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Outer East Health and Community Support Alliance Community Health Plan 2002-2003

JUNE 2002

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Appendices

1. Outer East Alliance members and service outline.

1. Introduction

The Primary Care Partnership Strategy - *Primary Care Partnerships: Going Forward*, (2000) aims to improve the health and wellbeing of the community through a functionally integrated, cooperative and coordinated approach to service planning and delivery within the community health and primary care services sector.

Primary care partnerships (PCP) have been formed based on collaboration between local government, community health services, district nursing services, Divisions of General Practice, non-government service providers, consumers, carers and a range of other key stakeholders with a focus on service planning, service coordination and service partnerships. The main goals of the reform are to:

- improve the experience and outcomes for people who use primary care services
- develop integrated population based health promotion strategies aimed at achieving the best health and well being of the community
- reduce the preventable use of hospital, medical and residential services through a greater emphasis on health promotion programs and by responding to the early signs of disease and/or people's needs for support.

A key directive of the strategy is the development and implementation of Community Health Plans to help achieve this vision. Consumers and carers are to be the focus of reform and services and programs will be delivered in accordance with a quality framework which includes a charter of consumer and carers rights. The Community Health Plan is to be implemented by voluntary alliances which typically cover two or three local government areas.

1.1 The Outer East Alliance

The Outer East Health and Community Support Alliance (henceforth referred to as the Outer East Alliance) is an alliance of agencies that cover the municipalities of Knox, Maroondah and Yarra Ranges. The Outer East Alliance is the auspice for the Primary Care Partnership Program and includes:

- Angliss Hospital
- Care Connect
- Eastern Access Community Health
- Knox City Council
- Eastern Drug and Alcohol Service
- Knox Community Health Services
- Knox Division of General Practice
- Maroondah City Council
- Maroondah Hospital
- Outer East Aged Care Assessment Service
- Sherbrooke and Pakenham Division of General Practice
- Ranges Community Health Service
- Shire of Yarra Ranges
- Richmond Fellowship of Victoria
- Royal District Nursing Services
- Villa Maria Society
- Whitehorse Division of General Practice
- Women's Health East
- Yarra Ranges Health Service
- Yarra Valley Community Health Service
- Yarra Valley Division of General Practice

Appendix 1 provides a brief profile of each service.

1.2 Vision

The Outer East Alliance is committed to the PCP strategy and best practice in service planning and delivery to ensure efficient, coordinated and consumer focused services. Through local and sub regional planning mechanisms and protocols, residents of the Knox, Maroondah and Yarra Ranges municipalities will have access to high quality, responsive and integrated primary care services.

The Outer East Alliance aims to improve and sustain the quality of life of its residents and the health and wellbeing of the community as a whole.

The Outer East Alliance recognises that the functional coordination of services is a key factor in providing high quality and responsive services to the community and particularly for consumers with complex and multiple needs. It also recognises that effective links between General Practice and the broader health care system is fundamental to a truly integrated system with "seamless" care.

1.3 Strategic objectives

Priorities for the Outer East Community Health Support Alliance include:

- Working towards the vision in a partnership and collaborative approach in a structured and considered framework, building on existing work in the Outer East.
- Review and refinement of directions and strategies to ensure ongoing policy and planning developments are well informed; and
- An ongoing working relationship with the Department of Human Services (DHS).

The Outer East PCP has prioritised six key elements to enable agencies to work together to improve the health of the community:

- Partnerships
- Service Coordination
- Service Planning
- Communication
- Consultation
- Evaluation

The first three elements reflect Community Health Plan requirements of the Department of Human Services and are described, along with progress for 2001-2002 in the Key Achievements Section. In addition, three 'Umbrella' strategies have been developed by the Outer East Alliance.

The Outer East Community Health Plan reflects and builds-on current plans of Outer East Alliance members and does not replace individual organisation plans.

1.3.1 Communication

Communication is a critical component of all Outer East Alliance work and is essential to the effective implementation and management of change. The Communication Strategy aims to ensure ongoing, effective communication within and external to the Outer East Alliance, including consumers, carers and the community.

1.3.2 Consultation

Consultation must be an integral component of all projects to ensure that projects meet the needs of service providers and consumers. The Consultation Strategy aims to ensure relevant stakeholders are adequately consulted in relation to all PCP projects.

1.3.3 Evaluation

The process of evaluation will help determine whether Outer East Alliance aims are being met, needs are being addressed and what improvements can be made. The Evaluation Strategy includes:

- Impact evaluation of each of the Outer East Alliance PCP Projects to determine their effectiveness and to enable initiatives to be improved, built upon and learnt from.
- Undertaking an Outer East Process Evaluation Project that will evaluate Outer East Alliance processes, enabling review and improved performance.

1.4 Partnerships

The Partnership strategy aims to enhance the ways in which organisations and sectors work together in implementing the Outer East Community Health Plan. Included in this element are the following initiatives.

1.4.1 Outer East Consumer Engagement Strategy

Consumer engagement is critical to ensure all Outer East PCP projects are effective, appropriate and meeting the needs of consumers, carers and the community. A Consumer Engagement Strategy is being developed that will outline how consumers, carers and community will be engaged in relation to all Outer East Alliance PCP initiatives and processes. Included in the Consumer Engagement Strategy will be the implementation of a Consumer Right and Responsibility Charter.

1.4.2 GP Engagement

General practitioners (GPs) represent the cornerstone to primary care. It is therefore critical that effective relationships are established between GPs and the primary care sector. To assist, the Outer East Alliance is developing a Framework that outlines how the Outer East Alliance, Divisions of General Practice and GPs can work together in

undertaking initiatives that aim to improve and sustain the quality of life of residents and the overall health and well being of the community.

The four GP Divisions who are members of the Outer East Alliance, being Knox, Sherbrooke/Pakenham, Whitehorse and Yarra Valley have formed a working group together with PCP Program representatives, to undertake a number of initiatives. Included in the work is the formulation of a framework which outlines how the Outer East Alliance, the Divisions of General Practice and GPs will work together regarding PCP initiatives. The GP Engagement Framework outlines:

- Roles and responsibilities
- Communication and consultation
- Processes
- Principles Resources/infrastructure.

The Outer East Alliance has funded a GP care planning project involving GPs and Divisions of General Practice representatives and PCP Program representatives. The Project explores the interface between work to develop practices, protocols, processes and systems (PPPS) and care planning initiatives such as the Commonwealth Enhanced Primary Care (EPC) MBS Care Planning items and the potential to interrelate the Outer East Service Coordination Project.

1.5 Service coordination

The Service Coordination Strategy aims to enhance the service system so that service provision is better coordinated and the service system inter-relates and hence enables improved consumer access to services.

The overall approach of the Outer East Alliance is based on building and adding value to existing work and working relationships, with a strong commitment to working together for outcomes to consumers based on a social model of health. To achieve this aim, a number of projects are being undertaken in the Outer East.

1.5.1 Service coordination, initial needs identification and care planning

Implementation of service coordination in the Outer East is a priority for the Alliance and is guided by a Service Coordination Implementation and Support Strategy, which embraces a number of elements:

- Finalisation of the Outer East Practices, Protocols and Process Manual, developed as a result of a series of consultative forums, and which outlines a shared vision, the Outer East service coordination model, detailed protocols and a commitment by agencies to agreed services coordination processes
- Introduction by member agencies of the Outer East service coordination model and state-wide tool templates
- A key practitioner group across the Alliance to lead and monitor implementation within individual agencies

- Agency support via staff information sessions and assistance to develop implementation/transition plans for each agency
- Workforce training in relation to the Outer East Service Coordination Model, use and application of the state-wide tool templates, Practices, Protocols and Process Manual, and privacy/consent
- Integrating the rollout of the electronic referral system (see below), with service coordination implementation.

This Service Coordination Implementation and Support Strategy will achieve a level of consistency and functional integration across Alliance members, resulting in better access to services and care outcomes for consumers.

1.5.2 Maroondah IT Project Rollout

The Maroondah IT Project is building on an existing project to improve and support communications and sharing of information between service providers as a key element of the Outer East Service Coordination Strategy. This project includes the following components:

- **Implementation of an electronic referral process**

In the Outer East, the draft Templates of August 2001 have been adapted into an electronic referral system that is being piloted with a group of eight agencies. This enables service providers to collect information that is consistent, and with client consent can be shared, where appropriate. An effective electronic referral process increases the likelihood of relevant consumer information being provided to appropriate service providers, without consumers having to continually repeat such information. The system will be updated to implement the final templates and “rolled out” to all Alliance members to support the implementation of the Service Coordination Strategy.

- **Finalisation of protocols**

The most critical component of the Service Coordination Strategy is the development of agreed protocols to support these initiatives. The protocols provide a common language for service providers and clearer processes for service providers and consumers alike.

- **Electronic health information**

Electronic access to health information will be linked to the service directory, including health education brochures that can be viewed on screen or printed as required. Links to appropriate health sites will also be included to enable ready access to up to date information.

- **Development of protocols**

The most critical component of the Service Coordination Strategy to ensuring improved service coordination in the Outer East is the development of agreed protocols to support these initiatives. These protocols will provide a common language for service providers and clearer processes for service providers and consumers alike.

1.6 Integrated service planning

The Integrated Service Planning element aims to identify the population health needs of the Outer East catchment and propose strategies to address these needs. The following components are included.

