COMMUNITY HEALTH FIRST

COMMUNITY HEALTH IMPACT REPORT 2023-24

Healthier Victorians, Stronger Communities








About Community Health First

Community Health First is an initiative led by all 24 registered independent community health services in Victoria united by one shared goal – improving the health, wellbeing and quality of life for all Victorians.

ACCESS Health & Community
Ballarat Community Health
Banyule Community Health
bch Bellarine Community Health
bendigo Community Health services
BHN Better Health Network
cohealth care for all
DPV Health®
each health . hope . opportunity
gateway health People living well
Gippsland Lakes COMPLETE Health
Grampians Community Health
healthAbility
inspiro health
ipc Health
Latrobe Community Health Service
Merri Health Healthcare that moves with you
nexus Primary Health living well in your community
north richmond community health Wulempuri - Kertheba
NOCH
PRIMARY CARE CONNECT
SUNBURY COBAW COMMUNITY HEALTH
SCHS Sunraysia Community Health Services
your COMMUNITY HEALTH

Community Health First acknowledges the Traditional Owners of the land on which we live and work. We pay our respects to Elders past and present and recognise that sovereignty was never ceded.

A message from the Community Health First Steering Committee

Community Health First was established in 2023 with one simple but ambitious goal – uniting all registered, independent community health services across Victoria to improve health and wellbeing outcomes for our communities.

As we reflect on the year that has been for community health and our first year of working together through Community Health First, it is clear that community health has never been more critical to meeting the needs of Victorians. With the lingering impacts of COVID-19 continuing to challenge our health system and the escalating cost-of-living placing more pressure on Victorians, community health provides a critical safety net to ensure every Victorian can access affordable health care and to alleviate strain on our hospitals.

Community health celebrated its 50th anniversary year in 2023. So much has been achieved over those 50 years to lay a foundation for the vibrant, dynamic sector that we are today. However, now more than ever we must build on these foundations to find bold, innovative solutions that can address the needs of our changing communities. This is what community health has always done, and the last year is no exception.

As demand for services has continued to skyrocket over the last year, our sector has expanded to reach over 608,000 Victorians, improving health and wellbeing outcomes and reducing demand on our hospitals.

We have continued to collaborate and innovate to implement and scale new programs that address the major challenges facing our communities such as escalating rates of chronic diseases like type 2 diabetes and heart disease, social isolation and loneliness, and family violence. We have been a critical partner in implementing major reforms and initiatives by the Victorian Government; establishing new Urgent Care Centres to take strain off our hospitals, scaling women's sexual and reproductive health centres across the state and being a major provider in the delivery of new mental health services established in response to the Victorian Royal Commission.

We have continued to ensure that all Victorians have access to quality care by implementing innovative outreach models in rural and regional communities and programs tailored for culturally diverse and LGBTQI+ communities. We have supported struggling Victorian families by expanding free dental services for public school children and providing early childhood services for the many children with development delays.

There is so much to be proud of in the year that has been, but as a sector we continue to look forward and consider how we can do better. We know that we have services that work – for Victorians, for communities and for our economy. We need to be investing in scaling this work now to builder a fairer, healthier and more sustainable Victoria. We look forward to continuing our strong relationship with the Victorian Government as we enter a period of health system reform to consider how best to leverage the immense capability of community health in the system.

The Steering Committee would like to thank the leaders and teams at each of the 24 organisations that forms Community Health First for their ongoing commitment to our work together and the time each of has contributed. **It is a testament to the shared vision, values and deep commitment to collaboration of our sector that we can work together in this way to amplify our impact.**

Contents

About Community Health

The Community Health Model

Registered independent community health services play a unique and important role within the Victorian health and social service systems to support people at every age and stage of life. To do this, community health works at multiple levels – with individuals and families, communities and systems – to achieve improved health outcomes and lasting community impact.

Community health works within a social model that recognises that health outcomes are largely determined by social factors such as economic stability, education access, and community context. By combining robust clinical health service delivery, a wide range of social services, and population health initiatives, community health services can address these social determinants of health to achieve change.

A key focus of the work of community health is prevention and early intervention. By working to prevent health and social needs arising or stepping in early to stop issues escalating, community health services play a key role in reducing the burden on hospitals and ambulance services, while helping address long-term acute service challenges and down-stream expenditure.

Community health services are deeply embedded within communities, with a commitment to ensuring communities are engaged within the governance, design and delivery of services. With a strong focus on health equity, community health services work within communities to find and engage those who most often miss out on services.

The sector's deep knowledge of the health and social service systems and the needs of communities, developed over 50 years, fosters design solutions that are cost effective by avoiding duplication and ensuring culturally safe services are delivered in the right place and at the right time. The services and programs delivered by community health are strengthened by our ability to share knowledge and evidence to learn from our peers and uplift our collective capabilities. A commitment to investment in innovation, research and evaluation, and workforce development ensures our work leaves a lasting system impact.

11,075
employees

608,000
Victorians supported

24
registered independent community health organisations

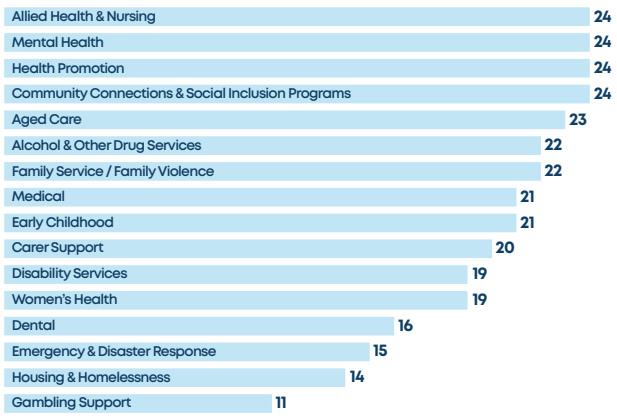
259
sites across Victoria

$1.2 billion
annual revenue

2,244
volunteers

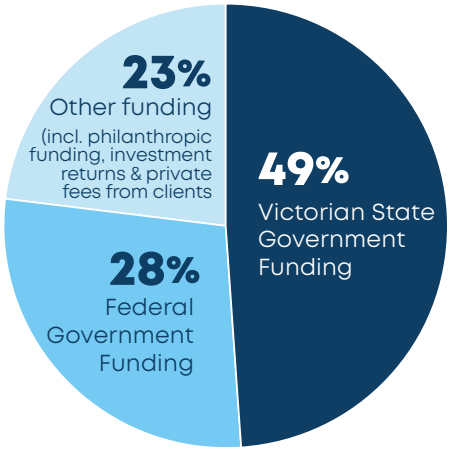
Community health delivers a wide range of services funded by the Victorian and Federal government to meet the diverse needs of all Victorians. This unique service scope means that community health can act as a 'one-stop-shop' offering tailored, wrap-around support that delivers better outcomes and experience for Victorians.

Number of community health organisations providing each type of service:



Community Health Funding

Community health sources and aggregates funding from multiple sources to respond to the needs of community. This approach allows for flexible, efficient and innovative solutions. In the last year community health organisations saw $1.2 billion in revenue, of which 7.5% ($94.1 million) was funded through the Victorian Government Community Health Program.



Client Satisfaction with Community Health

The 2024 client sentiment survey results demonstrate a high level of satisfaction with the services provided by community health. Community health plays a crucial role supporting Victorians to remain healthy, improve their wellbeing, and to ensure access to affordable and inclusive services close to home.

Maintaining health and wellbeing

An impressive **91.2%** of respondents agreed or strongly agreed that receiving support from their local community health organisation helps to keep them healthy and well. Services provided are effective in promoting preventative health care, supporting long-term wellness, and reducing the need for acute interventions.

69% of clients access more than one service or program from their local community health organisation, with over **65.6%** of respondents stating that community health helps them stay connected to their community.

Affordability of services

89.5% of respondents agreed or strongly agreed that their local community health organisation provides services at a cost they can manage. Community health is meeting a critical need for accessible healthcare, particularly for those who may not have access to private health services, and as cost-of-living increases pressure on individual and family budgets.

Accessibility of Support

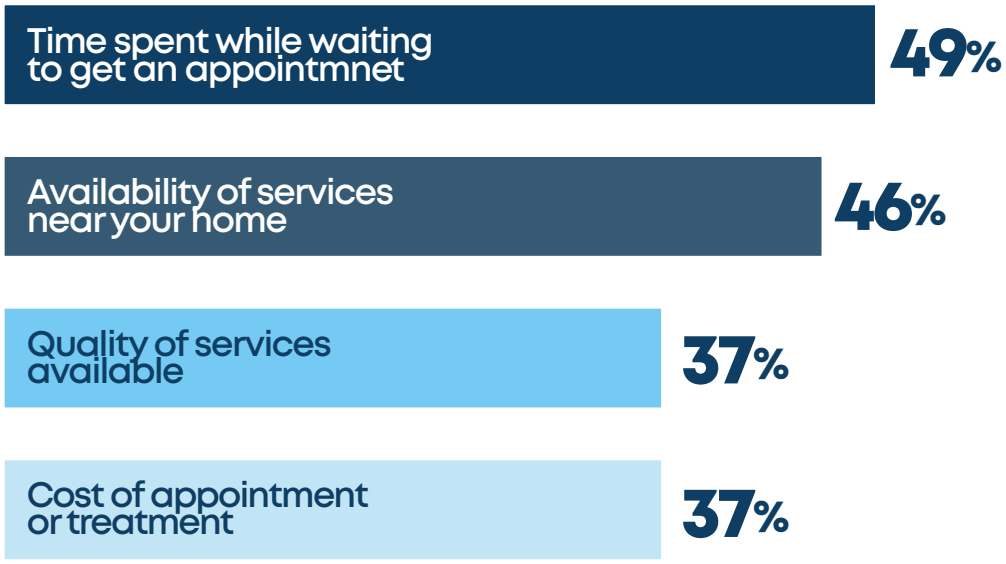
84.9% of respondents reported that their local community health organisation makes it easier for them to access the supports and services they need. Community health is succeeding in providing timely and convenient access to essential healthcare services for Victorians.

