HACC[1] Regional Diversity Plan

1. Summary of evidence

1.1 Quantitative data sources

Quantitative data	Data source
HACC Aboriginal[2] clients by LGA	Department of Health (2010)
CALD data	Department of Health, Hume Region, based on Census 2006
Estimated Aboriginal population by LGA	Department of Health (2010)
HACC clients memory by LGA	Hume Region HACC MDS data 2010-2011
HACC clients accommodation by LGA	Hume Region HACC MDS data 2010-2011
HACC clients age by LGA	Hume Region HACC MDS data 2010-2011
HACC clients country of birth and preferred language by LGA	Hume Region HACC MDS data 2010-2011
HACC clients remoteness by LGA	Hume Region HACC MDS data 2010-2011
HACC clients by service type and LGA	Hume Region HACC MDS data 2010-2011

[1] The HACC program is jointly funded by the Commonwealth and Victorian governments
[2] Aboriginal refers to people who identify as Aboriginal, Torres Strait Islander or both Aboriginal and Torres Strait Islander

Quantitative data	Data source
HACC Clients reason for cessation of services by LGA	Hume Region HACC MDS data 2010-2011
Homelessness count by SSD	Chamberlain and MacKenzie, Counting the Homeless (2006) (unpublished)
IRSED scores by LGA	Socio-economic Indexes for Areas (SEIFA), Australian Bureau of Statistics
Need for assistance	2006 Census of Housing and Population, Australian Bureau of Statistics
Need for assistance	Community profile, Australian Bureau of Statistics, based on Census 2006
Local government area statistical profiles	2010 Local Government Area Statistical profiles, Department of Health (2011)
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)

1.2 Qualitative data sources

Qualitative data	Data source
Consultation with service providers	HACC Triennial Plan and Diversity Plan Consultation, 17-Nov-2011, Benalla
Anecdotal evidence regarding Hume immigrant populations	Department of Health, Hume Region

1.3 Interpretation of data

Commentary and issues identified	Source of information used	Possible priority
Low proportion of Aboriginal people in all LGAs except Greater Shepparton, Wodonga and Towong accessing services.	HACC Aboriginal clients by LGA and estimated Aboriginal population by LGA from Department of Health (2010)	Improve accessibility to HACC services for Aboriginal people.
Increase in ageing culturally and linguistically diverse (CALD) population in Alpine, Greater Shepparton and Wodonga.	CALD data from Department of Health, Hume Region, based on Census 2006	Improve accessibility to HACC services for CALD people.
Increasing ageing population and associated estimated prevalence of dementia in Alpine, Benalla, Strathbogie and Towong.	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.
High level of socio-economic disadvantage in Benalla, Greater Shepparton and Strathbogie	IRSED scores by LGA from Census data 2006, Australian Bureau of Statistics	Increase access to HACC services by people who are financially disadvantaged, homeless or living in insecure accommodation.
High proportion of HACC clients who are homeless or at risk of homelessness in Greater Shepparton, Indigo and Murrindindi	Homelessness count by SSD from Chamberlain and MacKenzie, Counting the Homeless (2006) (unpublished) and HACC clients accommodation by LGA from Hume Region HACC MDS data 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 areas in Towong, Alpine and Mansfield	HACC clients remoteness by LGA from Hume 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 Hume region.	Gay and Lesbian Health Victoria report	Further scope GLBTI issues and explore possible opportunities for action.

2. Priorities and strategies

Priority/goal	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 '*Improving every Victorian's health status and experiences'*, maximise access across the Hume region by HACC eligible **Aboriginal** people to HACC services.	Increased access to HACC services by the HACC eligible Aboriginal community, to equal or above their proportionate representation in each local government area, as measured by the HACC MDS.	a) Liaise with the Aboriginal Community Controlled Organisations in the Hume region to develop approaches and agreed actions in all local government areas in the region, with a particular focus on those areas where Aboriginal people are currently under represented based on the population profile (Alpine, Benalla, Indigo, Mansfield, Moira, Murrindindi, Strathbogie and Wangaratta) and ensure alignment with the regional and local Closing the Gap plans and strategies. b) Improve the cultural competence of HACC service provider organisations by promoting the use of the Hume region Closing The Health Gap cultural competence framework, audit tool and resource kit. c) Promote training and employment opportunities for Aboriginal people.	Year 1 Year 2 Year 2
2. In accordance with the Victorian Health priority of '*Improving every Victorian's health status and experiences',* continue to increase access to HACC services by eligible **CALD** people.	Increased access to HACC services by HACC eligible CALD people, to equal or above their proportionate representation in each local government area, as measured by the HACC MDS.	a) Increase the number of eligible CALD people accessing HACC services, particularly in local government areas where they are currently under represented based on the population profile, which are Alpine, Benalla, Greater Shepparton, Indigo, Mansfield, Mitchell, Moira, Murrindindi, Strathbogie, Towong, Wangaratta, Wodonga. b) Promote uniform recording by HACC service providers of CALD MDS data. c) Investigate and promote service delivery models applicable to outlying areas where there are isolated CALD communities, with a focus on person, family and community centred care. d) Ensure information dissemination and promote access to the full range of HACC service types by HACC eligible CALD people, and consider new, innovative and person and family centred approaches for under-used service types such as case management, respite, meals and planned activity groups.	Year 1 Year 1 Year 2 Year 2

