

Community and Women's Health Program Guidelines, 2003-04 to 2005-06

**Primary and Community Health Branch
Victorian Department of Human Services**

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Foreword

I am pleased to present the *Community and Women's Health Program Guidelines, 2003–04 to 2005–06*. The guidelines reflect the changes that have happened in the program during the previous twelve months and which continue to occur to provide improved service provision to consumers.

The presentation of the Community and Women's Health Program Guidelines as a three yearly rather than an annual document is a key part of the Department's change to a three-year Service Agreement cycle. Information about changes during the three year cycle, such as new funding initiatives, will be provided in annual updates which will be published to support the *Rural and Regional Health and Aged Care Services (RRHACS) Division Policy and Funding Plan, 2003–04 to 2005–06*.

Primary Health Reform during 2003–04 to 2005–06 will see further work in the areas of integrated health promotion and service coordination, with practice change in services resulting in improved outcomes for consumers and carers. Organisational health promotion planning and reporting will be supported with the release of two key resource documents – *Integrated Health Promotion: A Practice Guide for Service Providers* and *Measuring health promotion impacts: A guide to impact evaluation in integrated health*

promotion in 2003. The implementation of measures to improve service coordination has already demonstrated improvements for consumers of Community and Women's Health Services.

The challenge for Community and Women's Health Services for the 2003–04 to 2005–06 period is to embed service coordination into routine agency practices and processes; to contribute to the implementation of all elements of the 'Better Access to Services Operational Framework'; and to increase the evidence base, through stronger evaluation processes, for the effectiveness of integrated health promotion.

Work on the Community Health Policy Framework will continue during 2003–2004. It is planned to finalise this work during 2003–2004 following consultation with agencies, sector bodies and the public. The policy framework will clarify the role of Community Health Services within the Victorian health system and identify developments necessary to support that role.

A new funding and accountability approach was introduced for Primary Health programs during 2002–03, with a two-year implementation period from July 2002 to June 2004. The new approach has three major components: direct service delivery to individuals; health promotion; and

development and resourcing (previously known as 'infrastructure').

A review of counselling services funded by the Community Health Program will be completed in consultation with the sector, during 2003–04. The outcome of this review will form the basis of new policy and program guidelines for counselling services.

Primary and Community Health Branch is currently preparing policy and program guidelines to support the provision of additional general practice clinics in Community Health Services. This work will be undertaken during 2003 for implementation from 1 July 2004. Agencies and stakeholder groups will be consulted during 2003.

I look forward to continuing a collaborative and productive working relationship with you.



Tracey Slatter

A/ Director, Primary & Community Health

Chapter 1: Introduction

These guidelines cover the following programs:

- Community Health Program
- Women's Health Program
- Family Planning
- Innovative Health Services for Homeless Youth (IHSY)
- Family and Reproductive Rights Education Program (FARREP)
- Suicide Prevention.

1.1 How to consult these Guidelines

These Guidelines should be read in conjunction with the following publications:

- Rural & Regional Health & Aged Care Services (RRHACS) Policy and Funding Plan for 2003-04 to 2005-06;

- Service Agreement Information Kit for Agencies 2003-04 to 2005-06;
- Dental Health Program Service Standards & Guidelines 2003-04 to 2005-06;
- Community & Women's Health Program 2003-2004 Data Reporting Requirements (incorporated in summary form in Chapter 4);
- Integrated Health Promotion: A Practice Guide for Service Providers;
- A Guide to Impact Evaluation in Integrated Health Promotion; and
- PCP Service Coordination Guidelines.

These publications can be accessed on the Primary Health Knowledge Base web site (PHKB) at www.dhs.vic.gov.au/phkb. The PHKB provides information for agencies and

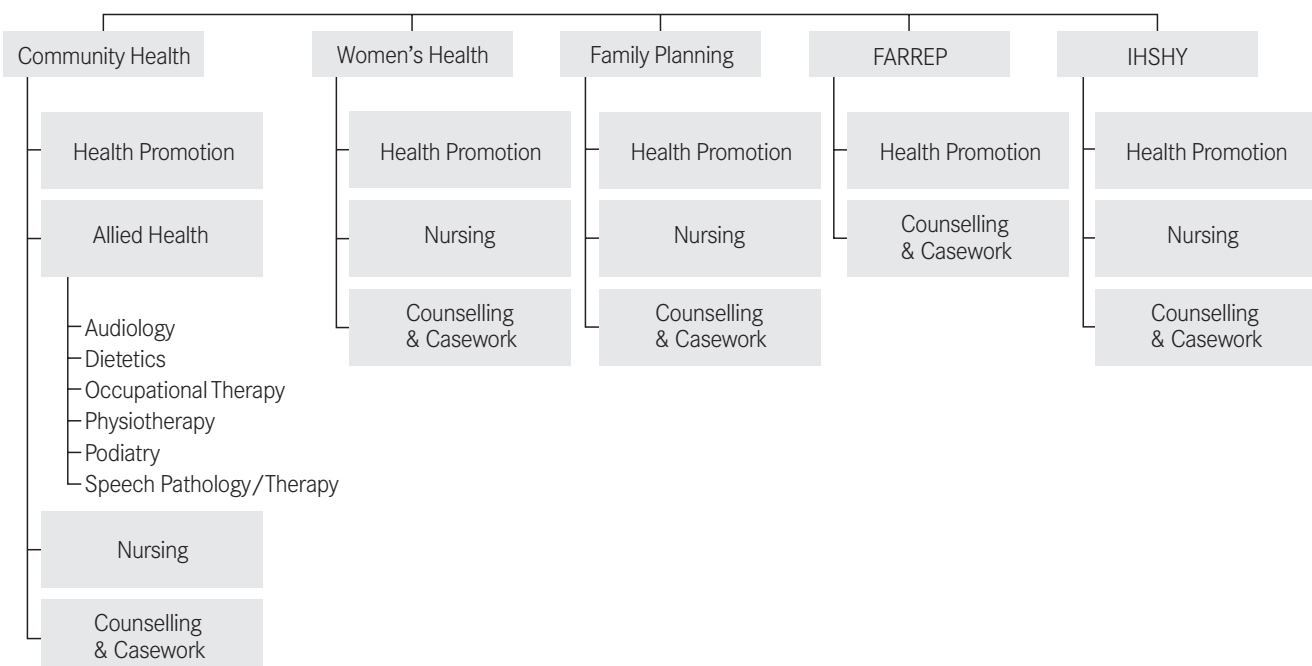
includes a useful collection of data and publications. It also has links to other sites of interest to Community and Women's Health Services. It aims to promote and support effective exchange of information relevant to providers of the primary health services in Victoria.

1.2 Expectations of funded agencies

In addition to adhering to the Guidelines for Community and Women's Health, agencies will be expected to work within the framework provided by the:

- Primary Care Partnership Strategy;
- DHS Service Agreement;
- Reporting Guidelines;

Figure 1: Community and Women's Health programs and activities, 2003-04 to 2005-06



- Service Agreement Information Kit for Agencies; and
- Other relevant service initiatives.
All agencies in receipt of Community and Women's Health funding must participate in a recognised external quality assurance program, such as:
- Quality Improvement Council (QIC) National Review and Accreditation Program;
- Evaluation of Quality Improvement Program (EQulP); and
- International Standards Organisation (ISO).

1.3 Changes to these Guidelines

The 2003–04 to 2005–06 Guidelines contain a number of changes from the 2002–2003 Guidelines. The presentation of the Community and Women's Health Program Guidelines as a three yearly rather than an annual document is a key part of the Department's change to a three-year Service Agreement cycle.

Information about changes during the three year cycle, such as new funding initiatives, will be provided in annual updates which will be published to support the Rural and Regional Health and Aged Care Services (RRHACS) Division Policy and Funding Plan, 2003–04 to 2005–06.

Major changes are more strongly aligning the directions of Community and Women's Health programs with the directions of Primary Health Reform.

Reforming the primary health care sector is a priority of the Victorian Government as well as many other jurisdictions in Australia and internationally. Stronger primary health services are necessary to respond to escalating demand, consumer preferences to receive services in the community, the need to support the ageing population and to reduce the incidence of preventable disease that leads to poor health outcomes and the requirement for more acute and specialist care.

Primary Health Reform has two key elements that relate to Community and Women's Health Programs:

- The Primary Health Funding Approach – see 1.4.
- The Primary Care Partnership Strategy – see 1.5.

1.4 Primary Health Funding Approach (Year 2 implementation)

When the new Primary Health Funding Approach was introduced in July 2002, there was an agreement that full implementation would take place over a two year implementation period. 2003–2004 is the second year of implementation. Throughout 2002–2003, there has been ongoing consultation with the sector and within the Department of Human Services (DHS) to:

- Monitor and evaluate the way in which the new approach is working and strengthen the approach where necessary;

- Clarify definitions within and between each of the three components;
- Provide ongoing development and training for DHS and sector stakeholders to support the implementation;
- Analyse service provision data, particularly monitoring any impacts on both performance and service mix; and
- Further refine the Development and Resourcing component of the approach.

The Primary Health Funding Approach groups funds allocated through the Community and Women's Health Programs into three categories:

- **Primary health care services to individuals** (allied health, counselling/casework, nursing) funded on a unit price basis;
- **Health promotion** funded according to agency specific health promotion plans; and
- **Development and resourcing** (formerly known as Infrastructure) which includes management and administration, other operating expenses and development initiatives and is block funded.
The approach aims to provide a framework which is consistently applied across the state while responding to local health needs and service delivery expertise. In most cases, it is expected that agencies will apportion their Community Health Program budgets in the following way:
- Primary health care services to individuals (50%–70%);

- Health promotion (15%-35%); and
- Development and resourcing (up to 25% – refer to section 3.5.4 for further detail).

In most cases, Women's Health agency budgets will be apportioned in the following way:

- Health promotion (75%-85%); and
- Development and resourcing (15%-25%).

As occurred in 2002-2003, *total funding* for each agency in 2003-2004 will reflect the previous year's funding levels, with adjustments for productivity and other budget movements.

The application of the components is further described in chapter 3 of these guidelines.

Throughout 2003-2004, there will be ongoing monitoring and evaluation of the funding approach in keeping with the two-year implementation commitment.

There is minimal change for this second year of implementation in 2003-2004. Additional information or changes relating to the three components is outlined below:

Services to individuals

- No changes to 2002-2003 definitions but refer to *Development and Resourcing* component information in Section 3.5.4 for clarification of distinction between components.

- Unit prices for *services to individuals* (allied health, counselling/casework and nursing activities) have been updated. For information about the price build ups please refer to Appendix 8.

Health promotion

- Agencies are required to submit a health promotion plan that includes 100% of their health promotion budget by allocating a minimum of 60-70% of the health promotion funds to planned work in priority areas. Further details are outlined in Section 3.5.3.

Development and resourcing

- Information about the approach to this component is outlined in Section 3.5.4.

1.5 Primary Care Partnership Strategy

The Victorian Government's response to the issues faced by the primary health sector included the 1999 election policy to reform primary health care. In April 2000, following consultation with the primary health care sector, the Government launched the Primary Care Partnership (PCP) Strategy to achieve reform of primary health and to address the perceived fragmentation in the primary care system.

Community and Women's Health Services have a leadership role to play in the PCP Strategy. This is particularly relevant for improving service coordination and integrated health promotion where these individual agencies have a critical role to play.

PCPs provide an integral link between community health and other agencies within a given catchment area.

These guidelines have been updated to reflect the core deliverables of the PCP Strategy for 2003-04 that have implications for Community and Women's Health Services.

By 1 July 2004 Primary Care funded agencies should have embedded Service Coordination into routine agency practice.

A review process is underway which will determine the PCP deliverables beyond July 2004. Community and Women's Health Services are key stakeholders whose input will be critical to determining future directions.

The PCP deliverables of integrated health promotion and service coordination will continue to reflect the requirements of Community and Women's Health Services as mandated in DHS Service Agreements.

Community Health Plans will continue to be refined to align with other planning processes.

1.6 RRHACS strategic priorities

Rural and Regional Health and Aged Care Services Division (RRHACS) has adopted the following strategic priorities for Primary Health:

- Reduce inequalities in oral health and improve access to public dental services;

- Implement evidence-based oral health promotion strategies including increasing the proportion of Victorians who have access to fluoridated water;
- Improve service coordination within and between State primary health services, GPs and hospital services;
- Develop and implement a policy framework for community-based health services to strengthen their role in improving health and wellbeing and preventing avoidable hospital admissions;
- Work towards simplified funding and accountability arrangements, particularly the development of more compatible arrangements for the range of programs delivered by community health services;
- Improve electronic connectivity, electronic health and service information and client information management systems; and
- Enhance and improve school nursing in line with national and international evidence.

1.7 New funding and accountability approach for small rural health services

A new funding and accountability approach for small rural health services is being introduced from 2003–04. The changes aim to:

- improve the health status of Victorians living in small rural communities;
- support a sustainable configuration of health and aged care services in these communities that is responsive to local needs; and

- facilitate delivery of a locally determined mix of services, with an emphasis on those which are community-based and in-home.

The new funding and accountability approach aims to give funded agencies more flexibility in determining service type and volume, and therefore more opportunity to tailor service responses to local community need. It will also change the nature of department-agency relationships, moving from a focus on very detailed, program-specific funding and target issues to a focus on service mix, local needs and health outcomes.

The new approach will be locally driven and implemented incrementally over a two to three year period, with some changes introduced, tested and monitored during 2003–04 and adjustments and further development planned for 2004–05 and beyond. This incremental approach aims to achieve change at a realistic pace that allows both agency and DHS staff to move successfully to a new way of working.

In 2003–04 the new, more flexible funding and accountability arrangements will be available to 67 agencies across rural Victoria that deliver a range of health and aged care services and have all sites/campuses located in towns with a population of less than 5,000. The agencies that fall into this category are primarily Group D & E Hospitals (including Multi-Purpose Services and Healthstreams) and Bush Nursing Centres, plus a small number of stand-alone community health services. (The new arrangements will not apply to 'sites'

or 'campuses' of larger agencies such as Group C hospitals.)

The new approach covers health and aged care funding these agencies receive through the RRHACS and MHACS (Metropolitan Health and Aged Care Services) Divisions (with the possible exception of Mental Health and Public Health funding). The new arrangements assume each agency's 2002–03 recurrent base budget as the starting point, subject to any adjustments to agency budgets as a result of annual State and Commonwealth budget decisions.

In the first year, flexible use of funds will primarily be available across acute health, sub-acute health and primary health funds. The aim is to progressively achieve flexibility across traditional departmental program boundaries over time.

This developmental work will involve ongoing research and analysis, and consultation with and feedback from agencies and peak bodies. Over the next three years, DHS will explore further opportunities for increased flexibility, including via negotiations with relevant Commonwealth departments.

When considering existing or changed budget expenditure on primary health services, small rural health services should use the Primary Health Funding Approach (PHFA) to guide discussions within their own organisation and with regional offices. For example:

- Decisions about primary health service provision in 2003-2004 should consider the applicability of the standard proportional allocation of funding to the three components of primary health funding recommended statewide under the PHFA; services to individuals, (allied health, nursing and counselling); health promotion activities; development and resourcing to support these services. Like a small number of other agencies across the state, some small rural health services may have good reason for allocating funds outside these standard proportions.
- Decisions should also consider the proportional allocations that the small rural health services adopted for the first year of implementation of the PHFA in 2002-2003, and any plans already in place to work towards adjusting the balance across the three PHFA components in 2003-2004.

1.8 DHS flagship projects

Since 2001, DHS has established a range of projects designed to address key strategic issues facing the Department over a 12-18 month period. Projects involve significant corporate focus, cross-divisional coordination and strong and active partnerships within the Department and between the Department and external agencies.

Flagship projects are resourced by corporate contribution and led by Policy and Strategic Projects Division for an identified client.

Current flagship projects are:

Workforce planning: seeks to effectively determine workforce numbers, distribution, skills and workplace organisation through a framework for workplace planning. The project is developing a program of rolling forecasts and policy responses in key industries, including those with workforce shortages, such as child protection, disability services and a range of sectors using nurses.

Child protection outcomes: focuses on improving outcomes for children, young people and families who are notified to the child protection system or are in statutory care. The project examines legislation, policy directions and practice across Australia and overseas to identify the widest range of frameworks to protect children.

Partnership in practice: seeks to strengthen the Department's relationship with funded agencies across the portfolio to reflect a partnership approach to developing and providing services. The project is focusing on streamlining and enhancing funding and accountability processes, including introduction of three-year service agreements.

Funding models: examines the Department's capacity to change the model of funding the non-government sector in a way that (i) increases the capacity for services to meet client need by facilitating client-focused and integrated service provision, (ii) encourages aggregate and outcome-focused reporting, (iii) maintains sufficient standards and

accountabilities and (iv) strengthens the links between planning and funding.

Disability housing: examines accommodation options for people with a disability. The project will have input from four divisions: Disability Services, Policy and Strategic Projects, Housing and Community Building, and Rural and Regional Health and Aged Care Services.

Commonwealth-State relations: involves working closely with the Department of Premier and Cabinet to identify opportunities to improve Commonwealth-State policy and financial interactions affecting the delivery of human services in Victoria. This will involve identifying and analysing trends associated with the negotiation and development of Commonwealth-State agreements and Commonwealth initiatives.

Chapter 2: Programs and services

This chapter provides a description of Programs and Services and outlines policy on funding, providing guidelines as to what may be funded.

2.1 Community Health Program

Aim

To provide primary care services that improve the physical, mental and social well-being of Victorians and to reduce the requirements for hospital and other specialist institutional services.

Target groups

All Victorians are eligible to access services funded through the Community Health Program and CHSs should not place restrictions on access based on geography or other criteria. However, CHSs should prioritise their services towards population groups and individuals who have chronic and complex health issues and who are in lower socio-economic groups. This may include groups such as low-income earners, people from culturally or linguistically diverse backgrounds, Kooris and homeless people.

Consistent with this prioritisation, Community Health Program services should be directed to support communities in Neighbourhood Renewal areas as part of the Neighbourhood Renewal Strategy's commitment to people in greatest need due to socio-economic circumstances or health status. Neighbourhood Renewal is a whole-of government initiative to narrow the gap between the most disadvantaged

neighbourhoods in Victoria and the rest of the State.

Community Health Service priorities should be clearly linked to the analysis of community needs and priorities in Community Health Plans. Community Health Plans are a key tool for CHSs to negotiate and define their role within their PCP catchment.

Mode of service delivery

There are three principal service delivery modes in Community and Women's Health funded services:

- services to individuals in one-to-one contacts,
- group sessions, and
- population based services and projects generally referred to as health promotion.

Philosophy

Agencies funded must support the following core community health principles:

- Promote the understanding of health as a complete state of physical, social and emotional well-being, not merely the absence of disease;
- Contribute to meeting the main health needs of a defined community. This includes taking a leadership role in driving primary health reform through the PCP Strategy through a number of areas:
 - Population health and integrated service planning;
 - Service coordination;
 - Integrated health promotion; and
 - Chronic disease management.

- Promote equity and accessibility by providing services close to where people live and work, without financial, geographic, cultural or other barriers;
- Develop and maintain comprehensive program content that addresses the social, emotional, physical, cultural and environmental aspects of health, through service provision or networking with other providers;
- Promote the participation of people and communities in debate and decision-making about health and service development issues;
- Ensure the participation of individuals in decision-making about their health care;
- Have organisational structures that promote multi-disciplinary teamwork;
- Promote health through working collaboratively with other sectors;
- Ensure accountability to the communities served by having efficient and effective management practices; and
- Facilitate community involvement in managing Community Health Services.

Statewide Community Health Agencies

The following specialist statewide agencies are funded through the Community Health Program:

- Victorian Foundation for Survivors of Torture Inc;
- International Diabetes Institute;
- Centre for Adolescent Health; and
- Centre for Culture, Ethnicity and Health.

These agencies provide a mix of primary health and health promotion services relevant to their particular contexts.

Community participation

To reflect the philosophy of the Community and Women's Health Programs, communities and clients should be encouraged to be actively involved in the planning, development and management of services.

In designated Community Health Centres (CHCs) this is facilitated through Centre membership and the election of members of Boards of Management, but it should also include participation in specific project planning, implementation and evaluation.

