

**MOONEE VALLEY MELBOURNE  
PRIMARY CARE PARTNERSHIP**

**COMMUNITY HEALTH PLAN 2006 – 09**

**March 2007**

Endorsed by PCP Chair:

Name: Hazel Ingram

Signature:



Date: 02/05/07

## ACKNOWLEDGEMENTS

The Moonee Valley Melbourne Community Health Plan for 2006 – 09 was prepared by the Executive Officer for the Moonee Valley Melbourne Primary Care Partnership (MVM PCP), Joan Nankervis, with assistance from other MVM PCP staff including,

- Angela Vindigni, Health Promotion Officer (to October 2006)
- Neela Jayakody, Refugee Health Service Coordination Project Officer
- Gulsun Besim, Cultural and Linguistically Diverse (CALD) Community Development Officer and
- Linda Emmanuel, Administrative Officer.

The author would like to acknowledge the previous MVM PCP Executive Officer, Dianne Couch, author of the MVM Community Health Plan for 2004-06. This current plan has been adapted from the Community Health Plan for 2004-06 and it's priorities and strategies refined to reflect changes in the broader planning environment.

This Community Health Plan would not have been possible without the significant work of the member agencies<sup>1</sup> of the MVM PCP who participated in the development of a plan for strengthening the partnership to support achievement of the Partnership's goals relating to Integrated Health Promotion, Service Coordination and Integrated Chronic Disease Management. These member agencies and their representatives include:

- Hazel Ingram, Manager, Community Services, Moonee Valley City Council
- Caz Healy, Chief Executive Officer, Doutta Galla Community Health Service
- Di Couch, General Manager, Primary and Community Health, Doutta Galla Community Health Service
- Jane Gilchrist, Manager, Community Partnerships Melbourne Health
- Melissa Afentoulis, Chief Executive Officer, Women's Health West
- Jo McMillan, Centre Manger, Essendon, Royal District Nursing Service
- Debra Goldfinch, Chief Executive Officer, Melbourne Division of General Practice

As well as the member agencies the authors would also like to acknowledge the contributions of the two major PCP working groups which report to the Steering Committee:

- The Health Promotion Working Group (HPWG)
- The Service Coordination Implementation Working Group (SCIG)

In the past twelve months the MVM PCP has collaborated with the Hume and Moreland PCP on areas of work which are common to both PCPs, including service coordination as well as a joint project to develop and test an appropriate structure and process for area based planning across the Moonee Valley Melbourne and Hume Moreland PCP catchments. Thanks also to the contributions of the Hume Moreland PCP staff and member agency representatives, in particular to the development of the Service Coordination Plan.

---

<sup>1</sup> *At the time this Community Health Plan was prepared, the City of Melbourne had suspended their participation in the PCP while undertaking a review of their ongoing involvement within the existing primary care partnership arrangement.*

# FOREWORD

The Moonee Valley Melbourne Primary Care Partnership (MVM PCP) facilitates collaboration between primary health care providers to promote health and wellbeing in the community and to reduce preventable use of hospital services.

Primary Care Partnerships are funded by the Victorian government's Department of Human Services, Primary Care Branch. The four key areas identified by the Victorian government as essential for a primary care service system that will promote health and wellbeing and reduce preventable use of hospital services are:

- Partnership strengthening (Deliverable 1);
- Integrated health promotion (Deliverable 2);
- Service coordination (Deliverable 3); and
- Integrated chronic disease management (Deliverable 4).

The 2006–09 MVM PCP Moonee Valley Melbourne Primary Care Partnership Plan details the steps required to continue building a responsive and cohesive primary care system that delivers in the above areas.

This plan builds on past MVM PCP plans, however the 2006–09 plan's objectives and strategies have been refined to reflect changes in the broader planning environment, in particular the Victorian Government's addition of the fourth strategic direction – Integrated Chronic Disease Management – to the PCP's range of responsibilities, and also the introduction of Area Based Health Planning for Ambulatory Care ("Care in the Community"), which will involve reconfiguring the healthcare system to provide a broader range of ambulatory care services in community-based settings (Department of Human Services, 2006).

The MVM PCP catchment is characterised by people at both ends of the income spectrum. The City of Melbourne has the highest concentration of homeless people in Victoria, and within the cities of Moonee Valley and Melbourne are the suburbs of Kensington, North Melbourne, Flemington and Ascot Vale, which have the second-largest number of public housing dwellings in Victoria and many high-rise blocks prominent on their skylines. Unemployment rates are high, and Flemington is one of Melbourne's five most disadvantaged suburbs. A priority for the Partnership are the needs of the most vulnerable – the homeless and the residents of public housing, particularly high-rise dwellers.

These suburbs are also exceptionally culturally diverse so along with environmental factors that discourage physical activity, significant language barriers and cultural attitudes towards physical activity and nutrition also have to be addressed. The objectives and strategies of this plan are designed to improve the reach and impact of member agencies' health promotion activities to the most disadvantaged residents in their catchments.

The Integrated Health Promotion section of the Strategic Plan seeks to continue and build on the 2004–06 objectives regarding physical activity, nutrition and mental health and wellbeing, and presents the strategies member agencies are implementing to achieve the Partnership's health promotion priorities. This PCP plan will be further refined in 2007 to take account of member agencies' plans that are presently being developed.

The Moonee Valley Melbourne PCP has traditionally worked in partnership with Westbay and Brimbank/Melton PCPs to coordinate services and initiatives such as e-referral and care planning, as well as health promotion for older people from Culturally and Linguistically Diverse (CALD)

communities. In the past twelve months this collaboration has extended to the Hume and Moreland PCP so this MVM PCP plan also addresses areas of work which are common to both PCPs. This includes service coordination as well as joint project to develop and test an appropriate structure and process for area based planning across the Moonee Valley Melbourne and Hume Moreland PCP catchments.

A handwritten signature in black ink, appearing to read 'H D Ingram', written in a cursive style.

Hazel Ingram  
Chairperson,  
Moonee Valley Melbourne  
Primary Care Partnership

# TABLE OF CONTENTS

- OVERVIEW OF COMMUNITY HEALTH PLANNING FOR THE MVM PCP ..... 1
- 1. PARTNERSHIP STRENGTHENING (DELIVERABLE 1)..... 3**
  - PARTNERSHIP VISION..... 3
  - ACHIEVING THE VISION: CAPACITY BUILDING PLAN ..... 3
  - GOAL 1: ..... 4
  - PCP MEMBER AGENCIES..... 5
- 2. INTEGRATED HEALTH PROMOTION CATCHMENT PLAN: (DELIVERABLE 2) ..... 8**
  - VISION ..... 8
  - PRIORITY SETTING AND PROBLEM DEFINITION ..... 8
    - National and State Health priorities..... 8
    - Catchment Priorities for 2006-09 ..... 9
    - Rationale ..... 9
  - SOLUTION GENERATION ..... 11
  - GOAL 1: PHYSICAL ACTIVITY ..... 12
    - Physical Activity Network ..... 12
    - Children ..... 13
    - Adults ..... 14
    - Older Adults ..... 16
  - GOAL 2: FOOD AND NUTRITION ..... 19
    - Children ..... 19
    - Vitamin D Deficiency ..... 19
  - GOAL 3: MENTAL HEALTH AND WELL BEING..... 21
    - Young adults ..... 21
    - Preventing Violence against Women..... 22
    - Older Adults ..... 24
  - RESOURCES ..... 26
    - Estimated IHP PCP resource allocation ..... 26
    - Additional IHP Resources ..... 26
  - PLANNING FOR QUALITY HEALTH PROMOTION PRACTICE ..... 27
- 3. SERVICE CO-ORDINATION: (DELIVERABLE 3)..... 28**
  - INTRODUCTION..... 28
  - GOAL 1: MANDATED AGENCIES ..... 28

GOAL 2 : ENGAGEMENT OF NEW SECTORS.....	30
GOAL 3: SUSTAINED REFERRAL SYSTEMS AND PRACTICES BETWEEN PRIMARY CARE/ ACUTE / SUB ACUTE SERVICES .....	31
GOAL 4: COORDINATED MULTI DISCIPLINARY CARE .....	33
GOAL 5: REFUGEE HEALTH SERVICE COORDINATION .....	34
RESOURCES .....	35
Estimated Service Coordination PCP resource allocation.....	35
Additional Service Coordination Resources.....	35
<b>4. INTEGRATED CHRONIC DISEASE MANAGEMENT PLAN (DELIVERABLE 4) .....</b>	<b>36</b>
GOAL 1.....	36
<b>GLOSSARY .....</b>	<b>38</b>
<b>APPENDICES .....</b>	<b>39</b>
APPENDIX 1.....	40
COMMUNITY PROFILE .....	40
APPENDIX 2.....	42
SUMMARY OF INTEGRATED HEALTH PROMOTION INITIATIVES IN THE MVM PCP .....	42
APPENDIX 3: MVM PCP MEMBER AGENCIES PRIORITIES FOR PHYSICAL ACTIVITY AND BETTER NUTRITION.....Attachment to Main Document	
APPENDIX 4: MVM PCP MEMBER AGENCIES PRIORITIES FOR MENTAL HEALTH AND WELLBEING.....Attachment to Main Document	

# OVERVIEW OF COMMUNITY HEALTH PLANNING FOR THE MVM PCP

Community Health Plans for PCPs identify health and wellbeing needs of the community and describe how the partners will work with each other and other key stakeholders to respond to those needs.

Four areas are identified by DHS as essential to creating a primary care service system that will improve health and wellbeing outcomes for consumers and reduce preventable use of hospital services. These areas constitute the following key deliverables for Primary Care Partnerships:

- Partnership strengthening (Deliverable 1);
- Integrated health promotion (Deliverable 2); and
- Service coordination; and (Deliverable 3)
- Integrated chronic disease management (Deliverable 4)

Department of Human Services Community Health Planning and Reporting Guidelines require PCPs to include plans for the four deliverables identified above. This document builds on past MVM PCP plans, in particular the operational plan for 2004–06.

DHS requires PCPs to identify for each deliverable identified above the goals, objectives, strategies and estimated impacts for their catchment which address broad goals DHS has stipulated for each deliverable. State Government *Guidelines for completing the Community Health Plan and Community Health Plan Implementation (CHPIA) templates* (DHS, 2006) reflect an increased emphasis on change management and capacity building in the planning and reporting process for 2006 to 2009.

Capacity building for effective health promotion program delivery requires the development of sustainable skills, organisational structures, resources and commitment to health improvement to prolong and multiple health gains many times over. Key action areas for building capacity include:

- organisational development
- workforce development
- resources
- leadership
- partnerships

(Health Promotion Strategies Unit, 1999, *A framework for building capacity to improve health*, NSW Health, Sydney in the *Integrated Health Promotion Resource Kit*, Department of Human Services, 2003)

PCPs are responsible for effecting these actions in working with member agencies to build capacity for the delivery of effective health promotion program delivery as illustrated in Figure 1. They are also actions, which the PCP effects to strengthen the systems and capacity of primary care agencies to achieve improvements in service coordination. Further examples of these actions are detailed in the *Integrated health promotion resource kit*, section 5, (DHS, 2003).

