

Primary Health report

Primary Health Branch

2005-06

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Director's foreword

I am pleased to present the *Primary Health Report 2005–06*. This report provides a snapshot of the achievements of the Primary Health Branch in 2005–06. In addition, it includes service delivery and client demographic information from the Community and Women's Health and Dental Health programs.

During 2005–06, a number of major initiatives were rolled out. These initiatives are aimed at improving the health and wellbeing of Victorians, focusing on different backgrounds, age groups and areas of disadvantage.

Care in your community sets out a framework for a consistent approach to the development of an integrated health care system. NURSE-ON-CALL has been well received and the number of calls is growing. Emphasis is given to managing chronic diseases for Aboriginal Victorians and the wider community. Multidisciplinary child health teams provide early intervention and coordinated efforts to improve the health and wellbeing of young children.

The continuing development of the Primary Care Partnerships and General Practitioners in Community Health Services strategies is well in progress. The increasing number of electronic referrals sent among the Primary Care Partnerships has saved significant amounts of administration time, which can be used for service delivery.

This report has been structured in a slightly different format to previous years. I am sure you will find it more readable.



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Highlights and achievements

Care in your community strategy

- *Care in your community: a planning framework for integrated ambulatory health care* was launched in April 2006 jointly by the Hon Bronwyn Pike MP, Minister for Health, and Gavin Jennings MLC, Minister for Aged Care.
- Implementation of the framework is being directed by a cross-divisional implementation group which is overseen by a steering committee chaired by the Executive Director, Rural and Regional Health and Aged Care Services Division.
- External advice to the project is provided by an advisory group comprising key stakeholders and chaired by the Secretary of the Department of Human Services.

NURSE-ON-CALL

- Launched in March 2006.
- By June 2006, 18 metropolitan hospitals and five rural hospitals were diverting calls to the service.
- Between March and June, 13,452 calls were diverted from hospitals to NURSE-ON-CALL, which represented a potential saving of 2,018 hours of nursing time previously provided by hospital staff.
- On 4 June 2006, the service was launched to the general public.
- By end of June 2006, 21,016 calls had been made to the service.

Aboriginal Health Promotion and Chronic Care Partnership

- The Victorian Government allocated \$1.7 million in 2005–06 (\$7.06 million over four years).
- Twelve community health services and eight Aboriginal Community Controlled Health Organisations formed partnerships, operating in seven Department of Human Services regions.
- Priority plans were implemented with a focus on health promotion and/or chronic disease in respective catchment populations.

Refugee Health Nurses

- Launched in August 2005.
- Nurses are operating from eight community health services in high refugee areas.
- Direct service/support was provided to 348 clients and their families, with an average of 2.6 contacts per client.

Early Intervention in Chronic Disease

- The 2005–06 State Budget allocated \$4.05 million to implement community-based integrated chronic disease management approaches for people with chronic disease and complex needs.
- Nine community health services and the nine corresponding Primary Care Partnerships (PCPs) received recurrent funding under this initiative (\$400,000 per annum for the community health services and \$50,000 per annum for each of the PCPs).
- Implementation began in the second half of 2005–06.

Primary Care Partnership strategy

- In Victoria, there are 31 PCPs, involving more than 800 agencies.
- The Minister for Health and the Minister for Aged Care endorsed the PCP strategy as an ongoing funded component of the primary health system in Victoria.
- In 2005–06, PCPs attracted \$2.7 million in funding in addition to core recurrent funding to progress initiatives such as electronic referral, integrated chronic disease management and general practitioners engagement.
- Of all the Integrated Health Promotion plans, 80 per cent gave priority to tackling physical activity, 71 per cent to mental wellbeing and social connectedness, 42 per cent to food and nutrition, and 10 per cent to tobacco, alcohol and other drug issues.
- In March 2006, updated Service Coordination Tool Templates (SCTTs) were released.
- Service coordination was facilitated by PCPs, with more than 530 services using SCTTs.
- In 2005–06, funding was provided from both the Primary Health and Home and Community Care (HACC) branches to PCPs to implement referral using the SCTTs.
- Compared to 2004–05, there was an increase of 155 per cent in the number of e-referrals.

General Practitioners in Community Health Services strategy

- This strategy has a budget of \$2 million per annum.
- By the end of 2005–06, there was an increase of 8.36 general practitioner (GP) full-time equivalent (FTE) and 19 practice staff (such as practice nurses and managers).
- An additional 190 new GP clinic hours were provided.
- Ninety-six per cent of GP consultations were bulk billed.

Community and Women's Health program

- In the seven years from 1999–2000, Community and Women's Health programs have been allocated \$659 million, rising from \$73 million to \$117 million in 2005–06, a 60 per cent increase.
- Compared to 2004–05, there was an increase of 7.3 per cent in funding, up from \$109 million to \$117 million.
- In 2005–06, there were 185,526 registered clients, up from 164,866 in 2004–05, or 12.5 per cent.
- In rural regions, there was an increase of registered clients between 2004–05 and 2005–06, up from 61,406 to 70,576, or 14.9 per cent.
- In metropolitan regions, there was an increase of registered clients between 2004–05 and 2005–06, up 11.1 per cent from 103,461 to 114,950.
- In 2005–06, there were 1,088,305 occasions of service, representing an increase of 4.7 per cent on the 1,039,830 occasions of service delivered in 2004–05.

- Of the 1,088,305 occasions of service:
 - 45.8 per cent were delivered in rural regions
 - 24 per cent were for counselling/casework
 - 22.2 per cent were for nursing
 - 16.9 per cent were for health promotion.
- Clients of podiatry and occupational therapy had the highest median age, both at 71 years of age.
- Regardless of age, 64 per cent of all clients were female.
- In 2005–06, there were 69,986 group sessions. This was an increase of 20 per cent, up from 55,511 in 2004–05.
- Of these group sessions, 61 per cent were held in rural regions and 39 per cent in metropolitan regions.

Dental Health program

- In 2005–06, funding to the Dental Health program was \$125 million, up from \$118 million in 2004–05.
- A total of 299,878 Victorians accessed dental services, an increase of 3.4 per cent from the previous year. There were 764,903 visits, an increase of 6.4 per cent.
- Five new public dental clinics opened, bringing the total number of dental clinics in Victoria to 68. An additional 26 dental chairs opened across Victoria, increasing the number of public dental chairs in community health services, School Dental Service and Royal Dental Hospital Melbourne to 393.
- The integration of School Dental Services with the Community Dental Program commenced. The dental service at Goulburn Valley Health opened as an integrated service and three existing sites (Barwon Health, Central Bayside Community Health Service and Western Region Community Health Service) commenced as demonstration projects.
- Waiting times for dentures decreased by 20 per cent from 28 to 22 months, and general care waiting times fell by 16 per cent from 28 to 23 months.

Primary Health Branch

Victorian Government policy emphasises the importance of primary health services as an integral part of the health care system. Services such as allied health, dental health care, nursing and health promotion improve the physical, mental and social wellbeing of Victorians, reduce the likelihood of serious illness and reduce the need for hospital and specialist medical services. The mission of the Department of Human Services is to enhance and protect the health and wellbeing of all Victorians, with particular emphasis on vulnerable groups and those most in need.

Consistent with the Victorian Government's 'Growing Victoria Together' agenda and the Department of Human Services' mission and objectives, the vision for the Primary Health Branch is:

To improve the health and wellbeing of Victorians, particularly those with or at risk of poorest health status, by developing strong, effective and modern primary and community health services as a valued and key part of Victoria's health care system.

The Primary Health Branch has five aims:

1. Strengthen, expand and integrate the primary health care service system.
2. Integrate primary health care services with acute and residential care to support substitution and diversion.
3. Expand service options and access to information to support: self-management; primary, secondary and tertiary prevention; and, integrated health promotion.
4. Improve performance including demand management, quality and safety of state funded primary health care services.
5. Value and improve consumer and carer participation in all primary health programs as a key aspect of continuous improvement of primary health care services.

The Primary Health Branch manages the Community, Women's and Dental Health programs and the Primary Care Partnership strategy. In 2005-06, the branch was responsible for a number of new initiatives including *Care in your community*, NURSE-ON-CALL, Early Intervention in Chronic Disease, Refugee Health Nurses, Child Health Teams, the Aboriginal Health Promotion and Chronic Care (AHPACC) Partnership and the General Practitioners in Community Health Services strategy.

The Primary Health Branch faces key challenges of managing demand for services; improving efficiency; and ensuring services and initiatives are evidence-based. A modern primary health care system also needs to build and maintain the capacity to keep pace with advances in technology; the ageing population; increasing levels of disadvantage; community-based management of people with complex and chronic conditions; and consumer preferences.

New initiatives

The Primary Health Branch started a number of new initiatives in 2005–06, which strengthen efforts to provide primary health services to all Victorians.

Care in your community strategy

Care in your community was released by the Ministers for Health and Aged Care in April 2006. *Care in your community* sets out a framework for a consistent approach to the development of an integrated health care system, building on existing strengths and trends in health care provision. It provides a vision and principles for integrated health care to be achieved over the next decade, as well as direction and priority actions for the next two to three years.

The vision is that the Victorian health care system will increasingly deliver person and family centred health care in community-based settings, reducing the need for inpatient care and improving the health outcomes of Victorians.

Care in your community builds on established and successful elements of the current health system. The guiding principles aim to maximise access, equality and continuity of care, service flexibility, opportunities for service substitution and diversion as well as optimal use of scarce resources.

Care in your community has adopted the principles that the government set out in its publication *Victoria: a better state of health*. Under these high level principles are specific principles that inform the development of the health care system under this framework.

The five principles are:

- 1 The best place to treat
- 2 Together we do better
- 3 Technology to benefit people
- 4 A better health care experience
- 5 A better place to work

Care in your community sets out a new methodology for planning integrated and community-based health care based on a common set of catchments and supported by area-based planning networks facilitated by Department of Human Services regional offices.

Planning for the delivery of integrated, community-based health care will be:

- based on a single set of area-based planning catchments
- informed by a single set of planning principles
- supported by area-based planning networks
- focused on three high level areas of need
- conducted on the basis of defined modes, settings and levels of care.

To enable the health care system to deliver integrated, community-based health care, specific action will be undertaken over the next 2–3 years in the following areas:

- funding models
- workforce
- integration tools
- information and communication technology (ICT) developments
- partnering arrangements.

In 2006–07, trials will be carried out in one regional and two metropolitan catchments to determine the strengths and weaknesses of this approach prior to rolling it out across the state. The trials will be supported by a high-level external consultancy managed by the Primary Health Branch.

Implementation of the framework is being directed by a cross-divisional implementation group which is overseen by a steering committee chaired by the Executive Director, Rural and Regional Health and Aged Care Services Division. External advice to the project is provided by an advisory group comprising key stakeholders and chaired by the Secretary of the Department of Human Services.

NURSE-ON-CALL

In March 2006, the NURSE-ON-CALL service was launched in Victoria. NURSE-ON-CALL is a 24-hour a day telephone health advice, referral and information service staffed by registered nurses.

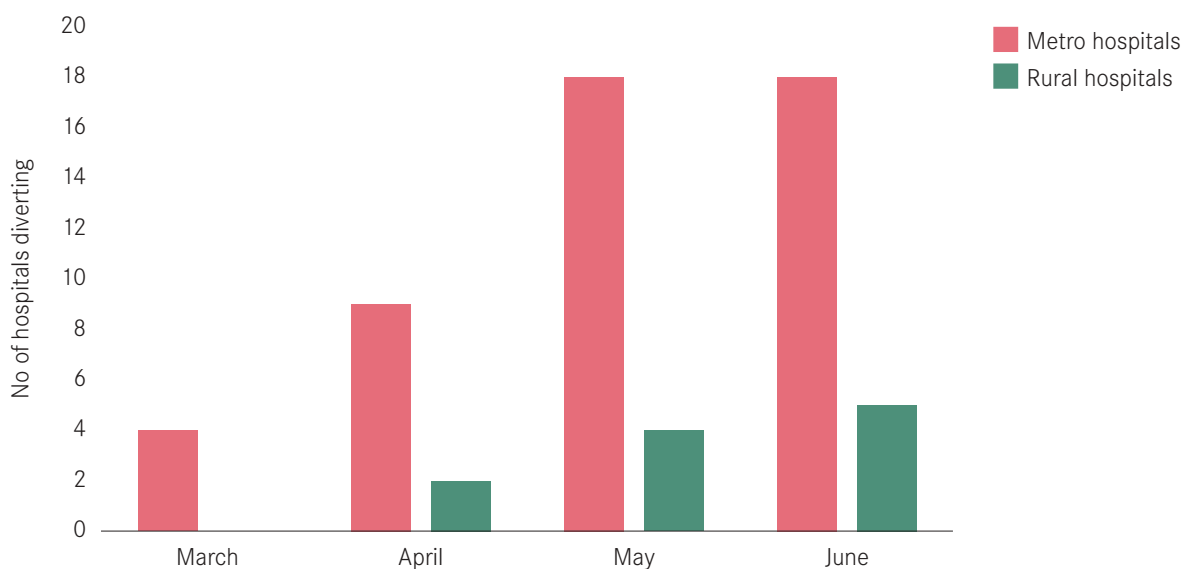
The aim of the NURSE-ON-CALL initiative is to ensure every Victorian has access to professional health advice any time of the day or night. It is an additional service to complement Victoria's public hospitals and emergency services. Callers ring 1300 60 60 24 for the cost of a local call from anywhere in Victoria. (Calls from mobile phones may be charged at a higher rate.) The National Relay Service is available to assist callers who are hearing or speech impaired.

In the first stage of implementation (March–May 2006), health services diverted general health advice and information calls to the service. In June 2006, the service was made available to the public.

Number of hospitals diverting

By June 2006, 18 metropolitan hospitals and five rural hospitals were diverting calls to the service.

Figure 1: Hospital diversion to NURSE-ON-CALL 2005–06



Number of calls diverted

During March–June 2006, 13,452 calls were diverted from hospitals to NURSE-ON-CALL, which represents a potential saving of 2,018 hours of nursing time previously provided by hospital staff.

