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| Community health integrated program guidelinesDirection for the Community Health Program |
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| To receive this publication in an accessible format, email Primary and Community Health <partnerships.primary@dhhs.vic.gov.au>Authorised and published by the Victorian Government, 1 Treasury Place, Melbourne.© State of Victoria, Department of Health and Human Services, first issued March 2015, reissued April 2019This work is licensed under a [Creative Commons Attribution 3.0 licence](https://creativecommons.org/licenses/by/3.0/au/) <https://creativecommons.org/licenses/by/3.0/au/>. It is a condition of this licence that you credit the State of Victoria as author.Available at [Community Health Integrated Program (CHIP) guidelines](https://www.health.vic.gov.au/community-health/community-health-integrated-program-chip-guidelines) <https://www.health.vic.gov.au/community-health/community-health-integrated-program-chip-guidelines>ISBN 978-1-76069-785-3 (pdf/online/MS word)(1903179) |
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Disclaimer

The Department of Health and Human Services has completed a preliminary revision of the suite of Community Health Program Guidelines. The suite of guidelines includes:

* *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*

Further revision and updates will be made as actions under the Victorian Auditor General’s Office audit of the Community Health Program are progressively implemented.

Contents

[Introduction 5](#_Toc5715106)

[Purpose of the guidelines 6](#_Toc5715107)

[The Community Health Program 8](#_Toc5715108)

[Alignment with key strategic frameworks 8](#_Toc5715109)

[Prioritising access for key population groups 9](#_Toc5715110)

[Community Health Minimum Data Set 9](#_Toc5715111)

[Principles of Community Health Program care 10](#_Toc5715112)

[Care is person-centred 11](#_Toc5715113)

[Care is culturally responsive 11](#_Toc5715114)

[Care is evidence based 12](#_Toc5715115)

[Care reflects a team approach 13](#_Toc5715116)

[Care is goal directed 13](#_Toc5715117)

[Care builds self-management capacity 13](#_Toc5715118)

[Care promotes health literacy 14](#_Toc5715119)

[Care promotes health and wellbeing 14](#_Toc5715120)

[Care is provided early 15](#_Toc5715121)

[Care is high quality 15](#_Toc5715122)

[Care is supported 18](#_Toc5715123)

[Translation into practice 20](#_Toc5715124)

[Access and initial contact 22](#_Toc5715125)

[Initial needs identification 24](#_Toc5715126)

[Assessment 26](#_Toc5715127)

[Care planning and implementation 28](#_Toc5715128)

[Monitoring and review 30](#_Toc5715129)

[Transition and exit 31](#_Toc5715130)

[References 33](#_Toc5715131)

[Appendix 1: Some key Victorian policies and frameworks 35](#_Toc5715132)

[Appendix 3: Glossary 37](#_Toc5715133)

[Appendix 4: Community health program funded activities 42](#_Toc5715134)

[Appendix 5: Text-equivalent descriptions of figures 43](#_Toc5715135)

# Introduction

The Community Health Program is a key state funded program delivered primarily by community health services

Each year the Community Health Program sees approximately 200,000 clients and provides over one million hours of nursing, allied health and counselling services to vulnerable Victorians, approximately half of whom are concession card holders.

The Community Health Program funds a range of activities as outlined in Figure 1. The department administers the Community Health Program through a flexible funding source that enables service providers to deliver local models of care and services that are responsive, flexible and person centred and that meet the needs of their community.

In addition, Community Health Program funding is also included within other initiatives and programs targeted at specific populations and conditions such as vulnerable pregnant women, refugee and asylum seeker and those with chronic condition and/or complex needs.

Figure 1: Activities funded by the Community Health Program



People’s health and wellbeing is also impacted by numerous other factors such as educational opportunities, the environment in which they live, their work and recreation and their lifestyle choices and decisions. Social determinants are important and include the conditions in which people are born, grow, live, work and age (World Health Organization 2019). Remaining healthy and well does not occur in isolation.

To this end, people who benefit from the services provided by the Community Health Program may also be accessing a range of other services. The person is the focus of all these efforts and the point where programs and services come together to meet that person’s needs. Integration and coordination is therefore an important consideration in developing genuinely person-centred care that can respond effectively to varied needs. By building partnerships with other organisations, sectors and businesses, health services also contribute to addressing the social determinants of health and support communities to become more resilient and active.

As the community changes, there are also changes in the way that healthcare is aligned, organised and delivered. Key areas of reform include Commonwealth reforms such as the National Disability Insurance Scheme, aged care and the establishment of Primary Health Networks. Changes such as these have implications for the Community Health Program.

Providers of the Community Health Program are continually seeking ways to improve service delivery to their local populations and deliver high-quality coordinated care. New and innovative approaches to service delivery will arise from continuing to strengthen current services as well as recognising and taking opportunities that present themselves from changes in the wider environment. The Community Health Program needs to continue to adapt and respond effectively to community needs in this changing environment.

The program guidelines provided in this document sit within this context, providing directions to guide a consistent approach to delivery of the Community Health Program, while retaining the flexibility to adapt to people’s changing needs, and the needs of the community.

## Purpose of the guidelines

These guidelines describe what is expected of organisations funded to deliver the Community Health Program. The aim is to improve consistency across the state in planning, program design and service delivery and clarify expectations for coordinated service provision. The guidelines are evidence based, and translate that evidence into practical components that underpin program delivery in the community-based settings.

This document provides an overarching framework for the Community Health Program and is complemented by separate documents that provide guidance on meeting the needs of specific groups of people:

* people with chronic disease
* children including vulnerable children
	+ refugee and asylum seekers.

The primary audience is organisations funded to deliver the Community Health Program. However, given the integrated nature of service provision, organisations involved with other primary health and community-based support services may also find these guidelines useful for guiding other program development and delivery.

Within this shared and consistent approach to program delivery, considerations at the local level concern the diversity in size and circumstance of Community Health Program service delivery settings. Strengths and priorities for service delivery will reflect local needs and communities. To this end the guidelines aim to accommodate the range of organisations funded to deliver Community Health Program services.

Boards, managers and staff, and the local community, will need to work together to ensure that their program is aligned with these requirements. Continuous quality improvement processes are a key element in the development and innovation required to deliver the best possible care.

These guidelines 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
* service agreements
	+ legislative and regulatory requirements, in particular the *Health Services Act 1988*. Some relevant policy documents are listed in Appendix 1 and 2.

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| The term person or people is used to refer to people who require services provided through the Community Health Program – this encompasses consumers, service users and clients.Providers of services are referred to as practitioners – this encompasses clinicians of all disciplines and types. |



# The Community Health Program

The aim of the Community Health Program is to provide effective healthcare services and support to priority populations. The program funds general counselling, allied health and nursing services that aim to maximise health and wellbeing and slow the progression of disease. The funded activities that form the Community Health Program are shown in ‘Appendix 4: Community Health Program’. The program provides support and services that are high quality, affordable and delivered in a flexible way that responds to the needs of people and communities. Service models are structured so that people with complex needs receive a more flexible and coordinated approach.

It is important to recognise that service providers involved in the delivery of the Community Health Program are also likely to be involved in the delivery of primary prevention through the funded activity Community Health – Health Promotion. This funding aims to tackle the social determinants of health at a population level. For more information, visit [health.vic. – Health promotion](https://www.health.vic.gov.au/population-health-systems/health-promotion) <https://www.health.vic.gov.au/population-health-systems/health-promotion>.

The delivery of culturally responsive and equitable services is a core activity of the Community Health Program. Funding is provided for language services through a variety of mechanisms, including the Language Services Credit Line system. The credit line provides access to onsite and telephone interpreting services, as well as translation services.

Enhancing access for those with poor access to alternative primary care services is a key priority, as outlined below.

## Alignment with key strategic frameworks

The Community Health Program makes an important contribution to delivering on key strategic frameworks and policies of the department through its delivery of services that are flexible, locally responsive, person centred and integrated. In particular, the Community Health Program contributes to meeting the aspirations of Health 2040 (link) – better health, better access and better care. It does this by:

* integrating primary health and social care for disadvantaged Victorians, many of whom have complex needs
* improving access to primary care services, including offering services to disadvantaged or isolated people and communities
	+ providing support in managing chronic disease, and enabling some lower acuity care to be moved into community settings
* In addition, the Community Health Program contributes to the delivery of the [Victorian Public Health and Wellbeing Plan](https://www.health.vic.gov.au/victorian-health-and-wellbeing-plan) <https://www.health.vic.gov.au/victorian-health-and-wellbeing-plan>. The Community Health Program supports the strategic directions of the plan by providing primary and preventative health services, including earlier and more connected support that is tailored to the health and wellbeing needs of local communities.