1.6.1 Outer East Population Based Plan

The Outer East Population Based Plan identified four identified priority health areas for the Outer East— cancer, chronic respiratory disease, cardiovascular disease and mental health and substance use. These priority health areas were identified through a process of data analysis, analysis of existing plans and consultation with key stakeholders. These priorities are now informing service planning activities.

1.6.2 Health promotion plan

The Outer East Health Promotion Strategy was developed on the basis of the Outer East Health Promotion Framework and the Social Determinants of Health Project which was conducted to examine the broader determinants of the four identified health priority areas, such as unemployment or social isolation. From the Social Determinants of Health Project, *social support networks* and *transport* were identified as the social determinants that would be addressed through the Health Promotion Strategy. As a result, the following projects are being undertaken:

- **Enhancing Health Promoting Capacity Program**
This aims to build the capacity of the Outer East Alliance to undertake effective health promotion action.
- **The Health and Well-being of Young People Project**
This project aims to improve the mental health and well being of young people in the Outer East.
- **Senior Connections Project**
This project aims to enhance the health of older people in the Outer East, by reducing their social isolation.
- **Foothold on safety project “Keeping upright in the Outer East”**
This project aims to reduce falls and injuries from falls among older people living in their own homes.

1.6.3 Reduction in avoidable hospital admissions

The Hospital Admission Risk Program (HARP) aims to avoid unnecessary use of emergency departments and inpatient services in the hospitals targeted by the Hospital Demand Management Strategy. This is to be achieved by ensuring models of care are developed so that people have their health and medical conditions better managed both within the hospital and while at home (Hospital Demand Management Strategy Bulletin, December 2001).

HARP is seeking to focus on tertiary prevention, by targeting people who have manifest disease and often where their illness has become chronic. While hospitals will have a central role, collaboration with specialist services in the community and primary care providers is considered critical to ensuring the effectiveness of new approaches to delivering care. Similarly, integrated disease management projects and the pro-active management of chronic conditions and case conferencing supported through the Enhanced Primary Care Medical Benefits Schedule Items will inform HARP.

Members of the Outer East Alliance have worked cooperatively with Eastern Health to identify the underlying causes of increased emergency demand for hospital services. This has involved collaboration on a number of HARP submissions aimed at addressing this issue. The Outer East Alliance will work with Eastern Health and other PCP's in the ongoing management of funded HARP projects.

2. Key achievements

This section describes the key activities undertaken in 2001-02 to achieve the objectives to the Alliance, including a summary of key outcomes.

KEY ACHIEVEMENTS: PARTNERSHIPS - The Partnership element aims to enhance the ways in which organisations and sectors work together.

| TASK | STATUS | OUTCOMES TO DATE |
|---|---|--|
| <p>Development and implementation of an Outer East Consumer Engagement Strategy</p> <p>GP Engagement Strategy</p> <p>Development of Service Linkages</p> | <ul style="list-style-type: none"> • Consumer participation on Partnership Working Group and Consumer Engagement Steering Committee established. • Project Brief developed and circulated. • Interviews to be undertaken 27th March. • Project to commence 15th April and be completed by 26th August 2002. • Draft Final GP Engagement Framework completed. The Framework outlines how the Outer East Alliance, the Divisions of GP and GPs will work together regarding PCP initiatives • GP Care Planning Working Group established. Directions currently being reviewed <ul style="list-style-type: none"> • Agreement to develop Protocols between WHE and OEA Outer East Alliance | <ul style="list-style-type: none"> • Agreed directions and recognition of the importance of consumer engagement <ul style="list-style-type: none"> • Shared understanding of required involvement and benefits for GPs in relation to PCP Projects. In particular, to health promotion and referral, sharing of information, care planning and case management • Shared understanding and agreement in relation to the four Divisions of GPs participation and involvement in PCP Projects • Greater involvement, input and access to GPs • Working with Divisions of GP and General Practitioners to assist awareness and utilisation of the EPC MBS items for care planning, case conferencing and health assessments <ul style="list-style-type: none"> • Process will assist to inform development of service linkage protocols with others |

KEY ACHIEVEMENTS: SERVICE COORDINATION - The Service Coordination Strategy aims to enhance the coordination of the service system to improve consumer access to services.

| TASK | STATUS | OUTCOMES TO DATE |
|--|--|---|
| <p>The following components are being undertaken:</p> <ul style="list-style-type: none"> • Development of Service Coordination Implementation and Support Strategy • Hosting of four consultation forums • Consultation on PPPS and drafting of comprehensive PPPS Manual to underpin implementation of service coordination • Refining of service coordination model and interpretation for Outer East agencies as Generic or targeted agencies in relation to Initial Contact and Initial Needs Identification • Development of key Practitioner Group • Provision of agency management and practitioner briefing and information sessions regarding PPPS, service coordination model and tool templates • Planned development and delivery of training programs to support implementation • Integration of electronic referral system into implementation process • Pilot of electronic referral system with eight agencies. | <ul style="list-style-type: none"> • Project Brief and Work Plan finalised and endorsed • Service Coordination Implementation and Support Strategy commenced May 2002 • Consultative forums completed • Complete draft PPPS Manual circulated for comment • Refining of service coordination model in progress • Management and practitioner agency briefings and information sessions in progress • Tool templates and guidelines being distributed and discussed • Demonstrations of electronic referral system to non-pilot agencies • Implementation planning commenced within individual agencies • Pilot electronic referral system live from 3rd June, 2002. Evaluation commenced. • Components commenced. | <ul style="list-style-type: none"> • Building on existing projects with a staged piloted approach • Agencies using Service Coordination ‘language’ and understanding the benefits of working together towards agreed directions and outcomes • Greater interagency collaboration and inter-sectorial dialogue • Provision of an opportunity to address vital issues for consumers like improved service co-ordination and service planning across the sub region • Participation in INI and SC Template pilot was a beneficial step towards informing the development of the protocols, processes and practices to support service coordination implementation and the Maroondah IT system • Outer East Alliance agencies have examined current practice and informed development of PPPS. • Implementation of a successful process for working together to design, develop and implement the Outer East Service Coordination Project • Implementation of pilot electronic referral system. |

KEY ACHIEVEMENTS: SERVICE PLANNING - The Service Planning element aims to identify the population health needs of the Outer East catchment and propose strategies to address these needs.

| TASK | STATUS | OUTCOMES TO DATE |
|--|---|---|
| <p>Projects undertaken include:</p> <ul style="list-style-type: none"> • Outer East Population Based Plan • Health Promotion Strategy • Social Determinants of Health Project • Well-being of Young People Project • Senior Connections Project. | <ul style="list-style-type: none"> • Outer East Population Based Plan completed. Four priority health areas identified for the Outer East, being cancer, chronic respiratory disease, cardiovascular disease and mental health and substance use. • Outer East Health Promotion Framework and Strategy completed. • The over arching Health Promotion Strategy (eg. Objective 1) was achieved. • The continued partnership between the OEPCP & the Outer East Health Promotion Network. • High rates of representation at the Health Promotion Short Course and active lobbying for further courses in the region. • Social Determinants of Health Project completed. • Well-being of Young People Project well underway, on-going input from three to four member agencies. • Senior Connections Project awarded to a consortium of four member agencies for implementation. | <ul style="list-style-type: none"> • A greater understanding of the tenets of Health Promotion and the benefits of working in collaboration to enhance the health and wellbeing of the community. • A consortium of agencies collaborated and worked together to develop the Health Promotion Framework and Strategy. The Strategy has been identified as best practice. • Funds have been maintained within the Outer East Alliance and local expertise well utilised. • Action research conducted with socially isolated young people in transient accommodation and relevant workers completed. Research report being compiled. • Draft youth friendly service criteria and accreditation process document currently with Youth Wellbeing Project Steering Committee. • Consumers actively engaged in Youth Well-being project via a Youth advisory Group. • A process has been developed and agreed to identify auspice agency for projects. • The research undertaken for the Population Based Plan and Social Determinants of Health Projects has been well-received and many have used these documents in own planning. • High levels of on-going co-operation and formal partnerships achieved between member agencies to deliver health promotion projects. |

3. Community and service profile

3.1 Demographic Overview

The Outer East Alliance catchment area covers the local government areas (LGA) of Knox, Maroondah and Yarra Ranges.

The Shire of Maroondah is the smallest of the three LGAs covering 63 sq km and having a population density of 1555.86 residents per sq km. The economy of Maroondah is mainly commercial and is anchored by the two main business centres at Croydon and Ringwood. There is also a significant concentration of industry in the south of the city.

The Shire of Yarra Ranges is the largest in area covering 2471.6 square kilometres, with approximately 10% being urban, 35% rural and 55% being parklands or reserves. The Shire of Yarra Ranges has a relatively low population density with 57.09 people per sq km. The fact that some of the residents live in fairly isolated areas, together with the topography of the Shire, has implications for service delivery and accessibility to services by residents.

The City of Knox covers 113.8 square kilometres and is far more densely populated with 1238.45 residents per sq km. While Knox has a large residential population base it also has substantial local employment in business, retail and manufacturing.