Table 1: Number of calls diverted from hospitals to NURSE-ON-CALL March to June 2006

	March	April	May	June
Number of calls diverted	223	2,524	4,788	5,917

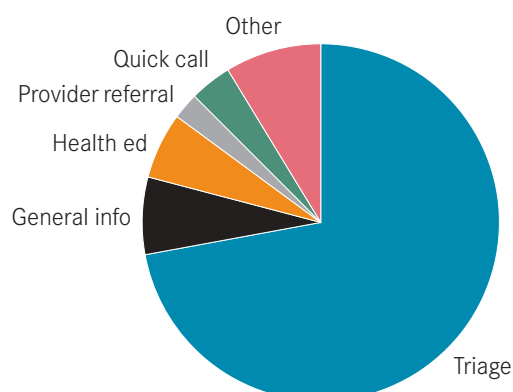
Launch to public

In June 2006, NURSE-ON-CALL was launched to the public. During the month of June 2006, there were 21,016 calls made to the service (15,099 calls directly to service and 5,917 diverted from hospitals).

Triage accounted for the majority of calls.

Table 2: Summary of calls by outcome

Summary by outcome—% of total calls	No	%
Triage	15,144	72.1%
General information provided	1,479	7.0%
Health education	1,253	6.0%
Provider referral	507	2.4%
Quick call (includes wrong numbers, prank, hoax calls)	807	3.8%
Other (not recorded, administration file, transferred internally, etc)	1,826	8.7%



A breakdown of the outcomes of calls triaged is shown in Table 3.

Table 3: Summary of final disposition of triages performed by NURSE-ON-CALL

Summary of final disposition	Total*	Percentage
Transfer to 000	882	5.6%
Attend Emergency Department immediately	3,239	20.7%
See health care provider	6,638	42.4%
Self care	4,801	30.6%
Other (includes poisons, Police, HACC referral)	107	0.7%

* NB: there can be more than one triage performed in one call

In addition, NURSE-ON-CALL:

- provides callers with other health related information, such as details of health services in their area or the number of phone help lines
- provides access to interpreting services for callers not confident with English.

Aboriginal Health Promotion and Chronic Care Partnership

There are significant inequalities in the health status of Aboriginal Victorians compared to non-Aboriginal Victorians. The life expectancy of Aboriginal Victorians is 17 years less than the rest of the population, and they have a greater likelihood of hospitalisation, and at a much earlier age, for diabetes, renal disease, cardiovascular disease and respiratory diseases, compared to non-Aboriginal Victorians.

As a response to this, the Victorian Government allocated \$1.7 million in 2005–06 (\$7.06 million over four years) to prevent and better manage chronic disease in Aboriginal people in eight geographical areas across Victoria through the Aboriginal Health Promotion and Chronic Care (AHPACC) Partnership.

The AHPACC Partnership is a new program model developed through a consultative process between the Department and the Victorian Aboriginal Council on Koori Health.

The vision for the AHPACC Partnership:

Aboriginal Victorians can access primary health care that is culturally respectful and addresses aspects of health including prevention, promotion and treatment, underpinned by principles of self-determination and collaboration, and endeavours to achieve a quality of life for Aboriginal people, equal with all other Victorians.

The AHPACC Partnership will support community health services and Aboriginal Community Controlled Health Organisations¹ to work in partnership to improve health outcomes for Aboriginal Victorians with, or at risk of, chronic disease.

The AHPACC Partnership will achieve this through:

- increased access to primary health care services by Aboriginal Victorians
- improved clinical service delivery, coordination and continuity of care, and support for chronic disease self-management approaches
- coordinated approaches to health promotion planning, implementation and evaluation by building upon other programs, for example, those targeting nutrition, physical activity, smoking cessation, mental health and wellbeing, healthy weight
- increased capacity of community health services in the provision of culturally sensitive services
- workforce development (including accredited training) and organisational support for both Aboriginal and mainstream workers and organisations in the implementation and evaluation of the AHPACC Partnership.

This program model includes the establishment of new positions supporting health promotion and access to chronic disease prevention and management services by Aboriginal people. In addition, the individual and joint roles of partner organisations and the acknowledgement of Aboriginal cultural influences, including historic, cultural and social contexts of communities, need to underpin the planning, implementation and evaluation of the AHPACC Partnership.

AHPACC Partnerships have commenced implementation and have identified priorities for action related to health promotion and/or chronic disease in their catchment populations.

¹ The term 'Aboriginal Community Controlled Health Organisations' is a collective term used for Aboriginal organisations with a focus on delivery of health services, but in the case of the AHPACC Partnership documentation, also includes one Aboriginal organisation which is an Aboriginal Community Controlled (not health) Organisation.

Table 4: AHPACC priorities for action related to health promotion and/or chronic disease

Region	Funded agencies		Health promotion focus	Chronic disease focus
	Community health services (CHS)	ACCHO		
Barwon-South Western	South West Healthcare (Warrnambool CHS)	Gunditjmara Aboriginal Cooperative	Physical activity, nutrition	CVD, diabetes Then COPD
Gippsland	Gippsland Lakes CHS	Gippsland and East Gippsland Aboriginal Cooperative	PCP priorities: employment and community participation (increasing access to economic resources), mental health, social connectedness, physical activity	Pending Healthy For Life planning
Hume	Goulburn Valley CHS (as fundholder) with Goulburn Valley Health	Rumbalara Aboriginal Cooperative	Smoking, nutrition, physical activity, obesity and hypertension (to be confirmed)	Undertaking consultation process linked to EliCD.
Loddon Mallee	Sunraysia CHS	Mildura Aboriginal Cooperative	Physical activity, nutrition	Diabetes—Type 1 and 2
Eastern Metropolitan	Eastern Access Community Health	Mullum Mullum Gathering Place	Nutrition, healthy lifestyle	Diabetes
North and West Metropolitan	Darebin CHS; North Yarra CHS; Dianella CHS/ Plenty Valley CHS	Victorian Aboriginal Health Service (VAHS)	Pending approval from VAHS board	TBC
	Western Region Health Service; Isis Primary Care	Western Region Gathering Place	Nutrition, physical activity, mental wellbeing, spirituality	Diabetes
Southern Metropolitan	Greater Dandenong CHS	Dandenong and District Aborigines Cooperative	Diabetes prevention (healthy living, sport, body image)	Type 2 Diabetes
	Frankston CHS	TBC	TBC	Diabetes, dental, mental health and drug/alcohol—to be refined/confirmed.

Abbreviations:

ACCHO—Aboriginal Community Controlled Health Organisations

CHS—community health service

COPD—chronic obstructive pulmonary disease

CVD—cardiovascular disease

EliCD—Early Intervention in Chronic Disease

TBC—to be confirmed

Refugee Health Nurses

The Minister for Health launched the Refugee Health Nurse initiative in August 2005. It aims to build a coordinated approach to refugee health by establishing 'sentinel sites' to increase access to primary health services, improve the response of health services to refugees' needs and support refugee communities to improve their health and wellbeing. Eight community health services in areas with high numbers of refugees were funded to employ a part-time Refugee Health Nurse to work on health promotion and early intervention programs, and develop referral networks and collaborative relationships with GPs and social support and orientation programs. Additional funding was allocated for language services. Program guidelines were issued in August 2005.

In 2005–06, Darebin, Western Region, Dianella, Doutta Galla, ISIS, South-West Health, Greater Dandenong and Goulburn Valley were funded. Nurses were employed at all eight community health services (total eight EFT). A total of 348 clients and their families were provided with direct service/support, with an average of 2.6 contacts per client. Nurses' activity included:

- direct care services for refugees (including health assessments)
- support to GPs (community health services and private) to deliver care to refugees
- education and training for community health service staff, including on the role of Refugee Health Nurses
- liaison and referral of refugee clients to specialist services (such as Royal Children's Hospital, Royal Melbourne Hospital)
- liaison with Adult Multicultural Education Services (AMES) and other refugee services
- advocacy, for example cost of pathology tests, high dose Vitamin D
- work on priority and triage systems (for example, dental) for refugee clients.

Several development and support projects also commenced:

Professional development and networking: Victorian Foundation of Survivors of Torture provided training sessions in February and May 2006 attended by all Refugee Health Nurses and other interested nurses.

Secondary consultation and organisational development: Western Region Health Centre was funded to provide organisational development advice to community health services and secondary consultation for nurses. All eight community health services took up this opportunity through regular meetings and phone consultations.

Refugee Health Assessment Project: General Practice Division of Victoria was funded to review and finalise the Refugee Health Assessment form, and promote refugee health issues and use of the assessment form with GP Divisions. This work commenced in 2005–06 and is continuing in 2006–07. An indication of the high profile of refugee health with GPs is that by June 2006, less than two months after the introduction of the new Medicare item for refugee health assessment, 281 of the total of 405 claims made across Australia were from Victoria.

Service coordination and general practice integration: Relevant PCPs were funded to develop service coordination, including links to services relevant to refugees (for example, acute infectious diseases clinics). By June 2006, most PCPs had commenced some activity, including consultations, GP visits and forums. This aspect will be fully implemented in 2006–07.

Evaluation: The Refugee Health Research Centre was funded to develop an evaluation framework. This commenced in 2005–06, with significant involvement from agencies and nurses in identifying indicators and data sources. This work will continue in 2006–07.

Early Intervention in Chronic Disease (EliCD)

The 2005–06 State Budget allocated \$4.05 million to implement community-based integrated chronic disease management approaches for people with chronic disease and complex needs. Nine community health services and the nine corresponding PCPs received recurrent funding under this initiative (\$400,000 per annum for the nine community health services and \$50,000 per annum for each of the nine corresponding PCPs).

The aim of this initiative is to improve the health, wellbeing and quality of life for people with chronic disease. The initiative aims to provide planned and well managed care to people with a range of chronic diseases. It complements existing programs by supporting people with chronic disease earlier in the disease continuum to delay and reduce the need for more intensive and costly interventions.

The guiding vision for the EliCD initiative is for a responsive, person-centred, effective system of care that aims to demonstrate improved health outcomes and quality of life for people with chronic disease and complex needs.

The provision of integrated chronic disease management approaches for people with chronic disease and complex needs through this initiative will provide best practice care to prevent complications of a chronic disease. The initiative builds on the work already being done by community health services to support people in the community who have chronic disease and complex needs. It provides additional funding to enhance the services and build in new components of care that are consistent with evidence-based chronic care. The role of the PCP is to work on service system integration and change management, particularly with general practice, building on existing PCP activities, especially service coordination. The challenge, for the service system, is to improve integration and continuity of care for clients over time and through different stages of disease progression.

The nine community health services and PCPs are:

1. ISIS Primary Care—Brimbank-Melton PCP
2. Western Region Health Centre—West Bay PCP
3. Banyule Community Health Service—Banyule Nillumbik PCP
4. Whitehorse Community Health Service—Inner East PCP
5. Frankston Community Health Service—Frankston-Mornington PCP
6. Greater Dandenong Community Health Service—South East PCP
7. Barwon Health—Barwon PCP
8. Sunraysia Community Health—Northern Mallee PCP
9. Goulburn Valley Community Health Service—Goulburn Valley PCP

Implementation began in the second half of 2005–06. Reporting of service delivery targets for the nine community health services will be available in 2006–07.

Child health teams

The government has identified improving the health and wellbeing of young children as a major priority, and the *Community Health Services—creating a healthier Victoria* policy, released in September 2004, identified that community health services should have a stronger focus on child and family health. Community health services vary in their capacity to provide services to children. Some have prioritised child health, and established multidisciplinary child health teams.

During 2005–06, 11 community health services were funded to participate in a survey on the role of multidisciplinary child health teams in the health, wellbeing and developmental needs of children, in particular children presenting with multiple needs. The survey covered demography, problem types, referral source, service provision and outcomes for 526 children treated over the past 18 months. It also investigated teamwork issues, carer views, partnerships and health promotion activities.

The findings showed that the community health services were providing early intervention in areas essential to young children's current and future health and wellbeing, in particular language, literacy and behaviour. Many of the findings demonstrated services were targeted effectively with significant gains. Areas identified as needing more development included multidisciplinary practice and goal setting and achievement. The report is available on the Department of Human Services website.

The 2006 State Budget allocated funding from July 2006 to expand and develop multidisciplinary child health teams in 12 community health services in high needs areas, as part of the Growing Communities Thriving Children initiative. This initiative aims to develop coordinated and innovative approaches to child health and wellbeing through working with children and families in coordination with local government and other early childhood services. The initiative will be established during 2006–07.

Community health service fabric pre-survey

In 2005, the Community Health Program, in partnership with Capital Management Branch of the department, undertook a fabric pre-survey of all community health services in Victoria.

Aims of this survey were to:

- gather evidence about the state of community health services' fabric, which will assist in the development of a capital development strategy
- collect data that describes community health services' capacity, which will be used for future service planning exercises in line with *Care in your community*.

Capital development

Information from the survey was collected and an evaluation made to select sites from across the state that required further investigation by technical consultants.

Decisions were based on a number of criteria: property ownership; building condition and functional suitability assessments provided by the agency; the size of the facility; and information provided by regional and program staff with knowledge of the facilities.

Sites that were well advanced in capital planning were excluded from the survey, as their needs were already known.

Two types of inspection were made:

- a technical survey (with a building surveyor and an architect)
- or
- an advisory survey (architect only).

Across the state, 149 buildings were inspected, 98 were full technical surveys and 51 advisory surveys.

Reports and recommendations on these site inspections are due to be submitted to the department in late 2006.

The reports will form the basis of ongoing strategic capital planning and will provide the regions with objective data in helping them allocate annual provision funds.

Service planning

The service capacity information from the pre-survey has also been used to collate and make available data about community health capacity across the state.

The types of information that was collected included:

- verification of site addresses, site activity, number of community health EFT positions and the nature of co-located services
- qualitative data about agencies' key issues in service delivery and future service and capital directions.