## Prioritising access for key population groups

The Community Health Program prioritises access for populations, families and children and those at risk of stigma and discrimination that are socially or economically disadvantaged, experience poorer health outcomes, have complex care needs and / or limited access to appropriate healthcare services.

The program’s priority population groups are:

* Aboriginal and Torres Strait Islander people[[1]](#footnote-1)
* people with an intellectual disability
* refugees and people seeking asylum[[2]](#footnote-2)
* people experiencing homelessness and people at risk of homelessness
* people with a serious mental illness
	+ children in out-of-home care.

More detail about prioritising access to the Community Health Program is provided in Towards a demand management framework for community health services and Community health priority tools. For more information, visit [Managing demand – an overview](https://www.health.vic.gov.au/community-health/managing-demand-for-community-health-services) <https://www.health.vic.gov.au/community-health/managing-demand-for-community-health-services>.

## Community Health Minimum Data Set

The Community Health Minimum Data Set (CHMDS) is the key data repository for the Community Health Program, and is a reporting requirement for organisations funded by the Department of Health and Human Services. The range of data collected and the data element definitions are detailed in the Community Health Program data reporting guidelines.

The dataset collects information about the people and populations that use services, as well as detail on various characteristics and needs, to assist with service planning at both a local and statewide level.

In addition, it ensures public accountability for expenditure, detailing the type and services delivered by funded agencies. CHMDS data is used in regular reports on the Community Health Program to government. For more information, visit [health.vic. Community health data reporting](https://www2.health.vic.gov.au/primary-and-community-health/community-health/community-health-program/community-health-data-reporting) <https://www2.health.vic.gov.au/primary-and-community-health/community-health/community-health-program/community-health-data-reporting>.

# Principles of Community Health Program care

The following principles of care provide a foundation for person-centred practice in the Community Health Program.

It should be acknowledged that the principles are underpinned by coordinated care and integrated service provision. These principles align with current evidence and can be applied to the delivery of service and support. They also provide guidance at both the system and organisational level to inform planning.

The application of the principles will vary according to circumstances. Critical analysis, clinical judgement and a good understanding of both individual and environmental factors will help determine how these principles are applied. This will ensure that the level of support is commensurate for the person, their family and/or carer’s needs and preferences, as well as assessment of the complexity and risk. As each person’s needs and circumstances are different, the configuration and duration of Community Health Program input will vary.

Figure 2: Principles of care



## Care is person-centred

Person-**centred** care is the delivery of services configured around the specific needs of the person, their family and/or carer. Effective person-centred care appreciates the diversity that exists within our communities and acknowledges the unique attributes and circumstances of people. This can include age, sexual orientation, gender and religious beliefs.

It encompasses ‘person-**directed** care’ in which the person, their family and/or carer is supported to determine their preferred care options and most appropriate pathways. Person-directed care emphasises people taking an active role in health and wellbeing, and gives greater control over the way that resources are used.

Self-directed care has been demonstrated to lead to better outcomes (Bauman et al. 2003), increased satisfaction in quality of life (Department of Health and Ageing 2012) and more effective and efficient use of resources (Bertakis and Azari 2011). People need to be informed about their care choices and for their decisions to be honoured.

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| ‘Self-directed support gives individuals and their families a greater voice and recognises that individuals and their families know what will best meet their support needs.’Victorian Department of Human Services, 2013 |

## Care is culturally responsive

Practitioners and organisations must respond to the cultural needs of people and the community. The diversity of the Victorian population makes culturally responsive care a key part of health service delivery for all health services. Cultural responsiveness (Department of Health 2009; 2012) refers to health services that are respectful of, and relevant to, the health beliefs, health practices, culture and linguistic needs of diverse populations and communities (that is, communities whose members identify as having particular cultural or linguistic affiliation by virtue of their place of birth, ancestry or ethnic origin, gender, religion, preferred language or language spoken at home).

Cultural responsiveness describes the capacity to actively respond to the healthcare issues of diverse communities. It thus requires knowledge and capacity at different levels of intervention: systemic, organisational, practitioner and individual. This appropriate response to cultural needs is integral to delivering effective person-centred care.

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| Cultural responsiveness is more than cultural awareness. Awareness is only a first step. What matters is how organisations and individuals within each organisation behave as a result of that awareness. Organisations need to put processes and systems in place if they are to achieve cultural change and to embed it in everyday behaviour. Cultural awareness and sensitivity are building blocks; cultural responsiveness is the desired outcome.’*Koolin Balit: Victorian Government strategic directions for Aboriginal health 2012–2022* |

## Care is evidence based

Evidence-based practice refers to using the best available evidence, integrated with expertise, to make decisions about the best care options and interventions. It promotes transparent processes that emphasise the importance of bringing research evidence into decision making.

Evidence-based care requires practitioners and organisations to actively review findings from all types of research and use this evidence when working with people to arrive at decisions about service models, program approaches and care and treatment options. Evidence-based practice requires practitioners and organisations to:

* seek the best available evidence from a variety of sources
* critically appraise the evidence
* decide what outcome is to be achieved
* apply that evidence in professional practice
	+ evaluate the outcome.

As well as the more traditional methods of research, evidence informed practice allows identification of models of care that have been proven effective through rigorous evaluation in practice. This allows models of care that are grounded in evidence to be applied within the current scope and context of the Community Health Program.

Practitioners and people accessing services benefit from drawing on and contributing to both these valuable resource pools. Ongoing evaluation of interventions will ensure practitioners deliver the most effective and current care to maximise outcomes for people requiring care and support.

Evidence based practice also applies to the processes of service planning and development. Gathering evidence about the local community needs will inform the services and the specific models of care that are required to meet these.



## Care reflects a team approach

While some people will only require episodic care, in many cases people will benefit from a team care approach. Team care consists of a dedicated team of practitioners working collaboratively with the person, their family and/or carer to address their needs. Effective communication between the range of practitioners, the person, their family and/or carer allows different perspectives and skills to be brought together to identify needs, achieve goals and enhance quality of care (O’Neill and Cowman 2008) and care outcomes (Tieman et al. 2007). The team can include practitioners, internal and external to the program, as well as staff working outside of health services. Teamwork has demonstrated positive associations between practitioner– person continuity and satisfaction, reduced service use, increased efficiency and better preventive care (Boeckxstaens and De Graaf 2011).

Providing structures and processes that facilitate multi or interdisciplinary management will help practitioners to use this best-practice approach. These include processes such as case conferences, care plans and care-coordination efforts.

Care coordination is the deliberate organisation of care activities between multiple practitioners involved in a person’s care, both within and between services. It is a key part of working effectively as a team. These activities ensure that all involved, including the person, their family and/or carer have a clear, shared expectation about their roles in the care (The Commonwealth Fund 2011). Coordination applies across a single course of care, multiple courses of care, and care across a range of Community Health Program practitioners as well as those from external organisations. In addition, coordination across the care continuum and disease progression is essential to ensure the most appropriate services are available when required. Effective care coordination can lead to improved health and wellbeing (Tieman et al. 2007) as well as reducing duplication, delays and conflicting information (Blendon et al. 2003).

## Care is goal directed

The assessment process is followed by goals, actions and interventions to address the issues identified. Goals are developed and agreed collaboratively with the person, their carers and family as well as other service providers. Identifying clear, concise and measurable goals provides direction and the opportunity to reflect on achievements within the episode or course of care.

Goal-directed care assists with:

* ensuring a person-centred approach
* ensuring awareness of the aims of interventions across all service providers
* facilitating a coordinated approach
* linking assessment, care planning and discharge
* directing effort towards improvements in everyday life.

## Care builds self-management capacity

Effective self-management allows people, their family and/or carer to take an active role in improving health and addressing health problems. Self-management aims to optimise a person’s capacity to manage the risk or impact of illness over time, and supports working effectively with a range of practitioners to identify and address priority needs. It is therefore particularly important in the effective management of chronic conditions. People who are actively engaged in self-management practices are better equipped to maintain optimal health.

