# Community Health Program Guidelines

May 2026



VICTORIA State Government | Department of Health

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# Contents

# Introduction

The Community Health Program is a Victorian Government funded program delivered primarily through Victoria's community health services.

The aim of the Community Health Program is to provide timely, affordable and effective healthcare services and support to people at risk of poor health outcomes. Effective care is safe, culturally responsive, goal directed, health promoting, and evidence based.

Community Health Program funding is provided flexibly and is designed to support service providers to deliver local models of care that are person centred, flexible and responsive to community need. The program operates from a social model of health that acknowledges the social, environmental and economic factors that affect health, as well as the biological and medical factors.

## Purpose

The Community Health Program guidelines (the guidelines) are designed to provide a clear framework for the delivery of the state-funded Community Health Program across Victoria. The guidelines support consistency, accountability, and alignment with broader health system priorities, and outline expectations for how organisations administer and deliver the Community Health Program in Victoria.

The guidelines should be used by practitioners, service providers and executives who have responsibility for delivering the Community Health Program and are designed to be used in conjunction with other key documents outlining the range of responsibilities and requirements that apply to funded organisations. These include:

- Policy and funding guidelines for health services
- Service agreements
- Legislative and regulatory requirements, in particular the Health Services Act 1988.
- Demand Management Toolkit, which supports community health service providers to deliver services effectively by considering service access and demand across the consumer journey.

**Refer to** Appendix 1 for a list of key resources.

## Scope

The guidelines apply to all service providers that receive funding to deliver the Community Health Program and complementary programs (see Appendix 2). This includes:

- Health services that deliver integrated community health (integrated community health services)
- Registered community health services (registered community health centres under the *Health Services Act 1988*)
- Other agencies funded under a Services Agreement with the Department of Health.

Compliance with these guidelines is a condition of funding for all Community Health Program activities under each Activity Description and the Policy and funding guidelines.

Service providers delivering the Community Health Program may also deliver a range of other health and wellbeing programs that are funded by other funding bodies including other state government departments, and the Commonwealth Government. While these guidelines may be used to inform planning and implementation of other programs, the scope of these guidelines relate

to services funded through the Victorian Community Health Program and complementary programs (see Appendix 2).

Many organisations that deliver the Victorian Community Health Program, also receive funding for the Community Health – Health Promotion program. Although complementary programs, the Community Health – Health Promotion is not within scope of these guidelines. For guidance, funded organisations should refer to the Community Health – Health Promotion guidelines <https://www.health.vic.gov.au/publications/community-health-health-promotion-2025-29>.

# Terminology

**Table 1: Key terms**

| Term | Description |
|---|---|
| Consumer | An individual accessing the Community Health Program |
| Service provider | An organisation that delivers the Community Health Program |
| Practitioner | The workforce that delivers the Community Health Program, regardless of discipline and qualifications |
| Community Health Program | The state-funded Victorian Community Health Program, and complementary programs detailed in Appendix 2 |

**Table 2: Other important terms**

| Term | Description |
|---|---|
| **Integrated care** | A patient-centred approach that organises health and social services around the needs of an individual rather than specific conditions or organisations. It involves collaboration between providers across different sectors to deliver seamless, efficient, and coordinated care, particularly for people with complex or chronic conditions |
| **Multidisciplinary care** | Two or more practitioners of different disciplines, working in parallel to support someone's overall health and wellbeing but focusing on discipline specific goals for an individual |
| **Interdisciplinary care** | Two or more practitioners of different disciplines, working collaboratively and blending disciplines to achieve a common goal for an individual |
| **Self-management** | Someone's ability to effectively manage their health to maintain overall wellbeing. It involves building knowledge, skills and confidence so an individual can make informed decisions about their health and wellbeing |
| **Care coordination** | The act of organising an individual's activities to ensure the appropriate delivery of health and wellbeing services. It helps to achieve consistency of care through clear communication, linkages and collaborative care planning across the health system. This is often delivered by a care coordinator |
| **Care plan** | A tailored, collaborative document outlining an individual's assessed health needs and goals, and specific interventions to meet needs and achieve goals |

# Key changes in this version

This version of the Community Health Program Guidelines replaces the Community Health Integrated Program Guidelines (2019).

The content has been updated to reflect contemporary messaging and language reflective of how the Community Health Program is being delivered across Victoria. There are no changes to the intent or the scope of the Community Health Program.