This data will be useful for agencies, consultants and the department in service planning, and will be used to demonstrate community health service capacity through:

- the development of profiles for each agency, which will be made available through the Primary Health Branch website
- the inclusion of metropolitan community health service agency profiles in the new Metropolitan Health Strategy document due for release in 2007
- describing community health service capacity from an area-based perspective in line with *Care in your community*.

Work will continue on these areas in 2006–07.

Providing primary health services to clients

There are three programs funded by the Primary Health Branch to provide direct primary health care services to clients.

Community Health program

Funded services include approximately 100 community health services across Victoria as well as family planning services and some statewide specialist services, including Victorian Foundation for the Survivors of Torture, International Diabetes Institute, Centre for Adolescent Health and Centre for Culture Ethnicity and Health.

The Community Health program also facilitates the delivery of the Innovative Health Services for Homeless Youth program. This is a Commonwealth/State program that provides funding to community organisations to promote health care for homeless and otherwise at risk young people.

Community health services

Community health services are located in every local government area in Victoria. The 100 community health services in Victoria operate from more than 400 sites. They are active participants in and contributors to their local communities. This strong connection to communities enables community health services to develop models of care that are responsive to their consumers and reflect the diverse underlying determinants of health. In this way, community health services combine the social model of health with clinical care to maximise outcomes for their consumers.

Thirty-nine community health services are independently managed. Local communities have the opportunity to elect representatives to boards of management of these services. The remaining community health services are auspiced by rural or metropolitan health services.

The community-based model of care supports community capacity building to promote health and wellbeing and encourages consumer participation in service planning, delivery and evaluation. In delivering a community-based model of care, community health services aim to provide a universal service as well as targeted services to particularly disadvantaged populations, such as people with the poorest health and greatest economic and social needs.

Community health services also provide health services for other population groups that may have trouble accessing appropriate health care. Examples of these groups are Aboriginal people, people with disabilities, refugees and people seeking asylum, the homeless and those at risk of homelessness, people from culturally and linguistically diverse backgrounds and, in some areas, people living in rural communities.

Strong community health services means a strong consumer-focused model of care can be provided across the acute/community-based interface and strengthens the capacity for partnerships with other sectors that influence the health of individuals and populations.

The type and scope of services managed and delivered by community health services varies throughout the state. The Community Health program funded services include health promotion and prevention, early identification and intervention, assessment and treatment (for example, allied health services such as physiotherapy and speech therapy, nursing and counselling/casework), and coordinated care with GPs, other primary providers, the acute, aged care and mental health sectors. Community health services also provide a platform for the delivery of a range of other primary health services, including drug and alcohol, dental, medical, post acute care, home and community care, community rehabilitation and day centres.

Community health services have combined annual budgets (from multiple program areas) estimated at about \$400 million. The Department of Human Services Community Health program funds approximately 25 per cent of the services provided by community health services: about \$75 million for direct services (counselling, allied health and nursing) and \$30 million for health promotion. The Dental Health program is also a significant source of funding for community health services. Other major sources of Department of Human Services funding include HACC, Disability Services, Drug Treatment Services, Mental Health, Office of Children and Aged Care.

The Community Health program has a number of associated programs. They are:

- **Innovative Health Services for Homeless Youth Program (IHSY)**

This is a Commonwealth/State cost shared program that provides funding to community organisations. The aim of the program is to promote health care for homeless and otherwise at risk young people through innovative approaches and through increasing access to mainstream and specialist services.

- **Telephone counselling**

The initiative provides telephone counselling 24 hours a day, seven days per week to provide individuals with support, information and referral. There are toll free generalist (13 114) and suicide prevention (1300 651 251) numbers. Recurrent funding of more than \$1.3 million was provided for the 2005–06 financial year.

- **Suicide prevention**

This program is run by the Victorian Foundation for Survivors of Torture and aims to reduce the incidence of suicide among child and adolescent refugees.

- **Health Self Help Program (HSHP)**

This program provides non-recurrent grants of up to \$5,000 to self-help groups for people with chronic illness, in recognition of the vital role played by the self-help movement in the health care system. Groups are composed of and managed by people who share, either directly and/or as a carer, a common chronic health condition. Grants are provided for general running expenses and minor equipment.

Women's Health program

The Women's Health program aims to improve the health and wellbeing of all Victorian women (with an emphasis on those most at risk), through the development and dissemination of health information and research and the provision of community and professional education. These activities take place directly with women and in partnership with the health and community sectors.

There are 12 services funded through the Women's Health program; nine regional services and three statewide services.

The Victorian Women's Health program was established in 1987 and was developed to provide services 'by women for women'. The dual strategy of delivering gender-specific health services while working to improve mainstream services remains a key aspect of women's health.

Women's health services prioritise those population groups for whom access to health services is difficult. These include Aboriginal women; women from culturally and linguistically diverse backgrounds; women with disabilities; rural women and those identified by statewide, regional and community health planning processes.

Women's health services are based on an understanding of health within a social context and recognise 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
- health promotion, prevention, equity of access and strengthening the community and home-based health system are necessary along with high quality treatment services.

A number of associated programs are operated under the scope of Women's Health program:

- **Family and Reproductive Rights Education (FARREP)**

The program works with communities that traditionally practise female genital mutilation to:

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

- **Family Planning (FPP)**

Family Planning Program assists Victorians to make individual choices on sexual and reproductive health matters by providing a range of accessible, culturally relevant and responsive services to people experiencing difficulty accessing mainstream services.

Dental Health program

Public dental services are provided in community and school dental clinics that are located in community health services and rural hospitals. In some cases, dental care is provided by private clinicians through the Victorian Emergency Dental Scheme (VEDS), the Victorian General Dental Scheme (VGDS) or the Victorian Denture Scheme (VDS).

Dental Health Services Victoria (DHSV) is responsible for the overall delivery of public dental services through:

- direct service provision through DHSV clinics, the Schools Dental Service and the Royal Dental Hospital Melbourne
- the distribution of funds to community health services and rural hospitals.

Public dental services provide routine and urgent care. People seeking urgent care are assessed, triaged and managed using the Emergency Demand Management Strategy.

People triaged as requiring urgent care are offered an appointment and those who require routine care are placed on the general waiting list. People are treated in the order in which they have been placed on the waiting list, unless they are deemed as needing priority access.

Access to public dental health services and co-payment requirements is population based.

Services for children

Children up the age of 12 have priority access to public dental care. Priority access is also provided to children aged 13–17 who are dependents or holders of health care or pensioner concession cards.

Eligible primary school aged children are offered services on a recall basis, which depends on their need. The service is free for dependents or holders of a health care or pensioner concession card, or \$27 for a course of care per child for other families (maximum of \$108 per family).

Services for adults

Health care and pensioner concession cardholders and their dependants over the age of 18 are eligible for oral health services. The service costs \$22 per visit, up to a maximum of \$88 for a complete course of care. Dentures generally cost around \$105.

In addition to the exemptions noted, there are co-payment exemptions for special needs groups including those experiencing financial hardship and registered clients of mental health and disability services.

Dental services are output funded using a funding formula based on the Department of Veteran Affairs Dental Items Schedule. Programs for special needs groups are block funded.

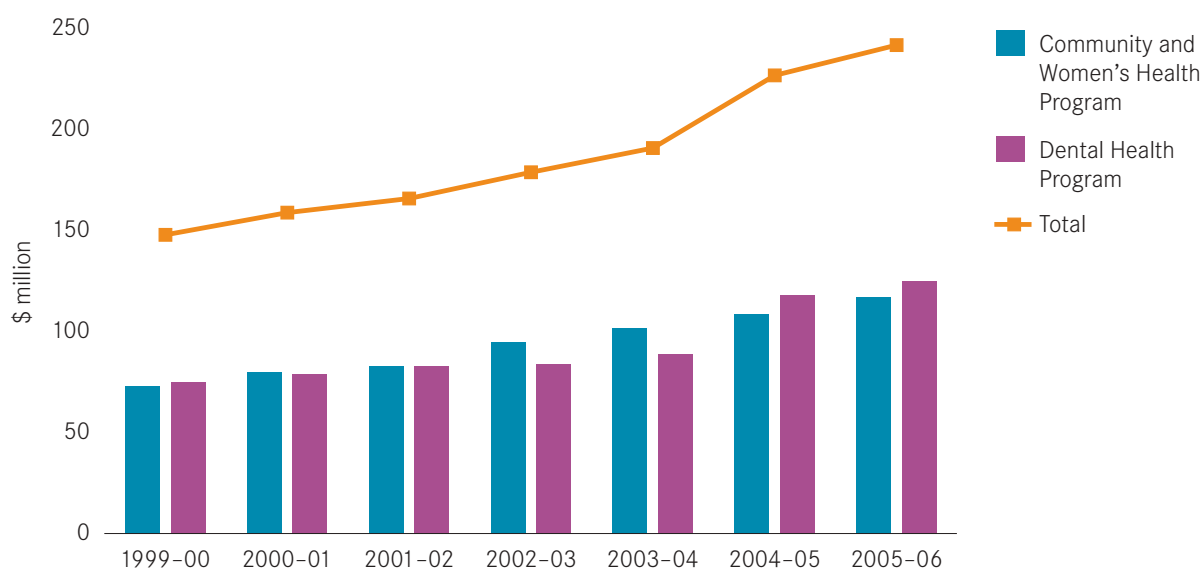
Funding and facilities

Total funding allocated to Community and Women's Health programs and Dental Health program has increased by 63.5 per cent in seven years, rising from \$148 million in 1999–2000 to \$242 million in 2005–06. Compared with 2004–05, there was an increase of 6.6 per cent in 2005–06.

In the past seven years, Community and Women's Health programs were allocated \$659 million, rising from \$73 million in 1999–2000 to \$117 million in 2005–06, or a 60 per cent increase. Compared with 2004–05, there was an increase of 7.3 per cent in 2005–06.

In the same period, the Dental Health program was allocated \$653 million, rising from \$75 million to \$125 million, or a 67 per cent increase. Compared with 2004–05, there was an increase of 5.9 per cent in 2005–06.

Figure 2: Funding allocated to Community and Women's Health and Dental Health programs 1999–2000 to 2005–06



Data source: (a) data for Community and Women's Health programs sourced from Primary Health Branch documents
 (b) data for Dental Health program sourced from *Your hospitals*, January to June 2006, page 35.

The number of dental chairs in community health services across the state continued to grow in the past seven years. Between 1999–2000 and 2005–06, there was a rise of 52 per cent, from 143 up to 217.

Compared with 2004–05, there was an increase of 10 per cent, from 197 up to 217.

Table 5: Dental Health program—number of dental chairs in community health services by regions—1999–2000 to 2005–06

Region	Year						
	1999–00	2000–01	2001–02	2002–03	2003–04	2004–05	2005–06
Barwon-South Western	16	21	23	23	23	22	22
Grampians	11	11	14	14	16	17	17
Loddon Mallee	16	17	18	17	17	16	17
Hume	7	8	8	8	8	9	21
Gippsland	11	13	13	14	14	14	14
North and West Metropolitan	42	44	48	54	58	58	63
Eastern Metropolitan	11	15	18	18	18	27	27
Southern Metropolitan	29	29	33	33	34	34	36
Total	143	158	175	181	188	197	217

Data source: Dental Health Services Victoria

Service utilisation

In 2005–06, there were 185,526 registered clients in the Community and Women’s Health program. Compared to 2004–05, this was an increase of 12.5 per cent, up from 164,866. In the past seven years, there has been an increase of 24 per cent, up from 150,077 in 1999–2000.

In the same period, there was an increase in clients in the Dental Health program, up from 289,211 in 2004–05 to 299,878 in 2005–06, or 3.7 per cent. The number fluctuated slightly in the past seven years. Note that the number included School Dental Service clients.

Figure 3: Number of clients—Community and Women’s Health and Dental Health programs, statewide 1999–2000 to 2005–06



Data source: (a) data for Community and Women’s Health program sourced from Agency Multi Purpose Report and Registered Clients Report (does not include data for agencies that report aggregate data only)
 (b) data for Dental Health program sourced from Dental Health Services Victoria.

In rural regions, there was an increase of registered clients between 2004–05 and 2005–06, up from 61,406 to 70,576, or 15 per cent. In the seven years between 1999–2000 and 2005–06, there was an increase of 14 per cent. In metropolitan regions, there was an increase of registered clients between 2004–05 and 2005–06, up from 103,461 to 114,950 or 11 per cent. In the seven years between 1999–2000 and 2005–06, there was an increase of 30 per cent.

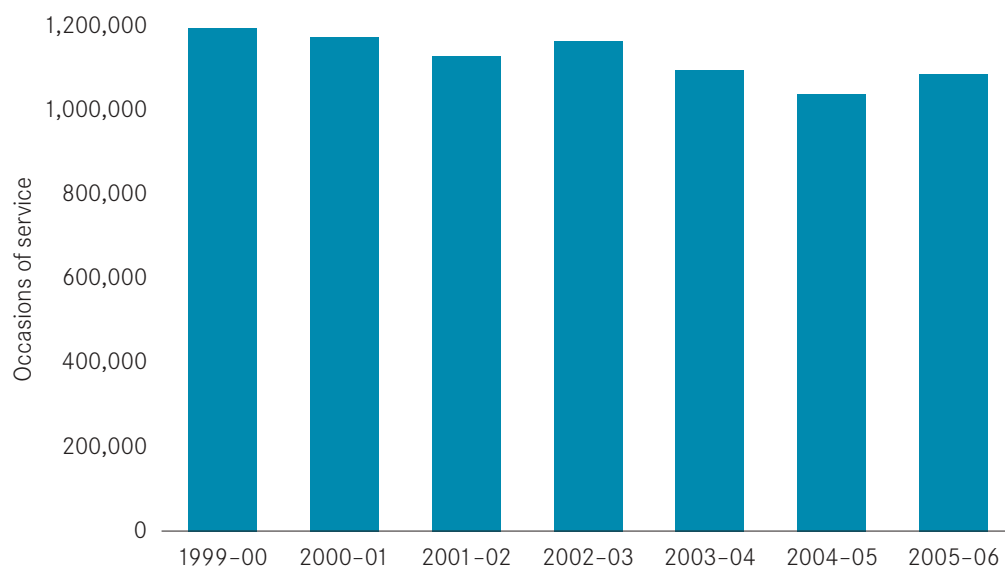
Figure 4: Distribution of registered clients—rural and metropolitan regions—Community and Women’s Health program 1999–2000 to 2005–06



Data source: Agency Multi Purpose Report and Registered Clients Report (does not include data for agencies that report aggregate data only)

In 2005–06, there were 1,088,305 occasions of service. Compared to 2004–05, this was an increase of 4.7 per cent, up from 1,039,830.