3.1.1 Population Growth

Table 1 shows the population of the Outer East at the 1996 Census of Population and Housing was estimated as being 369,877. By 2011, it is predicted that this will increase by 3.4% to 382,415 (*Victoria in Future*, 2000). This projected increase in population is significantly lower than the 13.6% increase predicted for Metropolitan Melbourne overall. Yarra Ranges had the lowest projected population growth with 1.4% and Knox had the highest with 5.0%.

Table 1 : Population Projections 1996–2011

| | 1996 | 2001 | 2006 | 2011 | % Change 1996-2011 |
|-----------------------------------|------------------|------------------|------------------|------------------|-----------------------|
| Knox | 136,825 | 142,589 | 143,480 | 143,657 | 5.0% |
| Maroondah | 95,879 | 98,784 | 99,306 | 99,677 | 4.0% |
| Yarra Ranges | 137,173 | 141,450 | 141,362 | 139,081 | 1.4% |
| Outer East | 369,877 | 382,823 | 383,148 | 382,415 | 3.4% |
| Metropolitan Melbourne | 3,284,007 | 3,454,339 | 3,604,537 | 3,731,319 | 13.6% |

Source: Department of Infrastructure – *Victoria in Future* (2000)

3.1.2 Age Structure

In terms of planning for primary care services, two age groups are of particular interest—the youngest (persons aged under 18) and oldest members of the community (persons aged 70 and over). Between 1996 and 2011 each municipality will experience a decline in the number of residents in the younger age groups and an increase in people aged 70

years and older. However, the population profile of the three LGAs will remain younger than Victoria overall.

**Table 2 : Outer East Population Changes 1996–2011
% of population by age group**

| Age group | Knox | | Maroondah | | Yarra Ranges | | Victoria | |
|------------|------------|------------|------------|------------|--------------|------------|------------|------------|
| | 1996 | 2011 | 1996 | 2011 | 1996 | 2011 | 1996 | 2011 |
| 0–4 | 7.9 | 5.7 | 7.4 | 5.6 | 7.6 | 5.7 | 6.9 | 5.4 |
| 5–17 | 20.9 | 17.3 | 18.4 | 16.3 | 21.9 | 17.4 | 18.0 | 15.4 |
| 70–84 | 4.8 | 6.7 | 6.6 | 8.1 | 5.0 | 6.5 | 7.4 | 8.3 |
| 85+ | 0.9 | 1.4 | 1.0 | 1.8 | 0.8 | 1.4 | 1.2 | 1.9 |

Source: Department of Infrastructure – Victoria in Future (2000)

3.1.3 Gender

The proportions of male to female ratio is consistent across all LGA located within the Outer East with a slightly higher percentage of females living in the three local government areas (50.7%) than males (49.3%). These figures are consistent with the Victorian average.

3.1.4 Indigenous People

Only 0.3% of people living in the Outer East were recorded as being Aboriginals or Torres Strait Islanders at the 1996 census. This is fewer than for all of Victoria (0.5%). However, it is possible that the numbers of recorded indigenous people in the catchment area under-represent the actual level. In addition, there is a higher percentage of indigenous people in the Healesville area.

3.1.5 Ethnicity

The Outer East had a relatively high proportion of residents who are Australian born. Just under one quarter of residents (24.2%) were born outside Australia. This compares to the rate of 27.4% for Victoria as a whole and 29.2% for the Eastern Metropolitan Region. The proportion of UK migrants in the catchment area was significantly higher (8.2%) when compared to the Eastern Metropolitan Region (6%) and Victoria (4.9%). There is some recent evidence at the local level to suggest migration patterns have changed with increased representation of people from South East Asia.

3.1.6 Employment

The unemployment rate for the Outer East for the September 2000 quarter (4.5%) was considerably lower than for both the Eastern Metropolitan Region (6.7%) and for all Victoria (7.6%).

Of those employed in the Outer East almost 70% were employed on a full time basis. Most people within the Outer East were employed in the areas of clerical work, trade related work and as professionals.

3.1.7 Income

The 1996 Census data showed a somewhat different pattern of income distribution for each of the three LGAs in the Outer East. Knox had the highest proportion of households earning \$700 or more—higher than the other two LGAs and the Eastern Metropolitan Region and Victorian averages. Maroondah on the other hand, had the highest proportion of the three LGAs of households earning between \$120 and \$299, which are regarded as low income earners.

3.1.8 Concession Card Users

Another useful indicator of socio-economic disadvantage is being the user of a Commonwealth concession card. As at March 1999, there were 44,448 holders of Pension Concession Cards and 29,289 Health Care Card holders in the Outer East. Yarra Ranges had the highest percentage of card holders and Maroondah the lowest.

3.1.9 Socio-Economic Disadvantage

The Index of Relative Socio-Economic Disadvantage (IRSD), which is calculated by the Australian Bureau of Statistics, summarises census information on education, occupation, income, family structure, race (the proportion of indigenous people), ethnicity (poor proficiency in the English language) and housing to arrive at a single index score for each local government area in Australia.

The average score for Australia is set at 1000, with lower scores reflecting greater disadvantage. On this basis, the Outer East was one of the least disadvantaged municipalities in Victoria with a score of 1053.75 compared to 1015.96 for all Victoria. Of the three local government areas in the Outer East, Yarra Ranges had the highest level of disadvantage with a score of 1046.88, compared to Knox (1056.72) and Maroondah (1059.33).

A picture of the socio economic status of the catchment was also provided in a study conducted by Professor Tony Vinson in August 1999, titled *Unequal in Life* as part of the research program of The Ignatius Centre, the policy and research arm of Jesuit Social Services. This study of social disadvantage drew on information available from a range of different sources, but rarely collated.

The 622 postcodes in Victoria were ranked according to how they scored against the selected criteria with 1 being the most disadvantaged postcode. The data demonstrated that while the Outer East municipalities are considered to be relatively well off in socio economic terms, there are pockets of disadvantage. The postcodes of Healesville, Yarra Junction and Warburton in particular, showed significant disadvantage.

3.2 Health profile

3.2.1 Overview

This section provides an overview of the health status of the catchment population and in addition provides information on specific client groups that were of particular interest to the Alliance such as:

- People with alcohol and drug problems
- People with a disability
- People with a mental illness and
- Carers.

3.2.2 Health Data Profile

The highlights of the analysis of the health profiles of the Outer East are as follows:

- The pattern of cause of death was reasonably consistent across the three LGA and reflected that for Victoria overall, in which 41% of deaths were the result of cardiovascular disease, 28% cancer and 31% having other causes.
- In the Outer East, years of life were more likely to be lost due to both cancer (32%) and cardiovascular disease (32%). This is slightly less than both the whole Eastern Metropolitan Region (33.7%) and the Victoria average (33.0%). Of the three Outer East local government areas, the most likely cause of Years of Life Lost was cancer. Maroondah had a higher rate of Years of Life Lost due to cancer (34%) than both Knox (31%) and Yarra Ranges (32%).
- Tobacco smoking was the risk factor responsible for the greatest ill health in the Eastern Metropolitan Region (11.5% in males and 6.5% in females), followed by alcohol harm. According to data provided by the Anti-Cancer Council of Victoria, there were 7,707 deaths due to smoking in the catchment area between 1993 and 1996—2,714 in Knox, 2,366 in Maroondah and 2,627 in Yarra Ranges. These included 326 deaths caused by lung cancer, 255 caused by chronic bronchitis and emphysema and 271 caused by heart disease.
- Students in Yarra Ranges were more likely than students in Knox or Maroondah to show depressive symptoms and have a lower sense of self esteem. Overall, the Outer East showed relatively low rates of depressive symptoms and incidents of deliberate self-harm, and relatively high rates of self esteem.
- In all three LGAs, the proportions of Years Lived with a Disability (YLD) due to mental disorders, cancer, cardiovascular disease, chronic respiratory diseases and musco-skeletal conditions were similar to that for Victoria. Mental disorders accounted for the most YLD, being by far the most important cause of disability for 20 to 50 year-olds and accounting for nearly all the non-fatal burden in early adulthood, peaking in the early 20s.
- Of the 40,541 Disability Adjusted Life Years (DALYs) for the Outer East, approximately three-quarters were accounted for by just four conditions:

cardiovascular disease (8,211), cancer (8,210), mental disorders (6,176) and neurological and sensory disorders (3,675). Most of the burden of disease caused by cardiovascular disease and cancer consisted of Years of Life Lost reflecting premature death. By contrast, for sensory and neurological and mental disorders, most of the burden reflected Years Lived with Disability, rather than death.

3.2.3 Specific Health Indicators

The following conditions were nominated as being of interest to the Alliance. More detailed information on these and additional conditions that contribute to the overall burden of disease such as cancer, physical inactivity, communicable diseases, poor immunisation rates and sexual and reproductive health can be found in the Community Profile Report prepared as part of the previous Community Health Plan (June 2001).

3.2.3.1 Alcohol and Substance Abuse

Turning Point Alcohol and Drug Centre has established a number of alcohol-related data sets to develop indicators of alcohol consumption and related harm at a regional and local level in Victoria. Data for 1994/95–1995/96 shows that alcohol-related admissions to hospital were significantly below the state average in the Outer East. Further, the alcohol outlet density (which represents the number of licensed premises per head of population) was well below the Victorian average of 18.39 and the per capita consumption of alcohol by persons aged 15 years and over was also below the Victorian average.

