health

Strengthening diversity planning and practice

Grampians Regional Diversity Plan 2012-15

May 2012

State Government Victoria

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Please note: This plan is a working document and will be continually developed and refined throughout the life of the plan

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

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Executive summary

With respect to HACC diversity planning, the pertinent demographic and health issues in the Grampians region are:

- It is a geographically large rural region.
- Whilst the population of the region is projected to grow, some LGAs will experience a population decline.
- All Local Government Areas (LGAs) are projected to experience a significant growth in the proportion of their population aged 65+.
- Life expectancy in the region is lower than the Victorian average and the burden of disease is higher. This is likely to be related to the region's rural status and relatively higher levels of socio-economic disadvantage;
- The proportion of people reporting high and very high levels of psychological distress is higher than the state average.
- The number of Aboriginal[1] people is relatively low, as is the number of people from culturally and linguistically diverse (CALD) backgrounds.
- Evidence indicates that the need for assistance in core activities is higher in both Aboriginal and CALD populations.
- The number of people in the region with dementia is projected to increase significantly.

The Grampians Regional HACC program staffs have developed this diversity plan which includes a number of proposed strategies and actions to respond to the issues outlined above.

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

Acknowledgements

The development of the Grampians Diversity Plan would not have been possible without the commitment and input of the organisations and networks within Grampians Region

Regional Home and Community Care Assessment Networks

Koori Aged and Disability Network Advisory Committee (KADNAC)

Regional Home and Community Care funded organisations that participated in regional workshops and consultations

Regional and Central Office Departmental of Health staff

Grampians Region would like to acknowledge and thank staff from the Barwon Regional HACC team for their assistance in the development of this plan

List of Acronyms used

ABS	Australian Bureau of Statistics
ACAS	Aged Care Assessment Services
ACCO	Aboriginal Community Controlled Organisation
ASGC	Australian Standard Geographical Classification
ASM	Active Service Model
CALD	Culturally and Linguistically Diverse
CCC Standards	Community Care Common Standards
DALYs	Disability Adjusted Life Years
GLBTI	Gay, lesbian, bisexual, transgender and intersex
HACC	Home and Community Care
KADNAC	Koori Aged and Disability Network Advisory Committee
LGA	Local Government Area
MDS	Minimum Data Set
SES	Social Economics Status
SRS	Supported Residential Services

Introduction

The Home and Community Care (HACC) Diversity Framework is contextualised within the broader government and HACC directions including the national and Victorian health and aged care priorities.

Diversity Planning and Practice

Policy Context

Diversity planning and practice aims to improve access to Home and Community Care (HACC) services by eligible people who are marginalised or disadvantaged and to improve the capacity of the service system to respond appropriately to their needs. As one of several quality improvement initiatives occurring concurrently in Victoria, Diversity planning and practice is designed to contribute to an equitable, accessible, person-centred, responsive and high quality HACC service system and ensures alignment to the Victorian Health Priorities as outlined below:

Figure 1: Victorian Government health priorities

- developing a system that is responsive to people's needs;
- improving every Victorian's health status and experiences;
- expanding service, workforce and system capacity;
- increasing the system's financial sustainability and productivity;
- implementing continuous improvements and innovation;
- increasing accountability and transparency; and
- utilising e-health and communications technology.

Source: Department of Health 2011, Victorian *Health Priorities Framework 2012-2022: Metropolitan Health Plan*, State Government of Victoria, Melbourne

HACC Diversity planning and practice contributes to meeting the following key Victorian Health Priorities:

- Developing a system that is responsive to people's needs
- Improving every Victorian's health status and experiences.

HACC diversity planning and practice is underpinned by three core principles:

- Firstly. a desire to achieve equitable access to HACC services by eligible people, regardless of their diversity or disadvantage;
- Secondly, the belief that effective service planning acknowledges a community, group and/or individual's uniqueness and complexity of need, and is conducted in a manner that is respectful of each individual's characteristics, circumstances, preferences and goals and central to strategic planning and leadership; and
- Thirdly, that diversity planning and practice is core business for all HACC funded agencies in Victoria.[2]

[2] Department of Health 2011, HACC Diversity planning and practice policy, State Government of Victoria, Melbourne

The plan will give particular consideration to the five HACC special needs groups who are:

- people from Aboriginal and Torres Strait Islander backgrounds;
- people from culturally and linguistically diverse backgrounds;
- people with dementia;
- people living in rural and remote areas; and
- people experiencing financial disadvantage (including people who are homeless or at risk of homelessness).

How diversity planning and practice will be achieved

The mechanism for achieving diversity planning and practice is twofold. Each Department of Health (the department) region will develop a regional diversity plan, and each HACC funded agency will be required to develop a diversity plan at the local level by 30 June 2012.

Regional diversity planning and practice is developmental and therefore change will be incremental. The focus in the first year is likely to be on scoping and understanding diversity across the region and sub-region and/or communities

The regional diversity plan aims to include the following:

- A specific articulation of the connection between priorities/goals and the Victorian health priorities and HACC triennial priorities
- A clear and concise summary of the information collected (data) and interpretation of the issues identified
- The selection of three to five regional priorities/goals including the rationale and link with state-wide priorities
- Related actions and timelines

Process and outcomes

The Grampians region used the following process to develop its diversity plan

- Collect and analyse key data and information
- Hold initial and follow up workshops with regional HACC funded organisations
- Developed a regional diversity plan background paper which contains demographic and epidemiological data in fuller detail than the diversity plan requires. Data and analysis in this paper will inform the goals and strategies in the final regional plan.
- Provide draft regional diversity plan for comment and endorsement by department's regional executive
- Submit final draft regional diversity plan to Department of Health HACC Program for approval

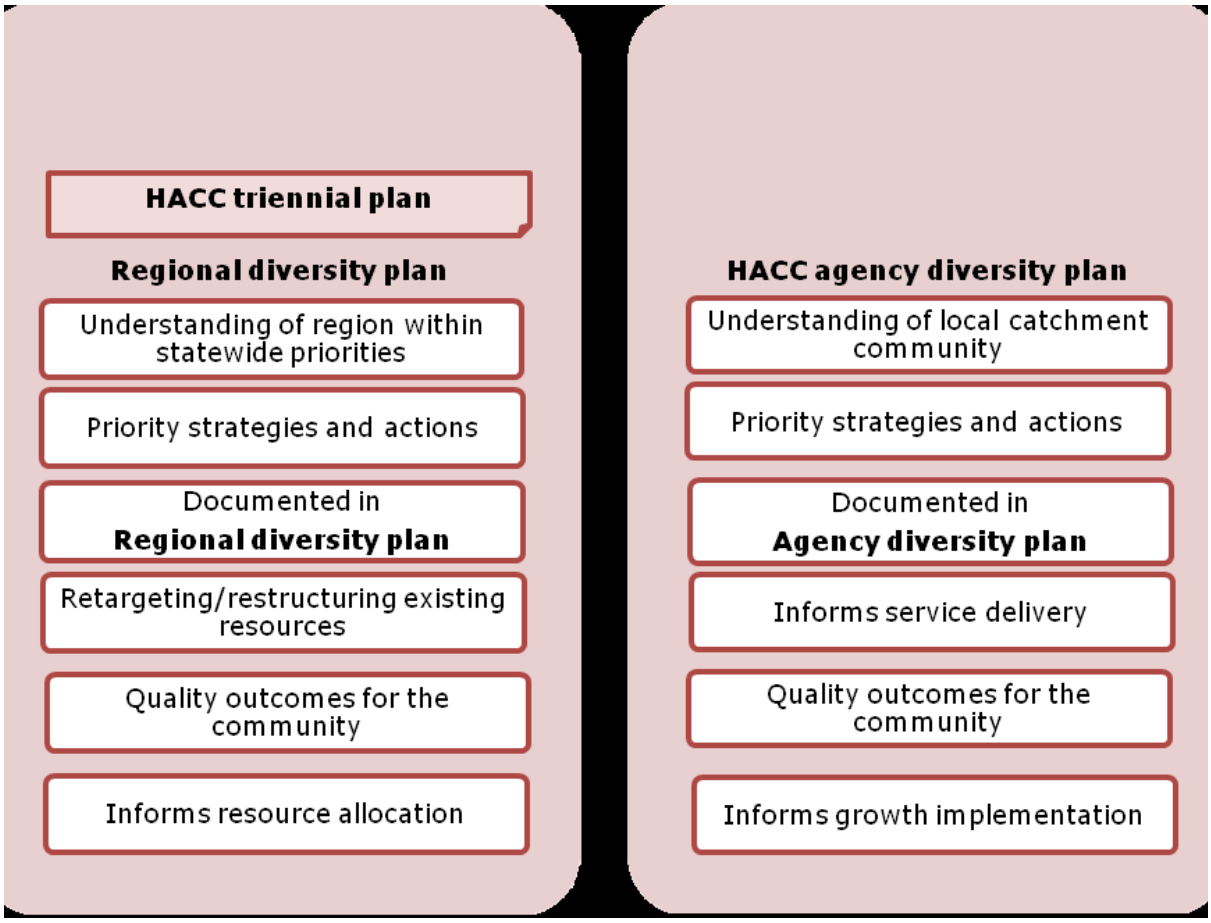
Regional diversity plan

The Grampians regional diversity plan will inform the local approach to maximising access to services for the HACC special needs groups, inform the allocation of resources for improved service access and outcomes for diverse people, and influence the diversity plans developed by individual HACC funded agencies.

