Home and Community Care (HACC) Diversity plan - Gippsland region

2012-2015

health

The HACC program is jointly funded by the Commonwealth and Victorian Governments

1. Summary of evidence

1.1 Quantitative data sources

Quantitative data	Data source
Gippsland Aboriginal Services Plan	Gippsland Region, Department of Human Services and Department of Health (2010)
Gippsland Health and Demographic Snapshot	(2010) based on 2006 Census, Australian Bureau of Statistics (ABS)
HACC clients by accommodation	Gippsland Region HACC MDS data 2008-2009 to 2010-2011
HACC clients by age and LGA	Gippsland Region HACC MDS data 2008-2009 to 2010-2011
HACC clients by country of birth	Gippsland Region HACC MDS data 2008-2009 to 2010-2011
HACC clients by Aboriginal1 status	Gippsland Region HACC MDS data 2008-2009 to 2010-2011
HACC clients by memory or confusion problems	Gippsland Region HACC MDS data 2008-2009 to 2010-2011
HACC clients by preferred language	Gippsland Region HACC MDS data 2008-2009 to 2010-2011
HACC clients by remoteness	Gippsland Region HACC MDS data 2008-2009 to 2010-2011
HACC clients by year	Gippsland Region HACC MDS data 2008-2009 to 2010-2011
HACC service usage by Aboriginal HACC clients	Gippsland Region HACC MDS data 2010-2011
HACC service usage by CALD HACC clients	Gippsland Region HACC MDS data 2010-2011
HACC service usage by HACC clients with insecure housing	Gippsland Region HACC MDS data 2008-2009 to 2010-2011
HACC service usage by HACC clients with memory or confusion problems	Gippsland Region HACC MDS data 2010-2011

1 Aboriginal refers to people who identify as Aboriginal, Torres Strait Islander or both Aboriginal and Torres Strait Islander

Quantitative data	Data source
Home and Community Care Culturally and Linguistically Diverse Plan	Gippsland Region, Department of Human Services (2008)
Home and Community Care fact sheet 2010-2011	Victorian Government, Department of Health (2011)
Homelessness count by SSD	Chamberlain and MacKenzie, Counting the Homeless (2006) (unpublished)
Local government area (LGA) community profile	2006 Census of Population and Housing, ABS
LGA statistical profiles 2010	Gippsland Region, Department of Health (2011)
Measuring remoteness: Accessibility/Remoteness Index of Australia (ARIA)	Commonwealth Department of Health and Ageing (2001)
Need for assistance target population	Department of Health, Aged Care Branch
Population data by LGA	Victoria in Future 2008, Department of Planning and Community Development (2009)
Projections of dementia prevalence in Victoria	Report by Access Economics Pty Limited for Alzheimer's Australia (2010)
Sex in Australia: sexual identity, sexual attraction and sexual experience among a representative sample of adults	Smith, A., et. al., 2003, *Australian and New Zealand Journal of Public Health*, 27(2), 138-145.

1.2 Qualitative data sources

Qualitative data	Data source
Consultation with service providers	HACC Triennial Plan and Diversity Plan Consultations, December 5-6 2011 (Bairnsdale, Traralgon, Leongatha)
Anecdotal evidence regarding Gippsland special needs populations	Department of Health, Gippsland Region

1.3 Interpretation of data

Commentary and issues identified	Source of information used	Possible priority
Increasing ageing population and associated increase in the prevalence of dementia in East Gippsland and Bass Coast.	Projections of dementia prevalence in Victoria Report by Access Economics Pty Limited for Alzheimer's Australia (2010)	An improved understanding of dementia services, practice models and improved processes and program interfaces.
Age profile indicates that more than 60 per cent of Aboriginal people in five LGAs are less than 30 years of age.	HACC Aboriginal clients by LGA and estimated Aboriginal population by LGA from Department of Health (2010)	Aim to improve awareness and accessibility to HACC services for Aboriginal people in particular for younger people with a disability.
Increase in ageing CALD population in all Gippsland LGAs.	CALD data from Department of Health, Gippsland Region, based on Census 2006	Improve accessibility to HACC services for CALD people.
High level of socio-economic disadvantage across the region, particularly in Latrobe.	IRSED scores by LGA, Socio-economic Indexes for Areas (SEIFA) 2006, ABS	Increase access to HACC services for people who are financially disadvantaged, homeless or living in insecure accommodation.

