

Primary Health Report

Primary Health Branch

2006-07

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Director's foreword

I am pleased to present the *Primary Health Report 2006–07*. The Primary Health Branch is responsible for statewide policy development, planning, funding and monitoring of primary health programs and initiatives. Its vision is to improve the health and wellbeing of Victorians, particularly those with or at risk of poorer health status, by developing strong, effective and modern primary health care services as part of Victoria's health care system.

This report provides an overview of activity funded by the Primary Health Branch during 2006–07. It includes strategies and descriptions of Primary Health Branch services.

During 2006–07, primary health programs were developed and strengthened. NURSE-ON-CALL had its first full year of operation since its launch in March 2006. Trials of the *Care in Your Community* planning framework for integrated ambulatory health care were undertaken. The Primary Care Partnerships Strategy was expanded to include integrated chronic disease management, new service coordination tools and health promotion activities.

Significantly, the Dental Health Policy *Improving Victoria's oral health* was launched at the very end of the financial year. The document sets the direction for an integrated area based model of dental services across the state as well as integrating dental services with other services within Community Health Services. The policy also supports the vision of oral health as an integral part of health promotion.

Other branch activity such as the Aboriginal Health Promotion and Chronic Care Partnership and expansion of the Early Intervention in Chronic Disease program move the sector towards achieving our vision.

On behalf of the branch, I thank those people who are delivering Victoria's primary health care services. The activity in 2006–07 provides a basis to meet the future challenges faced by the Victorian health system.



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About the Primary Health Branch

The Primary Health Branch's vision is to improve the health and wellbeing of Victorians, particularly those with or at risk of poorer health status, by developing strong, effective and modern primary health care services as part of Victoria's health care system. During the 2006–07 year, the branch had an output budget of approximately \$308 million.

The Primary Health Branch is responsible for:

- State funded primary and community health services including Community Health, Dental Health, Women's Health and Health Promotion;
- Liaison with the Commonwealth Government and General Practice to develop a coordinated and effective primary health care system;
- Strategies that improve the integration of the Primary Health Care sector, such as the Primary Care Partnership Strategy, and improve the interface between the Primary Health Care sector and the Acute Health Care sector—such as working closely with the Hospital Admission Risk Program;
- Developing the capacity of the primary health sector to respond to chronic disease; and
- Facilitating, together with Metropolitan Health & Aged Care Services, *Care in your Community*, the statewide ambulatory care framework.

At the highest level, the work of the Primary Health Branch is guided by two Victorian Government policies: *Growing Victoria Together* and *A Fairer Victoria*. *Growing Victoria Together* commits the Victorian Government to high quality, accessible health and community services. *A Fairer Victoria* establishes a framework to address disadvantage by developing and implementing innovative approaches to service delivery.

At the health policy level, four policy documents drive the development of primary health care services: *Care in your community*, *Community Health Services—creating a healthier Victoria*, *Primary Care Partnerships Strategy* and *Improving Victoria's oral health*.

Figure 1: Shows the relationship between key policies guiding Primary Health care in Victoria.



The Year in Review

Primary Health Integration and Coordination Strategies

Care in Your Community

Care in your community is a 10-year vision to provide a modern, integrated and person-centred health system in Victoria. This initiative aims to reduce the need for inpatient care and improve the health outcomes of Victorians.

In 2006–07, trials of integrated area-based ambulatory care health service planning were established in three sites: Gippsland (Whole Region), Eastern Metropolitan Region (Outer-East) and Southern Metropolitan Region (South-East). Planning networks were comprised of local and regional service providers.

The trials were supported and evaluated by a consultancy. The trials commenced in and will be completed by the end of July 2007. Outcomes will inform further development of the *Care in Your Community* initiative.

General Practitioners in Community Health Services Strategy 2004–08

The General Practitioners in Community Health Services strategy is a four year strategy which commenced in September 2004. Its aims are to:

- improve access to general practice, particularly for Victorians experiencing difficulty accessing a GP
- generate genuine service integration and coordination between GPs and Community Health Services (CHS)
- improve workforce capacity of CHS clinical teams.

The strategy reflects the government's commitment to strengthening the interface between GPs and community health services to improve access and continuity of care, particularly for Victorians from disadvantaged communities. The strategy recognises the valuable role played by GPs who work in or with community health services and the importance of primary health providers developing strong partnerships to deliver coordinated multidisciplinary care to those with complex and chronic conditions.

This strategy has a budget of \$2 million per annum. Since its inception, two major funding rounds have been conducted as part of the Strategy—2004–05 and 2006–08. Through these funding rounds, a total of 32 major projects have been funded across metropolitan and rural Victoria, ranging from the establishment or expansion of community health GP clinics to systems development and care coordination between general practice and community health. It is conservatively estimated that the funding will have enabled:

- The recruitment of approximately 15+ GPs and over 30 clinic support staff including practice managers, practice nurses, IT support staff and diabetes educators, and
- An increased number of bulk-billed medical consultations.

In addition to the major funded projects, a number of general practice-related initiatives have been supported through the Strategy. These initiatives include several rounds of the GP Integration Small Grants Program, two Statewide Support Projects, general practice integration in the Aboriginal Health Promotion and Chronic Care (AHPACC) partnerships, service coordination to support refugee health, Techno Refresh and eReferral. These general practice-related initiatives have added value to existing strategies being implemented through the Branch.

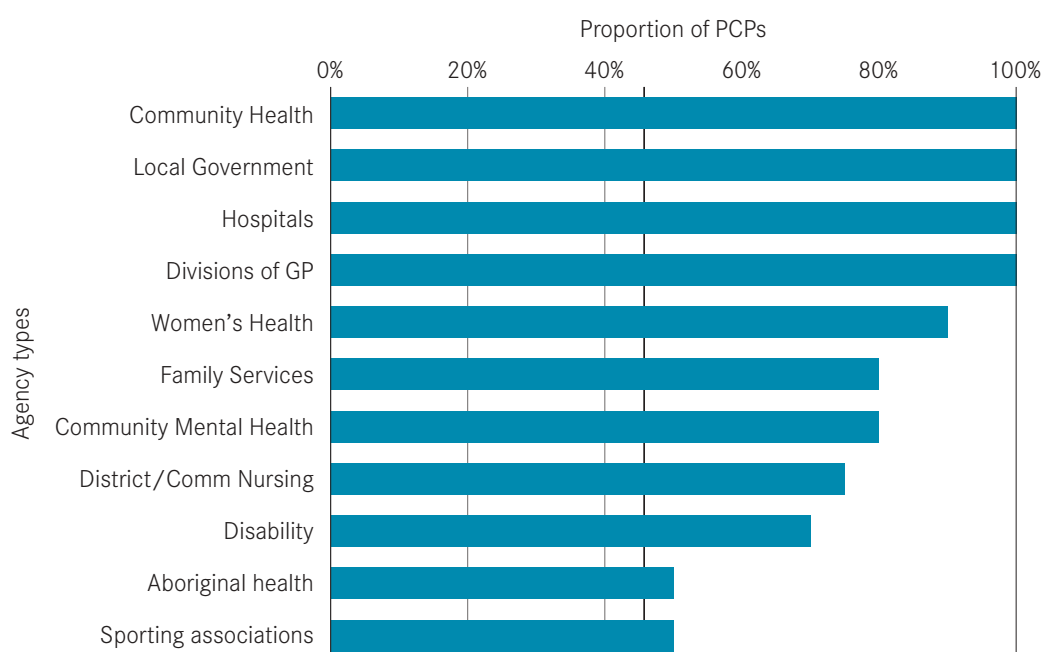
Primary Care Partnerships Strategy

The Primary Care Partnerships strategy 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.

A primary care partnership is a group of primary care providers that have formed a voluntary alliance to work together to improve health and wellbeing in their local communities. The 31 Primary Care Partnerships (PCPs) across the state are made up of a diverse range of member agencies including hospitals, community health services, local government and divisions of general practice as core members.

Figure 2 shows the level of representation of various organisations on PCPs.

Figure 2: Membership of PCPs



The Primary Care Partnership Strategy provides a platform for many other developments in the Primary Health Sector. During the 2006–07 year, these developments include:

- Service Coordination
- Integrated Chronic Disease Management
- Integrated Health Promotion

Details of these 2006–07 PCP-led developments follow.

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:

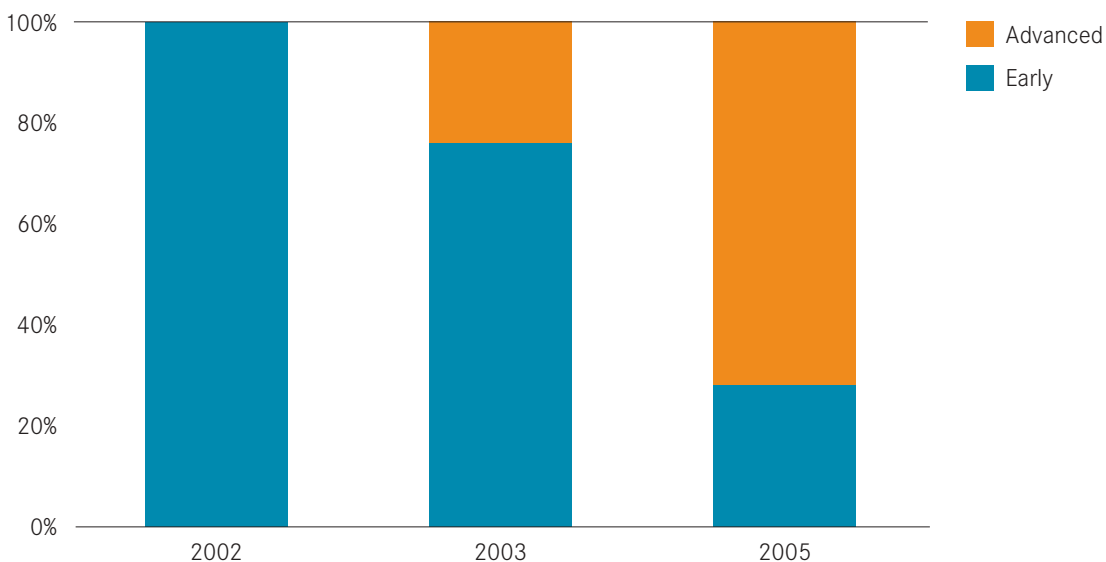
- Improve the way consumers come in contact with the service system and the way their health and care needs are identified
- Improve the way care is planned and managed
- Improve the way consumer health and care information is shared between services
- Minimise duplication of assessment
- Minimise the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

During 2006–07, the following activities in the area of service coordination progressed: Evaluation, Service Coordination Tool Revision, Care Planning Project, Electronic Referral and Connectivity.

Evaluation

The third in a series of evaluations of the Primary Care Partnership Strategy was completed by the Australian Institute of Primary Care in 2006. The evaluation found that the majority of Primary Care Partnerships were well-advanced in their Service Coordination activities (Refer Figure 3), including: consistent approaches to practice; agreements on client information sharing and information management; improvement in service planning and coordination.