The Grampians regional diversity plan will:

- Reflect the Victorian Government's health priorities
- Reflect the statewide priorities and directions outlined in the HACC triennial plan and inform the Victorian HACC triennial plan
- Set the framework for addressing access and diversity within the region
- Inform the local approach to maximising access to services for the HACC special needs groups
- Inform the allocation of resources for improved service access and outcomes for diverse people
- Influence and inform the diversity plans developed by individual HACC funded agencies.

Figure 2: Link between regional diversity plans and HACC agency diversity plans



Quality improvement frameworks supporting the development of the regional diversity plan

Diversity planning and practice, supporting the implementation person centred care and the Assessment Framework

Embedding person centred practice is fundamental to moving towards an active service model, implementing good practice for HACC assessment and improving diversity planning and practice. The central and shared aim of implementation of the Active Service Model (ASM), diversity planning and practice and the HACC Assessment Framework is to strengthen the capacity of HACC funded organisations to deliver services that are responsive and centred on the needs of the person and their families and carers. The ASM focuses on promoting person-centred care, capacity building and restorative care in service delivery. The goal of the ASM is for frail older people, people with disabilities and their carers within the HACC target group to live in the community independently and autonomously as possible.

Ultimately, HACC services are delivered in a way that promotes independence and wellness, and is respectful of and responsive to client's specific characteristics. This means that over time, organisations will adopt an ASM approach as core business, and planning, will be incorporated into organisations' quality improvement plans, which will also encompass actions relating to diversity planning and practice and implementation of an ASM approach to service delivery.[3]

Person centred practice respects the right and desire of the person to make their own decisions with particular regard to guiding service outcomes. 'For Aboriginal people, older people from CALD backgrounds, or younger people with a disability, family members may play a pivotal role in care relationships and in making decisions'. Central to this approach for assessment is the ability to 'build rapport within a conversation about where the person is at and not be led by a tool or checklist' and that 'the person's values, social and cultural identity are respected'.[4]

HACC Living at Home Assessments are designed to be respectful of and responsive to diversity. HACC Assessment Services are required to demonstrate a level of cultural awareness and competence when interacting with clients, and should facilitate the development of partnerships with specialist agencies and other services to facilitate care planning that is truly responsive to each person and their family and carers.[5]

Diversity planning and practice and the Community Care Common Standards

The Community Care Common (CCC) Standards have been jointly developed by the Australian government and State and Territory governments to monitor quality within community care programs including HACC. A number of standards require evident to support processes and practices that consider the access issues for special needs groups, and one standard that emphasises diversity planning:

- Expected Outcome 1.4 Community understanding and Engagement will require HACC funded organisations to demonstrate and 'understanding of the community in which they operate and their target population' in order to plan and develop services. Most significant for diversity planning are practices and processes that support community understanding and engagement that meet the needs of those 'who are the most disadvantaged and who have limited access to services due to cultural and linguistic barriers or special needs such as sensory loss or dementia'.

[3] Strengthening diversity planning practice: A guide for Victorian Home and Community Care services page 5

[4] Department of Health, Strengthening assessment and care planning: a guide for HACC assessment services in Victoria, State Government of Victoria, Melbourne, page 40

[5] Strengthening diversity planning practice: A guide for Victorian Home and Community Care services page 5

Processes and practices that support access issues or special needs groups, and community understanding and engagement to meet the needs of those who are most disadvantaged are considered within the following diversity goals of this plan:

- Improve access to services for HACC eligible people with dementia, their families and carers (relates to diversity goal 1)
- Improve access to services for eligible Aboriginal people to HACC funded services (relates to diversity plan goal 2)
- Increase service access for eligible clients from CALD backgrounds by providing services that are evidence based and culturally appropriate (relates to diversity plan goal 3)
- Improve access to services for HACC eligible people experiencing financial disadvantage (including people who are homeless or at risk of homelessness) (relates to diversity plan goal 4)
- Understanding the access issues for HACC special needs groups and develop improvement strategies (relates to diversity plan goal 7).[6]

Wellness

The literature scan conducted by Health Outcomes International (2011, p38, as part of *Review of social support and respite in HACC,* concluded that access to social support has been linked to the reduction of ill-health and improved self-perception of physical and psychological well-being.

The regional diversity plan goal of improving the response to people with dementia, their families and carers by enhancing the understanding of dementia services in the region and increasing dementia friendly environments and practice within regional HACC funded social support and respite services is intended to assist regional HACC funded organisations to improve the wellness of people affected with dementia and their carers.

This will be achieved by encouraging HACC funded social support and respite programs to improve dementia friendly environments and practice through the promotion of tools, training and resources that are designed to improve the access and social needs of clients with dementia and their carers. The regional Dementia Advisory Group and Project Officer will assist in this work.

Please note that the Department of Health is currently developing a Healthy Ageing Plan to promote active ageing and improve the health and wellbeing of older Victorians across a variety of settings, supported by a coordinated and responsive service system. This plan is expected to be finalised in 2012-13 and will provide the direction for further regional strategies. One strategy already implemented under the health ageing banner is the *Healthy Ageing Demonstration projects* which combine principles of three previous aged care initiatives namely *Well for Life, Making a Move and Count Us In.* Funding for this initiative is currently funding a number of projects across the region.

[6] Department of Health and Ageing 2010, Community Care Common Standards Guide, Australian Government, Canberra

Demographic Profile

The Grampians region is one of eight Department of Health regions in Victoria. It is a rural region that covers an area of 48,609km. In the context of the HACC service delivery system there are 11 local government areas, 14 hospitals, two stand-alone community health centres, four bush nursing centres, eight non-government organisations, three Aboriginal[7] Community Controlled Organisations, one multicultural organisation, and three neighbourhood houses. A number of these organisations operate from multiple campuses across the region.

Table 1: Grampians population by age and sex (2009)[8]

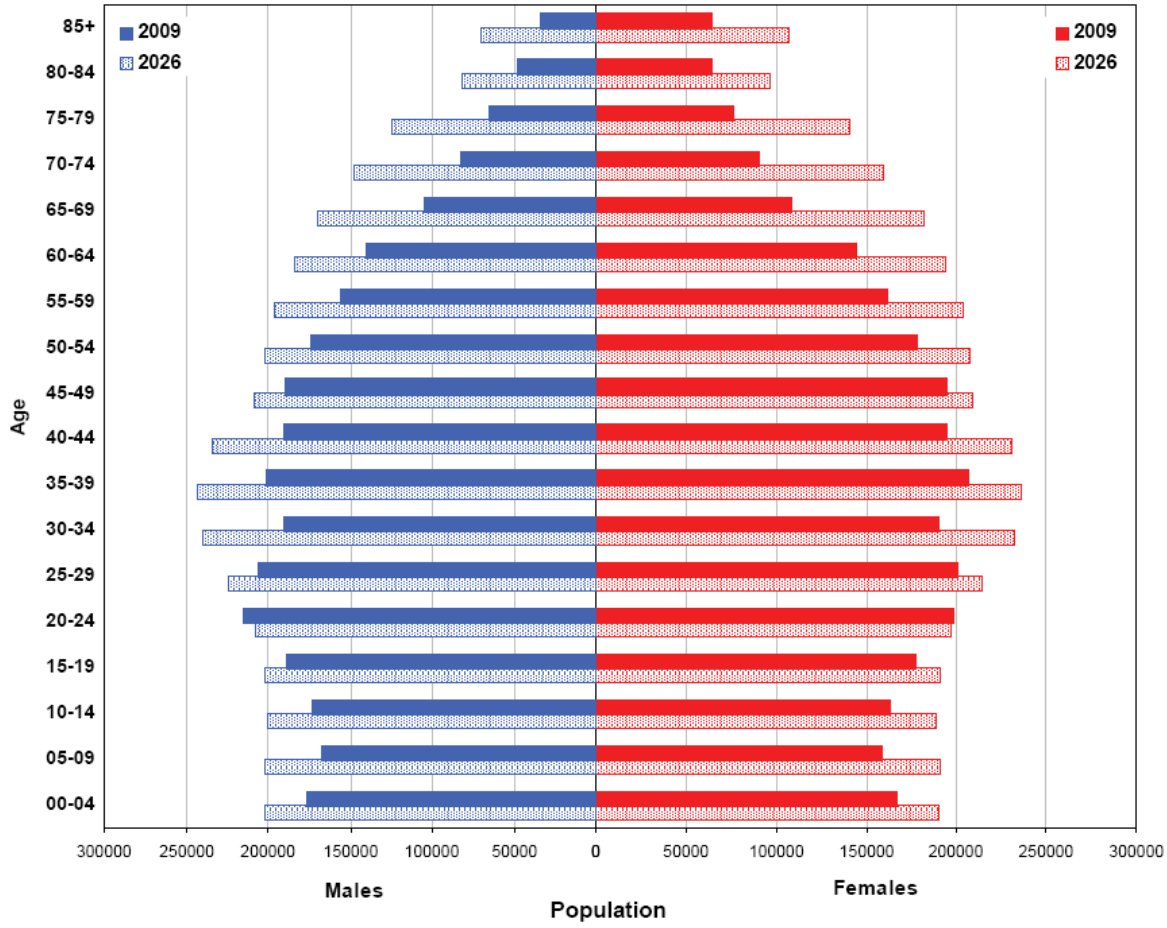
Age	Females	Males	Total	% of Grampians total population	% of Victoria's total population
0-14	21,367	22,018	43,385	19.3	18.5
15-24	14,603	15,823	30,426	13.5	14.3
25-44	28,314	27,081	55,395	24.7	29.0
45-64	30,182	30,277	60,459	26.9	24.6
65-84	16,088	14,313	30,401	13.5	11.8
85+	3,023	1,547	4,570	2.0	1.8
Total	113,577	111,059	224,636	100.0	100.0

The current population of the Grampians region is approximately 225,000. The table above illustrates the breakdown of the Grampians population by age and gender. As it shows, the proportion of the population aged 65 years and older is higher in the region (15.5%) than it is state-wide (13.6%). A similar pattern is apparent in those aged 45-64. The proportion of the population aged 15-44 is lower in the region (38.2%) than it is state-wide (43.3%).