This version consolidates several previously separate guideline documents into a single, streamlined resource, including:

- Community health integrated guidelines: direction for the community health program
- Refugee and asylum seeker health services: guidelines for the community health program
- Child health services: guidelines for the community health program
- Care for people with chronic conditions: guidelines for the community health program

# Community Health Program

## Strategic Alignment

The Community Health Program contributes to the objectives of the Department of Health's Strategic Plan 2023-27 and the Victorian Public Health and Wellbeing Plan 2023-27 by prioritising accessible, community-based care that addresses the social determinants of health.

It does this by:

- integrating primary health and social care for Victorians at risk of poor health outcomes, many of whom have complex needs.
- improving access to primary care services, including offering services to people who face barriers to accessing care through other services and in other settings, including isolated people and communities.
- providing support in managing chronic disease and enabling some lower acuity care to be moved into community settings.
- providing primary and preventative health services, including earlier and more connected support that is tailored to the health and wellbeing needs of local communities.
- supporting ongoing innovation and service improvement.

## Target cohort

Each year the Community Health Program provides over one million hours of allied health, nursing, general counselling and care coordination services to the Victorian community. Access is targeted to those with, or at risk of poorer health, who face barriers to accessing care through other services and in other settings. This includes:

- Aboriginal and Torres Strait Islander people
- refugees and people seeking asylum
- people experiencing homelessness and people at risk of homelessness
- children in care, and children and families accessing child protection, and Orange Door services
- people who hold a healthcare or pensioner concession card, or who are a dependent of a concession card holder.

These groups are also referred to as 'priority populations'.

Alongside the core Community Health Program, are complementary programs for specific population groups or people living with specific health conditions. Complementary programs are:

- Community Asthma Program
- Family Planning
- Healthy Mothers Healthy Babies
- Innovative Health Services for Homeless Youth
- Integrated Chronic Disease Management
- Multi-Disciplinary Centre Community Health Nurse
- Refugee and Asylum Seeker Health Services.

The Community Health Program access policy <https://www.health.vic.gov.au/community-health/community-health-program-access-policy> outlines the eligibility requirements and access principles for the Community Health Program. The eligibility criteria for complementary programs

varies based on the target cohort. Details are provided in Appendix 2 as well as in the relevant program Activity Description available from the Department of Families, Fairness and Housing and Department of Health activity search <https://providers.dffh.vic.gov.au/families-fairness-housing-health-activity-search>.

## Victoria's community health services

The Community Health Program is delivered across Victoria, through a network of community health service organisations. This includes registered and integrated community health services, and a small number of other organisations that support delivery of the Community Health Program in some parts of the state.

Community health services in Victoria, operate under two distinct legal and governance arrangements:

- Registered (or standalone) community health services – independently managed companies limited by guarantee and registered under the Health Services Act 1988
- Integrated community health services – integrated into rural or metropolitan health services, including small rural health services.

Community health services deliver a range of primary health, social services and community-based support to meet local community needs. They operate under a social model of health and provide targeted services for population groups at risk of poor health outcomes. Community health services sit alongside general practice and privately funded services to make up the primary health sector in Victoria.

Community health services range in size and in the scope of services offered, however all community health services in Victoria receive funding to deliver the Community Health Program. Some community health services are also major providers of a range of other health and social services including but not limited to, drug and alcohol, disability, dental, post-acute care, home and community care, mental health services and community rehabilitation.

Community health services receive funding for other programs and activities from the Department of Health and Department of Families, Fairness and Housing, as well as other Victorian State Government departments and from the Commonwealth Government. Community health services may also be registered providers for My Aged Care and the National Disability Insurance Scheme (NDIS).

A directory of providers in Victoria is available on the Community Health Directory <https://www.health.vic.gov.au/community-health/community-health-directory>.

## Principles of the Community Health Program

The following principles provide a foundation for the delivery of the Community Health Program.

### Person-centred and culturally safe care

- **Care is person centred** and accessible with services tailored to the unique needs, preferences and circumstances of a person, their family and/or carer.
- **Care is culturally responsive** and responds to the cultural needs of people and the community.
- **Care promotes health literacy** by providing people with information that is appropriate and relevant in a meaningful way to them and by supporting a person's active involvement decisions made about their health.

### Coordinated and goal-directed

- **Care is integrated and coordinated** across service providers, sectors and systems, and enables people to navigate the healthcare system and access appropriate care.
- **Care is goal directed**, with goals developed and agreed collaboratively between the person, their family and/or carer.
- **Care reflects a team approach** that enables effective communication between all members of a care team and the person and their family and/ or carer.