Commentary and issues identified	Source of information used	Possible priority
High proportion of HACC clients who are homeless or at risk of homelessness in East Gippsland and Wellington.	Homeless count by statistical subdivision (SSD) from Chamberlain and MacKenzie, Counting the Homeless (2006) (unpublished) and HACC clients accommodation by LGA from Gippsland Region HACC MDS data 2008-2009 to 2010-2011	Increase access to HACC services by people who are financially disadvantaged, homeless or living in insecure accommodation.
The majority of HACC clients living in outer regional or remote areas reside in Wellington and East Gippsland.	HACC clients remoteness by LGA from Gippsland Region HACC MDS data 2010-2011	Improve access and awareness of HACC services in outer regional communities.
Very little is known about gay, lesbian, bisexual, transgender and intersex (GLBTI) persons accessing HACC services in the Gippsland region.	Gay and Lesbian Health Victoria report	Further scope GLBTI issues and explore possible opportunities for action.

2. Priorities and strategies

Priority/goal (Reflecting the Victorian Government's health priorities and HACC priorities)	**What we want to achieve over the three years** (Measurable outcomes)	**Strategies/actions**	**Timeframe** (Years 1- 3)
1. In accordance with the Victorian Health priority of *'Implementing continuous improvement and innovation'* facilitate appropriate HACC service models to respond to HACC eligible people with **dementia.**	Improved access, delivery, coordination and expansion of services for HACC eligible people with dementia, based on the Gippsland Region Dementia Plan, as measured by a combination of HACC MDS data and narrative reporting.	1.1 Promote uniform recording by HACC service providers of the HACC MDS 'memory/confusion' item. 1.2 Improve awareness amongst service providers regarding available dementia specific services and improve coordinated care planning between referrers and providers (including GPs and practice nurses).[2] 1.3 In LGAs which have a small population with an older age profile, such as Bass Coast and East Gippsland, aim to increase the number of HACC eligible people with dementia accessing HACC services. 1.4 Further develop dementia service responses including key features to tailor services to service users and carer needs. For example, improved person and family centred assessment, an increased focus on care relationships, dementia specific social support options, and innovative approaches to supporting people with dementia.[3] 1.5 Identify the challenges that organisations face in delivering services to people with dementia or cognitive impairment, including awareness of appropriate referral pathways 1.6 Promote the uptake of the relevant accredited dementia competency units, either as a single stand alone unit or as part of a Certificate qualification, by community care workers and HACC assessors. 1.7 Provide carers with a platform to better understand the dementia service system or participate in activities such as dementia specific training, Creative ways to care.	Year 1 Year 1 Year 1 – 3 Year 1 – 3 Year 1 – 3 Year 1 – 3 Year 1 - 3
2. In accordance with the Victorian Health priority of *'Improving every Victorian's health status and experiences'*, maximise access across the Gippsland region by HACC eligible **Aboriginal** people to HACC services.	Increased access to culturally appropriate HACC services by the HACC eligible Aboriginal community, to equal or above their proportionate representation in each LGA, as	2.1 Undertake more detailed analysis of the Aboriginal population by age cohorts (for example, 0-25, 26-39, 40-60, 60+ years) to more accurately estimate expected rates of HACC service access by Aboriginal people by LGA. 2.2 In collaboration with the Aboriginal Community Controlled Organisations and the Aboriginal Liaison Officer roles, strengthen relationships with HACC assessment services and develop links with the Aboriginal community in LGAs	Year 1 Year 1

[2] Gippsland Dementia Plan 2011-2014 Priority Area One: Service coordination (page 18)
[3] Gippsland Dementia Plan 2011-2014 Priority Area Two: Access and service provision (page 22)