[7] Aboriginal refers to people who identify as Aboriginal, Torres Strait Islander or both Aboriginal and Torres Strait Islander

[8] Source: Department of Health 2011

Figure 3: Projected Victorian population by age group and sex (2009 – 2026)



Source: Department of Health 2011

The current Victorian population is projected to grow by 18.9% by 2026 (Department of Health 2010). This growth is illustrated in the figure above. Growth will not be uniform across the age groups or across Victoria. The uneven nature of this growth presents particular challenges for planning, service coordination and service delivery in a number of areas, including HACC services. Some LGAs will experience growth, others significant population decline.

Table 2: Projected Grampians region population change by LGA (2008 – 2026)

LGA	Projected Change (%)
Ararat	3.62%
Ballarat	29.38%
Golden Plains	37.87%
Hepburn	18.43%
Hindmarsh	-17.07%
Horsham	6.01%
Moorabool	27.39%
Northern Grampians	-10.89%
Pyrenees	17.38%
West Wimmera	-24.42%
Yarriambiack	-17.61%

Source: Department of Health 2010

As the table above illustrates, the population in four of the 11 LGAs in the region is projected to decline. The region contains the three LGAs with the greatest projected population decline in the state: West Wimmera; Yarriambiack; and Hindmarsh. What is particularly pertinent in a HACC context is that within these LGAs there is also a projected shift in the age profile of the population – the population decline is projected to be greatest in the younger age groups. As a result, the population is expected to both decline and age. For example, as the table below shows, whilst the population of West Wimmera is projected to decline by about one quarter – this will not be uniform across the age groups.

Table 3: Population change in West Wimmera LGA (2008-2026)

Age Group	Projected Change (%)
00-19	-40.1
20-44	-42.0
45-64	-29.8
65+	24.3
Total	-24.4

Source: Department of Health 2010

Table 4: People aged 65+ as a percentage of the LGAs total population, 2006 and 2026

Local Government Area	2006	2026
Ararat	18.1	27.7
Ballarat	14.4	22.6
Golden Plains	8.9	19.1
Hepburn	17.1	26.5
Hindmarsh	23.3	34.3
Horsham	16.6	25.7
Moorabool	10.7	21.8
Northern Grampians	17.9	32.6
Pyrenees	17.8	31.0
West Wimmera	19.8	33.5
Yarriambiack	23.0	36.6

Source: Department of Planning and Community Development 2009

The table above shows that, despite differences in age profiles between LGAs, they are all expected to see an increase in the proportion of their total population aged 65 years and above (and therefore a reduction in the proportion of the population aged less than 65 years). Possible implications of this projected change in the population, for the HACC program in the region, are twofold. Firstly, there may be an increased demand for HACC services. Secondly, and at the same time, agencies responsible for delivering services may have an ageing workforce and experience problems with workforce supply.

Health Profile

This section provides a brief general epidemiological profile of the region by describing issues such as risk factors, health status and health service utilisation. It then provides more detailed information on the five HACC specials needs groups including: Aboriginal people; people from culturally and linguistically diverse backgrounds; people with dementia; people living in rural and remote areas; and people experiencing financial disadvantage. It then discusses social isolation as another possible issue for consideration in diversity planning.

Table 5: Selected risk factors and measures of health status

Indicator	Regional measure (%)	Victorian measure (%)
People reporting fair or poor health	18.8	18.3
People 18+ who are current smokers	20.9	19.1
People at risk of short-term harm from alcohol use	10.7	10.2
People overweight or obese	52.1	48.6
People reporting high/very high degree of psychological distress	12.5	11.4
People reporting asthma	13.4	10.7
People reporting type 2 diabetes	4.7	4.8
People who do not meet fruit and vegetable dietary guidelines	52.5	48.2
People who do not meet physical activity guidelines	25.7	27.4

Source: Department of Health 2011

The information in the above table is collated from the Department of Health (2009) Victorian Population Health Survey 2008 and so is self-reported data. With the exception of physical activity, the proportion of residents in the Grampians region exposed to the major health risk factors (smoking, harmful alcohol use, overweight and obesity) is higher than the state averages, although these differences are small. The proportion of people reporting high or very high levels of psychological distress is also higher in the Grampians region. Women in this region are significantly more likely than men to report high or very high levels of psychological distress - 15.2% and 9.7% respectively.

Table 6: Service utilisation per 1,000 populations

Indicator	Regional measure (%)	Victorian measure (%)
Hospital inpatient separations	435.2	422.0
Emergency Department (ED) presentations	304.9	249.9
Primary care type presentation to ED	183.7	115.6
General practitioners (GPs)	0.89	1.03
Asthma admission rate ratio	0.87	1.0
Diabetes complication admission rate ratio	1.12	1.0
Drug and alcohol clients	6.7	5.3
Registered mental health clients	15.4	11.0
Primary health occasions of service [(a)]	342.9	163.7

Source: Department of Health (2011) Local Government Areas 2010 Statistical Profiles
[(a)] May include multiple services to one individual

The data in the table above shows some pertinent factors about health service utilisation in the region. Hospital admissions are lower than the state average for asthma but higher for diabetes complications. The region has a higher proportion of alcohol and drug clients, and people registered with the Area Mental Health Service. Presentations at emergency departments are significantly higher, as are the number of those presentations defined as 'primary care type'. Those type of presentations are defined as "assessed as of low urgency and acuity, did not arrive by ambulance, were self-referred, were presenting for a new episode of care and were not expecting to be admitted" Department of Health (2011) Local Government Areas 2010 Statistical Profiles p. 23. There is possibly a relationship between these presentations and peoples access to, and knowledge of, primary health care services (including general practitioners) in the region. Grampians region also has the second highest rate of primary health occasions of service in the state. These are defined as "the number of occasions of service per 1,000 population provided by primary health services to residents" Department of Health (2011) Local Government Areas 2010 Statistical Profiles p. 24. The information is provided by the Department's Integrated Care Branch. There may be a relationship between this figure and the region having the lowest number of GPs per 1,000 populations in the state.

Table 7: Life expectancy by LGA

Local Government Area	Males	Females
Ararat	76.8	82.0
Ballarat	77.7	82.7
Golden Plains	80.9	85.0
Hepburn	79.4	82.0
Hindmarsh	77.7	83.6
Horsham	77.8	84.1
Moorabool	79.3	84.3
Northern Grampians	75.7	82.8
Pyrenees	77.3	82.9
West Wimmera	76.7	85.0
Yarriambiack	78.1	84.8
Regional measure	79.1	83.6
Victorian measure	80.3	84.4

Source: Department of Health 2011

The table above shows the male and female life expectancy by LGA. Higher rates of mortality are reflected in the life expectancy which is lower than the state average in most cases.

The table below shows the number of Disability Adjusted Life Years (DALYs), per 1,000 of population, by LGA. DALYs measure the total burden of disease in a population by combining mortality and morbidity measures. They "estimate the loss of healthy life... one DALY can be thought of as one lost year of healthy life" (Webb, Bain and Pirozzo 2005 p.56). The higher the rate of DALYs, the higher the total burden of disease. Grampians has the third highest rate of DALYs of all Department of Health regions (Department of Health 2011).

Table 8: DALYs per 1,000 population by LGA

Local Government Area	Males	Females
Ararat	158.6	140.4
Ballarat	158.4	140.0
Golden Plains	149.4	130.3
Hepburn	158.6	140.4
Hindmarsh	158.6	140.4
Horsham	151.4	136.0
Moorabool	144.4	124.5
Northern Grampians	158.6	140.4
Pyrenees	158.6	140.4
West Wimmera	140.2	120.0
Yarriambiack	147.1	124.5
Regional measure	**154.8**	**136.3**
Victorian measure	**143.0**	**129.1**

Source: Department of Health 2011

Aboriginal people

Gathering and analysing demographic and epidemiological data on the Aboriginal population is difficult because the accuracy of the identification of Aboriginal people in administrative records varies, the population is relatively small (less than 3% of the Australian population) and about 25% of those people live in remote or very remote areas (AIHW 2010)

Although the Grampians region has the fourth highest proportion of Aboriginal people in Victoria, in absolute terms the total number of Aboriginal people is small, reflecting the relatively small size of the total Grampians population. A crude calculation[9] would indicate that there are approximately 2,022 Aboriginal people living in the Grampians region in 2011.