Self-management capacity can be supported through:

* a focus on building self-efficacy as well as a person’s and family’s knowledge and health literacy
* effective assessment, goal setting, action planning and problem solving
* providing psychosocial support, motivating behaviour change and building confidence
* being responsible and flexible in service delivery approaches.

## Care promotes health literacy

The World Health Organization’s definition of health literacy focuses on the capacity and skills of individuals. It is defined as

the cognitive and social skills that determine the motivation and ability of individuals to gain access to understand and use information in ways which promote and maintain good health. Health literacy means more than being able to read pamphlets and successfully make appointments. By improving people’s access to health information and their capacity to use it effectively, health literacy is critical to empowerment (World Health Organization 2009).

There are strong links between low health literacy, unhealthy behaviours and health outcomes. For example, people with chronic conditions who have suboptimal health literacy have been shown to lack knowledge about disease process and have poorer self-management skills (Gazmararian et al. 2003). Among seniors, lower health literacy has been associated with poorer overall health status and higher mortality (Berkman et al. 2011).

Making sure that people receive appropriate and relevant health information in a way that is meaningful to them, providing people with information, encouraging open communication, and supporting active involvement in health decisions promotes health literacy and is a key component in establishing a person-centred approach (Coulter 2002) to care.

A service environment that supports health literacy is one that makes it easier for people, carers and families to navigate, understand and use health information and services to make effective decisions and take appropriate action about health and healthcare (Australian Commission on Safety and Quality in Health Care 2013).

## Care promotes health and wellbeing

Health promoting practice involves practitioners using health promotion strategies to address primary, secondary and tertiary prevention. Organisations and practitioners have a role in emphasising the importance of overall health and wellbeing to people, carers and communities.

The clinical encounter is an opportunity to discuss the whole health picture and look at all the factors impacting on health. It may also provide an opportunity to deliver health promotion interventions targeting relevant risk factors or behaviours such as smoking or physical inactivity.

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| ‘Health promotion can be defined as the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social wellbeing, an individual or group must be able to identify and to realise aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasising social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond health lifestyles to wellbeing.’The Ottawa Charter 1986 |

## Care is provided early

Providing the right care at the right time is an important part of effective health service delivery. Early intervention is an important part of this.

Early intervention refers to intervening early in the disease, issue or life course to minimise adverse effects and promote ongoing health and wellbeing. The aims of early intervention include minimising the impact of disease, remediating existing or emerging issues, preventing disease progression and promoting self-management and adaptive methods of living. Early interventions target efforts to prevent escalation of problems already evident, and prevent the emergence of problems in at-risk population groups.

Timely referral and review of progress also ensure that early care can be provided. Similarly, effective mechanisms to manage demand are important to prioritise the most urgent care needs.

## Care is high quality

Continuous quality improvement (CQI) in health services improves people’s experience of and access to healthcare, as well as improving their health outcomes. By employing ongoing monitoring and review mechanisms, organisations and practitioners can ensure services are fit for purpose, and are providing a positive experience of care for those using the service.

CQI must be used across the Community Health Program at both an organisation and practitioner level.

Effective quality improvement requires a coordinated approach involving a number of different elements, including:

* systematic monitoring and review
* performance measurement
* accreditation systems and processes
* workforce skills and development
* effective clinical and non-clinical governance
	+ continuous improvement and innovation.

An important part of providing a good quality service is fostering an environment that supports learning, innovation and regular evaluation. Shared organisational values should embody a commitment to delivering safe and high quality care. Developing a culture of quality requires a range of measures and interventions to sustain effective services. Figure 3 highlights the Plan, Do, Study, Act cycle, a familiar quality framework used in community health.



Figure 3: Plan, Do, Study, Act cycle



Source: Department of Health 2010, *The Plan Do Study Act (PDSA)* [*Model for Improvement Project workbook*, State Government of Victoria, Melbourne](%3Chttps%3A/www2.health.vic.gov.au/about/publications/researchandreports/plan-do-study-act-psda-model-workbook) <https://www2.health.vic.gov.au/about/publications/researchandreports/plan-do-study-act-psda-model-workbook>.

### Accreditation

All organisations need to be independently accredited as a condition of receiving state funding and/or registration. Victorian health services and dental services must now be accredited against the National Safety and Quality Health Service (NSQHS) Standards.

The Victorian community health sector and the Department of Health and Human Services is working with the Australian Commission on Safety and Quality in Healthcare to develop guides and resources to support the introduction of the NSQHS Standards to community-based services, including community health.

### Performance measurement, monitoring and reporting

Performance measurement enables organisations to systematically assess progress toward defined goals and objectives (Jolley 2003).

All organisations receiving funding through the Community Health Program are subject to a monitoring framework which includes funding and reporting mechanisms, internal desktop reviews, annual financial assessments and accreditation.

The Community Health Practice Indicators have been developed of the as part of the Victorian Community Health Indicators project. The indicators can be used as part of an organisation’s existing quality process to monitor, review and drive service improvement and provide evidence to support their accreditation process. Additional work is underway to develop a suite of outcome indicators.

These are outlined in the ‘Victorian Community Health Indicators’ box in the ‘Translation to practice’ section.

### Quality of care reports

These annual quality of care reports have had the dual purpose of providing accountability to the Department of Health on quality and safety standards and to facilitate communication with the community about the status of quality and safety across the organisation.

#### Consumer feedback

All community health services are expected to participate in the annual Community Health Services Victorian Healthcare Experience Survey (VHES).

The VHES program measures patient experiences. This enables identification of the areas where these experiences can be improved leading to actions that enhance person-and family-centred care.

### Staff feedback

Compelling evidence has emerged in recent years that health organisations with high levels of staff engagement – where staff are strongly committed to their work and involved in decision-making – deliver better quality care, better client experience and lower rates of sickness absence and staff turnover. Most health services and community health services have been using staff surveys such as the Victorian Public Sector Commission - People Matter Survey.

Staff surveys, including the People Matter Survey, assist leaders to understand how staff perceive aspects of their organisation, including insights into how the organisation, leadership and workgroups operate.

The People Matter Survey gives particular attention to change management, job satisfaction, employee wellbeing and engagement. Staff perceptions and experiences shape their beliefs, beliefs drive behaviours and behaviours can make or break an organisation.

High levels of staff engagement are important for organisations committed to providing responsive and effective primary health services that respond to the needs of the community in their catchments. They also complement the Victorian Healthcare Experience Survey.

The [Victorian health service performance monitoring framework](https://www2.health.vic.gov.au/hospitals-and-health-services/funding-performance-accountability/performance-monitoring) <https://www2.health.vic.gov.au/hospitals-and-health-services/funding-performance-accountability/performance-monitoring> has extended monitoring for hospitals beyond the traditional financial, throughput and access indicators to include indicators of organisational wellbeing and culture. Building on the experience of the sector’s use of staff surveys, the Department of Health and Human Services will progress with the sector the inclusion of the PMS as part of the performance monitoring of community health services.

## Care is supported

### Governance

Public health services are incorporated public statutory authorities established under the *Health Services Act 1988*. They are governed by boards of directors and boards of management appointed by the Governor in Council on the Minster for Health’s recommendation. The Act has provisions for three statutory authority categories: public health services, public hospitals and multipurpose services.[[3]](#footnote-3)

Registered community health services operate as companies limited by guarantee that have chosen to become ‘registered’ under the *Health Services Act 1988*. These are often defined as stand-alone organisations. The Act provides a framework for governance and accountability which comprises a voluntary registration scheme and performance standards to ensure that quality services are provided to Victorian people.

Under the Act the performance standards for registered community health services are set by the Minister for Health and relate to five key areas: governance, management, financial management, risk management and quality service delivery and accreditation.

The [*Victorian health service performance monitoring* framework](https://www2.health.vic.gov.au/hospitals-and-health-services/funding-performance-accountability/performance-monitoring) <https://www2.health.vic.gov.au/hospitals-and-health-services/funding-performance-accountability/performance-monitoring> describes the mechanism used by the Department of Health to formally monitor health service performance. Health service strategic priorities for the forthcoming year are agreed as part of the annual statement of priorities or, where relevant, the service agreement process. The statement of priorities also specifies performance and activity targets to be achieved within the allocated annual budget.