Priority/goal (Reflecting the Victorian Government's health priorities and HACC priorities)	**What we want to achieve over the three years** (Measurable outcomes)	**Strategies/actions**	**Timeframe** (Years 1- 3)
	measured by the HACC MDS.	where Aboriginal people appear under-represented, such as Baw Baw and Bass Coast.[4] 2.3 Improve data reporting consistency by all agencies and encourage ongoing monitoring of MDS data in relation to HACC Aboriginal service users.[5] 2.4 In accordance with the Gippsland Aboriginal Services plan, ensure that information is disseminated to increase understanding about HACC and the active service model; and culturally appropriate approaches to the full range of HACC service types including under-used service types such as case management.[6] 2.5 In accordance with the Gippsland Aboriginal Services plan, improve the cultural competence of generic HACC service providers to ensure culturally responsive and culturally safe responses, for example, through promotion of the cultural competence audit, toolkit and workforce development. [7] 2.6 Promote workforce development strategies to recruit Aboriginal workers, and promote training opportunities for Aboriginal staff members based on an Aboriginal HACC services Workforce Development plan.[8]	Year 1 Year 1 – 2 Year 1 - 3 Year 1 - 3
3. In accordance with the Victorian Health priority of *'Improving every Victorian's health status and experiences',* continue to increase access to HACC services by HACC eligible **CALD** people.	Increased access to HACC services by HACC eligible CALD people, to equal or above their proportionate representation in each LGA, as measured by the HACC MDS.	3.1 Increase the number of HACC eligible CALD people accessing HACC services, in all LGAs where they may be under represented based on the population profile, including Bass Coast, Baw Baw, East Gippsland, Latrobe, South Gippsland and Wellington. 3.2 Promote uniform recording by HACC service providers of CALD MDS data and undertake further analysis in relation to the average hours of service use, particularly for people aged 60-85 years, in comparison to non-CALD service users.[9] 3.3 Promote the development and dissemination of HACC information which reflects culturally appropriate language, concepts and values, including person	Year 1 Year 1 Year 1

4 Gippsland HACC Aboriginal Plan 2011-2013 Goal 4: Partnerships (page 10)
5 Gippsland HACC Aboriginal Plan 2011-2013 Goal 1: Planning (page 6)
6 Gippsland HACC Aboriginal Plan 2011-2013 Goal 2: Access (page 7)
7 Gippsland HACC Aboriginal Plan 2011-2013 Goal 2: Access (page 7)
8 Gippsland HACC Aboriginal Plan 2011-2013 Goal 3: Building Capacity (page 8)
9 Gippsland HACC CALD Plan 2008 Goal 1: Understanding clients and their needs (page 8)

Priority/goal (Reflecting the Victorian Government's health priorities and HACC priorities)	**What we want to achieve over the three years** (Measurable outcomes)	**Strategies/actions**	**Timeframe** (Years 1- 3)
		and family centred approaches and restorative care, through partnerships approaches with ethno-specific or multicultural agencies.[10] 3.4 Promote access to the full range of HACC service types and consider new, innovative approaches for under-used service types such as case management, care coordination, respite, meals and personal care. 3.5 Implement ongoing and sustainable engagement with community leaders, to investigate and address barriers and promote service delivery models applicable in both larger and more isolated CALD communities; and engage with the access and support role to focus on person, family and community centred care and decision making.[11] 3.6 Promote workforce development strategies, particularly in those areas where there is a forecast increased population of CALD people aged over 70 years, such as Latrobe, South Gippsland and Bass Coast.[12]	Year 2 - 3 Year 2 – 3 Year 1 - 3
4. In accordance with the Victorian Health priority of *'Improving every Victorian's health status and experiences',* increase access to HACC services by HACC eligible people who are **financially disadvantaged, homeless** or living in insecure accommodation.	Improved access to services by HACC eligible people who are financially disadvantaged, homeless or living in insecure accommodation, as measured by the HACC MDS.	4.1 Improve and ensure uniform MDS data collection by circulating the definition of homelessness to HACC service providers for use in the MDS 'housing' item. 4.2 Seek additional data from the Office of Housing, crisis and transitional housing programs to develop baseline information in relation to homelessness experienced by HACC eligible. 4.3 Undertake further consultation (and possibly a forum) and collaborate to develop clear referral pathways, service coordination practices and improved interfaces between HACC and housing services. 4.4 Promote the knowledge, competence and confidence of HACC assessment and service provider organisations working with people who are financially disadvantaged, homeless or living in insecure accommodation.	Year 1 Year 2 Years 1 - 2 Year 1 - 3
5. In accordance with the Victorian Health priority of 'Improving every Victorian's health status and experiences,' ensure HACC services are accessible by HACC eligible	Increased access to HACC services by HACC eligible people living in outer regional or remote communities, as	5.1 Promote uniform recording of 'rurality' in the HACC MDS by service providers. 5.2 Ensure access by outlying communities to HACC services, and develop service delivery models applicable to outlying areas where there are isolated, small communities, with a focus on person, family and community centred care.	Year 1 Year 2

