standards in the country of origin – may not have had same access to GP services, screening, health information and health education
- Cultural differences in understanding of health and the role of the service system

Established communities

- Language difficulties persist for some communities long after arrival in Australia
- Some communities have low levels of literacy in their preferred language
- Cultural differences in understanding of health and the role of the service system

Refugees and Asylum seekers

There are communities of predominately Afghani and Iraqi asylum seekers with Temporary Protection Visas (TPV) residing in the NCMPCP catchment. TPVs last for up to five years and are starting to come up for renewal. People with TPVs are eligible for income support (excluding pensions or Newstart allowance), Medicare benefits, referral to the early health assessment and intervention program and trauma and torture counseling. They are not eligible for English language classes or Commonwealth funded settlement services and are not permitted to bring their family to Australia. These restrictions, along with uncertainty about long term immigration status, impact on the mental and physical health of people with TPVs as feelings of powerlessness, not speaking English and social isolation are established mental health risk factors.

Member agencies are actively involved in networks and activities to support these communities.

Refugees arriving in Australia are eligible for settlement services, English language classes and Medicare benefits however Australia does not provide on-arrival health screening for refugees who may be in poor health or have undiagnosed or untreated health conditions.

Aboriginal and Torres Strait Islander community and service profile

17.4% of Melbourne’s population who identified as indigenous in the 2001 Census lives in the NCMPCP catchment. This represents 8.33% of Victoria’s indigenous population as estimated in the 2001 Census.

Table 6: Indigenous Population 1986 to 2001 and as a % of total population

| | 1986 | | 1991 | | 1996 | | 2001 | | % increase 1991- 2001 |
|------------|-------|-----|-------|-----|-------|-----|-------|-----|--------------------------|
| | No. | % | No. | % | No. | % | No. | % | |
| Darebin | 868 | 0.7 | 891 | 0.7 | 1,135 | 0.9 | 1,202 | 0.9 | 34.9 |
| Whittlesea | 180 | 0.2 | 283 | 0.3 | 512 | 0.5 | 763 | 0.6 | 169.6 |
| Yarra | 314 | 0.5 | 285 | 0.4 | 307 | 0.5 | 362 | 0.5 | 27.0 |
| PCP | 1,362 | 0.5 | 1,459 | 0.5 | 1,954 | 0.7 | 2,327 | 0.7 | 59.5 |

Source: Australian Bureau of Statistics 2001 Census of Population and Housing: Aboriginal and Torres Strait Islander People: Victoria, Appendix 1

Darebin has the highest proportion and Whittlesea the third highest proportion of indigenous people in metropolitan Melbourne local government areas. The Aboriginal population in Yarra has remained relatively constant compared to Darebin and particularly Whittlesea where the proportion of people identifying as Aboriginal has tripled over the past 15 years.

Table 7: Indigenous Population age distribution 45 years and over

| | 45-49 | 50-54 | 55-59 | 60-64 | 65-69 | 70-74 | 75-79 | 80-84 | 85+ | Total |
|------------|-------|-------|-------|-------|-------|-------|-------|-------|-----|-------|
| Darebin | 52 | 41 | 28 | 18 | 12 | 8 | 5 | 7 | 3 | 174 |
| Whittlesea | 36 | 15 | 16 | 8 | 5 | 3 | 2 | 0 | 0 | 85 |
| Yarra | 17 | 17 | 9 | 12 | 5 | 4 | 1 | 1 | 1 | 62 |
| NCMPCP | | | | | | | | | | |
| NMR | 200 | 134 | 96 | 61 | 42 | 27 | 20 | 17 | 10 | 607 |

Source: Australian Bureau of Statistics 2001 Census of Population and Housing: Aboriginal and Torres Strait Islander People: Victoria

Key issues arising from aboriginal population profile

Aboriginal and Torres Strait Islander [ATSI] people have the worst health status of all Australians. ATSI people are the sickest, the poorest, the most imprisoned, the highest unemployed and the most studied group in Australia. The health of ATSI people has got worse to the point that life expectancy of ATSI people is 20 years less than non-ATSI people. ATSI people die much younger, are hospitalised more and suffer more complex health problems during their shorter life span than non-ATSI people.

This is reinforced with the history of colonisation, which has very much impacted on health and social issues affecting Aboriginal people. For ATSI people, colonisation has a profound and generally sustained wholistic disadvantage. Therefore most ATSI people are not in control of their lives and are very much conditioned from the turbulent history and dispossession which underpins poor health – both physical and mental. All of this influences the level of connection with mainstream society. Disempowerment is overwhelming. Expressing identity and culture is isolated and limited and yet this is very vital to the health and well being of ATSI people.

The biggest killer of ATSI people is cardiovascular disease, which relates predominantly to diet related illness. Cardiovascular disease is the major cause of ATSI death for the 30+ age group. ATSI people have a high prevalence of cardiovascular risk factors, which include high blood pressure, obesity, smoking, excessive alcohol intake and diets high in salt, fat and sugar. Included with this is excessive use of drugs and alcohol, frequent contact with the justice and social welfare system.

Issues in the Northern region

According to the ABS 2001, an ‘experimental estimate’ of the ATSI population there was 27,928 persons of ATSI origin in Victoria. Of this, 52% live in rural regions whilst 48% live in the metropolitan areas. In the metro regions Eastern has 2,459 ATSI, Western has 2,558 ATSI, Southern has 4,094 and Northern being the largest number at 4,283 ATSI. These statistics would be very inaccurate given that a large number of ATSI people would not have identified at census and the fact that a very large transit ATSI population exists. The age profile of ATSI people in Victoria is very different to that of non-ATSI people. Whereas 10% of the non- ATSI population is over 70 years of age, only 2% of the ATSI population is this age or above. The proportion of young people [under 20 years] is much higher in the ATSI community – 49% as against 27% for non-ATSI people.

The ATSI community in the Northern suburbs has become a very culturally diverse group, and is made up of many ATSI people from different regions of Australia. There has been a distinct drive towards outer suburbs where public and Aboriginal housing has been purchased due to price factors. Suburbs such as Whittlesea, Broadmeadows, Craigieburn and Epping have large numbers of ATSI people living in these areas. Included with this is a large number of ATSI people who travel into the city suburbs from the rural regions to stay with family and access services that they might not be able to access in their home towns. A large ATSI prisoner release program also operates in a lot of these suburbs which adds also to ATSI numbers.

ATSI people struggle for acceptance and recognition in this highly multicultural setting. The lack of acceptance is also conditioned by a lack of knowledge of ATSI issues by newly arrived multicultural groups. In saying this, ATSI people have a lot to offer in terms of culture, spirituality and connection to land which a lot of Australians can embrace in terms of an Australian identity.

(Text provided by Daryl Naylor, Aboriginal Liaison Officer, Northern Health, and Northern/North East Divisions of General Practice)

SERVICE PROFILE

Primary Care Services

The Partnership has identified that the publicly funded health and community services are the component parts of the primary care service system relevant to the socially disadvantaged.

The key services in the system include the **community based General Practitioner**, particularly the bulk billing or low co-payment GP

Table 8: General Practitioner Workforce Characteristics

| LGA | Est. 2001 population * | No. GP | | % of GP (97-99) | | F_W_E | | | |
|-----------------|------------------------|----------------|-------------------------|-----------------|-------------|----------------|-----------------------------|-----------------------------|---------------|
| | | 98-99 | % change 97-98 to 98-99 | Male | Female | FWE 98-99 | FWE % change 97-98 to 98-99 | FWE GPs per 1,000 residents | FWE: GP 98-99 |
| Darebin | 128,402 | 155.1 | -8.0% | 73.3 | 26.7 | 131.7 | 2.7% | 1.03 | 0.85 |
| Whittlesea | 118,292 | 91.9 | 3.3% | 86.3 | 13.7 | 91.8 | -0.9% | 0.78 | 1.00 |
| Yarra | 69,564 | 242.3 | -6.5% | 67.1 | 32.9 | 97.0 | -3.4% | 1.39 | 0.40 |
| NCMPCP | 316,258 | 489.3 | -5.3% | | | 320.5 | -0.3% | 1.01 | 0.66 |
| NMR | 769,360 | 1014.7 | -5.5% | 75.2 | 24.8 | 702.8 | -1.1% | 0.91 | 0.69 |
| Metro | 3,489,334 | 4,423.8 | -1.7% | 75.3 | 24.7 | 3,072.3 | 0.5% | 0.88 | 0.69 |
| Rural | 1,333,230 | 1,378.3 | 2.6% | 82.8 | 17.2 | 879.5 | 0.7% | 0.66 | 0.64 |
| Victoria | 4,822,663 | 5,802.1 | -0.7% | 77.0 | 23.0 | 3,951.8 | 0.5% | 0.82 | 0.68 |

Data Sources:

HealthWIZ for General Practice 5.1 (GPW4 and GPW7) Reference Period 1997 – 1999 ABS Census
2001 Estimated resident population

Please note that the total figures from Victoria GP divisions are different from the Victoria LGAs due to different boundaries.

FWE: Full-time Workload Equivalents, FWE is calculated for each doctor by dividing the doctor's Medicare billing (schedule fee value of claims processed by the HIC during the reference period) by the mean billing of full-time doctors.

This table shows that across the NCMPCP catchment the number of GPs in 1998- 1999 decreased by 5 percent compared to the previous year, however, the decrease in full time workload equivalents (FWE) was marginal (0.3%).

The ratio of GP FWE per 1,000 residents was above the regional and state ratio in Darebin and Yarra however Whittlesea had notably fewer GP FWE per 1,000 people (0.78) than the rest of the catchment.

The gender mix and ratio of GPs to FWE illustrates differences in GP workforces in the three LGAs. General Practitioners in Whittlesea are more likely to be male (only 14% were female) and to work full time, as the 92 GPs in the area worked a total of 92 FWE.

