

| High-Risk Accommodation Response Extension (HRAR Extension) |
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| Service Specifications January 2022 |
| OFFICIAL |

| High-Risk Accommodation Response Extension (HRAR Extension)Service Specifications |
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| Originally endorsed by: Annette Lancy, Deputy Secretary, Readiness, Response and Emergency ManagementDate: 16 April 2021Updates endorsed by: Laura LoBianco-Smith, Acting Deputy Secretary, Readiness, Response and Emergency ManagementDate: 14 January 2022 |

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Contents

[Aboriginal Acknowledgement 6](#_Toc93905378)

[Purpose 6](#_Toc93905379)

[Introduction 6](#_Toc93905380)

[Background 6](#_Toc93905381)

[Overview of the HRAR Extension 7](#_Toc93905382)

[Governance 8](#_Toc93905383)

[Objectives and Goals 9](#_Toc93905384)

[Mission 9](#_Toc93905385)

[Objectives 9](#_Toc93905386)

[Principles 10](#_Toc93905387)

[Scope 11](#_Toc93905388)

[Catchment approach and boundaries 12](#_Toc93905389)

[High-risk Accommodation Response catchments 12](#_Toc93905390)

[Service Specifications 13](#_Toc93905391)

[Roles and responsibilities 13](#_Toc93905392)

[The tiered approach 14](#_Toc93905393)

[The five service pillars of the HRAR Extension 15](#_Toc93905394)

[Catchment partnerships (previously ‘catchment planning’) 15](#_Toc93905395)

[Community engagement 16](#_Toc93905396)

[Prevention and preparedness 19](#_Toc93905397)

[Active linkage to health and social supports 21](#_Toc93905398)

[Outbreak Support 23](#_Toc93905399)

[Reporting requirements 26](#_Toc93905400)

[Required Reporting 26](#_Toc93905401)

[Data and Reporting Framework 26](#_Toc93905402)

[Reporting frequency and governance 26](#_Toc93905403)

[Evaluation 27](#_Toc93905404)

[Reporting Metrics 28](#_Toc93905405)

[Other requirements 33](#_Toc93905406)

[Funding model 33](#_Toc93905407)

[Information Sharing and Privacy 34](#_Toc93905408)

[Incident Reporting 34](#_Toc93905409)

[Service agreement and Statement of Priorities arrangements 35](#_Toc93905410)

[Accreditation 35](#_Toc93905411)

[Applicable guidance 36](#_Toc93905412)

[Appendices 37](#_Toc93905413)

[Appendix 1: Sample Terms of Reference, Agenda Template and Minutes Format for a Catchment Leadership Group 38](#_Toc93905414)

[Appendix 2: Tier based operating model 43](#_Toc93905415)

[Appendix 3: Contract Specifications 51](#_Toc93905416)

[Appendix 4: Incident reporting systems 54](#_Toc93905417)

[Appendix 5: Data Reporting Templates 55](#_Toc93905418)

[Appendix 6: Service Mapping 69](#_Toc93905419)

[Appendix 7: Glossary 90](#_Toc93905420)

# Aboriginal Acknowledgement

The Victorian Government proudly acknowledges Victorian Aboriginal people as the First Peoples and Traditional Owners and custodians of the land and water on which we rely. We acknowledge and respect that Aboriginal communities are steeped in traditions and customs built on an incredibly disciplined social and cultural order. This social and cultural order has sustained up to 50,000 years of existence. We acknowledge the ongoing leadership role of the Aboriginal community.

# Purpose

This document provides updated service specifications and operational guidance for a further extended version of the High-risk Accommodation Response (HRAR Extension) program. The Victorian Department of Families, Fairness and Housing (the department) provides a range of service offerings to prevent, prepare for, and rapidly respond to the heightened risk of COVID-19 infection and outbreaks in priority communities involved with (or who may benefit from) human services supports. The HRAR program is one of these services, operating through a settings-based, catchment level approach.

The document provides updated detailed HRAR Extension program information to enable Lead Providers to continue delivering the model. Specifications provide updated guiding detail but retain the flexibility to reflect differences across metropolitan and regional areas, geographic clustering of facility types and the need to allow for local innovation and adaptation based on risk. It is expected that Lead Providers will inform planning and delivery via liaison with program stakeholders and catchment partnerships.

The updates made throughout this document reflect the changing nature of the HRAR program and associated shift in HRAR service supports to commence in 2022 (all additions have been highlighted in yellow). The additions describe the change in service provision to be provided by Lead Providers.

# Introduction

## Background

During the coronavirus (COVID-19) pandemic in Victoria, a significant number of cases and outbreaks occurred in high-risk accommodation settings. In general, each high-risk setting is characterised by shared common spaces and high-density living. In response, dedicated emergency management operations (Operation Benessere and the Victorian Disability Response Centre (VDRC)) were established to support risk mitigation and outbreak response.

For residential disability settings, the infection prevention and outbreak preparedness (IPOP) program were established. The IPOP approach was delivered through a series of work packages that sought to collect information, apply a risk framework to identify different settings and cohorts of risk and deliver targeted interventions according to the level of risk. This program was delivered through in-kind support from Health Clusters in collaboration with the Department of Health’s Infection Prevention and Control (IPCON) team.