### Quality, evidence and sustainability

- **Care is evidence based** and uses the best available evidence, integrated with expertise, to make decisions about care options and interventions.
- **Care builds self-management capacity** that enables the person, their family and/or carer to take an active role in improving and managing their health and wellbeing.
- **Care is provided early** and strives to minimise the impact of disease, remediating existing or emerging issues, preventing disease progression and promoting self-management.
- **Care is high quality** and informed by continuous quality improvement.
- **Care is supported** by effective organisational and clinical governance.

# Consumer journey

Each consumer's journey through the Community Health Program will differ based on the reason they are accessing the service, their individual needs, the local service models used and the setting in which care is provided. It is anticipated that consumers will access the Community Health Program at different points throughout their life. The duration of access, review points and exit are to be determined by the care team in partnership with the consumer and aligned with demand management principles (as outlined in the Demand Management Toolkit).

In broad terms, the consumer journey can be described in four key stages, noting this journey may not be linear, including:

1. Access
2. Assessment and planning
3. Service delivery
4. Exit and transition.

The consumer journey through the Community Health Program is not completed in isolation. The consumer, their family and/or carer may be interacting with a multitude of other services across the health and wellbeing systems. Service providers should seek to engage with other service providers where practicable and throughout the consumer journey, to support coordinated and integrated care.

## Access

Access refers to the initial entry point to the Community Health Program and involves intake workers reviewing referrals and supporting a streamlined entry point into services.

Access should consider the diverse needs of priority populations; this is enabled by having clear access pathways that are:

- sensitive to consumer needs
- consider barriers to access
- respectful of privacy.

Access typically involves the following steps:

- The service provider receives a referral or enquiry and establishes initial contact with the consumer.
- The service provider determines eligibility and priority for service in line with the Community Health Program Access Policy and the Community Health Demand Management Toolkit.
- In consultation with the consumer (and where appropriate, their family and/or carer), the service provider identifies the consumer's needs, and schedules appointments accordingly.

Referrals into the Community Health Program can come from multiple sources, including self-referral. Service providers must have clear and accessible referral information available to both referrers and consumers, to guide appropriate referrals into the Community Health Program and complementary programs. Eligibility criteria and fee schedules (if applicable) must be clearly displayed so that other service providers, consumers, their families and carers, can make informed decisions about referral.

### Managing demand in the Community Health Program

Service providers need to manage demand at all stages of a consumer's journey.

The Community Health Demand Management Toolkit was developed in consultation with the community health sector and provides Community Health Program services providers with strategies and guidance to support service access and demand management across the consumer journey.

Service providers should use the Community Health Demand Management Toolkit <https://www.health.vic.gov.au/community-health/community-health-demand-management-toolkit> in conjunction with these guidelines

### Some groups will have more complex barriers to accessing care

- Consider how different intersecting identities and structures can reinforce various forms of discrimination and influence health outcomes such as:
  - Unique circumstances: people can be impacted by their own unique circumstances; this can include the opportunities they had access to, their experience of adversity or where they were born.
  - Aspects of identity: Factors such as cultural and linguistic diversity, education level, disability, sexuality, gender or gender identity.
  - Discrimination impacting identity: The types of discrimination people experience due to the aspects of their identity, such as racism, sexism, homophobia, transphobia, or ableism, and how this may influence accessibility of broader healthcare services.
- Service providers should consider how organisational policies and processes can accommodate people with a range of access needs. This includes 'Did Not Attend' policies. Service providers should consider the factors that make attendance challenging, and develop a compassionate response to waitlist management, that balances throughput with the needs and safety of the consumer.

## Assessment and planning

Assessment is part of an ongoing investigative process that uses clinical judgement, interpersonal skills and in-depth enquiry to guide a responsive intervention. The consumer, their family and/or carer need to be part of the decision making.

Assessment will look different depending on the consumer, their journey and the workforce conducting the assessment. Assessment may need to be ongoing and iterative to build trust with the consumer. Assessment may occur through different mechanisms, including but not limited to:

- Initial needs identification (INI), a broad screening process that gives the consumer, their family and/or carer, the chance to explore both current and underlying issues, which may extend beyond the reason for their referral. The aim of the INI is to facilitate an appropriate response to a consumer's needs, including intervention and information sharing, at the earliest opportunity, and may be repeated at different points throughout the consumer's journey. INI may occur as part of intake, or as a separate process, and should be conducted by a suitably qualified person. Non-clinical staff must be supported by clinical supervision and decision support tools.

- An assessment that uses discipline specific and/or multidisciplinary assessment methods to understand a consumer's health needs.

Assessment should be used to identify and define treatment goals in partnership with the consumer, their family and/or carer. When appropriate, the process should also consider opportunities to support consumers to build self-management capabilities and improve health literacy.