The development of this plan acknowledges the different levels of planning that agencies are responsible for and the different planning frameworks they use. These include the NSW capacity building framework detailed in the *Integrated Health Promotion Resource Kit* (Department of Human Services, 2003) and frameworks for municipal public health planning, in particular, the *Environments for Health, Promoting Health and Wellbeing through Built, Social, Economic and Natural Environments* (Department of Human Service, 2003).

A review of member agencies health plans presents the strategies which individual member agencies are committed to implementing to achieve the agreed health promotion priorities of the Partnership (see Appendices 4 and 5). Further refinement of this PCP plan will be made in its second year, 2007 – 2008, to take account of health plans to be developed by some member agencies in 2007 and a review of the first year's (2006-2007) achievements.

# 1. PARTNERSHIP STRENGTHENING (DELIVERABLE 1)

## PARTNERSHIP VISION

*To develop a responsive, integrated and coordinated primary health care service system for the population of our catchment through integrated area based planning approaches.*

The vision for the Moonee Valley Melbourne Primary Care Partnership (MVM PCP) reflects the changes in the broader planning environment, in particular the Victorian Government's addition of the fourth strategic direction – Integrated Chronic Disease Management – to the PCP's range of responsibilities, and the introduction of Area Based Health Planning for Ambulatory Care (*Care in the Community*), which will involve reconfiguring the healthcare system to provide a broader range of ambulatory care services in community-based settings (Department of Human Services, 2006). This will be a major focus of activity for many PCP member agencies over the next three years and will require collaboration within and between primary, sub acute and acute sectors.

## ACHIEVING THE VISION: CAPACITY BUILDING PLAN

The MVM PCP is committed to taking a proactive approach to area based planning for ambulatory care and has agreed to undertake a joint ambulatory care planning project with the Hume Moreland PCP as a precursor to area based planning proposed in the DHS *Care in Your Community (CiYC)* policy. Community health and acute services have instigated this through the PCPs to ensure that planning for health care in the community is conducted in partnership with local government and the broader community. The two PCPs, which share a border, have a strong collaborative relationship around service coordination, partly as a result of the fact that Melbourne Health is a major provider of both acute and sub –acute services throughout the two PCP catchments.

A joint ambulatory care project to be undertaken with the Hume Moreland PCP provides the opportunity to develop and test an appropriate structure and process for area based planning across the two PCP catchments. The project will focus on mapping and planning services around one specific ambulatory care sensitive condition, diabetes. The rationale is to contain the project so that we can achieve specific outcomes in terms of the structure and process for area based ambulatory care planning and improvement to service integration. From both a strategic and resource allocation perspective, it makes sense to ensure compatibility between the PCP's Integrated Chronic Disease Management and area based planning activities.

Strategies to be implemented through the ambulatory care project with Hume Moreland PCP, which will achieve our goals relating to Partnership Strengthening, are detailed below. Similarly the strategies to be implemented through the project and which will contribute to achievement of our goals for Integrated Chronic Disease Management (ICDM) are detailed in the ICDM Plan (see Section 4).

## GOAL 1:

To build our capacity to lead and contribute to integrated area based planning for ambulatory care in line with the Department of Human Services *Care in your Community (CiYC)* policy and principles.

**Objective:** Establish a strategic partnership of key agencies and stakeholders to develop and test a structure and process for area based ambulatory care planning which will support achievement of our goals relating to Integrated Health Promotion, Service Coordination and Integrated Chronic Disease Management.

Strategies	Timeframe
Implement a process for jointly developing and implementing a pilot planning and service integration project focused on a specific ambulatory care sensitive condition, such as diabetes, with the Hume Moreland PCP <b>(L and P)</b> .	Commence November 2006
Identify the human and financial resources which member agencies can commit to facilitate implementation of the pilot planning and service integration project <b>(R)</b> .	Commence April 2007
Develop a communication strategy with member agencies and other key stakeholders <b>(R and P)</b> .	
Establish PDSA (Plan Do Study Act ) cycle for undertaking systematic quality improvement of structure and process for area based planning <b>(P)</b> .	
Increase participation of existing and potential member agencies through the implementation of this pilot project <b>(L and P)</b> .	Commence May 2007
Investigate ways to engage small agencies and agencies representing other sectors within the broader community <b>(P)</b> .	
Review structure and processes established for the pilot project and their suitability for ongoing area based planning across other ambulatory care services and conditions <b>(P)</b> .	Commence Oct 2007
Make recommendations to DHS on local area workforce development strategies and projects to support ongoing planning in line with the integrated area based planning approach outlined in the Department of Human Services <i>Care in your Community (CiYC)</i> <b>(WD)</b> .	Commence Oct 2007
Seek opportunities through DHS funding as part of the <i>CiYC</i> implementation to develop and implement local area workforce development strategies <b>(R and WD)</b> .	Commence 2008

### *Estimated Impacts*

Stronger commitment to the Partnership by member agencies and associated partners to achieving goals relating to Integrated Health Promotion, Service Coordination and Integrated Chronic Disease Management.

The PCP and member agencies have a deeper understanding of the Care in Your Community framework and its implications for their service delivery.

The PCP and member agencies are in a position to assess the viability of area based planning across a combined Hume-Moreland and Moonee-Valley Melbourne catchment area.

The PCP and member agencies have developed and refined a structure and process to support ongoing area based planning for ambulatory care and is well positioned to implement the CiYC policy and to make recommendations to DHS on the role of PCPs in area based planning.

## **PCP MEMBER AGENCIES**

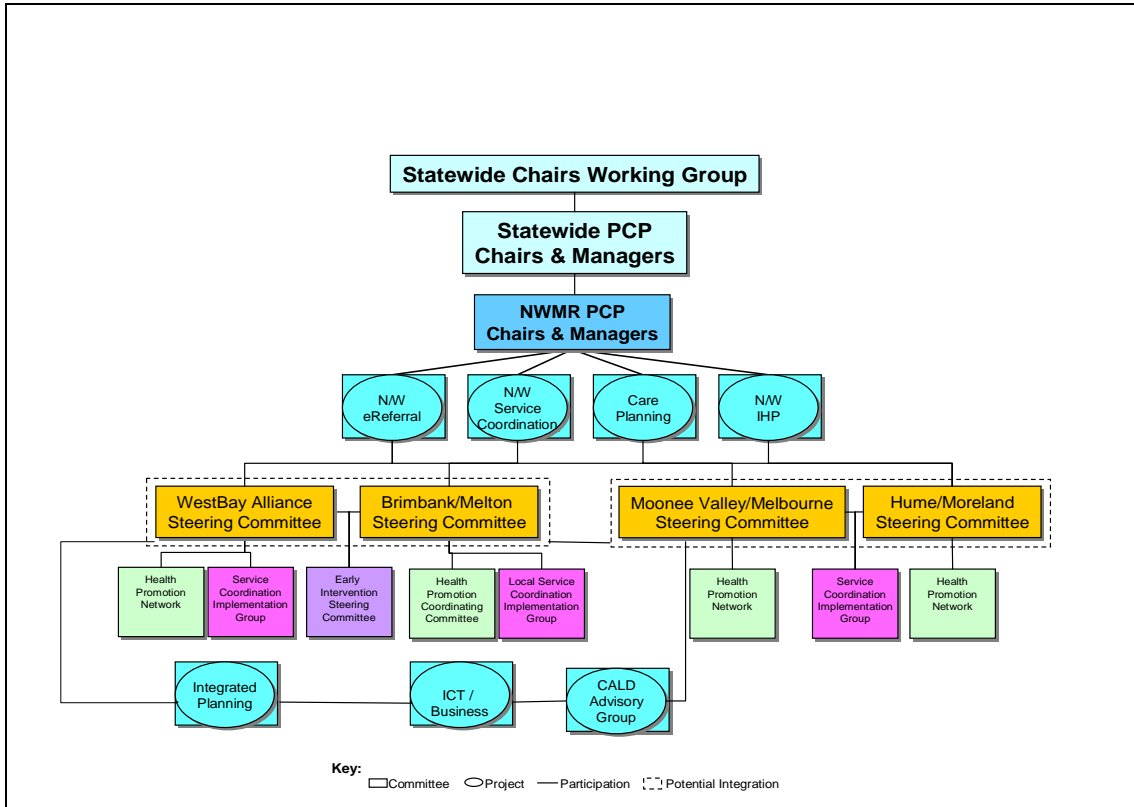
As well as the steering committee the two major PCP working groups which report to the Steering Committee are:

- The Health Promotion Working Group (HPWG)
- The Hume-Moreland Moonee Valley- Melbourne Service Coordination Implementation Working Group (SCIG)

Through our partnership with Westbay and Brimbank/Melton PCPs to coordinate services and initiatives, we are also responsible for overseeing the implementation of Western Metropolitan projects focusing on the needs of older people from Culturally and Linguistically Diverse (CALD) communities, through the Western Metropolitan Area CALD Aged Care Projects Advisory Committee. This includes monitoring the implementation of the CALD Aged Care Strategic Plan, which was prepared for the then Western Metropolitan Region for the period 2003-08. The committee structure for the MVM PCP and its relationship to other PCPs and regional committees in the North West Region is shown below in Box 1. The member agencies and associated partners who participate in the two major PCP committees and the CALD Aged Care Projects Advisory Committee are listed in Table 1.

A third tier of working groups support specific health promotion or service coordination projects and are usually time limited or project focused. Some of these committees include the Vitamin D Stakeholder Group, the Physical Activity and Chronic Disease working group and the Project Reference Group for the Dementia Care Planning Project. These committees and working groups enable engagement with agencies representing other sectors within the broader community.

Box 1: Moonee Valley Melbourne Primary Care Partnership's structure and links with subregional and regional committees in the North West Region.



Source: Kennedy L, Westbay Primary Care Partnership

Table 1: Moonee Valley Melbourne Primary Care Partnership member agencies and associated partners <sup>2</sup>

Agency	Steering Committee	Service Coordination Implementation Group	Health Promotion Working Group	CALD Aged Care Projects Advisory Committee
Aged Services Network - Western Region				✓
Australian Romanian Community Welfare		✓		
Carers Victoria		✓		
Doutta Galla Community Health Services	✓	✓	✓	✓
Essendon Adult Day Centre		✓		
Melbourne Division of General Practice	✓	✓		
North West Division of General Practice		✓		
Melbourne Health – Community Partnerships	✓	✓		
Melbourne Health - North West ACAS		✓		
Moonee Valley City Council	✓	✓	✓	✓
North Western Breastsreen			✓	
Royal District Nursing Service	✓	✓		✓
Royal Women's Hospital			✓	
Vision Australia		✓	✓	
Waratah Mental Health Services	✓		✓	
Western Region Health Centre				✓
Women's Health West	✓		✓	
North West Migrant Resource Centre				✓
Ethnic Services Network				✓

<sup>2</sup> At the time this Community Health Plan was prepared, the City of Melbourne had suspended their participation in the PCP while undertaking a review of their ongoing involvement within the existing primary care partnership arrangement.