Table 9: Proportion of Aboriginal people by LGA

Local Government Area	People (%)
Ararat	0.75
Ballarat	1.06
Golden Plains	0.60
Hepburn	0.67
Hindmarsh	1.09
Horsham	1.23
Moorabool	0.72
Northern Grampians	0.75
Pyrenees	0.62
West Wimmera	0.41
Yarriambiack	0.76
Regional measure	**0.90**
Victorian measure	**0.65**

Source: Department of Health 2011

As the table above indicates, the proportion of Aboriginal people varies across the region from less 0.5% in West Wimmera to 1.23% in the Horsham LGA. It is expected that as the Grampians total population increases, the Grampians Aboriginal population would increase by 0.9 percent.

The health of Aboriginal people in Australia is significantly worse than non-Aboriginal people across all indicators. Compared to non-Aboriginal people, Aboriginal people[10]:

- have a life expectancy that is 10-12 years less;
- have a mortality rate nearly twice as high;
- have a hospitalisation rate more than twice as high;
- have a disability prevalence rate nearly twice as high;
- experience a total burden of disease (measured in DALYs) more than twice as high; and
- are twice as likely to report their health as fair or poor (AIHW 2010).

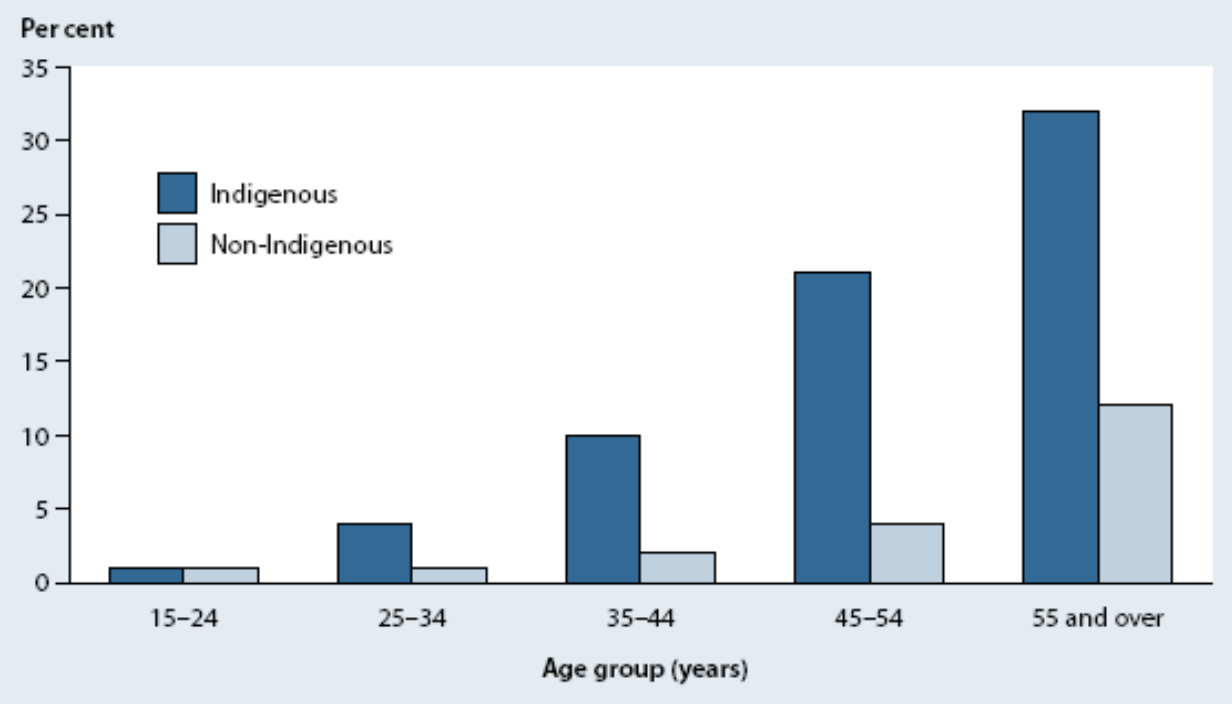
[9] Population 224,000 multiplied by the regional measure of 0.90%

[10] In most measures the health of Aboriginal men is poorer than Aboriginal women.

With a small number of exceptions, for example injury, the causes of morbidity and mortality in the Aboriginal population are the same as the non-Aboriginal population. However, the rates of these conditions are much higher in the Aboriginal population. Type 2 diabetes provides an example of this, as the figure below illustrates. The Australian Institute of Health and Welfare (AIHW) notes that:

> Indigenous Australians were three times as likely as non-Indigenous Australians to report diabetes as a long-term health condition. [in addition] hospitalisation rates for any diagnosis of diabetes were almost nine times as high for Aboriginal and Torres Strait Islander people as for other Australians... [and] Indigenous Australians were seven times as likely as non-Indigenous Australians to have diabetes recorded on their death certificate (AIHW 2010 p. 239)

Figure 4: Reported diabetes by age group and Indigenous status



Source: AIHW 2010

Poor Aboriginal health is attributable to a number of factors including low socioeconomic status (and associated determinants such as low education levels, unemployment and poor housing) and a greater exposure to risk factors (including smoking, obesity, alcohol abuse, poor nutrition and inadequate physical activity). Access to affordable and culturally appropriate health services is also an issue (AIHW 2010).

People from Culturally and Linguistically Diverse Backgrounds

Approximately one quarter of the Australian population were born overseas and about 50% of those people are from non-English speaking countries[11] (AIHW 2002). As the table below indicates, this proportion is significantly lower in the Grampians region.

Table 10: Selected measures of CALD by LGA

Local Government Area	Born overseas (%) [a]	English Proficiency [a] (%)	New Settlers (per 100,000) [b]	Humanitarian Arrivals [b] [c] (%)
Ararat	7.3	0.3	117.5	0.0
Ballarat	8.3	0.5	172.2	6.2
Golden Plains	10.7	0.3	77.0	0.0
Hepburn	12.7	0.5	216.2	0.0
Hindmarsh	5.8	0.3	112.9	14.3
Horsham	5.1	0.3	74.8	0.0
Moorabool	12.2	0.4	50.2	0.0
Northern Grampians	6.1	0.4	97.2	0.0
Pyrenees	9.4	0.3	0.0	0.0
West Wimmera	5.5	0.1	43.4	0.0
Yarriambiack	4.9	0.2	65.1	0.0
Regional measure	**8.5**	**0.4**	**123.3**	**4.0**
Victorian measure	**25.5**	**4.0**	**527.3**	**12.5**

Source: Department of Health (2011) Local Government Areas 2010 Statistical Profiles

[a] Information from the 2006 census. English proficiency is measured by the percentage of the population who indicated that they spoke English 'not well' or 'not at all'.
[b] Information is for 2009-10 and comes from the Department of Immigration and Citizenship's 'Settlement Database'. Data based on LGA of intended residence – not actual residence after arrival.
[c] Humanitarian arrivals as a percentage of new settlers.

Because the process of migrating to Australia requires passing certain health checks, the migrant population tends to have a better status than the host population. This is known as the 'healthy migrant effect'. However, this effect does not apply to all migrant groups and some, for example refugees, may have significantly poorer health status. In addition, some evidence suggests that this effect reduces over time and the health profile of migrant populations begins to look more like that of the host population.

Mortality rates for people born overseas are generally lower than those of the Australian born population for most causes of death. There are some exceptions and the mortality rate is higher for:

- lung cancer among those born in the Netherlands, and the United Kingdom and Ireland;
- diabetes among those born in Germany, Greece, India, Italy, Lebanon and Poland;
- coronary heart disease among those born in Poland; and
- influenza and pneumonia among those born in the United Kingdom and Ireland. (AIHW 2010 p.271)

[11] The largest single overseas-born groups are those from the UK and Ireland (27%).

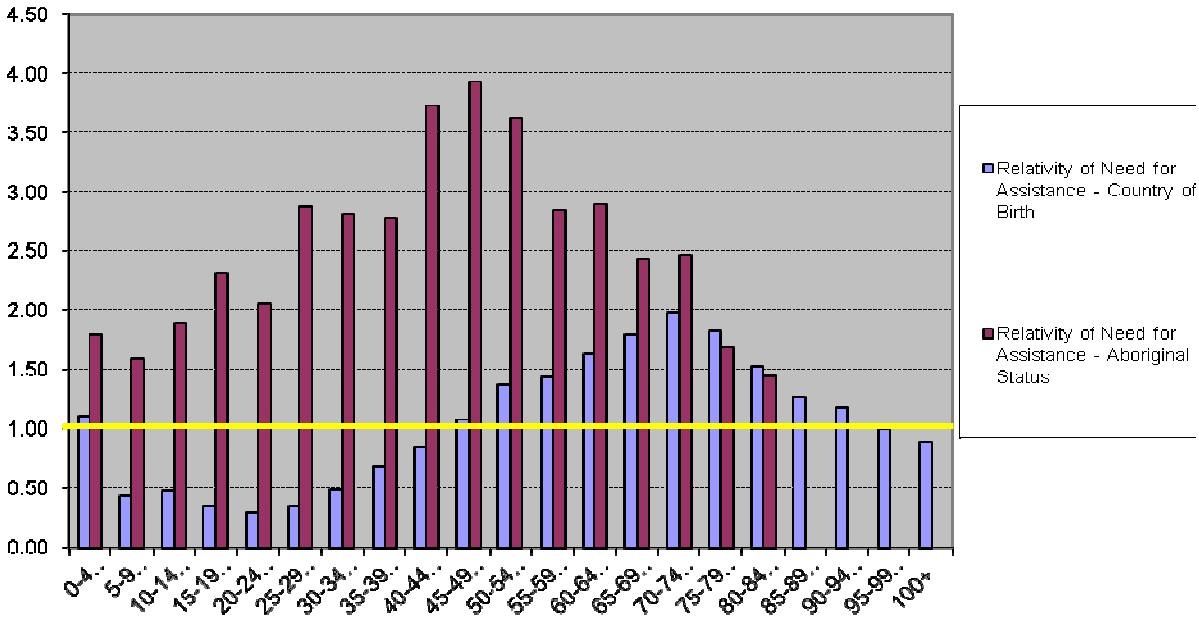
For CALD populations access to services that are culturally and linguistically appropriate is a critical factor, particularly for older migrants. Jirowong and Liamputtong (2009) note that people from CALD backgrounds, as a proportion of the total population over 65 years, is predicted to rise from 20% in 2003 to 22.5% in 2026. Further, “the CALD population ages more rapidly than other Australians as a consequence of migration patterns and the age at arrival of CALD migrants” (Jirowong and Liamputtong 2009 p.33).