For many consumers accessing Community Health Program funded services, a care plan will be required that considers the information obtained through referral and assessment processes, the consumer's needs and goals, and outlines an agreed course of action.

Service providers should take a goal-based approach. Goal identification and definition should be led by the consumer. Goals should be specific, measurable, achievable, realistic and timed (SMART) and may involve services delivered by other parts of the health and wellbeing system.

### Refugees and people seeking asylum

People who are refugees and people seeking asylum may have unique health issues to be addressed. On their arrival, refugees and people seeking asylum may have:

- relatively poor health and complex health needs
- limited or interrupted access to healthcare, particularly illness prevention and health promotion
- additional needs around access and care, due to language, social and cultural norms and stresses associated with resettlement, asylum and refugee experiences.

This population may also face additional barriers to accessing care due to:

- language barriers
- experiences of trauma
- limited access to transport and other geographical barriers
- poor understanding of the Australian healthcare system
- cultural differences and beliefs around acceptability of aspects of healthcare.

Addressing health issues at an early stage can help to promote health and wellbeing and optimise the chances of successful resettlement.

More information is available at Refugee and asylum seeker health and wellbeing <https://www.health.vic.gov.au/populations/refugee-and-asylum-seeker-health-and-wellbeing>.

## Service delivery

Service delivery refers to the stage in the consumers journey where services and supports identified through referral and assessment processes are provided and includes monitoring and review activities.

As each person's needs and circumstances are different, the configuration and duration of Community Health Program input will vary. Some consumers will only require a one-off service or short periods of service, whereas others might require care over a longer duration. Decisions about duration of care should be made collaboratively, consider consumer needs and circumstances and take into account demand management principles (as outlined in the Demand Management Toolkit).

Community Health Program funded services should use local and regional partnerships to improve service integration, reduce duplication and strengthen coordinated responses to individual consumer need.

Community Health Program funded services should be delivered in line with the social model of health that acknowledges the social, environmental, and economic factors that affect health.

Service delivery should be accompanied by strong communication (with consent) with key people in the consumer's life, including their GP.

Service providers may implement a range of different service models within the Community Health Program. Service providers are expected to deliver service models that align to the needs of their local communities and adapt the types of services and service delivery modes to meet both individual and community needs.

The Community Health Program funding may be used to deliver a broad range of services and supports, including[1]:

- audiology
- dietetics
- occupational therapy
- physiotherapy and exercise physiology
- podiatry
- speech pathology and therapy
- nursing
- counselling
- initial needs identification
- care coordination
- client education
- diabetes education.

Service providers should individualise responses to meet the needs of the consumer, as well as support throughout and access. Service providers should consider:

- Providing consumers with information to support self-management, including while consumers are waiting for a service
- Individual intervention – single or multiple, with defined treatment blocks or review points to support goal attainment and skill consolidation
- Multidisciplinary/interdisciplinary care to support consumers with multiple health and wellbeing needs, and limit the volume of service contacts required
- Group based therapies to increase the reach of services to a greater number of consumers and provide opportunities for social interaction and peer support

[1] The range of services and supports available differs between some activities and funding sources. Service providers should refer to the Community Health Minimum Data Set submission guidelines <https://www.health.vic.gov.au/primary-and-community-health/community-health-minimum-data-set-chmds> to understand the services and supports that can be delivered and reported, relevant to their funding.

- Telehealth and alternative service settings to address access barriers and extend reach of services

A review provides an opportunity for the Service Provider to respond to any changes in a consumer's needs, circumstances and priorities during the period they are engaged with the Community Health Program. The need for, and timing of, a review should be determined as part of the initial service or care planning and in collaboration with the person, their family and/or carer. A review should also consider whether the consumer has or is on track to achieving their care goals.

### People with chronic conditions

- Chronic conditions have a major impact on quality of life and are a main cause of premature mortality for Australians. They contribute significantly to Australia's overall burden of disease, including death, disability and diminished quality of life, as well as accounting for a significant proportion of healthcare costs.
- Chronic conditions occur across the life cycle and are broad ranging in their development, progress and effects. They are more prevalent with older age, and the number of conditions that a person may have also increases with age.
- People with chronic or complex health conditions often access services from a number of different public and private healthcare providers. Community Health Program service providers need to work in partnership with other members of a person's care team.
- To support people with chronic conditions, service providers could consider:
  - Delivering multidisciplinary or interdisciplinary care
  - Supporting linkages and pathways to other relevant supports, including social prescribing
  - Engaging with general practice to provide coordinated care and support transition
  - Providing self-management support