Reducing pressure on our hospitals

When asked whether the help they receive from their community health organisation has reduced the frequency of hospital visits, **58.3%** of respondents agreed or strongly agreed. Community health has the potential to further alleviate pressure on hospitals, reduce emergency department visits, and decrease ambulance callouts by helping people effectively manage chronic or complex health conditions outside of hospital settings and through the provision of evidence based preventative health programs that address health concerns early.

The issues that matter for Victorians

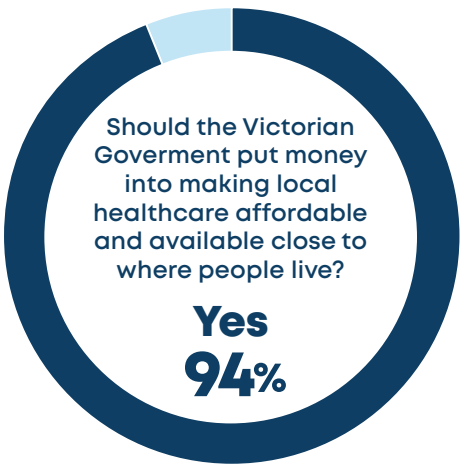
When asked about issues that concern people seeking support for current or future healthcare needs the following issues arose the most:



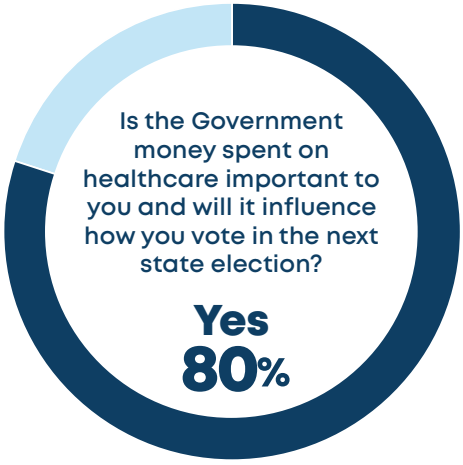
“Community health provided a service that was invaluable in my time of need. They helped and supported both myself and my partner when neither of us knew where to turn. For us, it was life changing, and for this assistance we are very grateful.”

Community Health client

When asked clients whether **the Victorian Government should put money into making local healthcare affordable and available close to where people liv**e 94% of respondents agreed.



When asked clients whether **Government money spent on healthcare is important to me and will influence how I vote in the next state election**, 80% of respondents said it would impact their vote.



1. Improving health outcomes for all Victorians

Why it matters

The Victorian Public Health and Wellbeing Plan 2023-27 sets out a bold vision for a Victoria that is "free of the avoidable burden of disease and injury, so that all Victorians can enjoy the highest standards of health, wellbeing and participation at every age"[1]. While Victorians do enjoy some of the best health outcomes in a global context, health outcomes are not always improving and in some cases are going backwards.

The proportion of Australians with one or more chronic diseases has continued to grow to nearly half of the population and this is only projected to continue increasing as our population ages and risk factors such as obesity rise[2]. Self-rated health status has not improved in the last ten years, with only forty per cent of Victorian adults rating their health as excellent or very good[3]. Importantly, these outcomes are significantly worse for Aboriginal and Torres Strait Islanders and those from culturally diverse backgrounds.

What we do

Community health delivers high quality physical, social and mental health services to our local communities, underpinned by best-practice clinical governance frameworks. Services are delivered by multi-disciplinary teams of doctors, nurses, allied health professionals, dentists, and oral health therapists, working together with clients to identify and deliver care to support their individual needs. Our services and programs are underpinned by a focus on the social determinants of health with a strong focus on building health literacy and self-management capability.

Our work to improve health outcomes for all Victorians includes:

Improving access to primary care close to home

Community health provides bulk-billed and low-cost access to medical services including General Practitioners and nurses, along with integrated allied health services including podiatry, physiotherapy, occupational therapy, speech pathology, dietetics, exercise physiology, and diabetes nurse educators.

Promoting community wellbeing

Community health is agile, enabling it to respond quickly to emerging issues and design health promotion activities with communities to build health literacy and address population health needs. Examples of current programs include improving healthy eating amongst school children, promoting physical activity, and educating young people and parents about vaping.

Improving oral health

Community health provides free and low-cost dental services through community health public dental clinics for people of all ages, and mobile and in-clinic 'Smile Squad' teams offering oral health education, free dental checks and services to Victorian public school students.

Preventing the development and progression of chronic disease

Multi-disciplinary medical, allied health and nursing teams operate across the state with a focus on team-based care, support, and education programs that target the causes and risks of chronic diseases such as type 2 diabetes, heart disease and chronic obstructive pulmonary (lung) disease. Programs are developed to reach members of the community who may otherwise not be receiving support to manage their health conditions. Where relevant, these programs are integrated with specialist health services such as endocrinology and cardiology.

Supporting people with a disability and older people

Specialist assessment and navigation services are available to support people to connect into the NDIS and Aged Care system, particularly those who are most vulnerable or at risk of missing out. Community health also provides NDIS-funded services for children and adults including support coordination, therapeutic services and psychosocial supports, community-based aged care services, and programs that address isolation and reduce loneliness.

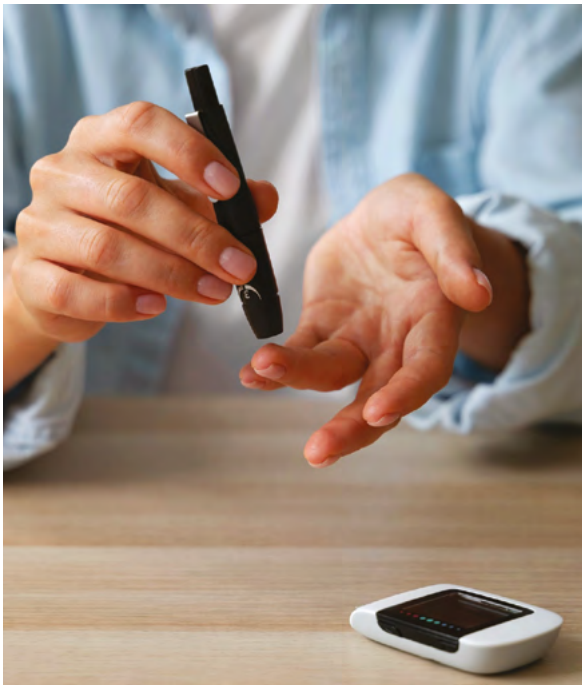
Case Study

Improving outcomes for Victorians with type 2 diabetes

The growth in rates of type 2 diabetes is a major challenge for the healthcare system, with 7.5 per cent of Victorians with the disease, up from 6.1 per cent in 2015. Between 2020 and 2022 alone, an additional 100,000 Victorians were diagnosed, risking overwhelming conventional hospital outpatient services.

People with type 2 diabetes can experience significant impacts on their physical and mental health and are nearly twice as likely to be hospitalised and have a longer stay when they are. Alongside genetic pre-disposition, lifestyle factors play a major role in the development of type 2 diabetes, including obesity, poor diet, and lack of physical activity. As such, access to quality, preventative and early intervention health services can be critical to avoiding type 2 diabetes or slowing its progression.

Community health has been innovating in diabetes care for over a decade, developing best-practice models that combine specialist support from diabetes nurse educators, dietitians, physiotherapists and exercise physiologists to address the underlying causes of type 2 diabetes. Services are overseen by medical professionals and include integrated care with specialist endocrinologists where appropriate.



IDEAS program

The Integrated Diabetes Education and Assessment Service (IDEAS) is a unique early intervention program for type 2 diabetes. Operating across six sites in eastern Melbourne, IDEAS provides integrated multidisciplinary care in partnership with primary and tertiary care providers within the community. Initially developed by healthAbility and Eastern Health to help reduce diabetes-related hospital presentations, in 2017 IDEAS expanded to deliver care across six sites in partnership with community health services, including Access Health and Community, EACH and Inspiro. By optimising available services and delivering them in a community-based setting, IDEAS improves health outcomes for patients with type 2 diabetes, reduces healthcare costs, and decreases hospital admissions.