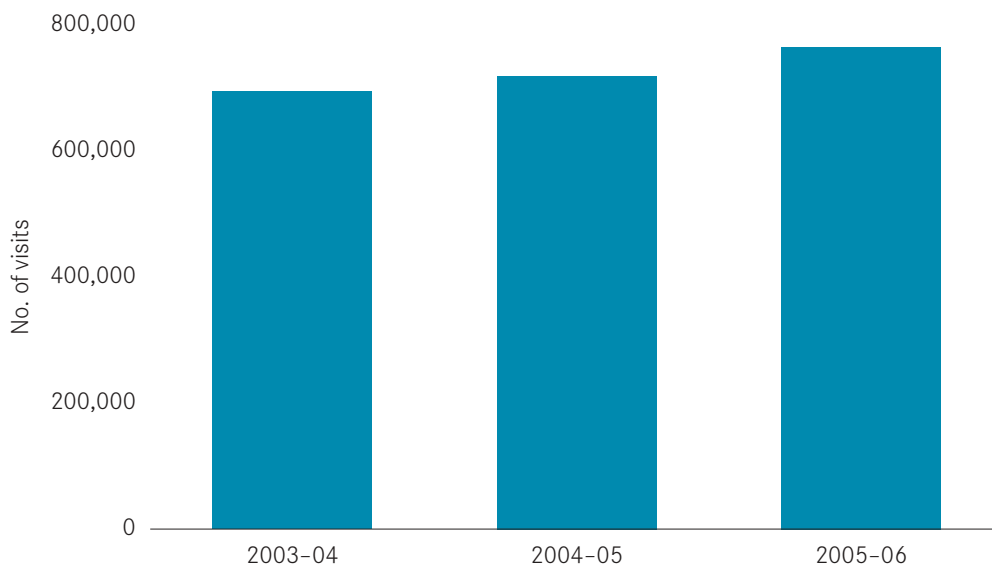
Figure 5: Community and Women’s Health program—occasions of service—statewide 1999–2000 to 2005–06



Data source: Agency Multi Purpose Report and Primary Care and Health Promotion Reports

In 2005–06, there were 764,903 visits. Compared to 2004–05, this was an increase of 6 per cent, up from 719,031. Note that the number included School Dental Service visits.

Figure 6: Dental Health program—number of visits—statewide 2003–04 to 2005–06



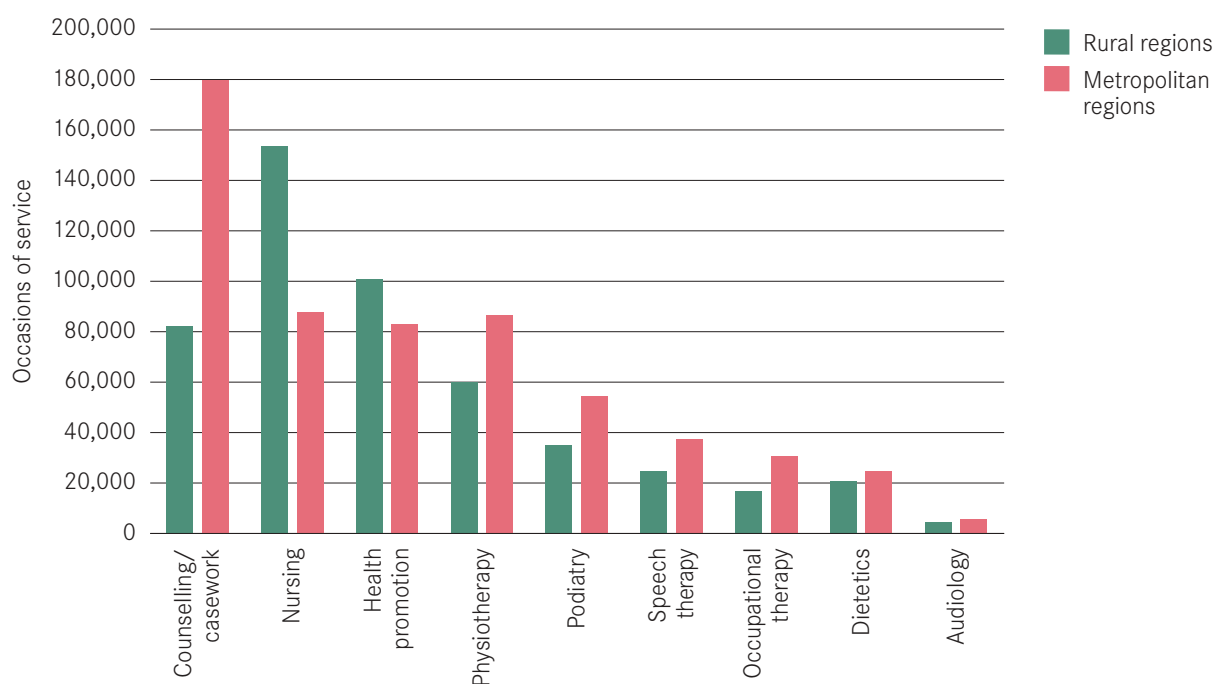
Data source: Dental Health Services Victoria

Of the 1,088,305 occasions of service, 46 per cent were delivered in rural regions.

Among the nine service types, counselling/casework constituted 24 per cent, followed by nursing at 22 per cent and health promotion at 17 per cent.

Rural regions delivered more nursing and health promotion services compared with metropolitan regions.

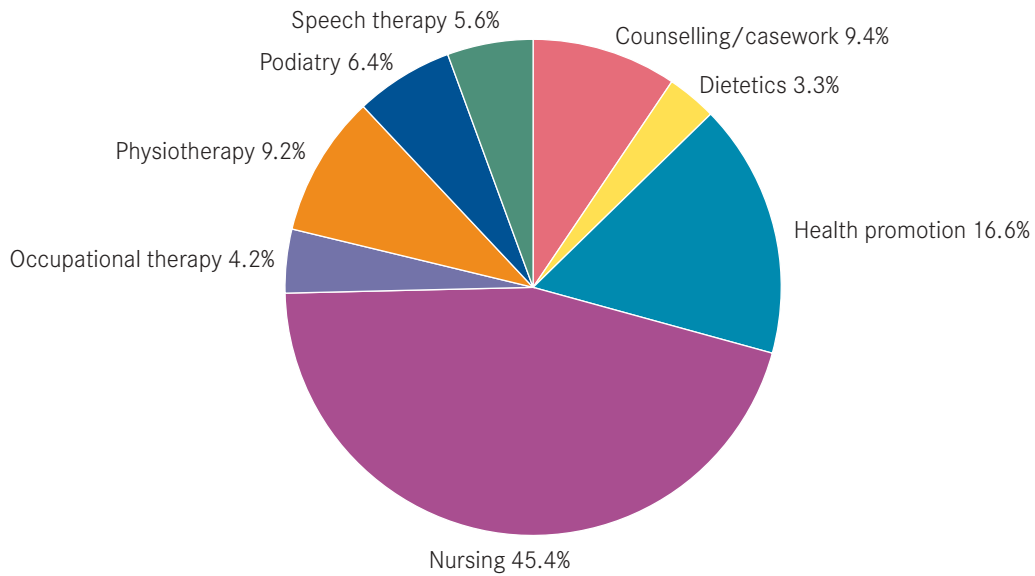
Figure 7: Community and Women’s Health program—number of occasions of service by rural and metropolitan regions 2005–06



Data source: Agency Multi Purpose Report and Primary Care and Health Promotion Reports

Of the 124,420 occasions of service in Barwon-South Western Region, 45.4 per cent were delivered for nursing, followed by health promotion 16.6 per cent.

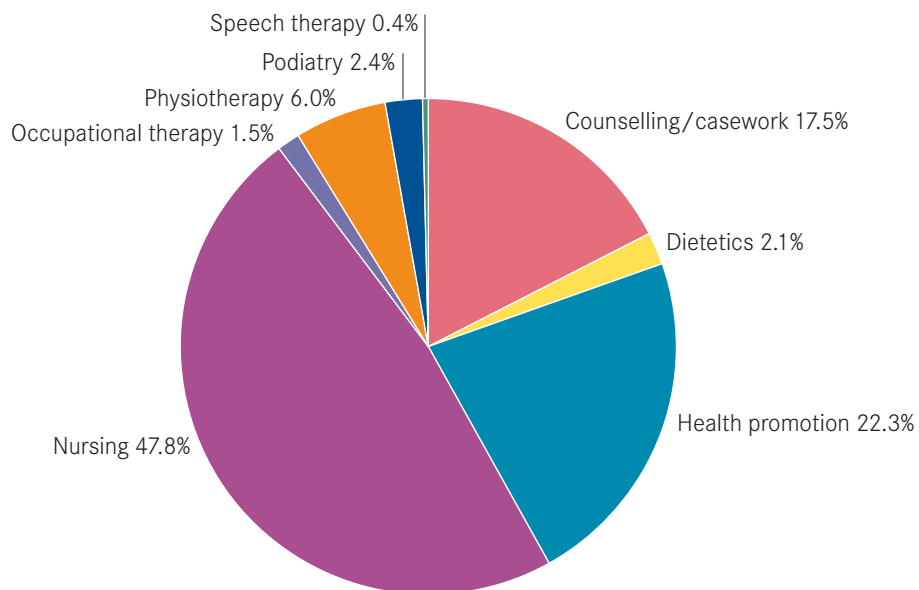
Figure 8: Barwon-South Western Region—Community and Women’s Health program—proportion of occasions of service by service type 2005–06



Data source: Agency Multi Purpose Report and Primary Care and Health Promotion Reports

Of the 96,618 occasions of service in Gippsland Region, 47.8 per cent were delivered for nursing, followed by health promotion 17.5 per cent.

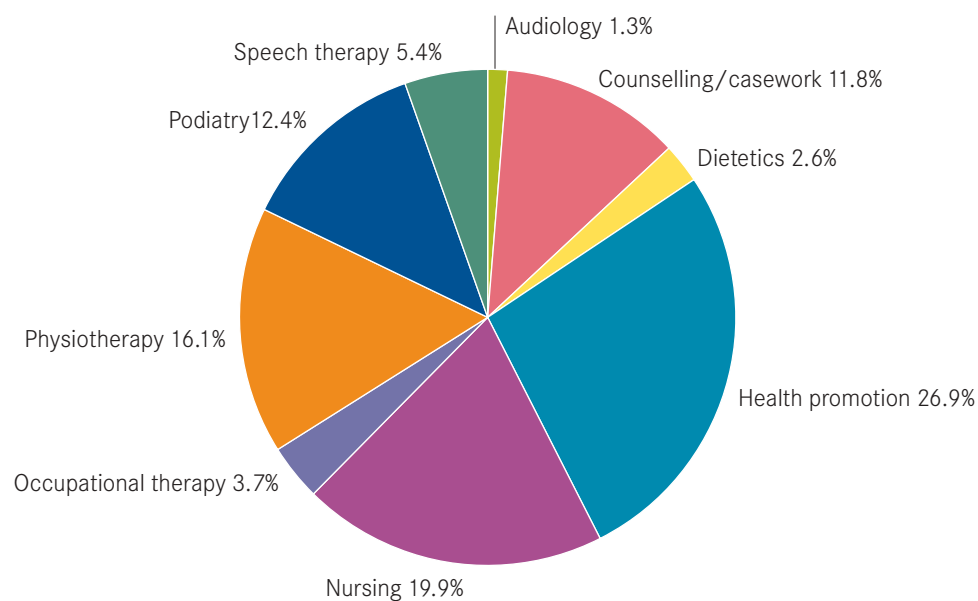
Figure 9: Gippsland Region—Community and Women’s Health program—proportion of occasions of service by service type 2005–06



Data source: Agency Multi Purpose Report and Primary Care and Health Promotion Reports

Of the 117,826 occasions of service in Grampians Region, 26.9 per cent were delivered for health promotion, followed by nursing 19.9 per cent.

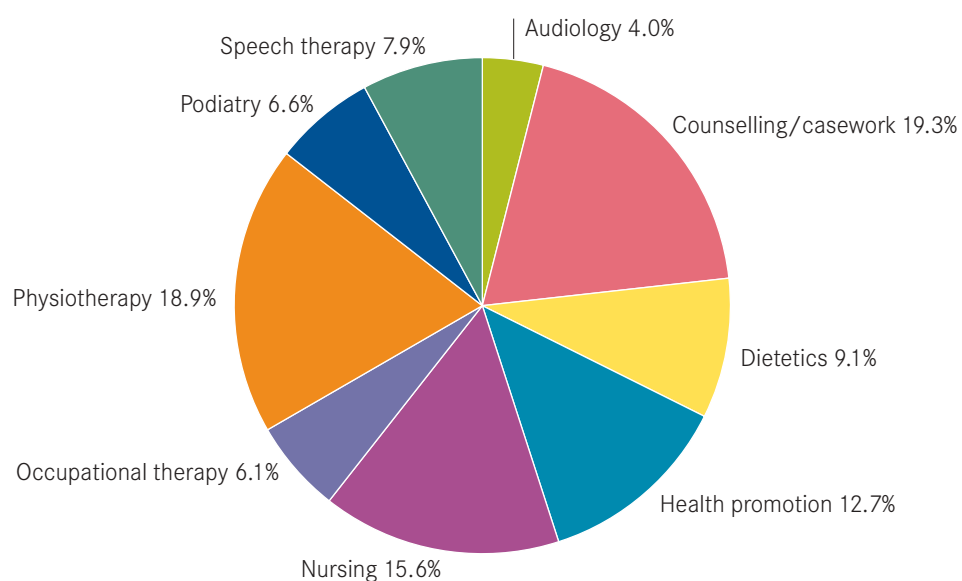
Figure 10: Grampians Region—Community and Women’s Health program—proportion of occasions of service by service type 2005–06



Data source: Agency Multi Purpose Report and Primary Care and Health Promotion Reports

Of the 72,798 occasions of service in Hume Region, 19.3 per cent were delivered for counselling/casework, followed by physiotherapy 18.9 per cent.