### Delivering child health services through the Community Health Program

- Child health services delivered through the Community Health Program play a critical role in providing early, targeted and developmentally informed responses to children and families, particularly those experiencing adversity.
- Child health services primarily support children from birth to 12 years of age, with a focus on early identification and intervention for children who experience developmental delay, vulnerability and/or barriers to accessing other services. Priority should be given to children and families who require a coordinated, multidisciplinary response due to developmental, health or psychosocial complexity.
- Services should be delivered using a child and family centred approach that recognises the child within the context of their family, culture, community and broader service system. Practitioners and organisations should work to deliver a flexible service response based on family-centred practice, ensuring the safety and wellbeing of the child is promoted.
- Practice should be grounded in a developmental framework, recognising that children's needs are dynamic and change over time. Assessment and interventions should consider developmental domains such as physical health, communication, cognitive development, social competence and emotional wellbeing, and aim to strengthen the capacity of parents, carers and families to support children's development within everyday routines and environments.
- Early intervention is a core foundation of child health services. Intervening early, when developmental concerns, risks or vulnerabilities are identified, supports better outcomes for children and reduces the need for more intensive intervention later in life. Services should prioritise timely access, goal-directed care and coordinated pathways to ensure children and families receive the right support at the right time.
- Child health services are delivered using a team-based approach, drawing on multidisciplinary and, where appropriate, interdisciplinary models of care. Practitioners work collaboratively with children, families and carers, and in partnership with relevant services across health, wellbeing, education and social service systems. The child and their family are recognised as active members of the care team.
- There are a range of additional supports available to children and families across the health, wellbeing and education service system. Making sure children and families are connected to the relevant supports is a key aspect of service delivery. These supports include;
  - Maternal and Child Health nurses <https://www.health.vic.gov.au/primary-and-community-health/maternal-and-child-health-service>
  - Early Parenting Centres <https://www.health.vic.gov.au/maternal-child-health/early-parenting-centres>
  - Child and adolescent mental health services <https://www.health.vic.gov.au/mental-health-services/child-and-adolescent-mental-health-services>
  - Child Health and Wellbeing Locals <https://www.betterhealth.vic.gov.au/childrens-health-and-wellbeing-locals>
  - Disability and inclusion supports in schools <https://www.schools.vic.gov.au/disability-inclusion>
  - Pathway to good health for children in care <https://www.health.vic.gov.au/populations/vulnerable-children/pathway-to-good-health-for-children-in-care>

## Transition and exit

There are many reasons why a consumer may transition and exit from Community Health Program services, including but not limited to:

- They have achieved their targeted care goals
- The identified intervention has been completed and there is a plan for ongoing, external support in place
- They no longer wish to receive the service
- They have identified a preferred alternative service for example, a service provider closer to home
- It is decided following a review that there will be no more benefit from continuing the service
- They have been referred to a service that is more appropriate to meet their needs.

Transition should be a collaborative and supported process wherever practicable. Service providers should consider the following when planning for transition:

- A transition or exit summary that outlines the services delivered, interventions used, outcomes achieved, and plans for ongoing care such as referrals or scheduled follow-ups. This should be provided to the consumer, and with their consent, shared directly with their treating GP and other relevant care providers
- Referrals to other services and supports, including warm referral approaches to facilitate a smooth transition for consumers
- Self-management supports, including resources and linkages with peer and community-based programs, activities and networks, as appropriate
- Guidance for re-engagement, should the consumer need Community Health Program services in the future.

For clinical services, service providers must have clinical handover process that are guided by best practice and consistent with relevant standards, such as:

- National Safety and Quality Health Service Standards, Communicating for Safety Standard[2]
- National Safety and Quality Primary and Community Healthcare Standards, Clinical Safety Standard[3]
- RACGP Standards for general practices, Criterion C5.3 – Clinical handover[4]

[2] Australian Commission on Safety and Quality in Health Care (2023). Communicating for Safety Standard. Accessed from https://www.safetyandquality.gov.au/standards/nsqhs-standards/communicating-safety-standard

[3] Australian Commission on Safety and Quality in Health Care (2023). Clinical Safety Standard. Accessed from https://www.safetyandquality.gov.au/standards/primary-and-community-healthcare/clinical-safety-standard

[4] RACGP (2023). Standards for general practices, Core module, Criterion C5.3 – Clinical handover. Accessed from https://www.racgp.org.au/running-a-practice/practice-standards/standards-5th-edition/standards-for-general-practices-5th-ed/core-standards/core-standard-5/criterion-c5-3-clinical-handover

# Organisational enablers

## Clinical governance

Clinical governance is defined by the Australian Commission on Quality and Safety in Health Care as “the set of relationships and responsibilities established by a health service organisation to ensure good clinical outcomes”.[5]

For Community Health Program service providers, clinical governance arrangements are required that reflect the Community Health Program’s unique service models, local partnerships and integrated care approach.