Services should ensure that consumers, carers and community members have opportunities to be involved in all aspects of service planning and evaluation. All agencies are encouraged to ensure that their quality and consumer participation processes seek to ensure that participation informs continuous quality improvement.

2.1.1 Service Coordination implementation

Agencies are developing an integrated approach to service coordination through the implementation of shared practice, processes, protocols and systems for Initial Contact, Initial Needs Identification, and Care Planning across local PCP catchments. This includes the implementation of good practice sharing of health and care information (e.g. referral)

between service providers through a consistent approach to reduce duplication of effort for agencies and improve access to services for clients.

Service Coordination Tool Templates

Agencies should have in place routine practices, processes, protocols and systems for the ongoing implementation (including processes for review and continuous improvement) of service coordination, utilising the tool templates listed below:

- | | |
|--|---|
| • Consumer Information | • Universal implementation |
| • Summary and Referral | • Universal implementation |
| • Consent form and consumer information brochure | • Universal implementation |
| • Supplementary profiles | • Optional use |
| | • Required use of the "living arrangements profile" (for agencies funded for HACC Assessment & Care Management) |
| • Service Coordination plan | • Recommended use |
| | • Required use (for agencies funded for HACC Assessment & Care Management) |

The Service Coordination Tool Templates and Guidelines are available on the Primary Health Knowledge Base at www.dhs.vic.gov.au/phkb. Appendix 4 outlines the service coordination elements and tool templates/supporting information for each element.

It is important that appropriate practice implemented by PCPs and agencies, in combination with the Tool Template Guidelines, determines how the tool templates are used.

A priority for expenditure of Workforce Development grants for 2003–04 to 2005–06 should be to support activities to embed Service Coordination into routine agency practices. Further details are outlined in section 2.7.

Use of the Service Coordination Tool Templates

Tool templates should be used by agencies across the state in a consistent manner. The tool templates should not be changed.

The use of the Service Coordination Tool Templates across the State is designed to support local practice by facilitating a consistent and shared approach to collection and sharing of consumer information. It provides the foundation for a statewide referral platform for primary care agencies. This is particularly important for GPs, statewide providers and providers that work across more than one PCP catchment.

If required, additions to the tool templates can be implemented as an additional profile. For example,

individual agencies may have other data requirements that will require additional data collection as part of internal business processes. Agencies are encouraged to maintain the integrity of the tool templates and consider an agency specific profile to collect “extra” data. This will negate the need to re-enter data into the core tool templates when receiving and sharing consumer information. The protocols developed will guide practice around the use of additional profiles.

Use of the service coordination tool templates and the practice underpinning their use replaces existing individual agency practice for the collection of this information to inform assessment, service delivery and referral requirements, and may be counted (for reporting purposes) as service delivery.

2.1.2 Integrated Health Promotion

Integrated Health Promotion is a key element of the primary health care system, and is a service which DHS wants to further strengthen and enhance. Strengthening health promotion planning and reporting in Community and Women's Health Services builds on the policy framework introduced through the Primary Care Partnership strategy. One of the expected outcomes of this strengthened approach is a greater focus on planned and integrated health promotion that will improve the health of local communities.

Agencies receiving over \$15,000 of health promotion funding through:

- Community Health;
 - Women's Health;
 - Innovative Health Services for Homeless Youth (IHSY);
 - Suicide Prevention;
 - Family Reproductive Rights Education (FARREP); and
 - Family Planning
- are required to plan and document their health promotion service delivery for each financial year.

The Organisational Health Promotion Plan Pro Forma is included in Appendix 1 of these guidelines. Planning for integrated health promotion is discussed in greater detail in section 3.5.3.

The approach to integrated health promotion will continue to emphasise the distinction between *planned* and *opportunistic* health promotion activities. Opportunistic health promotion (health promotion undertaken during a Primary Health Care Contact or Session) occurs as part of good practice in the provision of Allied Health, Counselling/ Casework and Nursing Activities. Health promotion is an integral part of quality health care and, as such, service providers should ensure that a health promotion approach is incorporated into treatment.

Agencies in receipt of Community and Women's Health Program funding for health promotion are also required to **report** against their health promotion plan. Progress and final reports on the

implementation of organisational health promotion plans will assist in determining the effectiveness and efficiency of particular strategies and interventions so that effort is not wasted in the future and limited resources can be put to best use. Evaluation that service providers conduct and report on will assist in building the evidence base for health promotion. DHS will disseminate learnings through the Primary Health Knowledge Base at www.dhs.vic.gov.au/phkb.

The Organisational Health Promotion Reporting Pro Forms are in Appendices 2a and 2b of these guidelines and reporting requirements are discussed in greater detail in Chapter 4.

2.1.3 General Practitioners in Community Health Services

General Practitioners (GPs) have a central role in the provision of primary health care. GPs located in Community Health Services provide an important element in shared care arrangements with other allied health providers.

In July 2002, the Community Health Program released a *Review of General Practitioners in Community Health Services*. The *Review* was commissioned as a direct result of the declining numbers of GPs in Community Health and the consequent adverse impacts of this in the management of consumers with complex and chronic medical/social problems, particularly those from disadvantaged groups who are over

represented in utilisation of primary and acute hospital services.

The *Review* report argues that well managed Community Health general practices can be financially viable, but only where they can achieve a critical mass of GPs. The report is entitled *Study of General Practitioners in Community Health Services* and a copy may be obtained through the Primary Health Knowledge Base at: www.dhs.vic.gov.au/phkb.

The State Government's *Healthy Communities – Labor's plan for seniors and community health*, allocates \$6M over 4 years to develop strategies and incentives to recruit GPs to CHS. Funds will be available from 2004–05.

Options for the allocation of funds are currently being developed, with a consultation phase to occur with the sector in 2003. Policy and guidelines will be developed, with the allocation of funds due for release in March 2004.

In preparation of the allocation some preliminary work is currently occurring including:

- the provision of a statewide industry consultant providing practice management advice to services; and
- an allocation of minor works grants to CHS targeting GP services.

2.1.4 Counselling in Community Health

A Review of Counselling in Community Health has been undertaken. Guidelines will now be developed to provide guidance on the role of counselling services in community health.

The Review has been conducted in two stages. Stage One has provided information and recommendations that have assisted the Department to develop benchmarks for resource allocation of growth funds. Stage Two has identified a range of issues related to the role of community health program funded counselling within the broader primary care system, as well as the type and quality of such services.

The *Review of Counselling in Community Health* discussion paper has been completed for Stage One of the Review. The report was widely circulated for consideration from the field and the Community Health Unit has received written comment, which will be considered and utilised to inform the completion of Stage Two of the Review.

Stage Two of the Review is developing a policy framework, guidelines for community health counselling and a recommended implementation plan. Once completed, the policy and guidelines will form the basis for future directions of the Community Health Program counselling services. We expect to release this work during 2003–04.

2.1.5 Governance

New governance arrangements for declared CHCs were introduced on 1 April 2001 as a result of amendments to the *Health Services Act 1988* by the *Health Services (Amendment) Act 2001*. The new arrangements replaced fully appointed CHC boards of management with part-appointed, part-elected boards.

Information regarding CHC governance arrangements is available in the '*Guidelines for the Governance, Election and Appointment of Members of Boards of Declared CHCs, December 2002*' and a copy may be obtained through the Primary Health Knowledge Base at: www.dhs.vic.gov.au/phkb. These guidelines were amended following a review of the board election and appointment process conducted during 2002.

Under the new legislation the Secretary may provide an annual grant to the board of a CHC to defray the reimbursement of reasonable expenses incurred. For the financial year 2003–2004, DHS will provide funding of \$3,000 for each CHC for the reimbursement of board member expenses.

During 2004, CHCs will be required to run full election and appointment processes to have new Boards of Management in place by the 2004 Annual General Meeting. It will be important for CHCs to build a strong membership base by early 2004 to ensure the validity of the election process.

2.1.6 Needle and Syringe Program

The Victorian Needle and Syringe Program (NSP) is a public health service. Community Health Services are a critical component of the NSP, and agency participation in providing NSP services is essential for the continued success of the program.

Some Community Health Services auspice primary needle and syringe programs funded through the Public Health Branch of DHS. Such activities are outside the scope of these Guidelines.

There are two main modes of service delivery within a NSP:

a. Through contact with a Community Health Service Practitioner

These Contacts may be provided by a Social Worker, Psychologist, Youth or Welfare Worker, Community Development Worker, Community Nurse or whichever trained practitioner the agency has considered appropriate to the needs of the service user. In these instances, the Contact should be recorded either as a *Health Promotion* Contact or as an appropriate *Primary Health Activity*, such as *Nursing or Counselling/ Casework*.

Generally no special accommodation needs to be made in Service Plans for this Health Promotion work, other than noting that some Contacts will be NSP service provision.

b. Through a brief exchange 'over the counter' with a receptionist

These interactions may be very brief, often only two or three minutes duration. Because of their brevity they are not considered Contacts within Primary Health Program definitions. However, in agencies where a high volume of exchanges take place, the demand of this work should be examined in service plan negotiations, and the time spent on direct health

promotion work by the receptionist recognised.

In addition to this service provision, there may be time spent by the agency coordinating the NSP. The agency may have a nominated NSP coordinator who maintains supplies, undertakes secondary consultations, runs community and professional education and liaises with the police on NSP issues. Time spent on these health promotion tasks should be counted as such.

In negotiating service plans regional negotiators should consider the volume of NSP work that a Community Health Service is likely to experience. The total number of visits per agency is an indication of the volume of service, but it does not detail the distinction between the two modes of service delivery described above. Agencies should be able to provide an indication of how many NSP visits would be provided as Contacts.

In instances where provision of the NSP does not make a significant impact upon receptionist time, it may be meaningless to allocate proportions of receptionist time to Health Promotion.

2.2 Women's Health Program

Aim

To improve the health and well being of Victorian women (with an emphasis on those most at risk), through the development and dissemination of health information and research and through the provision of community

and professional education. These activities take place directly with women and in partnership with the health and community sectors.

Target group

Women's Health Services work to improve the health and wellbeing of women, but prioritise those population groups for whom access to health services is difficult. These include Koori women, women from culturally and linguistically diverse backgrounds, women with disabilities, rural women and those identified by state-wide, regional, PCP and community health planning processes, eg women from drought and bushfire affected areas.

Philosophy

The Women's Health Program is based on an understanding of health within a social context and recognises that:

- health factors are determined by a broad range of social, environmental and economic factors;
 - differences in health status and health outcomes are linked to a range of factors including gender, sexual orientation, socioeconomic status, ethnicity and disability, refugee status; and
 - integrated health promotion, prevention and early intervention, equity of access and strengthening the community and home based health system are necessary along with high quality treatment services.
- Health services for women must:
- be in all ways accessible, appropriate, affordable and acceptable to women;

- reflect the various roles of women in society and encompass all women's life stages;
- seek to promote health and prevent illness, injury or disability;
- where possible, provide a choice of gender of health practitioner to women;
- adopt a holistic approach and ensure linkages with related services;
- ensure the needs of special groups are recognised in planning for all service provision;
- recognise women's rights as health care consumers to be treated with dignity, confidentiality and to give informed consent;
- acknowledge that informed decisions about health and health care require accessible and appropriately targeted health information; and
- will involve women consumers actively in the planning, development and management of Women's Health Services.

Roles of statewide and regional agencies

Statewide Women's Health Services will:

- consult and liaise with regional Women's Health Services to strategically plan and address and Victorian women's health priorities as informed by state and regional planning;

- undertake health resource development and distribution and the provision of health information in cooperation with regional Women's Health Services and other mainstream services;
- develop in collaboration with each other and regionally based Women's Health services, gendered policy responses and policy approaches to planning and provision of health services;
- conduct and promote research into priority women's health issues in consultation and in partnership with other services, including regional Women's Health Services;
- provide a consultancy service to agencies offering women's health services, with a focus on integrating current research into contemporary women's health practice;
- provide health education including individual and group information sessions, community education campaigns and training of health care providers;
- develop linkages with Primary Care Partnerships;
- act as a resource to the regional Women's Health Services to assist them in their role as 'multi' PCP Alliance members; and
- support Women's Health Services in working in participating in other government initiatives seeking to enable local communities, such as the Neighbourhood Renewal projects and Drought and Bushfire recovery programs.

Regional Women's Health Services will:

- plan, implement and evaluate quality integrated health promotion programs in partnership with the identified population groups. For each target population group, the priority issue, relevant program objectives and evidence based health promotion interventions and strategies should be identified in the agency's organisational health promotion plan. From 2003–2004 agencies are required to plan and report against reach and impact indicators in their organisational health promotion plan;
- work strategically and collaboratively on Victorian women's health priorities as informed by state and regional planning;
- provide consultation to relevant agencies, with an emphasis on service development and practitioner training;
- consult and liaise with Statewide Women's Health Services to coordinate and ensure efficient use of resources;
- contribute to best practice models in the primary, secondary and tertiary sectors and provide leadership in women-sensitive and gendered practice;
- participate in Primary Care Partnerships as Alliance members; and
- as part of the development of best practice models, provide primary health services including:
 - conduct health promotion activities, including individual and group

information sessions, community education campaigns and training of health care providers; where possible in line with regional health promotion activities and in conjunction with other providers;

- conduct and promote research into priority women's health issues of relevance in their region;
- support for individual and group counselling and self help groups; and
- health assessment and screening.

Priority issues

- Women's Health Services will develop rigorous organisational health promotion plans that use evidence as a rationale for identification of population groups and priority issues, identify a range of strategies and interventions to deliver health promotion to the population group and commence reporting on the reach and impact of the interventions;
- Women's Health Services may also provide specialist advice to agencies that identify women as a population group for health promotion activity;
- DHS will work with services to improve current data collection systems, including SWITCH reporting capacity, and the recording of health promotion activities;
- Women's Health Services will continue to pursue service coordination and linkages with other primary health programs, particularly through the PCP Strategy and additionally support women to participate in the consumer carer initiatives through PCP. This

includes supporting the utilisation of the WHS/PCP Service Linkages Strategy Protocol Framework, and the recommendations from the PCP Best Practice Gender Sensitive Projects;

- Provide advice and expertise to other regional and statewide providers with regard to implementation of the State Government's Women's Health and Well-being Strategy;
- Women's Health Services will actively participate in workforce development initiatives; and
- Take a leadership role within PCPs in accessing and engaging marginalised communities and encouraging providers to develop gendered and culturally sensitive initiatives and practices.

Service coordination implementation

Women's Health Services that provide clinical or counselling services should have implemented agreed PCP practices, policies, protocols and systems and be routinely using the Service Coordination Tool Templates (See section 2.1.2) to collect consumer information, identify consumer needs and/or when making a referral to other services.

Where this information is not currently collected for activities such as health promotion groups, Women's Health Services should use existing processes. Women's Health Services are often an initial contact point to the primary health system, providing health information or service information without the collection of consumer information. Participation in

the PCP service coordination work will support all of these activities.

Community participation

To reflect the philosophy of the Women's Health Program, women consumers must be actively involved in the planning, development and management of Women's Health Services.

2.3 Innovative Health Services for Homeless Youth

Aim

The Innovative Health Services for Homeless Youth (IHSY) Program is a Commonwealth/State cost shared program that provides funding to community based organisations for the provision of health services to homeless and 'at risk' young people. The IHSY program is subject to an Agreement between the Commonwealth and State.

The aim of the program is to promote healthcare for homeless and otherwise at-risk young people through innovative approaches and through increasing access to mainstream and specialist services.

Target group

Homeless young people or young people at risk of homelessness.

Philosophy

- Primary health services provided to homeless youth should be non-judgemental and recognise the complex health needs of homeless young people.

- Services should provide relevant health information to the target group via other agencies/services targeting homeless youth.
- Services should provide direct assessment of health needs and accessible direct health services via outreach health service models.
- Training for service providers should be appropriate to the nature of the work and the model of service delivery.

Priority issues

- To increase the number of homeless young people utilising mainstream services appropriate to their needs.
- To plan, implement and evaluate quality integrated health promotion programs in partnership with the target population group – homeless young people and those at risk of homelessness. For this target population group, the priority issue, relevant program objectives and evidence based health promotion interventions and strategies should be identified in the agency's organisational health promotion plan. From 2003–04 agencies will be required to plan and report against reach and impact indicators in their organisational health promotion plan.
- To provide secondary consultation to other agencies that identify the IHSY target group as a priority population group.
- To provide advice to Primary Care Partnerships in accessing and engaging marginalised communities.

- Develop linkages with PCP alliances to support involvement in service coordination activities.
- Networking and collaboration with other services working with youth and homeless people is highly desirable.
- Participation in workforce development initiatives.
- Participation in PCP alliances and contribute to Community Health Plans where appropriate, in particular assisting to identify the needs of homeless young people.

Service co-ordination implementation

Agencies that provide IHSY clinical or counselling services should have implemented agreed PCP practices, policies, protocols and systems and be routinely using the Service Coordination Tool Templates (See section 2.1.2) to collect consumer information, identify consumer needs and/or when making a referral to other services.

2.4 Family Planning Program

Aim

To enable Victorians to make individual choices on sexual and reproductive health matters through the provision of a range of services which are accessible, culturally relevant and responsive to the needs of community members who experience difficulty accessing mainstream services.

Target group

People with special needs who are less able to obtain adequate family planning services from mainstream health services. These include young people, women from culturally, sexually and linguistically diverse backgrounds, Kooris, and people with disabilities.

Philosophy

The Family Planning Program is based on an understanding of health within a social context and seeks to:

- Promote equity and accessibility by providing flexible services where people live and work, without financial, geographic, cultural or other barriers;
- Encourage participation of individuals in decision-making about their sexual and reproductive health care;
- Ensure that individuals are given choices and full information about their options, and
- Be non-judgemental in service planning and delivery and understand that people with special needs face complex health and wellbeing issues.

Roles of statewide and regional/sub-regional services

Statewide Family Planning Services (eg. Family Planning Victoria Inc.) will:

- Develop linkages with PCP alliances to support involvement in service coordination activities;
- Provide leadership at political, professional and community levels on sexual and reproductive health issues;

- Educate and train those who have a role in promoting sexual and reproductive health;
- Educate the community about sexual and reproductive health issues, including safe sex, STD/HIV, pap smears and breast examination; and
- Provide clinical services for target groups for training and development purposes, including fertility management, pregnancy testing and counselling.

Regional/sub-regional Family Planning Services will:

- Provide clinical services to target groups, including fertility management, pregnancy testing and counselling; and/or
- Educate the community about sexual and reproductive health issues, including safe sex, STD/HIV, pap smears and breast examination.

Priority issues

Service co-ordination implementation

Agencies that provide clinical or counselling services should have implemented agreed PCP practices, policies, protocols and systems and be routinely using the Service Coordination Tool Templates (See section 2.1.2) to collect consumer information, identify consumer needs and/or when making a referral to other services.

Integrated health promotion planning

The target population group for family planning services, including health promotion are people with special

needs who are less able to obtain adequate family planning services from mainstream health services. These include young people, women from culturally and linguistically diverse backgrounds, Kooris and people with disabilities. For this target population group, the priority issue, relevant program objectives and evidence based health promotion strategies and interventions an strategies should be identified in the Agency's organisational health promotion plan. From 2003–2004 agencies are required to plan and report against reach and impact indicators in their organisational health promotion plan.

2.5 Family and Reproductive Rights Education Program

Aim

The Family and Reproductive Rights Education Program (FARREP) aims to work with communities that practice female genital mutilation (FGM) in order to:

- increase their access to primary health services;
- improve the physical and emotional health and well-being of women, young girls and their families; and
- encourage the health system to be more responsive to their needs.

Target group

With a focus on those most at risk, the Program targets all communities that practice FGM regardless of mode of arrival, period of settlement, race,

religion, and culture. Currently some communities that are known to practice FGM are newly arrived (women and young girls through the Woman at Risk program, having survived many other forms of trauma in their lives), whilst others have a long history of settlement in Australia. (See *Female Genital Mutilation Information for Health Professionals 1997*, Royal Australian College of Obstetrics and Gynaecologists for further information.)

In addition, the Program also targets health and other related professionals who work with the affected communities.