The proportion of female to male GPs is above the state average in Darebin and Yarra where females make up 27% and 33% of the GP workforces.

Between 1997/98 and 1998/99 the number of GPs in Darebin decreased by 8%, however the FWE increased by almost 3 per cent suggesting a reduction in part time work. The ratio of FWE to GPs (0.85) indicates that more GPs work part time than in Whittlesea.

The low ratio of FWE to GPs in Yarra indicates a higher proportion of part time GPs in the workforce in Yarra as compared to the rest of the region and the state.

Medicare Enhanced Primary Care Items

This is a key Commonwealth incentive to encourage the engagement of GPs in care planning , referral and care coordination practice. Lower levels of uptake of EPC items imply lower levels of GP involvement in care planning and care coordination.

Table 9: Uptake of Medicare Enhanced Primary Care Items 1.7.01 – 30.6.02

| Division | Total providers | Estimated take up |
|-----------------|------------------------|--------------------------|
| NDGP | 199 | 53% |
| Melb | 293 | 40% |
| Vic | 4,368 | 63% |
| Aust | 17,640 | 62% |

Source: Dept Health and Aging, GP Branch

Most GPs in the NCMPCP catchment are members of either the Northern or Melbourne Divisions of General Practice. The Northern Division encompasses Darebin and Whittlesea, Yarra is covered by the Melbourne Division however it is important to note that GPs choose which Division they join and are not limited by geographic boundaries. It is not possible (from this information) to calculate the proportion of the population benefiting from the uptake of EPC items in each LGA because of differences in boundaries.

The table above shows that the estimated take-up of EPC items is lower amongst GPs in the Melbourne and Northern Divisions than the state and national averages.

Anecdotal evidence is that a significant barrier to the uptake of EPC items is the time required to provide care planning and care coordination services, this is particularly evident in areas where there is an undersupply of practitioners.

Northern Division of General Practice

The Northern Division of General Practice (NDGP) is an active participant in primary care policy and strategy development in the catchment. The NCMPCP has strengthened its relationship with the Division's project staff through co-locating the NCMPCP Project Team with the NDGP.

The NDGP has led with Aboriginal Health Services in the development of an Aboriginal Services Directory and the employment of an Aboriginal Liaison Officer to improve access for Aboriginal people to GPs in the community. The Division is an accredited training provider and can develop incentives for GPs to be engaged in practice improvement initiatives. Project staff have portfolio areas in relation to disease types, eg diabetes, asthma, mental health, as well as an information technology officer, a pharmacy liaison officer, health promotion officers, and general executive staff. The NDGP leads an asthma HARP initiative funded in 2002 with Northern Health, and a community management of diabetes HARP initiative funded in 2003. The NDGP is represented on the HARP governance groups of Northern Health, Austin Health and St Vincent' Health.

Community Health Services

There are four mainstream Community Health Services in the catchment:

- **North Yarra Community Health Service** which employs 10 GPs, runs a bulk billing General Practice, manages a Primary Health Care facility for Injecting Drug Users, houses the Primary Mental Health Early Intervention Team, provides Allied Health, Psychiatric Disability Support Services, and a broad range of health promotion initiatives particularly targeted to the needs of the public housing and transient housing populations of the City of Yarra.
- **North Richmond Community Health Service** which auspices, amongst other initiatives, the Centre for Ethnicity and Health, Inner Melbourne Post Acute Care and the Peer led Self Management of Chronic Disease Project, is a base for bulk billing General Practice in the Richmond public housing estate, and provides a range of culturally appropriate health promotion, allied health, Psychiatric Disability Support, and drug and alcohol support services to the local community.
- **Darebin Community Health Service** which provides community health services to the Darebin community including a bulk billing General Practice, allied health, is a base for the Northern Area Mental Health Service Primary Mental Health Early Intervention Team, and a range of health promotion programs and initiatives particularly targeted to socially disadvantaged groups in the community. Darebin Community Health Service leads a HARP chronic disease management in the community initiative to commence in 2003 with Northern Health, and is a partner in HARP initiatives with St Vincent's Health and Austin health targeted to people with chronic and complex conditions in the local community.
- **Plenty Valley Community Health Service** is located in Whittlesea with the main site co-located with Northern Hospital and the Northern Area Community Mental Health Services, is a base for the Northern Area Mental Health Service Primary Mental Health Early Intervention, and provides a range of allied health and health promotion programs to people in the City of Whittlesea. Plenty Valley Community Health Service leads a HARP mental health initiative funded in 2002 with Northern Health – the Northern Alliance Suicide and Self Harm Prevention Project.

The following service utilisation data serves as an activity report for Community Health in the catchment, indicating what the funded service levels are, rather than what the demand or need in the catchment for such services.

Table 10: Community Health Service Utilisation

| Service types | 2001-2002 | | | |
|------------------------|----------------|------------------|---------------|------------------|
| | Contacts N | Contact Hours | Sessions N | Session Hours |
| Audiology | 2,973 | 2,336 | 6 | 8 |
| Counselling / Casework | 46,682 | 34,538 | 534 | 1,273 |
| Dietetics | 4,835 | 3,754 | 157 | 308 |
| Health Promotion | 41,343 | 20,034 | 5,126 | 11,345 |
| Nursing | 31,717 | 16,462 | 479 | 1,332 |
| Occupational Therapy | 8,170 | 5,267 | 170 | 349 |
| Physiotherapy | 29,193 | 16,465 | 1,182 | 1,773 |
| Podiatry | 22,573 | 13,359 | 155 | 213 |
| Speech Pathology | 11,599 | 8,431 | 157 | 324 |
| Total | 199,085 | 120,646 | 7,966 | 16,924 |

Anecdotal reports from Post Acute Care Services in the catchment suggest there is a gross undersupply of Allied Health Services in Community Health, particularly in the following areas:

- Occupational Therapy
- Physiotherapy
- Podiatry
- Nursing

Brokerage models have not proved effective in gaining rapid response Allied Health Services in a Community Health Service setting.

Local Government

There are three Councils in the NCMPCP – Yarra, Darebin and Whittlesea.

All three Councils are active in providing leadership and resources to collaborative planning processes, particularly municipal public health planning, and have all been engaged in local service coordination improvement projects through the PCP Strategy over the last 18 months.

All three Councils are key providers of Home and Community Care Services.

The City of Whittlesea has identified a key issue as being the lack of services in Whittlesea and an urgent need to increase service levels and service types in the municipality.

The City of Darebin has identified in its recent Aged and Disability Services Strategy a ceiling for its investment in Home and Community Care Services that presently amounts to a substantial \$10 million per annum.

A key issue for this Council is the growing number of clients in the Home and Community Care system that require long term high level use of home and community care services. Many will enter the service system with a lower level of need, but their needs will increase over time as they age and/or their illness or condition worsens without the capacity within the system to respond to those increasing needs.

The data concerning use of hospitals by the population of Darebin and the estimates of the numbers of people with complex conditions who are high level users of health services including hospitals provides some idea of the scope of the issue for the primary care and acute service systems relating to Darebin.

Another key issue for Darebin is the high number of service providers involved in the provision of CACPs and Linkages packages and the complexity of the present system, and the lack of uniformity in what people on different packages are able to receive.

The City of Darebin and Darebin community health Service have been engaged in a service coordination project to improve Council and Community Health Service intake and referral practices.

The City of Yarra has identified a key local issue as being priority of access to aged care packages and has been engaged in a service coordination improvement project to better manage the waiting list for packages.

Royal District Nursing Service

The Yarra Centre relates to Yarra and Darebin and the Diamond Valley Centre relates to Whittlesea. The RDNS Homeless Persons Service is a community nursing innovation well suited to the transient housing and homeless populations in Yarra and Darebin. RDNS manages the largest community nursing workforce in the catchment and have well developed linkages with hospitals, through RDNS liaison positions, with GPs in the catchment. RDNS nurses are trained in EPC item use but report few referrals from GPs in the catchment for this service- a practice nurse type function.

Specialist services

The catchment is home to many specialist services, small and large. Women's Health in the North, NEAMI (Psychiatric Disability Support Service) and Migrant Resource Centre North East are members of the NCMPCP Project Management group.

Acute Health Services

The three major public hospitals used by residents in the NCMPCP catchment are Northern Health, St Vincent's Hospital and Austin Health. The Repatriation campus of Austin Health specializes in the health needs of veterans and Bundoora Extended Care Centre, a Northern Health service has an aged care focus.

The NCMPCP is a member of the Northern Health and St Vincent's Health HARP Governance structures, and Northern Health is represented in the NCMPCP Project Management Group.

The following table shows the number of admissions to these hospitals over the three years to June 2001.