## 2. INTEGRATED HEALTH PROMOTION CATCHMENT PLAN: (DELIVERABLE 2)

### VISION

*To improve the health and well being of the population of our catchment through a collaborative and coordinated approach to health promotion which is informed by the population's health needs.*

### PRIORITY SETTING AND PROBLEM DEFINITION

The key activities undertaken as part of this phase of the planning process have included:

- Reviewing State and Commonwealth key health priorities/ directions.
- Collating population health data for the catchment. The most recent analysis of this data has been prepared for the *Doutta Galla Community Health Service Plan and Model of Care, 2006* (nlt Consulting, 2006). A brief summary of this analysis is provided in Appendix 1.
- Reviewing the 2004-06 MVM Community Health Plan and health promotion initiatives implemented in the catchment which related to the PCP priorities. A summary of these initiatives is included in Appendix 2.
- Locating local health plans, including Municipal Health Plans and Community Health Services Health Promotion plans to identify shared priorities and health promotion activities.

Health promotion staff in the MVM PCP attended a workshop organised by the PCP Health Promotion Working Group to generate actions to address these goals and objectives. Regular meetings of the MVM PCP Health Promotion Working Group have since been held to further develop the integrated health promotion plan.

This Integrated Health Promotion plan will be refined in the second year of the plan, 2007 – 2008, to take account of health plans to be developed by some member agencies in 2007 and a review of the first year's (2006-2007) achievements.

### National and State Health priorities

The National Health Priority Areas are cancer control, injury prevention and control, cardiovascular health, diabetes mellitus, mental health, asthma, and arthritis and musculoskeletal conditions.

(URL reference: <http://www.health.vic.gov.au/nhpa/>)

Victorian State Government health promotion priorities for 2007 – 2012 are:

- Promoting physical activity and active communities
- Promoting accessible and nutritious food
- Promoting mental health and wellbeing
- Reducing tobacco-related harm
- Reducing and minimising harm from alcohol and other drugs

- Safe environments to prevent unintentional injury
- Sexual and reproductive health

(URL reference: <http://www.health.vic.gov.au/healthpromotion/role/index.htm#hpps>)

## Catchment Priorities for 2006-09

### Physical activity

**Goal:** To improve the health and well-being of children, adults and older adults within the PCP catchment through increased participation in physical activity

**Objectives:**

Strengthen partnerships between PCP member agencies to achieve more physically active communities

Increase participation of children in physical activity through the integration of the H2O for Moonee Valley Kids program with the Kids Go for Your Life

Increase participation of CALD communities in local walking groups through the sustainability and expansion of the Walk for Well-being program.

Provide active living programs for older adults at varying levels of intensity and duration and in a range of settings.

Build capacity in primary and community care services to enhance physical activity and better nutrition for older people through Well for Life initiatives.

### Food and Nutrition

**Goal:** To improve the health and well-being of women and children from newly arrived CALD communities

**Objectives:**

Decrease the incidence of Vitamin D deficiency in women and children from high risk population groups, in particular, dark skinned and veiled communities

### Mental health and well-being

**Goal:** To improve the mental health well-being of high risk population groups in the cities of Moonee Valley and Melbourne.

**Objectives:**

Support initiatives which aim to improve the mental health and well being of young people.

Develop a coordinated catchment plan to prevent violence against women

Improve the focus on health promotion in aged care services including a focus on well-being, illness prevention and ill management to culturally and linguistically diverse communities.

## Rationale

Areas identified as Integrated Health Promotion Priority Areas for the MVM PCP for 2004-06 will remain priority areas for the PCP for 2006-09. More recent analysis of the health status of the Melbourne and Moonee Valley population for the *Doutta Galla Community Health Service Plan and Model of Care, 2006* provides further confirmation of these priorities. The major indicators of health status used for this analysis include:

- above average causes of disability as defined and measured in the Department of Human Services, Victorian *Burden of Disease Study* 2001
- an analysis of the risk factors, which contribute to the burden of disease based on Department of Human Services data
- the top six Ambulatory Care Sensitive Conditions (ACSCs) for the MVM PCP catchment for 2004/05.

(*Doutta Galla Community Health Service Plan and Model of Care, 2006*, nlt Consulting, 2006).

DGCHS's analysis indicates that the most prevalent condition contributing to the burden of disease for the Moonee Valley and Melbourne population aged 15 to 44 years is mental health disorders, predominantly depression. The most prevalent conditions contributing to the burden of disease for adults aged 45 – 64 years are malignant cancers (predominantly breast cancer for women and lung cancers for men) and cardiovascular disease. As the population ages the prevalence of neurological sense disorders, increases in both municipalities and becomes the third greatest contributor to the burden of disease in the population aged 55 plus. The most predominant neurological sense disorder amongst the male population aged 55 plus in the City of Melbourne is dementia, whereas in Moonee Valley, dementia predominates amongst the neurological sense disorders in the population 65 plus (*Victorian Burden of Disease Study, Department of Hume Services, 2001* in the *Doutta Galla Community Health Service Plan and Model of Care, 2006*, nlt Consulting, 2006).

In analysing the risk factors which contribute to the burden of disease the DGCHS Service Plan (nlt Consulting, 2006), compares the former Western Region with Victoria and finds that, for males, alcohol harm and illicit drugs are the two risk factors where the region had a higher attributable burden than Victoria. For females, intimate partner violence and obesity were the two risk factors which exceeded the Victorian percentage (nlt Consulting, 2006). This Integrated Health Promotion Plan accordingly identifies mental health and wellbeing as a priority area and in particular initiatives to prevent violence against women. A service coordination project, to be implemented in 2007, which will focus on people in the Central Business District who are homeless, will inform further priorities for health promotion which address the needs of this most vulnerable group.

The third indicator of health status used in the analysis prepared for the DGCHS Service Plan is Ambulatory Care Sensitive Conditions (ACSCs). These are conditions which hospitalisation is thought to be avoidable if preventative care and early disease management are applied, usually in the ambulatory setting (nlt Consulting, 2006). Based on an analysis of Department of Human Services data on ACSCs (DHS, 2004) the DGCHS Service Plan identifies that within the MVM PCP in 2004/05:

- The admission rates for the total ACSCs increased from 28.18 per 1,000 people in 2000/01 to 36.69 per 1,000 people in 2004/05;
- Diabetes complications were the leading cause of admissions in 2004/05 with 2,830 admissions, a rate of 16.25 per 1000 persons; and
- The admission rate ratios for the top ten ACSCs admissions were either similar to or lower than the Victorian average in 2004/05.

(nlt Consulting, 2006).

Since physical activity and poor nutrition are risk factors for a variety of disease and conditions including diabetes and cardiovascular disease, these are therefore health promotion priorities for the MVM PCP.

As well as the health status summarised above, local area data has also influenced the determination of health promotion priorities for the PCP. In 2003 Moonee Valley City Council (MVCC) Maternal and Child Health nurses reported an increased incidence of Vitamin D deficiency in women and young children in Moonee Valley, prompting further investigation by MVCC, the Dousta Galla Community Health Service (DGCHS) and the Moonee Valley Melbourne Primary Care Partnership (MVM PCP). Vitamin D deficiency causes rickets and other painful bone disease associated with muscle weakness and has been linked to increased risk of some types of cancer, diabetes and osteoporosis in adults (*MVM PCP Community Health Plan, 2004-06*).

Results of a 10-month study of pregnant dark skinned and/or veiled women conducted by the Royal Women's Hospital in Melbourne provided supporting evidence of this increased incidence. The most recent arrivals to both Moonee Valley and Melbourne cities are people from the Horn of Africa countries and most of these people are living in the high rise public housing estates.

Since 2004, the PCP has supported food and nutrition initiatives which have focused on addressing the prevalence of Vitamin D deficiency amongst the dark skinned and veiled population residing in the MVM catchment. This work will continue and will focus on implementation of a community based health promotion program addressing system, health care provider and consumer barriers.

## SOLUTION GENERATION

The development of this Plan acknowledges the different levels of planning that agencies are responsible for and the different planning frameworks they use. These include the NSW capacity building framework detailed in the *Integrated Health Promotion Resource Kit* (Department of Human Services, 2003) and frameworks for municipal public health planning, in particular, the *Environments for Health, Promoting Health and Wellbeing through Built, Social, Economic and Natural Environments* (Department of Human Service, 2003).

In acknowledging this difference this Plan refers to the strategies or interventions detailed in agencies existing health promotion and public health plans which relate to this PCP's health promotion priorities. This information is presented in Appendices 3 and 4 which include the relevant extracts from member agencies plans.

The NSW capacity building framework detailed in the *Integrated Health Promotion Resource Kit* (Department of Human Services, 2003) has been used in the development of this Plan to identify capacity building actions of the PCP to improve the reach and impact of member agencies' health promotion activities. These actions address the following:

- organisational development ( **OD** )
- workforce development ( **WD** )
- resources ( **R** )
- leadership ( **L** )
- partnerships ( **P** )

Examples of each of these actions are identified in the IHP plan by their initials.

# GOAL 1: PHYSICAL ACTIVITY

## Physical Activity Network

*Objective:* Strengthen partnerships between PCP member agencies to achieve more physically active communities.

### *Member agencies actions*

Given Local government encompasses all three dimensions of physical activity – health, sport and recreation and infrastructure planning it is ideally placed to coordinate a physical activity network for the local area. It is recommended then that Councils establish and support physical activity networks as an information sharing forum, to meet quarterly and with links established to the Local Government physical activity network through Kinect.

PCP capacity building actions	Timeline
Facilitate development of relationships and links with relevant local, regional and statewide organisations (P)	2007
Provide evidence based information and resources relevant to physical activity to member agencies through the physical activity network (R)	2007-09
Publicise membership, role and activities of the physical activity network to agencies within the MVM PCP catchment through PCP communication strategies (R)	2007-09

### *Estimated Reach*

Areas within MVCC (neighbourhood houses, sustainable transport, recreation, strategic planning), PCP member agencies, including Dootta Galla Community Health Service, Melbourne Health and other agencies representing the broader community.

### *Estimated Impacts*

- Participants of the network have increased knowledge and understanding of the role and activities of other agencies involved in physical activity.
- Member agencies are aware of broader developments in physical activity area.
- Physical activity interventions are evidence based.

## Children

**Objective:** To increase the participation of children in physical activity through the integration of the H2O program with the Kids Go for Your Life strategy.

### **Member agencies actions**

(See Appendix 2)

DGCHS Health promotion interventions:

- Kids Go for Your Life
- Go for Your Life

MVCC strategies:

- Continue to develop partnerships with schools (including preschools) to promote programs that contribute to physical and recreational activities.

City of Melbourne priority areas:

- Services: Childcare

PCP capacity building actions	Timeline
Support collaboration between Doutta Galla Community Health Service and primary schools and pre-schools who participated in the H2O for Moonee Valley Kids program to integrate the H2O Program with the Kids Go for Your Life strategy and to pilot this integrated program in one school. <b>(P)</b>	2006-08
Work with DGCHS to strengthen links between primary schools who participated in the <i>H2O for Moonee Valley Kids</i> program with the MVCC and CoM Walking School Bus programs, Stride and Ride and Turn off Switch to Play programs to encourage shared goals and agreements between stakeholders on the further development of the physical activity components of the <i>Kids Go for Your Life</i> strategy <b>(P)</b>	2006-09

### **Estimated Reach**

One school selected for piloting the Kids *Go for Your Life* strategy with adoption of the strategy by at least 80% of schools who participated in the H2O program.