Need for Assistance

The graph below was developed by the department's Aged Care Branch using data from the 2006 Census of Population and Housing. The Need for Assistance question, which considers the core activities of self-care, mobility and communication, is a new measure that attempts to capture profound and severe disability.

The general population's level of need is represented by the yellow line and is set at one. CALD populations are indicated by the blue bars and Aboriginal people by the purple bars, indicating their level of need relative to the total population.

Figure 5: Need for Assistance - Victoria



The graph illustrates how the need for assistance varies across the age groups. From a service planning point of view it suggests that, even where the actual numbers are small, the higher need for assistance should be taken into account.

Dementia

Establishing the prevalence[12] and incidence[13] of dementia in the region is difficult in the absence of detailed epidemiological data. Various Australian studies suggest different prevalence rates[14]. Despite these differences, there is consensus that rates increase with age and are higher in women. Access Economics suggests that the prevalence of people with dementia is higher outside the capital cities in each state. They predict that not only will the prevalence rate increase, but the difference between capital cities and the rest of the state will be amplified:

> People with dementia represent 1.1% of the total population in capital cities and 1.2% of the population in the balance of the states [in 2009]. By 2050, these proportions will increase to 2.9% in capital cities and 3.8% in the balance of the states... The faster ageing of regional Australia is important for dementia service delivery planning (Access Economics 2009 p.iii).

Table 11: Estimated number of people with dementia by LGA (2010, 2030, 2050)

Local Government Area	2010	2030	2050
Ararat	203	408	739
Ballarat	1,295	2,891	5,233
Golden Plains	119	389	746
Hepburn	230	464	803
Hindmarsh	163	255	376
Horsham	315	661	1,093
Moorabool	284	788	1,499
Northern Grampians	215	367	605
Pyrenees	117	231	355
West Wimmera	78	129	197
Yarriambiack	164	248	373
Total	**3,183**	**6,831**	**12,019**

Source: Access Economics 2010

The table above shows the latest projections from modelling undertaken by Access Economics (2010). All the LGAs in the region are expected to experience a significant increase in the number of people with dementia in their catchment. The LGA with the greatest increase in actual numbers, to 2050, is Ballarat – whilst Golden Plains will have the largest percentage increase.

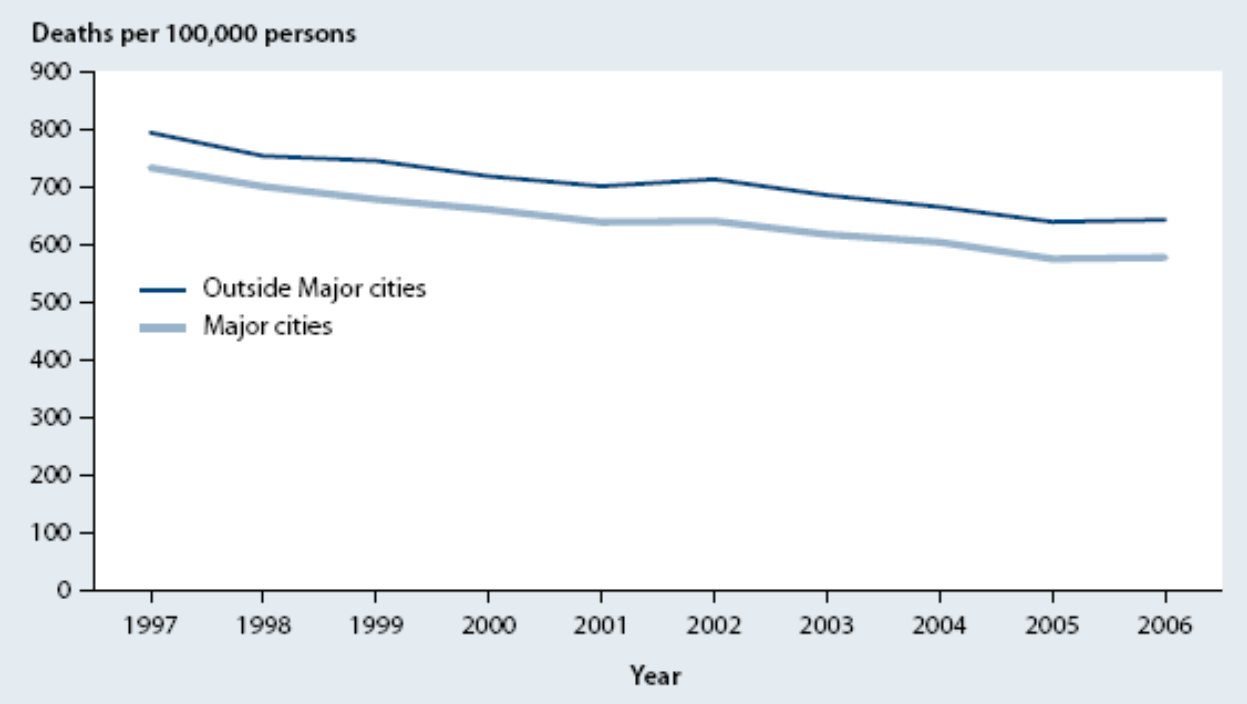
A review of the literature by Access Economics indicates that some of the risk factors for dementia are not modifiable. These factors include: age; family history; Down Syndrome; and gender. Indirectly modifiable risk factors include: stroke, diabetes mellitus; hypertension; and depression, whilst modifiable factors are: smoking; obesity; and exposure to environmental toxins (2009). Probable protective factors include: education and IQ; intellectually stimulating work; physical activity; social interaction and cognitive activity; and mild alcohol consumption (Access Economics 2009). Consideration could be given, in service planning, to activities that contribute to a reduction in modifiable risk factors and/or enhance protective factors.

[12] Proportion of the population with the condition
[13] Number of new cases within a given period
[14] See the appendices for estimated prevalence rates in the different studies

Rural and remote communities

Research evidence consistently indicates that people living in rural and remote areas have higher rates of morbidity and mortality than those in metropolitan areas (AIHW 2008)[15].

Figure 6: Deaths in Australia from all causes (1997-2006)



Source: AIHW 2010

As the figure above indicates, mortality rates in Australia declined in the decade to 2006. However, the gap between metropolitan and rural areas remained largely unchanged.

[15] Please see the appendices for a definition of rural and remote.

Table 12: Selected health indicators in Australia by location - rate ratio

Indicator	Major cities	Outside major cities [(a)]
Reported excellent or very good health	1.0	0.94
Incidence of cancer	1.0	0.95
Reported osteoporosis	1.0	1.07
Reported bronchitis	1.0	1.16
Reported injury	1.0	1.33
Reported arthritis	1.0	1.29
Lifetime mental disorder	1.0	1.08
Lifetime substance use disorder	1.0	1.25

Source: AIHW 2010
[(a)] all figures are statistically significant

Outside major cities people are less likely to report their health as excellent or very good, and more likely to have a range of health conditions including injury and mental disorders. As the table above shows, cancer is one exception[16]. In the context of service planning for HACC, higher rates of disability are particularly pertinent. In major cities the rate of the population with a disability is 19% and 5.9% with a disability resulting in severe or profound activity limitation. In inner regional areas those figures are 21.6% and 7.2% respectively, whilst in outer regional and remote areas they are 22.7% and 6.7% (AIHW 2008).

This pattern of higher morbidity and mortality in rural areas is seen in the Grampians region, as seen in the life expectancy data and disability adjusted life year (DALY) rates discussed earlier in this section. There are multiple factors that may account for this including lower socio-economic status, occupational exposures (for example from farming or mining), higher levels of obesity, smoking and risky alcohol use, less access to health services, and the hazards associated with driving long distances (AIHW 2010 p.245).

[16] This is the measure for 'all cancers'. There is a higher incidence of head, neck, and lip cancer and melanoma outside major cities.

People experiencing financial disadvantage

There is overwhelming and consistent evidence of a link between socio-economic status (SES) and health. This is not just a difference between the poorest in the community and everyone else, but a gradient exists – so that those in the mid-quintile of disadvantage have better health than those in the fifth and poorer health than those in the first.