Philosophy

The Program is based on an understanding of health within a social and cultural context and recognises that:

- community education and health promotion services need to be delivered in recognition of the cultural diversity and literacy levels of affected communities;
- services need to be flexible and culturally responsive to emerging issues;
- programs need to be integrated into general service delivery, and the community education resources developed are to be part of standard service of the agencies involved; and
- the cost of service be free.

The Program encourages health services to:

- provide a choice of gender or gender sensitive health services to women and their families;

- reflect the various roles of women, their partners, families and communities in their culture and within Australian society;
- seek to promote well being and prevent illness, injury or disability;
- adopt a holistic approach and ensure linkages exist between health and other professionals who work with the affected communities; and
- recognise women and their families rights as health care recipients to be treated with dignity, confidentiality and give informed consent.

See *Operating Framework for the National Education Program on Female Genital Mutilation 1995* for further information at www.dhs.vic.gov.au/phkb.

Priority issues

The following priority issues are identified for the Family and Reproductive Rights Education Program:

- To plan, implement and evaluate planned quality health promotion programs in partnership with the FARREP population group. For this target population group, the priority issue, relevant program objectives and evidence based health promotion interventions and strategies should be identified in the agency's organisational health promotion plan. From 2003–2004 agencies are required to plan and report against reach and impact indicators in their organisational health promotion plan;

- To provide secondary consultation to other agencies that identify the FARREP target group as a priority population group;
- Assisting agencies to target services to all affected communities (particularly SAHEL Africa and Middle East);
- Agency staff to be informed and resourced regarding community, culture and race issues;
- Develop strategies for fully integrating target communities and the program into general service delivery of the Community and Women's Health Programs;
- Professional education to improve coordination between acute and primary health services for mother and baby particularly when female children are born to families where FGM is customary in their country of origin; and
- Development of key messages to the communities who customarily practice FGM.

Service co-ordination implementation

Agencies that provide clinical or counselling services should have implemented agreed PCP practices, policies, protocols and systems and be routinely using the Service Coordination Tool Templates (See section 2.1.2) to collect consumer information, identify consumer needs and/or when making a referral to other services.

2.6 Suicide prevention

Aim

To reduce the incidence of suicide among child and adolescent refugees.

Target group

The Victorian Foundation for Survivors of Torture will provide services to child and adolescent refugees, including children who came to Australia as part of the unaccompanied minors program.

Philosophy

The Suicide Prevention Initiative is the result of the Victorian Government's response to the *Suicide Prevention Task Force Report*. Services are based upon three underlying philosophies of the Report's recommendations, namely:

- That there is no one cause of suicide and there is no one solution;
- That responsibility for finding solutions to suicide lies with the community, business sector and all levels of government working in partnership; and
- That there needs to be better integration, coordination and focusing of existing services.

Service co-ordination implementation

Agencies that provide clinical or counselling services should have implemented agreed PCP practices, policies, protocols and systems and be routinely using the Service Coordination Tool Templates (See section 2.1.2) to collect consumer

information, identify consumer needs and/or when making a referral to other services.

Integrated health promotion

To plan, implement and evaluate quality integrated health promotion programs in partnership with the target population groups including child and adolescent refugees including children who came to Australia as part of the unaccompanied minors program. For this target population group, the priority issue, relevant program objectives and evidence based health promotion interventions and strategies should be identified in the agency's organisational health promotion plan. From 2003–04 agencies are required to plan and report against reach and impact indicators in their organisational health promotion plan.

2.7 Workforce development

Purpose

Workforce development is an integral component of improving the quality and effectiveness of primary health care services. The Community and Women's Health Programs provide separate workforce development funding to support strategically relevant activities incorporating the following:

- Individual staff learning and training;
- Leadership, governance, and management development;
- Organisational development activities; and
- Sector-wide development activities.

Individual staff development

includes a broad range of strategies to strengthen individual clinical and teamwork skills including evidence based practice, health promotion, and working within a social model of health. Individual staff learning and training activities should reflect identified and strategically aligned learning needs.

Leadership, governance, and management development activities are those that strengthen and encourage development of skilled leaders and managers, including Board members.

Organisational development activities are those that aim to strengthen the organisation's capacity to respond to and manage change and plan strategically.

Sector-wide activities encourage collaborative policy development, research and information sharing, and include participation in consultations with DHS, Primary Care Partnerships, peak bodies and research institutes.

Workforce development funding

The Community and Women's Health Program unit cost formula includes recognition of workforce development as a component of funded activity (see Appendix 8). Additionally, specific workforce development grants are allocated to agencies in receipt of Community Health Program funds.

Target group

The primary target group of workforce development grants is all staff, managers, and Board members

funded through Community and Women's Health Programs.

It is recognised that agencies receive funds for programs other than those funded by the Community Health Program, and that the CHP Workforce Development grants are used across an agency's staff and service profile.

Examples of workforce development activities include:

- Short courses, conferences, workshops, in-service training, purchase of consultancy and facilitation related to improvement of service delivery and organisational development;
- Scholarships, secondments, job rotations, skill enhancement of bi-lingual workers;
- Formal external supervision, peer support programs, or access to specialist advice and support for establishment of action learning groups;
- Participation in research projects; and
- Replacing staff when they attend training days or development activities.

Guidelines for expenditure of Workforce Development grants

A major priority for expenditure of Workforce Development grants for 2003–04 to 2005–06 is for agencies to embed Service Coordination into routine practice by supporting training and organisational development and change management to support systems for undertaking initial client contact, initial needs identification, and referral and care planning.

An additional major priority for workforce development is to support the implementation of Organisational Health Promotion Plans. Health Promotion funding allocated through Community Health, Women's Health, Innovative Health Services for Homeless Youth (ISHY), Suicide Prevention, Family & Reproductive Rights Education (FARREP) and Family Planning can support workforce development in health promotion.

Health promotion workforce development strategies should be developed as part of the organisation-wide problem definition and solution generation processes for health promotion. They should be documented as part of the Agency's Health Promotion Plan and reported half-yearly (see Appendix 1 and 2 for the Health Promotion planning and reporting proformas). Internal agency workforce development in health promotion should also be counted in the combined activity reporting as detailed below.

Workforce Development Report Sheet

The purpose of the Report Sheet is to map workforce development activity across the agency, across all staff – not just those staff funded via the Community Health Program. All workforce development activities need to be reported using the revised Workforce Development Report (see 4.12 below) which is available from the Primary Health Knowledge Base at www.dhs.vic.gov.au/phkb. This report requires agencies to report half-yearly (previously quarterly) on three items:

- Identify three strategic workforce development priorities for the following 6-month period. The identified priorities may or may not change from one reporting period to another. The electronic report sheet includes drop down menus to assist with this task. Selections are detailed in the report as listed below:
 - service coordination;
 - working with GPs;
 - client needs assessment;
 - evidence based practice;
 - quality improvement – clinical skill upgrades (including counselling skills);
 - health promotion;
 - managing demand;
 - social model of health;
 - evaluation;
 - strategic planning;
 - program planning;
 - collaboration and partnerships;
 - leadership skills;
 - financial management;
 - team work;
 - working with culturally diverse communities;
 - community participation;
 - governance; and
 - other.
- The combined total number of staff and Board members who have participated in workforce development (not just Community Health Program funded staff) during the previous six-month period.

- The combined total number of hours of workforce development activity that all staff and Board members (as per above) have participated in for the previous six-month period. For example, a four-hour workshop attended by three staff represents 12 hours of workforce development activity [travel time is not to be included].

Please note that these guidelines may be subject to change from 2004–2005 following review of workforce development issues and needs currently underway.

2.8 Language services

DHS Multicultural Strategy Unit has developed guidelines on *Accessing Language Services for DHS funded Agencies* (Appendix 5). The guidelines outline the context, eligibility criteria and process for accessing fee-free language services made available/funded by specified program areas in the Department.

The Community Health Unit has allocated specific funds for interpreting and translating services that are provided by two language service providers – the Central Health Interpreting Service (CHIS) and the Victorian Interpreting and Translating Service (VITS).

The purpose of these arrangements is to enable provision of some government funded interpreting and translating to clients of Community and Women's Health Program funded services. The funds allocated to the Community Health Program also include Dental Health Program

initiatives in Community Health. The program has established specific credit lines for the specialist agency that works with refugee and humanitarian entrants – Victorian Foundation for Survivors of Torture and for Women's Health Services.

Other programs that are located within Community Health Services will need to ascertain the credit line/funding arrangements that are specified in the DHS Guidelines (See Appendix 5).

VITS and CHIS have different organisational structures and arrangements in providing language services. Below is a brief description of current arrangements with these agencies.

Victorian Interpreting and Translating Service (VITS)

The Community Health Unit has established several credit lines with VITS which have specific budget allocations attached.

In addition to a range of other program areas, VITS has credit lines specifically established for:

- Community Health Program funded services;
- Victorian Foundation for Survivors of Torture; and
- Women's Health Services.

These credit lines enable access to:

- Telephone Interpreting;
- Pre-booked on-site interpreting; and
- Translations of documents.

Access to a credit line is subject to approval from the DHS Multicultural Strategy Unit and the Community Health Unit. Once approved the agency will be provided with a PIN.

The approval process and relevant contact details are outlined in the DHS Guidelines for access to language services. The eligibility criteria and use of the credit line for interpreting and translating is also outlined in the document.

Central Health Interpreting Service (CHIS)

The Community Health Program has specific arrangements with CHIS for on-site interpreting for Community Health Services. All CHSs have access to this facility and will be notified of their entitlements by CHIS.

Other services provided by CHIS and VITS

These language service providers can also provide advice on planning for language services (including arrangements such as block bookings etc) as well as training in working with interpreters. Other services apart from those specified may incur a fee for the services provided.

Chapter 3: Funding arrangements

3.1 Introduction

Although detail on Departmental funding is provided in the RRHACS Policy and Funding Plan 2003-04 to 2005-06 (www.dhs.vic.gov.au/phkb), a short overview is provided below to explain the broader context for Community and Women's Health Services.

Figure 2 shows how different stakeholders receive Government funding and account for and report on their performance. Funding decisions are made at a number of different levels. Data about the performance of Community and Women's Health Services is aggregated and ultimately presented in State Budget Papers and reported to Parliament.

Community and Women's Health Services are funded by DHS Regional Offices through Agency Service Agreements to provide a range of activities. Information on activities from Regional Offices is then aggregated into outputs for the Rural and Regional Health and Aged Care Services Division.

Primary Health is the Output Group for most activities relating to Community and Women's Health. It has three outputs:

- Community Health Care;
- School Nursing; and
- Primary Health Service System Development and Resourcing.

Figure 2: Funding and accounting for divisionally funded activities



3.2 Changes to RRHACS Chart of Accounts

The key change to the RRHACS Chart of Accounts for 2003-04 to 2005-06 involves the creation of outputs specifically for small rural health service activities such as allied health, counselling, nursing and health promotion and an output for service system development and resourcing for small rural health services.

Information in service agreements and in the remittance advice/recipient created tax advice (RCTI) from the Regional Office may change, as follows:

- Some activities no longer appear as separate activities;
- The activity number may be different;
- The activity (service) name may be different; and
- There may be new activities/services.

Table 1 outlines the key changes to the RRHACS Chart of Accounts for 2003-04 to 2005-06.

Table 1: Changes to activities for 2003-04 to 2005-06 – Primary Health Output Group

2002/03 Number and name	Change	2003/04-2005/06 Number and name
28034 Women's Health – Individual, Community & Organisational Research & Development	Deleted	
28039 PCP – Training & Community Development	Deleted	
28046 Rural Health Innovative Services Projects	Deleted	
	New Activity	28053 Flexible Transport
	New Activity	35000 Small Rural – Health Service Development Projects and Systems Support
	New Activity	35002 Small Rural – Annual Provisions/Minor Works
	New Activity	35040 Small Rural – Allied Health, Counselling & Nursing
	New Activity	35041 Small Rural – Health Promotion

3.3 Funded activities

Service providers and Regional Offices negotiate the amount and mix of activities.

The following table lists the activities that are funded through Community and Women's Health Programs.

Table 2: Activities funded through Community and Women's Health Programs

Output name	Activity (number)	Activity (name)	
Community Health	28001	Community Health – Health Promotion	
	28007	Allied Health – Podiatry	
	28008	Allied Health – Occupational therapy	
	28009	Allied Health – Speech Therapy	
	28010	Allied Health – Dietetics	
	28011	Allied Health – Physiotherapy	
	28012	Allied Health – Audiology	
	28013	Community Health – Nursing	
	28014	Community Health – Counselling/Casework	
	28015	FARREP – Counselling/Casework	
	28016	FARREP – Health Promotion	
	28017	Family Planning – Counselling/Casework	
	28018	Family Planning – Health Promotion	
	28019	Family Planning – Nursing	
	28020	IHSY – Counselling/Casework	
	28021	IHSY – Health Promotion	
	28022	IHSY – Nursing	
	28023	Suicide Prevention – Counselling/Casework	
	28024	Suicide Prevention – Health Promotion	
	28025	Women's Health – Counselling/Casework	
	28026	Women's Health – Nursing	
	28048	Language Services	
	28050	Women's Health – Health Promotion	
	35041	Small Rural – Health Promotion	
	35040	Small Rural – Allied Health, Counselling and Nursing	
	Primary Health Development & Resourcing	28033	Annual Provisions/Minor Works
		28035	PCP – Development and Planning
28036		PCP – Better Access to Services	
28037		PCP – Information Management	
28038		PCP – Disease Management Pilot Project	
28040		PCP – Integrated Health Promotion	
28041		ICT Development	
28042		ICT Maintenance and Support	
28043		Workforce Development	
28047		Disaster Support and Recovery	
28049		Primary Health Development and Resourcing	
28053		Flexible Transport	
35000		Small Rural Service Development and Support	
35002		Small Rural – Annual Provisions/Minor Works	

The following table lists the activities that can be purchased within each service plan:

Table 3: Activities by service plan

Service plans	Nursing	Counselling/ Casework	Allied Health	Health Promotion	Other
Community Health	✓	✓	✓	✓	✓
Family Planning	✓	✓		✓	✓
FARREP		✓		✓	✓
IHSY	✓	✓		✓	✓
Suicide Prevention		✓		✓	✓
Women's Health	✓	✓*		✓	✓
Language Services					✓
Health Self Help					✓

* *Counselling/Casework is only available as an activity for Women's Health where it has been provided for at least three years and where it can be clearly demonstrated that no other providers in the local community are providing a similar service.*

3.4 Service agreements

Service agreements document:

- Which services (or activities) agencies are funded to provide;
- The level of service to be provided;
- The level and type of funding;
- The data and reports agencies are required to submit to the Department;
- The basis on which agency performance will be assessed; and
- The service standards and guidelines that apply.

A Department of Human Services service agreement has several parts, known as schedules. The 2003-04 to 2005-06 agreement comprises the following sections:

- *Schedule 1:* signatory page and the terms and conditions under which the services will be delivered;

- *Schedule 2:* financial summary of the funding to be provided for service delivery;
- *Schedule 3:* service plan(s) listing: services funded, level and type of funding, funding guidelines, performance measures and targets. A separate list of standards and guidelines and a list of reporting requirements are included as part of this schedule;
- *Schedule 4:* information pertaining to the relationship between the agency and the Department of Human Services. This schedule now also holds other requirements that may be negotiated when providing services; and
- *Schedule 5:* financial accountability requirements.

Other conditions of funding

Service providers receiving RRHACS funding are advised to also refer to:

- The 2003-2004 to 2005-2006 Policy and Funding Plans produced by other Divisions of the Department of Human Services, where relevant; and
- The Service Agreement Kit for Agencies produced for all agencies funded by the Department, not just those funded by the RRHACS Division.

From time to time, the information provided in the RRHACS Agency Service Agreement Kit may need to be updated or amended. More specific and detailed information may also need to be disseminated to agencies or service providers. In these circumstances, throughout 2003-04 to 2005-06, Program Circulars containing extra information will be distributed to the relevant services providers. In addition, these circulars will be available on the Department's Internet website.

3.5 Expectations of agencies

3.5.1 General requirements

It is a condition of funding for agencies and service providers that they comply with requirements contained in the Divisional Policy and Funding Plan and these Guidelines.

Agencies in receipt of RRHACS funding are expected to:

- Implement or deliver the specific service for which Departmental funding is provided;
- Deliver quality services, as well as a certain volume of services;
- Deliver services that are accessible, inclusive and responsive to the diversity of the Victorian community;
- Provide data and other evidence that funding has been used appropriately; and
- Work with the Department to develop new approaches to service delivery.

In addition agencies are expected to:

- Develop and implement a health promotion plan using a standard template and report against it during the year;
- Provide information on development and resourcing (formerly termed “*infrastructure*”) costs to assist in the further analysis of this component of funding, as referred to in Section 1.4; and
- Implement agreed PCP practices, policies, protocols and systems and the Service Coordination Tool Templates to collect and share

consumer information in a consistent manner and to support referral.

3.5.2 Primary Health Care

Primary Health Care incorporates the *Allied Health, Nursing and Counselling Casework* Activities. These Activities can be undertaken by a range of suitably qualified health workers.

Service providers are expected to collect and share consumer information in a consistent way (using the agreed PCP practices, policies, protocols and systems and the Service Coordination Tool Templates as per Section 2.1.2) to undertake appropriate needs identification, to inform analyses to strategically plan services, and deliver effective Primary Health Care Activities, based on principles of ‘best practice’. As most Community and Women’s Health providers will be participating in the PCP redevelopment, it is expected that cooperation with other agencies and sectors in developing and implementing programs will be undertaken.

In order to further facilitate this ‘cross service’ approach, it is accepted that Community Health Services and their staff will be involved in activities including: case conferencing, common planning processes, integrated health promotion activities, and the ongoing review as part of agency quality systems of common initial contact, initial needs identification, referral and care planning and information management procedures.

These linkages within the service delivery system are highly valued as are consultations with service users.

As indicated in Section 2.1.2, participation in initial contact, initial needs identification, assessment and care planning processes for all community health funded activities, are considered a component of direct service. Use of the service coordination tool templates and the practice underpinning their use, is not seen as additional activity, instead it replaces existing practice for the collection of this information to inform assessment, service delivery and referral requirements.

3.5.3 Integrated health promotion planning and implementation

Agencies receiving over \$15,000 of health promotion funding are required to develop and submit an organisational health promotion plan that relates to 100% of this funding (refer to Appendix 1 for the 2003–04 Organisational Health Promotion Planning proforma).

This includes funding received through Community Health, Women’s Health, Innovative Health Services for Homeless Youth (IHSY), Suicide Prevention, Family and Reproductive Rights Education (FARREP) and Family Planning.

Priority issues and target population groups for integrated health promotion

Organisational health promotion program plans should draw their priority setting rationale from PCP Community Health Plans, Burden of Disease data, Municipal Public Health Plans (MPHP), relevant local needs

assessments, and State and National Priority Health issues. This should include systematic analysis of the issues presenting to agencies through their direct service provision and draw on the views of consumers, carers and community members.

These plans have taken into account all available data to identify health and well being needs of their communities and have been developed in collaboration with the broad range of stakeholders in PCPs (including Community and Women's Health Services). This planning process includes the development of a community profile that takes into account the broad range of factors that influence health and wellbeing.

Particular population groups that will be the focus of the health promotion service should be determined through the planning process and will depend upon the priority issue(s) being addressed. However, emphasis should be given to lower socioeconomic groups who have significantly poorer health status and to groups that are more difficult to reach.

Please refer to *Integrated Health Promotion: A practice guide for service providers (2003)* for further information on integrated health promotion planning. This resource is available at www.dhs.vic.gov.au/phkb under Health Promotion Publications and Resources.

The structure of the plan

The plan should articulate the organisational vision statement, priority issues for health promotion activity and provide supporting rationales for these priorities. For each of the priority issues, the plan should document problem definition, solution generation and a mix of interventions (of both individual and population wide health promotion interventions) supported by identified capacity building strategies, that contribute to achieving the goal and objectives stated for that health promotion priority. Appendix 1 outlines definitions of the interventions and capacity building strategies.

For evaluation purposes, agencies are required to estimate **reach** as a process indicator in the plan. Reach is the number of key stakeholders, settings or members of the community affected by the health promotion program. Further information on reach can be found in Appendix 3.