The board of the organisation is ultimately accountable for all aspects of operations as per the performance standards. The governance of clinical services occurs within the context of the broader governance role of boards, which includes financial and corporate functions, setting strategic direction, managing risk, improving performance and ensuring compliance with statutory requirements. Boards will ensure the core business of the organisation reflects local need, supplemented by opportunities to develop and integrate services.



### Clinical governance

Clinical governance is a key responsibility of boards of health services and registered community health services. All state-funded health services will have a formal and effective clinical governance framework in operation whereby:

* practitioners and clinical teams are directly responsible and accountable for the safety and quality of care they provide
	+ boards of governance, chief executive officers and management are accountable for the systems and processes to provide safe, high quality healthcare, and for ensuring practitioners participate in clinical governance activities.

The Department of Health and Human Services has developed the [Victorian clinical governance framework](https://bettersafercare.vic.gov.au/reports-and-publications/clinical-governance-framework) <https://bettersafercare.vic.gov.au/reports-and-publications/clinical-governance-framework>along with additional resources to assist organisations implement a clinical governance framework within their organisations:

Management and reporting to different stakeholders on the safety and quality of community health services is supported by several key initiatives.

### Infrastructure

The infrastructure, resources and equipment requirements of the Community Health Program are shaped by a clinical/ services plan that details the range of services and the associated models of care to be provided. Services may be delivered in stand-alone buildings in the community, located on a hospital site or collocated with other health and human service providers (private, public and NGOs). When alternative models of care are needed more often, such as outreach and home visiting services, the required resources will need to be considered.

### Workforce

The skills of the Community Health Program workforce reflect the requirements of the program. To effectively support people and communities, organisations need to ensure a diverse range of workforce capacity and skill mix. This means, for example being equipped to respond to the often complex and multiple needs of people and communities.

Practitioners must work within the required scope of practice and adhere to professional standards and ethics. Appropriate supervision and management arrangements support both clinical and non-clinical staff. Providing professional development opportunities maintains appropriate skill and knowledge levels. Continued learning and staff development is also is a key part of ensuring the workforce’s skill mix aligns with the services required by the local community.

### Technology and e-health

Use of e-health, including e-referral, e-care coordination, telehealth, personal health monitoring, smartphone and social media technologies, can enhance service coordination and continuity of care to reduce the time, distance and other cost and access barriers to the delivery of care.

E-health can also support better use of data, particularly for monitoring and planning the delivery of services and for decision making at the point of care. Examples of this include the Victorian Service Coordination Tool Templates and directory services such as the Victorian Human Services Directory and the National Human Services Directory.

The governance, practice, technology and data standards and access protocols to support e-health will continue to improve. This will require strong partnerships and change management from all facets of the healthcare sector, government and other partners including Primary Care Partnerships and the computer software vendor community.

### Volunteers

Volunteers are a valued resource within community health. Volunteer involvement within Community Health Programs can help to establish stronger links within the local community widen the skill base and extend the reach of programs.

## Translation into practice

The principles of Community Health Program care apply across all aspects of service delivery and planning. They are equally applicable to all services delivered through the program from child and family support to chronic disease management services.

This section applies the principles of Community Health Program care across the service-user journey, providing a standardised framework incorporating aspects of service coordination practice. It aims to provide practical guidance for putting theory into practice across the episode of care.

Although the model identifies and describes components in the journey, it is dynamic,

with overlap between the stages of practice. For example, initial contact and initial needs identification may be delivered by the same qualified member of staff, or assessment and care planning may take place in a single visit. Figure 4 illustrates the stages of the service-user journey.

Note that the journey through community health is not completed in isolation. The person, their family and/or carer may be interacting and intervening with a multitude of other services across the care continuum. Integration across services is needed to ensure the most appropriate response is prioritised and providers are consolidating effort and interventions.

Figure 4: Service-user journey



This approach to the service-user journey is informed by and complements a range of other policies, tools and guidelines that together aim to strengthen service coordination. These include the [Victorian service coordination practice manual (2012](https://www2.health.vic.gov.au/about/publications/policiesandguidelines/victorian-service-coordination-practice-manual-2012)), which provides an overarching service coordination framework applicable across a range of sectors and services. The manual details the principles of service coordination and defines practices that support it, to assist practitioners to consistently implement service coordination. The Community Health Integrated Program guidelines complement and add value to these existing principles. Service coordination is the foundation for further service improvement.

In addition, the process indicators developed through the Victorian Community Health Indicators project match the corresponding service-user journey component. These indicators support coordinated services and evidence-based practices. Further detail is provided on both service coordination resources and the indicators project in the following breakout boxes.

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| **Service coordination** aims to place people at the centre of service delivery – ensuring they have access to the services they need, opportunities for early intervention and health promotion and improved health outcomes. Service coordination supports more effective ways of working with people with complex and multiple needs. For example, it provides a good foundation for the practice of integrated chronic disease management. Since 2001, the Department of Health and Human Services and Primary Care Partnerships have developed resources to assist in the implementation of service coordination. These include:practice standards – Victorian service coordination practice manualinformation standards – Service Coordination Tool Templates (SCTT)technical standards – SCTT specifications for software vendorsHuman Services Directory.The SCTT is a suite of templates that facilitate service coordination. They support the collection, recording and sharing of initial contact, initial needs identification, referral, information exchange and care planning information in a standardised way. They provide consistent information standards to facilitate electronic sharing of information, and a common language between a range of services.These can be used throughout the service-user journey. |

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| **The Victorian Community Health Indicators project** This project is a partnership between the sector, the Victorian Healthcare Association and the Department of Health and Human Services. An initial set of indicators, the Community Health Practice Indicators (CHPIs) will enable organisations providing the Community Health Program to measure key service delivery and care-coordination activities that make up the service-user journey. The CHPIs can be used as part of an organisation’s existing quality processes to monitor, review and drive service improvement. The CHPIs relate to the relevant sections of the service-user journey. Additional work is underway to develop a suite of outcome indicators, the Community Health Impact Indicators (CHIIs) that will enable providers to measure the efficacy of the models of chronic disease care they deliver.The indicators:support continuous quality improvement rather simply measuring performance – agencies will need to report on use of indicators through their quality of care report.are consistent with the ACSQH practice-level indicators of safety and quality for primary health care (excluding GPs)are consistent with major accreditation standards including QIP, ACHS-EQuIP and NSQHS.All organisations funded through the Community Health Program are required to monitor their quality of practice through the indicators.The indicators align with state and Commonwealth frameworks (including the National Health Performance Framework), the full range of accreditation standards that currently apply to primary health providers and the indicators that organisations collect when reporting on service coordination. |

## Access and initial contact

### Access

Access refers to people finding their way or being supported to the appropriate service. Ensuring fair and equitable access includes proactively reaching out to individuals and communities who experience barriers. Appropriate access is guided by relative need and is timely, equitable and non-discriminatory.

Service models and service design, reception, information provision communication and ensuring a welcoming environment for people, their family and/or carers as well as referrers and other service providers is also an important aspect of building an accessible service.

### Key elements

Establishing and promoting a shared entry point for the range services available ensures people have access.

A defined point of access eliminates confusion and makes it easy for people to contact the service. Access needs to minimise barriers for people, especially vulnerable populations.

Access arrangements need to respect privacy and be sensitive to people’s needs and concerns.

### Good practice

* A centralised or single point of contact can help to streamline access to the range of Community Health Program services. Single access points can be established within or between organisations dependant on arrangements negotiated locally. See the ‘Single access system’ box below.
* Mechanisms to meet local community needs and address access barriers may include:
	+ - outreach models, alternate locations or co-location with essential services
		- ensuring signage and information is provided in community languages
		- models that extend beyond the traditional service hours and utilise technology to maximise reach and ease.
			* advantageously locating community based groups within the centre as a soft introduction to the range of services available.