### **Estimated Impacts**

- Schools' charter reflects healthier lifestyle principles.
- Physical activity incorporated into schools' curriculum.

## Adults

**Objective:** Increase the participation of CALD communities in local walking groups through the sustainability and expansion of the Walk for Well-being program.

### *Member agencies actions*

(See Appendix 3)

DGCHS Health promotion interventions:

- Walk for Well Being

MVCC strategies:

- Provide and promote a range of recreation and leisure options accessible for families.
- Provide and support opportunities to participate in physical activity for young people.
- Continue development of public spaces that facilitate participation including toilet facilities, seating, footpaths and access to transport.

City of Melbourne priority areas:

- Amenity
- Life opportunities and choices: Physical activity
- Transport: Encourage and support sustainable transport modes

Divisions of General Practice priority areas:

- Prevention early intervention - Life scripts

PCP capacity building actions	Timeline
<p>Organisation and support for a working group comprised initially of DGCHS and areas within MVCC (neighbourhood houses, sustainable transport, recreation, strategic planning) to plan and initiate actions to:</p> <ul style="list-style-type: none"> <li>• ensure the sustainability of walking groups for Arabic and Somali speaking communities initiated through the Walk for Well Being program and</li> <li>• spread this program to other CALD communities to facilitate participation and inclusion of the broader CALD community in local walking groups. <b>(L and P)</b></li> </ul>	2007
<p>Building on strategies implemented through Walktober, seek and disseminate information on funding opportunities to working group participants to support sustainability of existing walking groups and to increase local walking groups <b>(R)</b></p>	2007
<p>Strengthen inter sectoral links between the primary care sector and areas within Councils which are responsible for sustainable transport, urban, economic development and strategic planning to ensure:</p> <ul style="list-style-type: none"> <li>• support for the establishment of a mechanism to support and coordinate development of community walking groups in the MVM catchment, building on the experience of similar initiatives, such as, Go West (and walk) initiated by the Brimbank and Melton Councils</li> <li>• a greater focus on developing the built and natural environments to support physical activity in the development of MVCC structure plans for Activity Centres (Melbourne 2030) in Ascot Vale, Flemington and Kensington. <b>(P)</b></li> </ul>	2007–09

Promote walking groups as well as other physical activity options to Melbourne Health through the Health Promoting Emergency Department Officer and Divisions of General Practice through programs such as COACH (provided through MDGP) self management program and the Life scripts program. (L and P)	2007-09
--	---------

***Estimated reach***

Initially to ensure the sustainability of walking groups for Arabic and Somali speaking communities initiated through the Walk for Well Being program, with the aim to spread this program to other CALD communities to facilitate participation and inclusion of the broader CALD community in local walking groups.

***Estimated Impacts***

- Increased participation of CALD communities in local walking groups
- Increased participation of self nominated community members from CALD communities in the 'Walking Leaders Workshop' conducted by the Centre for Multicultural Youth Issues (CMYI).
- Walking groups are sustained by community facilitators
- General Practitioners use Life scripts to refer people to local walking groups through established coordinating mechanism
- Increased opportunities for active transport through connecting and new paths, inclusion of water fountains and increased seating within the urban design in the development of Activity Centres.

## Older Adults

**Objective:** Provide active living programs for older adults at varying levels of intensity and duration and in a range of settings.

### **Member agencies actions**

(See Appendix 3)

DGCHS Health promotion interventions:

- Living Longer Living Stronger
- Chinese and Vietnamese exercise programs

MVCC strategies:

- Provide recreation and leisure facilities for older people.
- Develop a program of integrated health promotion activities focusing on identified high risks for older adults including physical and emotional health.

City of Melbourne priority areas:

- Life opportunities and choices: Physical activity

Divisions of General Practice priority areas:

- Prevention early intervention - Life scripts
- Chronic disease management (links with self management programs, such as COACH)

Melbourne Health

HARP: Melbourne Health Consortium and Melbourne Health Community Therapy Service to assist in developing processes and practices to facilitate referral of older people to programs which best suit their needs.

PCP Health promotion capacity building actions	Timeline
Seek and disseminate information on funding opportunities to member agencies to resource DGCHS and MVCC to collaboratively develop a "continuum" of active living programs for older people and people with chronic disease. <b>(R)</b>	2006 -09
Allocate resources to access expert advice on a standard grading format to locate best practice community based active living programs provided at varying levels of intensity and duration and provided in a range of settings. <b>(R)</b>	2007
Facilitate collaboration between allied health professionals at DGCHS, HARP, Melbourne Health and MVCC with Connectingcare to ensure information on physical activity programs is available, regularly maintained by agencies on an online service directory through Connecting care and is downloaded and produced as a hard copy directory for distribution to older people. <b>(P)</b>	2007-08
Promote active living programs (including walking groups) to Melbourne Health through the Health Promoting Emergency Department Officer and Divisions of General Practice through programs such as COACH (provided through MDGP) and self management program and the Life scripts program. <b>(L and P)</b>	2007-08

Support allied health and community services staff in DGCHS, MVCC, General Practitioners HARP: Melbourne Health Consortium and Melbourne Health Community Therapy Service to develop processes and practices to facilitate referral of older people to programs which best suit their needs. (P)	
Support the establishment of programs required to ensure pathways to: <ul style="list-style-type: none"> <li>physical activity programs based in neighbourhood and community settings to sustain the benefits achieved through participation in transition LLLS programs, or which alternatively may provide a transition to LLLS programs provided in primary care settings.</li> <li>programs through which social connections with other participants can be continued. (R)</li> </ul>	2006-08
Promote the MVCC Older Adults Network to allied health and community services staff as a means of engaging older people in planning and implementing active living programs. (L)	2006-09
Ensure <i>Living Longer Living Stronger</i> quality assurance and evaluation data maintained by DGCHS is shared with key partners so that changes in the reach of the program(s), and the value of the program in assisting older people to take up programs in other settings can be observed and assessed. (OD).	2006-09
Promote the MVCC Seniors Expo held as part of the Councils' Seniors Festival, to key partners as a means of providing information and resources on active living programs to Moonee Valley's older adults. (L)	2007, 08, 09.

### ***Estimated reach***

Older adults, particularly those from CALD communities.

### ***Estimated Impacts***

- Referrers are able to locate best practice community based active living programs provided at varying levels of intensity and in a range of settings through an online directory of group based physical activity programs and LLLS programs assessed according to a standard grading format.
- Identified single points of contact within the key organisations: DGCHS, MVCC, local gyms, including AVSFC and EKLC, HARP: Melbourne Health Consortium and Melbourne Health Community Therapy Service to facilitate referral of people to programs.
- General Practitioners use Life scripts to refer people to active living programs through established coordinating mechanisms.
- A "continuum" of programs identified which will enable older people to readily access:
  - transition LLLS programs provided in primary care settings without waiting long periods
  - mainstream programs through local gyms or alternatively physical activity programs based in neighbourhood and community settings to sustain the benefits achieved through participation in transition LLLS programs. Physical activity programs based in neighbourhood and community settings may also provide for some older people a transition to LLLS programs provided in primary care settings.
  - maintenance programs through which social connections with other participants can be maintained.

**Objective:** Build capacity in primary and community care services to enhance physical activity and better nutrition for older people through Well for Life initiatives.

The intention of this objective is to:

1) Enhance staff capacity to:

- discuss with older individuals their physical activity and nutritional needs;
- identify areas to enhance opportunities for improved nutrition and physical activity
- identify ways to achieve consistency and quality in screening and assessment;
- lead group discussions around nutrition and physical activity and supporting continuous improvement in everyday practice
- support organisations plan and deliver preventive initiatives around nutrition and physical activity

2) Foster links between community care staff and health professionals and medical staff who could provide advice and assistance in the areas of nutrition and physical activity for older people.

A proposal to address this objective will be developed with the Health Promotion Working Group in 2007. The proposal will involve the implementation of a quality improvement methodology, involving staff in primary care and community services, to introduce ways in which the Well for Life resources, designed for primary health and community service organisations, can be used to support improvements in nutrition and physical activity for older people. These resources published by the Department of Human Services in 2005, include:

**Guide to action** – Guidelines to support staff lead a group process to identify continuous improvement opportunities in nutrition and physical activity and self-assessment tools to evaluate the effectiveness of current practice.

**Help sheets** – evidence based information/guidelines and tips to inform discussion, strategies and action on physical activity and nutrition for older people

**Education supplements** – Training modules and case studies to support quality improvement in organisational practice.

The proposal will detail strategies for implementation, timelines and resources required. It is expected that this work could occur in 2008 and 2009.

## GOAL 2: FOOD AND NUTRITION

To improve the health and well being of women and children from newly arrived CALD communities

### Children

*Objective:* See Kids for Your Life strategy under Goal 1.

### Vitamin D Deficiency

*Objective:* Decrease the incidence of vitamin D deficiency in women and children from high-risk population groups, in particular, dark skinned and veiled communities.

#### *Member agencies actions*

Health care providers

- Education of GPs, other health professionals and service providers to increase their knowledge and awareness as well as their cultural sensitivity to recognise and respond to women who feel inhibited or discouraged to ask about health issues.
- Increase awareness and knowledge of at risk communities by providing information in different settings and using a variety of media: community radio, community leaders, and community newspapers/letters.

(Refer Appendix 3, DGCHS Health promotion interventions:

- Vitamin D deficiency
- Walk for Well being
- Refugee Health).

Local Government and community organisations

- Explore opportunities to creating environments (built), including modification of existing facilities, to meet religious and cultural needs.
- Develop a range of strategies to increase access to open spaces for families at risk of developing Vitamin D deficiency.
- Develop programs that integrate with support for different social needs, such as childcare, to increase opportunities for women to access Vitamin D through sun exposure.

(Refer Appendix 3, MVCC strategies:

- Provide and promote a range of recreation and leisure options accessible for families.
- Continue development of public spaces that facilitate participation including toilet facilities, seating, footpaths and access to transport).