In addition to estimating reach, agencies are required to identify intended **impacts** as part of their planning process. *Measuring health promotion impacts: A guide to impact evaluation in integrated health promotion (2003)* has been developed to assist agencies in identifying, planning and evaluating against impacts. This resource is available at www.dhs.vic.gov.au/phkb under Health Promotion Publications and Resources.

Percentage of budget required to be planned and reported

Agencies receiving over \$15,000 of health promotion funding through the Community and Women's Health Programs are required to develop and submit an organisational health promotion plan that relates to 100% of this funding. This allocation includes a minimum of **60–70% of the health promotion funds to planned work in priority areas**.

The remaining **30–40% of health promotion funds can be used more flexibly** to respond to health promotion issues that are not identified as priority areas. This flexible component should be used for new and/or emerging issues that arise in the local community and for transitional changes happening within the organisation, to ensure future good practice in integrated health promotion service delivery. Details of the planning for the flexible 30–40% can be found on the Organisational Health Promotion Plan proforma in Appendix 1. The end of financial year final report is however required to reflect 100% of the health promotion budget (including the flexible component identified in the 2003–04 plan) from the Community and Women's Health Programs.

Given that the goal of integrated health promotion planning is to have an organisational plan, agencies are encouraged to include activity that is funded through other sources. A column is provided in the proforma for agencies to complete, if they wish to do so, to delineate funds from other sources.

Supporting capacity building

The Department continues to support Primary Health Reform, including health promotion planning and reporting, through specific workforce development opportunities.

More broadly, the Department has a number of strategies and resources to improve the health promotion capacity in Victoria that compliment the Primary Health Funding Approach. These include:

- A series of evidence-based reviews and program planning guidelines on specific health issues and risk factors. These reviews are accessible at <http://www.dhs.vic.gov.au/phd/ebhp/>
- The Department's Regional Health Promotion Officers and Regional Advisors, who are a valuable resource for assistance and advice;
- *Integrated Health Promotion: A practice guide for service providers (2003)*: This document aims to support the practice of key principles of health promotion and government policy directions; and guide effective planning and management of integrated health promotion services. The Guide is available at www.dhs.vic.gov.au/phkb under Health Promotion Publications and Resources; and
- *Measuring health promotion impacts: A guide to impact evaluation in integrated health promotion (2003)* is available at www.dhs.vic.gov.au/phkb under Health Promotion Publications and Resources.

3.5.4 Development and Resourcing (formerly Infrastructure)

In addition to primary health care and health promotion, there is a third component of the primary health funding model as outlined earlier in this document (section 1.4), called Development and Resourcing.

An explanation of activities which fall within this category is at Appendix 6. Broadly speaking, it refers to management, administration, overheads and service development aspects of an agency's core business. Included are those costs that contribute to the support of the service in its day to day running as distinct from costs associated directly with seeing clients either individually or in groups.

Work was undertaken throughout 2002–2003 to identify key cost drivers which impact on agencies and on their management and operating costs. The approach for 2003–2004 aims to provide a framework for more transparent negotiations and greater consistency of application across the state.

Four differentiating factors which impact on agency management and operating costs have been established to guide decision making about agency infrastructure levels. These factors are:

- Having 3 or more sites;
- Rurality;
- Complexity of provision; and
- Budget size.

Definitions of these factors are found in Appendix 7.

Factors will be applied in the following way:

<i>0 factors</i>	Development and resourcing range: up to 20%.
<i>1–2 factors</i>	Development and resourcing range: up to 23%.
<i>3–4 factors</i>	Development and resourcing range: up to 25%.

As with the current year service agreement negotiations, it is anticipated that agency and regional representatives will negotiate within these ranges to accommodate local circumstances or one-off issues within the context of targets to be achieved. Exceptional circumstances may require more extensive discussions about an agency's capacity to work within the ranges.

3.6 Performance measures

3.6.1 General requirements

Each activity has performance measures which aim to describe the delivery of service associated with that activity. Performance measures enable a clear assessment of how well the activities meet consumer needs and whether the activities have actually been delivered. Ideally performance measures identify:

- the quantity of activities to be delivered;

- the quality of activities to be delivered;
- the time frame for delivery of activities; and
- the full cost to the Government of output delivery.

Agencies will be expected to deliver 100% of the set annual targets. Any shortfall on targets will be the subject of discussion, analysis and negotiation between agencies and their regional liaison officers.

3.6.2 Primary Health Care

The key Output Measure for Primary Health Care is Service Hours. The number of Service Hours, set as a target for a Primary Health Care activity, is:

- Number of contact hours and/or session hours
PLUS
- Number of indirect hours supporting contacts or sessions
PLUS
- Number of travel hours supporting contacts or sessions.

It is these three components that are to be included in an employee's full time working week, calculated on standard working hours set by the Department in previous years.

Note that indirect hours and travel hours are only counted towards a Service Hour when the activities they encompass relate to provision of a service, e.g. preparation time for treatment session with a client and travelling to a client's location. Hours spent by staff in management, office

administration, travel between sites and general travel are *not* included in a Service Hour.

3.6.3 Health Promotion

The key Output Measure for Health Promotion is Service Hours. The number of Service Hours, set as a target for a Health Promotion activity, is:

- Number of contact hours and/or session hours
PLUS
- Number of indirect hours supporting contacts or sessions
PLUS
- Number of travel hours supporting contacts or sessions.

It is these three components that are to be included in an employee's full time working week.

Note that indirect hours and travel hours are only counted towards a Service Hour when the activities they encompass relate to provision of a service, e.g. preparation time for an educational session and travelling to the location where the session is to be delivered. Hours spent by staff in management, office administration travel between sites and general travel are *not* included in a Service Hour.

3.6.4 Development and Resourcing (formerly Infrastructure)

There are no formal reporting requirements for this component of the funding approach but agencies will be asked to engage in further research

and analysis to inform the finalisation of work on Development and Resourcing.

The analysis that was undertaken in the preparation and early implementation of the Primary Health Funding Approach has provided information and mechanisms for driving greater efficiencies in the management and delivery of Primary and Community Health programs. The next steps in maximising the benefits to the sector and DHS in this work is to develop a range of mechanisms including improved financial reporting, procurement savings, benchmarking of practices and performance, and skill development which drive greater efficiencies.

3.7 Target setting and negotiation

For 2003–2004 to 2005–06 agency budgets will be apportioned according to the following components:

- Services to individuals;
- Health promotion; and
- Development and Resourcing.

There is an expectation that the proportion of agency budgets allocated to services to individuals falls within the range of 50% to 70%.

There is an expectation that the proportion of agency budgets allocated to health promotion falls within the range of 15% to 35%. In the case of Women's Health agencies, the proportion of the budget allocated to health promotion will be 75%–85%.

It is anticipated that the proportion of agency funds spent on system development and resourcing will be up to 25% of the total primary health budget.

DHS will do the initial calculation of funding and targets for the components based on the current agency splits and the unit prices identified in previous research and consultation. DHS will then negotiate with agencies on agreed levels within the ranges outlined above.

3.8 Student supervision

In the interests of developing the workforce of the future, as well as providing opportunities for practitioners to link with continuing education developments, the Department supports agencies in making placements available for students.

Practitioner time devoted to student supervision should be counted in the following manner:

- Time spent by a practitioner with a student while a student delivers a contact or a session (direct supervision) should be counted as a contact or a session against the appropriate Activity;
- All other student supervision time (including preparatory or follow-up discussions for contacts/sessions, and separate one-on-one supervision) should be counted as a Primary Health Development and Resourcing Activity (28049); and

- Time spent by a student without a supervisor present delivering contacts, sessions or indirect service is not counted towards an agency's targets.

3.9 Fees (Community Health Services only)

A statewide fees policy for Community Health Services was introduced in August 1997. All Community Health Service providers are required to implement the fees policy.

Fees are chargeable for all activities except Health Promotion and other group activities, where fees are optional. Adolescents are not charged for any service. Inability to pay cannot be used as a basis for refusing a service to people who are assessed as requiring a service.

Fee Revenue Targets for Community Health providers will be noted in Service Agreements as an 'Other Requirement'.

For further details, including exemptions from fee payment, refer to the *DHS Fees Policy for Community Health Program, Home and Community Care Program and Aged Care District/Visiting Nursing and Allied Health, July 1998* on the PHKB website at www.dhs.vic.gov.au/phkb.

Chapter 4: Reporting requirements

This section describes the data collection and reporting requirements for agencies funded by the Community and Women's Health Program and those program-funded agencies that provide services to Department of Veterans' Affairs members.

4.1 Changes to reporting requirements 2003-2004

Health Promotion report

In order to improve the implementation of the Organisational Health Promotion plan additional data code values have been introduced for 2003-2004 - based on the feedback received from the sector.

These additional codes (listed in Tables 12 & 13) refer to recording of *Population Group* and *Priority Issue* information for clients accessing Health Promotion services. Please refer to standard reporting templates on the Primary Health Knowledge Base web site at www.dhs.vic.gov.au/phkb.

Demand Management Survey - extension of scope

The 2003-2004 Demand Management Survey will now include delivery of allied health services that are funded by the Home and Community Care Program (HACC).

The extension of the scope of the Demand Management Survey will assist in building a more comprehensive picture on demand and waiting list management practice. The bi-annual survey reduces the burden of quarterly data collection on

agencies while delivering valuable multi-program information on service demand for allied health services providers and DHS.

Reduced workforce development reporting and changed reporting format

All workforce development activities **regardless of their funding base** (funding source) need to be reported using the revised Workforce Development Report which may be downloaded from the Primary Health Knowledge Base. This report frequency has been reduced from quarterly to 6-monthly (refer to Section 4.12 for further details).

Service coordination implementation

It is anticipated that the SWITCH (State Wide Information Technology for Community Health) system will be further modified in July 2003 to streamline process of capturing all necessary information as per the service coordination tools standards. The July 2003 release of SWITCH will have further functionality supporting collection of information specified by the Service Coordination Tool Template standards.

Feedback for service providers

The provision of feedback reports on service delivery outputs, client demographic characteristics and quality of data reports at the **agency** level will continue during 2003-04 as per the established practice.

The electronic feedback process implemented by the Information Management & Support Unit in 2003-04 has been received very positively and assists DHS and agency staff with service monitoring and planning.

The web-base access to all feedback reports will be piloted in collaboration with the Funded Agency Channel (FAC) team and progressively implemented over the next few months.

Data Reporting Help Line

The Data Reporting Help Line plays an important role in the Data Quality Management Framework. The Data Reporting Help Line provides support to assist agencies to develop and implement more effective data management practices and to improve data quality, in terms of timeliness, accuracy, completeness and validity.

In order to manage data reporting resources more effectively and to deal with relevant reporting issues more pro-actively, operation of the Data reporting Helpline will change in 2003-04 to focus on enhancing knowledge and capabilities of staff responsible for data reporting.

As a consequence, rather than use all helpline resources simply to respond to telephone calls, resources will be reallocated so that the following activities can take place as part of the operation of Helpline in 2003-04:

- Data Reporting Workshops & Distribution of the Data Reporting Training Kit;

- Data Reporting Helpline (to operate on designated dates – in total 558 hours);
- Quarterly Email/Fax broadcasts on common data management issues and problems;
- Establishment of regional Peer Support Groups (one in each region); and
- Detailed report on Helpline's operation.

In 2003–04 the hours of operation of the Helpline telephone service will be as follows:

- Between 10.00am and 4:00pm daily during the following periods:
 - 1 July 2003–31 July 2003
 - 1 October 2003–31 October 2003
 - 5 January 2004–6 February 2004
 - 1 April 2004–30 April 2004.
- In addition, Helpline will accept email and fax queries during the whole year and provide weekly responses to all queries (typically at the end of each week).

4.2 Purpose of reporting

The current information management framework has been set out to monitor funded agencies and service system performance to ensure funds are directed to appropriate services.

Accordingly, funded agencies are required to submit data reports and other evidence that funding has been used appropriately to help the Department in this monitoring role.

The purposes of data reporting are to support one or more of the following functions:

- Reporting to the Victorian Department of Finance in respect of agreed output targets;
- Internal reporting to DHS Directors, program managers and regional offices for:
 - DHS policy development, monitoring and strategic planning;
 - DHS service monitoring and targeting;
 - DHS budget and resource allocation processes; and
 - DHS research.
- Providing feedback to funded service provider agencies; and
- Providing research and policy development information required by various research and policy development projects (internal and external).

4.3 Who should report

- All service agencies that have a Community Health and/or Primary Health Programs Service Plan attached to their respective Service Agreements;
- Community Health Service providers claiming for *Allied Health* and *Community health – counselling and nursing services* delivered to Department of Veterans' Affairs members; and

- Agencies funded under the new proposed Small Rural Health Services (SRHS) funding model (to be piloted during the 2003–04 financial year) are to comply with relevant data management and reporting requirements of the Department.

4.4 What to report – Mandatory Data Reports

For 2003–2004, Community and Women's Health Program funded agencies are required to provide reports as shown in Table 4. Activities funded by the Community and Women's Health Program are listed in Table 5.

Table 4: Mandatory data reports for Primary and Community Health Programs*

Report type	Programs						Reporting frequency
	Community Health	Women's Health	Innovative Health Services for Homeless Youth	Family Planning	Family & Reproductive Rights Education	Suicide Prevention	
Primary Health Care	✓	✓	✓	✓	✓	✓	Quarterly
Health Promotion	✓	✓	✓	✓	✓	✓	Quarterly
Fees Collection	✓						Quarterly
Client Type	✓	✓	✓	✓	✓	✓	Quarterly
Registered Clients	✓	✓	✓	✓	✓	✓	Quarterly
Workforce Development	✓	✓	✓	✓	✓	✓	Six-monthly
Demand Management Survey **	✓	✓	✓	✓	✓	✓	Six-monthly

Mandatory

* Agencies covered by the new funding and accountability approach for Small Rural Health Services (SRHSs), to be implemented from the 2003-04 financial year, are to comply with relevant data management and reporting requirements of the Department.

** The First Demand Management Survey in 2003-04 will also include collection of information regarding the number of equivalent full time staff (EFT) for all staff categories from different funding sources.

Table 5: Activities funded by Primary and Community Health Programs

Community Health Care	Women's Health Services
Allied Health - Audiology	Women's Health - Counselling/Casework
Allied Health - Dietetics	Women's Health - Nursing
Allied Health - Occupational Therapy	Women's Health - Health Promotion
Allied Health - Physiotherapy	
Allied Health - Podiatry	
Allied Health - Speech Therapy	
Community Health - Counselling/Casework	
Community Health - Health Promotion	
Community Health - Nursing	
Family Planning - Health Promotion	
Family Planning - Counselling/Casework	
Family Planning - Nursing	
Family And Reproductive Rights Education Program - Counselling/Casework	
Family And Reproductive Rights Education Program - Health Promotion	
Innovative Health Services for Homeless Youth - Counselling/Casework	
Innovative Health Services for Homeless Youth - Health Promotion	
Innovative Health Services for Homeless Youth - Nursing	
Suicide Prevention - Counselling/Casework	
Suicide Prevention - Health Promotion	
Workforce Development	

4.5 When to report

Agencies are required to submit all reports to the Department of Human Services according to the following time frames listed in Table 6.

Table 6: Data reporting timeframe for Primary and Community Health Programs

Report type	Reporting frequency	When to submit data report	Notes
Primary Health Care Report	Quarterly	15 Oct 2003 15 Jan 2004 15 Apr 2004 15 July 2004	15th day after the end of each quarter
Health Promotion Report	Quarterly	15 Oct 2003 15 Jan 2004 15 Apr 2004 15 July 2004	
Fees Collection Report	Quarterly	15 Oct 2003 15 Jan 2004 15 Apr 2004 15 July 2004	
Client Type Report	Quarterly	15 Oct 2003 15 Jan 2004 15 Apr 2004 15 July 2004	
Registered Clients Report	Quarterly	15 Oct 2003 15 Jan 2004 15 Apr 2004 15 July 2004	
Workforce Development Report ¹	6-monthly	15 Jan 2004 15 July 2004	
The Multipurpose Report* pilot stage (Agencies – using PJB Software only)	Quarterly	15 Oct 2003 15 Jan 2004 15 Apr 2004 15 July 2004	
Demand Management Survey	Twice a year	1 Sept 2003# 5 April 2004	Survey will take place during the week 11–15 August 2003 and 15–19 March 2004

* Please refer to section 4.14 – Multipurpose Report (pilot stage)

The first Demand Management Survey will include collection of information regarding the number of equivalent full time staff (EFT) for all staff categories from different funding sources.

¹ New report is to cover all Workforce activities regardless of their funding base

4.6 Data collection and reporting processes

Data collection tools

The main data collection systems used by Community Health service providers are:

- SWITCH (State Wide Information Technology for Community Health);
- AIMS (Agency Information Management System);
- Other System adopted by agencies eg. Jade Care, PJB Software, iSoft etc; or
- DHS data reporting templates (Excel spreadsheets).

Service provider agencies are responsible for arranging their own internal data management processes so that quarterly reports are provided to DHS in a timely manner in full compliance with the requirements and relevant formats set out in this document.

Updated (2003–04) electronic Data Return Forms or templates in Excel formats are available from the Primary Health Knowledge Base website at: www.dhs.vic.gov.au/phkb.

Selection of data submission method

At the commencement of the financial year, agencies are required to choose **only one** preferred method of data submission, which subsequently must be used for the remainder of the financial year.

Multiple reporting methods will **not** be permitted (e.g. SWITCH & AIMS). Once chosen, agencies will be required to

continue with their chosen reporting method during the course of the financial year unless adequate justification can be provided (e.g. amalgamation).

If both SWITCH and other systems are used to collect data, agencies are encouraged to use SWITCH for the purpose of reporting back to DHS.

Agencies electing to report through the AIMS system must comply with the respective reporting protocols of AIMS.

Acceptable reporting formats

All reports must be submitted **electronically** to the Department in common acceptable formats.

Acceptable formats of these reports include SWITCH-based electronic reports exported into any common spreadsheet package (Excel), or reports using the Department's electronic data return forms (templates).

Data reporting processes

In general, it involves following the 1–2–3 data reporting model where:

- agencies collect the required data;
- agencies check the collected data for completeness, accuracy and validity; and
- agencies send the data reports to DHS regional offices by due date in electronic format.

DHS Regional offices are expected to further check and validate data reports prior to sending it to the Information Management & Support Unit.

The Information Management & Support Unit will then prepare the data for upload to the Primary Health Data Mart (central data repository). During this phase, further checks will be conducted on the received files and missing data, erroneous and questionable data will be identified through this process.

Submitted data that do not meet the quality standard or that are fundamentally flawed will be returned to agencies and both the Data Reporting Help Line and DHS Regional offices will be notified in each instance.

Data Validation Exception Reports will be provided to assist agencies to take corrective actions.