In developing clinical governance arrangements, service providers should be guided by relevant state and national frameworks, such as:

- Delivering high-quality healthcare, Victorian clinical governance framework[6]
- Community services quality governance framework[7]
- National Model Clinical Governance Framework[8]

## Funding

Delivery of the Community Health Program supports the efficient use of health system resources and contributes to improved system sustainability and outcomes. Community Health Program funding is activity-based and the activity measure is service hours.

Funding can be used flexibly to meet the needs of local populations. To ensure services are targeted appropriately, service providers should consider:

- population health needs across different age groups and across the care continuum
- gaps in services for specific population groups that experience inequity in access or health outcomes
- the development of service models that are appropriate and accessible to local populations
- complementary services offered by other service providers and mechanisms for service coordination.

Funded organisations that identify a need for a specific population response should prioritise their Community Health Program funding appropriately and refer to the relevant Activity Description and any supplementary initiative guidelines that may be applicable.

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[5] Australian Commission on Quality and Safety in Health Care (2017). National Model Clinical Governance Framework. Accessed from https://www.safetyandquality.gov.au/our-work/clinical-governance/national-model-clinical-governance-framework

[6] Safer Care Victoria (2018). Delivering high-quality healthcare, Victorian clinical governance framework. Accessed from https://www.safercare.vic.gov.au/support-training/clinical-governance

[7] Victorian Government (2018). Community services quality governance framework. Accessed from https://www.dffh.vic.gov.au/publications/community-services-quality-governance-framework

[8] Australian Commission on Quality and Safety in Health Care (2017). National Model Clinical Governance Framework. Accessed from https://www.safetyandquality.gov.au/our-work/clinical-governance/national-model-clinical-governance-framework

## Community Health Single Unit Price

In response to the Victorian Auditor General's Office (VAGO) audit of the Community Health Program and recommendations from the Community Health Taskforce, the Department of Health introduced a single unit price for the Community Health Program and complementary programs. This was finalised for all Community Health Program activities and service providers from 1 July 2025.

A single unit price allows services to be more responsive and adaptable to community needs and to utilise their workforce more flexibly, ultimately supporting better integrated and coordinated care for consumers with chronic and complex conditions. This funding reform did not change the amount of funding service providers receive to deliver these services.

Community Health Program funding is based on 'service hours'. The single unit price funds one hour of service delivery, and this includes the direct and indirect costs of delivering that service.

**Table 3: Costs included in the Community Health single unit price – hour of service**

| Direct costs | Indirect costs |
|---|---|
| • Staffing costs for the delivery of an hour of service | • Travel expenses<br>• General operating costs and overheads<br>• Corporate costs (e.g., corporate support functions, rent, facility maintenance etc) |

Funding is allocated according to target service hours and calculated using the single unit price. Service-hour targets are undifferentiated and can be applied flexibly across services and workforce. Service providers report against their service-hour targets through the Community Health Minimum Data Set (see Community Health data) An hour of service is counted as the direct and indirect time spent providing a service to a client, and does not include all hours worked by staff or all activities undertaken in delivering the Community Health Program. These costs are built into the unit price and should be funded through the difference between the direct cost of service, and the unit price.

**Table 4: Counting rules for Community Health Program service-hour targets**

| Reportable as service-hours | Not reportable as service hours |
|---|---|
| • Direct time: time spent directly providing a service either face-to-face, video link or telephone communication<br>• Indirect time: time spent away from a client or clients, in essential activities to provide support to a client or clients, such as<br>– Organising and/or attending case meetings/conferences<br>– Preparing case notes and other required documentation<br>– Monitoring and reviewing treatment plans<br>– Referral and system navigation<br>– Clinical supervision, including individual group and peer<br>– Preparation for group sessions<br>– Secondary consultation | • Travel time<br>• Professional development<br>• Compliance activities<br>• Block funded activities, including Community Health-Health Promotion (28085)<br>• Activities funded outside of the Community Health Program, for example:<br>– Other Department of Health funded activities<br>– MBS billed services<br>– NDIS billed services<br>• Service provided to clients in a private capacity (i.e., where the full cost of the service is paid by the client or the fee charged exceeds the maximum fee set in the Community Health Program fee policy) |

| | |
|---|---|
| – Preparation for a not attended session | |

Service providers should refer to the Policy and Funding Guidelines <https://www.health.vic.gov.au/policy-and-funding-guidelines-for-health-services> for more information about funding policy, noting these are updated annually.