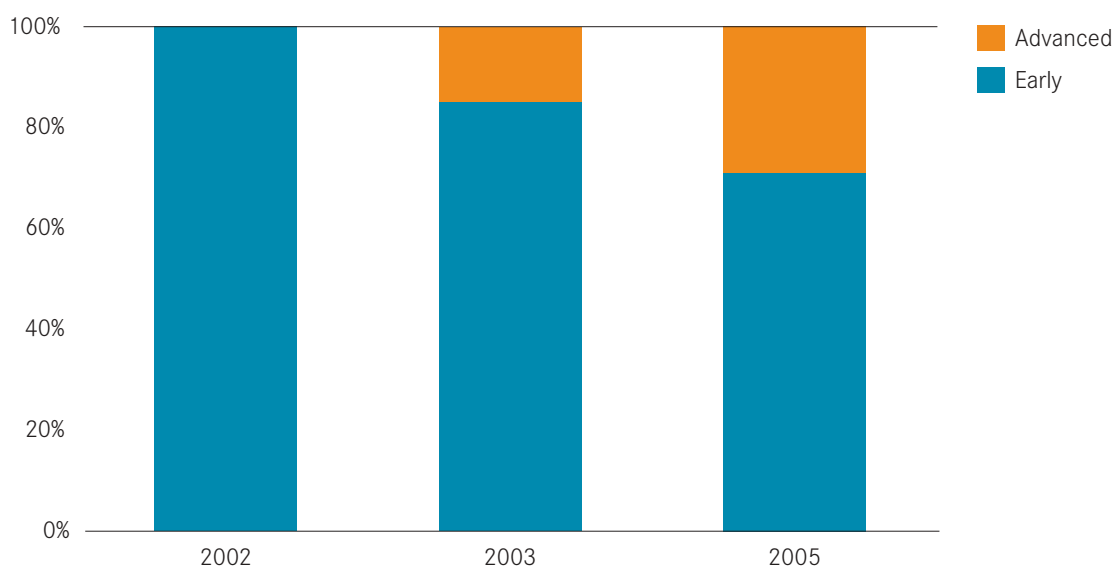
Figure 3: Phase of Implementation of a consistent approach to Service Coordination (initial contact, initial needs identification & care planning)



Key findings included:

- In agencies where implementation of Service Coordination was more progressed, consumers were more likely to report frequent positive experiences of information sharing between agencies and more likely to view the agency as accessible and convenient with information about the services and appointments available for consumers.
- The rate of having care plans among consumers with complex needs (who had visited more than three services, making more than 10 visits in the past three months) had increased from 46 per cent in 2002, 49 per cent in 2003 to 58 per cent in 2005. This demonstrates a positive trend for care planning for appropriate consumers.
- Gradual progress is being made to improve timely and comprehensive formal and informal communication between general practitioners and other service providers (Refer Figure 4)

Figure 4: Communication and feedback between GPs and other service providers



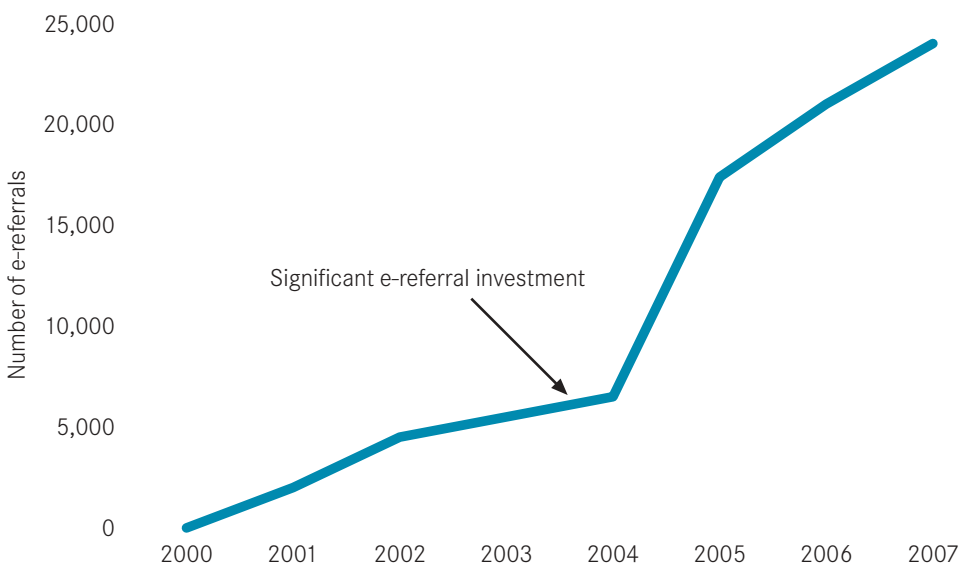
Service Coordination Tool Templates revision

The second cycle of the Service Coordination Tool Templates (SCTT) revision commenced in December 2006. The revised SCTT will be released to agencies on 1 July 2009. The aim of each revision is to ensure that the SCTT continues to meet the needs of new consumer groups and practitioners. This revision involves a broader range of stakeholders within DHS and increased engagement of general practice in the revision. The supporting resources of the SCTT will also be revised to reflect the changes and support the implementation in client management software systems

E-referral

During 2006–07, further funding was provided to PCPs to progress the implementation of electronic referral using change management and the SCTT suite of tools. This 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. Data collected at the end of June 2007 again shows promising growth in electronic referral across the state.

Figure 5: Statewide E-referrals



Agencies are able to access information about other services quickly and effectively by using an electronic service directory. The department has developed the Human Services Directory which will become the source of data for all service directories meaning that information only has to be updated in one directory. This can be found at <http://humanservicesdirectory.vic.gov.au/>

Victorian Service Coordination Practice Manual

During 2006–07, the Primary Care Partnership Chairs Working Group led a project funded by the Primary Health Branch to move Service Coordination practices from a local to a statewide approach. The resulting product, the *Victorian Service Coordination Practice Manual*, defines the practices, processes, protocols and systems which support Service Coordination across Victoria. The manual represents agreement by over 800 agencies in Victoria about how they will work together for the benefit of consumers.

Care planning project

The Service Coordination Plan/Care Planning Project commenced in early 2007. The project includes mapping of inter-agency care planning work across Victoria, identifying models and resources to support improvements in practice and revision of the SCTT Service Coordination Plan. An advisory group has been established with representatives from: consumers, carers, General Practice Divisions Victoria, community health, Hospital Admissions Risk Program, post acute care services, Primary Care Partnerships staff and a broad range of DHS program areas (including: Community and Women’s Health, Drugs Policy and Services, Aged Care, Early Years Services, Mental Health, Outpatient Services, Continuing Care, Disability, Public Housing and Community Building and Housing and Sector Development). A website has been established to support knowledge sharing on care planning.

Integrated Chronic Disease Management

PCPs have broadened their scope over the past six years, collaborating with the acute sector around Hospital Admission Risk Program—Chronic Disease Management and participating in a range of chronic disease initiatives.

Integrated Chronic Disease Management (ICDM) funding of \$4.15 million over 4 years has been allocated to PCPs to improve communication, referral and care planning between agencies in line with the Wagner Model. Activities focus on facilitating service system integration and change management.

ICDM is now a key deliverable for all PCPs. The challenge is to better coordinate chronic disease care across service providers/agencies over time and through the different stages of disease progression for the population whose care needs are not yet highly complex. The funding acknowledges that all PCPs have an important role to play in bringing agencies together to develop systems that support a coordinated approach to the planning and delivery of services for clients with chronic disease.

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 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.

Health Promotion Priority Setting

Each PCP is encouraged to tailor their Community Health Plan to suit issues relevant to their geographic location.

PCPs work together with their members to achieve mutually beneficial outcomes for the community. During 2006–07, the following are the overall state health promotion priorities as determined by each individual PCP:

1. Promoting physical activity and active communities
2. Promoting accessible and nutritious food
3. Promoting mental health and wellbeing
4. Reducing tobacco-related harm
5. Reducing and minimising harm from alcohol and other drugs
6. Safe environments to prevent unintentional injury
7. Sexual and reproductive health.

Neighbourhood Renewal sites were also confirmed as one of the priority settings for health promotion practice from 2007.

In addition to core PCP funding for integrated health promotion, other initiatives funded in 2006–07 include:

- *Go for your life* community projects to tackle obesity—\$3.6 million over 3 years for six new community 'Go for your life' initiatives delivered through PCPs to combat obesity by increasing physical activity and promoting healthy eating for children, families and older Victorians. Funded by Department of Victorian Communities.
- *Go for your life* walk together grants—\$360,000 for 12 PCPs over 12 months to establish and maintain sustainable walking groups in Victoria. Funded by Department of Victorian Communities.
- *Go for your life* fruit and veg for life—local action—\$180,000 for three PCPs to deliver local intervention to increase consumption of fruit and vegetables in local catchments. Involves building on established DHS resources and establishment of a coordinating hub at statewide level.

Primary Health Services

Aboriginal Health Promotion and Chronic Care Partnership

The Aboriginal Health Promotion and Chronic Care (AHPACC) Partnership program is developing a new model of primary health care to prevent and manage chronic disease in Aboriginal communities in nine geographical areas across Victoria. The program is supported by Victorian Aboriginal Community Controlled Health Organisation and the Primary Health Branch.

Since 2005, the Government has invested \$1.7 million per year toward AHPACC. In total, \$7.06 million over 4 years has been committed.

The vision for the AHPACC Partnership is that:

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 which endeavours to achieve a quality of life for Aboriginal people, equal with all other Victorians.

The AHPACC Partnership program supports Aboriginal Community Controlled Organisations, community health services and other key partners such as Divisions of General Practice, to work in partnership to improve health outcomes for Aboriginal Victorians with, or at risk of, chronic disease. Workforce development is another focus of the AHPACC program. A significant development in the first year has been the recruitment and training of 20 AHPACC workers, 15 of whom are Indigenous. Of this group, 10 Aboriginal and 2 non-Aboriginal workers completed the Health Promotion Short course conducted by the Victorian Aboriginal Community Controlled Health Organisation.

Examples from local partnerships

Several AHPACC partnerships have developed strategies and opportunities for more collaborative arrangements for workers, management, and Board members. For example, the AHPACC Partnership of Mildura Aboriginal Co-operative and Sunraysia Community Health Service has developed and implemented a range of targeted strategies to consolidate and strengthen the partnership, including:

- Management representation on Northern Mallee Chronic Disease Reference Group.
- Artwork commissioned by local Aboriginal artist, depicting the collaboration between the two health services. The completed work hangs in Sunraysia Community Health Services reception, a copy of original design to be used on AHPACC stationery by both the Mildura Aboriginal Co-operative and AHPACC.
- Sunraysia Community Health Services AHPACC worker working very closely with Mildura Aboriginal Co-operative

In 2006–07, 783 hours of primary health services and 1283 hours of health promotion were provided through the AHPACC program.

Child Health Teams Initiative

Funded from 2006–07, the whole of Government *Growing Communities Thriving Children* initiative aims to address the infrastructure and access issues evidenced particularly in the growth corridors and the level of disadvantage for families in the nine council areas situated at the interface between urban and rural settings. These areas include the City of Wyndham, the Shire of Melton, the City of Hume, the City of Whittlesea, the Shire of Nillumbik, the Shire of Yarra Ranges, the Shire of Cardinia, the City of Casey and the Shire of Mornington Peninsula.

One component of the *Growing Communities Thriving Children* initiative extends child health teams in the nine interface councils and three additional areas where social disadvantage and high populations of children occur (Greater Dandenong, Maroondah, Frankston). Funding was provided to support community based early intervention services and targeted health promotion for children experiencing developmental delays, behavioural issues or other health conditions.

Funding provides for the recruitment of allied health professionals and support staff to complement an existing team or to establish a new child health team. Implementation commenced in early 2007. CHSs have developed child health team implementation plans, undertaken recruitment and are now providing additional service delivery through group based programs, health promotion activity and individual care.

Community Health Program

The Community Health Program funds over 100 agencies to deliver a range of community based health services across Victoria. Community Health Services (CHSs) are located in every local government area in Victoria and are active participants in, and contributors to their local communities. The services provided by the CHSs include:

- Health promotion
- Prevention and early identification;
- Assessment, therapy and ongoing care (provided by a range of health professionals such as physiotherapists occupational therapists, speech therapists, nurses and counselors); and
- Coordinating care for clients with multiple or complex health issues.

The Community Health Program also funds 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.

Demand Management Strategy

The *Waiting time measurement within Community Health Services Practice Guidelines* (July 2006) describes a consistent standardised approach to measuring demand for CHSs. Measurements are taken throughout the client journey through a CHS to identify the times between key components of service provision.

A suite of Priority Tools for individual disciplines and a Generic Priority Tool applicable to all CHS clients has been developed in consultation with clinical working groups. The Priority Tools are designed to identify people that require a priority for service due to their population characteristics. This includes groups that are known to have poor health status, disadvantaged groups and those who are at risk. These tools can be applied to all clients accessing the CHS.

17 CHSs received non-recurrent funding to implement strategies and provide additional services designed to reduce waiting lists and waiting times. Across all the projects a total reduction in waiting times from 2,500 days to 773 days was achieved. This is an average reduction from 147 days to 45 days representing an overall reduction of 69 per cent. The number of clients on the waiting lists was reduced was from 2,126 to 820 in total. Across the seventeen projects this is an average reduction from 125 to 48 clients representing an overall reduction of 61 per cent.