3. 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 and expansion of services for HACC eligible people with dementia, including an improved understanding of current services, program interfaces and new practice models for HACC clients with memory and confusion problems	a) Identify the challenges that organisations face in delivering services to people with dementia or cognitive impairment, including awareness of appropriate referral pathways b) Promote uniform recording by HACC service providers of the MDS 'memory/confusion' item. c) Ensure all referring HACC agencies are informed and aware of HACC services in relation to people with dementia, including GPs, practice nurses and so forth, and that information for consumers is available at these locations. d) Increase the number of HACC eligible people with dementia accessing HACC services, particularly in those local government areas which have a small population with an older age profile, and where people with dementia are currently under represented, such as Benalla, Strathbogie and Towong. e) 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	Year 1 Year 1 Year 2 Year 2 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, delivery and expansion of services to HACC eligible people who are financially disadvantaged, homeless or living in insecure accommodation, as measured by the HACC MDS.	a) Improve information recording by providing an agreed definition of homelessness to HACC service providers and staff, to ensure uniform MDS data collection in relation to the 'housing' item, and to enable the development of a more detailed profile of the range of needs of this vulnerable group. b) Work with community service organisations, housing programs and case management programs to improve access, ensure clear referral pathways, coordinate approaches and improve the interfaces between HACC and other community services. c) Investigate flexible service responses and service delivery models to specific to the needs of this group, including consideration of the use of trained volunteers and active service model approaches.	Year 1 Year 2 Year 3

5. 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	a) Begin discussions regarding opportunities for further investigation, research and dissemination of information about GLBTI inclusive service provision, for example using the expertise of Gay and Lesbian Health Victoria. b) Promote an inclusive culture of service delivery by funded agencies, through the use of practical tools such as the Rainbow checklist or similar. c) Develop a region wide innovative project to monitor and evaluate the impact outcomes of these strategies and the responsiveness of HACC services to people who identify as GLBTI.	Year 1 Year 2 Year 3
6. In accordance with the Victorian Health priority of '*Improving every Victorian's health status and experiences',* ensure HACC services are accessible by HACC eligible people living in **rural** areas.	Increased access to HACC services by HACC eligible people living in outer regional or remote communities, as measured by the HACC MDS.	a) Promote uniform recording by HACC service providers of the 'rurality' item. b) Promote 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 1 - 3
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 Hume 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.	a) Begin, 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, service expansion and models, strategy development and implementation and so forth. b) Present quarterly MDS data 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. c) Develop 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 - 3

3. Implementation Context, Structures and Processes

The Hume Diversity Plan is ambitious and is one of many current, inter-related plans and initiatives to improve access to appropriate aged care services, including:

3.1 HACC Active Service Model

3.2 Transition to the HACC access and support activity (relevant agencies)

3.3 Hume region's Integrated Aged Care Plan 2010-2015 (completed December 2010)

3.4 Hume Allied Health Review (completed October 2011)

3.5 Hume District Nursing Service Review (pending finalisation early 2012)

3.6 Industry Consultant ~ Dementia (to be appointed for 2 years, early 2012, to work with the sector to: *Improve needs identification, assessment and service supports for people with dementia their families and carers to optimise their health and well-being*)

3.7 Hume Transition of Care Project (12 month project commencing 2012 to develop and trial a model of support for older people in caring relationships, particularly those affected by dementia or involved in the transition process from community-based to residential care).

3.8 Industry Consultant ~ Residential Aged Care (to be appointed for 2 years, early 2012, to work with the sector to: *Improve service quality and business performance in Hume PSRACS)*

3.9 Improving Liveability of Older People initiatives (commencing 2012 at Moira, Strathbogie, Alpine and Towong shires)

3.10 Introduction, and support for the implementation, of Hume region's Guidelines for Improving Social Connectedness

3.11 Various Aged Care Program initiatives (Healthy Ageing, Well for Life extensions, improving HACC Assessment Services)

3.12 Improving Hume region's *Platforms for Collaborative Planning* (i.e. there will be significant reform of existing PCPs in 2012 and the region will continue to promote and support LGA alliances for collaborative planning and development)

3.13 Other related Program initiatives (*Closing the Health Gap, Chronic Disease Management, Health & Well-being Plans)*