PCP capacity building actions	Timeline
Advocate at Local, State and Commonwealth levels, as well as within professional training bodies to ensure Vitamin D deficiency is identified as a priority in organisations health promotion plans <b>(L)</b>	2006-09
Support continued research to develop an evidence base for interventions <b>(L and P)</b>	2006-09
Advocate for access to effective pharmacological intervention <b>(L)</b>	2006-09
Organisation and support for the Vitamin D Stakeholder Group which facilitates links partnership opportunities between stakeholders with shared goals and common work. <b>(P and OD)</b> .	2006 -2008
Promote actions required to prevent Vit D deficiency to key stakeholders through effectively communicating findings from activities including research, education and awareness raising activities. <b>(L)</b> .	2006 -2008
Draw on the knowledge and expertise of key stakeholders, including refugee health networks, coordinate development of an innovative dissemination strategy through the Vit D Stakeholder Group to affect knowledge transfer in a variety of settings, using a variety of media. <b>(R)</b>	2006 -2008
Identify and procure resources to support actions required of key stakeholders, such as, further research and translation and printing of the Vitamin D brochure into a range of community languages, in addition to Arabic and Vietnamese. <b>(R)</b>	2006 -2008
Utilise Divisions of General Practice, through the Refugee Health Service Coordination Project, to educate GPs to increase their knowledge and awareness as well as their cultural sensitivity to recognise and respond to women who feel inhibited or discouraged to ask about health issues. <b>(WD)</b>	2007

### ***Estimated reach***

Dark skinned and veiled communities living in high rise accommodation in the southern end of the City of Moonee Valley and parts of the City of Melbourne.

### ***Estimated Impacts***

- Strategies which aim to address Vitamin D deficiency in at risk populations are included in all member agencies public health and health promotion plans.
- Formal responsibility for Vit D project is established/ maintained within management positions within all member agencies.
- Other languages for translation of the brochure have been identified, funds obtained for translation and printing and brochures produced.
- Research which will evaluate knowledge transfer through innovative dissemination strategies to dark skinned and veiled communities living in the southern end of the City of Moonee Valley and parts of the City of Melbourne has been implemented.
- Education has been provided to General Practitioners and other health professionals, such as Maternal and Child Health nurses.
- Environments (built) and program opportunities for women to access appropriate levels of sun exposure and meet religious and cultural needs are planned.

## GOAL 3: MENTAL HEALTH AND WELL BEING

To improve the mental health well-being of high risk population groups in the cities of Moonee Valley and Melbourne.

### Young adults

**Objective:** Support initiatives which aim to improve the mental health and well being of young people.

#### *Member agencies actions*

(See Appendix 4)

DGCHS Health promotion interventions:

- Young people, CALD backgrounds (*DGCHS Community Health Service Plan and Model of Care, 2006*)

MVCC strategies:

- Continue to develop responses to mental health issues for young people

City of Melbourne priority areas:

- Services: Social well being

Melbourne Division of General Practice:

(Strategic plan to be developed in 2007)

PCP capacity building actions	Timeline
Disseminate information across networks within the MVM PCP to member agencies so that they may become interested and engaged in coordinated approaches to addressing the health needs of this population group. (R)	2007-09

#### *Estimated Impact*

Enhanced knowledge of approaches to addressing the health needs of young people from the North Melbourne and Flemington Public Housing Estates reported by the PCP member agencies.

## Preventing Violence against Women

**Objective:** Develop a coordinated catchment plan to prevent violence against women

### *Member agencies actions*

(See Appendix 4)

The actions of the member agencies in supporting further work to prevent violence against women would be:

Women's Health West

- Western Region Strategy for preventing violence against women.

DGCHS Health promotion interventions

- Violence Against Women

MVCC strategies:

- Develop systems to increase service coordination and responsiveness to maximise positive health outcomes for children
- Develop safety plans for neighbourhoods considering all environments that affect the health and wellbeing of families and children

City of Melbourne priority areas:

- Services: Social well being

Royal Women's Hospital

(Review of health promotion priorities / strategies in process)

PCP capacity building actions	Timeline
Membership of Project Management Group and Expert Advisory Group for the project <i>Building the capacity of organisations in the western region to prevent violence against women: A guide to health promotion action</i> pending funding (P)	2007-09
Assist in locating and developing materials and resources and in the development of knowledge about identifying, planning and implementing effective strategies to prevent violence against women. (R)	2007-09
Disseminate information across networks within the MVM PCP to member agencies so that they may become interested and engaged in also developing projects that aim to stop violence before it starts. (R)	2007-09
Co-convene a research forum with WHW and other PCPs to: encourage the development of activities to monitor and evaluate policies and practices supportive of prevention of violence share information about health promotion strategies for prevention of violence against women strengthen networking encourage partnership opportunities between member agencies (L)	2007-09
Advocate for the inclusion of health promotion activities aimed at the prevention of violence against women in organisational health promotion plans, municipal public health plans and other related strategic plans (OD)	2007-09

### *Estimated reach*

Two workers from each of six member agencies of the western region PCPs who nominate for involvement (including local government, community health and other agencies) will participate in the action research-based project designed to work with a small sample of agencies in the western region who currently receive health promotion funding.

### *Estimated Impact*

- Enhanced knowledge of approaches to preventing violence against women reported by the project participants
- Participants report increased awareness and use of resources to assist in planning and implementing health promotion projects to prevent violence against women
- Agencies report increased skill base among workers with responsibility for violence prevention activities
- Increased focus on prevention approaches in member agencies plans.

## Older Adults

**Objective:** Improve the focus on health promotion in aged care services including a focus on well-being, illness prevention and illness management to culturally and linguistically diverse consumers. (WMA CALD Aged Care Strategic Plan, 2003 – 08)

### **Actions of member agencies of the Western Metropolitan Area CALD Aged Care Projects Advisory Committee**

The WMA CALD Aged Care Projects Advisory Committee will aim to improve the social connectedness of older members of the Coptic Egyptian and Horn of African communities in the Western Metropolitan Area through the implementation of the following health promotion actions through PCP health promotion committees.

- Educate health and community service providers to increase their knowledge and cultural awareness and sensitivity to the needs of Coptic Egyptian and Horn of African communities through the Ethnic Services Network CALD Skills Training Project and ongoing training opportunities through the WMA Aged Services Network.
- Increase awareness and knowledge of the targeted communities of Home and Community Care (HACC) services by providing information in different settings and using a variety of media including but not limited to: community radio, community newspapers/letters, community leaders and outreach services such as friendly visiting services.
- Identify health information needs of the targeted communities and increase their opportunities to receive information and screening services through establishing links with outreach and mobile services provided by health organisations.
- Increase the range of planned activities available to members of the targeted communities by facilitating their access to facilities, equipment and local government community transport services and by linking them into existing health promotion and HACC funded activities programs provided through local Government and community health providers.
- Explore opportunities for language and skill enhancement to increase community capacity of the targeted communities.

HACC CDO capacity building actions	Timeline
Organisation and support for the WMA CALD Aged Care Advisory Committee which facilitates links between stakeholders to initiate key actions and continued emphasis on health promotion targeting older people from CALD communities (with a focus on Egyptian Coptic and Horn of Africa communities) as a priority area for PCPs' in the Western metropolitan area (P and OD).	2006-09
Advocate for the inclusion of health promotion activities for older members of the targeted CALD communities in organisational cultural action plans, health promotion plans, municipal public health plans and other related strategic plans (OD).	2006-09
Identify and engage key partners to assist with planning and implementing health promotion strategies designed to address above objectives by further developing a work plan which identifies key actions, responsibilities and timelines and which builds on any existing initiatives (P and L).	2006-09
Strengthen links with health promotion working groups for PCPs' in the WMA to share information and increase potential for collaborative work to address the above objectives (P).	

Effectively communicate to member agencies of the WMA CALD Aged Care Advisory Committee and consumer representatives' findings from activities undertaken to address the above objectives, for example, education and awareness raising activities undertaken through the Ethnic Services Network CALD Skills Training Project (L).	2006-09
Seek and disseminate information on funding opportunities to member agencies of the WMA CALD Aged Care Advisory Committee which would enable achievement of above objectives (R).	2006-09

***Estimated reach***

Older members of the Coptic Egyptian and Horn of African communities living in the Western Metropolitan area.

***Estimated Impact***

- Enhanced cultural awareness reported by health and community service providers.
- Older members of the Coptic Egyptian and Horn of African communities report increased awareness and use of home and community care services.
- Increased focus on prevention approaches in member agencies plans.

# RESOURCES

## Estimated IHP PCP resource allocation

Capacity building components	DHS Funded PCP IHP	Member contributions
Partnership development	30%	
Leadership	30%	
Resources	25%	
Organisational development	10%	
Planning for evaluation and dissemination	5%	
Workforce development		
Estimated total PCP resource/budget allocation	\$49,000 pa	

Note: The most common PCP health promotion capacity building actions are partnership development (30%), leadership (30%), and procuring resources (25%). A plan for systematic quality improvement of health promotion practice and evaluation is detailed below. This plan will identify the human and financial resources required to undertake evaluation.

## Additional IHP Resources

Funding source /project	Links to catchments priority	Income 2005/06	Income 2006/07
DHS	Food and Nutrition: Vit D deficiency		\$1,800
Cities of Melbourne and Moonee Valley	Food and Nutrition: Vit D deficiency	\$6,000	
DVC	Physical Activity: Older adults (active living programs)	\$20,000	
DVC	Physical Activity: Adults (Walk for Well-being)	\$10,000	\$1,000

# PLANNING FOR QUALITY HEALTH PROMOTION PRACTICE

A key task for the PCP is the development of an evaluation plan to assess the reach, value and impact of this IHP Plan. This work will be undertaken in 2007 and will identify:

- the broad approach and focus of the evaluation
- key questions an evaluation would need to address
- strategies for data collection, management and analysis
- strategies for dissemination
- timelines and budget required to conduct evaluation

The form of evaluation will be based on a capacity building and interactive approach to support staff from member agencies undertake systematic enquiry of their health promotion activities using an action learning approach, such as the PDSA (Plan Do Study Act) quality improvement methodology. This approach involves staff:

- seeking agreement on key issues to be addressed;
- exploring the range of suitable actions to address the identified key issues;
- seeking agreement on a plan (s) of action;
- implementing the actions;
- reflecting on the implemented actions; and
- evaluating the outcomes and refining actions and / or identifying new or modified actions as needed.

Through this approach staff from member agencies will be able to identify key barriers and enablers to implementing health promotion activities identified in the Integrated Health Promotion Plan. Solutions that may be generated from this exploration of barriers and enablers, could include education and training sessions in planning health promotion, developing partnerships etc..

The development this plan will occur through the Health Promotion Working Group and will utilise skills and expertise available through member agencies, other PCPs, health promotion experts and advisers and will refer to recommended resources, such as the *Planning for effective evaluation* (DHS, 2005).

# 3. SERVICE CO-ORDINATION: (DELIVERABLE 3)

## INTRODUCTION

This section of the Community Health Plan focuses on strengthening the systems and capacity of primary care agencies across the PCP to coordinate and respond to the needs of the clients and community. This service coordination component is a joint plan across the Moonee Valley Melbourne and Hume Moreland Primary Care Partnerships, reflecting the commitment by both management groups to extend collaboration across the PCPs where common work is occurring.

Many of the components of the plan are ongoing activities that aim to consolidate the progress of implementation of the Better Access to Services (BATS) framework that has formed much of the work of the PCP over the past 5 years. Over the next three years there will be further emphasis on supporting the expansion of the service coordination strategy into new program areas (see Goal 2) and facilitating systems development to coordinate care planning (see Goal 4). The Refugee Health Service Coordination project (see Goal 5) is a new Service Coordination initiative being implemented in 2006/07.