Service Coordination

A Service Coordination industry consultant was employed between February 2006 and 2007 to further embed Service Coordination principles into practice within CHSs. The consultant worked directly with CHSs to progress this work at an agency level, and developed *Service Access Models: A Way Forward Resource Guide for Community Health Services* to ensure all CHSs have access to this information.

Community Health Services Profiles

The *Profile of Community Health Services across Victoria 2006* brings together a range of information about individual agencies and is available at:

http://www.health.vic.gov.au/communityhealth/service_provider/community_health_directory.htm.

The profile is a useful service planning and information resource for DHS program areas, DHS regions and CHSs.

Clinical Governance

The Victorian Healthcare Association was funded to work with CHSs to develop clinical governance capacity. Major outcomes in 2006–07 included:

- Clinical Risk Management Framework;
- Board of Management Clinical Governance Reporting Guidelines;
- Scope of Practice and Credentialling: a Literature Review and a Generic Primary Health Framework;
- Clinical Governance Survey that identified strong awareness of clinical governance in sector and the need to develop more effective systems; and
- Clinical Governance Education.

Further information can be found on the VHA website www.vha.org.au

Primary Health Care Consumer Opinion Survey

Between 2005–06 and 2006–07 all agencies in receipt of Community and Women’s Health and Dental Health funding participated in the Primary Health Care Consumer Opinion Survey. The survey provided agencies with a validated instrument and data, an opportunity to benchmark results, and more focused opportunities to improve programs and services. The survey results are available at <http://www.latrobe.edu.au/aipc/projects/phccos/pdf/about.pdf>

Counselling in Community Health Services

Training

In 2006–07, a three year agreement began with The Bouverie Centre at La Trobe University to conduct the Single Session Work (SSW) Implementation Project. This project provides additional training places each year in SSW and individual consultations and support to CHSs as required to fully implement a SSW approach.

The SSW Implementation Project has included setting up clinical support networks to sustain good practice. The networks were broadened to include two other topic areas that were the focus of training in 2006–07:

- Training CHS counsellors in Family Therapy skills to increase the number of families offered counselling.
- Training in the provision of clinical supervision to senior CHS counsellors to help CHSs meet their clinical governance obligations.
- A comprehensive evaluation of the SSW Implementation Project is being conducted with the final report due in February 2008. The evaluation will identify factors that affected the implementation of a SSW counselling framework and sustained practice change. A preliminary report indicated that a crucial supporting factor is that Intake Workers understand what SSW is and are familiar with the process and also that Managers have an understanding of the SSW Framework.

Trial of new CHS counselling guidelines

Fifteen CHSs received grants of \$15,000 to trial implementation of new CHS counselling guidelines. Feedback received will inform the development of the final guidelines.

Support for Community Mental Health services

In 2006–07, a recurrent amount of \$725,000 (\$500K from Mental Health Branch and \$225K from Primary Health Branch) was provided to 19 CHSs to support increased CHS counselling services for people with high prevalence disorders.

Community Health Teaching and Research Project

The Community Health Teaching and Research Project was established to develop an organised approach to student placement and research opportunities in CHSs. As part of the project, the following activities were completed:

- Approximately 80 staff from CHSs, tertiary training organisations and DHS attended the first Community Health Teaching and Research Project Forum in February 2007.
- The Victorian Healthcare Association was funded to work with CHSs and teaching institutions to support them to develop improved student placement arrangements. As part of this work they have:
 - clarified the roles and responsibilities of CHSs and teaching organisations;
 - identified and promoted successful and innovative student placement and research practice;
 - researched and collated student placement material already available;
 - developed a resource kit; and
 - consulted with key stakeholders about the content of the resource kit.

Information on the project can be found at:

http://www.health.vic.gov.au/communityhealth/service_provider/tarp.htmhas

Dental Health

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

Dental Health Services Victoria is responsible for the delivery of public dental services through direct provision in clinics, School Dental Service and the Royal Dental Hospital Melbourne and funding community health services and rural hospitals under condition sets set by the department.

Service integration

The integration of the community and school dental services is a key policy objective. With integration, community dental clinics will provide a service for children and eligible adults operating under the management of community health services and some rural hospitals. Service integration will provide a more streamlined public dental service and will allow families to access dental and other primary health services together.

In 2006–07 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) successfully trialled integration.

The policy development, to deal with the administrative arrangements for the integration of school and community dental services, was finalised by June 2007 and it is anticipated that integration will be completed by June 2008.

Improving Victoria's oral health

In June 2007, the strategic document *Improving Victoria's oral health* was finalised. Launched in July 2007, the document provides a vision and planning framework for oral health services based on the principles of *Care in Your Community* over the next four years. Realisation of the vision will come about through six strategic priorities:

1. Oral health service planning framework
2. Integrated service model for adults and children
3. Workforce strategy
4. Oral health promotion
5. Responding to high needs groups
6. Oral health funding, accountability and evaluation.

The planning framework together with an integrated service model will mean that public oral health services will be an integrated part of Victoria's network of community health services, and will work collaboratively to provide health promotion, prevention, early intervention, treatment and self management.

The workforce strategy will develop and consolidate a diverse, robust public dental workforce and will equip the Victorian oral health care system to meet the future needs of communities and individual users. The strategy will build on existing Government health and human services policy and provide longer-term strategic direction to Victorian dental health workforce planning.

The department will undertake work in the areas of funding and accountability that will support improved service planning and integration. This will include the establishment of better performance indicators so that the community and providers can better understand the operations of the dental system and the extent to which it is achieving its goals.

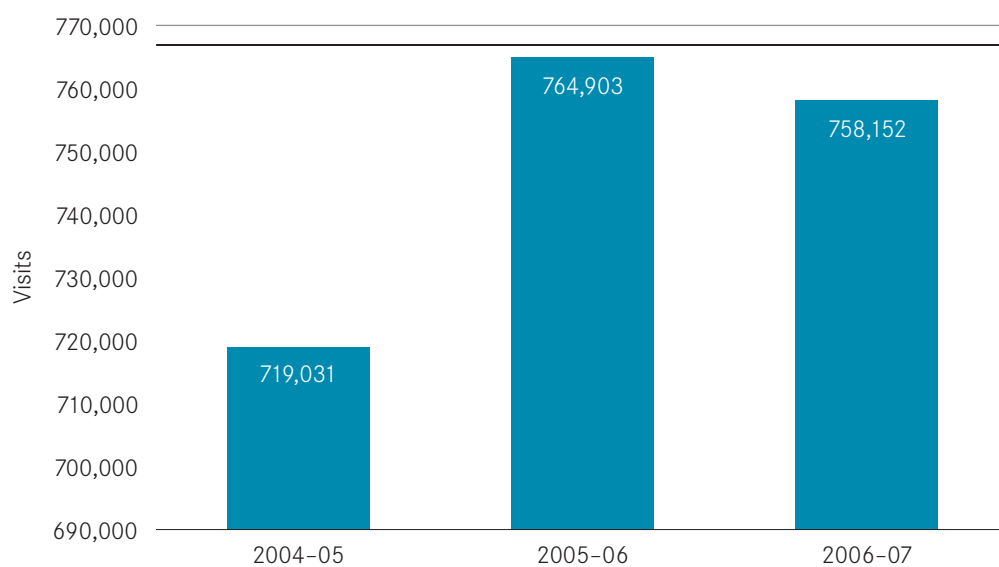
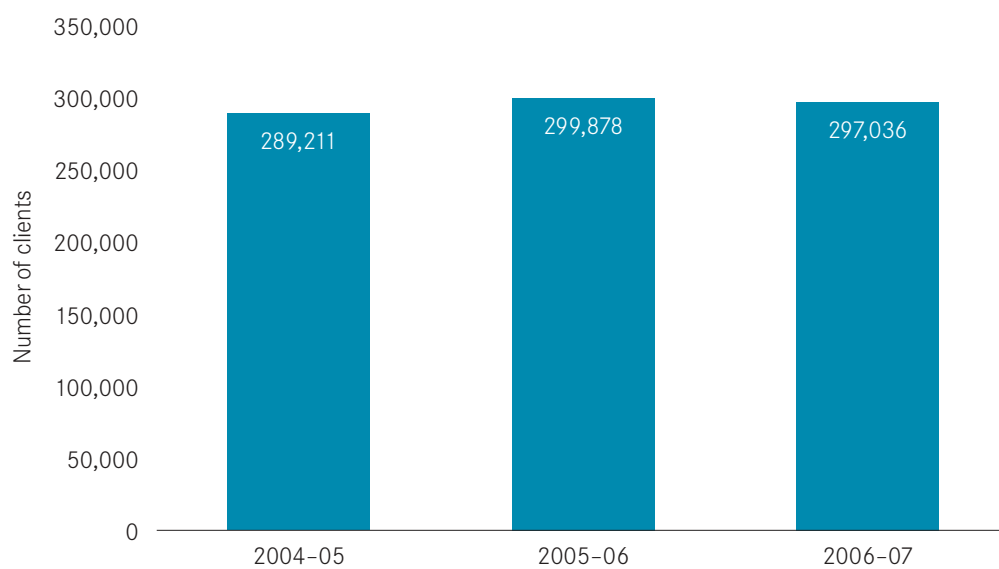
Implementation of the strategic priorities outlined in *Improving Victoria's oral health* will occur in consultation with community health services across the state in 2007–08.

Between December 2005 and December 2006, five new community dental clinics were opened, bringing the total number to 68. This allowed an addition 26 dental chairs to be opened increasing the number of dental chairs in Victoria to 241.

Table 1: Number of dental chairs by region 2006–07

| Regions | 2006–07 |
|--------------------------------------|------------|
| Barwon-South Western | 38 |
| Grampians | 23 |
| Loddon Mallee | 43 |
| Hume | 34 |
| Gippsland | 26 |
| North and West Metropolitan | 114 |
| Eastern Metropolitan | 45 |
| Southern Metropolitan | 66 |
| Total Number of dental chairs | 389 |

In 2006–07, there were 755,237 visits. Note that this number includes School Dental Service visits.

Figure 6: Dental Health Program Visits 2004-05 to 2006-07**Figure 7: Number of Clients in Dental Health Program 2004-05 to 2006-07**

Diabetes Self-Management

The self-management approach has been recognised by the Victorian Government as a key component of the management of chronic disease, including diabetes. The 2006–07 State Budget allocated \$3.1 million over four years for the Diabetes Self-Management program. The Diabetes Self-Management program is delivered in rural PCP catchments where there is a prevalence of diabetes but where there is not an EliCD program.

Self-management is about people being actively involved in their health care. The funding supports early intervention for people with high risk and newly diagnosed with Type 2 diabetes to assist them to become an active partner in the management of their health. Services deliver a structured coordinated program that assists people with newly diagnosed Type 2 diabetes to better manage their illness and to reduce the incidence of complications.

The initiative builds on the work already being done by health services to support people in the community who have chronic disease and complex needs.

Drought Initiatives

In October 2006, the Victorian Government allocated \$3.75 million across drought declared areas of rural Victoria under the *Tackling Mental Health Strategy*, in recognition of the personal impact of drought on rural communities. This program involves four branches across the Department of Human Services including Mental Health, Primary Health, Family Services and is led by Emergency Management. A strong strategic and coordinated approach across central and regional DHS programs has built productive partnerships with Department of Primary Industries, Victorian Farmers Federation, VicRelief, Department of Planning and Community Development and a range of other departments and cross-sectoral organisations.

For Primary Health, this drought funding increases access to counselling services by providing for 20 equivalent full-time positions through the Family Services Program and the Community Health Program. In addition, Primary Care Partnerships (PCPs) in the areas worst affected by drought were funded to further strengthen service coordination and integrated health promotion. Activities were supported by extensive workforce development and training.

Counsellors have been supported by the La Trobe University's Bouverie Centre, who have provided a comprehensive training and clinical support package. This project includes a qualitative research project in which the counsellors and Bouverie are working together to identify effective counselling approaches to reach people in rural settings. The lessons from this project will be shared with counsellors across all Department of Human Services programs who work in rural settings.