For more information on reporting, refer to the Community health data section of this document or visit:

- Community health data reporting <https://www.health.vic.gov.au/community-health/community-health-data-reporting>
- Community Health Minimum Data Set <https://www.health.vic.gov.au/primary-and-community-health/community-health-minimum-data-set-chmds>

### Acknowledgement of Community Health Program Funding

Service providers must acknowledge the use of Community Health Program funding in program advertising and promotion. This will support community and Government visibility of how funding is being utilised. This includes on service provider websites and in communications materials. The Department recommends the following:

> *This service is delivered with Victorian Government funding and is part of the Victorian Community Health Program.*

### Community Health Program fee policy

Service providers may implement fees for Community Health Program activities to support service delivery costs and to generate income to invest back into services.

Service providers are not required to charge fees.

Service providers that do charge fees, must only do so in line with the Department's Community Health Program fee policy <https://www.health.vic.gov.au/community-health/community-health-fees-schedule-and-income-ranges>.

## Workforce

Delivery of the Community Health Program requires a workforce that is equipped with a diverse range of skills and experience, and the capability and capacity to respond to diverse community needs. Workforce models will vary between service providers based on local service models, workforce availability and community needs.

Practitioners must work within their required scope of practice and adhere to professional standards and ethics. Appropriate supervision and management arrangements are required to support both clinical and non-clinical staff.

## Community health data

As a condition of funding, service providers are required to report back to the department about the services they deliver through the Community Health Program. The Community Health Minimum Data Set (CHMDS) is the key data repository for the Community Health Program. The range of data collected, and the data element definitions are detailed in the Community Health Minimum Data Set submission guidelines <https://www.health.vic.gov.au/primary-and-community-health/community-health-minimum-data-set-chmds>.

The department uses CHMDS data for a variety of purposes, including performance monitoring, service planning and policy development.

The department may from time to time, request additional information from Community Health Program service providers, or require additional reporting for a specific activity.

For more information, service providers should refer to Community Heath data reporting <https://www.health.vic.gov.au/community-health/community-health-data-reporting>.

## Accreditation

Accreditation is an important part of the regulatory framework for organisations that receive Victorian Government funding to deliver services to consumers. Accreditation provides assurance to government and the community that systems are present to protect the public from harm and ensure the quality of services provided.

Accreditation requirements for Community Health Program services vary based on the type of organisation delivering the service:

- Integrated community health services are subject to the accreditation requirements of their parent health service and must comply with the National Safety and Quality Health Service Standards.
- Registered community health services and all other organisations that receive funding through the Community Health Program to deliver services to consumers, must be accredited by a body or entity certified by the International Society for Quality in Health Care or the Joint Accreditation System of Australia and New Zealand. For a list of applicable standards, service providers should refer to the department's Policy and funding guidelines <https://www.health.vic.gov.au/policy-and-funding-guidelines-for-health-services> or Registration, accreditation and governance of community health centres <https://www.health.vic.gov.au/community-health/registration-and-governance-of-community-health-centres>.

# Appendix 1 – Key links and resources

| Topic | Link |
|---|---|
| Demand Management Toolkit | https://www.health.vic.gov.au/community-health/community-health-demand-management-toolkit |
| Language services policy | https://www.health.vic.gov.au/publications/language-services-policy |
| Policy and funding guidelines | https://www.health.vic.gov.au/policy-and-funding-guidelines-for-health-services |
| Community Health data reporting | https://www.health.vic.gov.au/community-health/community-health-data-reporting |
| Community Health Minimum Data Set (CHMDS) | https://www.health.vic.gov.au/primary-and-community-health/community-health-minimum-data-set-chmds |
| Registration and Governance of Community Health Centres | https://www.health.vic.gov.au/community-health/registration-and-governance-of-community-health-centres |
| Community Health access policy | https://www.health.vic.gov.au/community-health/community-health-program-access-policy |
| Incident reporting for community health services | https://www.health.vic.gov.au/incident-reporting-community-health-services |
| Community Health fees policy | https://www.health.vic.gov.au/community-health/community-health-fees-schedule-and-income-ranges |
| Aboriginal Health | https://www.health.vic.gov.au/health-strategies/aboriginal-health<br>https://www.firstpeoplesrelations.vic.gov.au/victorian-aboriginal-affairs-framework |
| Children, Youth and Families | https://www.health.vic.gov.au/community-health/children-youth-and-families |
| Healthy Mothers Healthy Babies | https://www2.health.vic.gov.au/primary-and-community-health/community-health/population-groups/children-youth-and-families/healthy-mothers-healthy-babies |
| Vulnerable Children | https://www.health.vic.gov.au/populations/vulnerable-children |
| Refugee and asylum seeker health and wellbeing | https://www.health.vic.gov.au/populations/refugee-and-asylum-seeker-health-and-wellbeing<br>https://www.health.vic.gov.au/community-health/refugee-health-program |