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| **A single access system** has a single access point from which a range of services or supports may be provided. It is characterised by integrated and consistent intake practice for all services.A single-access model allows the service system to respond more holistically to people’s needs, particularly those with complex or chronic needs and places an onus on services to support the navigation of the system.It also provides the opportunity to provide additional services early in a person’s circumstances as it promotes holistic screening, moving beyond simply identifying a presenting need, eligibility screening and providing information.For a single access system to operate effectively, intake and service functions must be clearly identified described and documented within policies and guidelines. They must be understood by all staff and, most importantly, be consistently provided and monitored. |

### Initial contact

Initial contact establishes the connection between the person and the service. It is a dynamic interaction that develops and assists people, their family and/or carers to make informed decisions about the most effective way to meet their needs and support them in their situation

It may be a direct contact or be facilitated by a referrer, family member or carer.

During initial contact the range of available services and the intake processes such as the role of initial needs identification (INI) is explained. Initial contact is also an opportunity to exchange information about other relevant services or supports.

#### Key elements

Initial contact facilitates a smooth process for accessing services. It provides consistency for referrers and assurance that the referral is received by the appropriate service for INI, assessment and care.

After a referral, the person, their family and/or carer need to be contacted in a timely manner and the referrer also requires acknowledgment and/or feedback.

The information provided needs to be appropriate to the person’s level of health literacy.

Language and cultural needs (including use of interpreters and bicultural workers) needs to be explored with the person, their family and/or carer at this stage.

Risk assessment begins at the initial contact stage. This is an ongoing process that will continue throughout the involvement with community health.

#### Good practice

* Give people, their family and/or carer information about the structure of service, what to expect during assessment processes, and timeframes for services.
* With a person’s consent, source additional information about their needs and circumstances. This may be from family members or additional service providers. When planning subsequent interactions, discuss the most appropriate environment and who needs to be there to limit duplication.
	+ Connect the person, their family and/or carer with the most appropriate service to meet their needs. As this service may be external or additional to the organisation, facilitating onward referral is an essential role of initial discussions, which will extend into INI. Discussing additional and complementary options such as targeted services and the range of private options may be appropriate at this stage.

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| **Community health indicators**Percentage of clients who have been referred whose referral acknowledgment was sent within:two working days of receipt (urgent referral)seven working days of receipt (routine referral) |

## Initial needs identification

Initial needs identification (INI) is a broad screening process that gives the person, their family and/or carer the chance to explore both current and underlying issues. The aim is to determine a person’s needs and the most appropriate response. This discussion will allow opportunities for intervention and information sharing to be highlighted early in the person’s contact with the service. INI is not a diagnostic process, but an identification of the person’s needs, risk, eligibility and priority for service.

### Key elements

During INI the person, their family and/or carer have time to share and discuss issues impacting on their health and wellbeing. This can involve circumstances beyond issues initially raised.

INI must be completed by qualified staff who are able to employ clinical reasoning skills to tailor the extent, intensity and outcomes of the process.

The Service Coordination Tool Templates suite supports the collection, recording and sharing of information throughout the service-user journey. A range of optional templates can be used to support INI. These include the single page screener for health and social needs, health and chronic conditions and social and emotional wellbeing. Not all templates will be relevant, and some items on a template may not be required. They can be used to screen for additional health and social risk and determine the need for further action.

INI helps determine the most appropriate response, range of services or pathway to meet the person’s overall needs, and considers the urgency of the situation. There may be a need to engage and coordinate the response with additional partners. This also includes supplementary supports such as peer support groups.

There is an emphasis on collaboration, and the person, their family and/or carer is at the centre of the process. People should be able to direct, control and make choices about the options available to them. Use a range of communication and clinical techniques to maximise sharing and interaction, depending on individual learning styles and needs.

Needs identification is a dynamic process that will continue throughout the intervention. Needs identification is a process that every practitioner should be involved with.



### Good practice

* Take a holistic approach and consider the complexity of the situation. For example, a person with many, complex needs and minimal family support may require a highly coordinated response across multiple providers.
* In line with consent, team members will share information across service providers where required. Contact key stakeholders at this point to limit duplication.
* INI can be used to identify the degree of care planning that will be required, considering aspects such as the level of response and amount of coordination needed.
* There is flexibility in the implementation of this initial screening process, as one staff member may complete both INI and initial contact simultaneously, or each component may be completed separately by specific practitioners over several days.

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| **Community health indicators**Percentage of clients with INI commenced within no more than seven days of initial contact. Percentage of clients with referrals who have completed consent for disclosure of personal information. |

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| [Community health priority tools](https://www2.health.vic.gov.au/primary-and-community-health/community-health/community-health-program/ch-demand-management/priority-tools-for-community-health-services) <https://www2.health.vic.gov.au/primary-and-community-health/community-health/community-health-program/ch-demand-management/priority-tools-for-community-health-services> are a suite of evidence-based tools developed for community health services to help prioritise people who need services. They provide decision-making support and guide good practice consistently across the state, helping those who most need care to receive it quickly.There are two types of tools.The **generic priority tool** assists services to prioritise people who belong to identified population groups. These groups include people with the poorest health status and the greatest economic and social need for services, as well as those with complex care needs that need a coordinated team approach. It recognises the multiple determinants that influence the health of individuals and communities and helps determine the appropriateness of the services to address people’s needs. The generic priority tool provides a first step in the prioritisation of people requiring a service.The **clinical priority tools** look at the clinical presentation. They can be used if one or more services have been identified. If a person needs more than one of these services, all applicable clinical priority tools should be used. |

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| The [demand management framework](https://www2.health.vic.gov.au/primary-and-community-health/community-health/community-health-program/ch-demand-management/demand-management-overview) <https://www2.health.vic.gov.au/primary-and-community-health/community-health/community-health-program/ch-demand-management/demand-management-overview> allows for a consistent approach to demand management. It provides waiting list definition, and prioritisation and management of allied health, counselling and nursing services throughout the Community Health Program. It:supports navigation through the service system and provides assisted referrals to obtain required servicessupports measurement of demand and unmet needsupports development and application of consistent demand management policies and practicesenhances management of increasing demand for services while balancing the organisation’s capacity and the person’s presenting needsenhances consistent waiting list definition, categorisation and managementsupports development and implementation of early intervention strategies that –* + - allow for intervention while waiting for assessment or services
		- reduce service-user duplication on waiting lists
		- reduce waiting list times and numbers
		- improve service-user outcomes.
 |

## Assessment

Assessment is a decision-making methodology that collects and interprets information about the person and their situation. It is part of an ongoing investigative process that uses professional, interpersonal skills and in-depth enquiry to guide a responsive intervention. The person, their family or carers need to be part of the decision making.

### Key elements

Consider the preferred method and ability to contribute of the person and their family and/or carer. This considers health literacy, communication, cultural, language and cognitive requirements.

While each discipline has specific assessment methods, these can be incorporated into a broader multidisciplinary assessment. This will help reduce duplication for people. The process will also take into account general skills such as self-management and health literacy skills as well as identify opportunities for health promotion.

Clinical reasoning, which takes into account people’s personal preferences, current evidence as well as relevant service and clinical guidelines, is required to make effective intervention and treatment decisions.

Feedback about assessment findings will help the person, their family and/or carer to make informed decisions about care options and responses. The person, their family and/or carer need to be fully aware and understand their responsibilities and role in the subsequent course of care.

### Good practice

* Assessment can cut across different areas of service delivery and will build on existing information gathered from INI, recent assessments, referrers’ information and current service provision.
* The assessment process will lead to the development of the most appropriate response and people to be involved including team members such as allied health assistant or key worker.
* GPs often conduct health assessments as part of good medical care and prevention. Communicate with GPs and other external service providers to determine what services, assessments and/or care plans are already in place.
	+ Disseminate assessment findings to the internal team and external partners, via team meeting discussions or specific case conferences. This is another opportunity to identify care planning and coordination needs.

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| **Community health indicators**Percentage of clients who have indicated the need for an interpreter who actually receive interpreters on their first contact with service/program areaAverage number of calendar days from INI to service-specific assessment for service users within the:higher priority categorymiddle priority categorylower priority category. |



## Care planning and implementation

Care planning outlines how issues will be managed. It incorporates many of the stages of care, including assessment, coordination, case management, referral, information exchange, review, reassessment, monitoring and exiting. The process will produce a unique care plan.

The *Victorian service coordination practice manual* (2012) defines service-specific care planning, which occurs at an individual provider level as well as shared care planning, which involves coordinating support of multiple program areas from within or between organisations.