Primary Care Partnerships funded by this initiative have drawn together the human services sector in conjunction with rural industry groups and organisations. Through planning, leadership from local government, collaboration between Divisions of General Practice, community health, schools, and a range of other agencies new models of service delivery are developing with innovative and creative health promotion focused on ways of best protecting and supporting mental health and wellbeing. PCPs have also facilitated the delivery of Mental Health First Aid courses across all local government areas in Hume, Grampians, Loddon Mallee and Gippsland regions. Eight PCPs in the worst drought affected areas have also collaborated with VicHealth in delivering Mental Health Promotion Short courses. These initiatives have been further supported through the establishment of the Drought Personal Support Line which has provided easily accessible information and counselling support over the telephone. Also, additional capacity was added to the Sustainable Farm Families program established by Western District Health Service which provided training to 30 community health nurses from across rural Victoria and seeded four new programs.

Early Intervention in Chronic Disease in Community Health

The Early Intervention in Chronic Disease in Community Health (EliCD) initiative is a government investment of \$36.8 million over four years in community based early intervention services for people with chronic diseases. It responds to the *Community Health Services—creating a healthier Victoria* policy released in September 2004 which outlined the role of community health services (CHSs) in providing:

- integrated disease management programs for people with chronic and complex conditions
- an expanded range of community-based ambulatory care services, as appropriate.

The initiative builds on the work already being done by CHSs to support people in the community who have chronic disease. It provides additional funding to increase service delivery to this population and to build in new components of care that are consistent with evidence based chronic care. Through the provision of planned and well managed care to people with a range of chronic diseases, the EliCD initiative supports people with chronic disease early in the disease continuum to delay and reduce the need for more intensive and costly interventions. Support is provided to clients through a range of self-management programs to empower and prepare them to manage their own health and health care. Additional services may include the provision of key workers, multi-disciplinary care planning and allied health services.

In addition, CHSs are working on building capacity, internal systems changes and partnerships with a particular focus on engagement with general practice to deliver an Integrated Chronic Disease Management (ICDM) model of care developed with the PCP and other key agencies.

As part of the state/Commonwealth Australian Better Health Initiative, the EliCD initiative was extended in 2006–07 to a further nine CHSs. There are now 18 CHSs each receiving recurrent funding of \$400,000 per annum, primarily for additional service delivery in a responsive, person-centred, effective system of care.

Evaluation

During 2006–07, the EliCD initiative was evaluated by the Australian Institute of Primary Care. Preliminary evaluation results indicate that overall, the 2005–06 funded EliCD programs report that:

- Advanced progress has been made with internal systems elements (e.g. business processes, facilities allocation, internal staff information), and
- Other aspects such as GP/other liaison pathways, staff recruitment and planning, remain a work in progress.

The 2006–07 funded programs are in an early phase of implementation with some indications of advanced work on the development of internal systems.

Family and Reproductive Rights Education

The Family and Reproductive Rights Education Project (FARREP) was established in 1997 to address issues related to female genital mutilation (FGM) in Victoria.

The program aims to increase the cultural responsiveness of care in the host agencies and local services system whilst increasing access to sexual and reproductive health services for communities affected by FGM.

The program seeks to prevent FGM and provide support to address FGM related issues in communities affected by FGM.

FARREP workers are based in a variety of settings, including community health centres, women's health services and some metropolitan hospitals. The FARREP workers seek to increase quality of care and access to sexual and reproductive health services for communities affected by FGM.

There were 1,100 hours of direct care services and 5,100 hours of health promotion provided by the FARREP program in 2006–07.

Family Planning

The Family Planning Program assists Victorians to make individual choices on sexual and reproductive health matters by providing a range of services that are accessible, culturally relevant and responsive to the needs of people who experience difficulty accessing mainstream services.

In 2006–07 Family Planning Victoria provided medical, nursing or counselling services to 8,505 clients, and over 24,000 people accessed a range of health promotion activities delivered by Family Planning Victoria.¹

Innovative Health Services for Homeless Youth

Innovative Health Services for Homeless Youth Program is a shared Commonwealth and State 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.

There were 10,607 hours of direct care services and 7,942 hours of health promotion provided by the Innovative Health Services for Homeless Youth program in 2006–07.

NURSE-ON-CALL

NURSE-ON-CALL is a telephone health line, providing Victorians with immediate, expert health information and advice 24 hours a day, 7 days a week.

Call Volume

Since its launch to the public on 4 June 2006, NURSE-ON-CALL has answered over 418,000 calls. On average each caller spoke to a registered nurse for 8.38 minutes.

Call Outcomes

Triage accounted for 71 per cent of calls during the period 1 July 2006 to 30 June 2007. A summary of call outcomes is shown in the graph on the following page. Please note that a single call made to NURSE-ON-CALL can result in two or more call outcomes. For example, a caller might be provided with general information and a referral to a service.

Figure 8: Call outcome 2006-07

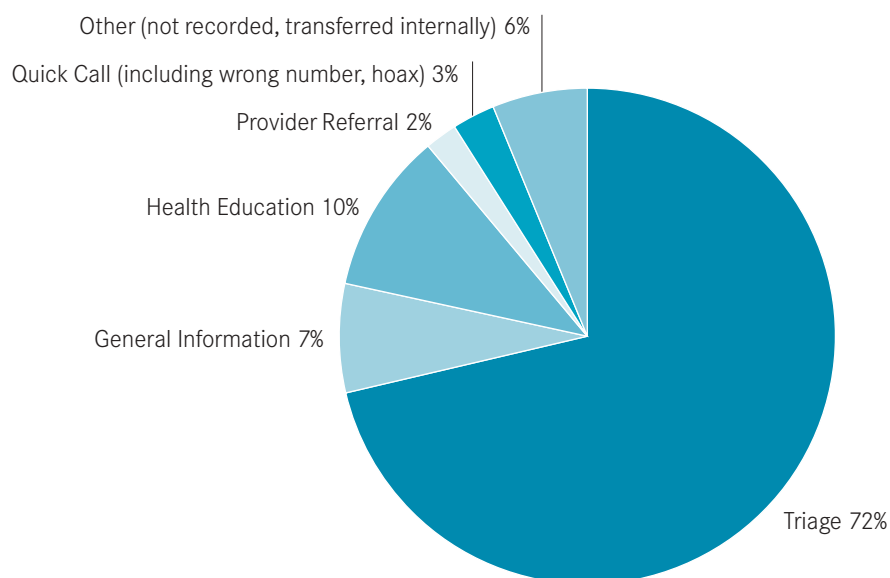
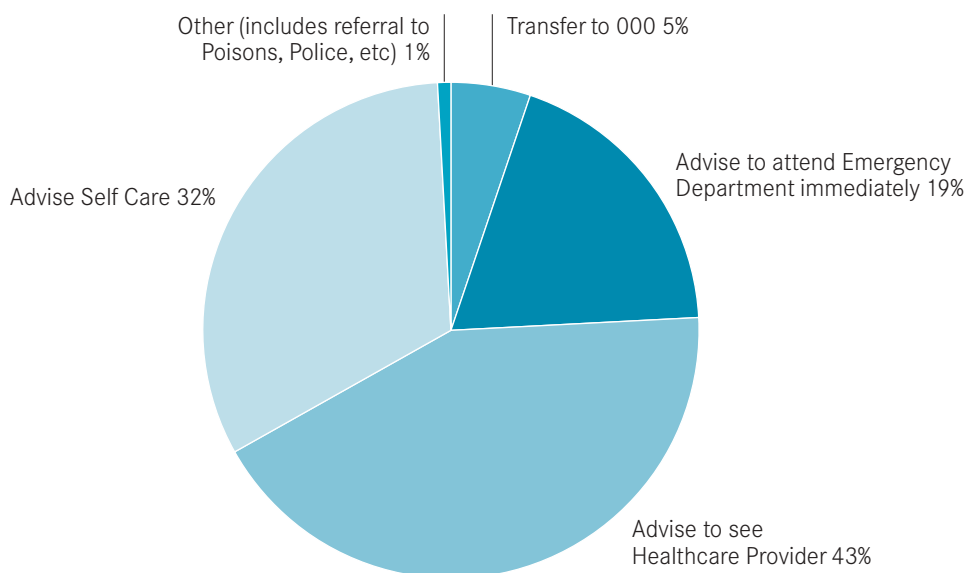


Figure 9: Breakdown of triage calls 2006-07



Approximately 70 per cent of callers were asked what they would have done if they had not rung NURSE-ON-CALL. In some cases the action that callers intended to take was different to the action NURSE-ON-CALL advised them to take. For example, of this group of callers, there was a possible 55 per cent reduction in calls to 000, and a possible 65 per cent reduction in patients presenting to an emergency department. It should be noted that whilst NURSE-ON-CALL may recommend an action, the caller may not necessarily heed the advice given.

Each month there are also a small proportion of callers who do not realise the severity of their illness and intend to stay at home and care for themselves. For example, of the 38,322 callers who said that they would have stayed at home, 2.6 per cent of them needed urgent medical care and/or an ambulance transfer.

Reach and User Feedback

A campaign to raise awareness of the NURSE-ON-CALL service for cultural and linguistically diverse (CALD) communities was undertaken. This included articles in ethnic media, spots on ethnic radio, information sessions held in rural and metropolitan Victoria, the production of information pamphlets and wallet sized 'z cards' in 15 different languages.

In late 2006, research was conducted with CALD communities to evaluate the effectiveness of the NURSE-ON-CALL marketing campaign. Research participants included members of the Arabic, Chinese, Greek, Italian, Somali and Vietnamese communities. Research results concluded that awareness of the service among CALD communities is quite high and the service has generally been well received.

Preliminary results of a customer satisfaction survey undertaken in February 2007 showed that:

- 98 per cent of respondents indicated they were satisfied with the service provided.
- 95 per cent of respondents felt that they were carefully listened to.
- 98 per cent of respondents felt NURSE-ON-CALL was a valuable first step in managing their health issue.
- 95 per cent of respondents felt that they were likely to use the service again.

Celebration

On 3 June 2007 NURSE-ON-CALL celebrated its first birthday. The celebration was held at the Richmond call centre and attended by the then Minister for Health, Hon Bronwyn Pike, MP.

Refugee Health Nurse Program

The Refugee Health Nurse Program (RHNP) ensures newly arrived people from a refugee background have timely and appropriate access to primary health care. The program is well established in nine agencies covering Kensington, Moonee Valley/Melbourne, East Preston, Darebin, Broadmeadows, Hume, Deer Park, Brimbank, Footscray, Maribyrnong, Warrnambool, Shepparton, Dandenong, Greater Dandenong and Ballarat.

Victoria receives approximately one third of all offshore humanitarian entrants each year. In 2006–07, a total of 3,629 entrants came to Victoria under the Humanitarian Program for refugees and others in humanitarian need.² Since commencement in September 2005, it is estimated that over 3,300 individuals or families have accessed the RHNP. Figure 10 on the following page outlines the estimated number of clients and contact hours by financial year.³

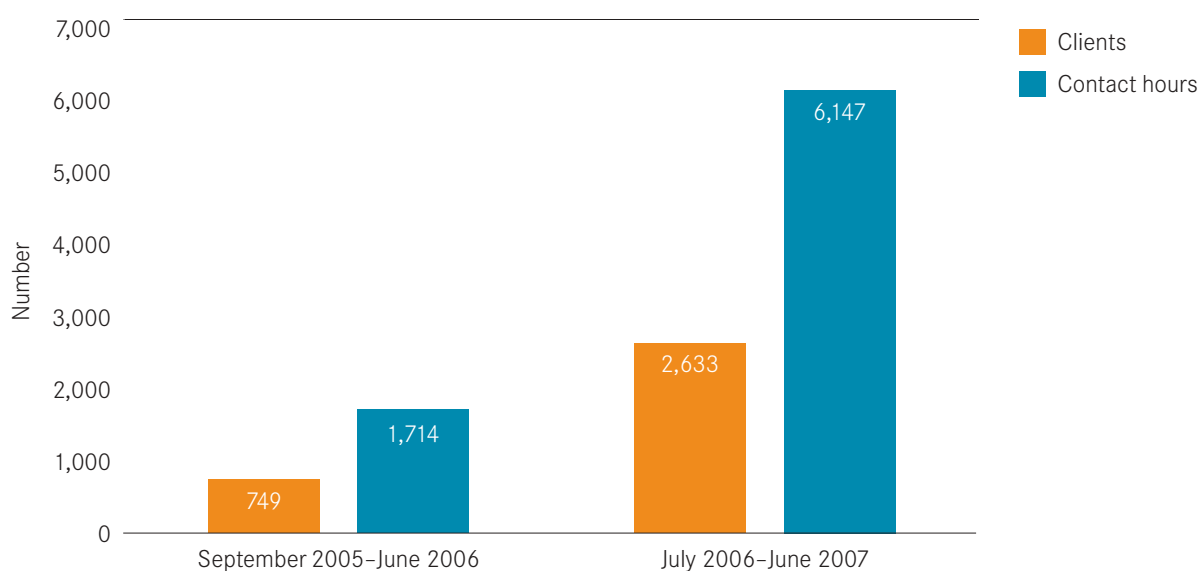
A report⁴ prepared by the Refugee Health Research Centre states that “there is clear demonstrable evidence that the RHNP has had a major impact on improving the response of the primary health care sector in addressing the health needs of newly arrived humanitarian refugees. The RHNP is a model that has made a contribution to reducing health inequalities in Victoria.”