The Alcohol Index is the summary score of the alcohol related harm of an LGA, with 1 representing the minimum score and 6 the maximum. It is designed to identify those areas with the greatest need for alcohol services and prevention programs. Both Knox and Yarra Ranges had a lower ranking (2) than Maroondah which had a ranking of 3, around the middle point for alcohol related harm.

The Adolescent Health and Well-being Survey found that alcohol use among Victorian secondary school students showed a steady and approximately linear rise across year levels from Year 7 through to 11. The majority of Year 7 students (51%) reported that they had drunk alcohol. While binge drinking (defined as having five or more alcoholic drinks in a row) was reported by only 5.5% of Year 7 students, binge-drinking rates had risen to 39% by Year 11 (Bond et al, 2000:22). On the whole, drinking rates in the Outer East were slightly higher than those found for the Eastern Metropolitan Region and indicate that substantial numbers of secondary school students use alcohol, with a worrying number involved in binge drinking.

Although a smaller proportion of indigenous people drink alcohol compared with the Australian population as a whole, those indigenous people who do drink are more likely to do so at dangerous levels. This is the case for both males and females (Australian Institute of Health & Welfare: 1998:146–147). This may be an issue for the Outer East and especially for Yarra Ranges.

Illicit drug use is a significant direct and indirect cause of death and ill health. Conditions associated with illicit drug use include overdose, HIV/AIDS, hepatitis C, low birth weight, poisoning, suicide and self-inflicted injury. Approximately 2% of the total burden of disease in Australia can be attributed to illicit drug use, with the age-specific burden

peaking in the 25–34 year age group. Data from the 1998 *National Drug Strategy Household Survey* show that an estimated 3.3 million Australians aged 14 years or older have used an illicit drug in the past 12 months. Most of this use is associated with marijuana/cannabis, with 18% of people reporting usage in the past year. Although rates of usage of heroin are lower than those for cannabis and other illicit drugs, such as amphetamines, cocaine and ecstasy, the health and social burden is much greater and has been rising rapidly. There also appears to have been large increases in the numbers of heroin overdoses in Melbourne, with the average daily attendance by ambulances at non-fatal heroin overdoses increasing from 5.2 to 9.9 between June 1998 and July 1999.

Drug-related ambulance call-outs for this period for the Outer East show that the catchment area was the location for less than 7% of all call-outs for heroin and alcohol, and more than 10% of call-outs for other drugs for the whole of Melbourne. The “other” category was comprised mainly of benzodiazepines, analgesics and antidepressants.

The 1999 *Adolescent Health and Well-Being Survey* found that marijuana was the illicit drug most commonly used by Victorian secondary school students, with rates of ever having tried the drug rising from 3% for Year 7 students to 40% of Year 11 students. Ecstasy (3%), solvents (6%), amphetamines (2%), cocaine (2%) and tranquillisers (6%) had all been used by more young people than heroin (1%) (Bond et al, 2000:2). The survey found that the proportion of students in the Outer East who had ever used marijuana and the number who have used marijuana in the last 30 days is slightly higher than the average for the Eastern Metropolitan Region. Usage rates for other drugs in the Outer East were around or slightly higher than those for the state overall.

3.2.3.2 Disability

In this section, the issue of disability will be approached from a functional perspective, with a view to estimating how many people in the Outer East are either suffering from a disability themselves or caring for someone with a disability, and the extent to which their needs for assistance are being met. Since population data on functional disability is not available at LGA level, data on Victoria as a whole from the 1998 *Disability, Ageing and Carers Survey* has been used to estimate the situation in the catchment area (Australian Bureau of Statistics, 1999b). The rate of disability in the community has been found to increase with age. The 1998 *Survey on Disability, Ageing and Carers* showed that the disability rate rose, from 3% for children aged 0–4 to 52% of those aged 75–79, to 81% for those aged 85 and over, with the trend being similar for males and females. Overall, 18% of the population suffered from a disability, a higher rate than in previous such surveys, with 16% experiencing specific restrictions in the core activities of self-care, mobility and communication and/or in schooling or employment.

If the ABS Survey results for Victoria as a whole are applied to the estimated resident population of the Outer East for 1996, then nearly 22,000 people could be expected to suffer from either a profound or severe core activity restriction. This means that they are either unable to perform at least one core activity, or always or sometimes need assistance in performing it.

According to the 1998 ABS Survey, 56.0% of Victorians with a disability living in households needed assistance to move around or go out, shower or dress, prepare meals, do housework, light property maintenance or paperwork, or communicate. Members of the Alliance also felt that because of the limited availability of public transport in the

Outer East, assistance with transport might be a bigger issue than is indicated by the survey. Assuming that disability levels in the Outer East are equivalent to those for Victoria as a whole, some 15,509 people would be expected to need assistance with at least one activity, ranging from an estimated 1,163 needing assistance with communication to around 9,444 needing assistance with property maintenance.

While a high proportion of people requiring assistance in these areas are receiving at least some help, if the Victorian situation holds true for the Outer East, over 1,500 people in the catchment are not having their needs for assistance met at all, and another 11,000 are only having their needs only partly met. The ABS Survey results indicated that the proportion of people receiving help varied with the severity of restriction. People with profound or severe restriction who needed assistance were very likely to receive help; however, they were less likely to have their needs fully met than those with milder restrictions.

3.2.4 Carers

Carers have been defined as people who provide some assistance to people who need help because of disability or ageing (ABS, 1998). In Victoria in 1998, about 13% of the population was defined as carers. Both males and females were well represented as carers, although a majority of these people (56%) were female. Of those providing some assistance, 36% were in the 35–54 age range – a part of the life cycle when caring responsibilities may involve children, partners and ageing parents. Primary carers are those who provide the most informal assistance with personal activities to a person with a disability and therefore caring plays a major part in their lives. For Victoria in 1998, 18% of all people providing assistance were primary carers and most of these were female (62%). Most primary carers cared for a person in the same household.

If the Disability Survey results for Victoria hold true for the Outer East, then it could be reasonably estimated that there are just over 38,000 carers, including more than 6,500 primary carers in the Outer East.

Most of the assistance provided to disabled people is given informally by family and friends. Primary carers, in particular, shoulder a great deal of the burden in this area, and as a result are often vulnerable to physical and psychological problems. According to the Victorian results of the 1998 ABS Disability Survey, about 57% of primary carers were receiving some assistance in providing care. However, about one third of these carers stated that they required further assistance. About 43% of primary carers received no assistance, and of these, about a fifth required assistance. Around 60% of primary carers had a fall back carer available. The Survey asked primary carers specifically about their need for respite care, and all together nearly 20% stated that they needed respite care – these included carers who had used respite care in the past and those who had never used it. If the Victorian results translate to the Outer East, there is likely to be a substantial amount of unmet need in the area for carer support in general and respite care in particular.

3.2.4.1 Mental Health and Wellbeing

As the Burden of Disease data showed, mental illness is a serious health problem in Victoria overall and in the Outer East. At the national level, mental health has been identified as a National Health Priority Area, with depression the first priority for action.

One reason that mental illness contributes so greatly to the burden of disease is that the first incident of chronic mental illness tends to occur in early adulthood, with the subsequent disability experienced for many years into the future. This characteristic of mental illness points to the need for early intervention if the burden is to be reduced.

Depression

Of the specific conditions associated with mental illness, depression is the biggest problem both nationally and within the Outer East in terms of the burden of disease. Depression accounted for 5.67 per 1,000 of all (DALYs) for females in the Outer East and 3.85 per 1,000 Disability Adjusted Life Years (DALYs) for males, ranking only behind Chronic Obstructive Pulmonary Disease, ischaemic heart disease, stroke and dementia. Depression was the most common specific mental disorder reported by Victorian adults in the 1997 Survey of Mental Health and Wellbeing, with 3.0% of men and 6.2% of women reporting the condition (ABS, 1998b, p1). Depression was the fourth most common problem managed by Australian general practitioners in 1998–99 as revealed by the BEACH survey, at a rate of 35 per 1,000 encounters. The majority of patients were females (68%) and between the ages of 25 and 64 years (72%). However, there is evidence that depression is under diagnosed and under treated in primary care settings (AIHW, 2000, p83).

Depression frequently occurs in combination with anxiety disorders, substance-related disorders, conduct disorders, eating disorders, attention deficit/hyperactivity disorder and chronic conditions such as heart disease, cancer and diabetes. People with depression may also indulge in more risky health behaviours. There is evidence that 35% of people with mental disorders smoke. The effect is age specific, being more prevalent in younger adults (p84).

The 1999 *Adolescent Health and Well-Being Survey* found that there was a marked trend among Victorian secondary school students for depressive symptomatology to increase from a prevalence of 13% in Year 7 students to 20% in Year 9, and to 22% in Year 11. Girls (23%) were twice as likely as boys (12%) to report high levels of depressive symptoms. The prevalence of deliberate self-harm was similar for both males and females. Less than 4% of Year 7 students reported an episode of deliberate self-harm, rising to 6% for students in Years 9 and back to 5% for Year 11 (Bond et al, 2000:25). From a maximum score of 10, students at all year levels and of both sexes showed a mean score of 6 on a self-esteem measure.