IDEAS applies a whole-of-person approach, acknowledging that each person's experience with type 2 diabetes is unique. This ethos informs a person-centred team-based approach to service delivery that leverages different clinical and social disciplines to support clients' physical, mental, and social needs.

An independent cost-benefit analysis estimates that IDEAS saves the health system $7,348,265 annually and frees up approximately 1,984 hospital bed days, increasing clients' ability to participate fully in the economy and their community.

For every $1 invested, there is a $3.08 saving due to reduced use of tertiary and specialist services.

Building on this established track record and evidence-base, community health is developing and implementing a new program – Diabetes Connect – in partnership with the State Government. This model embeds health coaches and care coordinators within community health services, to engage Victorians with type 2 diabetes early and provide tailored support that prevents disease progression and avoids hospitalisation. Seven community health services are piloting the service across five locations – DPV Health, IPC Health, healthAbility with Access Health and Community and EACH, Latrobe Community Health, and Grampians Community Health. In only a short time since the service was established, hundreds of people have been reached and empowered to reclaim control over their health

Case Study

Improving access to dental services for Victorians kids

> **“The IDEAS clinic has been absolutely amazing. I cannot rate the service highly enough – 100%. I have felt so well supported by Jasper the Endocrinologist and Kate the Diabetes Educator. I have been given the security of knowing who to ring when I have been concerned about my diabetes. The professionalism and advice have just been wonderful. The IDEAS clinic has also supported me through tough times and provided me with the mental support I needed. I cannot thank everyone enough!”**

IDEAS clinic client

Diabetes Connect Program, Grampians Community Health

Building on the success of existing chronic disease management programs, Grampians Community Health has launched the Diabetes Connect pilot program at one of the program’s six sites in Victoria. This initiative extends the proven “Take Action Nurse” model to individuals managing type 2 diabetes in Western Victoria. Notably, participants have reported transformative outcomes: one individual with a disability now manages their diabetes medication independently, thanks to the support of a Diabetes Connect nurse. Another participant has successfully gained control over symptoms associated with heart disease, stroke, leg and foot issues, as well as eye and kidney diseases.

Through the combined efforts of the “Take Action Nurse” and Diabetes Connect programs, rural communities in Western Victoria are being empowered to reclaim control over their chronic health conditions. Grampians Community Health remains committed to advancing healthcare accessibility and outcomes, ensuring that every individual receives the support they need to thrive.

Smile Squad

Good dental and oral health are essential for overall health and wellbeing. Community health organisations are key partners in delivering and expanding Smile Squad to Victorian students. Smile Squad was launched by the Victorian government in 2020 to improve dental health for public school students. **With 43% of children aged between 5-10 having signs of tooth decay, early detection and treatment is key to improving oral health outcomes.** Smile Squad vans and in-clinic services make getting check-ups easy by visiting school campuses and striving to make oral health free, fun, and accessible.

4D Care

The 4D Care model (**D**eveloping strategies for the families of children with **D**isabilities or **D**evelopmental concerns to improve **D**ental Care) was developed in 2023 when Access Health and Community partnered with the University of Melbourne to develop new models of care that improve access and uptake of dental services by children with disabilities and developmental delays. These children and families experience significant challenges in accessing services, resulting in low rates of screening, higher rates of poor oral health and hospitalisation for dental reasons. The project was funded through an Innovation Grant from the Victorian Department of Health.

Over a year, the project developed new resources for children and families to support their engagement with dental services and developed the capability of dental practitioners to effectively support children with a disability. By integrating support from Access Health and Community’s specialist early childhood support teams, alongside dental services, children were better supported to access screening and preventative care. **A unique outreach model into early childhood settings, such as community centres and the home where the children were most comfortable, resulted in 96% of appointments being conducted outside of a clinic setting.** Access Health and Community and the University of Melbourne are now exploring how these models can be embedded within ongoing care.

2. Supporting children, families and carers to thrive

Why it matters

Happy, healthy children and strong families lay the foundation for life-long health and wellbeing.

Experiences in childhood often determine social, economic, health and wellbeing outcomes later in life. As young people continue to recover from the impacts of the pandemic and as cost-of-living pressures impact more families, it is more important than ever to support children, young families and carers to thrive.

While the majority of Victorian children are doing well, more can be done to give every child the best opportunity at a long, healthy life. More than ten percent of children have emotional and development behaviour problems [4]. Overall children's physical health is worsening with fewer children eating the recommended fruit and vegetable intake compared to a decade ago, less than half engaging in sufficient physical activity, and a third exceeding the recommended screen time each day[5].

Incidents of poor mental health in parents are rising and carers are at significantly higher risk of poor mental health, often experiencing social isolation and financial stress[6]. Family violence remains persistently high and under-reported despite record investment and attention by the Victorian Government.

What we do

Community health services play a key role in keeping Victorian children, families and carers healthy, well and connected to their communities.

Our work to improve health outcomes for all Victorians includes:

Improving children's health and wellbeing

Community health provides services for developmentally delayed and vulnerable children delivered by multi-disciplinary teams of allied health professionals operating in a 'key worker' model. They support parents with capability building programs and work to support children through early childhood programs and NDIS support.

Improving family functioning

Community health services deliver evidence-based parenting support programs that build capability and confidence for parents and specialist family therapy services by trained specialists.

Keeping children and families safe

Community health provides specialist family violence services integrated into relevant local services and networks, such as the Orange Door, that provide tailored advice and support for children and their families who are at risk, including Integrated Family Services to improve parenting and family functioning.

Caring for carers

Community health services support carers to navigate the complex service system, deliver programs that connect them to their peers and provide opportunities for social connection, and offer a break from caring through flexible respite solutions.

Case Study

Investing in stronger parents

One in four Australian children grow up experiencing significant early life adversity such as family violence, conflict, poor parent mental health and poverty. Supporting parents and strengthening families to raise happy, healthy children in the face of challenging life circumstances is critical.

Family Foundations is an innovative, evidence-based program that improves parent mental health, reduces conflict and strengthens parent and caregiver partnerships during pregnancy and critical early childhood years. Merri Health partnered with Murdoch Children's Research Institute to bring Family Foundations, developed by Pennsylvania State University, to Victoria and evaluate outcomes.

Family Foundations is for families who may be experiencing stress, health and wellbeing difficulties, and challenges in their family relationships including disagreements, arguments and conflict. The program, delivered by Merri Health, is a 10-session evidence-based program delivered in partnership with Murdoch Children's Research Institute and Deakin University. It is underpinned by cognitive-behaviour therapy, family stress theories, emotional security and attachment theories. Each session is delivered to both parents/caregivers by 2 practitioners (social work or counselling trained) using discussion-based activities, modelling and skills practice. Content is focused on building skills in emotion regulation, stress management, attachment, healthy communication, co-parenting support, conflict resolution and problem solving.

More than 820 families have been supported by Family Foundations program since 2018, including 353 in the past two years.

Program results shows statistically significant and meaningful **reductions in**:

- parent psychological distress and stress symptoms
- parental conflict
- children's exposure to conflict, verbal and physical aggression
- avoidance of addressing conflict and problem solving
- verbal and physical aggression

And statistically significant and meaningful **increases in**:

- cooperation and problem solving
- closeness in parent-child relationships.

Case Study

Giving children the best start in life

The best opportunity to build a strong foundation for lifelong health and wellbeing occurs during the first 1000 days – the period from conception, throughout pregnancy, and during a child's first two years. Better Health Network's Better Start project highlights that children living in public housing are more likely to be exposed to conditions that adversely impact their health and wellbeing during the crucial first 1000 days of development.

The project, funded by Better Health Network with financial contribution from the City of Port Phillip and partnering with Centre for Community Child Health, was the first time that mothers in Victorian public housing had been consulted about how their living environment affects their own, and their families, health and wellbeing. The project aimed to understand parents' experiences of raising children to inform new ways to deliver services and supports to better meet the needs of families.

Overall, 22 mothers living at Park Towers, a high-rise public housing building in South Melbourne, engaged with the Better Start project across over 50 community-based engagements. Mothers shared that they feel significantly unsafe in the building's communal spaces, limiting the way in which families engage with and utilise common areas. They voiced concerns about frequent incidents of violence, exposure to illicit drug use, and residents displaying challenging behaviour. They also shared photos and examples of substandard building maintenance which has led to increased exposure to environmental allergens. Such conditions can have strong adverse effects on the health and wellbeing outcomes of children.

Key findings of the Better Start Report included:

- Violence and unpredictable behaviour in common areas
- Their children becoming desensitised to the display of violent behaviours and drug taking
- Unsafe lifts and communal areas in which they are subjected to violence and a wide range of abuse
- Unmonitored areas like laundries becoming locations for violence, drug taking, and unauthorised entry

The recommendations demonstrate opportunities for change in public housing, to create homes that are safer, better resourced, and support the health and wellbeing outcomes of children during the first 1000 days and beyond.

3. Improving access and outcomes for rural and regional communities

Why it matters

Nearly one quarter of all Victorians – 1.7 million people - live in regional and rural areas and this is projected to increase by an average of 1.1 per cent every year for the next 15 years[7]. Residing in a regional area can have many social benefits with rural and regional Victorians less likely to be socially isolated and more likely to be involved in organised community groups[8].