# Appendix 2 Community Health Program Activities

Activity descriptions are available from the Department of Families, Fairness and Housing and Department of Health activity search <https://providers.dffh.vic.gov.au/families-fairness-housing-health-activity-search>.

| Activity | Objective | Description | Client Group |
|---|---|---|---|
| 28086 Community Health | To provide effective and accessible primary and community health care services and support to Victorians at risk of poor health outcomes. | The Community Health activity is part of the Victorian Community Health Program and provides funding for allied health, nursing, general counselling and care coordination services. | People at risk of poor health outcomes, who face barriers to accessing care through other services and in other settings. Eligibility criteria is provided in the Community Health access policy. |
| 35048 Small Rural – Primary Flexible Health Services | To provide effective and accessible primary and community health care services and support to Victorians at risk of poor health outcomes. | Small Rural Primary Health - Flexible Services activity is part of the Victorian Community Health Program and provides allied health, nursing, general counselling, care coordination and health promotion services. | People at risk of poor health outcomes, who face barriers to accessing care through other services and in other settings. Eligibility criteria is provided in the Community Health access policy. |
| 28091 Community Asthma Program | To support avoidable hospital admissions through the delivery of community-based services, with a focus on asthma self-management and improved cohesion of services for children and young people presenting asthma symptoms. | The Community Asthma Program activity is part of the Victorian Community Health Program and provides coordinated, responsive and preventative services, with a focus on education and self-management. | Children and young people (0-18 years old) with asthma symptoms and their families |

| Activity | Objective | Description | Client Group |
|---|---|---|---|
| 28068 Family Planning | To assist Victorians to make individual choices on sexual and reproductive health matters | The Family Planning activity is part of the Victorian Community Health Program and provides therapeutic intervention, clinical care, practical assistance, support, referral and/or advocacy that is responsive and cultural relevant. | People who face barriers to accessing care through other services and in other settings. Eligibility criteria is provided in the Community Health access policy. |
| 28080 Healthy Mothers, Healthy Babies | To improve the health and wellbeing of mothers and babies, and reduce health inequity by addressing maternal risk behaviours and providing support during pregnancy | The Healthy Mothers Healthy Babies activity is part of the Victorian Community Health Program and provides support, health education and referrals for pregnant women. | Pregnant women who face barriers to accessing antenatal services, or who need additional support during their pregnancy. Support is also available to link other family members to necessary services. |
| 28066 Innovative Health Services for Homeless Youth | To promote health care and improve access to services for young people who are homeless or at risk of homelessness | The Innovative Health Services for Homeless Youth activity is part of the Victorian Community Health Program and provides prevention services, clinical care, practical assistance, education, support, referral and advocacy. | Young people who are homeless or at risk of homelessness. |
| 28072 Integrated Chronic Disease Management | To assist people with chronic disease to improve their capacity to manage their condition, prevent complications and improve their health and wellbeing. | The Integrated Chronic Disease Management activity is part of the Victorian Community Health Program and provides allied health, nursing and general counselling services. | People with chronic disease who face barriers to accessing care through other services and in other settings. Eligibility criteria is provided in the Community Health access policy. |

| Activity | Objective | Description | Client Group |
|---|---|---|---|
| 28090 MDC – Community Health Nurse | Sexual Assault Multidisciplinary Centres (MDCs) bring together in a single location the key services involved in supporting children and adults who have experienced sexual assault. The community health nurse position aims to enhance the centre's capability to respond to the physical and social health and wellbeing needs of clients. | The MDC - Community Health Nurse activity is part of the Victorian Community Health Program and provides support to clients to identity health and care needs, and to navigate and access services and programs to meet each individual's needs. | People and non-offending family members, who have experienced either a recent or historical sexual assault. |
| 28076 Refugee and Asylum Seekers Health Services (Refugee Health Program) | To respond to the poor health and complex health issues of arriving refugees and people seeking asylum in Victoria. | The Refugee and Asylum Seeker Health Services activity is part of the Victorian Community Health Program and provides allied health, nursing, general counselling, casework services. | Refugees and people seeking asylum in Victoria |