Results of the survey *Improving the Lives of Young Victorians in our Community* (2000) showed students in Yarra Ranges were more likely than students in Knox or Maroondah to show depressive symptoms and have a lower sense of self-esteem. Overall, the Outer East showed relatively low rates of depressive symptoms and incidents of deliberate self-harm and relatively high rates of self-esteem. Nevertheless, these results highlight the

need to raise and maintain the level of resilience among the adolescent population with particular effort being required in Yarra Ranges.

The survey found a strong relationship between high levels of depressive symptomology and a range of risk and protective behaviours associated with young people's communities, family, school and peer/individual characteristics. The same factors were also important predictors of tobacco and alcohol use, suggesting that intervention targeted at some of these variables may have a number of positive outcomes. Table 3 compares the level of risk and protective factors for the Eastern Metropolitan Region and the Outer East LGAs.

Table 3. Risk and Protective Factors for young people, Outer East.

| | Risk Factors | | Protective Factors | |
|--------------|---|--|--|--|
| | Elevated | Reduced | Elevated | Reduced |
| Knox | Interaction with antisocial peers Early initiation of problem behaviour Parental attitude favoured towards drug use Antisocial behaviour | Reward for antisocial involvement | Community opportunity for prosocial involvement Community rewards for prosocial involvement | Social skills School rewards for prosocial involvement School opportunity for pro-social involvement |
| Maroondah | Low commitment to school Family conflict Community disorganisation Poor family discipline | Personal transition/mobility Gang involvement Parental attitude favoured to antisocial behaviour | Community opportunity for prosocial involvement | Social skills School rewards for prosocial involvement School opportunity for pro-social involvement |
| Yarra Ranges | Low commitment to school Community laws/norms favoured to drug use Favoured attitudes towards antisocial behaviours | Gang involvement Personal transition/mobility | Community opportunity for prosocial involvement | Social skills School rewards for prosocial involvement Family attachment |
| EMR | Perceived availability of drugs Family conflict Poor family discipline | Perceived risk of drug use | Community opportunity for prosocial involvement | Community rewards for prosocial involvement |

Source: Bond, L. et al (2000) *Improving the Lives of Young Victorians in our Community: a survey of risk and protective factors*. Centre for Adolescent Health, pp208–209, 244–245, 250–51, 278–279

3.2.5 Indigenous People

Very little detailed information is currently available regarding the mental health of indigenous people. However, as reported above in the discussion of disability, psychiatric disability is the primary disability type found among indigenous clients of disability

services in Victoria. Moreover, national data for 1996–1997 showed twice as many hospital separations as expected for mental disorders among people identified as indigenous. This category included a number of alcohol and drug-related conditions, as well as depression, psychosis and other conditions. Hospitalisation rates caused by intentional injuries, either self-inflicted or caused by another person, were also elevated among indigenous people. Deaths classified as suicide occurred 1.7 times more than expected among indigenous males and 1.4 times more than expected among indigenous females, based on all-Australian rates (Australian Bureau of Statistics, 1999:103–104).

3.2.6 Single Person Households

The Outer East had a higher percentage of lone parent households than the Metropolitan Melbourne average. Typically lone parent households are more likely to be socially isolated and have low disposable income. These are accepted risk factors for mental disorders and cardiovascular disease.

4. Operational plan

4.1 Priorities, gaps and emerging issues

The Outer East Alliance will continue to pursue its strategies around Partnerships, Service Coordination, Service Planning, Communication, Consultation and Evaluation to address the issues identified in this and the previous Community Health Plan. This includes the particular needs of key target groups within the community outlined at Table 4 and a focus on young people with mental health issues and older people, particularly those that are isolated or at risk of falls.

Table 4: Summary of Questionnaire Responses to Community Needs Questions

| Communities/Groups Identified As In Need | Services Needed |
|--|--|
| Young People People with Disabilities Aged People Low Income Culturally & Linguistically Diverse communities People with Acquired Brain Injury People with ADHD and other non-acute psych clients Families in Crisis General | Recreational activities, other relevant activities, transport. Respite for carers, residential care. Respite for carers, residential care, podiatry, transport, home visiting, community support. Low cost counselling, dental care, housing, financial counselling. CALD information and support services, interpreter services. Acute and disability support services. Mental health services, mental health education, community support services. Medium and intensive support, housing. Allied health services e.g. physiotherapy, podiatry, counselling, mental health services, rehabilitation services, community health education and public transport. |
| Emerging Communities/Groups | Services Needed |
| Younger Families People who are Ageing | Intensive family support services, affordable housing (including rental). Housing support, case management, occupational therapy, home modification assessments, HACC services, respite. |

In addition, there is recognition of the cluster of underlying social factors and disadvantage which negatively impact on health and broader social outcomes. While much of the Outer East is relatively advantaged, several areas of significant disadvantage have been identified which warrant a coordinated, cross sectoral approach. The suburbs of Healesville, Yarra Junction, Warburton, Boronia and Bayswater have been identified as areas where disadvantage is particularly evident.

Dealing with the issues in these areas may be amenable to a model such as “Neighbourhood Renewal”. Neighbourhood Renewal is a place-based response to disadvantage that seeks to create successful, thriving places where people want to live. It involves a partnership between Government, service providers and local communities to address relative disadvantage and inequality in a range of policy areas such as housing, education, employment, crime and safety and health. The constituency of the Outer East Alliance make it particularly suited to this type of approach and as such developing an approach to neighbourhood renewal is an emerging issue for the Alliance.

4.2 Strategies

4.2.1 Enhancing Health Promoting Capacity Program

Program Goal: To enhance the capacity of the Outer East Alliance to undertake effective Health Promotion action.

Target group/s: Managers & staff of Outer East Alliance member agencies.

| Program Objectives | Interventions/Activity | Timelines | Impacts (Qualitative &/or Quantitative) |
|---|---|-----------|--|
| 1. To establish and maintain clear boundaries, roles & responsibilities, communication paths and processes for key stakeholders in the Outer East Alliance in relation to Health Promotion. | <p>Organisational Development To develop and implement a Health Promotion framework outlining clear boundaries, roles & responsibilities, communication paths and processes for the Outer East Alliance.</p> | On-going | <ul style="list-style-type: none"> • Representation of at least three (other than auspice) member agencies maintained on all health promotion project steering committees • Quality of health promotion projects maintained & progressed |
| 2. To increase the skills and understanding of managers and staff of Outer East Alliance member agencies in Health Promotion principles and practice. | <p>Workforce Development To ensure that staff from all agencies participate in available training opportunities.</p> | June 2003 | <ul style="list-style-type: none"> • 30% of all participants on future health promotion shorts courses are from Outer East Alliance • 80% of all Outer East health promotion short course participants (01/02) attend Post health promotion short course professional development opportunities • 50% or more new Member Agency Staff to attend Introductory health promotion courses |
| 3. To ensure Outer East Alliance member agencies demonstrate a clear commitment to Health Promotion within their respective agencies. | <p>Organisation Development Provide recommendations to Outer East Alliance members regarding the importance of demonstrating a commitment to Health Promotion within each organisation and provide clear examples of how this can occur.</p> | On-going | <ul style="list-style-type: none"> • 50% increase in the number of member agencies with evidence of a clear commitment to Health Promotion in organisational documentation (eg. policy, strategic plan, Vision, Mission or an allocated health promotion budget). |

| Program Objectives | Interventions/Activity | Timelines | Impacts (Qualitative &/or Quantitative) |
|---|---|------------------|--|
| 4. To ensure Outer East Alliance member agencies have the infrastructure to support Health Promotion action within their respective agencies. | Organisation Development To investigate opportunities to incorporate learning's from the organisational infrastructure project currently being undertaken by the Health Promotion Community Health Special Initiative (HPCHSI) reference group into PCP member organisation's planning processes. | On-going | <ul style="list-style-type: none"> 50% increase in the number of member agencies with evidence of a clear commitment to Health Promotion in organisational documentation (eg. policy, strategic plan, Vision, Mission or an allocated health promotion budget). |

4.2.2 Young people and mental health

Program Goal: Promote the positive mental wellbeing of young people in the Outer East.