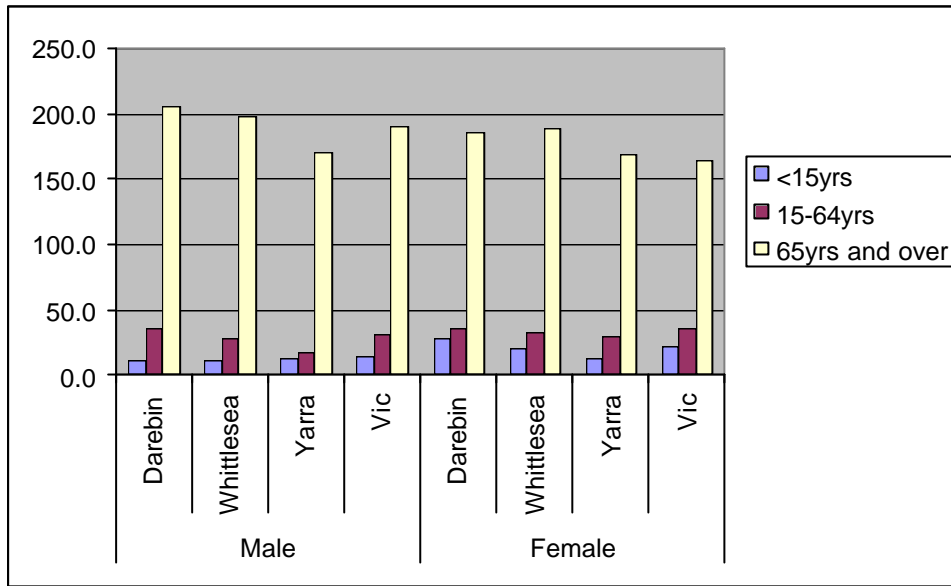
Table 11: Number of separations by hospital 1999 to 2001

| | Northern Epping | | St Vincent's* | | Austin Heidelberg | | Austin Repat* | | BECC* | |
|---------|-----------------|---------------|---------------|---------------|-------------------|---------------|---------------|---------------|--------|---------------|
| | Number | Annual change | Number | Annual change | Number | Annual change | Number | Annual change | Number | Annual change |
| 1999-00 | 5062 | | 9862 | | 13956 | | 262 | | 42 | |
| 2000-01 | 5451 | 7.7% | 10633 | 7.8% | 13237 | -5.2% | 287 | 9.5% | 46 | 9.5% |
| 2001-02 | 6058 | 11.1% | 10754 | 1.1% | 15133 | 14.3% | 317 | 10.5% | 41 | -10.9% |

* No children under 15

Data Source: Victorian Admitted Episode Dataset (VAED), Metropolitan Health and Aged Care Services, Department of Human Services.

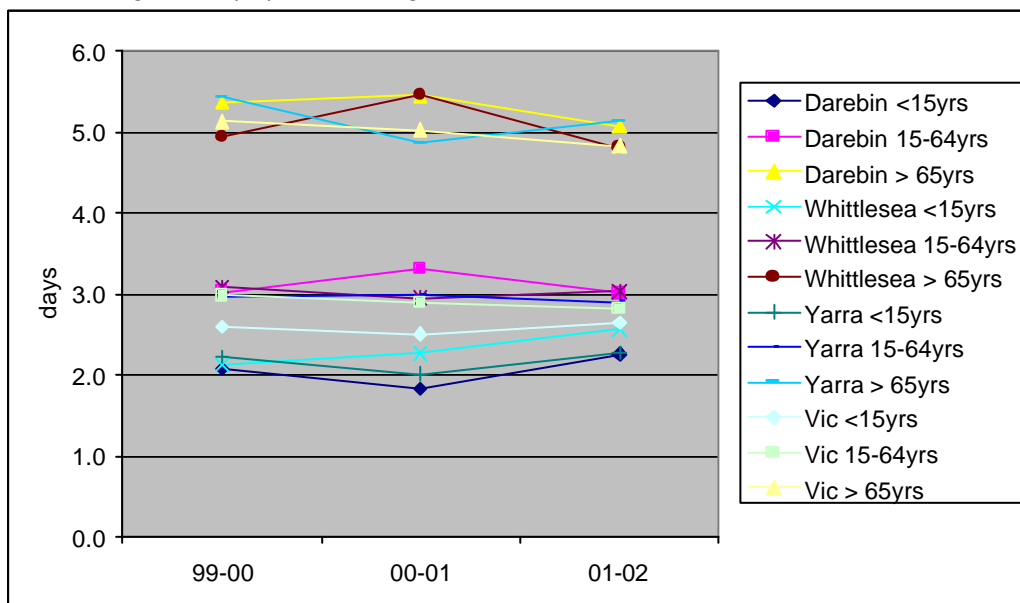
Chart 6: Separation rate per 1,000 population by age, gender and LGA



Data Sources: Victorian Admitted Episode Dataset (VAED), Metropolitan Health and Aged Care Services, Department of Human Services.
 Estimated Resident Population, ABS. Data reference period: 2001.

The chart above shows that both men and women in Darebin and Whittlesea aged 65 years and over had higher than the state average number of hospitalizations per 1,000 people while Yarra was below the state average for both men and women in this age group

Chart 7: Length of Stay by LGA and Age 1999 to 2001



Data Source: Victorian Admitted Episode Dataset (VAED), Metropolitan Health and Aged Care Services, Department of Human Services.

Hospital admissions

Hospital admission data was analysed to inform the HARP working party report on integrated care for clients with complex needs. Complex patients were defined as those having 4 or more emergency hospital admissions in any financial year between June 1999 and July 2002, admissions included same and multi day stays.

This analysis reported on the number of complex needs patients as defined above by postcode areas for each area with over 101 complex needs patients. This research provides information on the location of people with complex needs but does not indicate relative prevalence, as the populations of different postcode areas have not been taken into account.

Table 12: Postcodes with over 100 people with chronic disease*

| Postcode | Suburb | Number of Patients | Ranking in top 100 in Victoria |
|----------------------|--------------|--------------------|--------------------------------|
| DAREBIN | | | |
| 3073 | Reservoir | 402 | 3rd |
| 3072 | Preston | 231 | 13th |
| 3070 | Northcote | 142 | 35th |
| 3071 | Thornbury | 127 | 46th |
| Total | | 902 | |
| WHITTLESEA | | | |
| 3074 | Thomastown | 124 | 50 |
| 3083 | Bundoora | 103 | 79 |
| 3075 | Lalor | 117 | 59 |
| Total | | 334 | |
| YARRA | | | |
| 3121 | Richmond | 119 | 57 |
| 3065 | Fitzroy | 113 | 63 |
| 3068 | Clifton Hill | 108 | 69 |
| Total | | 340 | |
| NCMPCP TOTAL* | | 1576** | |

*Chronic disease = 4 or more emergency hospital admissions in any financial year between June 1999 and July 2002

The total figure of 1576 is less than the total number of people with complex needs in the NCMPCP catchment as postcodes with less than 100 patients meeting the definition of complex needs are not included.

Ambulatory Care Sensitive Conditions

Ambulatory Care Sensitive Conditions (ACSC) are health conditions that, with preventative care and early disease management, are thought to be manageable without hospitalisation. The Victorian Ambulatory Care Sensitive Conditions Study (DHS 2002) analysed hospital admissions data for ACSCs over a seven year period to 2000/2001. The most important factor determining the rate of ACSCs is the level of socio-economic barriers to care. (Comment by Z Ansari at NMR forum.)

Acute ACSCs refers to acute conditions that theoretically do not result in hospitalisation if adequate and timely primary care is received. Acute conditions may not be preventable and the objectives of primary care interventions are to reduce morbidity and pain through timely and appropriate treatment.

Chronic ACSCs refers to chronic conditions that can be managed effectively through primary care to prevent deterioration and hospitalisation. They include diseases for which hospitalisation is avoidable such as diabetes, asthma, angina, hypertension, chronic obstructive pulmonary disease and congestive heart failure. Some chronic ACSCs are preventable through behaviour modification and lifestyle change. The ACSC study makes the point that “An advanced stage of a chronic disease requiring hospitalisation may indicate the existence of one or more access barriers to personal health care services.” (p8)

The study reported that in the NCMPCP catchment:

- Admission rates for chronic ACSCs increased over the four years to June 2001
- There was no significant change in admission rates for acute ACSCs over the 7 years
- Chronic ACSCs were the top five causes of admissions in 2000/01
- Diabetes complications by far accounted for the majority of bed days for ACSCs
- The total bed days for diabetes complications was higher than the sum of total bed days for the nine next highest causes of ACSC hospitalisation.
- Average bed days for the top 10 ACSCs were 5.56 days and the average co-morbidity score was 1.1
- Hospital expenditure in 2000/01 for ACSC = \$28.2 million
- NCMPCP admission rate ratios (per 1,000 people) were significantly higher than the Victorian average rates for diabetes complications and congestive cardiac failure in 2000/01.

Table 13: Admissions for ACSC between July 97 and June 2001 from the NCMPCP catchment

| | Number of admissions | Per 1000 pop | Ave bed days | Total bed days | Average co - morbidity |
|---------------------------------|----------------------|--------------|--------------|----------------|------------------------|
| Diabetes complications | 3052 | 10.60 | 7.57 | 23105 | 1.77 |
| Angina | 876 | 3.05 | 3.10 | 2717 | 0.49 |
| COPD | 780 | 2.74 | 7.80 | 6082 | 1.46 |
| Congestive Cardiac failure | 766 | 2.72 | 6.85 | 5249 | 2.00 |
| Asthma | 632 | 2.16 | 2.62 | 1657 | 1.09 |
| Dehydration and gastroenteritis | 609 | 1.96 | 3.25 | 1978 | 0.47 |
| Convulsions & epilepsy | 410 | 1.33 | 3.64 | 1494 | 0.28 |
| Cellulitis | 382 | 1.29 | 5.56 | 2123 | 0.36 |
| Dental conditions | 367 | 1.21 | 1.27 | 467 | 0.09 |
| Ear, Nose & throat infections | 276 | 0.94 | 1.61 | 443 | 0.09 |

The increase in admissions for chronic ACSCs indicates a need to grow the capacity of the primary care service system to provide early intervention and integrated disease management in the NCMPCP catchment.