### Key elements

Care planning involves balancing competing needs and supporting and assisting people, their family and/or carer to make decisions that are appropriate to their needs, priorities, aspirations, values and circumstances.

Care planning establishes the goals for care and how these will be met through a range of interventions and services. The goals should be specific, measureable, achievable, realistic and timed (SMART).

Care plans articulate the different roles taken by different contributors. A care plan may involve a number of services including external organisations. It may be that community health input is only part of a shared care plan.

Effective communication strategies including documentation and information exchange will ensure the effectiveness of a shared care plan. A copy of the care plan should be provided to all involved.

### Good practice

* Nominate a single key worker or care coordinator to ensure effective communication between everyone involved. This person delivers and monitors the care plan, setting review dates, initiating reassessments and giving feedback to referring service providers. Make sure the person at the centre of the care plan and their family and/or carer understands the key worker’s role.
* Schedule case conferences to present and discuss a case. Case conferences support a team approach to care, bringing broader input into decision-making processes.
* Involve GPs in the care planning process to ensure continuity of care.
* Consider using interventions such as group work and allied health assistant support where appropriate.
* Use clinical outcome measures to examine impact of intervention, validate service, quantify improvements and record progress against goals. Reliable and valid measures can be implemented across specific clinical interventions – for example muscle strength or blood glucose levels. Measures can also be employed across qualitative domains such as quality of life scales.
* **Care plans** detail the goals of care and address:
	+ - presenting issues
		- the effect of issues
		- required intervention and care
		- self-management strategies
		- family and carer needs
		- need for additional formal and informal supports
		- ongoing proactive monitoring of progress and achievement of goals
		- regular review mechanisms
		- transition strategies and transfer of information
		- linkages with relevant service providers.
	+ The goal of care planning and implementation is to keep someone as well as possible for as long as possible.

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| **Care planning** is described in more detail in the training unit ‘Implementing goal-directed care planning’, which was developed by the Department of Health and Human Services, Primary Care Partnerships and the community service and health industry training board. It is a competency- based unit that aims to build the capacity of practitioners to undertake person-centred care planning. The unit also assists with coordinating care planning, particularly for people with chronic or complex needs.This training is delivered via the Victorian education and training sector by registered training organisations and is vocational graduate certificate level. It is targeted to a broad range of practitioners across the community and health sector and provides an opportunity to develop skills in knowledge in:working in a multidisciplinary contextfocusing on person-centred approachesbuilding self-management capacitycollaborative goal setting. |

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| **Community health indicators**Percentage of people who did not attend a booked servicePercentage of people with multiple or complex needs with a care plan and with a complete care planPercentage of people with chronic and complex disease with evidence of communication regarding a care plan from the community health service to their GPPercentage of people with type 1 or type 2 diabetes referred for any type of diabetes-related management who have diabetes-related results recorded in their client file |



## Monitoring and review

As people’s needs change over time, their circumstances and priorities should be regularly reviewed. This will ensure support is responsive to and continues to meet needs.

### Key elements

All care and support must be reviewed regularly. The need for, and timing of, a review is determined as part of the initial service or care plan.

Collaboratively update the person’s goals and set new goals to ensure goals continue to provide a focus for intervention.

When support is no longer required, evaluation ensures that all aspects of the service or care plan were delivered and assessed for their effectiveness.

### Good practice

* Mechanisms for reviewing and monitoring may include:
	+ - self-monitoring
		- reassessment
		- telephone contact
		- community-based clinic
		- general practitioner review
		- teleconferencing or videoconferencing
		- home visit
		- case conference
		- case review
		- family and carer meetings
		- a combination of the above.
* A recall pathway may be needed to ensure future review or follow-up of the person’s needs. Services will need to develop systems that facilitate clinically indicated recall pathways.
* Planned systematic recall may be indicated for a number of reasons:
	+ - disease requirement
		- risk
		- goal progression
		- intermittent support
			* concerns with ability to self-manage.

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| **Community health indicators**Percentage of clients with care plans that are reviewed systematically within four weeks of the planned review datePercentage of objectives/goals of care that have been met in the timeframe stated.Percentage of service users with type 1 or type 2 diabetes who have received the recommended reviews as part of best-practice diabetes care |

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| **Recall and review systems** are an effective way to manage people who have long-term needs or a chronic condition. They support planned, managed care and aim to reduce exacerbations in symptoms that may result in crisis interventions.Services should develop systems to identify people who need ongoing review or recall appointments. A recall pathway details a planned recall date and may be established for a number of reasons. The process of adhering to the pathway and the review date needs to be incorporated in the appointment and waiting-list management process. |

## Transition and exit

Transition or exit from a service is at a point where a person’s issues are resolved and/or they are able to manage their current and ongoing care needs. This may be in conjunction with additional formal or informal support or self-support. A planned approach to transition and exit will ensure a smooth, coordinated transition from service provision.

### Key elements

As services are goal orientated, there will be times when transition or exit is considered. Ensuring safety and effective management of ongoing care needs is essential.

Transition to additional care providers can assist the person with independent living and improvement in self-management skills.

A transition or exit summary will be provided to the team including additional service providers and GP. This summary contains feedback on the services and interventions provided and the outcomes achieved, as well as any arrangements for the ongoing management of care including referral or planned recall.

Appropriate transition and exit ensures the person, their family and/or carer can access community health and wider healthcare system if they need to in the future.

### Good practice

* Transition or exit may occur under the following circumstances:
	+ - the person has achieved all the goals documented in the care plan and no more goals are identified
		- the person is not complying with the program and all appropriate attempts to address issues have been made
		- the person no longer wishes to take part in the program
		- the person has been referred to a service that is more appropriate to meet their needs
		- the person has moved from their place of residence and has been referred to services closer to their new residence
		- following a review it is decided that there will be no more benefit from continuing the service
		- it is determined this course of care is complete and/or a planned recall is indicated
		- potential risk to the person or staff prevents service provision
		- circumstances change (such as a new acute hospital admission) and the current service is no longer required.
* Exiting can occur at any stage of the service provision and assists with throughput and access for new people who require service.

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| **Community health indicators**Percentage of people referred by a GP with evidence of discharge or end-of-episode communication from the community health service to the GPPercentage of people and carers satisfied or highly satisfied that the intervention helped them manage their problemPercentage of people and carers satisfied or highly satisfied with their involvement in decisions about their care or treatment. |



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# Appendix 1: Some key Victorian policies and frameworks

Numerous policies and considerations influence the development of the overarching guidelines for the Community Health Program; some of the key directions are discussed in further detail below.

[Department of Health and Human Services Strategic Plan](https://dhhs.vic.gov.au/publications/department-health-and-human-services-strategic-plan)
<https://dhhs.vic.gov.au/publications/department-health-and-human-services-strategic-plan>

The strategic plan sets out 27 departmental priorities and eight enabling actions which prioritise the department’s direction, effort and investment from 1 July 2017 – 31 December 2018

[Ending family violence Victoria’s Plan for change](https://w.www.vic.gov.au/familyviolence.html)
 <https://w.www.vic.gov.au/familyviolence.html>

This ten-year plan articulates how the government will deliver the Royal Commission into Family Violence recommendations, to ensure victim survivor safety and to build a future where Victorians live free from family violence.

[Equity in Participation: towards a new healthcare policy framework](https://www2.health.vic.gov.au/about/participation-and-communication/consumer-participation/equity-in-participation) <<https://www2.health.vic.gov.au/about/participation-and-communication/consumer-participation/equity-in-participation>>

The Department of Health and Human Services has commenced development of a new equity and participation policy. The aim is to align and strengthen consumer, carer and community participation, diversity and equity within a quality and safety framework. It will align the co-related concepts of health literacy, person and family-centred care, shared decision making and cultural responsiveness.

[**Health 2040: advancing health access and care**](https://www2.health.vic.gov.au/about/publications/policiesandguidelines/Health-2040-advancing-health-access-and-care)<https://www2.health.vic.gov.au/about/publications/policiesandguidelines/Health-2040-advancing-health-access-and-care>

Outlines the Victorian Government’s vision for the health system based around three pillars: better health, better access and better care.

[Victorian public health and wellbeing plan 2015-2019](https://www2.health.vic.gov.au/about/health-strategies/public-health-wellbeing-plan)
<https://www2.health.vic.gov.au/about/health-strategies/public-health-wellbeing-plan>

Articulates the government's vision for a Victoria free of the avoidable burden of disease and injury. The plan has strategic directions which set out priorities and actions to improve health and wellbeing on all Victorians.