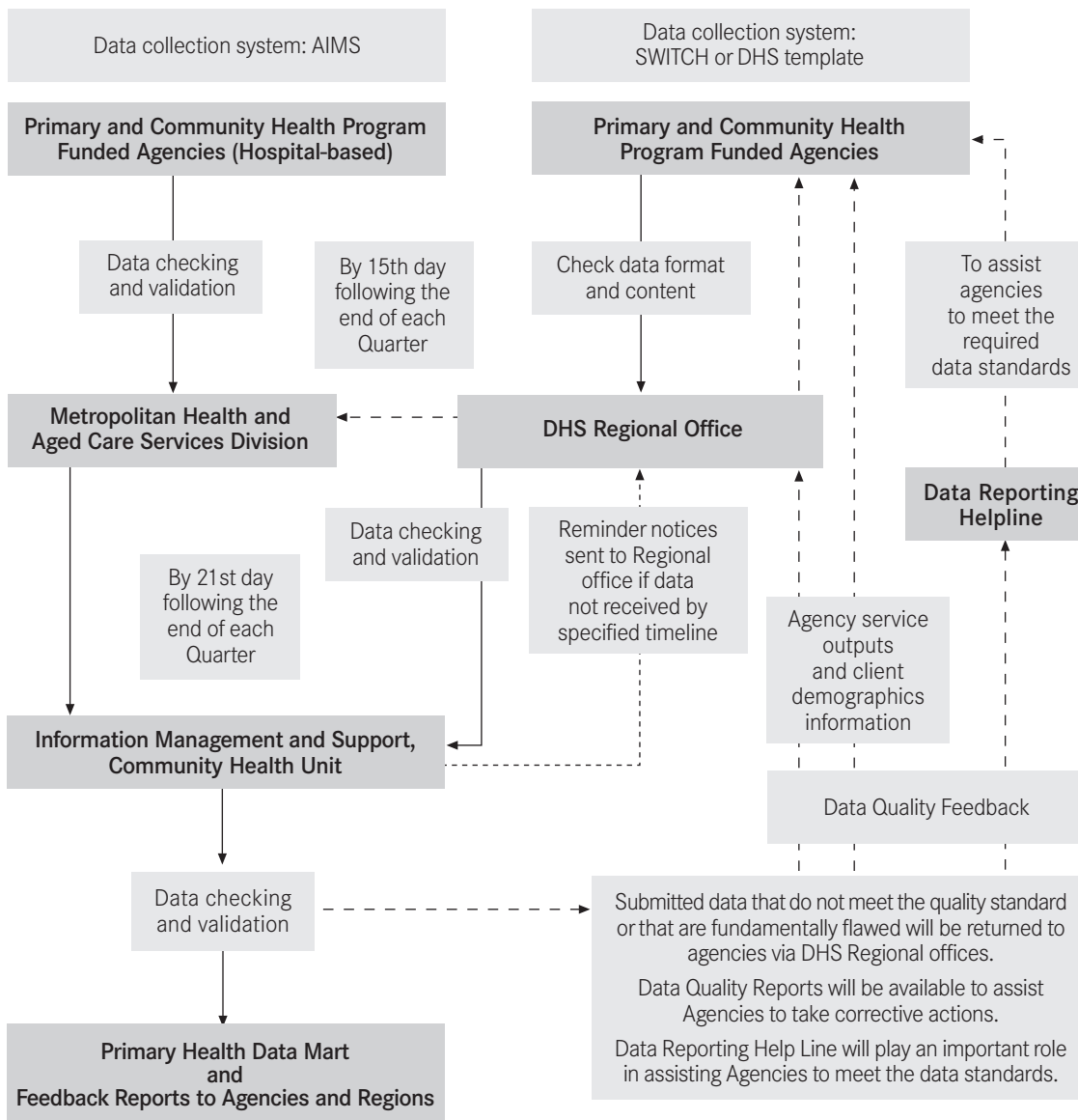
The Information Management & Support Unit will also monitor compliance with data submission according to the set reporting timeframes. Reminder notices will be sent to DHS Regional offices to follow up on outstanding data reports.

Data that meet the data quality standards will be uploaded to the central data repository (Primary Health Data Mart) and standard feedback reports will be generated for agencies and regions.

Some of the data will be up-loaded into the SAMS system.

There are slight variations in the process of sending data from agencies to DHS regional offices between those who use AIMS and SWITCH. An outline of the data reporting process is summarised in Figure 3.

Figure 3: Data reporting process for Primary and Community Health Quarterly Reports



Feedback for service providers

The Information Management & Support Unit will continue the provision of standard reports on service delivery outputs, client demographic characteristics and quality of data reports at the agency level for service providers and DHS regional advisers.

The purpose of this feedback process is to assist with performance monitoring and service planning. The data quality feedback reports will also assist with improving quality of submitted data

Roles and responsibilities

Funded agencies

It is the responsibilities of funded agencies to:

- Submit data in accordance with the Service Agreements and data reporting requirements stated in this document. That is, submitting all mandatory data reports that meet the data quality requirements, namely: **accuracy, completeness, validity and timeliness**;
- Check the data using the validation rules (described in each report type) to ensure that the data are complete and accurate prior to submission; and
- Ensure the latest reporting template is used (available from Primary Health Knowledge Base website at: www.dhs.vic.gov.au/phkb).

Data Reporting Help Line

- The objective of the Data Reporting Help Line is to assist agencies with data reporting and to improve data management practice.

- The role of the Data Reporting Help Line is to assist with agencies to comply with data reporting requirements outlined in this document in terms of data accuracy, completeness, validity and timeliness.
- DHS-funded Helpline activities **do not include** IT system support or IT users support and each agency needs to make suitable arrangements to ensure adequate support to staff.

Department of Human Services Regional offices

DHS Regional offices are required to:

- Check the format and validate contents of data submitted by agencies **prior to** forwarding to Information Management and Support Unit, Primary and Community Health Branch;
- Reject submitted data that are not in current format or that are fundamentally flawed; and
- Follow up on outstanding data reports, and submitted data that do not meet the quality standard in terms of accuracy, completeness and validity.

Information Management & Support Unit, Community Health

Information Management & Support Unit, will:

- Monitor timeliness of data submissions according to the set timelines;
- Monitor and review submitted data to determine if the data provided meet the agreed quality standard described in this document, in terms of completeness, accuracy and validity;

- Prepare and distribute Data Validation Exception Reports to Regional advisers and Data Reporting Help Line with the view to improve quality of submitted data;
- Liaise with DHS Regional offices to follow up on outstanding data reports and submitted data that appear to be questionable or not meeting the agreed quality standard defined in this document; and
- Provide standard feedback reports to all reporting agencies and regions.

Data quality requirements

Agencies submitting data to the Department must ensure that their internal data collection processes and practices are geared towards meeting the following requirements outlined in Table 7, which aim to improve and assure quality of data reported to the Department.

The purpose of measuring data quality is to determine the exact nature and magnitude of data problems. The process involves measuring conformance of submitted data to current validation rules established as data quality standards, and specified timeframe for data submission.

Questionable and missing data will be flagged in Data Validation Exception Reports, in which Information Management & Support Unit will liaise with DHS Regional Advisors and Data Reporting Help Line regarding follow up and corrective actions.

Data quality analysis

Information Management & Support Unit will apply computerised validation filters

Table 7: Data quality requirements

Data quality requirements	Description and example of requirements
1 Accuracy	This refers to data that are free of error.
2 Completeness	This refers to having data values in the data fields that require them. Example: Data fields for Agency ID, funding source, start date, end date, financial year should not be blank.
3 Timeliness	This refers to submission of data according to specified timeframe. For example: agencies are expected to submit their data reports to regions according to the specified timeframe.
4 Validity	This refers to data being within their allowable values. Example 1: For a registered client who is married, the data value in the data field for age should not indicate that the client is a child. Example 2: The data value for contact hours and number of contact should not result in an average duration per contact that is over say 48 hours.

to identify data that do not conform to the current validation rules. Historical error reports will also be generated to track data quality trends over time.

4.7 Primary Health Care report

The Primary Health Care report provides detailed quarterly service statistics for each activity purchased from agencies within the Community Health Care component.

Purpose

This report will permit the monitoring of levels of service provision to clients. The performance of agencies in meeting annual targets in service provision will be monitored based on the agreed performance measures.

Data Items

Table 8 outlines the data items to be reported and a sample of the Primary Health Care Report is included in Table 9.

Table 8: Data items for Primary Health Care report

Data Items
Agency ID
Agency Name
Start Date
End Date
Financial Year
Funding Source
Activity
Contacts
Contact Hours
Contacts Indirect Service Hours
Contacts Travel Time
Sessions
Session Hours
Session Attendees
Sessions Indirect Service Hours
Sessions Travel Time
Interpreting Time
Total Registered Clients Seen (unique clients count)
Revised #

This data item serves to alert Information Management and Support Unit that the data report is a revision of an earlier data report. Therefore, unless it is a re-submission, the value should be "No"

Table 9: Sample Primary Health Care Report

Agency ID	Agency name	Start date	End date	Financial year	Funding source	Activity	Contacts			Contact indirect service			Session			Total registered clients seen		
							Contacts	hours	travel time	Contact indirect service time	hours	travel time	Session attendees	indirect service time	travel time	Interpreting time	seen	report #
				2003/2004	Community Health Service	Allied Health – Audiology	12	6.0		0	0.0	0			0.0	12	No	
				2003/2004	Community Health Service	Allied Health – Dietetics										No	No	
				2003/2004	Community Health Service	Allied Health – Occupational Therapy										No	No	
				2003/2004	Community Health Service	Allied Health – Physiotherapy										No	No	
				2003/2004	Community Health Service	Allied Health – Podiatry										No	No	
				2003/2004	Community Health Service	Allied Health – Speech Pathology/ Therapy										No	No	
				2003/2004	Community Health Service	Nursing										No	No	
				2003/2004	Community Health Service	Counselling Casework										No	No	
				2003/2004	Women's Health Service	Nursing										No	No	
				2003/2004	Women's Health Service	Counselling Casework										No	No	
				2003/2004	Family Planning	Nursing										No	No	
				2003/2004	Family Planning	Counselling Casework										No	No	
				2003/2004	Innovative Health Services for Homeless Youth	Nursing										No	No	
				2003/2004	Innovative Health Services for Homeless Youth	Counselling Casework										No	No	
				2003/2004	Suicide Prevention Initiatives	Counselling Casework										No	No	
				2003/2004	Family Reproductive Rights Education Program	Counselling Casework										No	No	

* Registered Clients Seen = Total number of Registered Clients (uniquely identified i.e. no duplicate counts) who received a Primary Health Contact. (ie. This count excludes organisational clients and casual client contacts and/or Registered Clients part of group Sessions).

This data item serves to alert Information Management and Support Unit that the data report is a revision of an earlier data report. Therefore, unless it is a re-submission, the value should be "No".

4.8 Health Promotion Report

Purpose

The purpose of this report is to assist the monitoring of service provision for health promotion activities. The performance of agencies in meeting annual targets in service provision will be monitored based on the agreed performance measures.

Reporting on the Organisational Health Promotion Program Plan

All agencies receiving over \$15,000² for health promotion activity are required to report against their Organisational Health Promotion Program Plan at the end of the second and fourth quarters (see Appendices 2a and 2b for the Reporting Template).

The second quarter report should provide a description of the Flexible funding component to date and a narrative for each priority identified in the Organisational Health Promotion Program Plan. In addition, each agency is to meet with their regional office.

The fourth quarter report should provide relevant details concerning actual implementation actual impacts and actual reach, budgetary details and a narrative component. The fourth quarter reporting is required to reflect 100% of the 2003–04 health

promotion budget received from Primary and Community health, (including the flexible component identified in the 2003–04 plan).³

When reporting against the Organisational Health Promotion plan, it is not mandatory to report on the activities funded from elsewhere. However an extra column has been included, allowing the Agency to document this optional information so as to provide a better understanding of how much quality health promotion services cost.

Agencies' Organisational Health Promotion Reports should be submitted to DHS Regional Offices as per the Data reporting timeframe detailed in Table 6.

Health Promotion Report – quarterly

ALL agencies will also provide health promotion quarterly data collection reports (through SWITCH, AIMS or other electronic reporting method).

The priority issues and population groups reported through the quarterly data collection systems should reflect what was identified in the Agency's priority setting processes (and identified in the Health Promotion plan, where this is an applicable requirement). Descriptions of the *Priority Issues* and *Population Groups* are listed in Tables 12 & 13.

Health Promotion Data items

There is a requirement for the following measures to be collected and reported for all people accessing a Health Promotion service.

Table 10 lists the fields required for the Health Promotion Report. A Sample Report that includes the codes and descriptions for *Population Group* and *Priority Issues* is presented in Table 11.

² This includes funding received through Community Health, Women's Health, Innovative Health Services for Homeless Youth (IHSY), Suicide Prevention, Family and Reproductive Rights Education (FARREP) and Family Planning.

³ This includes funding received through Community Health, Women's Health, Innovative Health Services for Homeless Youth (IHSY), Suicide Prevention, Family and Reproductive Rights Education (FARREP) and Family Planning.

Table 10: Data items for the Health Promotion Report

Agency ID
Agency Name
Start Date
End Date
Financial Year
Funding Source
Population Group
Priority Issue
Contacts
Contact Hours
Contacts Indirect Service Time
Contacts Travel Time
Sessions
Session Hours
Session Attendees
Sessions Indirect Service Time
Session Travel Time
Interpreting Time
Registered Clients Seen*
Revised data report #

* *Registered Clients Seen = Total number of Registered Clients (uniquely identified i.e no duplicate counts) who received a Primary Health Contact. (ie. This count excludes organisational clients and casual client contacts and/or Registered Clients part of group Sessions).*

This data item serves to alert Information Management and Support, Community Health that the data report is a revision of an earlier data report. Therefore, unless it is a re-submission, the value should be "No".

Table 11: Sample Health Promotion Report

Agency ID	Agency name	Start date	End date	Financial year	Funding source	Priority issue	Population group	Contact			Session			Total			
								indirect service time	Travel time	Sessions	Session hours	Session attendees	indirect service time	Session travel time	Interpreting time	registered clients seen	Revised report #
BARMELBO	Melb CHC	01/07/2004	30/09/2004	2004/2004	Community Health Service	Injury	Men	6.00	2.00	3	6.00	20	8.00	0.0	0.0	6	No
BARMELBO	Melb CHC	01/07/2004	30/09/2004	2004/2004	Family Planning	Sexual & Reproductive health	CALD - Somali	1.00	1.00	0	0.00	0	0.50	0.0	0.0	0	No

Table 12: Population group

Population_Group_Code	Population Group Description	Comment
OB2	Children	"Children - Male" and "Children - Female" are no longer valid
OB5	Same sex attracted and transgender people	
OB6	Homeless People	
OB7	Aboriginal people and/or Torres Strait Islanders	
OB8	Men	
OB9	Mixed Population Group	
OB10	Older People	
OB11	Older People - Male	
OB12	Older People - Female	
OB13	Women	
OB14	Young People	
OB15	Young People - Male	
OB16	Young People - Female	
OB17	Other	
OB20	Carers	
OB21	Families	
OB22	Pre School Children	"Pre School Children - Male" and "Pre School Children - Female" are no longer valid
OB25	People with a disability	
OB26	<i>Asylum Seekers/Refugees/ Temporary Protection Visa Holders</i>	
OB27	<i>Organisation - Internal</i>	"Staff" and "Organisations" are no longer valid
OB28	<i>Organisations - External</i>	
OD1	CALD - Italian	
OD2	CALD - Greek	
OD3	CALD - Vietnamese	
OD4	CALD - Chinese	
OD5	CALD - Macedonian	
OD6	CALD - Turkish	
OD7	CALD - Arabic	
OD8	CALD - Croatian	
OD9	CALD - Spanish	
OD10	CALD - Indian	
OD11	CALD - Serbian	
OD12	CALD - Bosnian	

Table 12: Population Group (continued)

Population_Group_Code	Population Group Description	Comment
OD13	CALD - Montenegrin	
OD14	CALD - Slovenian	
OD15	CALD - Philippino	
OD16	CALD - Somalian	
OD17	CALD - Ethiopian	
OD18	CALD - Eritrean	
OD19	CALD - Iranian	
OD20	CALD - Iraqi	
OD21	CALD - Afghan	
OD22	CALD - Palestinian	
OD23	CALD - Kurdish	
<i>OD24</i>	<i>CALD - Albanian</i>	
<i>OD25</i>	<i>CALD - Cambodian</i>	
<i>OD26</i>	<i>CALD - Maltese</i>	
<i>OD27</i>	<i>CALD - Mixed</i>	
<i>OD28</i>	<i>CALD - Pakistani</i>	
<i>OD29</i>	<i>CALD - Polish</i>	
<i>OD30</i>	<i>CALD - Russian</i>	
<i>OD31</i>	<i>CALD - Sin(g)halese</i>	
<i>OD32</i>	<i>CALD - Sudanese</i>	
<i>OD33</i>	<i>CALD - Tamil</i>	
<i>OD34</i>	<i>CALD - Thai</i>	
<i>OD35</i>	<i>CALD - Timorese</i>	
OD99	CALD - Other	

Table 13: Priority issue

Source: Primary Health Datamart

Priority_Issue_Code	Priority Issue Description
OC1	Alcohol and Drugs
OC2	Asthma
OC3	Body Image
OC4	Cancer
OC5	Cardiovascular Disease
OC6	Community Building
OC7	Diabetes
OC8	Injury
OC9	Mental Health
OC10	Nutrition
OC11	Other
OC12	Physical Activity
OC13	Settings and Environments
OC14	Sexual & Reproductive Health
OC15	Social Connectedness
OC16	Sexual Assault
OC17	Smoking (Tobacco)
OC18	Family Violence
OC19	Capacity Building
OC20	Transport
OC21	Arthritis
OC22	Communicable Diseases
OC23	Chronic Obstructive Pulmonary Disease (COPD)
OC24	Stroke/Cerebrovascular Accident (CVA)
OC25	Chronic Illness
OC26	Falls Prevention
OC27	Family Health
OC28	Obesity
OC29	Polypharmacy
OC30	Employment

4.9 Client Type report

The Client Type report provides grouping of contacts by registered, casual and organizational clients for each activity funded by Community and Women's Health Programs.

Purpose

This report will complete the picture provided by the Primary Health Care and Health Promotion reports, by enabling a better understanding of what proportion of services are delivered to different clients.

Data items

The data items that relate to the client type report are listed below in Table 14.

Table 14: Client Type report

Funding source	Activity	Registered client contacts	Registered client contact hours	Casual client contacts	Casual client contact hours	Organisational client contacts	Organisational client contact hours	Revised report #
Community Health Service	Allied Health - Audiology							No
Community Health Service	Allied Health - Dietetics							No
Community Health Service	Allied Health - Occupational Therapy							No
Community Health Service	Allied Health - Physiotherapy							No
Community Health Service	Allied Health - Podiatry							No
Community Health Service	Allied Health - Speech Pathology/Therapy							No
Community Health Service	Nursing							No
Community Health Service	Counselling Casework							No
Community Health Service	Health Promotion							No
Womens Health Service	Nursing							No
Womens Health Service	Counselling Casework							No
Womens Health Service	Health Promotion							No
Family Planning	Nursing							No
Family Planning	Counselling Casework							No
Family Planning	Health Promotion							No
IHSY *	Nursing							No
IHSY *	Counselling Casework							No
IHSY *	Health Promotion							No
Suicide Prevention Initiatives	Counselling Casework							No
Suicide Prevention Initiatives	Health Promotion							No
FARREP **	Counselling Casework							No
FARREP **	Health Promotion							No

* IHSY - Innovative Health Services for Homeless Youth

** FARREP - Family And Reproductive Rights Education Program

This data item serves to alert Information Management and Support, Community Health that the data report is a revision of an earlier data report. Therefore, unless it is a re-submission, the value should be "no".

4.10 Fees Collection Report

The Fee Collection Report provides detailed quarterly fee collection statistics for each activity within the Community Health Care component. Only fees collected from activities funded by the Community Health Program are required.

Purpose

This information will assist in supporting agencies and regions in monitoring their negotiated revenue targets as determined by the fees policy.

Data items

The activities to be measured are listed below in Table 15. If an agency cannot provide fees collected at the activity level, total fees collected for activities funded by Community Health Program must be reported.

4.11 Registered Clients report

The Registered Clients report contains no performance measures, but rather provides the socio-demographic characteristics of each registered client accessing services at a particular centre within each quarter.

Purpose

The information gathered from this report will be used to monitor broad trends in the characteristics of clients accessing services, as well as the delivery of services to specified target groups.

Data reporting tool

SWITCH-based versions of this report will be exported directly to a common spreadsheet format.

Agencies using both SWITCH and AIMS or PJB Software and AIMS are

encouraged to use SWITCH or PJB Software for this data reporting, as typical reports can span thousands of individual records.

Agencies not using SWITCH, PJB Software or AIMS are required to export data from their local data collection systems into a common data format such as Excel, tab delimited or comma-delimited file.

The information gathered from this report will be used to monitor broad trends in the characteristics of clients accessing services, as well as the delivery of services to specified target groups.

Requirement

This report is mandatory for all agencies that provide a Community and Women's Health Service to registered clients.

Table 15: Fees Collection Report

Funding source	Activity	Fees collected (\$)	Revised report #
Community Health Service	Allied Health – Audiology		No
Community Health Service	Allied Health – Dietetics		No
Community Health Service	Allied Health – Occupational Therapy		No
Community Health Service	Allied Health – Physiotherapy		No
Community Health Service	Allied Health – Podiatry		No
Community Health Service	Allied Health – Speech Pathology/Therapy		No
Community Health Service	Nursing		No
Community Health Service	Counselling Casework		No
Community Health Service	Health Promotion		No
Community Health Service	Total Fees Collected		No

This data item serves to alert Information Management and Support, Community Health that the data report is a revision of an earlier data report. Therefore, unless it is a re-submission, the value should be "No".