Whilst some projects have specific funding attached (as detailed in the plan) many of the activities are reliant on the small amount of core funding the PCPs receive for service coordination. This results in having to prioritise what is achievable with the given resources. Many of the activities are also contingent on deliverables by DHS and these have been detailed under each major goal.

DHS have requested that the service coordination plans address five major areas of activity, as detailed below.

Key to DHS Service Coordination goals

1. Implement the BATS framework by progressing common practices, processes, protocols and systems for initial contact, initial needs identification, referral, assessment and care planning by member organisations;
2. Improve communication about clients (especially those with chronic disease and complex needs) with General Practice (GP) leading to more active GP participation with other service providers involved in the client's care;
3. Successful implementation of the Victorian Service Coordination Practice Manual and subsequent versions of the Service Coordination Tool Templates (SCTT);
4. Change management support for implementation of e-referral (if relevant); and,

## GOAL 1: MANDATED AGENCIES

That the aged care assessment service, community health services and Home and Community Care (HACC) funded organisations in the Hume Moreland and Moonee Valley Melbourne PCPs have fully implemented a sustainable level of service coordination by 2009.

*Objectives:*

- Adoption of the Statewide practices, processes, protocols and systems (PPPS) by the core service coordination agencies.
- Core service coordination agencies have implemented high quality referral practices including timely referral acknowledgement adherent to privacy legislation, using secure electronic mediums.
- Implementation of SCTT 2006 by core service coordination agencies.
- Full implementation of initial contact and initial needs identification by core service coordination agencies.
- Core service coordination agencies using DHS developed guidelines and tools for assessment.
- Maintenance of a high level of cohesion between core service coordination agencies.

Key actions	Timeline
Disseminate and facilitate adoption of the Statewide PPPS.	2006-07
Review Statewide PPPS to identify the need for specific supplementary protocols.	2006-07
Provide information and forums for discussion to assist implementation of SCTT 2006.	2006-07
Agency participation in annual interagency referral audit to establish patterns of referral traffic and baseline measures for assessing change over time and to provide information to assist in determining PCP priorities for engaging new program areas in service coordination activities (see Goal 3.2).	2006-07 and 2008-09
PCPs and agencies work to implement procedures to ensure that referral acknowledgements are completed and returned within the required time period to all referring agencies, including acute and sub acute.	Ongoing
Create ongoing opportunities for Connectingcare electronic referral training sessions for primary care workers.	Ongoing
Promote quality improvement in e-referral practices and processes through use of Plan Do Study Act (PDSA) cycles and implementation of resources such as self audit tools.	2008-09
Ensure maintenance of updated service directory through Connectingcare.	Ongoing
Publicise the new agencies that sign on to be electronic referral recipients to all services.	Ongoing
Maintain awareness of service coordination development and promote resources through service coordination page in PCP newsletters, PCP website etc.	Ongoing
Facilitate the joint Moonee Valley Melbourne and Hume Moreland PCPs Service Coordination Implementation Group and regularly evaluate its effectiveness in assisting development and implementation of the Service Coordination Plan for the PCPs.	Ongoing
Support the development and trialling of tools for assessment within the context of the BATS framework.	2006-09

### ***Estimated Impacts***

All core service coordination agencies are using the SCTT 2006 and have implemented the Statewide PPPS to undertake initial contact, initial needs identification, assessment and referral via secure electronic mediums. This can be measured by agency feedback and participation in the Interagency Referral Audit 2007 and 2009. Rates of use of electronic referral can also be measured and reported by Connectingcare.

Cohesiveness of the core service coordination agencies can be measured by the ongoing attendance at forums, workshops and training and the Service Coordination Implementation Group

meetings and the implementation of the VicHealth Partnership Analysis Tool as described in the Partnership Strengthening Plan.

***DHS Service Coordination goals \****

1, 3, 4, 5

***DHS Inputs***

- Distribution of the Statewide PPPS kits.
- Ensure that software vendors incorporate SCTT 2006.
- Funding for staff with relevant expertise to monitor and assist agency implementation of electronic referral practice.
- Annual interagency audit.
- Development of guidelines and tools for assessment.

## GOAL 2: ENGAGEMENT OF NEW SECTORS

That the Moonee Valley Melbourne and Hume Moreland PCPs engage mental health, palliative care, drug and alcohol, disability, and children’s services programs in participating in service coordination by 2009.

***Objectives***

- Increase understanding by all program areas of service coordination as set out in the Better Access to Services framework.
- Encourage responsiveness to the needs of all program areas in ongoing development of the SCTT.
- Adoption of service coordination and the Statewide PPPS within the specified program areas.
- Expand use of e-referral to include services with high level of referral traffic to and/or from Aged Care Assessment Service (ACAS), Community Health Service (CHS), and HACC funded organisations.

Key Actions	Timeline
Identify champions within organisations already implementing service coordination who can promote benefits of service coordination including improvement in client outcomes to specified new programs.	2006-09
Facilitate input by children’s services programs into the development of a profile for inclusion in SCTT v3.	2007-08
Promote use of the Connectingcare service directory to new program areas.	Ongoing
Create opportunities for Connectingcare electronic referral training sessions for primary care workers, including those from new program areas.	Ongoing
Hume Moreland PCP to support implementation/enhancement of service coordination including e-referral in Psychiatric Disability Rehabilitation and Support Services operated by Dianella and Moreland CHSs.	2007-08
Pilot approaches to service coordination with new program areas, such as mental health and drug and alcohol and disseminate outcomes to facilitate wider application in other	2006-07

program areas through the MVM PCP Melbourne Central Business District (CBD) project.	
Invite representatives from new program areas to participate on the Service Coordination Implementation Group to raise awareness of service coordination development and resources.	2006-09

***Estimated Impacts***

That the specified program areas are using the SCTT 2006 and have implemented the Statewide PPPS to undertake initial contact, initial needs identification, assessment and referral via secure electronic mediums to a level identified and supported by DHS. This can be measured by agency feedback and participation in the Interagency Referral Audit 2007 and 2009. Rates of use of electronic referral can also be measured and reported by Connectingcare.

Representation of the specified program areas at forums, workshops and training, and on the Service Coordination Implementation Group.

***DHS Service Coordination goals \****

1,3,4,5

***DHS Inputs***

- Provide leadership and direction at State and Regional program executive level.
- Resource and support implementation and training to facilitate adoption of PPPS and e-referral from new program areas.
- Ongoing developments of the SCTT to meet the needs of all program areas.
- Funding for staff with relevant expertise to monitor and assist agency implementation of e-referral practice.

**GOAL 3: SUSTAINED REFERRAL SYSTEMS AND PRACTICES BETWEEN PRIMARY CARE/ ACUTE / SUB ACUTE SERVICES**

That referral systems and practices between acute and sub acute services including ACAS, and primary care services, notably Community Health Services and HACC funded organisations within the Moonee Valley Melbourne and Hume Moreland PCPs be improved through the use of electronic referral and the service coordination tool templates.

***Objectives***

- Increase acute and sub acute services understanding of service coordination as set out in the Better Access to Services framework.
- Adoption of the service coordination and the Statewide PPPS by relevant acute and sub acute services, in particular Hospital Admission Risk Program (HARP), Post Acute Care Facilitation Unit (PACFU), community rehabilitation services and services involved in relevant DHS pilots and initiatives. For example, patient flow collaboratives.
- Expand use of e-referral from acute/sub acute services to ACAS, CHS, and HACC funded organisations.
- Increase the opportunity for acute, sub acute and primary agencies to interact and understand each other's business.

Key Actions	Timeline
Ensure ongoing participation of representatives from acute and sub acute areas on the Service Coordination Implementation Group to raise and maintain awareness of service coordination development and resources.	Ongoing
Invite acute and sub acute members to forums, workshops and presentations related to service coordination.	Ongoing
Create ongoing opportunities for Connectingcare electronic referral training sessions.	Ongoing
Publicise the new agencies that sign on to be electronic referral recipients to all services.	Ongoing
Promote use of the Connectingcare service directory.	Ongoing
PCP and agencies work to implement procedures to ensure that referral acknowledgements are completed and returned within the required time period to all referring organisations.	Ongoing
Facilitate primary care agencies participation in the Melbourne Health Community Gateways expo.	2007
Encourage expos at other acute and sub acute sites.	2006-09
Ensure PCP representation on relevant acute and sub acute committees and forums.	Ongoing

### ***Estimated Impacts***

Acute and sub acute programs are making secure electronic referrals using the SCTT 2006. The specified acute and sub acute programs are using the Statewide PPPS and SCTT 2006 for initial contact, initial needs identification, assessment and referral. This can be measured by agency feedback and participation in the Interagency Referral Audit 2007 and 2009. Rates of use of electronic referral can also be measured and reported by Connectingcare.

Agency participation can be recorded in the Melbourne Health Gateways Expo and any such events at other acute or sub acute sites.

### ***DHS Service Coordination goals \****

1, 3, 4, 5

### ***DHS Inputs***

Metropolitan Health Services section of DHS to encourage acute, sub acute & primary care services to work together to develop more integrated service models and delivery across the care continuum.

## GOAL 4: COORDINATED MULTI DISCIPLINARY CARE

To facilitate systems development to coordinate multi disciplinary care especially for people with chronic disease and complex conditions in the Hume Moreland and Moonee Valley Melbourne PCPs.

### Objectives

- Strengthen organisational and work force capacity to implement care planning, drawing on the learnings from the MVM PCP Interagency Care Planning Protocol Pilot, the HM PCP GPs and Community Health projects, and from HARP programs.
- Engage general practitioners, community health services, aged care assessment service and HACC funded agencies in multi disciplinary care planning.
- Development of strategies for testing and implementing the Protocol to achieve systematic multi disciplinary care for people with a range of chronic conditions and complex needs including dementia.

Key Actions	Timeline
Establish an Interagency Care Planning Protocol Working Group.	2006-07
Participate in development of a staged whole of region change management strategy for the effective implementation of the inter agency care planning protocol.	2006-09
Identify workforce development strategies for inter agency planning protocol implementation based on the MVM PCP pilot project.	2006-09
Develop agreement between agencies about which clients are offered comprehensive assessment and which agencies complete and are involved in comprehensive assessment.	2007
Review the Interagency Care Planning Protocol to ensure it supports GP and agency inclusion in care planning.	2006-07
Seek opportunities for funding through General Practice Division Victoria (GPDV ) and DHS for Community Health Services and GP Divisions to develop collaborative practice models for care planning.	2007-09
Implement GP Small Grant project focusing on provision of information on Melbourne Health services, specifically outpatient services, on Melbourne Health and GP division websites.	2006-07
Support the development of collaborative service models between acute and primary care sectors designed to implement evidence based best practice assessment and management for people with chronic disease. For example: diabetes and osteoarthritis.	2007-09
Implement the Transition Care project for people with dementia, funded by the State Government Aged Care Program.	2006-07
Collaborate with the Divisions of General Practice to maximise GP involvement in care planning.	2006-09
Collaborate with the Divisions of General Practice to ensure that GPs and agencies are aware of Medicare care items relevant to care planning.	2006-09
Promote care pathways to other sectors including acute and sub acute, to facilitate client access to community based primary care.	2007-09

### *Estimated Impacts*

A sustainable and participatory care planning processes have been developed, and protocols and supporting materials disseminated to PCP member agency staff. Rates of participation in care planning training and working groups can be recorded, as well as specific measures as identified in supporting projects.