Target group/s: People under 25 years in the Outer East.

| Program Objectives | Interventions/Activity | Timelines | Impacts (Qualitative &/or Quantitative) |
|---|---|--|---|
| <p>1. To strengthen the capacity of generic primary care agencies to better respond to the needs of young people, particularly in regard to access, availability, affordability, appropriateness and quality.</p> | <p>Health information Provide practical examples and models of best practice to facilitate agencies achieving 'Youth Friendly' status.</p> | <p>Project Worker July 2002</p> | <ul style="list-style-type: none"> Models of best practice and examples documented. [PROCESS] |
| | <p>Health education counselling and skill development Arrange any necessary training programs (with financial support) to assist agencies to meet the standards identified within the criteria developed for Youth Friendly Health Services.</p> | <p>Project Worker June-Nov 2002</p> | <ul style="list-style-type: none"> Training plan developed and implemented. [PROCESS] Representatives from 100% of participating OEA agencies attend training. Increased knowledge and skills of participants as evidenced by evaluation conducted as part of training plan. [IMPACT] |
| | <p>Community action Actively engage young people in all of the processes used throughout this project.</p> | <p>Project Worker Steering Committee (ongoing)</p> | <ul style="list-style-type: none"> An engagement plan is developed and implemented in conjunction with young people. [PROCESS] Evidence of young people's involvement throughout the project exists. [IMPACT] |
| | <p>Social marketing Establish an accreditation or recognition process that will be offered for those agencies that achieve the criteria of 'Youth Friendly Health Service'.</p> | <p>Project Worker June 2002</p> | <ul style="list-style-type: none"> Accreditation or recognition process developed and documented. [PROCESS] Accreditation or recognition process implemented and at least 50% of member agencies involved in the initial process. [IMPACT] |
| | <p>Organisational Development Develop a process for OEA member agencies to use the Youth friendly Health Service criteria</p> | <p>Project Worker June 2002</p> | <ul style="list-style-type: none"> Agreed criteria for 'Youth Friendly Health Services' is developed and documented. [PROCESS] 'Youth Friendly Health Services' criteria are utilised in the accreditation or recognition process for member agencies. [IMPACT] 40% of OEA agencies achieve 'Youth Friendly' status in first 12 months. [IMPACT] |

| Program Objectives | Interventions/Activity | Timelines | Impacts (Qualitative &/or Quantitative) |
|---|--|--|---|
| <p>2. To identify and engage with socially isolated young people within the Outer East who are poorly connected to support structures (particularly young people residing in caravan parks, transient housing or sub-standard accommodation) and to assist in the development of responses that promote improved connectedness.</p> | <p>Community action Undertake an action research process to work with the target group to identify their specific issues/ needs and determine possible solutions for addressing these needs.</p> <p>Assist with the establishment of social support structures that respond to the identified needs of the target group.</p> <p>Use additional (02/03) funding to support a targeted intervention by a collective of OEA member and partner agencies to meet the needs/issues identified in the action research</p> | <p>Project Worker July 2002</p> <p>Project Worker/OEA June 2003</p> <p>Project Worker /OEA August 2002</p> | <ul style="list-style-type: none"> Action research project undertaken and processes documented. [PROCESS] Issues and needs of target group identified and documented along with potential solutions. [PROCESS] Evidence of support structures implemented to address identified needs, exists. [IMPACT]. Identified needs amenable to changes are addressed using a range of health promotion interventions by OEA agencies[PROCESS] Funded agencies report increased engagement with target population [IMPACT] |
| | <p>Social Marketing Based on feedback from the action research process, the collective of OEA member & partner agencies (as above) develop appropriate social marketing responses to promote the targeted intervention.</p> | <p>Project Worker/OEA August 2002</p> | <ul style="list-style-type: none"> Social marketing strategies are developed and implemented to promote the issues of the target group. [PROCESS] Evaluation of social marketing strategies is conducted to assess the impact in changing the community perception of the target group's issues [IMPACT] |
| <p>3. To increase understanding of the issues affecting young people's mental wellbeing and promote positive community responses / actions addressing these issues.</p> | <p>Organisational Development Use the findings of this objective to inform the implementation of Objective 1 of this project, and to assist other networks and services to better respond to this target group.</p> | <p>Project Worker /OEA November 2002</p> | <ul style="list-style-type: none"> Evidence exists of the inclusion of findings into Objective 2a. [IMPACT] Dissemination of research report to OEA member and other participating agencies [PROCESS] |
| | <p>Community action Develop mechanisms to allow young people to contribute to the community in a positive way.</p> | <p>Project Worker June 2003</p> | <ul style="list-style-type: none"> Mechanisms which allow young people to contribute to the community in a positive way are developed and implemented. [PROCESS] |

4.2.3 Older People

Program Title: 'Senior Connections'

Program Goal: To enhance the health of older people in the Outer East by reducing social isolation

Target group/s: Older residents living in targeted groups of housing in the Outer East, where social connections do not exist

| Program Objectives | Interventions/Activity | Timelines | Impacts (Qualitative &/or Quantitative) |
|---|--|--------------------------|---|
| 1. To increase socialisation opportunities for Older residents living in groups of housing in the Outer East where social connections do not exist. | Undertake a local, Australia wide and international literature review to identify best practice methods of: <ul style="list-style-type: none"> • connecting older isolated residents • promoting health and well being • determining needs • identifying assessment processes capable of quantifying social isolation. | Aug- October 2002 | <ul style="list-style-type: none"> • Literature Review completed (PROCESS) • Literature review documented and analysed by Steering group • Tools identified Issues clarified (PROCESS) • Draft Assessment Tool being developed |
| | Organisational Development Trial the use of the Senior Connections tool in a targeted housing group. | December 2002 | <ul style="list-style-type: none"> • The tool is trialled in at least one targeted housing group in the Outer East. [PROCESS] • The evaluation of the trial is used to inform the redevelopment of the tool. [PROCESS] • The use of the tool is incorporated into the process, protocols and practises of the Outer East Service Coordination Strategy. [IMPACT] • Those initially assessed as being socially isolated in the trial targeted housing groups show a reduction in social isolation. [IMPACT] With consent, monitor engagement with GP's |

| Program Objectives | Interventions/Activity | Timelines | Impacts (Qualitative &/or Quantitative) |
|--------------------|---|--|---|
| | <p>Community action Working with older people, develop a tool designed to link socially isolated older people through the creation of socialisation opportunities.</p> <p>Develop and implement a process for consumer engagement, linked with the Outer East Consumer Engagement Strategy and Service Linkages Strategy, to be used through all stages of the project, with particular emphasis on marginalised groups such as Koori's.</p> | <p>Dec 2002</p> <p>Dec 2002</p> <p>Ongoing</p> | <ul style="list-style-type: none"> • A Community Development approach between older people and the project worker is used in the development of the tool. [PROCESS] • The working draft of the Senior Connections tool is produced and reviewed. [PROCESS] • Process developed and documented. [PROCESS] • Evidence exists of consumer engagement through all stages of the project. [IMPACT] |
| | <p>Linkages Develop connections to meet identified needs and incorporate health promotion activities to build personal and group cohesion.</p> | <p>December-February 2002</p> | <ul style="list-style-type: none"> • Identify best fit connections and implement (IMPACT) • Develop opportunities for group cohesion (IMPACT) • Develop sense of community (PROCESS) • Seek consumer support and input on project roll out (IMPACT) |
| | <p>Screening, individual risk assessment and immunisation Develop guidelines to assess social isolation amongst older people to be used by GP's and Primary Care workers.</p> | <p>Feb 2003</p> | <ul style="list-style-type: none"> • Guidelines developed and documented [PROCESS] • Guidelines incorporated into the PCP Initial Needs Identification process. [PROCESS] • All older people presenting to an OEA member agency have been assessed for social isolation. [IMPACT] |
| | <p>Health education counselling and skill development Key personnel in targeted housing groups are educated regarding the use of the Senior Connections tool to develop socialisation opportunities.</p> | <p>Feb 2003</p> | <ul style="list-style-type: none"> • Key personnel undergo training in the use of the Senior Connections tool. [PROCESS] • Key personnel are using the Senior Connections tool to develop socialisation opportunities in targeted housing groups. [IMPACT] |

Program Title: Keeping Upright in the Outer East

Program Goal: To reduce falls and injuries from falls among older people living in their own homes.

Target group: People aged 65 years or older, living in their own homes.

| Program Objectives | Interventions/Activities | Timelines | Impacts (Qualitative &/or Quantitative) |
|---|---|---|---|
| <p>1. To build capacity among Outer East Alliance members to reduce falls among the target population</p> <p>2. To involve the community in further developing falls prevention activity</p> <p>3. To support future falls prevention planning in the Outer East.</p> | <ul style="list-style-type: none"> • Undertake a literature search to identify best practice. • Commence ‘roll out’ of the Outer East Falls Prevention Models to the Outer East Alliance, in particular targeting GPs. <ol style="list-style-type: none"> 1. Establish mechanisms to better coordinate existing falls prevention initiatives and services. 2. Develop an Outer East Falls Prevention Education Resource to support and encourage peer educators to raise awareness of falls prevention in the Outer East. 3. Further develop links with CALD organisations and Koori Health Team, to enable expertise to be built upon and falls prevention needs addressed among these minority populations 4. Undertake process evaluation of the first year’s activities to guide future falls prevention activity directions for the Outer East. 5. Prepare work plan for second year of program. | <p>August 2002</p> <p>December 2002</p> <p>March 2003</p> <p>May 2003</p> <p>December 2002</p> <p>June 2002</p> <p>March 2002</p> | <ul style="list-style-type: none"> • Literature review used to inform falls prevention model. • Links established with EPC initiative. • CME session/s for GPs on falls prevention conducted. • Potential for Model incorporation into Divisions of GP IT Strategies explored. • Prevention Education Resource updated. • Associations with Koori Health Team and appropriate CALD organisations established. • Process evaluation undertaken. • Work plan agreed. |

4.2.4 Hospital demand management

Program Title: Hospital Admission Risk Program

Program Goal: A reduction in preventable hospital attendances and admissions.