The following four 'core' indicators are identified as the standard set of variables for use in determining the cultural and linguistic diversity of clients accessing Government services from 2003–2004.

- Country of birth;
- Main Language other than English (LOTE) spoken at home;
- Proficiency in Spoken English; and
- Indigenous Status.

The above indicators are consistent with the Service Co-Ordination Tool Templates Information Model and Data Dictionary.

Further details of the report including data fields and format are available from the *2003–2004 System Change Requirements, Community Health* document which is available at www.dhs.vic.gov.au/phkb.

4.12 Workforce development report

Workforce development is an integral component of developing and improving the quality and effectiveness of primary health care services. The Department recognises this through provision of separate funding for workforce development to agencies providing Primary Health Programs.

Purpose

The information gathered will be used to monitor the allocation and expenditure of workforce development funds from the Community & Women's Health Programs.

Data items

All workforce development activities need to be reported using the revised Workforce Development Report which is available from the Primary Health Knowledge Base at

www.dhs.vic.gov.au/phkb. This report requires agencies to report half-yearly (previously quarterly) on three items:

- Identify three strategic workforce development priorities for the following 6-month period. The identified priorities may or may not change from one reporting period to another;
- The combined total number of staff and Board members who have participated in workforce development (not just Community Health Program funded staff) during the previous six-month period; and
- The combined total number of hours of workforce development activity that **all staff and Board members** (as per above) have participated in for the previous six-month period. For example, a four-hour workshop attended by three staff represents 12 hours of workforce development activity [travel time is not to be included].

Workforce development activities

Table 16: Workforce development activities

Workforce development activities	Description
Individual staff learning and training	Individual staff learning and training are those activities that respond to identify learning needs. This includes a broad range of professional development strategies to strengthen individual skills including health promotion and providing services from an evidence base.
Leadership and Management development	Leadership and Management development are those activities, which encourage development of strong and visionary leaders, and managers who are able to advocate for health issues and health promoting strategies to be a priority in the organisational and local agenda.
Organisational development activities	Organisational development activities are those that aim to strengthen the organisation's capacity to improve the health and well being of the local community. It should assist organisations to respond to change, strategically plan and allocate resources, and foster strong leadership at all levels of the organisation. It includes an understanding that Board members, consumers and members of the community should be included as vital members of the organisation.

4.13 Demand Management Survey

One of the strategic priorities of the Community and Women's Health Program is to monitor and improve demand management in primary health.

The Demand Management Survey was introduced to collect information that would assist the development of possible indicators to monitor changes of demand over time.

Purpose

The aim of the survey is to generate information that will support the development of strategic policies that aim to achieve better practice of service demand management. The information collected from this survey will also be used for research and the development of relevant policy and program guidelines.

Who should report

All Community Health Service agencies that receive funding from the Community and Women's Health are required to complete this survey. In

addition, agencies also receiving funding from Home and Community Care are required to include HACC new clients and staffing levels in this survey. This reporting requirement is **mandatory** and applies to: Community Health, Family Planning, Suicide Prevention, Innovative Services for Homeless Youth, Family and Reproductive Rights Education Program, Women's Health and HACC Programs.

Agencies that do not operate a waiting list are still required to complete the survey regarding agency details and staff levels as well as to provide feedback on their local demand management practice.

When to report

Two surveys will be conducted in 2003–2004 during the following period listed in Table 17.

Changes introduced for 2003–2004

The survey has been expanded to include HACC funded Allied Health, Nursing, Counselling/Casework, Personal Care and Planned Activity services. Additional information on

referral source and status of chronic and complex condition will be required for new clients. A new comment box that enables agency provides additional explanation is added to each survey section.

What to report

Structure of the survey questionnaire

The survey questionnaire comprises of four sections:

Section 1 – This section aims to collect information regarding agency and service location site details.

Section 2 – This section aims to collect information regarding staffing levels.

Section 2a – Staffing levels for INDIVIDUAL SERVICE LOCATION SITE

For Community & Women's Health Program and Home & Community Care funded services and limited to **Allied Health, Nursing, Counselling/Casework, Health Promotion, Personal Care and Planned Activity ONLY**

Table 17: Demand Management Survey reporting timeframe

Demand Management Survey	Survey week	Data Report submission deadline	Notes	Where to send the survey report
2003–2004 August Survey	11–15 August 2003	1 September 2003	The August survey will incorporate collection of information on agency staffing levels and funding profile, which replaces the previous the Annual Statistical Returns Report	Survey data reports are to be sent to DHS regional contacts
2003–2004 March Survey	15–19 March 2004	5 April 2004		Survey data reports are to be sent to DHS regional contacts

Section 2b – Aggregated information on staffing levels at the **AGENCY LEVEL** for all staff categories and funding sources.

This includes other DHS funded programs, other Government funded programs, non-Government funded programs and fee for service program, and all other staffing categories.

This sub-section serves to collect information that is captured through

the previous Annual Statistical Return Report.

This sub-section is mandatory requirement for all agencies and applies only once a year.

Section 3 – This section aims to collect information regarding individual agency's demand management practice and reasons for referring clients to other service sites or providers.

Section 4 – This section aims to collect information on **new clients** who received their initial assessments or treatments during the survey week.

Demand Management Survey – core data items

The core data items to be collected that relate to waiting times are listed in Table 18.

Table 18: Core data items for Demand Management Survey

Core data item	Section of survey	Notes
Details of individual service sites	Section 1	
Number of EFTs (Allied Health, Nursing, Counselling/ Casework, Health Promotion, Personal Care, Planned Activity staff) at individual service site	Section 2a	List by CH&P and HACC funded EFT
Number of EFTs (Allied Health, Nursing, Counselling/ Casework, Health Promotion, Personal Care, Planned Activity staff) on leave at individual service site	Section 2a	
Number of EFT for all staff categories and funding sources at the parent Agency level	Section 2b	For August survey only
Demand management practices	Section 3	
Number of clients in the Waiting List	Section 3	Number of new client included in the Waiting list during survey week. Total number of clients on the WL by the end of survey week
Client Age	Section 4	
Client sex	Section 4	
Services type required	Section 4	Allied Health, Nursing, Counselling/Casework, Health Promotion, Personal Care, Planned Activity
Client funding source	Section 4	This collection will be used to determine the waiting time by funding source (eg HACC or P&CH)
Client presenting issue (Client's reason for seeking services)	Section 4	Seven categories of presentation were summarised from previous 2 DMS
Referral source (Use INI referral source code)	Section 4	This collection will be used to identify the distribution of hospital discharge, GP, other health professional and self referrals
Chronic and complex condition	Section 4	This data collection will be used to identify new clients with Chronic and Complex condition
Date of initial contact or listing	Section 4	These two data items will be used to determine waiting times
Date of initial face to face assessment/treatment	Section 4	

Reporting tool and support

The Demand Management Survey report should be sent to DHS Regional Offices using the **electronic template** provided through the Primary Health Knowledge Base at www.dhs.vic.gov.au/phkb.website. The website will also include up-to-date information on **Frequently Asked Questions** that will assist agencies to complete the Demand Management Survey.

For further information regarding the Demand Management Survey collection please contact:

Hua Zhang, Project Manager, DMS
Tel 03 9616 9959
Fax 03 9616 8277
Email: Hua.Zhang@dhs.vic.gov.au

4.14 Multi Purpose Report (Pilot stage)

Background

This report essentially consolidates many of the Community and Women's Health reports into one. This single report would enable us to collect all the required performance data, socio-demographic data and some limited characteristics of the casual clients. The full implementation of this report will relieve some of the burden associated with the numerous quarterly reports submitted for Community and Women's Health by substantially reducing the number of reports required. It will eliminate the need to submit the Primary Care, Health Promotion, Fees, DVA, Client Type and Registered Clients reports.

Initially, the report trial led by agencies using PJB would be run in addition to the existing reports to enable verifying by DHS that the details collected are correct by crosschecking this report with the existing Excel Templates and AIMS reports. Subject to satisfactory results it is envisaged that the pilot stage will last for approximately one quarter.

Requirement

A record would be generated for each occurrence of a contact (individual or group session) detailing the activity, the duration of the contact, any associated travel time and/or indirect time, whether a fee was collected and/or whether a DVA claim needs to be made, the socio-demographic characteristics of registered clients or whatever socio-demographic characteristics of casual clients that are available. The report would also need to collect any Indirect Service Time not associated with a contact or session.

The report would provide great flexibility by allowing very specific and detail for analysis of data.

File format for this report is Comma separated (CSV).

4.15 Department of Veterans' Affairs Report

Context

As from July 2001, funding for allied health, nursing and counselling services delivered to eligible veterans by Community Health and Primary Health Programs funded agencies has

been incorporated into the current Department of Human Services (DHS) – Department of Veterans' Affairs (DVA) Agreement.

Funding is provided on the condition that service eligibility is to be confirmed, in each instance, by DVA. **The Department will not accept any risk for "assumed revenue" where eligibility is denied.** However, the Department will attempt to verify all DVA contacts and will work closely with agencies and DVA to this end.

Funding under the current DHS-DVA arrangements is provided only on the basis of contacts reported back to the Department of Human Services as part of the quarterly reporting process. This is despite the fact that agencies may receive pre-payments for the 2004–2004 financial year in order to reduce the burden of agency contract's variation and funds processing. All payments forwarded to service providers will be reconciled against the submitted data reported back to DHS and any resulting over/underpayments will be rectified through the next payment's adjustments.

For the reimbursement process to work effectively community health and primary health funded service providers should not be making claims for allied health services delivered to DVA members direct to DVA.

It has to be noted that the DHS community health program fee policies do not apply to services provided to DVA members.

Who should report

All community health funded services claiming for allied health services delivered to Department of Veteran's Affairs members.

When to report

Strict reporting deadlines apply to the submission of DVA quarterly reports, due to the validation processes involved. The reporting timeframe are shown in Table 19.

Table 19: DVA reporting timeframe

Report type	Reporting frequency	When to submit data report	
Department of Veteran's Affairs Report	Quarterly	15 Oct 2003 15 Apr 2004	15 Jan 2004 15 Jul 2004

It has to be noted that Quarter 1 to 3 submitted data will be used as the basis to reconcile and rectify payments made to service providers. Therefore, it is essential that the DVA quarterly reports are submitted **on time**.

What to report**Table 20: Data items in DVA report**

Data items	Comments
Agency ID	That is the SWITCH ID allocated to agencies by DHS
Agency Name	Self explanatory
Start Date of Report	Self explanatory
End Date of Report	Self explanatory
Financial Year	Self explanatory
Amended Return	Yes/No
Client ID	i.e. internal system's client ID where applicable
Department of Veteran's Affairs Client Code/identifier*	This is a four-character text code comprising first two letters of the client's surname plus first two letters of the client's given name. * This data item is cross-referenced by DVA for identification.
Department of Veteran's Affairs Pension ID*	* This data item is cross-referenced by DVA for identification.
Client's Date of Birth*	* This data item is cross-referenced by DVA for identification.
Client's Postcode of Usual Residence*	* This data item is cross-referenced by DVA for identification.
Client's Gender*	* This data item is cross-referenced by DVA for identification.
Client's Indigenous Status Code*	Indigenous Code: 1=Aboriginal 2 = Torres Strait Islander 3=Aboriginal and Torres Strait Islander 4= Not Aboriginal and Torres Strait Islander. * This data item is cross-referenced by DVA for identification.
Date of Service	Self explanatory
Service Type Description	Refer to Table 3
Comments	For clients receiving the same service more than once on the same day, a brief explanation is required. For example: "client needed to have dressing changed".

Note: All the data items listed above are mandatory.

DVA funded services

The Community Health and Primary Health Program funded services delivered to DVA members (on an individual basis only) that are eligible for reimbursement are listed in Table 21.

Table 21: DVA funded services

Activities funded by DVA	Notes
Audiology	
Counselling/Casework	
Dietetics	
Occupational Therapy	
Physiotherapy	
Podiatry	
Speech Pathology/Therapy	
Nursing	HACC-funded service providers are specifically excluded from the above agreement. Agencies should also note that Nursing services under this arrangement do not include home-based community nursing services provided under separate contractual arrangements with DVA.

4.16 Contacts and support

Data Reporting Help Line

Phone: 0413 883 439

Fax: 03 5423 2133

Email: trishl@aussiebroadband.com

Information Management & Support Unit

Contact: Adam Buczko, Manager, IMS

Phone: 03 9616 7619

Fax: 03 9616 8277

Email: Adam.Buczko@dhs.vic.gov.au

Contact: Arron Hure, Project Manager –
Data Management & Reporting

Phone: 03 9616 8174

Fax: 03 9616 8277

Email: Arron.Hure@dhs.vic.gov.au

Contact: Anthony Ridler, Project Manager –
Data Systems Management

Phone: 03 9616 7646

Fax: 03 9616 8277

Email: Anthony.Ridler@dhs.vic.gov.au

Chapter 5: Terms and definitions

Community health care output

Outputs	Aim
Community Health Care	<ul style="list-style-type: none"> To restore people to optimal health and quality of life. To prevent illness, disease and injury, and promote independence, health and well being. To undertake professional education, research and other developmental tasks that support the provision of primary health service.

Funded activities

Activity	Description
Audiology	To provide Audiology services for the assessment, diagnosis, treatment and prevention of disorders of human hearing, performed by a suitably qualified person.
Counselling/Casework <i>Under Review-Definition may be changed</i>	Counselling/Casework is the term used to describe significant counselling and therapeutic activities, performed by suitably qualified persons, which often includes practical assistance and advocacy. Counselling/Casework also includes assessment, therapeutic interventions, practical assistance, crisis care, support, referral and advocacy with the goal of harm reduction, and/or improved quality of life, social function and/or health.
Dietetics	To provide nutritional care for individuals and groups in health and illness, performed by a suitably qualified person.
Nursing	Nursing services are provided by a suitably qualified person who is involved in the provision of clinical care, support and referral to individuals and/or their carers and groups regarding a variety of medical, social and environmental health issues.
Occupational Therapy	The assessment and treatment of persons with a temporary or permanent physical disability, performed by a suitably qualified person.
Physiotherapy	The assessment, diagnosis, treatment and prevention of disorders of human movement with special emphasis on the neurological, musculoskeletal and cardiovascular systems; performed by a suitably qualified person.
Podiatry	The diagnosis and treatment of ailments or abnormal conditions of the human foot, performed by a suitably qualified person.
Speech Therapy/Pathology	The assessment, diagnosis and treatment of individuals with speech disorders, eating and drinking difficulties and swallowing difficulties; performed by a suitably qualified person
Health Promotion	<p>To provide planned Health Promotion activities with the aim to prevent illness, disease and injury, and promote independence, health and well being through:</p> <ul style="list-style-type: none"> Screening, Individual Risk Factor Assessment and Immunisation Social Marketing and Health Information Health Education and Skill Development Community Action (for Social and Environmental Change) Settings and Supportive Environments Organisational Development for Health Promoting Practice Workforce Development Resources <p>Each of these is defined below.</p>

Activity	Description
Screening, Individual Risk Factor Assessment and Immunisation	<p>Screening involves the systematic use of a test or investigatory tool to detect individuals at risk of developing a specific disease that is amenable to prevention or treatment. It is a population-based strategy to identify specific conditions in targeted groups before any symptoms appear.</p> <p>Individual risk factor assessment involves a more comprehensive process of detecting the overall risk of a single disease or multiple diseases. These can include biological, psychological and behavioural risks.</p> <p>Immunisation aims to reduce the spread of vaccine-preventable diseases across targeted population groups.</p>
Social Marketing and Health Information	<p>Social marketing involves programs designed to advocate for change and influence the voluntary behaviour of target audiences to benefit this audience and society as a whole. It aims to shift attitudes, changes peoples view of themselves and their relationships with others change lifelong habits, values or behaviours. It typically uses persuasive (not just information) and cultural change processes. It can involve raising public awareness about a health issue through use of mass media eg. advertising in newspapers, magazines, pamphlets, and fliers or on radio, television etc. at local, state and national levels. It may also involve a mix of promotional strategies including public relations and face-to face communications.</p> <p>Health information aims to improve people's understanding about the causes of health and illness, the services and support available to help maintain or improve health, and personal responsibility for actions affecting their health.</p>
Health Education and Skill Development	<p>Health education and skill development include the provision of education to individuals (through discrete planned sessions) or groups, with the aim of improving knowledge, attitudes, self-efficacy and individual capacity to change.</p>
Community Action (for Social and Environmental Change)	<p>Community action aims to encourage and empower communities (both geographic areas and communities of interest) to build their capacity to develop and sustain improvements in their social and physical environments.</p>
Settings and Supportive Environments	<p>This includes:</p> <ul style="list-style-type: none"> • Organisational development – which aims to create a supportive environment for health promotion activities within organisations, such as schools, local businesses and sporting clubs. It involves ensuring that policies, service directions, priorities and practices integrate health promotion principles. • Economic and Regulatory Activities – which involves the application of financial and legislative incentives or disincentives to support healthy choices. These approaches typically focus on pricing, availability, restrictions and enforcement. • Advocacy – which involves a combination of individual, peer and social actions designed to gain political commitment, policy support, structural change, social acceptance and systems support for a particular goal. It includes direct political lobbying.
Organisational Development	<p>Strengthening organisational support for health promotion within provider agencies.</p> <p>Elements</p> <ul style="list-style-type: none"> • Policies and strategic plans • Organisational management structures • Management support and commitment • Recognition and reward systems • Information systems—monitoring and evaluation • Information resources • Quality improvement systems • Informal organisational culture

Activity	Description
Workforce Development	<p>Developing the health promotion skills and knowledge of the workforce.</p> <p>Elements</p> <ul style="list-style-type: none"> • On-the-job learning • Professional development opportunities/continuing education/undergraduate and postgraduate studies • Professional support and supervision systems • Performance management systems
Resources	<p>Ensuring and/or developing resources to support health promotion, and allocating them strategically</p> <p>Elements</p> <ul style="list-style-type: none"> • Human resources • Financial resources • Information resources including research and specialist advice • Decision making tools and models • Administrative and physical resources

Performance measures

Performance measure	Description
Service Hours	The duration (measured in hours) of individual Contacts and/or Sessions, indirect hours and travel hours. Indirect hours are time spent on service support (that is, preparation and follow-up for contacts and sessions) and/or time spent on health promotion development and other indirect service as part of the health promotion activity, such as policy development. Travel hours are only counted when immediately associated with service provision and/or health promotion development activities.

General terms and definitions

Term	Description
Assessment	Assessments (usually service specific in CHSs) will build on the information collected through the initial needs identification (INI) process. The INI process will have identified need for specialist, service specific or comprehensive assessment.
Care Planning	A process of deliberation that incorporates a range of existing activities such as care coordination, case management, referral, feedback, review, reassessment and monitoring.
Client	A client is an individual, organisation or group that receives a service from a provider. For the purposes of recording data, clients are considered to be either individuals (including individuals, and family units) or organisations (business, social, community, government or education body).
Contact	One to one consultations with individual clients, includes case conferencing, secondary consultation and advocacy (excludes groups).
EFT	Full time equivalent staff units represent the on-job hours paid for (including overtime) as well as hours of paid leave (of any type) divided by the number of normal hours paid for a full-time staff member under an award or agreement.
Individual client	An individual client may be one person, a couple or family receiving a one-to-one service from a service provider or providers. A family should be treated as an individual client where a one-to-one service is provided to the family unit. If individual family members receive a separate service, this should be treated as separate direct services.
Information Management	The practice, processes, protocols and systems to support the collection, use, disclosure, storage and disposal of consumer health and care information.