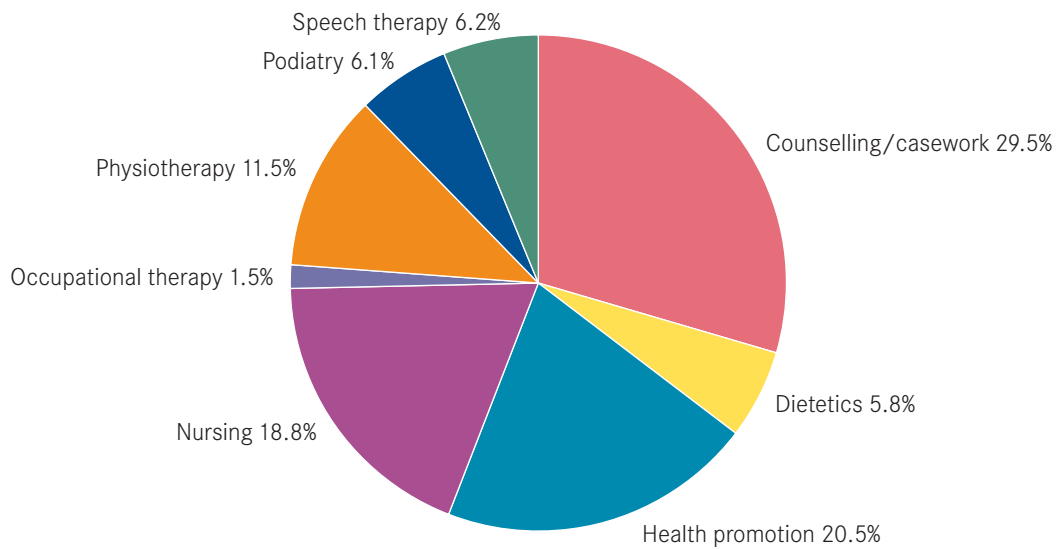
Figure 11: Hume Region—Community and Women’s Health program—proportion of occasions of service by service type 2005–06



Data source: Agency Multi Purpose Report and Primary Care and Health Promotion Reports

Of the 86,608 occasions of service in Loddon Mallee Region, 29.5 per cent were delivered for counselling/casework, followed by health promotion 20.5 per cent.

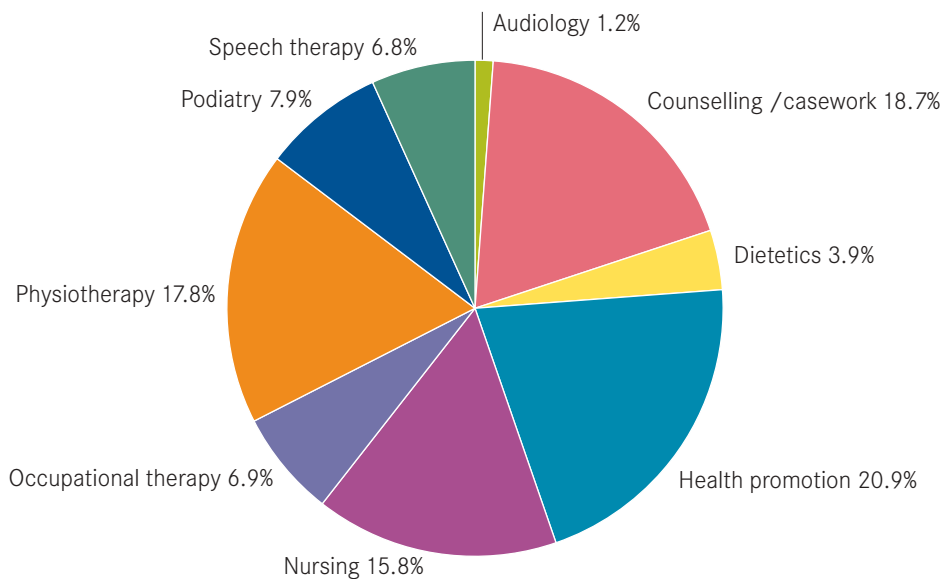
Figure 12: Loddon Mallee Region—Community and Women’s Health program—proportion of occasions of service by service type 2005–06



Data source: Agency Multi Purpose Report and Primary Care and Health Promotion Reports

Of the 136,621 occasions of service in Eastern Metropolitan Region, 20.9 per cent were delivered for health promotion, followed by counselling/casework 18.7 per cent.

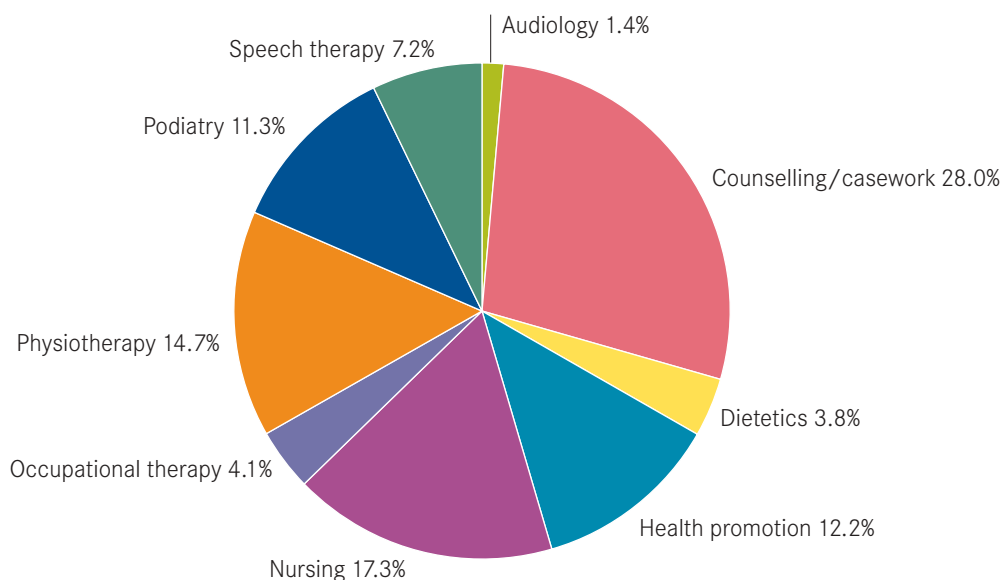
Figure 13: Eastern Metropolitan Region—Community and Women’s Health program—proportion of occasions of service by service type 2005–06



Data source: Agency Multi Purpose Report and Primary Care and Health Promotion Reports

Of the 281,128 occasions of service in North and West Metropolitan Region, 28 per cent were delivered for counselling/casework, followed by nursing 17.3 per cent.

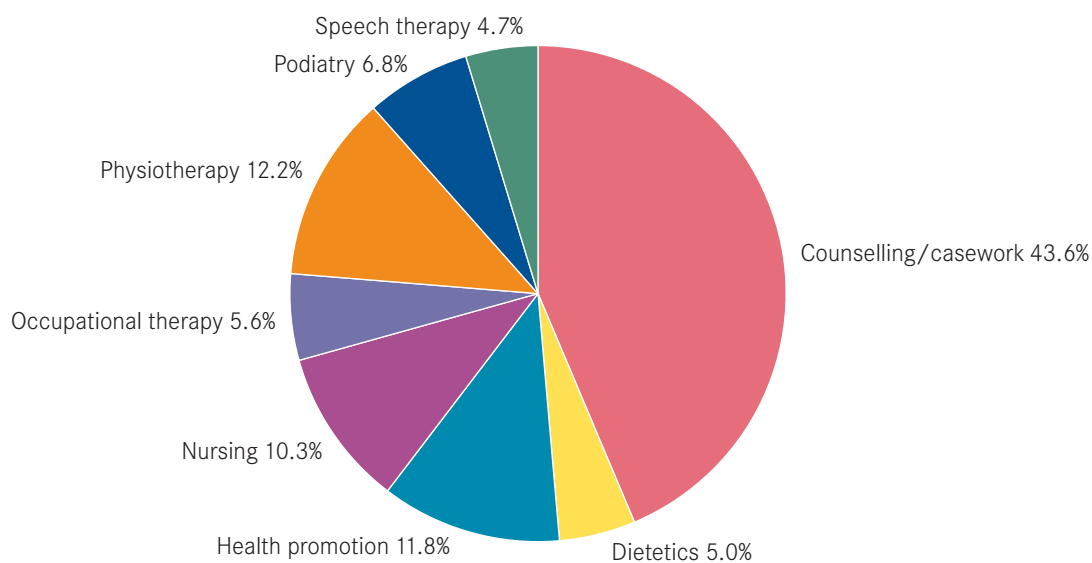
Figure 14: North and West Metropolitan Region—Community and Women’s Health program—proportion of occasions of service by service type 2005–06



Data source: Agency Multi Purpose Report and Primary Care and Health Promotion Reports

Of the 172,289 occasions of service in Southern Metropolitan Region, 43.6 per cent were delivered for counselling/casework, followed by physiotherapy 12.2 per cent.

Figure 15: Southern Metropolitan Region—Community and Women’s Health program—proportion of occasions of service by service type 2005–06

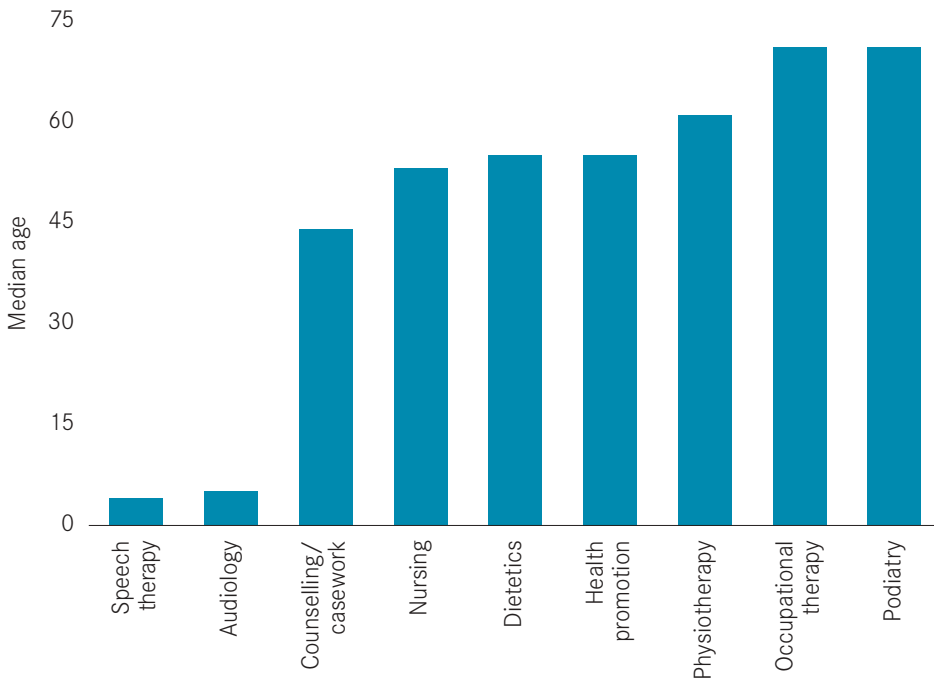


Data source: Agency Multi Purpose Report and Primary Care and Health Promotion Reports

Client demographics

Clients of podiatry and occupational therapy had the highest median age, both at 71 years of age.

Figure 16: Community and Women’s Health program—service use by median age and service type—statewide 2005–06

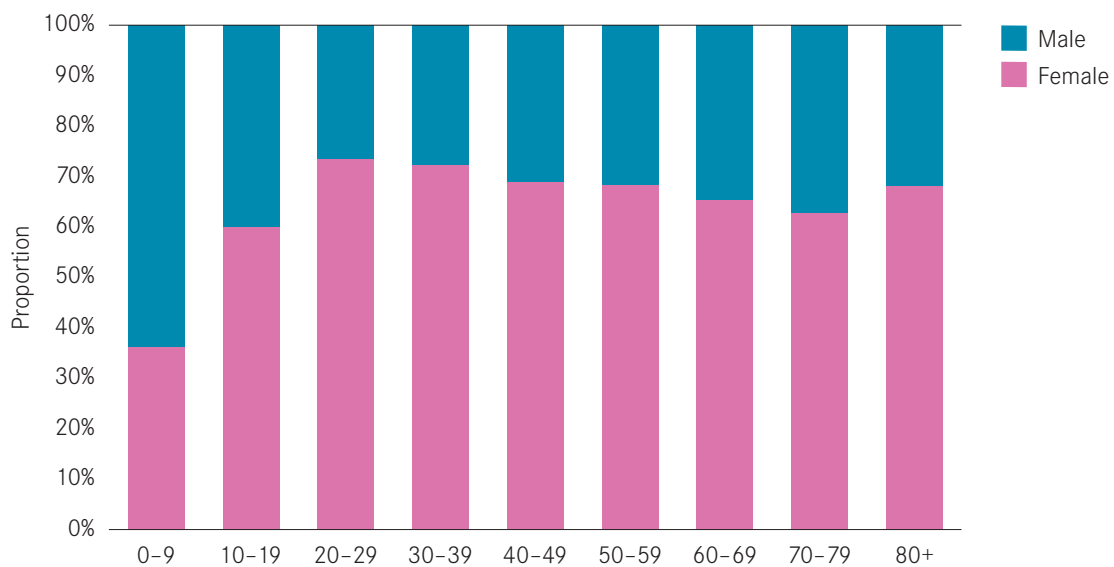


Data source: Agency Multi Purpose Report and Registered Clients Report (does not include data for agencies that report aggregate data only)

Sixty-four per cent of all clients were female.