Cultural and Linguistic Diversity in Hospital Presentations

Table 14: Emergency Department Presentations – CALD characteristics

| Hospital | Total ED presentations | Australian born | Born in NES country | Preference for English | Preference for LOTE | | |
|--------------|------------------------|-----------------|---------------------|------------------------|---------------------|-------|-----|
| | | # | % | # | % | | |
| Austin | 35,606 | 25,233 | 7,649 | 21.6 | 33,054 | 2,342 | 6.6 |
| St Vincent's | 30,465 | 18,155 | 9,301 | 30.5 | * | 2,597 | 8.5 |
| Northern | 42,198 | 26,942 | 12,153 | 28.8 | 28,361 | 3,154 | 7.5 |

Data Source: VEMD as reported in Totikidis (no year)

Data Period: 2001/2002 financial year

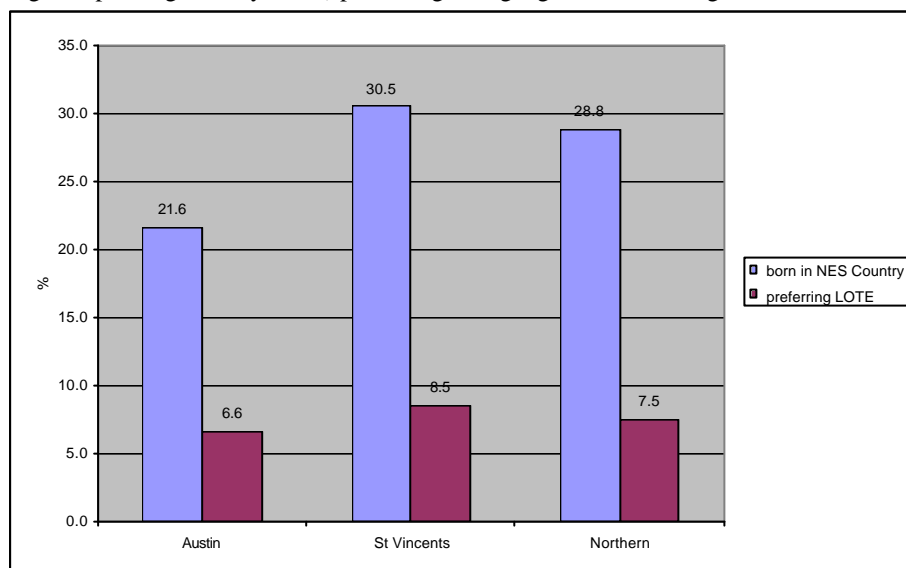
* 25,753 people at St Vincent's were recorded as not stating their language preference

NCMPCP Community Health Plan 2003 – 2004

The proportion of people attending emergency departments at the three main hospitals related to the NCMPCP catchment who were born overseas was 29% at the Austin, 36% at Northern Hospital and 40% at St Vincent's Hospital.

Northern Hospital's emergency department had the largest number of people presenting who preferred a language other than English (and also the busiest Emergency Department) while the proportion of people preferring a language other than English was highest at St Vincent's as shown in the following chart.

Chart 8: Percentage of Emergency Department Presentations in the 2001/2002 financial year a) born in a non English speaking country and b) preferring a language other than English



Data Source: VEMD as reported in Totikidis (no year)

Data Period: 2001/2002 financial year

The table below shows the most common countries of birth of people hospitalized at the three hospitals.

Table 15: Top Ten Countries of Birth of people from non English speaking countries – Hospital separations 2001/02

| Northern | | | St Vincent's | | | Austin | | |
|------------------|-----|------|------------------|------|------|---------------|------|-----|
| Country | No. | % | Country | No. | % | Country | No. | % |
| Italy | 760 | 13.0 | Italy | 1061 | 10.7 | Italy | 1235 | 8.4 |
| Greece | 332 | 5.7 | Greece | 576 | 5.8 | Greece | 823 | 5.6 |
| FYR of Macedonia | 206 | 3.5 | Lebanon | 129 | 1.3 | FYR Macedonia | 168 | 1.1 |
| Turkey | 129 | 2.2 | Viet Nam | 128 | 1.3 | Lebanon | 168 | 1.1 |
| Malta | 108 | 1.8 | Egypt | 113 | 1.1 | Germany | 142 | 1.0 |
| Lebanon | 101 | 1.7 | FYRs of Serbia & | | | China (ex | | |
| Cyprus | 60 | 1.0 | Montenegro | 103 | 1.0 | Taiwan) | 134 | 0.9 |
| Egypt | 54 | 0.9 | Malta | 101 | 1.0 | Croatia | 129 | 0.9 |
| Iraq | 50 | 0.9 | Turkey | 98 | 1.0 | Malta | 123 | 0.8 |
| Croatia | 49 | 0.8 | Germany | 96 | 1.0 | Poland | 100 | 0.7 |
| | | | Netherlands | 95 | 1.0 | Egypt | 77 | 0.5 |

Data Source: VEMD Data Period: 2001/2002 financial year

% = Percentage of total separations

Aboriginal use of health services

The reality of lower ATSI population statistics, and a noted under utilisation of mainstream primary health services by ATSI people, means that ATSI needs and aspirations find little voice in mainstream health planning and resource allocation. Barriers to access to mainstream primary care services include:

- Lack of awareness within mainstream health services of the needs and aspirations of ATSI people
- Lack of cultural relevance of programs and approaches
- Physical presentation of services – do ATSI people congregate here? Are we included in the life of the organisation as health care providers? As community leaders? As patients?

The key approach to addressing the poor health status of ATSI people is investing in a robust Aboriginal controlled health services system providing a comprehensive range of culturally relevant programs. Locally that system is under resourced and under developed to either address the key risk factors to prevent the development of disease and illness in the ATSI community or to ensure ATSI people with chronic and/or complex care conditions have access to “*the right care at the right time in the right place*” across the continuum of care needed to optimally manage their condition.

ATSI entitlement to Aboriginal controlled health services shouldn’t mitigate against ATSI entitlement to the same range of health interventions and the same standards of care enjoyed by the rest of the community. To achieve this there needs to be a process of change in mainstream health service provision to be more accessible and relevant to ATSI people, as well as increased investment in Aboriginal controlled health services so there is the capacity to provide a timely culturally relevant primary health care services.

To manage ATSI health effectively there needs to be more early screening, vigorous control of blood pressure and lifestyle counselling. A new approach needs to be visited in dealing with ATSI people. That is a new model of lifestyle mentoring / coaching where on a day to day basis ATSI people are encouraged to help themselves by using their local GP or going to a community health service –not in crisis mode – but in a preventative mode.

There needs to be the pathways for ATSI people from hospital care to relevant community based care where the capacity to optimally manage chronic and complex conditions is enhanced, preventing exacerbations and extending quality of life for many. *(Text provided by Daryl Naylor, Aboriginal Liaison Officer, Northern Health and Northern and North East Valley Divisions of General Practice)*

There were no statistics available for this report on ATSI use of hospitals across the catchment.

Summary of key health issues arising from the service profile and service utilisation data reported:

- Socio economic disadvantage is the key determinant of poor health status and higher use of health care services including hospitals and accounts for variations within and across the catchment in use of health care services
- Service levels do not keep up with demand in the community care sector for the following:
 - bulk billing General Practitioners
 - GPs utilising EPC items
 - Allied health in community health services, particularly OT, Physiotherapy, podiatry, nursing, and counselling services
 - Home and community care services through local government and RDNS
- There is a need to develop care systems that are responsive to increasing dependency with age or degeneration in health conditions
- There is a need to develop care systems and health promotion initiatives that are responsive to the cultural and linguistic diversity in the catchment

- There is a need to develop care systems and health promotion initiatives that are responsive to the ATSI community.

NCMPCP strategies for addressing population health issues

In setting goals and objectives for 2003/4 NCMPCP has been mindful of the reduced level of resources for the coming year and the need for a degree of flexibility in a dynamic environment. In 2003/2004 NCMPCP will continue to build on the work of previous years and will also undertake new activities to address key health issues for priority population groups as outlined in the following strategies.

In 2003/4 NCMPCP will continue activities, health promotion, service coordination and planning with the aim of improving health outcomes for the key population groups with an emphasis on preventing and minimizing the impact of chronic disease and mental health.

Recognising the impact of social inequities as determinants of health NCMPCP has also prioritised community building as a key well being need for these population groups.

The three strategic foci of NCMPCP in 2003/4 are:

- Community building;
- Reducing the impact of Chronic Disease and
- Promoting Mental Health.

Factors that have determined the priorities for action by NCMPCP are:

- Key health issues
- Community profile – level of social inequity
- Improving equity of access to health services
- Current level of knowledge
- Aiming for sustainable system development
- Drivers for change – HARP
- Capacity of member agencies and PCP project team
- Community capacity

Strategy One: Community Building

Community and service profile related to community building

- As discussed in the previous section the population of the NCMPCP catchment is culturally diverse, has areas with high levels socio-economic disadvantage and relatively high proportions of Aboriginal people who, as a group, have the poorest health status in the community. The population also has correspondingly high levels of prevalent mental health disorders and preventable chronic disease.

Good Practice models

The National Resource Centre for Consumer Participation in Health outlines examples of good practice for consumer participation, they include:

- Mechanisms for involving consumers at the establishment stage and at every stage in the development and evaluation of services
- Senior management and policy support for consumer participation
- Adequate resourcing and a defined budget, payment to consumers for involvement
- Consumer advocates employed by health services to focus on structural and cultural reforms
- Consumer representatives establishing processes for tapping into community views
- Long term strategic planning to involve consumers in health services planning and evaluation

Evidence base

The VicHealth “Together we do better” campaign has compiled an evidence base demonstrating that poor social relationships and a lack of community participation are strongly associated with poor psychological and physical health outcomes. The National Heart Foundation has reported that depression, social isolation and a lack of social support are significant risk factors for heart disease that are independent of, and of similar magnitude to, commonly acknowledged risk factors such as smoking, high cholesterol and hypertension.

The Victorian Population Health Survey 2001 (2002) found that people involved in fewer social networks were less likely to feel valued by society, were less tolerant of diversity in the places where they live and were more likely to not enjoy living among people of different lifestyles. Civic participation is very powerfully linked to wellbeing and has a greater impact on wellbeing than participation in sport or recreation activities. People involved in volunteer activities had higher levels of wellbeing than other workers.