Term	Description
Initial Contact	The point where a person makes his/her first contact with agency staff and often the service system (by telephone or in person). Often this point of contact will result in the presenting person either accessing a service (following an initial needs identification) or making an appointment to do so. It may simply be the point where basic health and service information is provided and no further service or intervention is necessary. (<i>Better Access to Services: A Policy and Operational Framework (Department of Human Services, July 2001)</i>). Available on-line at http://www.dhs.vic.gov.au/phkb (Primary Health Knowledge Base).
Initial Needs Identification	An initial screening process where the underlying issues as well as presenting issues are identified. This process determines the consumer's risk, eligibility and priority for service. (<i>Better Access to Services: A Policy and Operational Framework (Department of Human Services, July 2001)</i>). Available on-line at http://www.dhs.vic.gov.au/phkb (Primary Health Knowledge Base).
Group client	Target populations or a collection of individual clients receiving a service collectively or as part of a group audience. A group may be: <ul style="list-style-type: none"> • Informal or casual (for example, a presentation/display at a local fete or where a population or a segment of a population with common characteristics are targeted). In this case it is not significant who attends these group Sessions; or • Formal, which is used to provide the same service to a number of people at the same time (for example, a hydrotherapy class).
Individual staff learning and training	Those activities which respond to identified learning needs. This includes a broad range of professional development strategies to strengthen individual skills including health promotion and providing services from an evidence base.
Leadership and management development	Those activities which encourage development of strong and visionary leaders and managers who are able to advocate for health issues and health promoting strategies to be a priority in the organisational and local agenda.
Organisational client	A collection of people who, on behalf of an identifiable entity (such as a business, social, community, government or education body) receive a service from a provider/s (includes secondary consultation).
Organisational development activities	Activities that aim to strengthen the organisation's capacity to improve the health and well-being of the local community. It should assist organisations to respond to change, strategically plan and allocate resources, and foster strong leadership at all levels of the organisation. It includes an understanding that Board members, consumers and members of the community should be included as vital members of the organisation.
Sessions	Consultations that are delivered to groups of clients.
Sector-wide activities	Activities which encourage collaborative practise and sector-wide policy development, including participation in Primary Care Partnerships. This may include participation in forums and consultations for a range of purposes including health promotion and the Statewide Workforce Research and Development Strategy.
Treatment/further assessment	A clinical treatment or further health assessment that involves a face-to-face interaction between client and health professional(s) and occurs after a service need is identified.
Waiting list	A list of clients who currently don't have an appointment scheduled with Community Health services professionals, but are waiting to be scheduled. This occurs when the service provider is unable to provide an appointment time due to the current appointment booking list being full.
Integrated Health Promotion	Agencies and organisations from a wide range of sectors and communities in a catchment working in a collaborative manner, using a mix of health promotion interventions and capacity building strategies to address priority health and wellbeing issues.

Professional positions

Allied Health Assistant	Allied Health Assistants provide assistance to Allied Health practitioners in the delivery of Allied Health activities. Skills and training should be appropriate to the level of assistance of support provided.
Audiologist	Audiology is a service provided by a qualified Audiologist. A qualified Audiologist is a person who holds or is qualified to hold the degree of Bachelor of Science or Engineering plus a one year course Post Graduate Diploma in Audiology from the University of Melbourne and who has a Clinical Certification of the Audiology Society of Australia and has, or is supervised by someone with two years work experience under the supervision of a trained Audiologist.
Counsellor/Caseworker <i>Under Review-Definition may be changed</i>	Psychologist, Social Worker, person with graduate training in counselling, youth workers, indigenous community workers, ethnic health workers, welfare workers, nurses. It should be noted that social work education provides social workers with the capacity for a comprehensive and holistic approach that enhances their suitability for performing the Counselling/Casework Activity.
Dietician	Dietetics is a service provided by a qualified Dietician. A qualified dietician is a person who has completed a Graduate Diploma or Masters of Nutrition and Dietetics or equivalent qualification, accredited by the Dieticians Association of Australia (DAA) and is eligible for membership of the Accredited Practising Dieticians Program and DAA.
Nurse	Nursing is a service that is provided in an agency, or on an outreach basis in a variety of settings, including in an individual client's home, another agency or organisation, school, etc by a qualified Division 1 Nurse. A qualified Division 1 Nurse is a person who holds either a Bachelor of Nursing, Diploma in Nursing or a Certificate in General Nursing (Hospital). Clinical nursing services are claimable where they are provided separate to any medical practice. Clinical services are not claimable where assisting a medical practitioner or where the service is otherwise redeemable under Medicare.
Occupational Therapist	Occupational Therapy is a service provided by a qualified Occupational Therapist. A qualified Occupational Therapist is a person with a Degree in Applied Science, Occupational Therapy and/or Diploma in Occupational Therapy.
Physiotherapist	Physiotherapy is a service provided by a qualified Physiotherapist. A qualified Physiotherapist is a person holding a Bachelor of Applied Science, Physiotherapy or a Diploma of Physiotherapy or its equivalent who is registered with the Physiotherapists Registration Board of Victoria.
Podiatrist	Podiatry is a service provided by a qualified Podiatrist. A qualified Podiatrist is a person who is registered with the Podiatrists Registration Board of Victoria. Podiatry is the diagnosis and treatment of medical, surgical, electrical, mechanical or manual methods, of ailments or abnormal conditions of the human foot.
Speech Therapist/Pathologist	Speech Pathology is a service provided by a qualified Speech Pathologist. A qualified Speech Pathologist is a person holding a Bachelor of Applied Science, Speech Pathology or equivalent, who is eligible for membership of the Speech Pathology Association Australia, who preferably has a minimum of two years post-graduate experience in paediatrics and/or community health. Where the speech pathologist does not have two years postgraduate experience in paediatrics and/or community health, arrangements should be made for access to regular supervision by a speech pathologist with such experience.

Appendix 1: 2003–2004 Community and Women's Health Services Organisational Health Promotion Plan Pro Forma

Introduction

The Organisational Health Promotion planning requirement for 2003–04 involves 3 mandatory components including:

Part 1: Agency vision and priority setting process and description of the 30–40% flexible component.

Part 2: Outline.

Part 3: Health Promotion Summary planning grid.

Both parts 2 and 3 are **required** for each Priority issue identified from part 1 (priority setting process).

In 2003–04 Agencies are required to submit an Organisational Health Promotion plan that includes **100%** of their health promotion budget from the Community and Women's Health Programs. Given the goal of integrated health promotion planning is to have an organisational plan, rather than a plan for funds from one program area, agencies are encouraged to include activity that is funded through other sources. An optional column in part 3 is provided for this.

The Community Health Unit requires agencies that receive health promotion funds through the Community and Women's Health Programs to allocate a minimum of **60–70%** of the health promotion funds to planned work in priority areas. The remaining **30–40%** of health promotion funds can be used more flexibly to respond to health promotion issues that are not identified as priority areas.

The 60–70% (minimum) of the budget being allocated to priority issues (identified in part 1) will need to be documented in part 2 (outline for each priority) and part 3 (summary grid for each priority) using this 2003–04 Organisational health promotion plan proforma.

The remaining 30–40% of the budget can remain as a flexible component. This flexible component should be used for new and/or emerging issues that arise in the local community and for transitional changes happening within the organisation, to ensure future good practice in quality health promotion service delivery. Part 1.3 in the 2003–04 Plan proforma requires each agency to give a brief statement about the possible areas that this 30–40% will address (if known).

Parts 2 and 3 of the proforma are not required to be completed for this flexible component of budget, however the reporting proforma will require a 100% budget reporting, including this flexible component.

Submission of the Organisational Health Promotion planning requirement for 2003–04

The Organisational Health promotion plan (With all components compiled into one document) will be submitted to the relevant Regional office by 15 July 2003. The Agency CEO or Manager should sign off each report. The June report should be submitted to the relevant regional office electronically – by email, CD or disk (the region will forward an electronic copy to Michelle Lasek at Head Office email: michelle.lasek@dhs.vic.gov.au).

Integrated Health Promotion Organisational Plan 2003–04

Part 1: Agency vision, priority issues and description of the 30–40% flexible component

- 1.1 Articulate overall organisational vision statement that reflects health promotion principles.
- 1.2 Identify the organisational priority issues for health promotion activity and provide supporting rationales for these priorities.
- 1.3 Give a brief description of the possible areas that 30–40% (maximum) of the health promotion budget will address. This flexible component covers *new and/or emerging issues* that arise in the local community and *transitional changes* happening within the organisation, to ensure future good practice in quality health promotion service delivery.

Part 2: Outline

Given each of the Priority issues identified from part 1 outline the:

2.1 Problem definition

- Program Goal
- Program Objectives
- Target Population Groups

2.2 Solution generation

- Use evidence based health promotion and good practice models
- Identify relevant Statewide action
- Identify the appropriate mix and balance of both individual and population wide health promotion interventions

2.3 Capacity building–support and resources

- Identify the roles and responsibilities of the key stakeholders, including community, consumer and carer representatives.
- Assess and allocate appropriate resources
- Identify key capacity building strategies required to ensure success

2.4 Plan for review and Evaluation

including process (reach indicators must be included) and impact evaluation.

Part 3: Health Promotion Summary planning grid:
 To summarise this planning process including budget details (for each priority issue).

Program Goal:		<i>(links with Priority Issue column in Switch reporting)</i>			
Population Target Group/s:		<i>(links with Population Group column in Switch reporting)</i>			
Objective 1:					
Estimated Impacts¹ (Qualitative &/or Quantitative) for Objective 1					
Health Promotion Interventions & Capacity Building strategies²	Estimated Reach³	Timelines & by whom⁴	Estimated Budget from C & WH program⁵	OPTIONAL Estimated Other Funding sources⁶	
Screening, individual risk assessment and immunisation					
Social marketing and Health information					
Health education and skill development					
Community action					
Settings and Supportive Environments					
Organisational Development					
Workforce Development					
Resources					
		Total Budget per Objective			
		Total Budget per Program Goal			

Explanatory notes for the 2003-04 Organisational Health Promotion Planning Proforma

- 1 **Estimated impacts (qualitative &/or quantitative):** Planning requires the development of impact indicators to measure the achievement of program objectives. Agencies are required to identify intended impacts as part of their planning process and report against these in 2003-2004. Please refer to the document *A Guide to Impact Evaluation in Health Promotion December 2002* which can be downloaded from www.dhs.vic.gov.au/phkb under Health Promotion Publications and Resources.
- 2 Agencies are only required to fill in **interventions/strategies** that are planned for; all other interventions/strategies categories can be deleted. Please refer to the document *Health Promotion Resource - Community and Women's Health Services March 2003* which can be down loaded from www.dhs.vic.gov.au/phkb. This document describes these interventions and strategy types.
- 3 **Estimated reach:** Planning should involve the development of process indicators for each program. However, the Department requires only one type of process indicator - **Reach** to be documented in the health promotion summary grid. Please refer to the document *Health Promotion Resource - Community and Women's Health Services March 2003*. This document can be down loaded from www.dhs.vic.gov.au/phkb
- 4 **Timelines & by whom:** Timelines for implementation need to be identified as well as whom in the agency is responsible for carrying out the action.
- 5 **Estimated costs (staff and consumables):** Where possible include the estimate cost per intervention/strategy. Also include total cost per objective and total overall cost per program goal.
- 6 **OPTIONAL estimated other funding sources:** To support the concept of having an Organisational Health Promotion planning process, Agencies have the option of including actual cost derived from other funding sources. When reporting against the plan it is not mandatory to report on the activities funded from elsewhere, this column allows the Agency to also have a better understanding of how much quality health promotion services cost.

Appendix 2a: 2003–2004 Community and Women's Health Services Organisational Health Promotion December Reporting Pro Forma

Introduction

The reporting for 2003–04 December involves the following **3 requirements**:

1. **A Description of the Flexible component including:** What is the flexible component being used for? How was this identified? Will this be an ongoing priority for future years?
2. **A Narrative for each Priority issue identified in your Agency's 2003–04 Integrated Health Promotion Organisational Plan**
3. **Representatives from each agency are required to meet with their regional office to discuss and review the implementation and evaluation of their organisational Health Promotion Plan.**

All three requirements are mandatory. Each narrative (for every priority issue) should be **within the range of 2–5 pages**.

Submission of Reports

The description of the flexible component and the narratives for each priority area (compiled into one document) will be submitted to the relevant Regional office by 15 January 2004. The Agency CEO or Senior manager should sign off each report. The reports should be submitted to the relevant regional office electronically—by email, CD or disk (the region will forward an electronic copy to Michelle Lasek at Head Office michelle.lasek@dhs.vic.gov.au)

Your regional office will set review meetings in consultation with your agency for February/March 2004. This meeting will be used as an opportunity for discussion and reflection of the Agency planning, implementation and evaluation for 2003–04. This opportunity will also be used to prepare for the submission of the 2003–04 final report and 2004–05 Organisational Health Promotion Plan.

(Insert Agency Name) Integrated Health Promotion Organisational Plan-December Reporting 2003-04

Guidance for Narrative Requirement

Agencies are required to submit a narrative section for EACH Priority issue identified in their 2003-04 Integrated Health Promotion Organisational Plan. Use the headings and prompts below to guide this narrative.

- **2003-04 priority setting process** eg. What was the rationale that the priority was based on? How was the process based on population health and wellbeing data provided in the PCP Community Health Plan, Burden of Disease, Municipal Public health plans and relevant local needs assessments? In setting organisational health promotion priorities what was the decision-making process?
- **Consumer and community participation** eg. How were the key population groups involved in developing/implementing and participating in the priority?
- **Problem definition process** eg. Was the goal, objective and selection of target population group realistic?
- **Solution generation process** eg. Was the mix and balance of interventions (including both individual through to population interventions) appropriate to achieving the goal and objectives stated for the priority area?
- **Planning for and conducting evaluation strategies** eg. What was difference, how was changed observed? What were the evaluation processes and methods? From the evaluation are there any implications for future priority setting processes?
- **Capacity building** eg. Were there enough resources – time, infrastructure, personnel and community participation to achieve the goal and objectives? What were the enablers and barriers? If not do these need to be developed or should different interventions, objectives even program goal be planned for?
- **Budget** eg: What is your budget expenditure to date for each of your identified priority areas? How is the budget being monitored and recorded? How was the evaluation processes costed?
- **Any other comments?**

Appendix 2b: 2003–2004 Community and Women's Health Services Organisational Health Promotion July Reporting Pro Forma

Introduction

The reporting for 2003–04 involves 2 parts including the Narrative and the Health Promotion Summary Reporting grid. Both part 1 and 2 are mandatory for each Priority issue identified in your Agency's 2003–04 Integrated Health Promotion Organisational Plan. The end of financial year final report is required to reflect 100% of the health promotion budget (including the flexible component identified in the 2003–04 plan) from the Community and Women's Health Programs.

Submission of reports

The report (including parts 1 and 2 for each priority area, compiled into one document) will be submitted to the relevant Regional office by 30 July 2004. The Agency CEO or Manager should sign off each report. The reports should be submitted to the relevant regional office electronically—by email, CD or disk (the region will forward an electronic copy to Michelle Lasek at Head Office michelle.lasek@dhs.vic.gov.au)

(Insert Agency Name) Integrated Health Promotion Organisational Plan-Reporting 2003-04

PART 1 Narrative

Agencies are required to submit a narrative section for Priority issues identified in their 2003-04 Integrated Health Promotion Organisational Plan. Use the prompts below to guide this narrative.

- **2003-04 priority setting process** eg. What was the rationale that the priority was based on? How was the process based on population health and wellbeing data provided in the PCP Community Health Plan, Burden of Disease, Municipal Public health plans and relevant local needs assessments? In setting organisational health promotion priorities what was the decision-making process?
- **Consumer and community participation** eg. How were the key population groups involved in developing/implementing and participating in the priority?
- **Problem definition process** eg. Was the goal, objective and selection of target population group realistic?
- **Solution generation process** eg. Was the mix and balance of interventions (including both individual through to population interventions) appropriate to achieving the goal and objectives stated for the priority area?
- **Planning for and conducting evaluation strategies** eg. What was the difference, how was the change observed? What were the evaluation processes? From the evaluation are there any implications for future priority setting processes?
- **Capacity building** eg. Were there enough resources – time, infrastructure, personnel and community participation to achieve the goal and objectives? What were the enablers and barriers? If not do these need to be developed or should different interventions, objectives even program goals be planned for?
- **Any other comments?**

Part 2: (Insert Agency Name) Health Promotion Summary Reporting Grid

Program Goal:	<i>(links with Priority Issue column in Switch reporting)</i>			
Population Target Group/s:	<i>(links with Population Group column in Switch reporting)</i>			
Objective 1:				
Actual Impacts¹ (Qualitative &/or Quantitative) for Objective 1				
Health Promotion Interventions & Capacity Building strategies²	Actual Reach³	Timelines & by whom⁴	Actual budget from C & WH program⁵	OPTIONAL actual other funding sources⁶
Screening, individual risk assessment and immunisation				
Social marketing and Health information				
Health education and skill development				
Community action				
Settings and Supportive Environments				
Organisational Development				
Workforce Development				
Resources				
Total Budget per Objective				
Total Budget per Program Goal				

Explanatory notes for the 2003–04 Organisational Health Promotion Reporting Proforma

- 1 Actual impacts (qualitative &/or quantitative):** Agencies are required to report against impacts estimated in their 2003–04 Organisational Plan. Please refer to the document *A Guide to Impact Evaluation in Health Promotion December 2002* which can be downloaded from www.dhs.vic.gov.au/phkb under Health Promotion Publications and Resources.
- 2** Agencies are only required to report against **interventions/strategies** that were implemented in 2003–04; all other interventions/strategies categories can be deleted. Please refer to Chapter 5 of these guidelines *Terms and Definitions*, which describes these interventions and strategy types.
- 3 Actual reach:** Planning should involve the development of process indicators for each priority. However, the Department requires only one type of process indicator–Reach to be reported on. Please refer to Appendix 3 in these guidelines for further explanation of Reach.
- 4 Timelines & by whom:** Timelines of when implementation occurred and who in the agency carried out the action.
- 5 Actual budget from C & WH program (Staff and consumables):** Where possible include the estimate cost per intervention/strategy. Also include total cost per objective and total overall cost per program goal.
- 6 OPTIONAL actual other funding sources:** When reporting against the plan it is not mandatory to report on the activities funded from elsewhere. This column allows the Agency to also have a better understanding of how much quality health promotion services cost.

Appendix 3: Process Evaluation-Reach

Process evaluation covers all aspects of the process of delivering a program. This means focusing on the evaluation of the health promotion actions and involves the documentation of the activities' reach, quality and capacity of the system to deliver quality health promotion action. More specifically, reach performance indicators for health promotion should be reported for any health promotion interventions and capacity building strategies that are part of the health promotion program. Reach is the number of key stakeholders⁴, settings⁵ or members of the community affected by the health promotion program as follows:

- **Screening, individual risk assessment and immunisation:** Proportion of target group or number of people participating in screening, individual risk assessment and immunisation activities (counted only once per activity). Information collected through systematic staff estimates and participation records.
- **Social marketing/Health information:** Proportion of target group or number of people (counted as contacts) accessing or aware of funded social marketing/health information activities and resources. OR number of articles published and the population reach of the newspaper or newsletter. OR number of agencies participating in the development and dissemination of consistent information resources (from printed material to interactive technology).
- **Health education, and skill development:** Proportion of target group or number of people participating in funded health education and skill development (counted only once per activity such as a quit smoking course). Information based on actual participation records.
- **Community action:** Proportion of target group or number of people participating in funded community action activities (counted as contacts). Information collected through systematic staff estimates.
- **Settings and Supportive Environments:**
The number of:
 - **Settings** (such as schools, local businesses and sporting clubs) involved in creating a supportive health promoting environment. It involves ensuring that policies, service directions, priorities and practices integrate health promotion principles. (each setting counted only once per annum per health priority).
 - **Stakeholders** involved in economic and regulatory activities (each stakeholder counted only once per annum per health priority). Information gathered through staff estimates.
 - **Settings/Stakeholders** involved in advocacy activities designed to gain political commitment, policy support, social acceptance and systems support for a particular goal. It includes direct political lobbying. (each stakeholder/setting counted only once per annum per health priority).