Female clients were most strongly represented in the age groups: 20–29, 30–39 and 40–49.

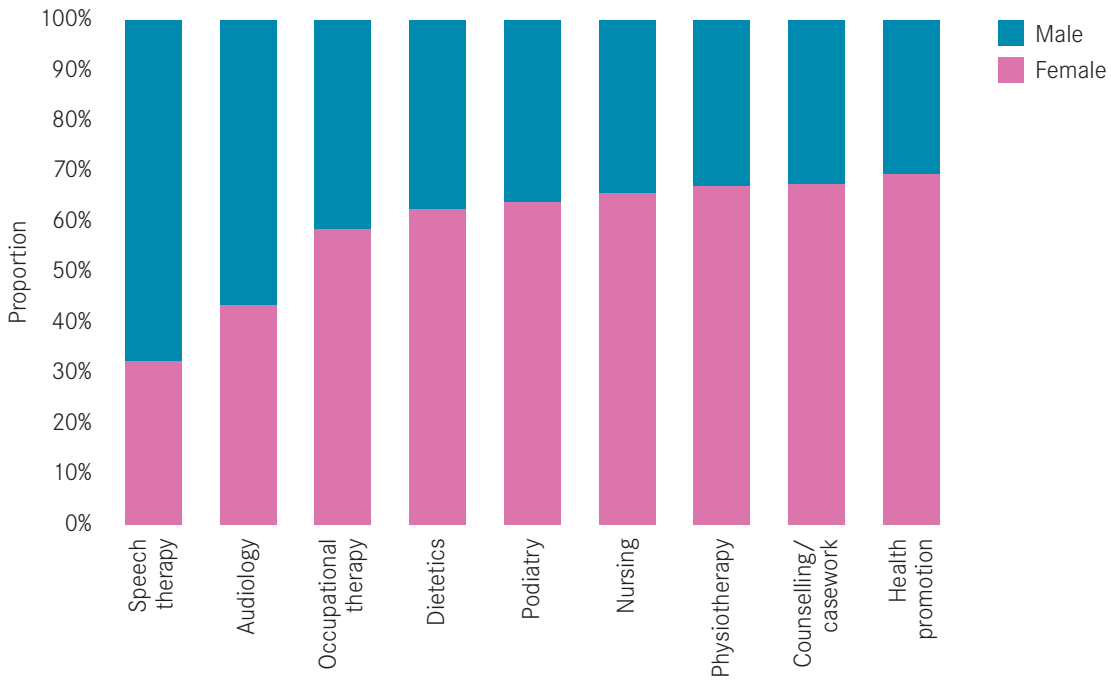
Figure 17: Community and Women’s Health program—proportion of clients by age group and gender—statewide 2005–06



Data source: Agency Multi Purpose Report and Registered Clients Report (does not include data for agencies that report aggregate data only)

Speech therapy had more male clients (67.5 per cent) among the various service types. Among the other service types, health promotion had the highest number of female clients (69.4 per cent).

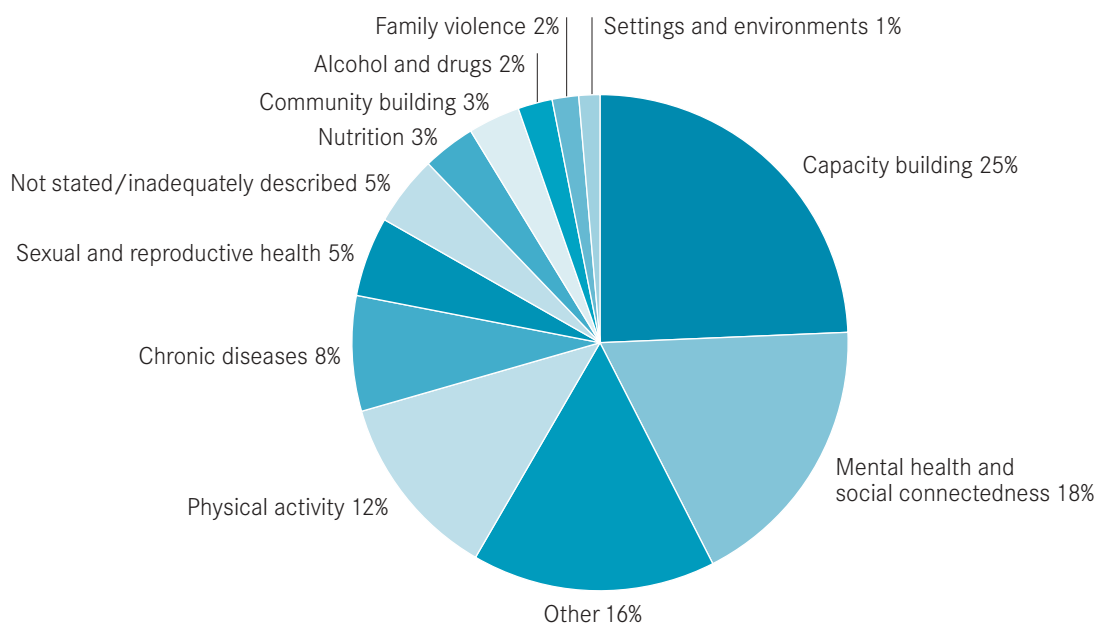
Figure 18: Community and Women’s Health program—proportion of clients by gender and service type—statewide 2005–06



Data source: Agency Multi Purpose Report and Registered Clients Report (does not include data for agencies that report aggregate data only)

Capacity building and mental health and social connectedness were the two top priorities in integrated health promotion priorities by service hours.

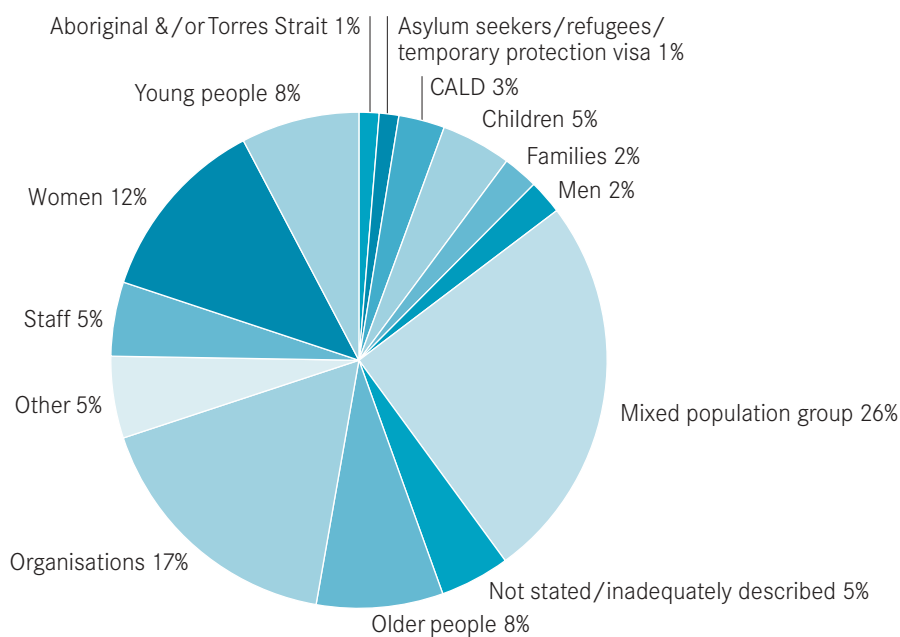
Figure 19: Community and Women’s Health program—integrated health promotion priorities by service hours—statewide 2005–06



Data Source: Primary Health Branch documents

Integrated health promotion targeted a range of population groups.

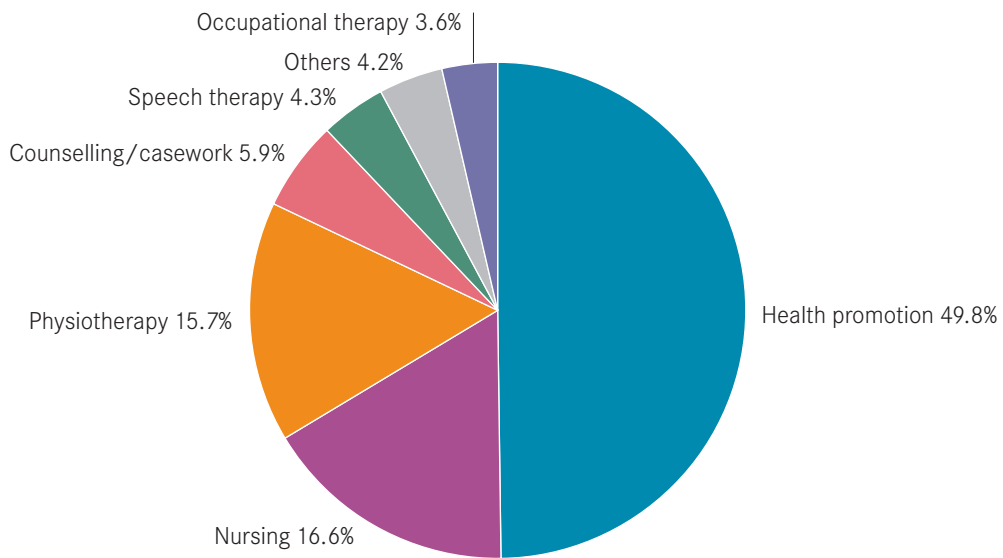
Figure 20: Community and Women’s Health program—integrated health promotion target population—statewide 2005–06



Data Source: Primary Health Branch documents

In 2005–06, there were 69,986 group sessions, an increase of 20.1 per cent from 2004–05 (55,511 sessions). Of these group sessions, 60.8 per cent were held in rural regions and 39.2 per cent in metropolitan regions. At the statewide level, group sessions for health promotion made up nearly 50 per cent of all sessions, followed by nursing 16.6 per cent.

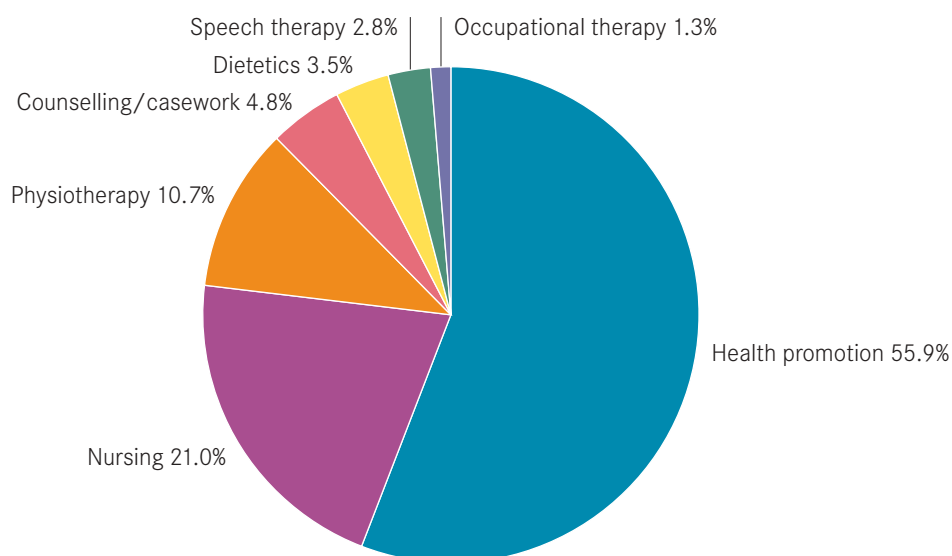
Figure 21: Community and Women’s Health program—composition of group sessions by service type—statewide 2005–06



Data source: Agency Multi Purpose Report and Primary Care and Health Promotion Reports

In rural regions, group sessions for health promotion made up nearly 56 per cent of all sessions, followed by nursing 21 per cent.

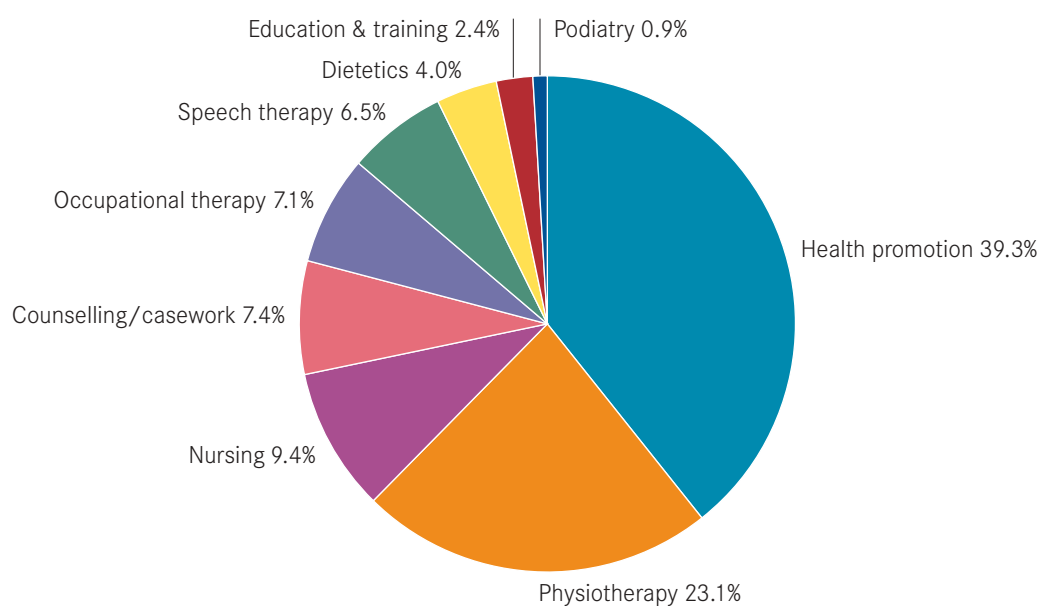
Figure 22: Community and Women's Health program—group sessions by service type—rural regions 2005–06



Data source: Agency Multi Purpose Report and Primary Care and Health Promotion Reports

In metropolitan regions, group sessions for health promotion made up nearly 40 per cent of all sessions, followed by physiotherapy 23 per cent.