GPs and the Divisions of General practice will be fully involved and protocols and systems established to support their participation.

### *DHS Service coordination goals\**

1, 2, 3, 4, 5

### *DHS Inputs*

Address resourcing issues related to care planning.

## **GOAL 5: REFUGEE HEALTH SERVICE COORDINATION**

To strengthen the relationships between local general practice providers and other refugee service providers to deliver better health outcomes for refugees building on service coordination practices and processes that have been developed in the MVM and the Hume Moreland PCP catchments.

### *Objectives*

- Establish protocols between GP practices and other agencies providing services to refugees.
- Develop care planning pathways to facilitate care coordination, monitoring and review of refugees who need this level of planning.

### *Key Actions*

Implement the Refugee Health Service Coordination Project.

### *Timelines*

October 2006- June 2007

### *DHS Service Coordination goals \**

1, 2, 3

### *DHS Inputs*

Support networking between PCP refugee health projects and other relevant Statewide players.

# RESOURCES

## Estimated Service Coordination PCP resource allocation

Service Coordination Goals	DHS Funded PCP service coordination	Member contributions
Mandated agencies		
Engaging new sectors		
Sustaining referrals systems with acute and sub acute		
Care planning		
Refugee health		
Estimated total PCP resource/budget allocation	0.5 EFT of Executive Officer time	

Note: Allocating the Executive Officer's time across each area of Service Coordination work is difficult to estimate. However an estimate of 0.5 EFT of the Executive Officer's time is required to implement the Service Coordination Plan, including the management of service coordination projects made possible through procurement of additional funds.

## Additional Service Coordination Resources

Funding source /project	Links to catchments priority	Income 2005/06	Income 2006/07
DHS	Goal 5: RHSC	\$25,000	
DHS	Goal 4: Care planning	\$20,000	
DHS	Goal 4: Care planning	\$12,500	
DHS	Goal 4: Care planning		\$50,000
City of Melbourne	Goal 2: Engaging new sectors	\$40,000	

## 4. INTEGRATED CHRONIC DISEASE MANAGEMENT PLAN (DELIVERABLE 4)

The Partnership Strengthening Plan refers to a joint ambulatory care project to be undertaken with the Hume Moreland PCP which will develop and test an appropriate structure and process for area based planning across the two PCP catchments by focussing on mapping and planning services around one specific ambulatory care sensitive condition. The project will focus on the ambulatory care needs of people with Type 2 diabetes, pre-diabetes or at risk of diabetes living in the Moonee Valley Melbourne Hume Moreland catchment. The rationale for containing this planning exercise is so that we can achieve specific outcomes in terms of the process for area based planning and improvement of service integration and develop a refined structure and process for ongoing planning across the full range of ambulatory care services and conditions.

The Victorian Ambulatory Care Sensitive Conditions (ACSCs) Study identified diabetes complications as the leading cause of admissions for ACSCs in Victoria overall, and in the Hume-Moreland-Moonee Valley Melbourne catchment specifically. High rates of hospital admissions for ACSCs may provide indirect evidence of difficulty accessing primary healthcare, limited preventive programs and high levels of social disadvantage. Within this context, diabetes complications have been identified as key conditions where interventions can result in a significant short term reduction in the need for hospital admission. [URL reference: <http://www.health.vic.gov.au/healthstatus/acsc/index.htm>] (Butler, A, 2007).

Strategies to be implemented through the ambulatory care project with Hume Moreland PCP, which will achieve our goals relating to Partnership Strengthening, have been detailed in Section 1. Similarly the strategies to be implemented through the project and which will contribute to achievement of our goals for Integrated Chronic Disease Management (ICDM) are incorporated in this ICDM Plan. MVM PCP resources will be dedicated to ensuring active participation of all key stakeholder institutions located in the MVM catchment in terms of providing data about services for the mapping aspects and participation in consultation and planning exercises for the joint project.

### GOAL 1:

To achieve improvement in service coordination and integration to ensure multidisciplinary care for people with chronic disease in multiple settings.

**Objective:** To map existing services across the care continuum in order to identify service gaps and opportunities for improved coordination and integration of ambulatory care services for people with diabetes in the Moonee Valley Melbourne catchment.

Strategies	Timeframe
Locate existing catchment level health status data relevant to diabetes in current Local Government, Community Health, Metropolitan Health Service and PCP plans.	Commence

Locate information about potential care needs of people at different stages of disease progression (including "at risk" groups) in national guidelines such as, National Service Improvement Framework for Diabetes (Australian Health Ministers' Conference, 2005)	May 2007
Map self management interventions using the Department of Human Services, self management survey.	
Map existing services and the diabetes service system (including eligibility criteria, scope of services, care and referral pathways).	
Collate available data on current service usage rates and patterns	
Identify best practice service models.	

**Objectives:** Facilitate service system improvements (such as integration, coordination, referral pathways) identified through the service mapping exercise that could be implemented within existing resources.

Strategies	Timeframe
<ul style="list-style-type: none"> <li>Identify service gaps.</li> </ul>	Commence July 2007
<ul style="list-style-type: none"> <li>Develop ideal client pathways, based on best practice guidelines and the national service improvement framework.</li> </ul>	
<ul style="list-style-type: none"> <li>Make recommendations for further integration and consolidation within existing resource constraints.</li> </ul>	
<ul style="list-style-type: none"> <li>Facilitate planning processes to develop self management activities within PCP member agencies which address identified gaps, and which should be considered at different stages of the disease (early onset to long term management) and care continuum.</li> </ul>	
<ul style="list-style-type: none"> <li>Facilitate processes for identifying and implementing enhancements to service coordination practices, processes, protocols and systems to address the needs of people with chronic disease which engage general practitioners, community health services, HACC funded agencies and acute services within the MVM PCP.</li> </ul>	
<ul style="list-style-type: none"> <li>Facilitate processes to include developing local agreements between agencies to ensure comprehensive assessment and multi disciplinary care planning.</li> </ul>	

### **Estimated impacts**

- Production of a comprehensive map of the diabetes service system in the Hume Moreland Moonee Valley Melbourne catchment.
- Recommendations for improvements to service coordination and integration which, when implemented, will provide improved access and continuity to the target population.
- Proposed plan for implementation of recommendations.
- Unmet needs and gaps in services will be identified which will form the basis for service development plans.
- Refined structure and process for ongoing planning across the full range of ambulatory care services and conditions.

# GLOSSARY

CALD	Culturally and linguistically diverse
DGCHS	Doutta Galla Community Health Service
MCC	Melbourne City Council
MDGP	Melbourne Division of General Practice
MH	Melbourne Health
MVCC	Moonee Valley City Council
MVM PCP	Moonee Valley Melbourne Primary Care Partnership
RDNS	Royal District Nursing Service
RMH	Royal Melbourne Hospital
WHW	Women's Health West

# APPENDICES

- Appendix 1: Extract from Executive Summary, DGCHS Service Plan
- Appendix 2: Summary of Integrated Health Promotion Initiatives in the MVM PCP
- Appendix 3: MVM PCP member agencies priorities for physical activity and better nutrition
- Appendix 4: MVM PCP member agencies priorities for mental health and wellbeing

# APPENDIX 1

## COMMUNITY PROFILE

*(Extract from the Doutta Galla Community Health Service Plan and Model of Care, 2006, prepared by nlt Consulting)*

### *Characteristics of the City of Melbourne:*

- One of the fastest growing municipalities in Victoria, with estimated growth from 67,061 in 2006 to almost 100,000 in 2016. The actual profile of residents is not clear, but the new developments in Docklands and the CBD indicate residents with high levels of income, older people and young families. This will need to be monitored over time;
- High numbers of young people, due to the high concentration of tertiary institutions;
- High levels of the population at both ends of the income spectrum;
- Professionals are the predominant occupation;
- Highest concentration of homeless people in Victoria – in 2001, inner Melbourne (Cities of Melbourne, Port Phillip and Yarra) had concentration of 149 homeless people per 10,000 compared to 43.6 per 10,000 across Victoria;
- Fifty percent of the population was born in a non-English speaking country (2001 Census); and
- High proportion of new settlers, but mainly in the skilled employment stream.

### *Characteristics of the City of Moonee Valley:*

- Significantly higher numbers of elderly people than Melbourne and one the fastest growing elderly populations in metropolitan Melbourne - has twice the proportion and three times the number of residents aged 70 years and above;
- High levels of the population at both ends of the income spectrum;
- Professionals are the predominant occupation
- Disadvantage in Kensington, North Melbourne, Flemington and Ascot Vale masked by affluence of the surrounding area;
- Almost 7,500 people live in public housing in Ascot Vale, Flemington, North Melbourne and Kensington;
- Distribution of the culturally and linguistically diverse (CALD) population in Moonee Valley – Italian in Avondale Heights, African in housing estates; and
- Moonee Valley is rated in the top ten municipalities for places where new settlers under the Humanitarian Entry Program to Australia indicated that they intended to live.

### *Health Status*

- Females born in 2004 in Moonee Valley can expect to have the highest Life Expectancy of any municipality in Victoria;

- Males born in 2004 in both Melbourne and Moonee Valley can expect to have a lower Life Expectancy than the average for Victoria;
- Conditions which impact on the Burden of Disease follow similar patterns to the State:
  - Asthma – 5 – 16 year age group;
  - Depression high until 45 years of age;
  - Heroin for young males is high;
  - Cancers – breast, colon; and
  - Lifestyle diseases, such as lung cancer, COPD, diabetes and ischemic heart disease are important;
- Ambulatory Care Sensitive Conditions which had the highest admission rates to hospital:
  - Diabetes;
  - Dental conditions;
  - Kidney disease;
  - Congestive Heart Failure; and
  - Asthma.

## APPENDIX 2

# SUMMARY OF INTEGRATED HEALTH PROMOTION INITIATIVES IN THE MVM PCP

### Physical Activity

A Physical Activity Network (PAN) was developed in 2005 to facilitate collaborative action in physical activity and support the various physical activity projects and programs within the PCP. Priorities identified by the network have included:

- coordination of a catchment-wide physical activity directory for promoting physical activity programs and services
- investigation of best practice and capacity building needs for effectively engaging CALD communities in physical activity.

### Children

- MVCC runs a successful walking school bus at Flemington and Kensington primary schools. The Council has worked with the schools, DGCHS and other community agencies to promote exercise and continues to expand the Walking School Bus program
- Kensington Primary School is participating in a new Council initiative to develop a school travel plan. Students, parents and teachers are actively involved in developing strategies to reduce car use for journeys to/from school through conduct of surveys, road safety audits and traffic counts to improve the safety of walking and cycling routes to school.

These initiatives are also being supported through MVCC's dedicated cycling and walking capital works budget to improve infrastructure.