As stated in the PCP Draft Health Promotion Guidelines:

“The most disadvantaged groups have the poorest health and the highest exposure to health-damaging risk factors” and, “Social capital is a key indicator of the building of healthy communities through mutually beneficial interaction and accomplishments, particularly those demonstrated by social and civic participation. Recent research has linked these types of activity to improved health outcomes.” (p17)

Relevant action already happening

- Community Health and Local Government in NCMPCP catchment have a variety of community consultation and participation mechanisms to monitor service quality and consumer/community satisfaction
- Councils and Community Health Centres in Yarra and Darebin are involved in significant community building projects in public housing estates
- Council and Community Health Centres in all LGAs have consumer participation mechanisms to inform planning.

NCMPCP Community Building Activities in 2003/3

The Strengthening Community Action project is an outcome of community participation in setting the priorities of NCMPCP. The idea for the project was generated and developed by the Consumer Carer Participation Advisory Committee, a committee of equal numbers of service providers and community advocates. The project is actively supported by NCMPCP member agencies and builds capacity for community participation at an agency as well as PCP level. Strengthening Community Action is the major health promotion activity for NCMPCP in 2003/4. The second intervention in the community building strategy builds on the outcomes of the Strengthening Community Action project by creating sustainable mechanisms for community participation in primary care planning.

The program logic for this new strategic focus is illustrated in Diagram one on the following page.

Goal Building social capital to improve the health of the most disadvantaged groups

Objective 1: Community members and health professionals have an enhanced capacity to support community involvement.

Objective 2: Members of the most disadvantaged communities have greater opportunities for social and civic participation.

Objective 3: Communities have sustainable mechanisms to participate in setting the health promotion priorities of the primary care system.

Population Target Groups:

Population target groups for this strategy are Aboriginal people, people from diverse cultural and linguistic backgrounds and socially disadvantaged people.

Mix of Interventions

1 Strengthening Community Action project

Providing training in action research, leadership and advocacy to community leaders and primary care service staff

2 Community collaboration in primary care planning

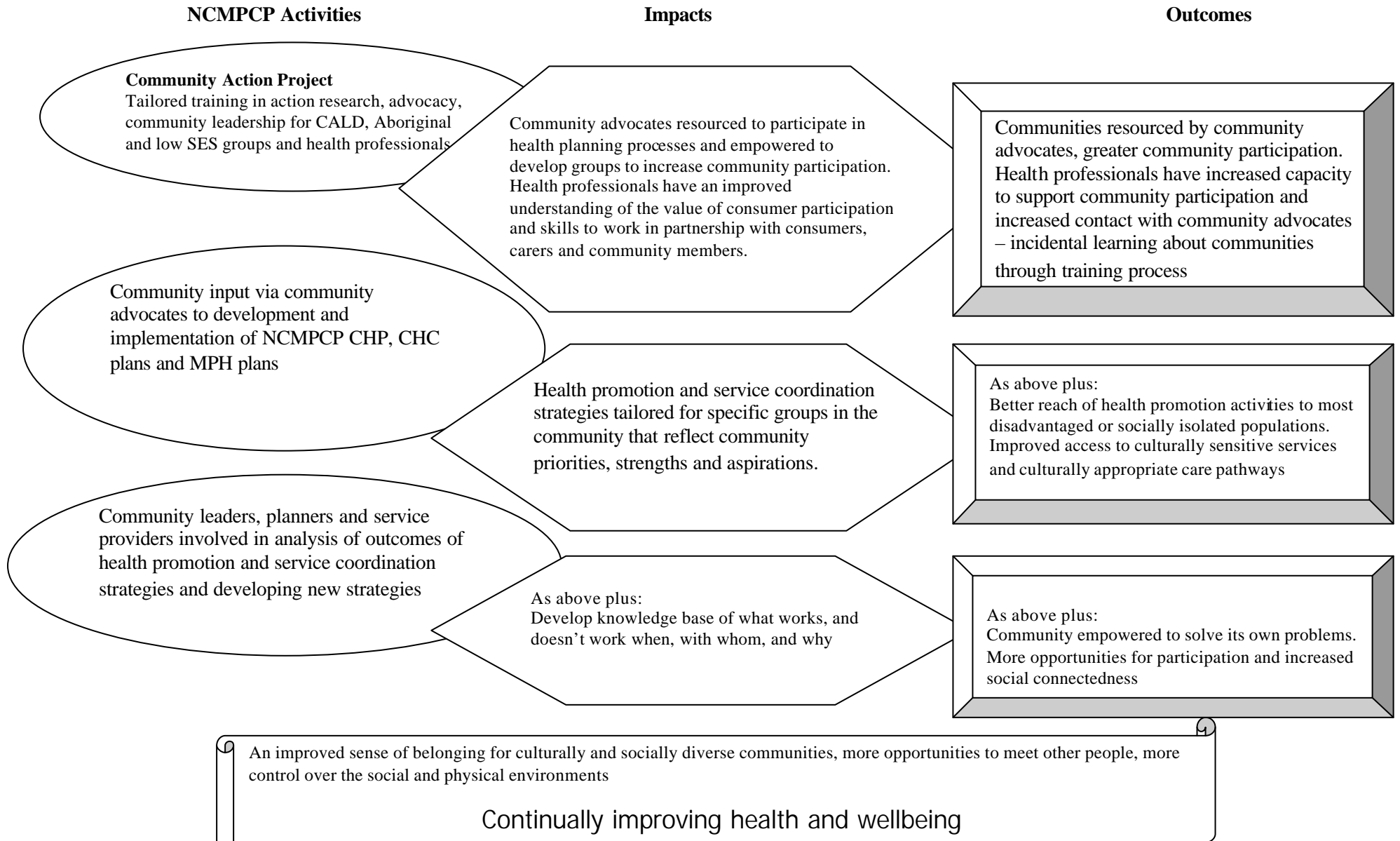
Develop collaborations between consumer advocates, Municipal Public Health Planners and Community Health Centre Health Promotion planners with the aim of optimizing integration of Community Health Centre Health Promotion Plans and Municipal Public Health Plans (MPHP).

Linking Community Grant Scheme priorities with MPHP priorities.

Broker and facilitate collaborative health promotion funding applications in line with MPHP priorities

Explore approaches based on the collaborative breakthrough model to support this intervention.

Diagram 1: **Community Building** - Strengthening Community Action and Integrated Health Promotion Planning – Integrated Program Logic



Strategy Two: Reducing the impact of Chronic Disease

Community and service profile relating to chronic disease

As discussed in the Community and Services Profile the top five ambulatory care sensitive conditions in people hospitalized in the four years to June 2001 were: Diabetes complications, Angina, Chronic Obstructive Pulmonary Disease, Congestive Cardiac Failure and Asthma. Diabetes complications was by far the largest single reason for presentations to hospital. As previously discussed socio-economic disadvantage is the strongest predictor of the rate of ambulatory care sensitive conditions.

In 2000-2001 hospital expenditure for diabetes complications, cardiac conditions and respiratory conditions in the NCMPCP catchment accounted for \$28.2 million.

Service system issues identified in the NCMPCP catchment in relation to the prevention and management of chronic disease are:

- Cultural differences in access to and use of health services
- Increasing accessibility and affordability of primary health care services including:
 - General practice – bulk billing rates are rapidly declining in the catchment
 - Community Health Services – long waiting lists for some disciplines
 - Publicly funded Home and Community care – again long waiting lists for some services and limits on the level of services that can be provided
 - Subsidised recreation and other tertiary health promotion opportunities – affordability can be a barrier to participation
- GPs are under-engaged in care planning
- Under-developed partnerships between GPs as medical care coordinators and the publicly funded allied health workforce and community services
- Lack of capacity of publicly funded primary health care services to respond in a timely manner
- The capacity of the patients themselves and their carers is underutilized.

NCMPCP has identified the following as critical for strategic investment in the primary care sector through HARP in improving community care of people with complex and chronic conditions :

- Increased community level screening of those at risk of admission to hospital because of a lack of optimal chronic disease management
- Access for consumers and carers to “*the right care at the right time*” in the home and community setting
- Greater involvement of General Practitioners in multidisciplinary care planning and coordination
- Greater involvement of General Practitioners in managing the hospital-community interface in chronic disease management
- Increased inclusion of *self management of chronic disease* elements in care planning

Good Practice models

The HARP working party report on integrated care for clients with complex needs details key components of integrated care models:

- Single point of contact
- Early intervention strategies
- Assessment
- Integrating care management and care pathways
- Care planning
- Communication
- Patient empowerment and self management
- Medication management
- Monitoring

Evidence base

The SNAP health promotion framework has a well documented evidence base showing that Smoking, Nutrition, Alcohol and Physical Activity are key risk and protective factors for preventing and limiting the impact of chronic disease.

Self management programs that reinforce positive behaviours have demonstrated improvements in pain and fatigue as well as improved activity rates (Lorig et al 1992, cited by Belfrage 2002 in Peer Led Self Management Of Chronic Illness project background material).

A literature review of effective models and interventions for chronic disease management in the primary care sector (DHS 2000) reported that the following elements were consistently identified as key elements of successful interventions:

- Use of explicit plans and protocols
- Reorganisation of practice systems and provider roles
- Systematic attention to the information and behavioural needs of patients
- Ready access to necessary expertise, and;
- Improved patient self-management

The PCP Better Access to Services framework presents the evidence and rationale for focusing attention on improving communication and interagency processes through the implementation of the PCP service coordination model.

Relevant action already happening

Peer Led Self Management

The PLSM trial will have started recruiting its target of 200 consumers with chronic disease from Italian, Greek, Chinese and Vietnamese communities – a total of 800 participants.