Figure 23: Community and Women's Health program—group sessions by service type—metropolitan regions 2005–06



Data source: Agency Multi Purpose Report and Primary Care and Health Promotion Reports

Consumer opinion

The Australian Institute of Primary Care (AIPC) is undertaking the Primary Health Care Consumer Opinion Survey (PHCCOS) for the Primary Health Branch. The survey is being conducted over a two-year period (May 2005 to August 2007), with approximately half the agencies participating in Year 1. A number of agencies in the Year 2 group have begun their surveying. Stand-alone and integrated community health services are participating.

The survey instrument was developed and trialled by the AIPC for application in community health services. Its reliability and validity (including psychometric testing) has been established.

The PHCCOS covers three domains:

1. **Centre environment:** Includes accessibility of the centre, wait to get an appointment, physical comfort of the waiting room, information about services, time spent with the health professional, cost of the visit and treatment by reception staff.
2. **Service provision:** Includes 'aspects of the professional' (information provided, concern shown, opportunity to discuss problems, opportunity to make choices, skill of the professional and extent to which presenting problem was helped) and 'benefits from the visit' (degree to which the visit improved the client's understanding of the problem, and the degree to which the client is better able to manage the problem).
3. **Special needs:** Refers to the agency's responsiveness to language, cultural and disability requirements of clients.

The survey period in each agency is 12 weeks. Respondents comprise those who received a service(s) at a community health service (the majority) and those who received care in their homes. Surveys are available in 15 community languages. Clients are asked to participate in the survey as they come out of their appointment. The survey takes approximately 10 minutes to complete and all participants are provided with a reply-paid envelope.

When all valid surveys from a community health service have been received and results analysed by AIPC, a report is provided to the agency. The agency report is written with an 'improvement' rather than a 'performance' focus. This approach addresses the high levels of satisfaction generally associated with such surveys and it is a way of helping agencies set priorities for improvement by highlighting aspects of the agency with which clients were less than 'very' satisfied. Once agencies have analysed their report, they are expected to contact their regional office to discuss what they have learnt and how they plan to respond to the findings within their annual quality plans.

Participation rates and demographics of respondents

AIPC provided almost 17,000 survey forms to agencies participating in Year 1 of the PHCCOS. Just over 5,000 valid surveys (30 per cent) were returned to AIPC.

The major characteristics of Year 1 respondents were:

- Two-thirds were female and just over half were 60 years of age or older.
- An approximately equal number had attended the centre once or twice, three to five times and over five times.
- Less than 20 per cent were of cultural and linguistically diverse (CALD) backgrounds, with 15 per cent stating that they spoke a language other-than English at home.
- The majority who attended a centre used podiatry (19.8 per cent), physiotherapy (17.1 per cent), dental (12.4 per cent), counselling or social work (10.8 per cent).
- The majority who received care in the home used nursing (30.6 per cent), occupational therapy (28.4 per cent) and podiatry (11.3 per cent).

Principal results

Clients rated community health services and their service provision very highly: 91.4 per cent of respondents were either satisfied or very satisfied with centre environment and 92.6 per cent stated they were either satisfied or very satisfied with the service provision.

Of those who received care in their home, 91.6 per cent were satisfied or very satisfied with the model of care and 94.8 per cent were either satisfied or very satisfied with the service they received.

Centre environment: Greatest satisfaction was shown with the treatment provided by reception staff and the time available with the health professional. Highest levels of dissatisfaction were recorded for waiting times to get an appointment, comfort levels of the waiting rooms, cost of the service and information about centre services.

Respondents who received care in the home were most satisfied with the time spent with the professional and the cost of the service. Greatest dissatisfaction was recorded for the waiting time to get an appointment, cost of the visit and information about the services of the centre.

Service provision: Greatest satisfaction was recorded for the skill of the professional, the concern shown by the professional and the information provided by the professional. Areas in greatest need of improvement were the degree to which the visit helped the client manage the problem and the opportunity to make choices for managing the problem.

Respondents who received care in the home were most satisfied with the skill of the professional and the concern shown by the health professional. The areas of greatest dissatisfaction were the opportunity to talk about the problem, the opportunity to make choices for managing the problem and the degree to which the visit assisted the client to manage the problem.

Special needs: Community health services are considered highly responsive to people with special needs. Notwithstanding, the PHCCOS identified some areas for further improvement:

- Approximately 9 per cent of respondents who speak a language other than English stated they had problems during their visit to the centre.
- 20 per cent of respondents from CALD backgrounds claimed that the community health service was not sensitive to their background.
- Eight per cent of respondents with a physical disability experienced problems during their visit to the community health services.

Strategic developments

Primary Care Partnership strategy

The Primary Care Partnership (PCP) strategy is a major reform in the way primary care and community support services are delivered in Victoria. Thirty-one partnerships have formed comprising more than 800 agencies.

The strategy aims to improve the overall health and wellbeing of Victorians by:

- improving the experience and outcomes for people who use primary care services
- reducing the preventable use of hospital, medical and residential services through a greater emphasis on health promotion programs and by responding to the early signs of disease and/or people's need for support.

Integrated health promotion, service coordination and integrated chronic disease management are the major areas of primary health reform within the PCP strategy.

The Minister for Health and the Minister for Aged Care endorsed the PCP strategy as an ongoing funded component of the primary health system in Victoria. This endorsement is an acknowledgement of the excellent work conducted by PCPs over the last five years.

Integrated health promotion

PCPs' role is to facilitate change management through building capacity and strengthening partnerships around integrated health promotion.

Integrated health promotion aims to:

- reorient the primary health care system to be population focused and underpinned by the social model of health
- consolidate and enhance health promotion infrastructure and resources to reduce duplication and fragmentation of effort
- contribute to the health promotion evidence base for priority issues and population groups
- increase the potential for sectors other than health to be involved in quality health promotion
- maintain emphasis on collaborative catchment planning and focus on integrated priority areas.

Priority health and wellbeing topics

There were five key priority topics and one priority setting for health promotion for the period 2005–06. The priority topics were:

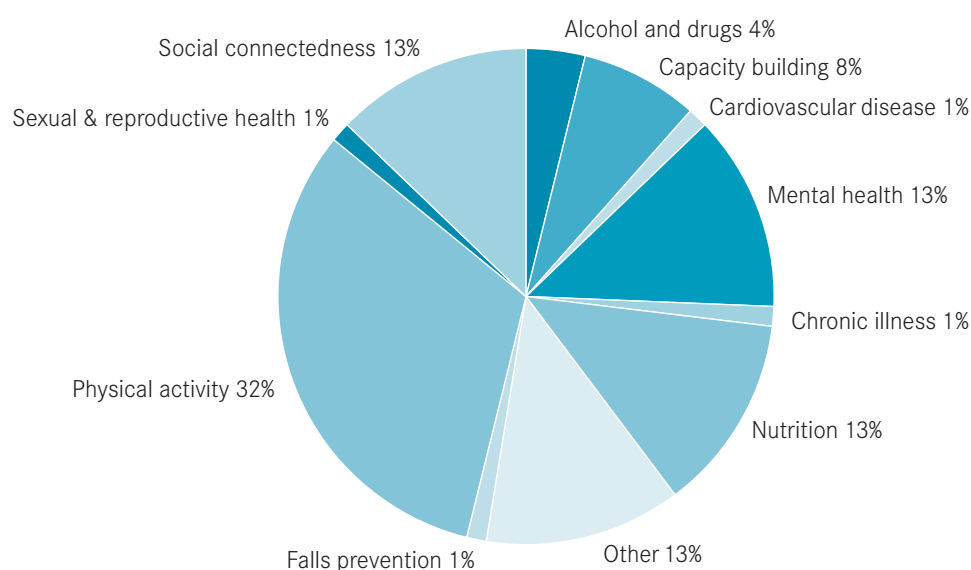
- physical activity
- food and nutrition
- mental wellbeing and social connectedness
- tobacco, alcohol and other drug issues
- healthy weight.

These five topics capture the most identified priorities in local needs assessment and in the majority of current PCP integrated health promotion activity. The priority setting is Neighbourhood Renewal sites where they exist in the PCP catchment.

Priorities in integrated health promotion plans

Each PCP is responsible for facilitating catchment planning for integrated health promotion. They produce catchment plans that specify key priorities for action. Of the 31 2005–06 community health plans that were implemented, 80 per cent gave priority to tackling physical activity, followed by 71 per cent for mental wellbeing and social connectedness, 55 per cent for others, 42 per cent for food and nutrition, and 10 per cent tobacco, alcohol and other drug issues.

Figure 24: Distribution of priority areas—integrated health promotion plans



Service coordination

Service coordination reform aims to place consumers at the centre of service delivery, ensuring that they have access to the services they need, opportunities for early intervention, health promotion and improved health outcomes. Service coordination is facilitated by PCPs where agencies come together to agree on how they will coordinate their services so that consumers experience a seamless continuum of care from a health system that works together.

The service coordination initiatives implemented by PCP member agencies aim to:

- improve the way consumers come in contact with the service system and the way their health and care needs are identified
- improve the way care is planned and managed
- improve the way consumer health and care information is shared between services
- minimise duplication of assessment
- minimise the need for consumers to ‘retell their story’.

An evaluation of PCPs by the Australian Institute of Primary Care conducted in October 2005 found that although the membership of PCPs varies across the state, PCP member agencies typically include local government, community health services, Divisions of General Practice, hospitals, aged care assessment services, district nursing and a range of other primary health and aged care service providers who have a role in service coordination and managing consumers with complex needs.

Better Access to Services (BATS)

BATS is a key policy document that describes the reasons why service coordination reform is being undertaken, the principles that guide service coordination, and the way to improve service coordination in Victoria.

The BATS framework provides a basis for service managers and practitioners to work together through PCPs to coordinate activities, develop consistent practices and define roles and responsibilities regarding consumers they have in common. Wherever possible, the BATS framework provides a basis to encourage common approaches across the state but allows flexibility for PCPs to develop local solutions where these are more appropriate.

Service Coordination Tool Templates

The SCTTs have been developed to support service coordination practice by assisting with identifying the initial needs of clients and providing a vehicle to collect and share core client information in a consistent way.

To support agency business and make the referral process easier for practitioners, the SCTTs were implemented in 30 different software applications used by service providers, including six popular GP clinical software applications. Service providers can use their software application to produce electronic copies of the SCTTs, which can be printed, faxed, saved and shared electronically within a secure environment.

Work has been undertaken to facilitate the use of the tools in an electronic environment. The development of a data dictionary and data model for the SCTTs and the inclusion of SCTTs in a number of key primary care and GP software products has enabled electronic transmission (e-referral) of the tools.

Revision of the Service Coordination Tool Templates

It is planned to regularly update the SCTTs to improve the content and format of the templates to better meet the needs of a variety of client groups. The first cycle of the revision of the tool templates commenced in March 2005 and the updated tool templates were released in March 2006. Major tasks of the revision included:

- gathering intelligence from the sector as to how the tool templates could be improved
- convening a steering committee with practitioner, department program and information management representation
- developing criteria to determine priority of changes
- testing of updated templates
- developing resources to support implementation of the revised SCTTs.

Suggestions as to how the tools could be improved were gathered through a statewide submission process in which more than 800 people provided 1,800 suggestions as to how the tool templates should be amended. Agreed criteria to determine the priority of the changes was applied to the suggestions and the high priority, short-term changes were actioned.

Following piloting in 22 agencies, the final version of the updated templates featured 110 changes from the original, including the development of two new templates, the Confidential Referral Cover Sheet and the Functional Assessment Summary.

The updated SCTTs and resources to support their implementation in client management systems software were released to vendors in March 2006. Resources include:

- *SCTT 2006 Data Model and Data Dictionary*
- *SCTT 2006 Messaging Implementers Specification*
- *SCTT 2006 Functional Specifications*

Other resources produced to assist practitioners in the use of the updated SCTT include:

- *SCTT 2006 User Guide*
- *SCTT 2006 Reference Guide*

In parallel with the SCTT revision, the GP version of the SCTT, the Victorian Statewide Referral Form, has been revised and updated in Medical Director software. A set of functional specifications for the inclusion of the Victorian Statewide Referral Form in other general practice software has also been produced.

Electronic referral and connectivity

During 2005–06, funding was provided from both the Primary Health and HACC branches to PCPs to develop and implement electronic referral using the SCTTs. Data has been collated from the final reports for the period to June 2006, which provides useful information to assist the roll out of additional funds planned for 2006–07.

Table 6 provides a basic overview of the information received from PCPs about the 2005–06 electronic referral.

Table 6: Statistical summary of the 2005–2006 PCP electronic referral project

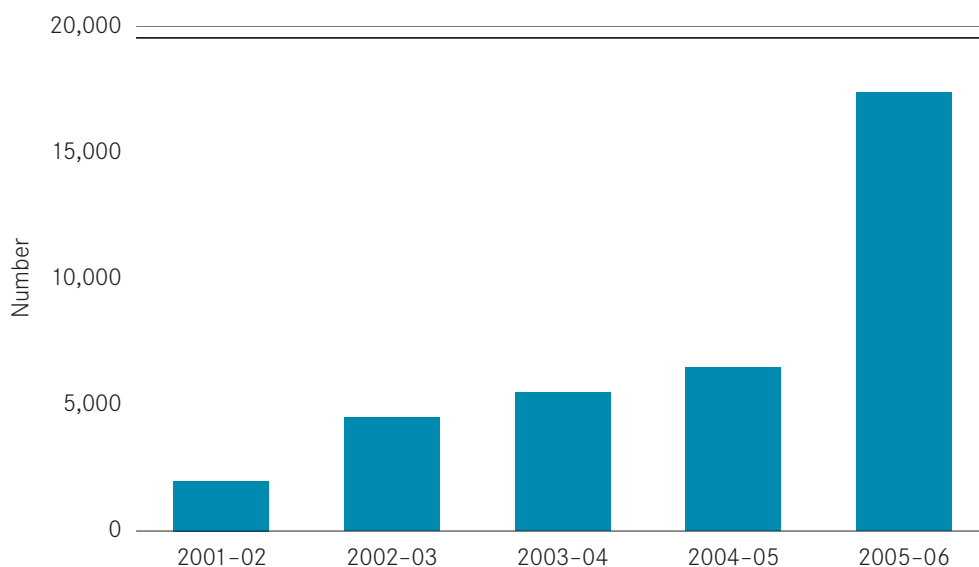
Results of PCP e-referral projects (a)	Total
Number of organisations/services listed that stated use of e-referral at 1 February 2005	172
Number of organisations/services listed that had e-referral infrastructure fully or partially installed at 1 February 2005	230
Number of participating organisations/services using e-referral or extended at 30 June 2006 (b)	291
Number of organisations/services listed that stated use of the Service Coordination Tool Templates and Service Coordination Practices, Protocols, Processes and Systems at 1 February 2005	533

Notes:

(a) This summary does not specify a range of other activities some PCPs undertook, such as development of e-referral policies.