- In April 2001, a project called "H2O for Moonee Valley Kids" commenced in the City of Moonee Valley. The project aimed to increase the consumption of water and decrease intake of sweetened drinks amongst children aged 0-12 years old. A survey of a local primary school in the catchment showed that 75% of children brought a sweet drink to school. This project received Commonwealth funding and was initially led by the Moonee Valley City Council. Following a review of the project on cessation of the funding, the Dousta Galla Community Health Service (DGHS) took over leadership.

The 'H2O' program was initially implemented at the Debney Meadows Primary School, next to the Flemington housing estate. The program was extended to five primary schools and eight pre-schools. A resource kit including a CD-Rom instruction manual and DVD were developed to engage additional schools and sustain their involvement in the program. Sustainability was also achieved through working with participating schools and pre schools on policies to support increased consumption of water amongst children.

The program has been integrated into a "Kids Go for your life" strategy to increase the components of physical activity for children.

## **Adults**

- MVCC has facilitated playgroups and **pram walking groups** through the Maternal and Child Health services, to encourage housebound young mothers to network and gain exercise.
- The **'Walk for Wellbeing'** program, initiated in 2006, aims to improve the health and well being of young Horn of Africa women from communities within the Moonee Valley-Melbourne PCP catchment, through increased participation in walking as a chosen activity in a group setting. A particular emphasis of the walking groups is the promotion of social and mental well being through increased opportunities for social connectedness, consumer participation and empowerment. The Walk for Well-being initiative was developed through consultation with the target population – young mothers from the Horn of Africa communities - and is supported financially through the 'Go for Your Life' Community Walking Grants – Phase Two with a budget of \$10,000. The DGCHS is the lead agency

The project leader uses the model espoused by Womensport and Recreation Victoria's (WSRV) Get Active Program (GAP) to facilitate group walking programs for the Arabic and Somali speaking communities from the Horn of Africa. Self-nominating community members are then encouraged and supported to participate in a 'Walking Leaders Workshop' conducted by the Centre For Multicultural Youth Issues (CMYI). This training will build the competence of community members to become co-facilitators with the project leader. These community leaders will be further supported by GAP Facilitator training through WSRV to build the capacity for community sustainability upon completion of the lead agency's direct involvement.

As well as increased participation in walking by young women from the Horn of Africa community, an increased sense of social connectedness and inclusion is an expected outcome of this project.

- MVCC conducted a community consultation process in October 2005, which raised a number of barriers for older adults accessing the Racecourse Road shopping centre. This consultation has led to inclusion of water fountains and increased seating within the urban design, through the **Racecourse Road Place Management Project**, to increase walking to the centre by people particularly from the public housing estates.
- In October and November 2006, DGCHS in liaison with MVCC and the CoM conducted a series of group sessions with selected CALD community groups to provide information on developing their own walking groups and to recruit volunteers for walking school bus programs. These sessions were targeted to the following groups: Italian older adults, Vietnamese, Chinese, Eritrean, Somalian, and Ethiopian. These sessions were funded through a **Walktober Activity Support grant**.

## **Older Adults**

The **Staying Stronger Standing Upright**, project, now the Living Longer Living Stronger program, initiated in 2005 aims to increase participation in strength training among older adults, particularly those from CALD communities.

The project is led by DGCHS. Collaborative partnerships have been built between two local health and fitness centres and the community health service to implement the project. Agencies have completed "Living Longer Living Stronger" (LLLS) training and CALD skills training to increase their cultural awareness. Strength training programs are delivered at the DGHS for older adults to build their capacity to take up programs offered in local health and fitness centres.

Early findings from process evaluation data reported for May 2006 for the Staying Stronger Standing Upright project indicate:

- 59% (n=23) of participants who have attended the LLLS program have come from CALD backgrounds
- 32% (n=10) of participants have successfully made the transition from the LLLS program conducted at DGCHS to programs conducted at local gyms
- 16% (n=5), have successfully made the transition to other community programs.

Waiting lists for the LLLS program conducted at the DGCHS are steadily increasing. In June 2006, 27 people were waiting to attend the LLLS program. The average waiting period is currently 6 to 7 months.

The throughput of people in the LLLS program has been slower than expected due to a large number of frail older adults who have required a program longer than the standard 6 weeks.

As well as the need to increase the number of LLLS programs to reduce waiting lists and ensure the program's ongoing effectiveness, program leaders have identified the need for a "continuum" of supervised programs for older people offered at varying levels of intensity and duration offered in a range of settings. The development of a range of physical activity programs that cater to different levels of ability and which are available in a range of settings and locations would address some identified barriers and increase participation of older people, particularly, population groups identified in the Go for Your Life Strategic Action Plan (DHS, 2006) as high risk.

A similar model to that adopted through the Active Living Project will be adopted by the MVCC to implement a Well for Life initiative in 2006 - 07. This will involve the delivery of a 12-week strength training to be conducted at the MVCC's seven neighbourhood centres. This program will supplement the Council's Life Plus program provided through their Planned Activity Groups.

As part of **Walktober 2006**, a series of talks across the municipalities of Moonee Valley and Melbourne were held in October/November, to seek volunteers from the older adult community for local walking school buses, and provide the opportunity to link older adults to walking groups.

## Food and nutrition

### *Vitamin D Deficiency*

The MVM PCP initiated collaborative action to reduce **vitamin D deficiency** in women and children from newly arrived communities in inner Melbourne. Dark skin, veiling and the built environment are the main factors predisposing this community to vitamin D deficiency. Many of these community members live in Office of Housing estates of North Melbourne, Flemington, Ascot Vale and Kensington areas where there is no access to private open spaces for veiled women to expose their skin to direct sunlight.

A Vitamin D Stakeholder Group began meeting in 2004 and included MVCC, Melbourne Health, University of Melbourne, DGCHS, City of Melbourne, MVCC Flemington and North Melbourne Community Centres, the Office of Housing and the Melbourne Division of General Practice (MDGP). Through the commitment of agencies to work together, a number of significant achievements have been made including:

- A community research project, conducted in August - October 2005 in collaboration with the Clinical Epidemiology and Health Service Evaluation Unit, Melbourne Health. The project aimed to determine the level of knowledge of Vitamin D within Horn of African communities, the barriers and enabling factors to uptake of recommended interventions to reduce risk of, or treat vitamin D deficiency. A paper has been developed by Melbourne Health and is being submitted for publication to an academic journal.

- Production of a vitamin D brochure to raise awareness amongst the at risk groups and direct them to visit their doctor or other health professional for further investigation. This was launched on October 6<sup>th</sup> 2006.
- Identification of vitamin D deficiency as a priority area in the DGCHS Health Promotion Plan and the MVCC Municipal Public Health Plan.
- Certification of the Vitamin D supplement, Ostelin, as Halal by its manufacturer.

Through this partnership some very significant gains have also been made in sharing the work being done at broader levels. Members of the Stakeholder Group have presented the Project and its achievements to Western Region Maternal and Child Health Nurses and a MVCC councillor on the Stakeholder Group has been instrumental in raising awareness of vitamin D deficiency within the political arena. Through the strong acute care and community care partnership in the MVM PCP, Professor John Wark from Melbourne University participated in meetings of the Stakeholder Group and has ensured reference to Vitamin D deficiency was included in developing the new *SunSmart Position Statement, Risks and Benefits of Sun Exposure Position Statement* (2005).

## **Mental health and well-being**

### ***Young Adults***

In 2006 the DGCHS led a community research project, funded by the Department of Justice, to examine the issue of problem gambling amongst culturally and linguistically diverse (CALD) young people from the North Melbourne and Flemington Public Housing Estates. A participatory action research model was used to identify gaps that may exist for CALD young people in accessing local services. The key recommendations from the report, *CALD Youth in North Melbourne and Flemington*, called for the establishment of a network by community workers to develop a more coordinated approach to addressing the health needs of this population group. DGCHS plans to utilise the results of this project to inform future agency planning to respond to the service needs of the CALD community in the southern part of Moonee Valley.

The MVM PCP supported Melbourne Division of General Practice's (MDGP) funding proposal to the Commonwealth Headspace initiative. This proposal, *Pathway Consortium - Community of Youth Services*, is a collaboration of over 30 government and non-government institutions who have expressed an interest to streamline and enhance the delivery of preventative and curative interventions to youth within the MDGP catchment which includes the Melbourne Central Business District.

### ***Prevention of violence against women***

In June 2006 Women's Health West (WHW) and the western metropolitan area PCPs, Brimbank Melton Primary Care Partnership (PCP) the Westbay Alliance in addition to the Moonee Valley Melbourne PCP, collaborated in a conference titled 'Health Promotion and Preventing Violence Against Women. 'What Does It Really Mean'? The conference was designed to record current activities, gather ideas about proposed health promotion actions and provide a framework and recommendations for planning to prevent violence against women that have since been used to inform the Integrated Health Promotion Plans of the PCPs and of many member agencies.

Building on this networking and engagement with agencies, the PCP has recently supported Womens Health West submissions to funding bodies to reduce the prevalence of violence against women in the Western Metropolitan Area by developing a step-by-step action resource guide to planning health promotion projects to prevent violence against women that will support the capacity of agencies to implement integrated violence prevention strategies.

The proposed project aims would be to:

- Increase the activity and skill development across a range of sectors, by working in partnership with PCPs, community health centres, local government and community organisations to build their capacity to engage in projects that aim to stop violence before it starts, while also developing projects for implementation.
- Increase sustained changes in policy and practices within communities and organisations by developing an action-based guide to planning and implementing a range of integrated health promotion activities, using a methodology designed to identify the resources, support, policies and information required by agencies to engage in sustained and effective work.
- Expand the evidence base for effective practice through researching and identifying existing resources and by developing projects that will add to a pool of knowledge about health promotion actions undertaken in the field.

## REFERENCES

- City of Melbourne (2005), *City Health 2005–09, City of Melbourne Municipal Public Health Plan*
- Department of Human Services (2004), *Ambulatory Care Sensitive Conditions*,
- Department of Human Services (2006), *Care in your community: A planning framework for integrated ambulatory health care*
- Department of Human Services (2006), *Guidelines for completing the Community Health Plan and Community Health Plan Implementation (CHPIA) templates*.
- Department of Human Services (2003) *Integrated Health Promotion Resource Kit*
- Department of Human Services (2005) *Planning for effective evaluation*
- Department of Human Services (2005), *Well for Life Resource Kit*
- Melbourne Health (2005), *Strategic directions 2005–10*
- Melbourne Health (2005), *Clinical services plan 2005–10*
- Moonee Valley City Council (2004), *Building Partnerships Building Communities, Achieving Health and Wellbeing in Moonee Valley, Moonee Valley Municipal Public Health Plan 2004-07*
- Moonee Valley Melbourne Primary Care Partnership (2004), *Community Health Plan 2004-2006*
- Moonee Valley Melbourne Primary Care Partnership (2006), *Western Metropolitan Region Revised CALD Aged Care Strategic Plan, 2006-09*
- nlt Consulting (2006), *Doutta Galla Community Health Service Plan and Model of Care, 2006*
- Womens Health West (2006), *Health Promotion Plan 2006-09*