However, an ageing population in our regions and the lack of affordable health care close to home often results in worse health and wellbeing outcomes than for those living in metropolitan areas. This includes higher rates of cancer; chronic diseases such as cardiovascular disease, chronic obstructive pulmonary disease and diabetes; mental ill health; and substance abuse. Potentially avoidable deaths for regional and rural Australians are 2.5 times higher than for those in metropolitan areas[9].

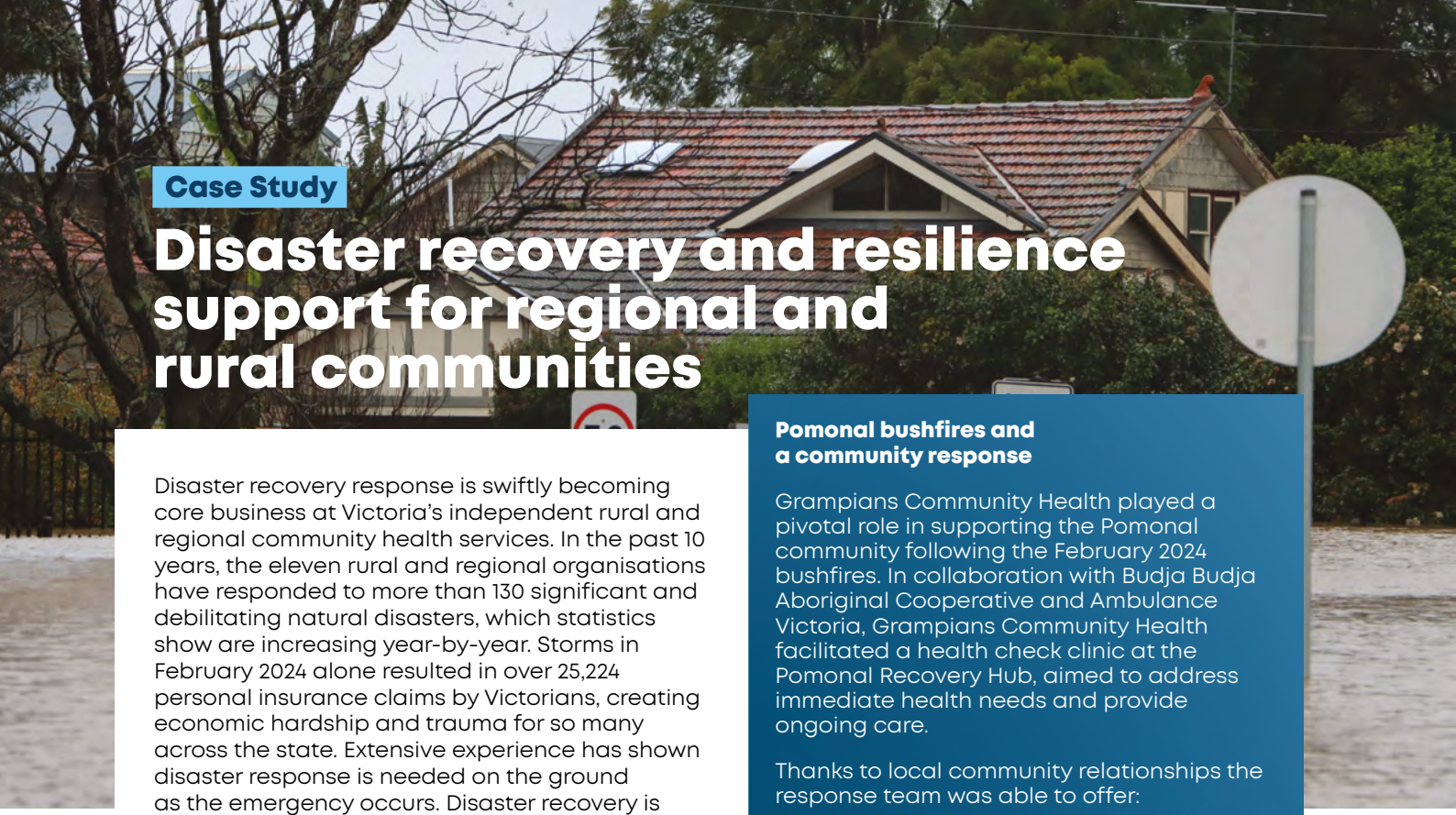
Victorians living in rural and regional areas experience longer wait times to see a GP or a dentist, may have to travel long distances to see a specialist, and struggle to access disability and aged care services[10]. This places additional strain on hospitals, with higher rates of preventable hospitalisation rates and emergency department presentations.

What we do

Community health plays a critical role in rural and regional communities across Victoria by ensuring access to high quality health and social care. Community health services are deeply embedded within regional and rural communities, meeting people wherever they are on their life journey, working collaboratively with their communities to design services and programs to meet local needs, and in turn contribute to the local economy and build the regional workforce.

Our impact

With over 75 sites, the 11 independent rural and regional community health services have a reach that covers 87 percent of rural and regional Victoria to deliver a wide range of integrated health and social care services. Across the last year rural and regional organisations have continued to implement innovative models such as community paramedics (through the CP@clinic) to reach those with the greatest health risks and work with communities to identify gaps in local supports such as building resilience and planning for natural disasters.



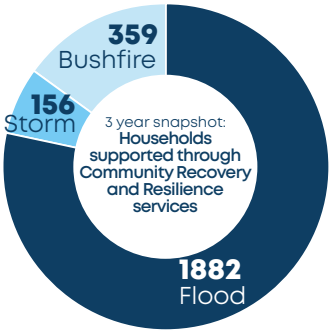
Case Study

Disaster recovery and resilience support for regional and rural communities

Disaster recovery response is swiftly becoming core business at Victoria's independent rural and regional community health services. In the past 10 years, the eleven rural and regional organisations have responded to more than 130 significant and debilitating natural disasters, which statistics show are increasing year-by-year. Storms in February 2024 alone resulted in over 25,224 personal insurance claims by Victorians, creating economic hardship and trauma for so many across the state. Extensive experience has shown disaster response is needed on the ground as the emergency occurs. Disaster recovery is highly complex and nuanced according to each individual and each community's needs, and support is required long after the ash has cooled, and the waters subsided.

Community Recovery and Resilience

Community Recovery and Resilience services embedded within community health organisations support timely disaster response and recovery at the local level, particularly for small, hard to reach communities.



Community health organisations are embedded in their local area and best placed to provide support to individuals, families and communities when disaster strikes. Families and individuals, in particular those from multi-cultural communities, are more likely to ask for help when they already have a trusted relationship with the service. Community health can also refer out to additional supports required following disasters, such as family violence support, food relief, and financial counselling, often within the same organisation making the experience as easy as possible for the families and individuals impacted.

Community Recovery and Resilience services can address the compounding trauma of continuous disasters, be ready to build preparedness and strengthen community resilience between disasters and support long-term community recovery.

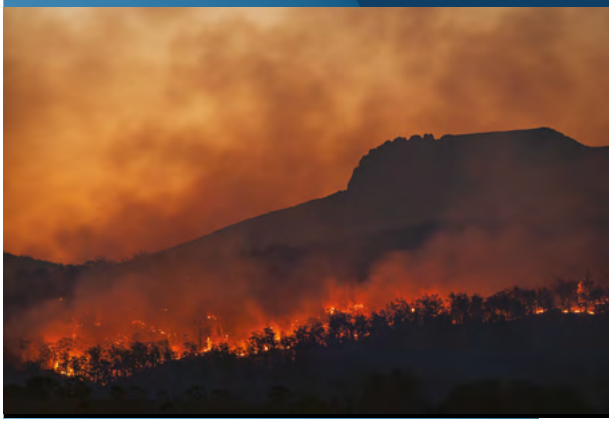
Pomonal bushfires and a community response

Grampians Community Health played a pivotal role in supporting the Pomonal community following the February 2024 bushfires. In collaboration with Budja Budja Aboriginal Cooperative and Ambulance Victoria, Grampians Community Health facilitated a health check clinic at the Pomonal Recovery Hub, aimed to address immediate health needs and provide ongoing care.

Thanks to local community relationships the response team was able to offer:

- **Mobile Health Services:** The Budja Budja mobile van attended, offering bulk-billed GP services and immunisations by trained nurses.
- **Comprehensive Health Checks:** Grampians Community Health community health nurses, both male and female, provided essential health information, blood pressure and blood sugar level checks, and facilitated referrals to additional programs and services.
- **Emergency Preparedness:** Ambulance Victoria conducted demonstrations and provided information on the GoodSAM app and the virtual Emergency Department.

Onsite health checks bring services directly to affected communities where people may still be processing the emotional trauma of the bushfire. **Having health professionals on site provided an opportunity to offer mental health assessments, early intervention, and counselling, which are crucial for community recovery.**



Case Study

CP@clinic community paramedic drop-in service leads to earlier detection and improved condition management

CP@clinic community paramedics provide a weekly drop-in service giving community members easy access health checks, health education and assistance with service navigation. The drop-in centre services are offered alongside a warm meal and the opportunity for social connection and are run from the same location, at the same time each week to increase connection and awareness of the service.