2 Refugee Health and Wellbeing Action Plan: 2007 progress report. Due for release in 2007

3 Data incomplete for the years 2005–06 and 2006–07. Figures taken from *Developing a Framework for Evaluating the Refugee Health Nurse Initiative: A report prepared by the Refugee Health Research Centre for the Victorian Department of Human Services*, November 2007

4 *Developing a Framework for Evaluating the Refugee Health Nurse Initiative: A report prepared by the Refugee Health Research Centre for the Victorian Department of Human Services*, November 2007

Figure 10: Number of clients and contact hours provided through the Refugee Health Nurse Program in 2005–06 and 2006–07



Suicide Prevention

Suicide prevention provides funding to some agencies to deliver counselling, support and health promotion activities to reduce suicide risk factors, particularly among children, adolescents and refugees.

There were 4,305 hours of direct care and 838 hours of health promotion provided by the Suicide Prevention program in 2006–07.

Telephone Counselling

Lifeline agencies receive both State and Commonwealth funding to provide confidential support, information and referral by telephone 24 hours a day, seven days per week. Recurrent funding of more than \$1 million was provided to Lifeline agencies in Victoria for the 2006–07 financial year.

Suicide helpline is provided by Crisis Support Services in Victoria. Suicide helpline provides crisis intervention, information and referral by telephone 24 hours a day, seven days per week to people at risk of suicide and to those concerned about others' suicidality. Recurrent funding of approximately \$0.7 million was provided to Crisis Support Services for the 2006–07 financial year.

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. 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 from gaps identified by statewide, regional and community health-planning processes.

Use of Primary Health Services

This section provides demographic and usage statistics from reported data provided by Primary Health Branch funded services. This information combines all reported data for 2006–07 from the following Primary Health Branch Programs:

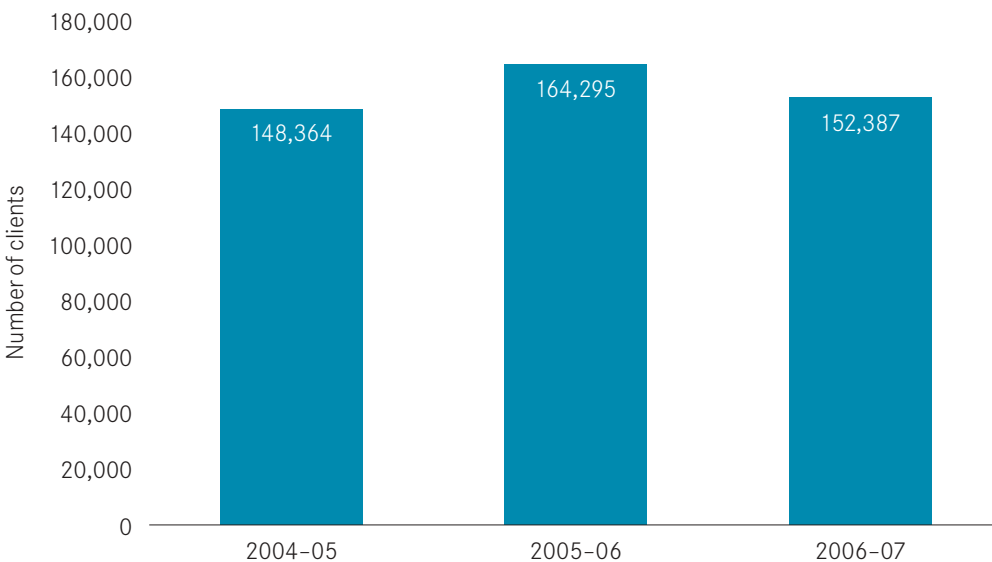
- Aboriginal Health Promotion and Chronic Care Partnership
- Community health
- Diabetes Self Management
- Early Intervention in Chronic Disease
- Family and Reproductive Rights Education
- Family Planning
- Innovative Health Services for Homeless Youth
- Suicide Prevention Initiatives
- Women’s health.

The reported data specifically excludes Dental Health and NURSE-ON-CALL. During 2006–07, the dental health and NURSE-ON-CALL data is not comparable or available as for the other primary health programs. Please note that at the time of data analysis, 13 per cent of 2006–07 data returns were outstanding.

Client numbers and demographics

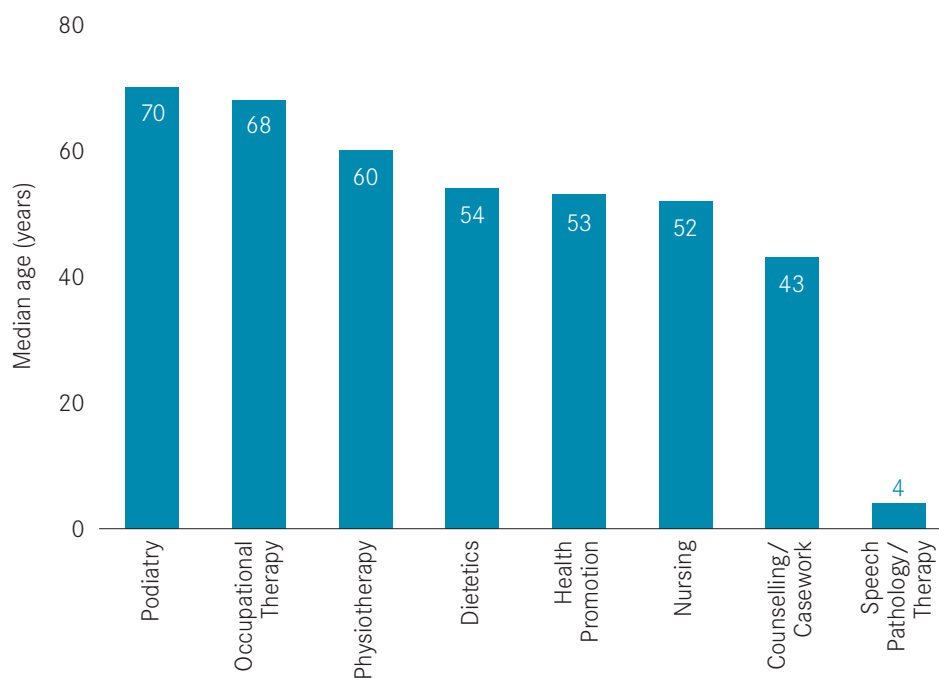
In 2006–07, there were 152,387 registered clients in the various Primary Health Service programs statewide and there were 1,009,333 occasions of service.

Figure 11: Number of Clients Statewide 2004–05 to 2006–07



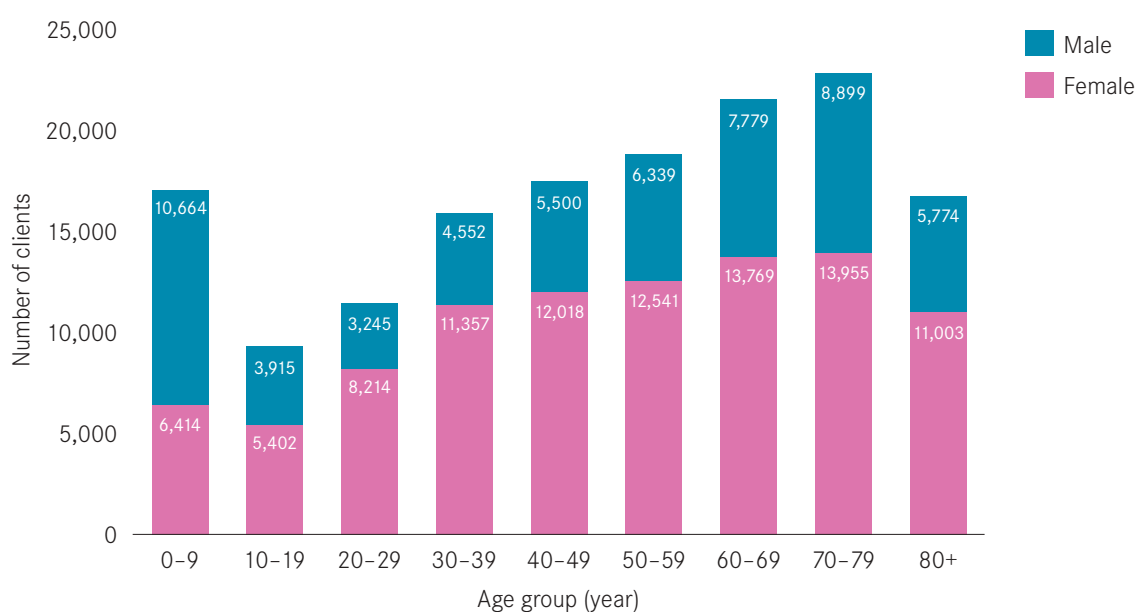
Clients of podiatry and occupational therapy had the highest median age, both at 70 and 68 years of age respectively.

Figure 12: Median age of clients using each type of service 2006–07



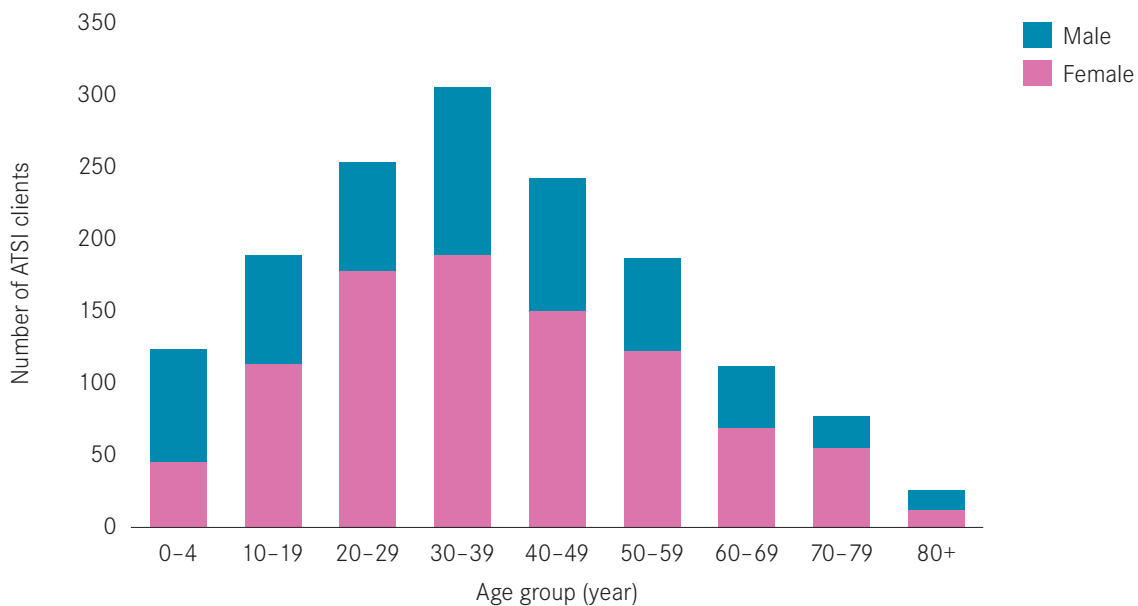
The largest number of clients are in the 60–69 years and 70–79 years age groups. 25.1 per cent of clients are younger than 30 years, 34.6 per cent are aged between 30 and 59 years, and 40.4 per cent are sixty years or older. Overall sixty four per cent of all clients were female. (Refer Figure 13).