Hospital Admission Risk Program

HARP projects currently underway in the NCMPCP catchment that address chronic disease and aged care include:

Northern Health

- A Diabetes Disease Management Model for Broadmeadows Health Service
- Community pulmonary rehabilitation for COPD
- Aged Care Outreach Service

St Vincent's

- Restoring Health –cardiac failure, COPD, diabetes
- COACH Program- cardiac rehabilitation
- TRAAC – Treatment, Response Assessment of Aged Care

Austin Health

- Improving Diabetes Care
- An Integrated Approach to Chronic Disease Management – Chronic Airway Limitation Disease and Congestive Heart Failure
- Community Link Rapid Response

Other projects and initiatives underway in the NCMPCP catchment having an impact on chronic disease include:

- Coordinated Care Trial
- Darebin medication review project
- Aboriginal Liaison Officer
- Northern Division of General Practice strategic directions and training program

NCMPCP activities in 2003/4 in to reduce the impact of chronic disease

NCMPCP has focused its activities in 2003/4 in the area of chronic disease on the key population groups, and in particular on developing the capacity of the primary care service system to respond to the needs of Aboriginal people. Two complementary activities involve Aboriginal member agencies in improving the accessibility of mainstream primary care services.

Improved communication in the management of chronic disease will be supported by interagency protocols and the use of common service coordination tools within primary care and as part of HARP projects; and by an enhanced capacity for electronic transfer of patient information.

Models for facilitating the self management of chronic disease are being promoted by the Hospital Demand Management Strategy as integral elements of integrated disease management program. NCMPCP is planning a number of activities to promote self management generally and is involved in the Peer Led Self Management of Chronic Disease Trial that is testing the Lorig model in four language groups.

Goal: To reduce the incidence of chronic disease amongst targeted populations and to improve the health, quality of life and reduce hospital presentations for people with a chronic disease.

Objective 1: Consumers have an enhanced capacity to self manage their health.

Objective 2: CALD and Koori consumers have improved access to relevant, culturally sensitive primary care services and integrated disease management systems.

Objective 3: People with chronic disease experience integrated, consumer focused, care management supported by effective communication between care providers

Objective 4: Primary care resources, from primary prevention to integrated disease management, are directed towards population health priorities

Population Target Groups:

The target groups for this strategy are:

- People who are most at risk of developing chronic disease: Aboriginal people and people who are socially and economically disadvantaged
- People with a chronic disease, recognizing that approaches and care pathways need to be tailored to meet the needs of Aboriginal people and people from diverse cultural and linguistic backgrounds

Chronic disease - mix of interventions

Note: An outcome of community collaboration in primary care planning intervention in the previous section will be a submission to VicHealth for a health promotion project that focuses on an element of the SNAP framework, eg Obesity

2.1 Self management

- Breakfast seminar with Professor Kate Lorig
- Life scripts
- Supporting the Peer Led Self Management project by promoting the project to CHCs and other potential referral sources

2.2 Aboriginal access and equity project.

- Developing standards and audit tools for ‘Aboriginal Friendly Services’
- NCMPCP to provide funding to enable DASN to undertake project

2.3 Update Koori health services directory

- Work with NDGP and Aboriginal services in consultation with HACC program and PCP Service Directory project staff to update the Aboriginal services directory. NCMPCP to provide project management and administrative support
- Incorporate updated information into the statewide health services directory – include information on mainstream services and GPs who have had cultural sensitivity training
- Train Aboriginal service providers in the use of the directory and establish processes for agencies to keep their information up to date

2.4 Service Coordination – improving communication & streamlining care pathways

- Continued support of the implementation of Service coordination Tool Templates and NCMPCP interagency protocols
- Promotion and training in the use of Version Two of the Statewide Health Services Directory
- Continued development of care planning protocols
- Build capacity for secure electronic communication between primary care services, GPs, sub acute and acute services - develop protocols between participating agencies - Install PKI on each agencies IT system
- Develop IT and practice systems within each agency to facilitate compliance with e-referral protocols

2.5 Build capacity for integrated acute/primary care population based planning

- Broker and facilitate partnerships and planning framework in collaboration with relevant PCPs, Local Government planners and DHS in order to:
 - strengthen relationships between Municipal Public Health Planners within each hospital catchment, and;
 - strengthen relationships between Municipal Public Health Planners and Hospital Population Health Advisory Committees re population health priorities
- Develop systems to monitor unmet demand for tertiary health promotion activities such as physical activity options to inform Local Government and Community Health Center planning.

Strategy Three: Mental Health

Community and service profile relating to mental health

Mental illness is a serious health problem in Victoria and the NCMPCP catchment. Mental illness accounts for sixteen percent of the total disease burden in the NCMPCP population. Depression is the most prevalent mental illness in the NCMPCP catchment.

In all LGAs in the NCMPCP catchment there are areas of high levels of socio-economic disadvantage. Homelessness and substance abuse are important mental health issues in Yarra and post-natal depression is an issue in Darebin and Whittlesea.

Aboriginal people have particular mental health issues related to the profound effect of the history of colonisation on their health and well being as well as present day disadvantages, discrimination and racism.

The Australian born population has slightly higher rates of mental health problems than people born overseas. The issue for CALD populations is access to culturally appropriate and accessible mental health promotion and services. Asylum seekers, newly arrived refugees and migrants who do not speak English have particular mental health needs.

Community mental health plans have described fragmented service systems that are difficult to access and navigate. The primary care service system provides a diverse range of programs that address mental health and is not able to meet current levels of demand for general and specialised counselling services and programs.

Generating Solutions

Good Practice models

Good practice models for addressing mental health issues take into account gender, cultural and social diversity, age and life stages. Some common elements are:

- Building mental health literacy amongst the general population and health professionals
- Increasing the capacity of primary care providers, including general practitioners, to detect early signs and symptoms of mental disorder and to provide effective interventions
- Streamlining access to the community based mental health service system
- Increasing community connectedness

Aboriginal people

The National Action Plan for Promotion, Prevention and Early Intervention for Mental Health (2000) recommends the following actions in relation to Aboriginal peoples and Torres Strait Islanders:

- Promote understanding, acceptance and valuing of Aboriginal people and Torres Strait Islanders
- Facilitate participation and inclusion and reduce racism and discrimination
- Highlighting issues relevant to Indigenous populations in planning and evaluation
- Supporting Indigenous communities to develop and evaluate culturally appropriate interventions
- Further develop partnerships in full consultation with Aboriginal Community Controlled Health Services

People from Culturally and Linguistically Diverse backgrounds

The National Action Plan identifies the following elements of good practice in mental health promotion, prevention and early intervention amongst culturally and linguistically diverse communities:

- Providing information and education in appropriate formats and languages to increase mental health literacy

- Liaising with community leaders to facilitate promotion, prevention and early identification
- Liaising with communities to ensure cultural sensitivity in the delivery of services
- Increasing cultural awareness in mainstream services

Evidence base

The Victorian Population Health Survey (2002) found that higher levels of psychological distress were associated with living in urban areas, being unemployed, being separated, having been born overseas and residing in households with lower incomes.

Aboriginal people as well as people from culturally and linguistically diverse backgrounds are vulnerable to racism and discrimination at individual, community and institutional levels. This acts on self esteem, feelings of belonging and personal safety, and can also be a barrier to accessing services. Protective factors include community acceptance and valuing of cultural, religious and ethnic diversity and, of particular importance to young people, having an ethnic identity as part of a sense of self and pride in cultural origins. (National Mental Health Promotion Strategy – monograph 2000)

Relevant action already happening

- HARP projects
Northern Health – Northern Alliance Suicide and Self Harm Prevention Project
St Vincent’s Health – Holding it Together
Austin Health – An integrated Approach to Mental Health Service Delivery
- NDGP – mental health training for GPs, Koori mental health interest group
- Primary Mental Health and Early Intervention Advisory Group
- Mental Health Training for primary care workforce project
- VicHealth ‘Together we do better’ campaign

NCMPCP activities in 2003/4 in to promote mental health

The activities described in this section focus on service system development, improving mental health literacy and meeting the specific needs of Aboriginal children and children of diverse cultural backgrounds who have a parent with a mental illness.

The activities of the new Community Building strategic focus also promote mental health and supplement the following activities by driving increased levels of community participation and facilitating the acceptance and valuing of social and cultural diversity.

Goal: **Improved mental health and well being for people with, or at risk of, psychological stress or mental illness.**

Objective 1: Consumers experience an integrated service system that includes primary prevention, early identification, early intervention, treatment, relapse prevention and rehabilitation.

Objective 2: People with mental illness or psychological distress experience coordinated community management of mental health issues and have a reduced need to attend hospital emergency departments

Objective 3 To attract funding to develop culturally appropriate systems to support the children of CALD and Aboriginal parents who have a mental illness.

Population Target Groups:

The target group for this strategy is people with, or at risk of a mental disorder or illness and children of CALD or Aboriginal parents who are mentally ill.

Mental Health – mix of interventions**3.1 Investment in service system development**

Continued investment in the reform of primary mental health and primary care led by the Primary Mental Health and Early Intervention Team to address systems interface issues including a focus on:

- working with Hospital catchments to develop response to patients with psychological stress or mental illness.
- the interface between mental health and drug and alcohol services
- a single point of access to the mental health service system.

Continued involvement in HARP working groups and governance structures

Further develop a submission to Beyondblue to explore and address interface issues between GPs, primary care, acute, clinical psychiatric and disability support services.

3.2 Improve mental health literacy in the primary and community care workforce

Maintain links with this project and promote via the SAAP network linking homelessness service providers into training opportunities

3.3 Promoting a participatory model to address the needs of children of parents with a mental illness from Koori and CALD backgrounds.

Explore funding options for submission developed by NCMPCP in a submission to VicHealth

Section Three - NCMPCP Activities 2003/2004

Community Building

Activity 1.1 Strengthening Community Action

Aim

To build capacity within diverse communities to actively participate in the vision building, decision making, priority setting, solution development and planning required to build healthy communities and to contribute to the reorientation of health planning processes in the three NCMPCP municipalities to further engage with community aspirations, needs and perspectives.