Building off a well-established and proven model in Canada that saw a 19-25% reduction in emergency call outs, Sunraysia Community Health Services, Gateway Health, and Primary Care Connect have established local CP@clinics to improve the health and wellbeing outcomes in their local communities.

The CP@clinics are focused on improving clients' ability to manage their health conditions, more easily access the right healthcare and wellbeing programs and pathways to stop, slow or treat chronic disease as well as addressing social isolation and loneliness. The model has been well received by local community members.

Outcomes

Community members who visited the Sunraysia CP@clinic from April to June 2024 show the program has been effective in reaching high-risk community members, with program participants reporting that:

- 39% of clients were a high falls risk
- 96% of clients have moderate to high risk of developing pre-diabetes or type 2 diabetes in the next 10 years
- 72% of clients experiencing pain
- 39% of clients reported anxiety or depression

Tony's journey after visiting a CP@clinic

Tony is 38, living in a caravan park because he cannot find permanent housing and is unable to work due to a complex medical history that includes mental health and other co-morbidities. He is also on a disability pension and is needing to manage his type 2 diabetes and epilepsy, problems further complicated by a lack of access to a GP or diabetes educator.

Tony turned to CP@clinic for help with his medication management after suffering several seizures. At the time, he was using his medications sparingly because, due to not having a GP or diabetes educator, he was forced to go to his local Emergency Department for medication scripts. The hospital only provides a script for one week's medication, prompting Tony to reduce his dose below therapeutic levels to try to make his supply last longer. As a result, Tony would have seizures, resulting in regular presentations to the emergency department.

The community paramedic at the CP@clinic organised for Tony to have scripts filled promptly at his local pharmacy, linked him with a GP and diabetes educator at Sunraysia Community Health Services. As a result of being connected with affordable and local services, Tony is now managing his diabetes much better and has not had a seizure or needed an ambulance since attending CP@clinic and no longer uses the emergency department for scripts and general health care.

4. Improving the mental health and wellbeing of Victorians

Why it matters

Most Victorians are likely to experience some type of psychological distress over the course of their lives, however, some people are more impacted than others depending on social and economic factors. Nearly one quarter percent of Victorians experience high or very high rates of psychological distress, an increase of five percentage points since 2019, reflecting increased social and economic stressors[11]. Resilience in adolescents has also fallen with an increase in psychological distress shown in this cohort since 2015; while more than 75 percent of mental health conditions occur before the age of 25[12].

Rates of addiction and harm from alcohol, other drug use and gambling also remain stubbornly high[13]. A quarter of Victorians consume alcohol at a level that puts their health at risk and one in six Victorians have used an illicit drug within the last year[14]. This has a direct impact on our acute care systems, with more than 110,000 admissions to Victorian hospitals related to alcohol and drug use each year[15].

What we do

Community health services play a critical role in delivering integrated mental health, alcohol and other drug and gambling support services. This includes services for Victorians across their whole lifespan including specialist child, youth and adult services, and support for the carers, families and supporters of those experience mental health and addiction. Community health services are integrated with primary and tertiary care services, from preventative community-based services to complex, residential care settings.

Community health services include:

Improving mental health and wellbeing outcomes

With funding from the Commonwealth and State Governments, Victoria's registered community health organisations provide integrated mental health services offering clinical, peer and psychosocial support services to Victorians experiencing psychological distress. Community health services provide support for people of all ages, stages and levels of clinical complexity with clinical services such as psychology, mental health nursing and psychiatry as well as peer support from those with lived/living experience of mental ill health and psychosocial supports that address emotional support needs available for those who need it most.

Supporting carers and families of people with mental ill health

Community health services provide support for the carers and families of those suffering from mental illness. Specialist counselling and peer support are available for parents and families, including lived-experience led mental health and wellbeing connect services that offer tailored supports, connections and service pathways to care for carers.

Reducing alcohol, other drug and gambling addiction

Community health services offer expert and specialist support close to home for those suffering from alcohol, other drug and gambling addiction in Victoria. From treatment services such as pharmacotherapy and home-based withdrawal for those in need, to community-based individual and group counselling and rehabilitation programs, such as Gamblers Helpline, community health provides support to Victorians throughout their recovery journey.

Reducing harm from drug and alcohol use

With specialist support offered in the community and where those in need are based, community health programs use specialist Harm Reduction Practitioners to offer engagement, education and support to reduce harm from drug and alcohol use. Overdose training and response, and needle and syringe exchange programs also help to ensure safer Victorian communities.

Case Study

Reforming Victoria's mental health system to improve outcomes

The Royal Commission into Victoria's Mental Health System delivered its final report in February 2021, finding that the system was fragmented and underfunded, leading to inadequate care and support for people with mental health needs. The report made a number of recommendations to ensure equitable, accessible care for all Victorians including increasing investment, integrating services, focusing on prevention and early intervention, and ensuring leadership of the system by those with lived and living experience.

A key aspect of the reform has been the establishment of a network of new Mental Health and Wellbeing Locals to deliver integrated, community-based mental health treatment, care and support for people aged 26 or older. Community health has played a critical role in the implementation of these new services over the past year, building on their strong track record in delivery of mental health services, expertise in integrating lived and living experience alongside clinical and psychosocial supports, and long-standing community partnerships. IPC Health, cohealth, Inspiro Community Health and Gippsland Lakes Complete Health are all lead partners in new Locals ensuring mental health services meet local community needs.

"When people in my community are struggling with mental health issues, they don't believe in making it public, and typically lean on family and friends – people who are like them, that they can trust. In my role, I need to build trust and rapport so that the person can tell me what they need. After that connection, I can suggest different services or support."

Lived experience peer worker, Brimbank Mental Health and Wellbeing local

The Royal Commission also recognised the need for improving services and supports for the carers, family and supporters of people with mental health needs. Since 2023, community health has played a leadership role in the establishment of a new network of Mental Health and Wellbeing Connect services across the state. These services provide support and connections for carers, families and supporters, with a focus on ensuring that the services are predominantly governed, led and delivered by people with lived and living experience to create a safe and welcoming space. In metropolitan Melbourne, Access Health and Community, healthAbility and Inspiro are partners in establishing services in their local communities. In regional Victoria, Gateway Health, Ballarat Community Health and Grampians Community Health are delivering services across the Hume and Grampians region.

"I telephoned. My call was received with empathy, patience, kindness. I was invited to drop in. It has given me a place to shed the veneer of 'coping'... To be able to speak with staff who have experienced carer challenges, are trained in peer support, and have learnt how to re-introduce and maintain joy in their own lives, was a light at the end of the tunnel for me."

Carer accessing Community Health services

Recognising the specific needs of children under the age of 11 who may be experiencing developmental, emotional, relational or behavioural challenges, the Victorian government has also invested in three Children's Health and Wellbeing Locals across the state. Two of these are being led by community health services, IPC Health and Bendigo Community Health Services. Since being established in 2022, these centres have offered specialist care to children and their families including psychology, psychiatry, paediatrics, allied health and family support.

Case Study

Connecting vulnerable young people in regional communities to mental health supports

Enrich is dedicated to assisting young people and their families in navigating the mental health system. Primarily working with young people identified as 'the missing middle' and utilising an outreach model, Enrich reaches out to those who struggle to access traditional therapy or clinic-based support, ensuring they receive the help they need.

As a vital bridging service, Enrich provides tailored support for young individuals grappling with a range of emerging mental health conditions. This includes addressing issues such as depression and anxiety, early signs of psychosis, eating disorders, personality disorders, and concerns related to self-harm or suicidality. Additionally, Enrich plays a crucial role in helping young people who may be disengaged from essential life supports, such as school, by offering the guidance and resources necessary to reconnect and thrive. Through its comprehensive approach, Enrich aims to make mental health support more accessible and effective for those who need it most.

178 young people have been provided expert mental health care by senior mental health clinicians through the program to date. Young people that have engaged with the Enrich program have demonstrated improved mental health outcomes and social inclusion. There is evidence of increased engagement with education. Only 9 young people have required tertiary mental health referral during this period.

"We can't even begin to describe the positive impact that the Enrich team have had on our most vulnerable and at-risk students at Sunbury College. The Sunbury College wellbeing team are so very grateful to Louise and Emily for their extensive practice experience, consultation and advice, alongside the incredible mental health support and case management they have provided to young people with varying and complex MH needs; who would otherwise never have engaged with any type of mental health service."

Mental Health Practitioner, Sunbury College

Case Study

Providing easy to access mental health support when people need it most

The After Hours Mental Health Nursing Service (AHMHNS) run by HealthAbility supports people experiencing mild to moderate mental health issues, such as anxiety, grief, stress or depression, during hours when other services are limited. The AHMHNS reduces emergency department demand in eastern Melbourne and improves mental health outcomes, by providing timely after-hours support for people experiencing mental health concerns.