Figure 13: Number of statewide clients by age group and gender 2006–07



With regard to Aboriginal and Torres Strait Islander (ATSI) registered clients, 61 per cent were female. The largest number of female registered clients are found in the 30-39 years age group while the largest proportion of males were at in 0-9 years. (Refer Figure 14)

Figure 14: Number of ATSI clients by age group and gender 2006-07



Group Sessions

Group sessions are a significant way of delivering services in primary health. These are sessions in which services are delivered to more than one client at one time.

In 2006–07, there were 53,912 group sessions. Of these group sessions, 51 per cent were held in metropolitan regions and 49 per cent in rural regions. At the statewide level, group sessions for health promotion made up 52 per cent of all sessions, followed by physiotherapy which comprise 16 per cent of all group sessions. (Refer Figure 15)

In rural regions, group sessions for health promotion made up nearly 70 per cent of all sessions, followed by physiotherapy with 12 per cent. (Refer Figure 16)

In metropolitan regions, group sessions for health promotion made up 34 per cent of all sessions, followed by physiotherapy with 20 per cent. (Refer Figure 17)

Figure 15: Composition of Group Sessions by Service Type—Statewide 2006–07

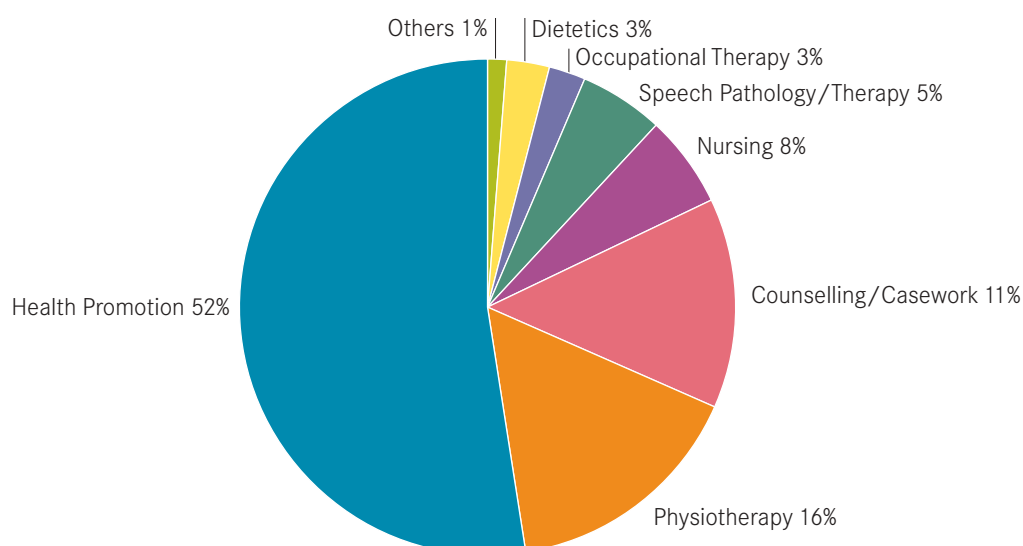


Figure 16: Group Sessions by Service Type—Rural Regions 2006–07

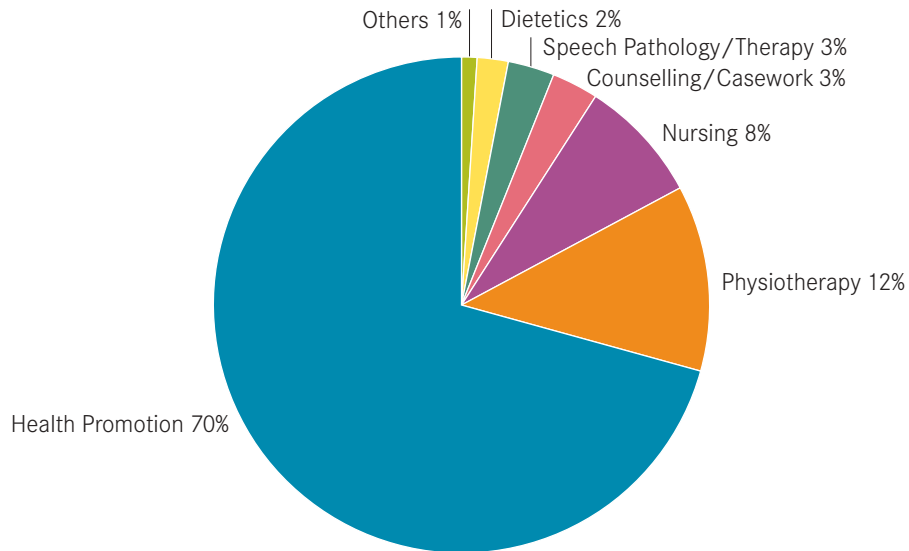
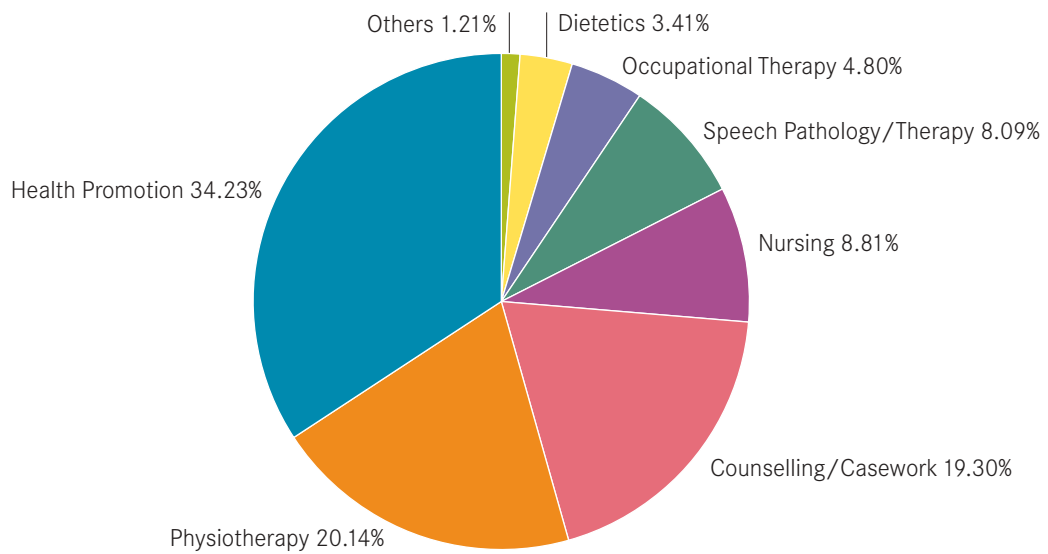


Figure 17: Group Sessions by Service Type—Metropolitan Regions 2006–07



Health Promotion

In 2006–07, mental health wellbeing and capacity building were the two top priorities in integrated health promotion priorities by service hours.

Figure 18: Integrated Health Promotion Priorities by Service Hours—Statewide 2006–07

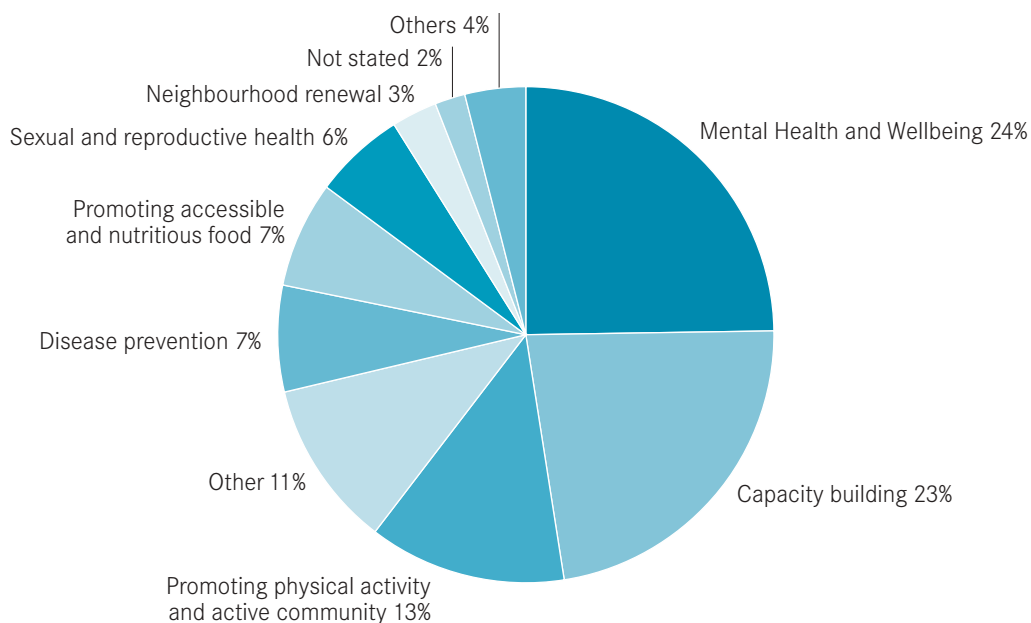
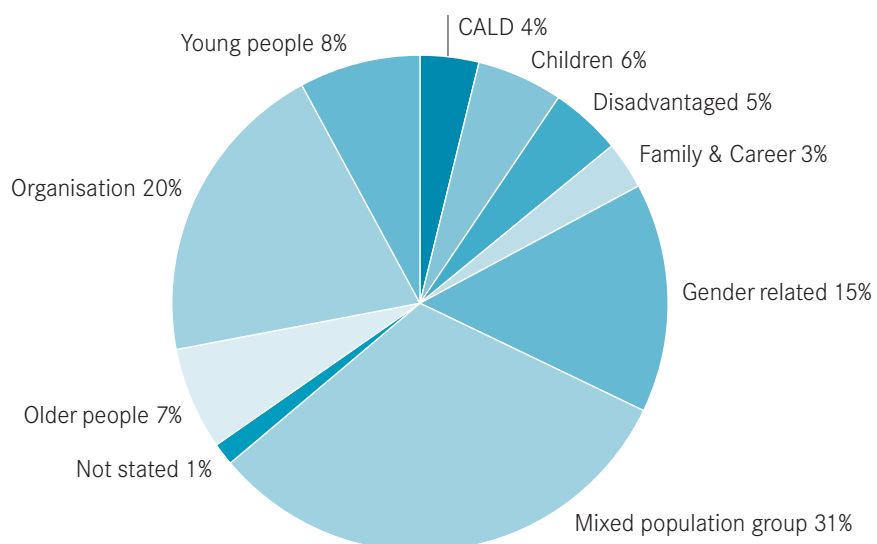