> Both material and psychosocial causes contribute to these differences and their effects extend to most diseases and causes of death... the longer people live in stressful economic and social circumstances, the greater the physiological wear and tear they suffer, and the less likely they are to enjoy a healthy old age. (Wilkinson and Marmot 2003 p. 10)

In most indicators of SES, Grampians region displays higher levels of disadvantage than state averages. However, as the table below indicates, within the region there are areas of relative advantage, as well as disadvantage.

Table 13: Selected measures of socio-economic status by LGA17

Local Government Area	Unemployment Rate (%) [a]	Households with income < $650 per week (%) [b]	People who did not complete Year 12 (%) [c]	IRSED[d]
Ararat	7.5	42.5	69.0	956.3
Ballarat	8.0	37.0	59.5	982.7
Golden Plains	4.1	27.9	66.2	1025.5
Hepburn	7.9	44.9	61.5	979.7
Hindmarsh	4.6	49.1	74.7	954.9
Horsham	5.6	38.0	66.3	993.3
Moorabool	5.2	29.9	64.5	1011.8
Nth Grampians	7.2	43.7	70.5	946.4
Pyrenees	8.1	49.7	71.5	943.9
West Wimmera	4.2	43.4	72.1	981.2
Yarriambiack	6.1	48.6	74.8	953.3
Regional measure	6.8	38.3	64.2	n/a
Victorian measure	5.5	30.6	51.3	n/a

Source: [a] [b] **and** [c] Department of Health 2011, (d) ABS 2008

Australian Bureau of Statistics (ABS) analysis has ranked the 79 LGAs in Victoria by levels of relative disadvantage, using information from the 2006 census (ABS 2008). The Index of Relative Socio-Economic Disadvantage (IRSED) is contained in the table above and allows comparisons to be made between geographical areas. "Scores are standardised... so that the average IRSED score across Australia is 1,000. Scores lower than 1,000 indicate relatively disadvantaged areas; the lower the score, the greater the level of relative disadvantage[18]" (ABS 2008). Using IRSED scores, four of the ten most disadvantaged LGAs in Victoria are in the Grampians region: Hindmarsh; Northern Grampians; Pyrenees; and Yarriambiack.

[17] There is no one objective measure of socio-economic status – some studies use income as a proxy; others use a mixture of income, education, employment and geographical location.

[18] The LGA with the highest level of disadvantage is Greater Dandenong (IRSED 894) whilst the LGA with the least disadvantage are Boroondara Nillumbik (IRSED 1104)

Table 14: Prevalence rate of selected health conditions by socio-economic status

Health Condition	5	4	3	2	1
Depression	3.5	3.3	3.5	4.0	4.4
Diabetes (type 2)	2.9	3.7	4.1	4.3	6.2
Chronic respiratory disease	2.2	2.7	2.8	3.1	3.3
Cardiovascular disease	17.3	17.1	21.0	22.2	23.8
Severe/profound disability	2.9	4.1	4.6	5.3	6.1

Source: AIHW 2010

The table above shows the prevalence rate for selected health conditions by socioeconomic status quintiles – quintile 5 is the most advantaged, quintile 1 the least advantaged.

Social Isolation

Evidence suggests that the social world in which people live has an impact on their health. Social isolation can have a negative influence on health – including higher levels of disability from chronic disease (Wilkinson and Marmot 2003). This research also suggests there is a correlation between socioeconomic status and levels of social isolation and social exclusion.

Table 15: Social isolation - possible risk and protective factors

Selected Measures	Grampians	Victoria
Aged 85+ (%)	2	1.8
Near to public transport (%)	45.2	72.6
Without a motor vehicle (%)	7.4	9.3
Aged 75+ and living alone (%)	2.8	2.2
Core activity need for assistance (%)	5.3	4.5
Offences (per 1,000 population)	71.2	67.2
Households with internet (%)	54	61
Help as a volunteer (%)	28.4	19.7
Able to get help from family (%)	84.3	80.3
Able to get help from neighbours (%)	57.4	50.2
Feel safe (%)	64.4	58.9

Source: Department of Health 2008 and 2011

The table above presents some of the possible risk and protective variables for social isolation. The first seven items are possible risk factors for social isolation. With the exception of 'households without a motor vehicle' this region scores more poorly than the Victorian average (Department of Health 2011). This may suggest a greater risk of social isolation. However, the final four items are those that may indicate social connectedness. Here Grampians has:

- a significantly higher proportion of the population who help out as volunteers
- a higher percentage of people who answered 'yes, definitely' to questions regarding whether they felt they could get help from family and neighbors if they needed it
- a higher percentage of people who answered 'yes, definitely' to a question asking whether they would feel safe walking by themselves after dark (Department of Health 2008).

HACC services in the Grampians region

This section provides some brief descriptive information regarding HACC services in the Grampians region.

Table 16: HACC clients per 1,000 of target population by LGA (2009-10)

Local Government Area	Clients aged 0-69	Clients aged 70 and above
Ararat	984.2	443.8
Ballarat	349.6	426.4
Golden Plains	402.8	418.9
Hepburn	248.7	490.7
Hindmarsh	321.4	499.2
Horsham	332.3	383.3
Moorabool	287.7	483.5
Northern Grampians	438.4	457.1
Pyrenees	683.2	588.9
West Wimmera	915.3	503.2
Yarriambiack	758.3	600.9
Regional measure	411.11	454.3
Victorian measure	257.3	368.3

Source: Department of Health 2011

The table above shows the number of people receiving services funded by the HACC program per 1,000 of the target population in each group and is calculated by the department's Aged Care Branch. Data of the number of HACC clients (the numerator) is from information submitted by funded agencies through the HACC Minimum Data Set. Data on the size of the eligible population (the denominator) are estimates. For the 0-69 population this is based on the size of the LGA population and state-wide disability rates. For those over 70 it is all the people in this age group except those eligible for Department of Veteran Affairs homecare (Department of Health 2011 p.26). These estimates are then weighted for variables including socio-economic status, Aboriginal and CALD status and geographical location.

The table illustrates the relatively high number of HACC clients in the Grampians region. It also indicates some differences between LGAs. However given the relatively small population of the region, caution should be used in interpreting this data. Small changes in the actual numbers of clients receiving a HACC service may make disproportional changes in the rates shown above.

Table 17: HACC Funded Agencies in Grampians Region

Local Government Area
Ararat Neighbourhood House
Ararat Rural City
Ballan District Health & Care
Ballarat & District Aboriginal Co-operative
Ballarat City Council
Ballarat Community Health
Ballarat District Nursing and Healthcare Inc
Ballarat Health Services
Ballarat Regional Multicultural Council
Beaufort and Skipton Health Service
Budja Budja Aboriginal Cooperative
Centacare, Catholic Diocese of Ballarat
Daylesford Neighbourhood House & Learning Centre
Djerriwarrh Health Services
Dunmunkle Health Services
East Grampians Health Service
East Wimmera Health Service
Edenhope & District Memorial Hospital
Elmhurst Bush Nursing Centre
Golden Plains Shire
Goolum Goolum Aboriginal Cooperative
Grampians Community Health
Harrow Bush Nursing Centre
Hepburn Health Service Inc
Hepburn Shire Council
Hindmarsh Shire Council
Horsham Rural City Council
Lake Bolac Bush Nursing Centre
Moorabool Shire
Northern Grampians Shire

Pyrenees Shire
PINARC Support Services
Rural Northwest Health
St John of God Hospital
Stawell Regional Health
Stawell Neighbourhood House
UnitingCare Ballarat Parish Mission
United Way Ballarat Community Fund
Vision Australia Foundation
West Wimmera Health Service
West Wimmera Shire
Wimmera Uniting Care
Wimmera Health Care Group
Wimmera Volunteers Inc
Woomelang & District Bush Nursing Centre
Yarriambiack Shire