Thirty percent of mental health-related presentations to hospital emergency departments are considered suitable for diversion to other services where appropriate alternatives are available. The AHMHNS provides an alternative mental health support service for people who present to EDs with semi-urgent or non-urgent mental health concerns, to help reduce the pressure on hospitals during the afterhours when other mental health services are limited.

Supporting over 1,600 clients each year, for every $1 invested in the AHMHNS there is a saving of $2.21 to the health system driven by the reduction in avoidable presentations to hospital and early intervention with clients to reduce mental ill health.

An independent evaluation found that the AHMHNS reduces psychological distress and enhances clients' functioning and capacity to contribute meaningfully to both society and the economy.

From the clients' perspective, the service fills a critical gap for individuals with mild to moderate mental health challenges, delivers a consistently high standard of care, provides greater flexibility and responsiveness than other after-hours services, and connects clients to ongoing mental health support in locations convenient to them. By focusing on early intervention and prevention, clients avoid hospitalisation, leading to improved health and increased productivity through greater economic participation.

Case Study

Reducing drug-related harm in the North Richmond community

Medically Supervised Injecting Room

The Medically Supervised Injecting Room (MSIR) in North Richmond is a place where people can inject drugs in a supervised health setting. If a community member overdoses in the room, a staff member can respond immediately. It is also a place to access other health services including mental health support, drug treatment, wound care and blood testing.

Since opening its doors the MSIR achieved exactly what it was intended to do – it has saved lives, connected people to the many critical health and social support services provided at North Richmond Community Health, and improved the local North Richmond community. Since 2018 the injecting room has had more than 500,000 visits and:

- Safely managed 9,115 overdoses inside the injecting room
- Provided 159,834 health and social supports on-site
- Successfully commenced 1,086 people on opioid agonist treatment.

On 4 May 2023, the Victorian Government passed legislation to establish the medically supervised injecting room as a permanent service, which is testament to the hard work and dedication of the medically supervised injecting room and all supporting stakeholders. A new enhanced model of care is now being implemented through a partnership model, led by North Richmond Community Health in partnership with St Vincent's Hospital Melbourne, Access Health and Community and Your Community Health.

The Proactive Overdose Response Initiative

The Proactive Overdose Response Initiative is delivered by North Richmond Community Health and works to support people who have experienced or are at risk of experiencing opioid overdose, with the goal of preventing future overdoses and reducing overdose related harm. The program works to reduce the harms of heroin and other opioid use in our community by working with people who use and inject opioids, their families, friends and peers, potential overdose witnesses or community bystanders to increase awareness of opioid overdose.

The program takes trainees through what an overdose is, what an overdose looks like, overdose statistics in Victoria, overdose, and stigma, and how to respond to an overdose in the community by administering the Naloxone spray Nyxoid. 1048 trainings have been conducted with clients, potential overdose witnesses, and NRCH staff and volunteers

Supporting a family member who overdosed

Client B was trained to administer naloxone and provided with units of Prenoxad, ampoules and Nyxoid. Although the client was familiar with the basics of administering Prenoxad and the ampoules, he was not familiar with how long to wait between administering each dose.

Recently, client B reported that they had reversed the overdose of a family friend at his residence with a combination of Nyxoid and Prenoxad that he accessed through the Take Home Naloxone Program. The client was very appreciative of the time taken to sit down with him to go through each step of the process. He reported that they called an ambulance and felt that the information shared, and the training provided through the PORI equipped him for the emergency.

5. Reducing demand on Victorian hospitals

Why it matters

Demand for Victoria's acute health services has continued to skyrocket as a result of the ageing population, growing chronic disease burden and the continued recovery from the COVID-19 pandemic. Emergency Department presentations and Code 1 (lights and sirens) ambulance call-outs increased by more than five per cent in 2023-24 as compared to the same time last year, the planned surgery waiting list remains above pre-pandemic levels[16] and length of stay is above targeted levels[17]. Despite the best efforts of hospitals, Victorians are waiting longer to receive the acute health services they need and staying in hospital longer when they do receive them.

This consistently increasing demand is placing unsustainable strain on the health system and increased cost burden on the Government. Public hospital expenditure per person by the Victorian Government has jumped significantly – rising to over $2,000 per person, up over eight per cent over five years[18]. With demand continuing to grow, the Australian Government is projecting a 35 percent increase over the next decade[19].

In this context, it is critical that Victoria ensures acute health services are targeted at those who need them. Research shows that many of those currently accessing hospitals do not need to be there and could be better supported through appropriate community-based healthcare. Each year, Victoria has more than 500,000 potentially avoidable emergency department presentations[20], a significant number of avoidable readmissions, and an increasing number of patients who are medically ready for discharge but are unable to be released from hospital due to a lack of availability of aged care and disability services[21].

What we do

Community health services play a critical role in delivering community-based healthcare services that reduce the need for costly hospital services. Working in partnership with Health Services, Ambulance Victoria and community-based services, community health services ensure Victorians have access to the right care, in the right place and at the right time.

These services include:

Reducing emergency department demand and health system costs

Community health offers urgent and priority care clinics, delivering General Practitioner led support for non-emergency but urgent care needs 7 days per week, 14 hours per day. The cost of a patient visiting an Urgent Care Clinic is one third of an average Emergency Department presentation.

Reducing length of stay and readmissions

Community health services work with patients prior to and after an admission to hospital, to lessen the need for a lengthy hospital stay and the risk of them being readmitted. Approximately $2000 dollars is saved for every bed day avoided. This includes delivering post-acute care services and transitional care arrangements, as well as integrated health and social services that address risk factors such as lack of care arrangements to support a discharge.

Reducing hospital attendance for 'frequent users'

Community health delivers targeted programs that engage and support those who are frequent users of hospitals due to complex needs. This includes programs that target those with poorly managed chronic disease and multiple co-morbidities, and in-reach and out-reach services for those with complex psychosocial needs such as mental health and or addiction issues.

Reducing planned surgery demand

Community health delivers a range of evidence-based interventions from multi-disciplinary teams of GPs, nurses and allied health practitioners that can reduce the need for surgery for some patients, such as those with osteoarthritis. In addition, tailored programs of 'prehabilitation' get people ready for planned surgery more effectively by addressing risk factors such as diet or physical activity prior to surgery to improve outcomes and reduce risks of complication or readmission.

Case Study

Expanding access to urgent care through Community Health

In late 2022 the Victorian Government announced a bold plan to alleviate strain on hospitals by investing in a network of 'Priority Primary Care Centres' (PPCCs) across the State. Now known as Urgent Care Clinics and jointly supported by the Australian Government, each clinic is linked to a hospital Emergency Department and provides community-based, General Practitioner led care to people who need urgent, but not emergency care. Services are free and available 7 days per week, 14 hours per day.

Community health services have played an important role in establishing the clinics in Victoria, with three metropolitan clinics in Richmond (Access Health and Community), Prahran and Frankston (Sandringham Ambulatory Care Centre, part of Better Health Network), and within the Royal Children's Hospital (cohealth), and two regional clinics in Mildura (Sunraysia Community Health) and Moe (Latrobe Community Health) run by community health. Community health's existing reputation, relationships and capability have supported rapid establishment and scaling of these services, with over 80,000 patients supported in just the first year of operations across the six clinics.

The evidence shows that community health-led clinics are already having a significant impact on communities and the system. An expert evaluation by For Purpose Evaluations commissioned by Access Health and Community, Sunraysia Community Health and Latrobe Community Health completed on the first year of operations for the services, conducted interviews with staff, patients and stakeholders. It found:

Community health led clinics are effective in reducing demand on acute health services:

- 57% of patients presenting at a Urgent Care Clinic would have attended an Emergency Department if the clinic had not been available.
- 53% of patients do not require further treatment after attending a clinic
- 91% report of patients report receiving adequate information to care for their condition at home.
- Clinics are having a positive impact on ambulance availability

Community health led clinics are cost effective:

- In their first year, the clinics had an average cost per patient of less than a third of an average Emergency Department presentation ($289 compared to $919)
- This cost is likely to reduce further in future years as the service become better known and scale over time.

Community health led clinics are valued by patients:

- The clinics received a 'Net Promoter Score' of 79 which is considered excellent
- 94% of patients said they were likely to use a clinic again
- 92% rates their quality of care as good or very good, compared to 84% in Victorian Emergency Departments

"As soon as we walked in, the nurses and doctors immediately made my 6-year-old daughter and I feel at ease. I have deep gratitude for the treatment and level of care we received, and the peace of mind we walked away with."

Urgent Care Clinic patient

Community health led clinics enhance the urgent care mode:

- The clinics use their specialist skills to build health literacy and address health inequities, and to connect those who need it back into other services.
- 88% of patients agreed tests and treatment were explained in a way that they could understand, compared to 58% of Emergency Department patients

"When it is in community health, we have lots of things we can offer the patient than just answers to health issues. Sometimes there are social aspects that can be looked into, mental health, drug and alcohol. They can be directed to services for more help and more stability in their life. This can be possible in hospital, but Emergency Departments need to focus on the problem."