[Koolin Balit: Victorian Government Strategic Directions for Aboriginal health 2012-2022](https://www2.health.vic.gov.au/about/health-strategies/aboriginal-health/koolin-balit)
< https://www2.health.vic.gov.au/about/health-strategies/aboriginal-health/koolin-balit>

‘Koolin balit’ means ‘healthy people’ in the Boonwurrung language. It is the Victorian Government’s strategic directions for Aboriginal health over the next 10 years.

*Koolin Balit* sets out what the Department of Health and Human Services, together with Aboriginal communities, other parts of government and service providers, will do to achieve the government’s commitment to improve Aboriginal health. It brings together Victoria’s total effort in Aboriginal health in an integrated, whole of life framework based around a set of key priorities and enablers.

[Statewide Design, Service and Infrastructure Plan for Victoria’s Healthcare System 2017-2037](https://www2.health.vic.gov.au/hospitals-and-health-services/health-system-design-planning/statewide-plan)
<https://www2.health.vic.gov.au/hospitals-and-health-services/health-system-design-planning/statewide-plan >

Provides a planning framework that will guide service, workforce and infrastructure investment in the health system over 20 years.

[Roadmap for Reform – Strong families, safe children](Roadmap%20for%20Reform%20%E2%80%93%20Strong%20families%2C%20safe%20children)
<https://dhhs.vic.gov.au/publications/roadmap-reform-strong-families-safe-children>

The Roadmap for Reform: strong families, safe children is one of its key platforms to respond to the Royal Commission into Family Violence’ - to deliver a place-based approach for Victoria’s most vulnerable individuals, families and communities to be better support and able to access and range of services, from preventions through to service interventions.

[Victorian Aboriginal Affairs Framework 2018-2023](https://w.www.vic.gov.au/aboriginalvictoria/policy/victorian-aboriginal-affairs-framework/victorian-aboriginal-affairs-framework-2018-2023.html)
<https://w.www.vic.gov.au/aboriginalvictoria/policy/victorian-aboriginal-affairs-framework/victorian-aboriginal-affairs-framework-2018-2023.html>

Since 2006, Victoria has implemented whole‑of‑government frameworks to address the gaps between Aboriginal and non-Aboriginal Victorians. This Framework provides a forward-looking agenda for Aboriginal affairs and has two key purposes:

1. It is the Victorian Government’s overarching framework for working with Aboriginal Victorians, organisations and the wider community to drive action and improve outcomes in people’s lives.
2. It sets out whole of government self‑determination enablers and principles, and commits government to significant structural and systemic transformation.

[Victoria’s 10 year Mental Health Plan](https://www2.health.vic.gov.au/mental-health/priorities-and-transformation/mental-health-plan)
<https://www2.health.vic.gov.au/mental-health/priorities-and-transformation/mental-health-plan>
Outlines the government’s 10-year plan to guide investment and drive better mental health outcomes for all Victorians, with attention for vulnerable groups.

[Women’s sexual and reproductive health key priorities 2017-2020](https://www2.health.vic.gov.au/about/publications/policiesandguidelines/womens-sexual-health-key-priorities)
<https://www2.health.vic.gov.au/about/publications/policiesandguidelines/womens-sexual-health-key-priorities>

Outlines the Victorian Government’s plan to improve the sexual and reproductive health of all Victorian women and create an effective system:

* that improves community knowledge of sexual and reproductive health,
* supports workforces’ continued learning and
* supports innovative modes of care four key priority areas

# Appendix 3: Glossary

**Allied Health professional**

Allied health professionals are autonomous practitioners who practise in an evidence-based paradigm using an internationally recognised body of knowledge to protect, restore and maintain optimal physical, sensory, psychological, cognitive, social and cultural function. They may utilise or supervise assistants and support workers. Visit the [Allied Health Professionals of Australia website](https://ahpa.com.au/) <https://ahpa.com.au/> for more information.

**Ambulatory Care Sensitive Conditions (ACSCs)**

ACSCs are those for which hospitalisation is thought to be avoidable with the application of public health interventions and early disease management, usually delivered in ambulatory setting such as primary care. High rates of hospital admissions for ACSCs may provide indirect evidence of problems with patient access to primary healthcare, inadequate skills and resources, or disconnection with specialist services.

**Assessment**

A decision-making methodology that collects, weighs and interprets relevant information about the person. Assessment is not an end in itself but part of a process of delivering care and treatment.

It is an investigative process using professional and interpersonal skills and in-depth enquiry to identify relevant issues that will guide a responsive intervention.

**Capacity building**

Building the skills of people, families, carers and communities to successfully engage and actively contribute to their health and wellbeing. A central construct is self-management which aims to optimise people’s capacity to manage the risk or impact of their illness over the lifespan and along the care continuum.

**Care planning**

A dynamic process that incorporates a range of activities such as care coordination, case management, referral, feedback, review, reassessment and monitoring. Care planning involves the judgement or determination of relative need as well as competing needs and assists people to come to decisions that are appropriate to their needs, wishes, values and circumstances.

* Service-specific care/case planning: May occur when a person has one or more issues that can be managed with the support of a single program area, for example an individual treatment plan.
* Shared care/case planning: This is required when the person has numerous issues that require the coordinated support of multiple program areas within or between organisations.

**Carer**

Carers provide unpaid support to a family member or friend who needs assistance. They may care for a frail aged person, someone with a disability, chronic illness or mental illness, or someone recovering from an illness or accident. Carers help people to remain living at home. The caring experience is a dynamic one with the level of support offered by carers changing in relation to the dependency and health needs of the care recipient. Visit the [Carers Victoria website](file:///C%3A%5CUsers%5Candrewmacrae%5CMEGA%5Cjobs15%5C190305_deb_formatting%5C01%5CCarers%20Victoria%20website) <http://www.carersvictoria.org.au/facts/who-are-carers> for more information.

**Chronic condition or chronic disease**

Chronic diseases are diseases of long duration and generally slow progression they include heart disease, stroke, cancer, chronic respiratory diseases and diabetes. Visit the World Health Organization [‘Noncommunicable diseases and their risk factors’ page](https://www.who.int/ncds/en/) <https://www.who.int/ncds/en/> for more information.

**Community health platform**

The community health platform refers to the range of health, human and social care services provided through the established Victorian network of community health services.

**Community health program**

The Community Health Program is a state-funded program provided through Victoria’s community health services for direct service delivery including allied health, counselling and nursing.

**Community health services**

Community health services are organisations that deliver a range of primary health, human services and community based support to meet local community needs.

**Continuous quality improvement**

Includes the use of tools and techniques to identify opportunities for improvement, action planning, measuring and monitoring improvements, empowering staff to identify opportunities and using

a team approach to solve problems and take action. Continuous quality improvement is person centred, driven by evidence and organised for safety.

**Cultural responsiveness**

Being respectful of and relevant to the beliefs, practices and cultural needs of the community.

It describes the capacity to respond to the issues and needs of Aboriginal and Torres Strait Islander peoples and people of culturally diverse backgrounds. Cultural awareness, sensitivity and competence are building blocks; cultural responsiveness is the desired outcome. Organisations will have processes and systems in place if they are to achieve cultural change that is embedded in everyday behaviour.

**Early intervention**

Early intervention refers to intervening early in the disease, issue or life course to minimise adverse effects and promote ongoing health and wellbeing. The aims of early intervention include minimising the impact of disease, remediating existing or emerging issues, preventing disease progression and promoting self-management and adaptive methods of living.

**Evidence-based practice**

Evidence-based practice refers to using the best available evidence, integrated with expertise, to make decisions about the care of an individual. It promotes transparent processes that emphasise the importance of bringing research evidence into decision making.

**Flexible models of service delivery**

Flexible service provision is a key principle of person-centred care and is required to meet the needs of the person, carers and families. Each person presents with a unique and often complex health profile and set of circumstances that require a responsive and flexible service. This ensures that support and care can be tailored to best meet the goals of the people using the service.

**General practice**

General practice provides primary medical health services and may include general practitioners (GPs), practice managers, practice nurses and other allied health and medical specialist services.