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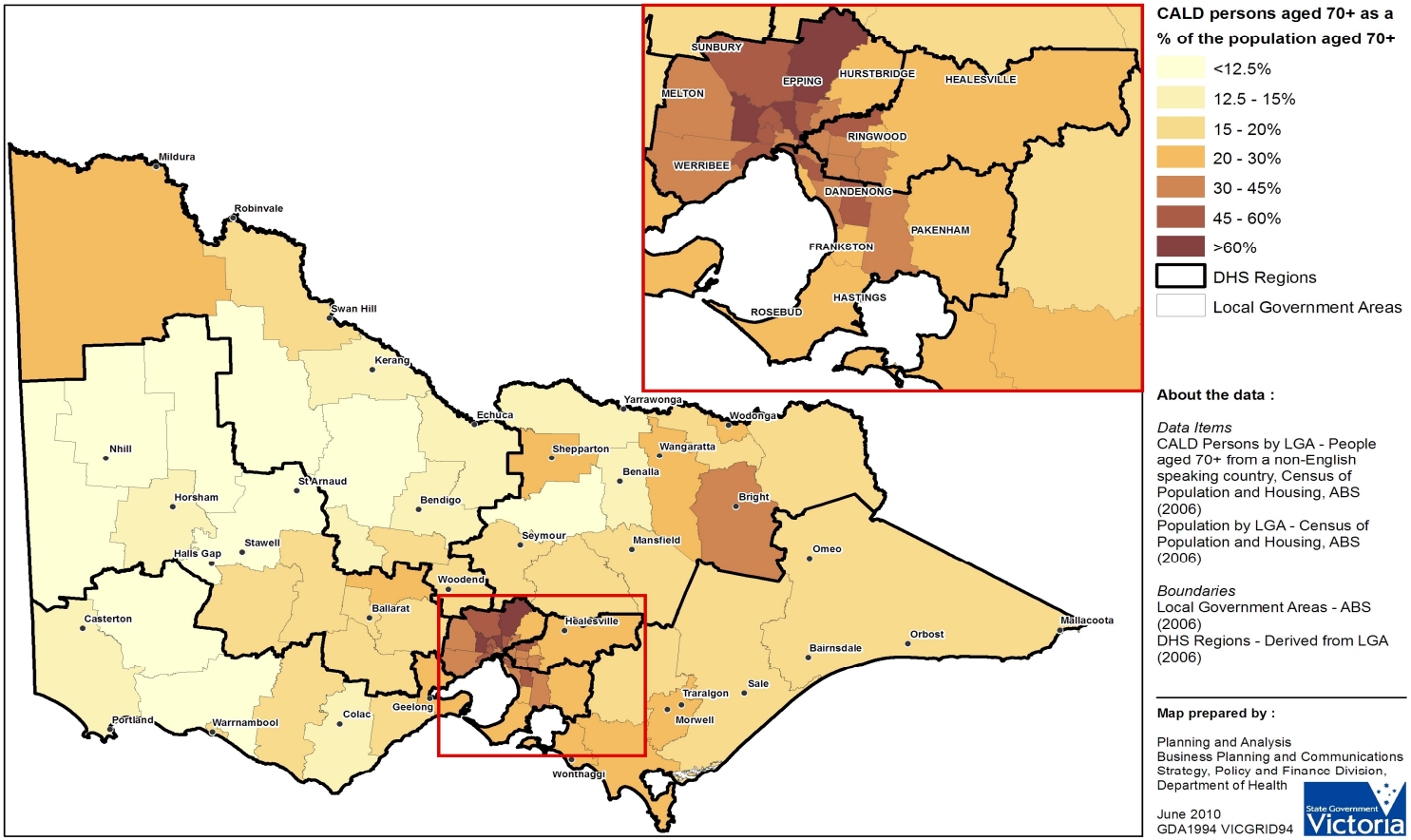
Appendices

CALD Persons

CALD Persons Aged 70+ as a Percentage of the Population Aged 70+ by LGA (2006)



Dementia prevalence rates

Table 1.4: Alternative dementia prevalence rate estimates for the Australian population

Age	Access Economics (2003) [a]		Jorm et al (2005) [b]		Access Economics (2005, 2006) [c]		Begg et al (2007), AIHW (2007) [d]		Anstey et al (2009)	
	Male (%)	Female (%)	Male (%)	Female (%)	Male (%)	Female (%)	Male (%)	Female (%)	Male (%)	Female (%)
<60	0.2	0.1	na	na	0.1	0.1	0.1	0	na	na
60-64	0.2	0.1	1.2	0.6	1.2	0.6	0.1	0	na	Na
65-69	1.9	1.1	1.7	1.3	1.7	1.3	1.6	1.0	2.2	2.5
70-74	1.9	1.1	3.5	3.3	3.5	3.3	2.9	3.1	4.9	5.6
75-79	5.7	6.8	5.8	6.3	5.8	6.3	5.6	6.0	8.2	9.2
80-84	5.7	6.8	11.8	12.6	11.8	12.6	11.0	12.6	12.3	17.0
85-89	22.8	33.6	18.6	21.5	18.6	21.5	12.8	20.2	18.8	22.8
90-94	22.8	33.6	31.1	33.3	31.1	33.3	22.1	30.8	41.2	32.7
95+	22.8	33.6	38.1	40.3	38.1	40.3	22.1	30.8	53.9	73.8

Note: (a) Prevalence for those under 25 years was considered zero (b) Uses an average of four meta analyses including Jorm et al (1987), Hofman et al (1991), Richie and Kildea (1995) and Lobo et al (2000) (c) Estimates were derived from Jorm et al (2005) (d) Based of Harvey et al (2003) for those <65 years old and Lobo et al (2000) for all other age groups.
Source: Access Economics (2003, 2005, 2006), Jorm et al (2005), Begg et al (2007), AIHW (2007), Anstey et al (2009).

Source: Access Economics 2009

Defining Rural and Remote Areas

"There are a number of different official geographical classifications currently being used in Australia... The AIHW recommends the use of the ASGC Remoteness Areas (RA). This classification allocates areas of land to one of five arbitrary categories" (AIHW). Using this system areas within the Grampians region are either Inner Regional, Outer Regional or Remote. No areas within the region are classified as Very Remote and Melbourne is the only area in Victoria classified as a Major City.

Table 18: ASGC Remoteness Area by Statistical Local Areas

Local Government Area	Remoteness
Ararat	Outer Regional (19) Inner Regional (81)
Ballarat	Inner Regional
Golden Plains	Inner Regional (98) Outer Regional (2)
Hepburn	Inner Regional
Hindmarsh	Outer Regional (87) Remote (13)
Horsham	Outer Regional
Moorabool	Inner Regional
Northern Grampians (St Arnaud)	Outer Regional
Northern Grampians (Stawell)	Outer Regional (23) Inner Regional (77)
Pyrenees (North)	Inner Regional (81) Outer Regional (19)
Pyrenees (South)	Outer Regional (5) Inner Regional (95)
West Wimmera	Remote (4) Outer Regional (96)
Yarriambiack (North)	Remote (70) Outer Regional (30)
Yarriambiack (South)	Outer Regional

Source: AIHW 2004

Grampians Region
Priorities and strategies
Planning Period 2012 - 2015

Please note: This plan is a working document and will be continually developed and refined throughout the life of the plan

Consultation with Regional HACC Providers

The Grampians region undertook a number of regional consultations with HACC funded organisation during the September – November 2011 period to solicit input into the development of the regional HACC diversity plan. As part of this process a survey was conducted to seek preliminary advice from each HACC funded organisation about the type of plan it will develop, priority areas and training needs. Forty organisations took part in this initial process by either completing the survey and / or attending the regional consultation.

The results indicate that of those organisations that returned the survey, a number of organisations intend to develop plans as part of an LGA partnership. LGA plans would have a number of common strategies but could also include some specific organisations strategies. Others indicated that they develop an organisational diversity plan either at a whole of organisation level or HACC specific.

Most HACC funded organisations identified dementia, rural and remote and aboriginal as priority areas which were also reflected in identified diversity planning training needs.

Further feedback was sought on the proposed regional goals in November 2011, as part of the HACC triennial planning consultations.

Aboriginal

The endorsement by regional HACC funded organisations to engage in service coordination workshops organised by the department is providing them with a good base for future networking and ideas on how to improve access for Aboriginal people to HACC services. The ideas generated so far through this project align closely with, and provide practical examples of, the strategies developed through Strengthening aged care assessment for Aboriginal consumers: A Guide for Aged Care Assessment Services in Victoria. This guide is intended to assist ACAS staff, however the ACCOs and the region have found many of the strategies are applicable for consideration and implementation by HACC funded organisations, particularly HACC Assessment Services (see diversity goal 2).

Department of Health, Aboriginal consumers: A Guide for Aged Care Assessment Services in Victoria, State Government of Victoria, Melbourne

Summary of evidence

2.1 Quantitative data sources

Quantitative data	Data source
The population of the region is projected to grow by nearly 20% by 2026. Some LGAs will experience population decline. All LGAs are projected to experience a significant increase in the proportion of their population aged 65+ by 2026.	Department of Health (2010) Projected Population Change in Victoria. Victorian State Government, Melbourne. ibid. Department of Planning and Community Development (2009) Victoria in Future 2008. Department of Planning and Community Development, Melbourne.
Although the proportion of people in the region from Aboriginal backgrounds is higher than the Victorian average, in absolute numbers it represents fewer than 2,200 people.	Department of Health (2011) Local Government Areas 2010 Statistical Profiles. Victorian State Government, Melbourne.
Evidence consistently demonstrates that Aboriginal people have significantly poorer health outcomes than the general population.	Australian Institute of Health and Welfare (2010) Australia's Health 2010. AIHW, Canberra.
In the Grampians region the proportion of people from CALD backgrounds is significantly lower than the Victorian average (measured by the percentage born overseas, English proficiency and numbers of 'New Settlers').	Department of Health (2011) Local Government Areas 2010 Statistical Profiles. Victorian State Government, Melbourne. (using data from the 2006 Census and the Department of Immigration and Citizenship)
Evidence suggests that the proportion of the population from CALD backgrounds is likely to increase and also likely to age faster than the general population.	Jirowong, S. and Liamputtong, P. (2009) 'Primary Health Care and Health Promotion' in Population Health, Communities and Health Promotion. S. Jirowong and P. Liamputtong (Eds). Oxford University Press, Melbourne.
In Aboriginal populations the need for assistance with core activities is higher than the general population, across all age groups. In CALD populations the need for assistance is higher than the general population in those aged 45+.	2006 Census of Population and Housing, Australian Bureau of Statistics (ABS)
Projections suggest that the proportion of the population with dementia will increase and that increase will be higher in regional areas. In the Grampians region the number of people with dementia is expected to nearly quadruple by 2050.	Access Economics (2009) Keeping Dementia Front of Mind: incidence and prevalence 2009-2050. Report prepared for Alzheimer's Australia. Access Economics (2010) Projections of dementia prevalence and incidence in Victoria 2010 – 2050: Department of Health Regions and Statistical Local Areas. Report prepared for Alzheimer's Australia.