Community Health Urgent Care Clinic staff member

Mildura PPCC helps get the right support in place

A patient presented to their PPCC requiring urgent treatment for a sexually transmitted infection. In this case, the PPCC GP identified a risk that the patient would not follow up with their regular GP due to financial barriers. In response, the GP connected them directly with the sexual health practitioner within Sunraysia Community Health. This would not have been easily facilitated if the PPCC provider was not a holistic health service with several health disciplines on hand.

Case Study

Keeping people with chronic disease out of hospital

The Pathways program, delivered by EACH in partnership with Eastern Health, commenced in 2023, building off earlier successful trial programs, to address chronic health conditions in the east of Melbourne. The program provides access to quality ongoing chronic disease management and social services through outreach and telehealth consultations, outside of the hospital system, to meet the individual needs of the client.

This program has demonstrated the ability to reduce the demand on hospital beds and programs through **reducing Emergency Department presentations by 61%, reducing hospital admissions by 54% and reducing total bed days by 64%**. For clients who had completed the program for more than 6 months, **61% have had no further hospital admissions**. In addition, the hospital admission risk program **length of stay reduced by 26%**, enabling this program to increase its ability to impact acute bed flow and demand.

In 2023-24 the program cost $551,201 to administer and led to an estimated $4,855,651 - $7,319,911 in consolidated savings to the healthcare system.

“The program kept me alive in a lot of ways, it saved our lives. Coming around to measure obs, taking weights and checking fluids. Very professional, no pushing or bossing. I learnt a lot!”

Pathways client

The program allows the client to embed behavioural change, gain confidence in their self-management, develop longer term trusted relationships with health care providers and hopefully get the best outcome for their ongoing management in the community.

Through the Eastern Melbourne Health Alliance, a collaboration between the four community health services in the East, Aboriginal Community Controlled Health Organisations, Eastern Health and Eastern Melbourne PHN, this model is being further developed and scaled across the East over the coming year.

“The Care Coordinator was great at making me understand my health issues and how to best manage them. I feel more positive and confident about my health because of her. She was also very helpful in informing me of the services that are available to me and contacting some of them on my behalf.”

Pathways client

6. Creating connected and inclusive communities

Why it matters

Social inclusion plays a vital role in supporting positive mental wellbeing and overall health outcomes. Being able to participate and feel included in society helps people enjoy life, feel valued and have the same opportunities to get an education, access health services and gain employment.

Social isolation and loneliness are significant risk factors that are linked to premature death, mental ill health, and the risk of developing dementia and chronic disease [22]. Given that being connected and feeling like you belong in a community can be such a positive determinant of health, it is concerning that only 58 per cent of Victorian adults report belonging to a group such as a sporting club, religious or community group, 14 per cent report not having someone to rely on in an emergency and only 51.7 per cent feel valued by society[23].

The impacts of social isolation and loneliness are not distributed evenly across our population, with those from low socio-economic backgrounds significantly more likely to experience these factors than the general population.

What we do

Support and services offered through community health organisations can help increase people's feelings of social inclusion, reduce loneliness, and improve mental health and wellbeing. Community health services are deeply embedded in local communities, with strong connections to thousands of community groups and local services across the state. As such, community health plays a key role in connecting Victorians to their communities and developing community resilience and inclusiveness to ensure all Victorians can access opportunities to participate and belong.

Community health work includes:

Increasing community engagement and participation

Community health services include innovative social prescribing models that support people to identify and engage in community activities that suit them. By delivering social participation programs for people at high risk of isolation including new parents, carers, older people and people with a disability, community health helps to keep Victorians connected.

Supporting communities to be healthier and more inclusive

Community health delivers health promotion activities that support communities to achieve improved health and wellbeing outcomes. These programs build the capacity of community services and local clubs to be more inclusive and welcoming of all Victorians.

Connecting vulnerable Victorians to services

Community health ensures that the most vulnerable stay connect by providing community outreach services with specialist health and wellbeing teams to communities with low engagement and higher risk factors, including the homeless and people living in social housing. These include specialist health and wellbeing services for vulnerable cohorts to increase equity including LGBTQIA+, culturally diverse and Aboriginal and Torres Strait Islanders.

Community health leading the way on reducing loneliness and improving social inclusion, a Merri Health led project

An innovative collaboration between services in the north and west is helping to demonstrate the collective impact of social inclusion interventions through shared evaluation practices.

The Social Inclusion Measurement Project had demonstrated that clients participating in a variety of services and programs offered through community health have reported increased participation in social activities, improved mental health, increased knowledge of communities that are different to their own, and feeling more connected to their local community.

Across all community health programs, on average 70% of program participants either agreed or strongly agreed their social inclusion had been improved in some way through participation in a community health program.

- 88% respondents reported improved mental wellbeing
- 80% respondents reported increased knowledge of communities different to their own
- 78% respondents reported increased sense of belonging
- 76% respondents reported increased involvement in community projects
- 73% respondents reported increased social connections

Project partners: Merri Health, DPV Health, Sunbury Cobaw Community Health, Your Community Health, North Richmond Community Health, Banyule Community Health, CoHealth, Access Health and Community, along with non-community health partners, including local government, neighbourhood houses and leisure centres

Case Study

Building health literacy in culturally diverse communities

The Bicultural Worker Health Literacy program run by DPV Health is a co-designed education program to address barriers refugees and asylum seekers face in rebuilding their lives.

For refugees and asylum seekers the most significant barriers to improved health are the navigation of the Australian healthcare system and accessing local healthcare and support services to receive treatment for physical and emotional trauma. The Bicultural Worker Health Literacy program aim was to increase awareness, knowledge, confidence, and skills to a point where at least 75% of clients reached a level where they could manage the health concern on behalf of their family.

DPV Health codesigned the program with the local community to ensure its effectiveness in meeting their needs. Over the last year 84 comprehensive group education session were delivered supporting 911 participants covering 11 topics: Dental Health, Healthy Eating, Heart Health, GP Visits/Access, Diabetes education, Skin Health, Asthma, Interpreting Services, Safe Use of Medicine, Family Wellbeing and Stress Management.

Before participating in the program, only 9% said they could manage the health concern on behalf of their family. After the program 95% of participants agreed or strongly agreed that they could now manage their health concerns. Participants also reported that their personal confidence and connections to other community members increased as a result of the social engagement and participation in social group activities available through the program.

Additional sustainable outcomes from the programs included translating education materials into Arabic, displaying materials in hard copy and on TVs in waiting areas, introducing an Arabic option on the phone system to navigate the system more effectively. The success and uptake of the program and resources lead to the introduction of Arabic exclusive dental services, prostate and cervical screening and a women's health service to better meet the needs of clients.

> **"This program changed my life. They showed me how to get help, gave me hope and made me feel healthy again."**
>
> Bicultural Worker Health Literacy program client

Case Study

Innovating in social prescribing

Community health services have been leading the way in implementing innovative new social prescribing models that work to address the social determinants of health. Social prescribing is a non-medical intervention that connects people with their communities to address loneliness, isolation and exclusion, all of which have a significant impact on health. Individuals who access the social prescribing program often face additional barriers to positive health, often expressing chronic illness, psychosocial barriers or disability that impact capacity and increase social isolation.

Social Prescribing programs are delivered by Wellbeing Coordinators (nurses, social workers, and counsellors) or Community Connectors (trained volunteers) who work to build purposeful relationships with isolated people or those disconnected from the health system. Wellbeing Coordinators and Community Connectors work with individuals to identify suitable community activities, social programs or peer support available with the end goal of establishing an ongoing and long-lasting connection to community.

The program has also had a positive impact on staff and volunteers. The program has reduced the workload for clinicians as clients become better at managing their health conditions. Program volunteers have reported that their participation has helped them avoid social isolation and has improved their own knowledge of the health system. For some volunteers the program provides an entry to a professional environment where they learn valuable skills for future employment.