4 Stakeholders may include community leaders, provider representatives and agency staff.

5 Settings are specific physical locations such as schools and workplaces.

- **Organisational development:** A number of reach process indicators could be considered for organisational development depending on the focus of the program plan:
 - The number of agency management/staff participating in funded health promotion activities (counted only once per annum). Information based on actual participation records such as diary notes and meeting papers.
 - The number of agency management/staff planning to or implementing health promoting workplace policy/organisational culture activities.
 - The number of agency management/staff planning to or implementing policies, plans, and/or management support mechanisms for health promotion activities in their agencies/organisations.
 - The number of agency management/staff using health promotion recognition systems, health promotion activity monitoring and evaluation systems, consistent information resources and/or best practice health promotion tools.
- **Workforce development:** The number of staff within the agency participating in funded health promotion workforce development activities (counted only once per workforce activity such as a continuing education course). Information based on attendance records and similar information. Depending on the focus of the program plan, workforce development activities may be more specifically articulated as: on the job learning, formal professional development/professional support and supervision/performance management systems.
- **Resources:** The number of key stakeholders participating in the health promotion strategy/program planning (each stakeholder counted only once per annum per health priority) and the average stakeholder resource commitment (time, action, financial/physical). Information based on actual participation records such as diary notes and meeting papers.

Appendix 4: Service Coordination Elements and Corresponding Service Coordination Tool Templates

Service Coordination element	Brief description of element	Relevant Tool Templates/Supporting Information
Initial Contact (IC)	The first point of contact with the service system. Includes the collection of consumer information and/or provision of health or service information.	<ul style="list-style-type: none"> • Consumer Information • Consumer Information Brochure “Your information, It’s private”
Initial Needs Identification (INI)	INI is an initial screening process where the underlying issues as well as presenting issues are identified.	<ul style="list-style-type: none"> • Consumer Information • Summary and Referral • Consent Form • Supplementary Profiles • Living Arrangements • Functional • Health Conditions • Psychosocial • Health Behaviours
Assessment	The INI process will have identified need for specialist, service specific or comprehensive assessment.	Assessments will build on the information collected through the use of the appropriate forms as part of the INI process.
Assessment	The INI process will have identified need for specialist, service specific or comprehensive assessment.	Assessments will build on the information collected through the use of the appropriate forms as part of the INI process.
Care Planning	A process of deliberation that incorporates a range of existing activities such as care coordination, case management, referral, feedback, review, reassessment and monitoring.	<ul style="list-style-type: none"> • Service Coordination Plan
Information Management	Sharing of health and care information: The practice, processes, protocols and systems to support the collection, use, disclosure, storage and disposal of consumer health and care information.	<ul style="list-style-type: none"> • Consumer Information • Summary and Referral • Consent Form • Profiles • Service Coordination Plan

Appendix 5: Accessing language services

What are language services

The term 'Language Services' refers to translating and interpreting services delivered by a professional provider and covers all community languages as well as Auslan.

The national context

The 1998 *Charter of Public Service in a Culturally Diverse Society*, which has been endorsed by all levels of Australian Government (Commonwealth, State/Territory and Local), sets out a framework for the delivery of culturally responsive government services. The *Charter* stresses that adequate language services need to be available in order to provide equitable access to services to people from culturally and linguistically diverse backgrounds.

The Victorian context

Several organisations provide interpreting and translating services in Victoria. Unless other arrangements apply, these services are usually provided to clients of Government departments and funded agencies on a fee-for-service ('userpays') basis.

However, several program areas within the Department of Human Services (DHS) currently fund the Victorian Interpreting and Translating Service (VITS) and/or the Central Health Interpreter Service (CHIS) to provide a specified annual volume of 'fee-free' language services to approved organisations. These language services are made available either to funded agencies that have been approved by DHS, or for services delivered by the Department directly (such as, for

example, child protection). In both cases the language services are supplied to support the provision of quality human services to clients of the Department of Human Services and its funded agencies.

These central arrangements do not apply to all DHS-funded agencies: some providers (in the mental health area, for example) are funded by departmental programs to purchase language services directly. Other areas such as Public Health provide limited access to centrally funded language services for specified agencies, while all other services are expected to purchase directly.

Accessing language services

The Multicultural Strategy Unit (MSU) within the Policy and Strategic Projects Division of the Department of Human Services is responsible for managing the central departmental agreements with VITS and CHIS, on behalf of the relevant program areas.

Approval in principle, to access the fee-free language services provided by either VITS or CHIS, is generally given only to human services that are 'core-funded' by particular program areas of the Department of Human Services—i.e., those program areas that have elected to use this method of providing language services assistance by contributing to the central agreements with VITS or CHIS. Other program areas or branches of the Department of Human Services have alternative arrangements or expectations. If unclear, agencies need to seek guidance from their Department of Human Services

Regional liaison officer in the first instance on which procedures apply.

Where available, language services funded by the Department of Human Services are provided to assist eligible agencies to obtain the language services necessary for the delivery of quality human services to clients from linguistically diverse backgrounds. Eligibility does not guarantee that such assistance will always be available, as access to these language services is subject to the availability of resources at any given time, within the relevant program-based budget.

In the event that a fee-free service is not available at the time of booking, or if an agency is not approved for access, the agency will need to make a judgement in relation to using its own budget to purchase the necessary service.

Agencies should be aware that it is a general expectation of the Department of Human Services that clients are not denied access to quality human services as a result of their cultural or linguistic backgrounds. Where this places agencies' resources under pressure, the implications (and details of precise needs) should be communicated in the first instance to the relevant regional liaison officer of DHS and, if required, be included in discussions on annual budgets, performance targets or unit costs.

Eligibility

Eligibility to access the fee-free language services provided by VITS or CHIS is generally available for agencies funded through the following Department of Human Services

program areas, although some exclusions apply; and the list may vary from time to time:

- Acute Health
- Aged Care
- Community Health Program
- Women's Health Program
- DisAbility Services
- Family and Community Support funded services
- Office of Housing (including Community Housing and SAAP services)
- Public Health.

Criteria

The Department of Human Services will approve access in principle to fee-free language services, on the basis of the following primary criteria, to organisations that:

- are funded by the Department of Human Services to provide direct health, housing or family and community support services to members of the Victorian public;
- are funded through those program areas of the Department of Human Services that allocate resources to the central departmental agreements with language service providers;
- are not the primary funding responsibility of the Commonwealth, of any other State Government Department, or of any Local Government Authority;
- do not have access to an appropriate funding allocation for language services through other funding sources; and

- cannot otherwise access interpreting and translating services without significant financial difficulty.

Conditions of use

The purpose of the conditions outlined below is to foster optimal use of the resources available for language services.

Access to language services is in general approved only for those *individual services or activity areas* provided by an agency that meet the above primary criteria; and for *direct service delivery* situations, such as interviews, consultations with agency clients and their families, or group situations that are either focused on specific health or well-being outcomes or are agreed integral practices of the approved service.

'In-principle' approval to access language services generally covers direct (on-site, or face-to-face) interpreting services (including Auslan), as well as telephone interpreting assistance and individual client-oriented translation activity. Where access to any of these particular services is restricted, agencies will be formally advised.

Interpreting services provided under these guidelines are not intended to include:

- Management meetings;
- Staff meetings; and
- Social meetings (unless group situations as described above).

Agency staff should note that language service providers generally charge for **cancellations of interpreters** made

less than 24 hours before the time of the appointment. Where such cancellation is genuinely unavoidable, the cancellation fee will be borne by the departmental credit line. However, funds of the Department of Human Services are not authorised for use in the event of poor booking practices on the part of human service agencies. In such cases, agencies may be expected to bear any cancellation fees from their own budgets – which may be as high as the full fee, where notice is under two hours. Language service providers are authorised by the Department of Human Services to make judgements according to the specific circumstances, and the frequency of such occurrences, and to advise agencies when charges will apply.

Priority in providing **translations** under these guidelines is given to the translation of documents that facilitate direct client-care or support. This generally will not include:

- Minutes of meetings;
- Annual reports;
- Corporate or business plans;
- Mission statements or organisational goals; and
- Advertising and agency publicity.

Generally, agencies wishing to undertake translation of the above types of material will need to absorb the cost, or negotiate with their funding body to secure a specific-purpose budget allocation.

In the case of translations of information sheets and documents, agencies are encouraged to check

whether relevant translated information currently exists, and to examine opportunities for sharing such information with other organisations, or adapting it. *A Brief Guide to Multilingual Health Publications Online* is available as an attachment to these Guidelines.

Requests for translations that are estimated by the language service provider as likely to exceed a specified 'ceiling' value will need individual approval from the relevant Department of Human Services program area. This process will be coordinated by the language service provider in consultation with the relevant program area. The 'ceiling' value varies according to the program stipulation.

The table below shows the current limits, where applying:

Program area	Translation limit
Acute Health	Up to \$1,000
Aged Care	Up to \$500
Community Health	Up to \$500
DisAbility	Up to \$500
Housing	Up to \$500
Public Health	Up to \$500
SAAP	No translations funded
Family and Community Support	No translations funded

Application process

Organisations seeking approval of eligibility to access fee-free language services should make an application on the attached form to the Manager, Multicultural Strategy Unit, Policy and Strategic Projects Division, Department of Human Services.

Applicants are urged to provide full detail, as the information will need to be verified before access can be approved.

Staff of the MSU will liaise with the appropriate program area(s) within the Department of Human Services to secure their decision to approve or reject any application for access to language services. The primary role of the MSU is an administrative one, as the decision as to whether or not to grant an agency credit line access is made by the program in consultation with DHS Regional staff, as appropriate.

The MSU will liaise with the language service provider(s) to arrange access for approved agencies and will advise the agency on booking procedures for language services. A copy of this correspondence will be sent to the DHS Regional Office and to the program area.

Agencies not approved for access will be formally advised by the MSU (or directly by the program area) in writing. Copies will be forwarded to the DHS Region and program.

Once an organisation has been approved for eligibility, it should notify the MSU immediately of any change in its status or circumstances, including significant adjustments to its funding relationship with the Department of Human Services, and new addresses or contact details.

Record keeping

To assist with ongoing liaison and negotiation with the Department of Human Services (usually via the

Regional Office), agencies are encouraged to maintain detailed ongoing records regarding language service provision.

These may include:

- the demand for use of language services by agency clients (or staff);
- the extent of access to fee-free language services that has been achieved;
- additional agency expenditure that has been incurred to meet the identified language service needs;
- the extent, (perceived) causes and (potential) impacts of any unmet demand; and
- alternative strategies that have been adopted to address the identified needs, such as the targeted employment (and support) of bilingual staff; and the effectiveness of such strategies.

Queries

For further information please contact:

Multicultural Strategy Unit
Policy and Strategic Projects Division,
Department of Human Services,
Level 5, 555 Collins Street,
Melbourne 3000
Tel 03 9616 7217
Fax 03 9616 8879

General agency concerns about resourcing of language services or the capacity to provide quality services to clients should be directed through the relevant Department of Human Services Regional liaison officer, in the first instance.

Multicultural Strategy Unit, DHS
August 2002

Department of Human Services
Policy and Strategic Projects Division—Multicultural Strategy Unit



Date of application

Application for Access to Funded Language Services

Name of agency/organisation
 Address Postcode
 Contact name (for queries on this application)
 Position
 E-mail address
 Phone number Fax number
 Department of Human Services Region
 Local Government Area
 Principal Department of Human Services regional contact officer.....
 Position
 Phone number.....

If your agency is a branch or service outlet of a larger agency, state the following:

Name of parent agency
 Address of parent agency Postcode
 Department of Human Services Region responsible for funding the parent agency (if applicable).....

Services or activity areas requesting access

Please provide separate details for each nominated service (see next page)

Please return completed forms to:
 Multicultural Strategy Unit
 Policy and Strategic Projects Division
 Department of Human Services
 Level 5, 555 Collins Street
 Melbourne 3000
 Fax: 03 9616 8879

Service or activity area requesting access

Please copy this page if necessary and submit a separate page for each different type of service; and indicate if the service is 'sub-contracted' to another agency (by ticking the appropriate box).

Type of service or activity:
 Service or activity delivered by Own agency Subcontractor (Please identify:)

Addresses of sites where service or activity is delivered. Attach separate sheet if more than 5 sites. (Please specify Department's region, and Local Government Area, if different from agency details on cover page.)

1.
2.
3.
4.
5.

Department of Human Services (DHS) Funding

Please complete the table below

Division	Amount of Funding	Percentage of total funding (DHS and other sources)	Period of funding	Is funding provided through a Contract or a Service Agreement (Please specify)	Access Sought
Acute Health					
Aged Care / HAACC					
Community Health					
Community Care (Family and Community Support)					
DisAbility Services					
Office of Housing / SAAP					
Public Health					
Other Department of Human Services programs (specify)					
Total Department of Human Services funding					

Please place a tick in the last column if you are seeking access to that program's creditline.

Other funding sources for this service/activity:

Source of Funding	Amount and period of funding	Proportion of total funding

Current level of demand: _____ interpreting sessions and _____ translations per month.



Appendix 6: Primary Health Funding Approach 2003–04 – Development and Resourcing Framework

The aim of this section is to provide a framework to assist DHS staff and agencies to distinguish Development & Resourcing (D&R) from other components of the model. D&R is one of the three components of the primary health funding model. Agencies see D&R under two categories (A&B below).

D&R category A: Management, administration & service development

What's included?*	What's excluded?	In practical terms...
<p>Management, Administration & Service Development includes items such as:</p> <ul style="list-style-type: none"> • Staff coordinator salary and salary related oncosts • CEO salary (with appropriate proportion attributed to the Community Health Program) • Other primary health manager salaries • Service Development staff salaries – eg PCPs, Service Coordination • Administration and reception 	<p>The salaries for non-contact time of allied health, nursing, counselling and health promotion staff are not included. Rather, they are accounted for in the unit price build up for services to individuals. The unit price build up allows for:</p> <ul style="list-style-type: none"> • Annual leave • Sick leave • External training • Public holidays • Professional development and staff meeting time <p>Note that where these staff members have management, administration or service development roles, then salary costs for all their time, including contact and non-contact hours, should be split between D&R and service delivery according to the proportions of time allocated for different roles.</p>	<p>For those staff who, in addition to service provision duties, perform management/administration/service development duties, their time is attributed as in the following example: A staff member spends three days per week on staff coordination activities and provides counselling services two days per week. Their time would be attributed 60:40 between management and service provision.</p>

D&R category B: Operating

What's included?*	What's excluded?	In practical terms...
<p>Operating includes items such as:</p> <ul style="list-style-type: none"> • Costs associated with cleaning, maintenance and gardening • Building, equipment and ICT maintenance costs, eg contractors and materials • Occupancy costs (rental, insurance, security) • Non-salary related administration – eg accounting, stationery, bank charges, utilities • Motor Vehicle costs – purchase of, petrol, registration, maintenance • ICT – purchases, support • Operating items associated with service development, eg for PCPs, service coordination, other initiatives. <p>For each of the above, it is expected that where there are multiple program funding sources, the appropriate proportion is attributed to the Community Health Program.</p>	<p>There is a wide array of consumable costs that are not included in the D&R component because they relate directly to the provision of services. Here are some examples of those service provision consumables which are not D&R items:</p> <ul style="list-style-type: none"> • Allied health consumables and equipment: the total costs of materials used in treating patients, including splints, continence and medical supplies, and minor equipment and aids. • Nursing consumables and equipment: the cost of goods used in providing nursing, including surgical dressings, pharmaceutical, surgical instruments and medical appliances. • Counselling/casework consumables and equipment: the cost of goods used in providing counselling/casework, including tests, aids and appliances. • Health promotion consumables • For all service provision staff, the cost of purchasing and cleaning uniforms and protective clothing worn by service provision staff <p>Therefore, these costs should not be attributed to the D&R component.</p>	<p>If an agency were to purchase stationery for the general operation of the centre, then this would be considered as spending under the D&R component. However, if stationery were purchased for service provision, such as prescription pads or the printing of referrals, then this would be a consumable funded via the unit price.</p>

* *Note: This document does not itemise every single element under D&R or imply that the Department has taken a position to fund D&R elements in full.*

Appendix 7: Primary Health Funding Approach 2003–04 – Definition of Development and Resourcing Factors

[The use of factors enables the recognition of the different characteristics of agencies that potentially impact on the level of D&R. It endeavours to be responsive to the differentiating cost drivers and issues consistently identified by agencies, whilst at the same time balancing and supplementing this rationale with evidence from existing data. The approach acknowledges the diversity that exists in the sector whilst providing a consistent platform for negotiations. Further work to validate and explore the model and these particular factors will be undertaken in 2003–2004.]

Factor	1. Number of sites	2. Rurality	3. Service and Funding Complexity	4. Volume and Proportion of Primary and Community Health Funding
Rationale	Having multiple sites has consistently been identified as increasing costs for agencies.	Issues such as those associated with recruitment/ retention of staff, and provision of accessible services result in increased costs for many rural agencies, particularly those outside the larger rural centres.	Complexity of funding sources and service provision is likely to increase agency management costs, particularly those in relation to reporting and staff management.	Development and Resourcing costs for smaller agencies represent a higher proportion of budgets than for agencies with more substantial budgets
Definition	<p>Three or more sites providing DHS Primary and Community Health program funded services</p> <ul style="list-style-type: none"> • Each site must provide DHS Primary and Community Health program funded services. • The Primary Health agency should be the principal occupant of the site; that is, be responsible for providing reception, administration and management of the operation of the building. • Multiple buildings situated at one physical location are considered to be one site. 	<p>Agencies located in Small Towns and District Centres</p> <ul style="list-style-type: none"> • The rurality factor is applied to all agencies located in Small Towns and District Centres (1,000–5,000 persons and 5,000–20,000 persons respectively)* • Agencies must have all sites in towns of less than 20,000 to qualify for this factor • Regional Centres of 20,000+ persons* do not receive this factor. <p>* as defined by Australian Bureau of Statistics</p>	<p>Agency receiving funding across at least five outputs within at least three DHS Output Groups</p> <p>The DHS chart of accounts structure is used as a proxy measure for service complexity at an agency level. This is available on line at – www.dhs.vic.gov.au/ar2002/div_report_menu.htm#section2 or in Divisional Policy and Funding Plans, available on line through the funded agency channel www.dhs.vic.gov.au/fac</p>	<p>Recurrent Primary and Community Health funding less than the statewide average and more than 50% of the total DHS funding</p> <ul style="list-style-type: none"> • Budget size will only be recognised as a factor where the Primary and Community Health budget represents the majority of an agency's funding. • Non-recurrent allocations such as workforce development & annual provisions are not considered in this factor. • The statewide recurrent funding average in 2002–03 was \$666,698 with budgets ranging between \$6981 and \$3,997,430.

Appendix 8: Unit price build up

With its implementation in July 2002, the primary health funding approach established unit prices for all allied health, counselling casework and nursing activities.

Calculations for setting unit prices were based on the mid-point between the lowest and highest annual award rates of pay for relevant practitioners*. Loadings were then applied for the following on- costs:

On-cost item	%
Superannuation	9.0000
Workcover	1.8400
Annual leave loading	1.3462
Long service leave accrual	1.2000

An annual amount for consumables utilised in the course of practice was also included.

For 2003–04:

- The salaries component has been updated to reflect increases which came into effect in March 2003. Award increases occurring after 1 July 2003 will be paid in the usual manner and built into unit prices for 2004–05.

- The consumables component has been increased by the CPI. In 2003–04, the consumables amount is \$5,125 for all activities other than counselling, where it is \$4,100 (provided primarily to cover supervision expenses).
- A productivity requirement of 1.5% has been applied to the unit prices, reflecting the State Government productivity improvement policy of requiring savings to occur through increased productivity without affecting service delivery to clients.

The 2003–04 unit prices are listed in the table below and have been discounted by 4% in accordance with the fees policy applying to Community Health activities. For programs not covered by this policy (Women's Health, Family Planning, IHSY, Suicide Prevention, and FARREP), the discount will not be applied. (The prices in the table below can be divided by 0.96 to derive unit prices for activities where the fees discount does not apply.)

Activity	Unit price (\$ per hour)
Audiology	\$47.05
Dietetics	\$53.01
Occupational Therapy	\$56.75
Physiotherapy	\$56.75
Podiatry	\$48.40
Speech Pathology	\$50.69
Counselling Casework	\$49.05
Nursing	\$51.46
Health Promotion	\$51.65

* In most cases, the mid-point rate was selected as the rate for price setting, with the exception of Registered Nurses (RNs) and counsellors, for whom an average rate was calculated. In the case of RNs, the rate was the average of the rate for the classifications 3BCHY1 and 4BCHY2. In the case of Counselling, the rate calculated was the average of the midpoint of the Social Work and Psychologist classifications.