Quantitative data	Data source
Grampians is a rural region and evidence indicates that rural and remote communities have poorer health outcomes than those in metropolitan areas. Life expectancy within the region is lower than for Victoria and the burden of disease (measured in Disability Adjusted Life Years) is higher.	Australian Institute of Health and Welfare (2008). Rural, Regional and Remote Health: indicators of health status and the determinants of health. Rural Health Series no. 9. AIHW, Canberra. Department of Health (2011) Local Government Areas 2010 Statistical Profiles. Victorian State Government, Melbourne.
The percentage of people reporting high or very high rates of psychological distress is higher in the region than the Victorian average.	Department of Health (2009) Victorian Population Health Survey 2008. Victorian State Government, Melbourne.
There is a strong link between socio-economic status (SES) and health. SES can be measured by unemployment, income, education or a combination of these and other indicators (e.g. IRSED). Using any of these measures, Grampians region has poorer SES indicators than Victorian figures.	Department of Health (2011) Local Government Areas 2010 Statistical Profiles. DH, Melbourne. Australian Bureau of Statistics (2008) Census of Population and Housing: Socio-Economic Indexes for Areas (SEIFA): 2033.0.55.001. ABS, Canberra. Wilkinson, R. and Marmot, M. (2003) Social Determinants of Health: the Solid Facts 2nd edition. World Health Organization, Copenhagen.

2.2 Qualitative data sources

Qualitative data	Data source
Feedback from service providers suggests that a number of HACC assessment officers feel uncomfortable completing the psycho-social component of the HACC assessments (see diversity goal 6).	Consultation with service providers.
Feedback from service providers indicates that they are witnessing an increase in the number of clients with dementia. They express some concern regarding access to services for those clients, their families and carers (see diversity goal 1).	Consultation with service providers.
HACC Living at Home Assessment providers have identified the need for clearer links and stronger relationships between themselves and the region's Aboriginal Community Controlled Organisations (ACCOs) to improve client access to services (see diversity goal 2).	Feedback from service providers.
HACC providers have identified unmet allied health needs of Supported Residential Services (SRS) residents especially in the area of podiatry (see diversity goal 4).	Consultation with service providers.
HACC funded organisations indicated that as part of the implementation of their initial diversity plans, they would be interested in undertaking diversity audits for specific special needs groups such as gay, lesbian, bisexual, transgender and intersex (GLBTI) people (see diversity goal 7).	Consultation with service providers
There appears to be an emerging trend of those people who are financially disadvantaged moving to small rural communities due to the availability of relatively inexpensive housing (see diversity goal 7).	Consultation with service providers

2.3 Interpretation of analysis

Commentary and issues identified	Source of information used	Possible priority
In all LGAs the proportion of the population aged 65+ is expected to increase significantly. In some LGAs this will occur at the same time as a decline in the working aged population.	Department of Planning and Community Development	Discussion with funded organisations about strategic response to potential increased demand coupled with workforce shortages.
The number of people with dementia is projected to increase significantly in all LGAs in the region.	Access Economics reports	Improving knowledge about dementia services across the regions – for all stakeholders including funded services, people with dementia, their families and carers
Some HACC assessment officers reportedly have issues completing the psycho-social component of the assessment tools. This may mean that opportunities for the early identification of clients with psycho-social issues are missed.	Consultation with funded agencies	HACC assessment officers provided with training in psycho-social assessment and appropriate referral pathways
Actual numbers of Aboriginal people are small but their need for assistance is higher than the general population. Improving partnerships between HACC agencies and the region's ACCOs would enhance service coordination and therefore outcomes for clients.	Department of Health central office data	Scope issues and explore possible opportunities for action. Include possible activities to improve partnerships between organisations.
The number of people from CALD backgrounds is reportedly low in the region. However, exact numbers are not known. Evidence suggests that in populations aged 45+ their need for assistance is higher than the general population.	Department of Health central office data	Scope issues and explore possible opportunities for action (including strategies that may have been successful in similar regions). This may include the collation of information from funded agencies regarding the number of clients from CALD backgrounds.

Priorities and strategies

Priority goal ((Reflecting the Victorian Government's health priorities)	What we want to achieve over the three years (Measurable outcomes)	Strategies/actions	Timeframe (Years 1- 3)
1. DEMENTIA: Address Heath Priority Two '*improving every Victorian's health status and experiences*' by improving access to services for HACC eligible people with dementia their families and carers.	Improve the response to people with dementia, their families and carers by enhancing the understanding of dementia services in the region and increasing knowledge about appropriate referral pathways.	Establish a regional dementia advisory group. Encourage HACC funded organisations to participate in, and consult with the Regional Dementia Advisory group, specialist service organisations and programs to support referral processes and improve dementia friendly environments and practice within the region.	Year 1 Year 2-3
		Map available services including support groups in the region – for those with dementia, their families and carers.	Year 1
		Identify and document service gaps, or areas of duplication, in the region.	Year 1-2
		Identify challenges that organisations face in delivering services to people with dementia or cognitive impairment, including awareness of appropriate referral pathways	Year 1-2
		Promote the uptake of the relevant accredited dementia competency units, either as a single stand alone unit or as part of a Certificate qualification, to relevant staff working in HACC funded programs.	Years 1-3
		Work with HACC funded organisations to explore support options for younger people with dementia.	Year 2-3
	Increasing dementia friendly environments and practice within regional HACC funded social support and respite programs.	Promote the use of education resources and appropriate tools that are available to progress dementia friendly environments and practices within HACC social support and respite programs.	Year 1
		Encourage HACC funded agencies to identify personal development opportunities for social support and respite program staff to better enable them to demystify dementia for clients and carers.	Year 1-3

Priority goal ((Reflecting the Victorian Government's health priorities)	What we want to achieve over the three years (Measurable outcomes)	Strategies/actions	Timeframe (Years 1- 3)
2. ABORIGINAL: Address Heath Priority One '*developing a system that is responsive to peoples needs*', improve access for Aboriginal clients to HACC funded services.	Improve access to services for eligible Aboriginal people by strengthening the relationships between HACC funded Living at Home Assessment organisations and the three ACCOs in the region.	Develop and endorse a project plan (to improve partnerships).	Year 1
		Ensure commitment and participation of relevant HACC funded organisations and ACCO'S.	Year 1
		Facilitate four forums – one for each ACCO and the HACC Living at Home Assessment services in their catchment, to identify activities that will improve partnerships.	Year 1
		Monitor the implementation of identified partnering activities.	Year 2 – 3
3. CALD: Address Heath Priority Two '*improving every Victorian's health status and experiences*' by improving access to services for HACC eligible people from CALD backgrounds.	Increase service access for eligible clients from CALD backgrounds by providing services that are evidence based and culturally appropriate.	Work with HACC funded organisations to develop evidence regarding number of potential clients from CALD backgrounds.	Year 2
		Scope issues and explore possible opportunities for action.	Year 2
		Develop a plan for service improvements based on the accumulated evidence.	Year 2-3
4. GENERAL: Address Health Priority *Two 'improving every Victorian's health status and experiences'* by improving access to services for HACC eligible people experiencing financial disadvantage (including people who are homeless or at risk of homelessness).	Increase service access for eligible clients from Supported Residential Services by providing allied health services that are evidence based.	Work with HACC funded organisations to develop evidence regarding the number of potential clients from SRS facilities.	Year 1
		Scope issues and explore possible opportunities for action. Develop a plan for service delivery based on accumulated evidence.	Year 1 Year 1-2

Priority goal ((Reflecting the Victorian Government's health priorities)	What we want to achieve over the three years (Measurable outcomes)	Strategies/actions	Timeframe (Years 1- 3)
5. RURAL AND REMOTE: Address Health Priority Two *'improving every Victorian's health status and experiences'* by improving access to services for HACC eligible people living in rural and remote areas.	Improve the service response to people living in rural and remote areas of the region to increase opportunities to reduce social isolation.	Work with HACC funded organisations to develop evidence regarding the number of potential socially isolated clients living in their individual local government catchments.	Year 1
		Scope and explore possible opportunities for action.	Years 1-2
		Develop a plan for service improvements based on the accumulated evidence for inclusion in the next regional diversity plan.	Year 2 -3
6: GENERAL: Address Heath Priority One '*developing a system that is responsive to people's needs*' by improving the services responses to HACC eligible people with possible mental health issues.	Improve the capacity of HACC assessment and community care staff to respond effectively to clients with possible mental health issues.	Establish a working group to develop and lead project (including Psycho Geriatric services from the Area Mental Health Service).	Year 1
		Develop and deliver opportunities for HACC Assessment staff to increase their knowledge and skills to enable them to respond effectively to clients with possible mental health issues.	Year 1
		Develop opportunities for HACC community care workers to increase their knowledge and skills to enable them to respond effectively to clients with possible mental health issues.	Year 1
7. GENERAL: Address Health Priority One *'Developing a system that is responsive to people's needs'*, identify HACC special need groups that are encountering access barriers to HACC services.	Understand the access issues for HACC special needs groups and develop improvement strategies for inclusion in the next regional diversity plan.	Identify appropriate tools for use by HACC funded organisations to assist them to understand and address access issues for special needs groups.	Year 1-2
		Collate access issues from HACC funded organisations for inclusion in the next regional diversity plan.	Year 2-3

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