Objectives

- To work in partnership with initiatives in community capacity building around health planning in each local government area through the provision of participatory action research and leadership training to community participants and staff involved in these projects.
- To provide advocacy training to consumers, and consumer participation training to staff, who are involved in, or wish to become involved in, governance, steering, advisory or reference bodies in primary health organizations or projects
- To develop and document a leadership/action research training module and an advocacy training module oriented to a primary health context
- To develop a train the trainer program around the leadership/action research training module and an advocacy training module
- To conduct a consumer gathering /networking opportunity for participants in the training programs and other consumer advocates

Key Stakeholders

- Community advocates, community members
- Agencies seeking to engage consumers in planning and governance.
- Agencies and consumers representing diversity and priority target groups for NCMPCP activity , i.e. culturally and linguistically diverse, low socio-economic status, Aboriginal community.
- Health Issues Centre: Consumer nominees program
- Centre for Ethnicity and Health: Diversity training for staff

Roles and Responsibilities

NCMPCP project worker –managing and implementing project, marketing project, recruiting participants, designing and delivering training, project evaluations, paying for Consumer and Carer Sub-Committee members to participate, paying for consumer to participate in focus group stage of training module development.

The following organisations have committed to participating in the development of the training modules through focus group participation, selecting consumers for training, in most cases paying for consumers to participate in a 6 hour training program, and releasing staff to participate in piloting staff training module:

- North East Migrant Resource Centre
- Northern Health
- Northern Area Mental Health Service
- Neami
- North Yarra Community Health Service
- St Mary's House of Welcome
- CarerLinks North

- City of Darebin
- City of Whittlesea
- Centre for Ethnicity and Health Trainer is co-facilitating training and collaborating to develop the staff training module.
- Health Issues Centre are collaborating to develop the consumer training module and including the trained consumers and the consumer training within their Consumer Nominees Program.

Resources

NCMPCP:

- 12 months x 0.8 EFT Project Worker
- Management support including support and resourcing of
 - Consumer and Carer Steering Committee to the project, comprising 10 service provider representatives and 10 consumer representatives
 - 12 meetings x \$700 per meeting (includes 10 consumer representatives x 2 hours at \$25 per hour, catering and venue)
- Administrative support

Centre for Ethnicity and Health Trainer and training resources

Health Issues Centre Trainer and training resources

Banyule-Nillumbik PCP Consumer Participation Training Manual- basis for staff training module.

Capacity Building Strategies

- Building capacity of local health and community services and municipal public health planners to support community participation
- Recruited agency-consumer partnerships to participate in the project eg a staff member and the consumers that the agency hopes to have participate in the agency – required significant agency commitment to the project
- Training material produced by project available to member agencies and community groups
- Community advocates will receive “train the trainer” training
- Training programs will be looked after and made available to the sector after completion of the project through Health Issues Centre and Centre for Ethnicity and Health.

Time lines

| | |
|---|-----------------|
| Project phase 1: Recruitment of participants | May 2003 |
| Project phase 2 : Development of training modules to be piloted | July 2003 |
| Project phase 3: Pilot Training | July-Oct 2003 |
| Project phase 4: Evaluation/Finalisation of Training Modules | November 2003 |
| Project phase 5: Launch of Training Modules/ Awarding of training certificates | December 2003 |
| Project phase 6: Development and piloting of Train the Trainer | Jan- March 2003 |
| Project phase 7: Printing and distribution of Train the Trainer | April 2003 |

Evaluation measures

Process/Reach

- Numbers of Expressions of Interest to participate in project
- Numbers of staff and consumers proposed within EOI's
- EOI's reflect diversity of NCMPCP member agency base

Impact

- Proportion of people who report independent and continued (sustainable) participation following training
- Satisfaction of staff and consumers who participated in training with the training program

Activity 1.2 Community collaboration in primary care planning

Aim

To improve community participation in the development of Municipal Public Health Plans, and Community Health Centre health promotion plans and integrate health promotion effort and resources at a local government area level in the catchment.

Objectives

- To improve the reach of health promotion activities to people who are disadvantaged and culturally and socially diverse communities
- To increase opportunities for civic and social participation
- To build on the Strengthening Community Action Project by involving consumer advocates in designing and implementing action research projects

Key Stakeholders

- Community members, groups and community advocates
- Local Government, Community Health, Migrant Resource Centre, NCMPCP

Roles and Responsibilities

NCMPCP

- Develop collaborations between consumer advocates, Municipal Public Health Planners and Community Health Centre Health Promotion planners with the aim of integration of Community Health Centre Health Promotion Plans and Municipal Public Health Plans (MPHP).
- Explore approaches based on the “breakthrough collaborative” model used to support practice innovations across multi sites in acute health to support this intervention in the three local government areas that make up the NCMPCP catchment.
- Broker and facilitate collaborative health promotion funding applications in line with MPHP priorities
- Facilitate alignment of Local Government Community Grant Scheme priorities with integrated health promotion plan priorities.

Yarra Health Promotion Team

City of Yarra
North Yarra Community Health service
North Richmond Community Health service
Inner East Community Health Service
Melbourne Division of General Practice
Consumer and carer representatives

Darebin Health Promotion Team

City of Darebin
Darebin Community Health Service
Northern Division of General Practice
Consumer and carer representatives

Whittlesea Health Promotion Team

City of Whittlesea
Plenty Valley Community Health Service
Northern Division of General Practice
Consumer and carer representatives

Resources

- NCMPCP project team
- Community health and local government
- Consumers and carers

Capacity Building Strategies

- Participant agencies allocate proportion of planning budgets for collaborative planning processes and resourcing community participation in MPHP development
- Local government ensures MPHP informs resource and support allocations eg Community Grants Scheme funding priorities
- Community Health ensures MPHPs inform Health Promotion Plans
- Develop a collaborative submission for funding to Vic Health around a key MPHP health promotion priority for an integrated health promotion project.

Time lines

| | |
|---|---------------|
| Elaboration of Project and Marketing to required participants | October 2003 |
| Teams recruited /Protocols developed | December 2003 |
| Work plan for community inclusion in Health promotion Vision Building and strategy development completed for participating local government areas | March 2003 |
| Submissions for a major integrated health promotion projects in participating local government area | April 2003 |

Evaluation measures

Process

Number of community members and community advocates participating in planning process
Diversity in terms of age, gender and culture of the community members and community advocates

Impact

Measures of the satisfaction of community members and community advocates with their opportunities for input and their impact on the outcome of the process.

Outcomes

A completed funding submission for an integrated health promotion project for each participating team

The extent to which Community Health Service Health Promotion Plans align with MPHP Health Promotion Plans

The extent to which Local Government Community Grant Scheme priorities reflect MPHP Health Promotion Plans

Chronic Disease

Activity 2.1 Promoting self management of chronic disease

Aim

Improve consumer and carer participation in the optimal management of chronic conditions to optimize health and wellbeing

Objectives

- Facilitate the development of better health self management program capacity in Community Health Services in the catchment
- Facilitate the development of capacity for better health self management in culturally and linguistically diverse communities in Community health services in the catchment through increasing reach and take up of the Peer led Self Management of Chronic Disease Program
- Increase referrals by GPs and other health service providers in the catchment to health self management opportunities
- Identify and address barriers to access to better health self management opportunities for consumers in the catchment
- Support the recruitment phase of the Peer led Self Management of Chronic Disease Project

Key Stakeholders

- NDGP
- Community Health Centres- North Yarra CHS, Nth Richmond CHS, Darebin CHS, Plenty Valley CHS
- Peer Led Self Management of Chronic Disease project
- GPs, pharmacists, hospital based health care staff
- Consumers and carers

Roles and Responsibilities

NCMPCP & NDGP - organising breakfast seminar with Professor Kate Lorig

NDGP include GP training in better health self management as eligible for practice improvement points.

NCMPCP – sponsoring participation of Aboriginal health professionals and community advocates in Lorig seminar

NCMPCP, CHC, Local Government, MRC –developing mechanisms to increase referrals to Peer Led Self management of Chronic Disease project

Resources

- NCMPCP project team
- Capacity Building Strategies
- Workforce development
- Community education

Time lines

| | |
|-------------------|--------------|
| Breakfast seminar | 15 July 2003 |
| PLSM | ongoing |

Evaluation measures

Process/reach

- Numbers attending GP breakfast
- Increase in numbers of referrals to PLSM
- Numbers of consumers/carers referring to better health self management
- Number of community health services committing to better health self management program development
- Diversity of community health service based better health self management programs.

Activity 2.2 Aboriginal access and equity project

Aim

To increase use of mainstream health and community services by Aboriginal people in the catchment.

Objectives

- Developing standards and audit tools for 'Aboriginal Friendly Services'
- Developing protocols between local government area level Aboriginal community groups and local NCMPCP member agencies to implement the standards
- Developing monitoring and reporting mechanisms to evaluate impact of tools implementation on Aboriginal access to mainstream primary health services

Key Stakeholders

- Darebin Aboriginal Services Network
- NCMPCP core member agencies- Project Management Group members
- Aboriginal Liaison Officers
- Local Government Area Aboriginal community groups-
 - Whittlesea Reconciliation Network/City of Whittlesea
 - City of Darebin Aboriginal Advisory Committee
 - Yarra Aboriginal Health Network/City of Yarra
- Aboriginal consumers in the catchment

Roles and Responsibilities

- NCMPCP to provide support and resources to DASN to lead and facilitate the development of the standards in consultation with a broad cross section of the local Aboriginal community
- NCMPCP to pay the costs associated with broad consumer consultation processes
- NCMPCP Project staff to be responsible for the overall project management, protocol development, and setting up of ongoing monitoring and evaluation mechanisms in partnership with DASN

Resources

- NCMPCP Project staff
- Consumer consultation
- Contracted labour to be accountable to DASN to undertake standards development process.