Figure 19: Integrated Health Promotion Target Population—Statewide 2006–07



Regional Data

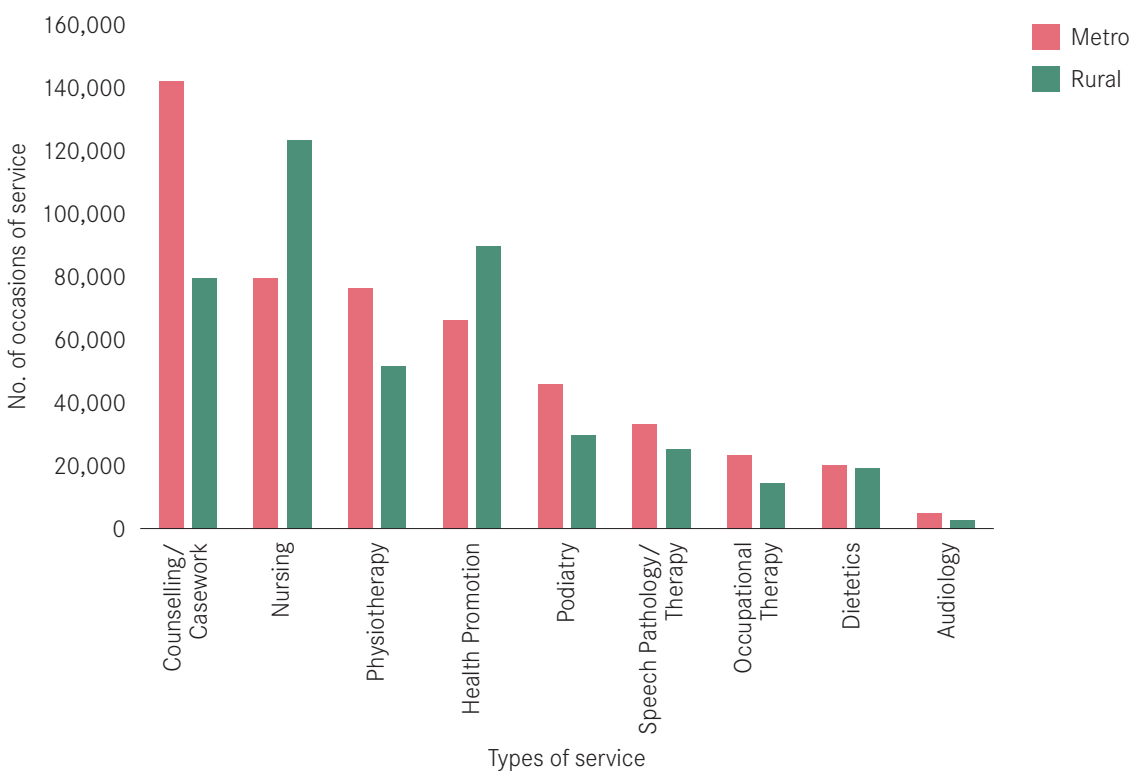
Of the 910,409 occasions of service in 2006–07, 47 per cent were delivered in rural regions. Rural regions only service 28 per cent of Victoria’s population so this means there is a high rate of service provision per rural population compared with metropolitan regions.

Among the nine types of service provided, 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 while metropolitan regions delivered more counselling or casework sessions.

Figure 20: Distribution of registered clients: Metropolitan and Rural Regions



Figure 21: Type of Service delivered by rural and metropolitan regions 2006–07



The following eight graphs show the variation between regions in the occasions of service by service type. Some of this variation is due to the differing needs of the regions, availability of workforce and funding for that type of service.

Figure 22: Barwon-South Western Region—Proportion of occasions of service by service type 2006–07

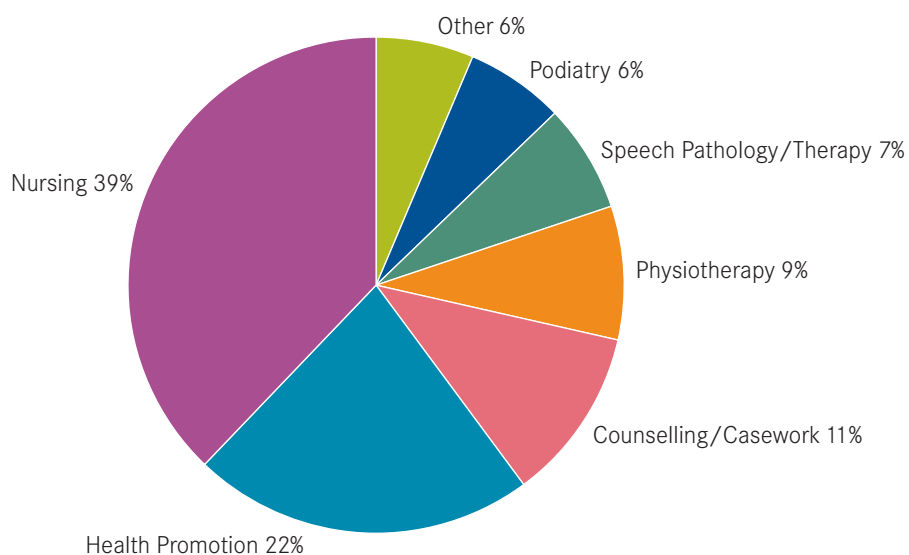


Figure 23: Gippsland Region—Proportion of occasions of service by service type 2006–07

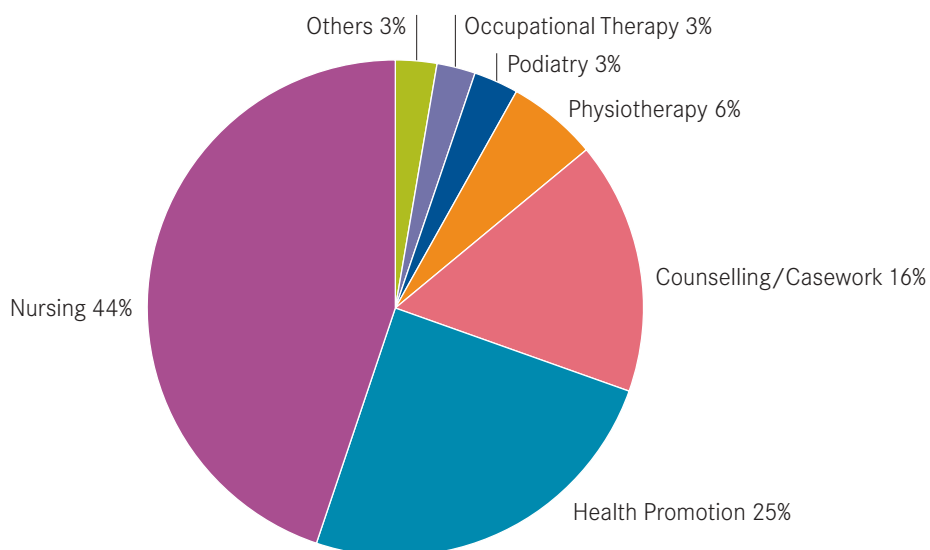


Figure 24: Grampians Region—Proportion of occasions of service by service type 2006–07

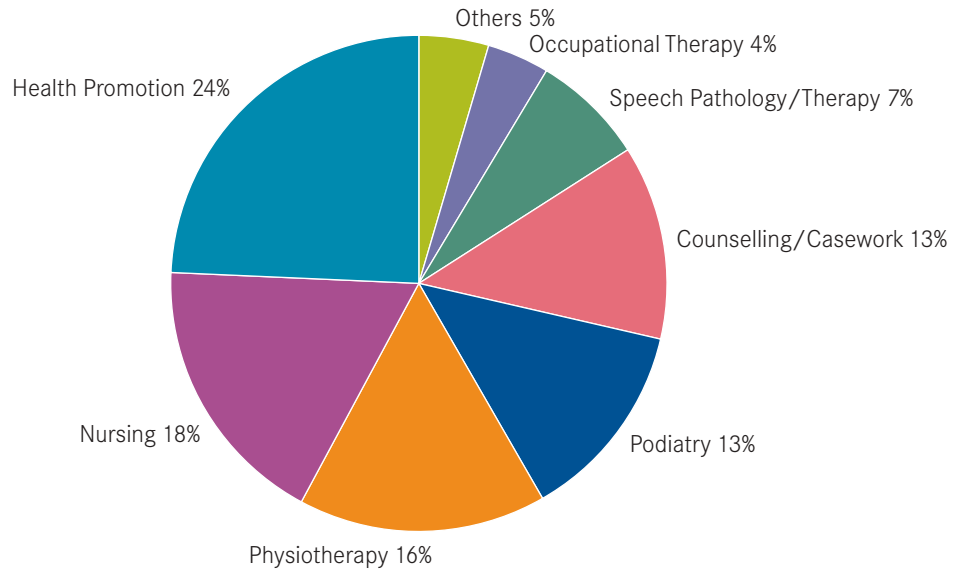


Figure 25: Hume Region—Proportion of occasions of service by service type 2006–07

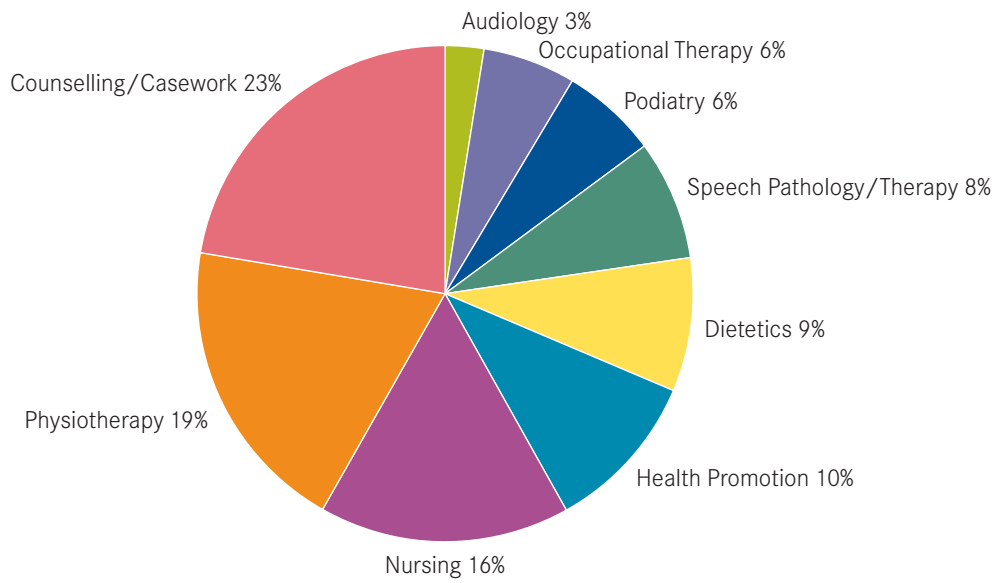


Figure 26: Loddon Mallee Region—Proportion of occasions of service by service type 2006–07

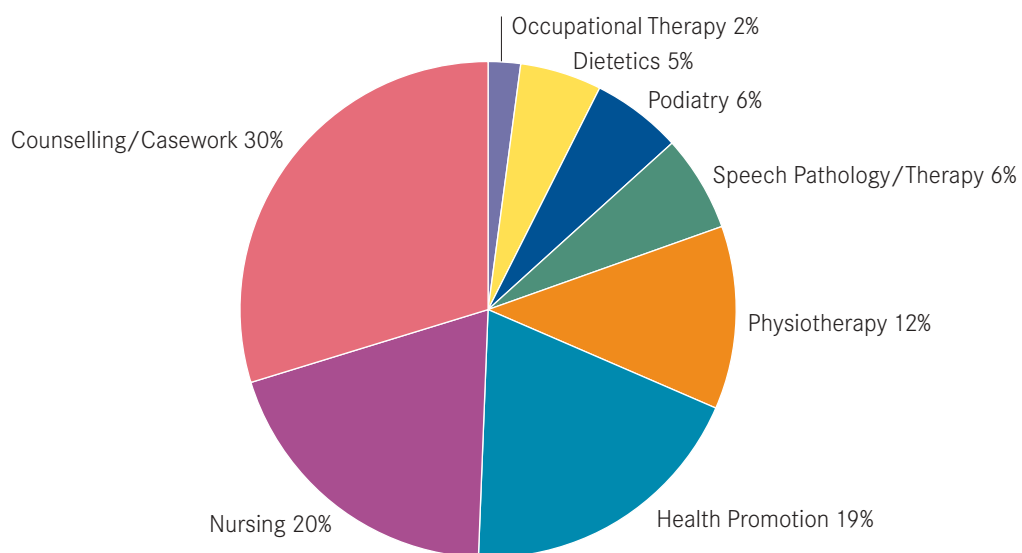


Figure 27: Eastern Metropolitan Region—Proportion of occasions of service by service type 2006–07