Target group: People attending hospital emergency departments with ambulatory sensitive conditions.

| Program Objectives | Interventions/Activities | Timelines | Impacts (Qualitative &/or Quantitative) |
|---|--|--|--|
| <p>1. To build capacity among Outer East Alliance members to prevent unnecessary hospital attendances and admissions.</p> | <ol style="list-style-type: none"> 1. Work with Eastern Health to implement successful HARP submissions. 2. Establish an ongoing forum with Eastern Health to examine and address hospital demand management. 3. Analyse factors contributing to increased demand for emergency department attendances, emergency admissions and multiple attendances. 4. Determine strategies to reduce preventable emergency department attendances and admissions. 5. Submit a number of joint HARP submissions with Eastern Health to DHS which engage the primary care sector in a systematic way to reduce preventable emergency department attendances and admissions. | <p>July 2002</p> <p>July 2002</p> <p>September 2002</p> <p>December 2002</p> <p>By due date.</p> | <ul style="list-style-type: none"> • Establishment of cooperative programs to reduce preventable hospital admissions. • Establishment of regular communication and partnership arrangements with Eastern Health around HARP initiatives. • Enhanced understanding of increased demand for emergency hospital services. • Identify service coordination, health promotion and integrated disease management approaches to address emergency demand. • Reduced preventable emergency department attendances and admissions. |

4.2.5 Partnerships

Program Title: General Practitioner Engagement Strategy.

Program Goal: To develop effective relationships between General Practitioners and the primary care sector to improve the health and wellbeing of the people living in the Outer East.

Target group: General Practitioners practicing in the Outer East Alliance catchment.

| Program Objectives | Interventions/Activities | Timelines | Impacts (Qualitative &/or Quantitative) |
|--|--|---|--|
| 1. To develop service coordination links between primary care service providers and General Practitioners. | 1. Work with the Divisions of General Practice and GPs to include GPs in the information sharing pilot and electronic Service directory (outlined above). 2. Recruit GPs as expert practitioners. 3. Review the acceptance of GPs of Service Coordination strategy. 4. Support GP use of EPC MBS items for care coordination with OEA agencies. | September 2002 September 2002 March 2003 June 2003 | <ul style="list-style-type: none"> • Number of GPs competent in use of agreed PPP. • Number of GPs engaged in electronic referrals. • GP interviews reflect high acceptance and use of PPP. • Increased use of EPC item numbers. |

Program Title: Consumer, Carer and Community Engagement Strategy.

Program Goal: To develop effective relationships between consumers and the primary care sector to ensure services better meet the needs of consumers.

Target group: Consumers and potential consumers of health services.

| Program Objectives | Interventions/Activities | Timelines | Impacts (Qualitative &/or Quantitative) |
|---|---|--|---|
| 1. To increase consumer and carer participation in Outer East Alliance decision-making. | <ol style="list-style-type: none"> 1. Define key terms and scope of the strategy. 2. Investigate best practice approaches to consumer engagement. 3. Prepare a Consumer, Carer and Community Rights and Responsibilities Charter. 4. Prepare a two year Consumer, Carer and Community engagement strategy for endorsement of the OEA. | <p style="text-align: center;">July 2002</p> <p style="text-align: center;">September 2002</p> <p style="text-align: center;">September 2002</p> | <ul style="list-style-type: none"> • Consumer, Carer and Community engagement strategy completed and endorsed. |

4.2.6 Service coordination

Program Goal: To enhance service system coordination and integration to enable improved consumer access to services.

Target group: Outer East Alliance service providers.

| Program Objectives | Interventions/Activities | Timelines | Impacts (Qualitative &/or Quantitative) |
|---|---|---|---|
| <p>Service coordination implementation – Implement agreed service coordination model, DHS tool templates, practices, protocols, processes and systems to support information sharing and service coordination between primary care providers to achieve better access and outcomes for consumers.</p> <p>Enhance the Maroondah IT project referral system and roll out to member agencies.</p> | <ol style="list-style-type: none"> 1. Finalise and refine interpretation of Outer East service coordination model by individual agencies as <i>Generic</i> or <i>Targeted</i> agencies for the purposes of Initial Contact and Initial Needs Identification 2. Finalise agreed Processes, Practices, Protocols and Systems (PPPS) to support information sharing and service coordination. 3. Lead and support implementation of state-wide DHS tool templates across member agencies as part of implementation of the service coordination model 4. Evaluate pilot IT system rollout 5. Achieve sign-off of PPPS documentation by Outer East Alliance (OEA) agencies. 6. Train 80 people from OEA agencies in use of agreed PPPS. 7. Evaluate rollout process and plan ongoing support. 8. Evaluate and review practice change in line with agreed information sharing PPPS and BATS strategy. 9. Enhance IT system and roll out to Outer East Alliance agencies 10. Develop and agree to ongoing governance arrangements for Electronic referral system | <p>July 2002</p> <p>July 2002</p> <p>June 2002 ongoing</p> <p>July 2002 August 2002</p> <p>August/September 2002</p> <p>December 2002</p> <p>December 2002</p> <p>June 2003</p> <p>March 2003</p> | <ul style="list-style-type: none"> • Processes, Practices and Protocols (PPPS) to support information sharing in place. • 80 people from OEA agencies competent in use of agreed PPP. • Staff interviews reflect high usage of agreed PPPS. • Systems measurements record high use of electronic referrals. • Ongoing system support in place. |
| <p>Service directory enhancement</p> | <ol style="list-style-type: none"> 1. Finalise agreed Processes, Practices and Protocols | <p>July 2002</p> | <ul style="list-style-type: none"> • PPPS to support use and update of |

| Program Objectives | Interventions/Activities | Timelines | Impacts (Qualitative &/or Quantitative) |
|--|--|---|--|
| <p>and integration – Integrate local service provider information with the Better Health Channel Directory.</p> | <p>(PPPS) to support use and update of local service directory.</p> <ol style="list-style-type: none"> 2. Implement local service directory as part of roll out of electronic referral system 3. Support implementation of agreed service directory PPPS and use of service directory. | <p>August 2002</p> <p>December 2002</p> | <p>local service directory agreed.</p> <ul style="list-style-type: none"> • Local service directory implemented. • Ongoing support of service directory PPPS agreed. |

5. Conclusion

This plan seeks to support the previous *Outer East Community Health Plan* submitted to the Department of Human Services in June 2001. It is founded on the substantial work undertaken in developing the previous plan and should be considered in conjunction with that document.

This plan provides an update for 2002-03 of activities which will be pursued to support the key strategies from the previous plan, along with some additional strategies formulated subsequently. The range of strategies proposed will be collaboratively addressed by the Outer East Alliance and its various working groups, in association with a range of key stakeholder groups to continue to *improve and sustain the quality of life for residents of the Outer East and the health and wellbeing of the community as a whole.*

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Knox Local Government Area (LGA)

Knox Municipal Health Plan Policy, Parts 1 & 2, 1998–2001

Knox Urban Indicators

Maroondah LGA

Maroondah Municipal Public Health Plan 2000–2002

Maroondah Annual Report 1998–1999

Yarra Ranges LGA

Shire of Yarra Ranges Annual Report 1999 – 2000

Yarra Ranges Public Health Plan, Health Profile 2000

Yarra Ranges Public Health Plan 1998 – 2000

Yarra Ranges Public Health Plan 1998–2000 Update

Shire of Yarra Ranges, Vision 2020

Appendix 1

Outer East Alliance members and service outline

| Name of Organisation (OE Alliance) | Brief Description (eg. Core business) |
|---|---|
| ACAS, Outer East | Comprehensive assessment services for aged. |
| Angliss Hospital | Acute medicine and surgery, acute rehabilitation, aged care and assessment services. |
| Care Connect | Case management and brokerage services (aged and disability) |
| Eastern Access Community Health | Community health (including, counselling, drug and alcohol, problem gambling, aged care, allied health and health promotion services), Psychiatric Disability Support, Disability Day Programs, and Child, Youth and Family Services. |
| Eastern Drug and Alcohol Service Consortium | Counselling to youth, adults and families, secondary consultation, training, education, community development. |
| Knox City Council | Local Government Authority responsible for planning, providing and purchasing of human services for aged and disabled, children, youth and families. |
| Knox Community Health Services | Community health service providing counselling, drug and alcohol, and health promotion services |
| Knox Division of General Practice | Co-ordination of education and training for GP's and provision of a mechanism for coordinated communication with relevant agencies and consumers. |
| Maroondah City Council | Local Government Authority responsible for planning, providing and purchasing of human services for aged and disabled, children, youth and families. |
| Maroondah Hospital | Acute medicine and surgery, psychiatric services and aged care services. |
| Ranges Community Health Service | Community health service providing allied health services and needle exchange. |
| Richmond Fellowship of Victoria | For people who experience psychiatric disability: residential rehabilitation services, long term housing, outreach, respite and psychosocial rehabilitation day program. |
| Royal District Nursing Service - South and East Region. | Provider of nursing services in the home to consumers. |
| Sherbrooke & Pakenham Division of General Practice | Co-ordination of education and training for GP's and provision of a mechanism for coordinated communication with relevant agencies and consumers. |
| Shire of Yarra Ranges | Local Government Authority responsible for planning, providing and purchasing of human services for aged and disabled, children, youth and families. |
| Villa Maria Society | Services and support for people with disabilities. |
| Whitehorse Division of General Practice | Co-ordination of education and training for GP's and provision of a mechanism for coordinated communication with relevant agencies and consumers. |
| Women's Health East | Services and support for women and service providers relating to women's health and well-being, including information, referrals, education and training, and medical services for sexual and reproductive health. |
| Yarra Ranges Health Service | Acute medical, aged care facility, and auspice for community health services. |
| Yarra Valley Community Health Service | Community health service providing counselling, drug and alcohol, and health promotion services |
| Yarra Valley Division of General Practice | Co-ordination of education and training for GP's and provision of a mechanism for coordinated communication with relevant agencies and consumers. |

1.1 Health Promotion Reporting Template (mandatory)

Program Goal: To enhance the capacity of the Outer East Alliance to undertake effective Health Promotion action.