**Goal-directed care**

Care needs to be directed by specific, measurable, achievable, realistic and timed goals. These goals are collaboratively developed by the person, families and carers and relevant practitioners. Developing goals to care provides direction as well as the opportunity to regularly monitor progress within the course of care.

**Governance**

Corporate governance refers to the process by which the organisation is directed, controlled and held to account. It encompasses authority, accountability, stewardship, leadership, direction and control exercise in the organisation.

Clinical governance refers to the systematic approach to maintaining and improving the quality of care. It encompasses education and training, clinical quality and safety, clinical effectiveness, research and development, risk management, credentialing and scope of practice. Successfully implementing clinical governance requires developing strong and effective partnerships with

practitioners and managers for providing safe and effective healthcare. A key component of clinical governance is recognition by all staff that they share the responsibility for the quality of care delivered by the service.

**Health and wellbeing**

Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity.

**Health literacy**

The World Health Organization defines health literacy as ‘… the cognitive and social skills which determine the motivation and ability of individuals to access, understand and use information in ways which promote and maintain good health. Health literacy means more than being able to read pamphlets and successfully make appointments. By improving people’s access to health information and their capacity to use it effectively, health literacy is critical to empowerment’ (World Health Organization 2009).

**Health promotion**

The Ottawa charter for health promotion (1986) defines health promotion as ‘… the process of enabling people to increase control over and to improve their health. To reach a state of complete physical, mental and social wellbeing, an individual or group must be able to identify and realise aspirations, to satisfy needs and to change or cope with the environment. Health is, therefore seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasising social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy lifestyles to wellbeing’ (World Health Organization 1986).

**Health-promoting clinical practice**

Health-promoting clinical practice involves practitioners using health promotion strategies to address primary, secondary and tertiary prevention in an opportunistic way. Organisations and practitioners have a role in emphasising the importance of overall health and wellbeing to people, carers and communities. The clinical encounter can be an opportunity to discuss the whole health picture and look at all the factors that can impact on health.

**Integrated care**

Care provided to a person that is coordinated and connected across the continuum of services and among providers in all sectors and levels. The World Health Organization defines healthcare integration as the ‘bringing together of inputs, delivery, management and organisation of services as a means of improving access, quality, user satisfaction and efficiency’ (Gröne and Garcia-Barbero 2002).

**Integrated chronic disease management**

Integrated chronic disease management is the provision of person-centred care in which health services work with each other and the person to ensure coordination, consistency and continuity of care over time and through the different stages of their condition.

**Integrated health promotion**

In Victoria, the term ‘integrated health promotion’ refers to ‘agencies and organisations from a wide range of sectors and communities in a catchment (local area) working in collaboration using a mix of health promotion interventions and capacity building strategies to address priority health and wellbeing issues’ (Department of Human Services 2012).

**Local government**

Local government is the third level of government in Australia. It was established by an Act of state parliament, which specifies local government powers, duties and functions. Councils are area-based, representative governments with a legislative and electoral mandate to manage local issues and plan for the community’s needs. Visit the [Municipal Association of Victoria website](https://www.mav.asn.au/) <https://www.mav.asn.au/> for more information.

**Medicare Benefits Scheme**

The Medicare Benefits Schedule (MBS) is a listing of Medicare services subsidised by the Commonwealth Government. Visit the [Australian Government Department of Health website](http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Home) <http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Home> for more information.

**Medicare Local/Primary Health Networks**

Independent companies which form an organised system for primary healthcare across the country. They are regional primary healthcare organisations built on the foundations of Divisions of General practice and play a key role in planning and coordinating primary healthcare services for their respective populations.

**Model of care**

A model of care is an overarching design for the provision of a particular type of healthcare service that is shaped by evidence based practice and defined standards (Davidson et al. 2006).

**Partnerships**

Working in a collaborative way across health (public and private) and non-health sectors to focus on a shared commitment in addressing health and wellbeing of people and communities.

**Person-centred care**

Person-centred care is the delivery of services configured around the specific needs of the person using the service, their carers and family. This approach positions the person at the centre of the care so that all supports and interventions align with their needs and wants and are planned and coordinated accordingly.

**Primary Care Partnerships (PCPs)**

A PCP is a group of services that has formed a voluntary alliance to improve health and wellbeing in their local community.

**Primary healthcare**

The Australian Medical Association defines primary healthcare as, ‘Socially appropriate, universally accessible, scientifically sound first level care provided by a suitably trained workforce supported by integrated referral systems and in a way that gives priority to those most need, maximizes community and individual self-reliance and participation and involves collaboration with other sectors. It includes health promotion, illness prevention, care of the sick, advocacy and community development’ (Australian Medical Association 2010).

**Self-management**

The person, and their family or carers as appropriate, working in partnership with their practitioner to:

* know their condition(s) and various options
* negotiate a plan of care
* engage in activities that protect and promote health
* monitor and manage the symptoms and signs of their condition(s)
	+ manage the impact of their condition(s) on physical functioning, emotions and interpersonal relationships.

**Service coordination**

Service coordination aims to place people 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. The practice of service coordination particularly supports more effective ways of working with people with complex and multiple needs.

**Service-user journey**

The service user journey provides a standardised framework for the course of care in community health. It includes the components of access, initial needs identification, assessment, care planning, monitoring and review and transition and exit.

**Social determinants of health**

The range of personal, social, economic and environmental factors that determine the health status of people or populations.

**Team approach**

Practitioners work across services and disciplines to provide care from a team perspective, examples of types of approaches include multidisciplinary, interdisciplinary, intradisciplinary and transdisciplinary.

# Appendix 4: Community health program funded activities

|  |  |
| --- | --- |
| Activity no. | Activity name |
| 28015 | FARREP |
| 28048 | Language services |
| 28062 | Telephone Counselling |
| 28063 | Family planning – education and training |
| 28064 | Family planning – clinical services and training |
| 28066 | IHSHY |
| 28067 | Women’s health |
| 28068 | Family planning |
| 28072 | Integrated chronic disease management |
| 28076 | Refugee health nurses |
| 28080 | Healthy Mothers Healthy Babies |
| 28081 | National Diabetes Services Scheme |
| 28086 | Community health |
| 28090 | Community health nurses in Sexual Assault Multidisciplinary Centres |
| 28091 | Community asthma program |

# Appendix 5: Text-equivalent descriptions of figures

**Figure 1: Activities funded by the Community Health Program**

The Community Health Program funds the following activities:

* audiology
* dietetics
* occupational therapy
* physiotherapy
* podiatry
* speech pathology and therapy
* nursing
* counselling and casework
* initial needs identification

**Figure 2: Principles of care**

The principles of care outlined in the Community Health Integrated Program guidelines are for person-centred care that is high quality and supported. The principles include:

* culturally responsive
* goal directed
* health literacy
* health promoting
* self-management
* early intervention
* evidence based
	+ team approach.

**Figure 3: Plan, Do, Study, Act cycle**

Plan

* objective
* predictions
* plan to carry out the cycle (who, what, where, when)
	+ plan for data collection

Do

* carry out the plan
* document observations
	+ record data

Study

* analyse data
* compare results to predictions
	+ summarise what was learned

Act

* what changes are to be made?
	+ next cycle?

**Figure 4: Service-user journey**

The journey starts with access and initial contact.

The next four phases are inter-related:

* initial needs identification
* assessment
* monitoring and review
	+ care planning

The final phase is transition and exit.

1. [The Victorian Aboriginal Affairs Framework](https://www.firstpeoplesrelations.vic.gov.au/victorian-aboriginal-affairs-framework) (VAAF) <https://www.firstpeoplesrelations.vic.gov.au/victorian-aboriginal-affairs-framework>Standards detail how to enhance access for Aboriginal people. [↑](#footnote-ref-1)
2. The Department of Health and Human service website provides further information on the [Refugee Health Program](https://www.health.vic.gov.au/community-health/refugee-health-program) <https://www.health.vic.gov.au/community-health/refugee-health-program> [↑](#footnote-ref-2)
3. Metropolitan health services and major regional health services are defined under the Act as ‘public health services’ and are governed by boards of directors. The subregional and smaller rural health services are ‘public hospitals’ and governed by boards of management. In this document the term ‘public health services’ is used to refer to public health services and public hospitals. [↑](#footnote-ref-3)