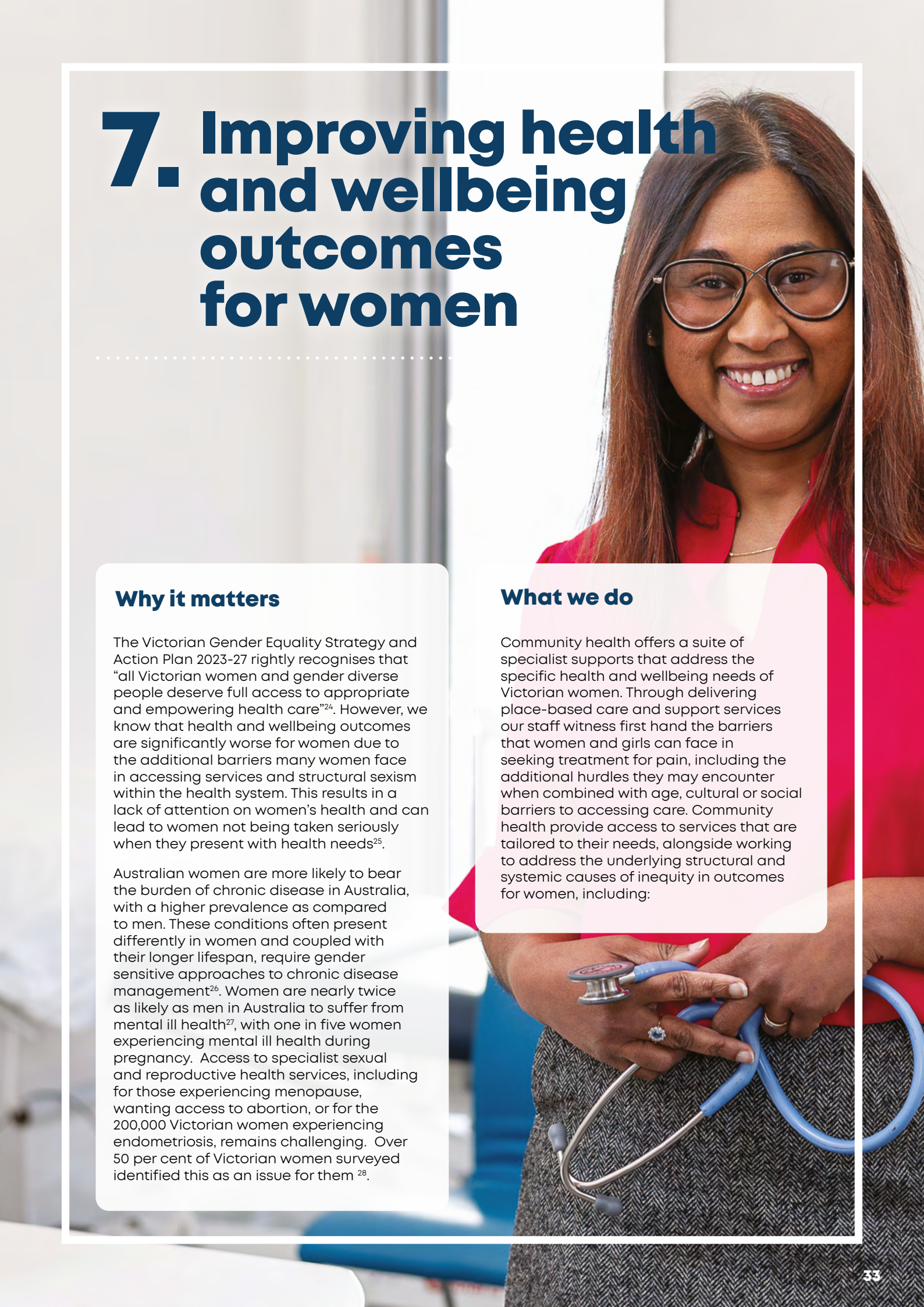
These programs are delivering great results. At IPC Health, participants report that the program:

- Has helped them feel valued, heard and become connected.
- Improved their mental health and wellbeing with 60% reporting an improvement.
- Has helped them become more active in their local community.
- Is more culturally accessible than more clinically based mental health services.
- Allowed them to practice their social skills and start them on a path to employment.
- Significantly impacted their experience with loneliness. With a 24% decrease in high to severe loneliness and a 12% increase in minimal to no loneliness.
- Reduced their need to see a GP, with a 50% reported a decrease in the number of visits.

Program results show that participation:

- Reduced the likelihood of participants developing more serious health conditions.
- Improved the psychosocial wellbeing of participants.
- Prevented escalation of potentially complex health risks and avoidable emergency department presentations.
- Reduced the burden on hospitals with a 23% reduction in Emergency Department presentations and 56% reduction in unplanned nights in hospital.

7. Improving health and wellbeing outcomes for women



Why it matters

The Victorian Gender Equality Strategy and Action Plan 2023-27 rightly recognises that "all Victorian women and gender diverse people deserve full access to appropriate and empowering health care"[24]. However, we know that health and wellbeing outcomes are significantly worse for women due to the additional barriers many women face in accessing services and structural sexism within the health system. This results in a lack of attention on women's health and can lead to women not being taken seriously when they present with health needs[25].

Australian women are more likely to bear the burden of chronic disease in Australia, with a higher prevalence as compared to men. These conditions often present differently in women and coupled with their longer lifespan, require gender sensitive approaches to chronic disease management[26]. Women are nearly twice as likely as men in Australia to suffer from mental ill health[27], with one in five women experiencing mental ill health during pregnancy. Access to specialist sexual and reproductive health services, including for those experiencing menopause, wanting access to abortion, or for the 200,000 Victorian women experiencing endometriosis, remains challenging. Over 50 per cent of Victorian women surveyed identified this as an issue for them [28].

What we do

Community health offers a suite of specialist supports that address the specific health and wellbeing needs of Victorian women. Through delivering place-based care and support services our staff witness first hand the barriers that women and girls can face in seeking treatment for pain, including the additional hurdles they may encounter when combined with age, cultural or social barriers to accessing care. Community health provide access to services that are tailored to their needs, alongside working to address the underlying structural and systemic causes of inequity in outcomes for women, including:

Case Study

Overcoming pain

Power Over Pain, run by **IPC Health**, uses non-medical strategies to help people experiencing persistent pain to relieve pain symptoms and encourage them to re-engage with day-to-day activities. 3.4 million Australians are affected by persistent pain and the waiting time to see a public pain specialist through the hospital system can be up to two years.

Many people presenting to emergency departments continue to return frequently without support or intervention due to the hospital waiting times. Power Over Pain has been co-designed with clients living with persistent pain, hospital clinicians and IPC Health clinicians to respond to each individual's unique set of medical and social needs to set goals and a self-management pain plan. An interdisciplinary team works with individuals to engage in learning about their pain which enables better understanding and find intervening strategies to reduce pain and prevent emergency department presentations.

The program is delivered by a wellbeing coordinator who provides pain education, links clients to other relevant services and support groups, reviews current medications, assists clients to get the most out of their existing healthcare team, and provides opportunities for social connection through local social groups and activities. The wellbeing coordinator works alongside a interdisciplinary team with a pharmacist, physiotherapist, psychologist, a pelvic pain specialist, and an occupational therapist and others as needed to provide wrap around care.

The program is for people experiencing persistent and chronic pain, who have not been able to address their pain due to lack of access to medical care, cost of treatment, or compounding issues such as unstable housing or work impacting their ability to consistently attend appointments. 70% of Power Over Pain participants are women between 40 and 70 years of age.

Outcomes:

- Clients expressed a transformative shift in their perception of pain.
- 56% of clients had an increase in their sense of self belief in pain management.
- 40% reported a reduction in GP presentations for management of pain.
- 53% reduction in severity of pain.
- 97% reduction in ED presentations.
- Overall reduction in risk for Opioid Use Disorder.

Case Study

Improving sexual and reproductive health for women

Women's sexual and reproductive health hubs provide a critical service for Victorian women, girls and gender diverse people throughout metropolitan Melbourne and regional Victoria.

With dedicated GPs, nursing staff and sexual health workers the hubs provide holistic health and sexual health assessments, support for unplanned pregnancies, medical abortion and accessing surgical abortion, screening services for blood-borne viruses, information and support on contraception, sexual health testing and treatment, care coordination, community outreach and school education programs,

Since 2017 community health has played a critical role in the rollout and implementation of the women's sexual and reproductive health hubs, with six of the first eight sexual health hubs being established by registered community health organisations. In 2024, registered independent community health now operates 13 of the 17 current hubs.

Community health was and continues to be well placed to deliver sexual health subs with our long-standing community partnerships, strong connections with local Women's Health Networks and expertise in delivery care through multi-disciplinary teams. Co-location, outreach, culturally appropriate and affordable services play an important part in the hub's success, along with being flexible and adapting to local and emerging needs.

"I saw a sexual health nurse, made me feel a lot better and more validated of my feelings, concerns and problems! It was an amazing experience compared to regular GPs."

Community health client

Community health leading the way on reducing loneliness and improving social inclusion, a Merri Health led project

Latrobe Community Health Service operates the Sexual and Reproductive Health Hub in Morwell and has a core focus on being able to take care of people's health needs in one appointment - instead of the typical three or four appointments elsewhere. This saves people time and money and ensures the services remains accessible and affordable to those who would otherwise not be able to access this essential healthcare.

In 2023-24 Morwell Sexual Health Hub:

- Completed 116 medical terminations of pregnancy
- Inserted 20 IUDs and 32 implanons (long-acting reversible contraception)
- Tested 60 people for STIs
- Provided 48 women with cervical screenings and education around menopause, sexual health and continence.
- Delivered counselling on contraception use and provided oral and injectable contraception prescriptions.

A no wrong door approach for all health care needs

A woman from a culturally and linguistically diverse background contacted Clinic 281, run by Gippsland Lakes Complete Health, seeking advice on a suspected unplanned pregnancy. With the support of translation services, the clinic provided a consultation where the women was advised that she was not eligible for a medical abortion.

With no local access to surgical abortion services in the area, Clinic 281 staff contacted several known services in Melbourne and found a suitable and affordable option. Clinic 281 staff developed a step-by-step plan to ensure the client could safely attend the appointment and organised follow-up care. This included helping her buy train tickets and transport once in Melbourne.

As a result of the care and support provided by the staff at Clinic 281, other women from her community have attended the hub for information and support.

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