Population group/s: Manager & staff of Outer East Alliance member agencies

| Program Objectives | Interventions/Capacity Building strategies (include specific activities under the appropriate heading) | By whom & Timelines | Actual Impacts (Qualitative &/or Quantitative) | Actual Staff costs (including staff on costs) | Actual Consumables | Total cost | Actual Reach |
|---|--|---------------------|---|---|--------------------|-----------------|---|
| <p>Objective 1a: To establish and maintain clear boundaries, roles & responsibilities, communication paths and processes for key stakeholders in the Outer East Alliance in relation to Health Promotion.</p> <p>Objective 1b: To increase the skills and understanding of managers and staff of OEA member agencies in Health Promotion principles and practice.</p> | Capacity building strategies | | | | | | |
| | <p>Organisational Development To develop and implement a Health Promotion framework outlining clear boundaries, roles & responsibilities, communication paths and processes for the Outer East Alliance.</p> | <p>SPWG</p> | <p>HP Framework used by the Outer East Alliance to guide Health Promotion decision making, communication and action.</p> | <p>\$12,794.00</p> | <p>\$2,206.00</p> | <p>\$15,000</p> | <p>21 Member agencies initially engaged for framework development</p> |
| | <p>Workforce Development To ensure that staff from all agencies participate in available training opportunities. - DHS HP Short Course - Introduction to HP (CH only) - HP training for managers (currently in development)</p> | <p>OEA</p> | <p>34 people from Outer East attended DHS HP Short course & a demand for course created (11 people currently on waiting list)</p> <p>All CH member agencies have new & existing staff routinely undertaking Introduction to HP training.</p> <p>Approx 40% of SPWG & OEHPN members have attended workforce development opportunities, providing a sufficiently skilled and knowledgeable group to plan and implement Health Promotion action.</p> | <p>No PCP HP funds used. Unfunded costs: Approx \$650pp for 5 day course delivery (DHS funded) Costs for staff absence calc. in excess \$600pp for 5 days (Org. Funded)</p> | | <p>Unfunded</p> | <p>Minimum 34 staff from PCP member agencies</p> |

| Program Objectives | Interventions/Capacity Building strategies (include specific activities under the appropriate heading) | By whom & Timelines | Actual Impacts (Qualitative &/or Quantitative) | Actual Staff costs (including staff on costs) | Actual Consumables | Total cost | Actual Reach |
|--|--|---|---|---|--------------------|------------|---|
| | <p>Organisational Development Advocate for the continuation of training opportunities for managers and staff of OEA member agencies.</p> <p>Investigate opportunities for expanding the CH Introduction to HP training to include broader Primary Care agencies as well.</p> <p>Investigate options for mentoring between designated HP practitioners and others.</p> | HPN SPWG OEA | <p>Letter sent to Minister advocating for further HP short courses (process) –response received confirming further funding.</p> <p>Resources not available to expand availability of Intro HP course.</p> | <p>No PCP funding:</p> <p>Unfunded staff time cost approx: \$240 @ \$30/pp/hr</p> | | Unfunded | Stakeholders: 21 Member agencies |
| Objective 1c: To ensure Outer East Alliance member agencies demonstrate a clear commitment to Health Promotion within their respective agencies. | Organisation Development Provide recommendations to OEA members regarding the importance of demonstrating a commitment to Health Promotion within each organisation and provide clear examples of how this can occur. | OEA HPN (Jun 2002) | An audit of member agencies demonstrated commitment to Health Promotion has been conducted. [PROCESS] | Unfunded costs: Staff time: \$500 @ \$30 pp/hr | | Unfunded | Stakeholders: 21 Member agencies |
| Objective 1d: To ensure Outer East Alliance member agencies have the infrastructure to support Health Promotion action within their respective agencies. | Organisation Development To investigate opportunities to incorporate learning's from the organisational infrastructure project currently being undertaken by the Health Promotion Community Health Special Initiative (HPCHSI) reference group into PCP member organisation's planning processes. | CH members of the HPN (Jun 2002) | Report currently being considered by CH managers for comment [Process] | Unfunded Staff time unknown | | Unfunded | Stake holders: 4 Community Health Services |

| Program Objectives | Interventions/Capacity Building strategies (include specific activities under the appropriate heading) | By whom & Timelines | Actual Impacts (Qualitative &/or Quantitative) | Actual Staff costs (including staff on costs) | Actual Consumables | Total cost | Actual Reach |
|--|--|-----------------------------------|---|---|---------------------------------------|--|-------------------------------------|
| Objective 1e: To allocate resources to strengthen the capacity of the OEA. | Resource Allocation Allocate \$15,000 to the development of the Outer East Health Promotion Strategy from the 2000/2001 financial year. Allocate \$10,000 to the Social Determinants of Health Project from 2001/2002 fin year. | OEA Consultants (Oct 2001) | Framework developed as described above (1a) Social Determinants report written [Process] & recommendations incorporated into current PCP HP project planning | See above for costs (1a) \$9,800 | See above for costs (1a) \$200 | See above for costs (1a) \$10,000 | Stakeholders: 21 Member agencies |
| Total Budget | | | | | | \$15,000 | |

1.1 continued: Health Promotion Planning Template 2002-03 (Mandatory)

Program Goal: To enhance the capacity of the Outer East Alliance to undertake effective Health Promotion action.

Population group/s: Manager & staff of Outer East Alliance member agencies

| Program Objectives | Interventions/Capacity strategies (include specific activities under the appropriate heading) | Building strategies | By whom & Timelines | Estimated Impacts (Qualitative &/or Quantitative) | Estimated Staff costs (including staff on costs) | Estimated Consumables | Estimated Total cost | Estimated Reach |
|--|---|---------------------|---|---|---|-----------------------|----------------------|---|
| Objective 1a: | Capacity building strategies | | | | | | | |
| To establish and maintain clear boundaries, roles & responsibilities, communication paths and processes for key stakeholders in the Outer East Alliance in relation to Health Promotion. | Organisational Development To develop and implement a Health Promotion framework outlining clear boundaries, roles & responsibilities, communication paths and processes for the Outer East Alliance. | | SPWG HPN | Representation of at least 3 (other than auspice) member agencies maintained on all HP project steering committees Quality of HP projects maintained & progressed | Unfunded | | Unfunded | Stakeholders: 6 member agencies |
| Objective 1b: | | | | | | | | |
| To increase the skills and understanding of managers and staff of OEA member agencies in Health Promotion principles and practice. | Workforce Development To ensure that staff from all agencies participate in available training opportunities. - DHS HP Short Course - Introduction to HP (currently CH only) - Post HP Short Course PD opportunities Delivery of Introductory HP course to staff outside CH Organisational Development Advocate for attendance of managers and staff of OEA member agencies at HP Short Course & Introductory HP course. | | OEA SPWG HPN | 30% of all participants on future HP shorts courses are from OEA 80% of all Outer East HP short course participants (01/02) attend Post HP short course PD opportunities 50% or more new Member Agency Staff to attend Introductory HP courses | Unfunded HP Short Course DHS Funded Post HP Short Course PD opportunities DHS funded Staff time attend Organisation funded | | Unfunded | Stakeholders: 21 member agencies 20+ staff participate in short course 27 + staff attend Post HP short course opportunities |

| Program Objectives | Interventions/Capacity Building strategies (include specific activities under the appropriate heading) | By whom & Timelines | Estimated Impacts (Qualitative &/or Quantitative) | Estimated Staff costs (including staff on costs) | Estimated Consumables | Estimated Total cost | Estimated Reach |
|--|---|------------------------------|--|--|-----------------------|----------------------|----------------------------------|
| Objective 1c: To ensure Outer East Alliance member agencies demonstrate a clear commitment to Health Promotion within their respective agencies. | Organisation Development Provide recommendations to OEA members regarding the importance of demonstrating a commitment to Health Promotion within each organisation and provide clear examples of how this can occur. | OEA HPN | 50% increase in the number of member agencies with evidence of a clear commitment to Health Promotion in organisational documentation (eg. policy, strategic plan, Vision, Mission or an allocated HP budget). | Unfunded Cost unknown: Staff time attending meetings & work time Cost unknown: Resource re-allocation to change re-orientate organisation | | Unfunded | Stakeholders: 21 member agencies |
| Objective 1d: To ensure Outer East Alliance member agencies have the infrastructure to support Health Promotion action within their respective agencies. | Organisation Development To investigate opportunities to incorporate learning's from the organisational infrastructure project currently being undertaken by the Health Promotion Community Health Special Initiative (HPCHSI) reference group into PCP member organisation's planning processes. | OEA HPN | 50% increase in the number of member agencies with evidence of a clear commitment to Health Promotion in organisational documentation (eg. policy, strategic plan, Vision, Mission or an allocated HP budget). | Unfunded Cost unknown: 8 staff members from 4 CH centres attending meetings & work time Resource re-allocation to change re-orientate organisation | | Unfunded | Stakeholders: 21 member agencies |
| Budget | | | | | | Unfunded | |