(b) Figure based on participating organisations only and excludes Hume data as the region was in the process of selecting an e-referral product during the project period.

Electronic referral is gaining momentum. An investment in 2005–06 for electronic referral change management has resulted in an escalation in electronic referral and the engagement of a range of sectors including acute, mental health, disability, local government and community health.

Figure 25: Number of e-referrals 2001–02 to 2005–06

Since 2005, the number of referrals sent electronically across the state has increased by nearly 11,000. Because electronic referrals save the receiving agency up to 50 per cent of the time taken for registration and needs identification, this means that over 2005–06 there have been significant efficiency gains. It could mean up to 6,000 hours have been spent on service delivery rather than administration.

Building blocks for electronic referral

PCP member agencies and the department have worked hard to put in place the necessary building blocks to enable electronic referral to happen:

- All agencies have agreed to standard service coordination practices (such as referral standards, feedback requirements, consent). Recently they moved to one statewide approach (the upcoming Victorian Service Coordination Practice Manual).
- More than 500 agencies now use a single suite of tools (the SCTTs) to document consumer information, identify client need and provide quality referrals.
- The Department of Human Services has provided guides to software vendors that enable the effective and consistent deployment of the suite of tools in an electronic environment (such as a data dictionary, data standards).

Agencies are able to access information about other services quickly and effectively by using electronic service directory. The department has developed the *Human Services Directory* which will become the source of data for all service directories—this means agencies will only have to update information in one directory. The URL for this directory is <http://humanservicesdirectory.vic.gov.au/> or visit the Department of Human Services website at www.dhs.vic.gov.au.

General Practitioners in Community Health Services strategy 2004–08

The General Practitioners in Community Health Services strategy was launched in September 2004. The goal is to strengthen the interface between GPs and other primary health services.

The strategy reflects the government's commitment to strengthening the valuable role played by GPs who work in or with community health services. The strategy is a key element of delivering quality medical care through the Community Health policy.

The strategy recognises community health services as unique settings to deliver general medical services as well as tailored responses. The department supports the development of thriving community-based medical services that have the capacity to respond to the needs of the local community by delivering targeted, often resources intensive, medical services within the general practice.

The strategy has the potential to aid the health sector to increase, complement and strength practices, programs and relationships. It will assist coordination of an Australian Government funded activity (general practice through Medicare) in a state-funded setting.

This strategy has a budget of \$2 million per annum. Since funding was first available in 2004–05, a variety of projects have been supported ranging from systems enhancement to the establishment of new community health service GP clinics. These included a mix of one, two and three-year projects.

By the end of 2005–06, there was an increase of 8.36 GP FTE, 19 practice staff (for example, practice nurses and managers) and 190 new GP clinic hours. Ninety-six per cent of GP consultations were bulk billed.

In 2005–06, a range of initiatives were funded including:

- establishment of new general practices and models of care including outreach in rural areas
- three initiatives to model development of collaborative practice between Divisions of General Practice and community health services
- support for e-referral initiatives
- strategic development of the relationship between GPs and health service providers with Aboriginal and refugee clients.

Apart from the strategy, the branch has a range of initiatives that support GPs working in or with community health services. This includes:

- GP Small Grants
- Refugee Health Assessments
- AHPACC Partnerships
- Early Intervention in Chronic Disease teams
- service coordination reforms
- PCPs

References

Terms and definitions

Acronym/term	Description
Ambulatory care	Care that takes place as a day attendance at a health care facility or at the consumer's home. This umbrella term incorporates: primary, secondary and tertiary level services, services provided to individuals or populations, services provided on a same day basis and acute episodic or longitudinal care.
Audiology	To provide audiology services for the assessment, diagnosis, treatment and prevention of disorders of human hearing, including population/public health approach to targeted population groups—all performed by a suitably qualified person.
Casual client	Client who has brief interaction with service agencies.
Chronic and complex conditions	A chronic condition is continuous or persistent over an extended period of time and not easily or quickly resolved. Amongst Australia's national health priorities are chronic conditions that are our greatest burdens of disease: asthma, cancer, cardiovascular disease, diabetes mellitus, mental health conditions, arthritis and musculoskeletal conditions. A complex condition typically involves co-morbidities and psychosocial factors.
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).
Community health service	Agencies in receipt of Victorian Community Health program funding that also deliver wide range of other primary health and support services to meet local community needs. This definition includes community health centres and primary health units or divisions of rural and metropolitan health services.
Contact	One-to-one consultations with individual clients, includes case conferencing, secondary consultation and advocacy (excludes groups).
Counselling	Significant counselling and therapeutic activities, performed by suitably qualified persons, often includes practical assistance and advocacy. 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.
Department	The Department of Human Services
Dietetics	To provide nutritional support for individuals and groups in health and illness, including population/public health nutrition approach to targeted population groups—all performed by a suitably qualified person.
DHSV	Dental Health Services Victoria
FARREP	Family and Reproductive Rights Education Program
Government	The Victorian State Government (unless otherwise specified).
GP	General practitioner
Health	A complete state of physical, mental and social wellbeing, not merely the absence of disease or infirmity.

Acronym/term	Description
Health promotion	Health promotion is the process of enabling people to increase control over, and improve, their health. Health is seen as a resource for everyday life, not the objective of living. Health promotion is not just the responsibility of the health sector, but goes beyond healthy lifestyles to wellbeing. The fundamental conditions and resources needed for good health are peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity.
Health service	A publicly funded organisation providing health care. This includes hospitals, rehabilitation centres, aged care services, community health centres and primary care services.
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 invoice, this should be treated as separate direct services.
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.
Metropolitan Health and Aged Care Services Division	This Department of Human Services division is responsible for the full range of health and aged care services in metropolitan Melbourne. It also has statewide policy and program responsibility for acute, sub-acute, ambulance and mental health services.
Neighbourhood Renewal	Neighbourhood Renewal is a major State Government initiative aimed at tackling socioeconomic disadvantage in Victoria. Locations have been selected because of their relative disadvantage compared to other parts of Victoria and are generally where there are concentrations of public housing.
Nursing	Nursing services are provided by a suitably qualified person who is involved in the provision of clinical care, support and referrals to individuals and/or their carers and groups regarding a variety of medical, social and environmental issues.
Occasions of service	For the purpose of this document only, this refers to the total number of contacts and sessions.
Occupational therapy	The assessment and treatment of people with a temporary or permanent physical disability, including population/public health approaches to targeted population groups—all performed by a suitably qualified person.
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).
Physiotherapy	The assessment, diagnosis, treatment and prevention of disorders of human movement, including population/public health approaches to targeted population groups, with a special emphasis on the neurological, musculo-skeletal and cardiovascular systems—all performed by a suitable qualified person.
Podiatry	The diagnosis and treatment of ailments of abnormal conditions of the human foot, including population/public approaches to targeted population groups—all performed by a suitably qualified person.

Acronym/term	Description
Primary health care/ Primary care	The terms primary health care and primary care are sometimes used interchangeably in the literature, however, primary care is commonly associated with primary medical care. Primary medical care is a term used to specify the role of general practice within the primary care system. Other primary care providers include community health nurses, Aboriginal health workers, and allied health practitioners. (Specialist care, or tertiary services, may be provided by accident and emergency services, hospital wards, youth health or mental health services.) The broader term of primary health care is commonly used to describe the first level of the health system from sick care to the development of health, seeking to protect and promote the health of defined communities and to address individual and population health problems at an early stage.
Primary Care Partnership (PCP)	A group of primary care providers that have formed a voluntary alliance to work together to improve health and wellbeing in their local communities.
PCP strategy	Primary Care Partnership strategy. A strategy that aims to enable primary care services to achieve positive outcomes for consumers and deliver improved health and wellbeing for the community. This strategy provides a framework for improving the planning and delivery of primary care services and for ensuring they work effectively together.
Referral	The transmission (physically or by other means) of personal and/or health information relating to an individual from one service provider to another service provider with the individual's consent and for the purpose of care or treatment.
Refugee	According to the United Nations Convention (1951) and Protocol (1967) relating to the Status of Refugees, a refugee is defined as any person who: <p data-bbox="507 1238 1417 1444"><i>‘...owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence, is unable or, owing to such fear, is unwilling to return to it.’</i></p>
Registered client	Clients for whom service providers keep detailed demographic and service use information
Rural and Regional Health and Aged Care Services (RRHACS) Division	This Department of Human Services division is responsible for the full range of health and aged care services in rural and regional Victoria. It also has statewide policy and program responsibility for aged care, primary health, dental health and public health and drugs treatment services.
Service coordination	Service coordination aims to place consumers at the centre of service delivery, ensuring that they have access to the services they need, opportunities for early intervention and health promotion and improved health outcomes.
Service planning	Planning that is undertaken periodically with the aim of providing an effective and efficient health service which meets the needs of the catchment population.

Acronym/term	Description
Social model of health	A conceptual framework within which improvements in health and wellbeing are achieved by directing effort towards addressing the social and environmental determinants of health, in tandem with biological and medical factors.
Speech therapy	The assessment, diagnosis and treatment of individuals with speech disorders, eating and drinking difficulties and swallowing difficulties, including population/public health approaches to targeted population groups—all performed by a suitably qualified person.
Visit	For the purpose of this report, a dental visit is an attendance to a dental service for assessment and treatment

Independently managed (stand-alone) community health services as declared under the *Health Services Act 1988*

Of Victoria's 100 community health services, 39 are independently managed or 'stand-alone' community health centres as declared under the *Health Services Act 1988*. The others are larger health services that provide community health as one component, and a small number of non-government organisations.

The following is a list of these independently managed CHSs.

Region	Name of community health service
Barwon-South Western	Bellarine Community Health
Eastern Metropolitan	Eastern Access Community Health
Eastern Metropolitan	Inner East Community Health Service
Eastern Metropolitan	Knox Community Health Service
Eastern Metropolitan	Manningham Community Health Service
Eastern Metropolitan	MonashLink Community Health Service
Eastern Metropolitan	Ranges Community Health Service
Eastern Metropolitan	Whitehorse Community Health Service
Gippsland	Bass Coast Community Health Service
Gippsland	Ensay Community Health Centre
Gippsland	Lakes Entrance Community Health Centre
Gippsland	Latrobe Community Health Service
Gippsland	Nowa Nowa Community Health Centre
Grampians	Ballarat Community Health Centre
Grampians	Grampians Community Health Centre
Hume	Goulburn Valley Community Health Service
Hume	Mitchell Community Health Services
Hume	Ovens and King Community Health Service
Hume	Upper Hume Community Health Service
Loddon Mallee	Bendigo Community Health Services
Loddon Mallee	Castlemaine & District Community Health Service (CHIRP)
Loddon Mallee	Cobaw Community Health Service
Loddon Mallee	Northern District Community Health Service
Loddon Mallee	Sunraysia Community Health Services

Region	Name of community health service
North and West Metropolitan	Banyule Community Health Service
North and West Metropolitan	Darebin Community Health Service
North and West Metropolitan	Dianella Community Health
North and West Metropolitan	Doutta Galla Community Health Service
North and West Metropolitan	ISIS Primary Care
North and West Metropolitan	Moreland Community Health Service
North and West Metropolitan	Nillumbik Community Health Service
North and West Metropolitan	North Richmond Community Health Centre
North and West Metropolitan	North Yarra Community Health
North and West Metropolitan	Plenty Valley Community Health Services
North and West Metropolitan	Sunbury Community Health Centre
Southern Metropolitan	Bentleigh Bayside Community Health Service
Southern Metropolitan	Central Bayside Community Health Services
Southern Metropolitan	Inner South Community Health Service
Southern Metropolitan	Peninsula Community Health Service

Primary Care Partnerships

There are 31 PCPs, comprising 800 services, across Victoria. Details of these PCPs can be found at:
<http://www.health.vic.gov.au/pcps/webpages/index.htm>

PCPs in rural regions

Barwon-South Western Region

Southern Grampians—Glenelg PCP
South West PCP
Barwon PCP

Grampians Region

Wimmera PCP
Grampians Pyrenees PCP
Central Highlands PCP

Loddon Mallee Region

Northern Mallee PCP
Southern Mallee PCP
Bendigo-Loddon PCP
Campaspe PCP
Central Victorian Health Alliance

Gippsland Region

East Gippsland PCP
Wellington PCP
Central West Gippsland PCP
South Coast Health Services Consortium PCP

Hume Region

Lower Hume PCP
Goulburn Valley PCP
Central Hume PCP
Upper Hume PCP

PCPs in metropolitan regions

Northern and West Metropolitan Region

Hume-Moreland PCP

Banyule-Nillumbik PCP

North Central Metropolitan PCP

Moonee Valley—Melbourne PCP

Westbay PCP

Brimbank-Melton PCP

Eastern Metropolitan Region

Inner East PCP

Outer East Health and Community Support Alliance

Southern Metropolitan Region

Inner South East Partnership in Community and Health

Kingston-Bayside PCP

South East PCP

Frankston-Mornington Peninsula PCP