Capacity Building Strategies

Workforce development, organisational development

Time lines

| | |
|---|-------------------------|
| Project phase 1 Standards development process | completed December 2003 |
| Project phase 2 Development of local protocols | completed March 2004 |
| Project phase 3 Development of ongoing monitoring process | completed April 2004 |
| Implementation of protocol commitments within agencies | ongoing |
| Awards ceremony for participating agencies NAIDOC week | July 2004 |

Evaluation measures

Reach/process

Number of agencies and community members involved in project planning and monitoring
Participants satisfaction with consultation processes
Number of agencies involved in developing protocols
Number of agencies adopting protocols

Impacts

Changes in number and sources of referrals to primary care services for Aboriginal people
Level of participation of Aboriginal people in health promotion interventions
Range of culturally appropriate health promotion opportunities offered by primary care agencies (primary, secondary and tertiary health promotion)
Number of Aboriginal people with a chronic illness who have care plans/care coordination

Activity 2.3 Update Koori Health Services Directory

Aim

Improve access to culturally appropriate primary care services for Aboriginal people

Objectives

- Update the NDGP Koori Services Directory
- Increase referrals between Aboriginal controlled and / or targeted and mainstream services
- Incorporate updated information into the statewide health services directory
- Train Aboriginal service providers in the use of the directory and establish processes for agencies to keep their information up to date

Key Stakeholders

- NDGP
- NCMPCP
- Aboriginal health services

Roles and Responsibilities

NDGP and NCMPCP collaboration
NCMPCP Project staff to undertake project

Resources

NDGP Aboriginal Liaison Officer
NCMPCP project team

Capacity Building Strategies

Linking the directory to the PCP Health Services Directory will facilitate regular updating of information
Workforce development

Time lines

| | |
|---|------------------------|
| Establish Project Steering Group /Project Work Plan | September 2003 |
| Update directory entries | October 2003- Jan 2004 |
| Directory included in Statewide services Directory | February 2004 |
| Training of Aboriginal and other primary health care workers in use of the Directory | March 2004 |

Evaluation measures

Process/reach

Number of Aboriginal health care staff familiar with web based Statewide Directory

Outcomes

Directory updated
Directory included in web based Statewide Directory

Activity 2.4 Implementation of Service Coordination Protocols and Tool Templates

Aim

Consumers experience an accessible, efficient, person centered and responsive primary care service system

Objectives

- Improve communication and feedback processes between primary care providers
- Streamline care pathways
- Coordinated medical and community care for people with chronic disease to reduce hospital presentations

Key Stakeholders

- Community members and consumer advocates linked to health services
- Community Health Services, Local Government, HACC providers, ACAS and other programs mandated to use the Service Coordination Tool Templates
- NDGP & GPs
- Acute and Post Acute services, HARP projects

Roles and Responsibilities

- Continued support of the implementation of NCMPCP interagency protocols and PCP Service Coordination Tool Templates through catchment wide forums, LGA networks, interest/working

group networks (eg intake/assessment staff providing Initial Contact and/or Initial Needs Identification services) and resourcing agencies.

- Promotion and training in the use of Version Two of the Statewide Health Services Directory
- Build capacity for secure electronic communication between primary care services, GPs, sub acute and acute services - develop protocols between participating agencies - Install PKI on each agencies IT system
- Support the development of IT and practice systems within each agency to facilitate compliance with e-referral protocols

Resources

NCMPCP project staff

Capacity Building Strategies

Workforce training in:

- Service coordination models
- Service directory
- Privacy and encryption

Organisation development – implementing SCTTs and service coordination systems

Time lines

| | |
|--|----------------|
| Supporting implementation of service coordination model and tool templates | Ongoing |
| Develop protocol and service coordination monitoring and review process | Dec 03 |
| Review protocols | May 04 |
| Training in Version 2 of PCP service directory | When available |

Evaluation measures

Reach/process

- Number of agencies implementing protocols and tool templates
- Number of agencies using web based service directories
- Number of agencies with electronic referral capacity

Impact

- Number and source of referrals
- Quality and completeness of information provided at referrals
- Frequency and quality of referral feedback
- Waiting times for primary care services
- Survey and consult member agencies re impact of service coordination implementation to inform review of NCMPCP protocols
- Survey and consult consumers re their experience of initial contact, initial needs identification, assessment, care planning, and referral processes to inform review of NCMPCP protocols

Activity 2.5 Build capacity for integrated acute/primary care population based planning

Aim

To develop and strengthen primary care – acute collaborations in the catchment to address population health priorities

Objectives

- Strengthen relationships between Municipal Public Health Planners/Social planners and planners within hospitals/health networks in the catchment
- Strengthen the capacity of MPHPS to inform hospital /health network resource allocations in the catchment and health network priorities to inform primary care system developments and primary and secondary prevention programs
- Share data to improve local and health network level knowledge about population health priorities and evidence based best practice in primary care-acute collaborations to improve health status in the catchment
- Progress NCMPCP Community Health plan priorities through opportunities presented by the Hospitals Admissions Risk Program

Key Stakeholders

- City of Whittlesea
- City of Darebin
- City of Yarra
- Northern Health
- Austin Health
- St Vincent's Health
- Hume-Moreland PCP
- Banyule-Nillimbik PCP
- Boroondara PCP
- Department of Human Services

Roles and Responsibilities

NCMPCP Project staff are responsible for resourcing the project

Local Government, particularly Municipal Public Health Planners in the catchment are responsible for providing leadership to the project and brokering and sustaining the planning partnerships with health networks.

Resources

NCMPCP Project Team

Capacity Building Strategies

Organisation development

Workforce development

Time lines

| | |
|--|-----------------|
| Planning Forum to commence relationships | September, 2003 |
| Development of partnership planning agreements between: | December, 2003 |
| - City of Yarra and St Vincent's Health | |
| - City of Darebin and St Vincent's Health, Austin Health and Northern Health | |
| - City of Whittlesea and Northern Health | |

Evaluation measures

Process/reach

The number of people participating in planning forum

The number of relevant health networks engaged in planning protocol development

Outcomes

Three Local Government- Health Network population health improvement agreements relevant to NCMPCP catchment

Mental Health

Activity 3.1 Investment in service system development

Aim

People with mental illness or psychological distress experience an accessible, efficient, person centered and responsive primary care service system.

Objectives

- Early identification and easy access to early intervention services for people with mental health issues
- Streamlined care pathways for people attending hospital emergency departments with mental health issues
- Coordinated medical and community care for people with a mental illness

Key Stakeholders

Community Health Services, NDGP & GPs, Primary Mental Health Services, PMHEIT Steering Committee

Roles and Responsibilities

- Continued investment in the reform of primary mental health and primary care led by the Primary Mental Health and Early Intervention Team to address systems interface issues including a focus on:
 - working with Hospital catchments to develop response to patients with psychological stress or mental illness
 - the interface between mental health and drug and alcohol services
 - a single point of access to the mental health service system
- Continued involvement in HARP working groups and governance structures
- Further develop a submission to beyondblue to explore and address interface issues between GPs, primary care, acute, clinical psychiatric and disability support services.

Resources

NCMPCP project team

Capacity Building Strategies

Workforce development
Organisation development

Time lines

Reconvene working group in the new financial year to work up the submission to the Victorian Centre of Excellence in Depression for the November, 2003 funding round.

PMHEIT Steering Committee meetings ongoing

Evaluation measures

Incorporation of these systems improvements into relevant mental health service and HARP programs.

Activity 3.2 Improve mental health literacy in the primary and community care workforce

Aim

Increase capacity of non-mental health services personnel to support people experiencing psychological stress in the community

Objectives

- Increase mental health literacy of housing workers, community health and other non-mental health service staff in the catchment
- Improve support provided to people experiencing psychological stress in the community

Key Stakeholders

Housing workers
Community Health
Community Mental Health
Primary Mental Health Training Project

Roles and Responsibilities

NCMPCP to maintain links with the project and promote via NCMPCP networks and the Northern SAAP network to linking homelessness service providers into training opportunities for primary care services.

Resources

NCMPCP project team

Capacity Building Strategies

Workforce development

Time lines

Training opportunities commence to be provided before end 2003

Evaluation measures

Process

NCMPCP level of participation in planning the delivery of training to the primary and community care workforce

Impact

Numbers of staff from housing sector and community health sector to take up training in the catchment and evaluation of training

Outcome

Self assessment of level of learning at time of training
Follow-up survey of impact of training on practice

Activity 3.3 Promoting a participatory model to address the needs of children of parents with a mental illness from Koori and CALD backgrounds.

Aim

To secure funding to pilot a participatory action-research approach to service model development to address mental health needs of Aboriginal and culturally and linguistically diverse communities.

Objectives

- To promote participatory action-research processes for developing responsive and empowering models of care
- To increase the participation of marginalized or small and emerging communities in planning and developing services to meet their needs

Key Stakeholders

CALD and Aboriginal Community leaders
Mental health services
Target consumers

Roles and Responsibilities

NCMPCP – reconvene working group and review submission, further develop partnerships with relevant communities and services, actively seek resources to pilot the approach

Resources

NCMPCP project team

Capacity Building Strategies

Community action

Time lines

Final timelines to be determined by funding opportunities

Evaluation measures**Process**

Number of agencies supporting new funding application to implement model

Impact

Number of agencies using the information in the submission to inform planning and/or service delivery

Outcome

Submissions made, success of submissions

Ongoing Projects

NCMPCP activities in 2003/4 will also include health promotion projects that commenced in the last financial year that are still to be completed. These projects were outlined in last years community health plan and are underway:

- Extending no-smoking environments in PDSS services
- Yarra Health & Housing project – addresses nutrition and social connectedness
- Whittlesea Health and Housing project – participatory process where men who are socially and financially disadvantaged will develop health promotion activities