[10] Gippsland HACC CALD Plan 2008 Goal 2: Partnerships with Multicultural Ethno specific and Mainstream Agencies/services and Consumers (page 9)
[11] To be guided by Year three 2011-2012 evaluation of Gippsland HACC CALD Plan Year one 2009-2010 and Year two 2010-2011 activity 'East Gippsland agencies pilot for service to isolated clients'.
[12] Gippsland HACC CALD Plan 2008 Goal 3: A culturally diverse and sensitive workforce (page 11)

Priority/goal (Reflecting the Victorian Government's health priorities and HACC priorities)	**What we want to achieve over the three years** (Measurable outcomes)	**Strategies/actions**	**Timeframe** (Years 1- 3)
people living in **rural and remote** areas.	measured by the HACC MDS.	5.3 Consider workforce recruitment strategies targeting male community care workers in remote areas.	Year 1 - 3
6. In accordance with the Victorian Health priority of '*Developing a system that is responsive to people's needs,* facilitate inclusive HACC services to respond to HACC eligible people who identify as **GLBTI**.	Increased number of HACC service providers who have considered and developed GLBTI inclusive practice, as measured by narrative reporting.	6.1 Identify opportunities for further identification and dissemination of information about GLBTI inclusive service provision and practice, for example, using the expertise of Gay and Lesbian Health Victoria. 6.2 Promote an inclusive culture of service delivery by funded agencies, through the provision of workforce skill development opportunities and the use of tools such as the Rainbow checklist or similar.	Year 1 Year 2
7. In accordance with the Victorian Health priority of '*implementing continuous improvements and innovation'* and *'increasing accountability and transparency',* monitor and evaluate the impacts and outcomes of this plan and priority goals and strategies in the Gippsland region.	Increased monitoring end evaluation of the impact and outcomes of the plan in collaboration with HACC service providers to inform continuous improvement and actions, as measured through a combination of MDS and narrative reporting.	7.1 Prepare and distribute profiles to each LGA with diversity data and HACC MDS service use by each special needs group to inform development of agency diversity/social inclusion plans. 7.2 Use the evidence base in the discussion paper, and as periodically updated, to allocate access and support resources, and monitor outcomes to access rates for specific groups are improving. For example, based on evidence in the discussion paper, allocate resources to achieve improved access for people with dementia. 7.3 Provide quarterly MDS reports to service provider network meetings to enable shared discussion and monitoring in relation to progress against milestones and access across local government areas, by all special needs groups, to all HACC service types. 7.4 In collaboration with central office and service delivery agencies, develop and implement a region wide framework for monitoring and evaluating the progress and outcomes of the regional diversity plan, including monitoring against population profiles, service type use and so forth, using a simple series of visual graphics and reporting with trend lines for distribution to key stakeholders, to monitor progress and build a three year longitudinal record to inform annual reviews and future planning.	Year 1 Year 1 – 3 Year 1 - 3 Year 1 - 3

Authorised by the Victorian Government, Melbourne. To receive this publication in an accessible format email jennifer.doultree@health.vic.gov.au