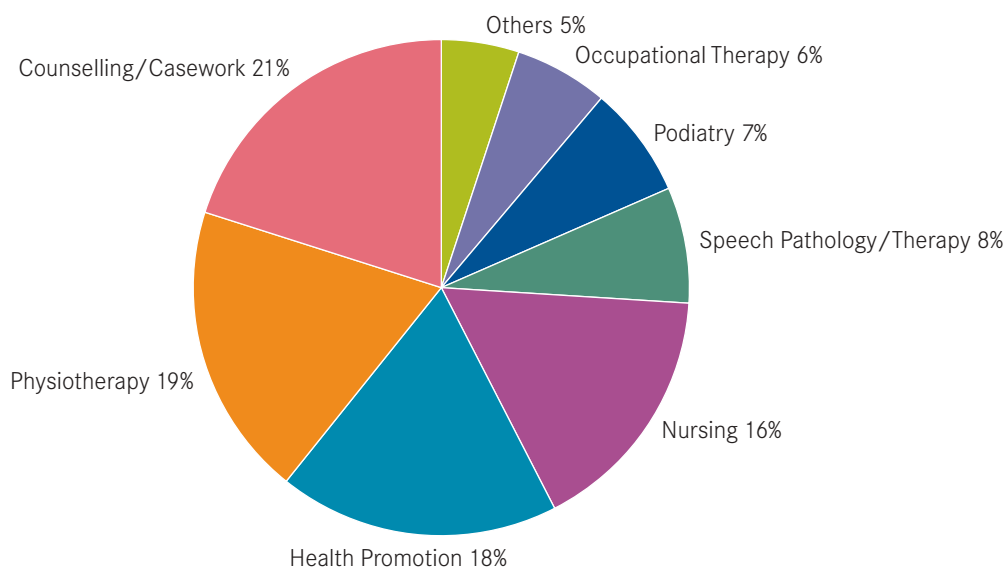


Figure 28: North and West Metropolitan Region—Proportion of occasions of service by service type 2006–07

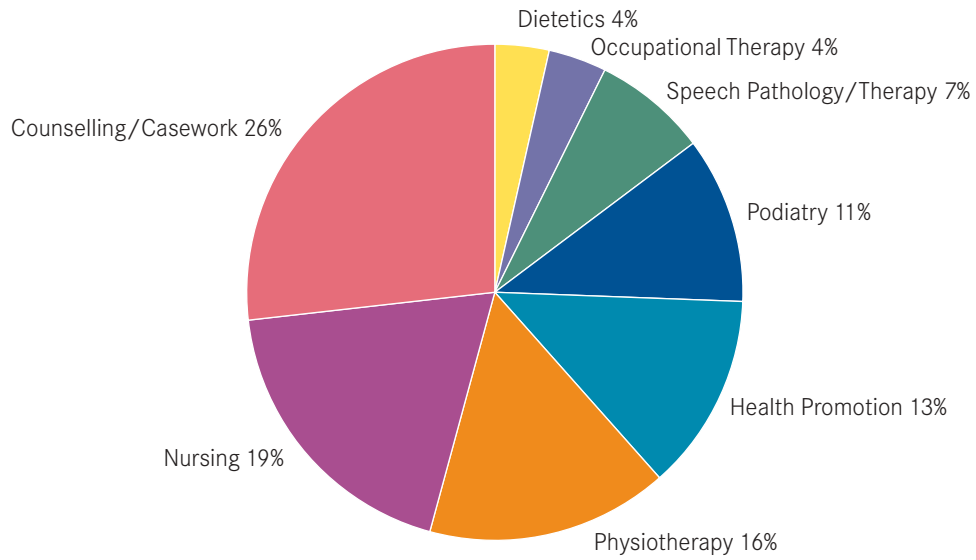
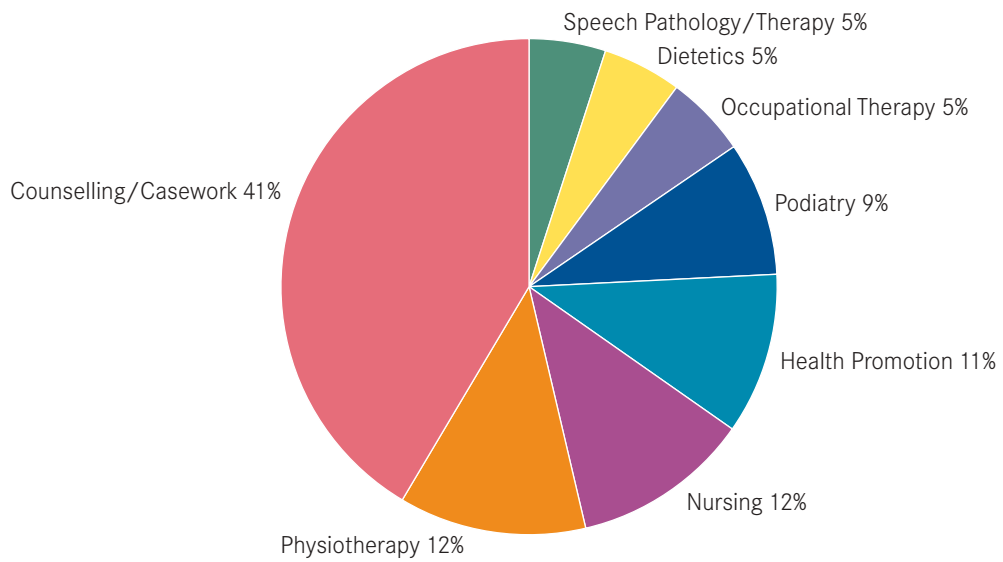


Figure 29: Southern Metropolitan Region—Proportion of occasions of service by service type 2006–07



Appendices

Community Health Services

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 called 'integrated community health services', and a small number of non-government organisations.

The following is a list of these independently managed CHSs.

Table 2: Independently managed community health services

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

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

Integrated community health services are community health services which are part of larger health services or hospitals

Table 3: Integrated community health services

| Region | Name of integrated community service |
|----------------------------------|---|
| Barwon South Western | Barwon Health |
| | Casterton Memorial Hospital |
| | Colac Area Health |
| | Hesse Rural Health Service |
| | Lorne Community Hospital |
| | Moyne Health Services |
| | Portland and District Community Health Centre |
| | South West Healthcare |
| | Terang and Mortlake Health Service |
| | Coleraine District Health Services |
| | Penshurst & District Health Service |
| | Western District Health Service |
| Eastern Metropolitan | Angliss Health Services |
| | Box Hill Hospital |
| | Maroondah Hospital |
| | Yarra Valley Community Health Service |
| Gippsland | Bairnsdale Regional Health Service |
| | Central Gippsland Health Service |
| | Gippsland Southern Health Service |
| | South Gippsland Hospital |
| | West Gippsland Healthcare Group |
| Yarram & District Health Service | |

| Region | Name of integrated community service |
|-----------------------------|--|
| Grampians | Ballarat Health Services Beaufort and Skipton Health Service Dunmunkle Health Services East Grampians Health Service East Wimmera Health Service Edenhope & District Memorial Hospital Hepburn Health Service Rural Northwest Health Stawell Regional Health West Wimmera Health Service Wimmera Health Care Group |
| Hume | Alexandra District Hospital Beechworth Health Service Delatite Community Health Service Cobram District Hospital Glenview Community Care Inc. Goulburn Valley Health Mansfield District Hospital Northeast Health Wangaratta Numurkah District Health Service Seymour District Memorial Hospital Tallangatta Health Service Wodonga Regional Health Service Yarrawonga District Health Service Yea & District Memorial Hospital |
| Loddon Mallee | Bendigo Health Care Group Echuca Regional Health Inglewood & Districts Health Service Kyabram & District Health Services Macedon Ranges Health Services Maryborough District Health Service Mclvor Health and Community Services Swan Hill District Hospital |
| North and West Metropolitan | Djerriwarrh Health Services |
| Southern Metropolitan | Caulfield Community Health Service Frankston Community Health Service Cardinia Casey Community Health Service Inc. Greater Dandenong Community Health Service Kingston Centre |

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>

Table 4

| Region | Name of Primary Care Partnership |
|-----------------------|---|
| Barwon-South Western | Barwon PCP South West PCP Southern Grampians-Glenelg PCP |
| Eastern Metropolitan | Inner East PCP Outer East Health and Community Support Alliance |
| Gippsland | Central West Gippsland PCP East Gippsland PCP South Coast Health Services Consortium Wellington PCP |
| Grampians | Central Highlands PCP Grampians Pyrenees PCP Wimmera PCP |
| Hume | Central Hume PCP Goulburn Valley PCP Lower Hume PCP Upper Hume PCP |
| Loddon Mallee | Bendigo-Loddon PCP Campaspe PCP Central Victorian Health Alliance Northern Mallee PCP Southern Mallee PCP |
| North West | Banyule-Nillumbik PCP Brimbank-Melton PCP Hume-Moreland PCP Moonee Valley-Melbourne PCP North Central Metropolitan PCP Westbay PCP |
| Southern Metropolitan | Frankston-Mornington Peninsula PCP Inner South East Partnership in Community Health Kingston-Bayside PCP South East PCP |

Community Dental Clinics in Victoria

Table 5

| Region | Name of community health service |
|----------------------|--|
| Barwon-South Western | Barwon Health—Belmont |
| | Barwon Health—Corio |
| | Barwon Health—Newcomb |
| | Bellarine Community Health |
| | Colac Area Health Services |
| | Hamilton Dental Clinic |
| | Portland District Health |
| | South West Healthcare |
| Eastern Metropolitan | Eastern Access Community Health—Maroondah |
| | Inner East Community Health Service—The Craig Centre |
| | Knox Community Health Service |
| | Ranges Community Health Service |
| | Whitehorse Community Health Service |
| Gippsland | Bairnsdale Regional Health Service |
| | Bass Coast Regional Health |
| | Central Gippsland Health Service |
| | Latrobe Community Health Service—Churchill |
| | Latrobe Community Health Service—Moe |
| | Omeo District Health |
| | Orbost Regional Health |
| Grampians | Ballarat Health Services |
| | East Grampians Health Service |
| | East Wimmera Health Service |
| | Edenhope and District Memorial Hospital |
| | Hepburn Health Service—Creswick |
| | Hepburn Health Service—Daylesford |
| | West Wimmera Health Service |
| | Wimmera Health Care Group—Dimboola |
| | Wimmera Health Care Group—Horsham Base Hospital |
| Hume | Goulburn Valley Health |
| | Northeast Health Wangaratta |
| | Northeast Health Wangaratta—Benalla |
| | Rumbalara Aboriginal Cooperative |
| | Tallangatta Health Services |
| | Wodonga Regional Health Service |

| Region | Name of community health service |
|-----------------------|---|
| Loddon Mallee | Bendigo Health Care Group Boort District Hospital Echuca Regional Health Service Mallee Track Health and Community Services Maryborough District Health Service Sunraysia Community Health Services Swan Hill District Hospital |
| North West | Banyule Community Health Service Darebin Community Health Service—East Preston Darebin Community Health Service—Northcote Darebin Community Health Service—PANCH Dianella Community Health Doutta Galla Community Health—Kensington Doutta Galla Community Health—Niddrie ISIS Primary Care—Brimbank ISIS Primary Care—Wyndham Moreland Community Health Service Nillumbik Community Health Centre North Richmond Community Health Centre—Richmond North Yarra Community Health Plenty Valley Community Health Service Sunbury Community Health Service Western Region Health Centre |
| Southern Metropolitan | Bentleigh Bayside Community Health Service Cardinia/Casey Community Health Service—Berwick Cardinia/Casey Community Health Service—Cranbourne Site Central Bayside Community Health Services Greater Dandenong Community Health Service Greater Dandenong Community Health Service—Dandenong Greater Dandenong Community Health Service—Kingston Inner South Community Health Service—Prahran Inner South Community Health Service—South Port MonashLink Community Health Service Peninsula Community Health Service—Frankston Peninsula Community Health Service—Rosebud |

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 | 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. |
| 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 a 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. |
| FARREP | Family and Reproductive Rights Education Program |
| Health promotion | Health promotion is the process of enabling people to increase control over, and improve, their health. 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. |

| Acronym/term | Description |
|-----------------------|--|
| 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. |
| 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: ‘...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.’ |
| Registered client | Clients for whom service providers keep detailed demographic and service use information. |
| 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 |
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| 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. |