For high-risk accommodation settings, including public housing, community housing, rooming houses, supported residential services (SRS) and other sensitive settings, the high-risk accommodation response (HRAR) program was established. The core functions were broadly aligned with the IPOP program and included catchment planning, community engagement, prevention and preparedness activities and support for outbreak response. This program was delivered through commissioned health services.

These programs have now been integrated into the Readiness, Response and Emergency Management Division (RREM), within the department.

The HRAR Extension has been established to create a sustainable operating model for proactively reducing the risk of COVID-19 transmission and preparing for and responding early to infection or outbreaks in high-risk accommodation settings.

HRAR has had three separate and distinct iterations:

* Stage One: September 2020 to February 2021
* Stage Two: March 2021 to June 2021
* Stage Three: July 2021 to December 2021

Service Specifications for HRAR Stage One were substantially reviewed for HRAR Stage Two. During May 2021, a period of low COVID-19 risk in Victoria, the HRAR Extension Services Specifications (April 2021) were finalised to cover ongoing HRAR operations until the end of 2021.

In June 2021, the COVID risk in Victoria heightened considerably and positive COVID-19 case numbers increased. It is expected that high positive COVID-19 cases will continue into the first half of 2022.

Vaccination is recognised as a critical COVID-19 mitigation, alongside continued COVID-19 safety precautions. With increasing level of vaccinations, maintaining strong community connection to ensure hard to reach cohorts remain engaged with public health messages and initiatives that will become part of living safely with COVID, such as boosters, flu vaccinations and rapid antigen testing will become increasingly important. Supporting people who continue to be negatively affected, both by risk of illness, and the compounding impacts of the pandemic on their health, social supports and economic stability will also be an important part of enabling social recovery.

Acknowledging the increasing number of positive cases into 2022, as we move into a further HRAR Extension post December 2021, there will be an associated shift in HRAR service supports to outbreak management in high risk and priority cohorts and supporting those at the highest risk of adverse health outcomes and compounding social disadvantage. For catchment areas where outbreaks are not a predominant focus, transition to activities which support recovery and growth will be the focus.

## Overview of the HRAR Extension

The HRAR and HRAR Extensions adopt a service model that enables the rapid delivery of prevention, preparedness and outbreak response activities by appropriately skilled professionals within a robust governance framework. It works to ensure appropriate public health measures are in place to protect the health and wellbeing of residents living in high-risk accommodation settings. The program continues to promote creativity in responses in order to provide adequate, culturally appropriate and accessible services and supports (including health and social services, food and essential supplies). It also prioritises the development and delivery of tailored community engagement strategies suitable for the diverse range of residents, workers/volunteers and landlords/proprietors and service providers covered by the extended program.

The HRAR Extension (January 2022) will continue to build on and consolidate the functions that are already in place and designed to respond to transmission risk in high-risk accommodation settings, such as the prevention and control processes established for SRS’ and in high-rise public housing estates. It also complements broader health responses in local areas, including COVID-19 testing, COVID positive care pathway responses and vaccination programs.

## Governance

RREM central team is accountable for the objectives and goals of the HRAR Extension program.

Lead Providers have established and regularly convene with catchment leadership groups. Lead Providers should continue to consider membership of key stakeholders including local government and local public health units (LPHU). These groups will not have formal decision-making capacity but will act as a mechanism for collaboration, strategic direction and relationship building. This is one way for Lead Providers to include key stakeholders in catchment partnerships, however, Lead Providers may choose alternate engagement methods or strategies.



Diagram One: HRAR Governance Structure

A range of other stakeholders, including identified community leaders, local government, local health services, disability providers and non-government community services, will be part of the program delivery. This may be through formal inclusion in geographic catchment leadership groups.

# Objectives and Goals

The HRAR Extension (January 2022) continues to act to prevent, prepare for and respond early to coronavirus (COVID-19) infection within public housing and other high-risk accommodation settings with shared facilities.

The changing nature of the HRAR program has resulted in alterations to the overarching objectives as described in the HRAR Extension Services Specifications (April 2021). The operation will now be in accordance with the following mission and objectives (principles remain the same).

## Mission

The overarching mission of the HRAR extension (January 2022) is to support ongoing outbreaks, emergency COVID-19 variants and vaccine hesitancy as well as those at the highest risk of adverse health outcomes and compounding social disadvantage.

## Objectives

The overarching objectives of the HRAR Extension is to provide:

**Catchment partnerships:** The focus in this pillar will shift to maintaining catchment-based governance, the links established with local organisations and the place-based methodology. As the establishment and development phase of catchment planning has already been completed in previous HRAR work, the expectation is that fewer resources are required, and the focus will be on catchment leaderships/meetings and partnerships.

**Community engagement:** The focus of community engagement will shift to:

* unvaccinated, partially vaccinated and newly eligible cohorts
* promotion of booster and 3rd dose shots
* education regarding rapid antigen testing
* education regarding flu vaccine
* how to prepare for becoming a case or a close contact including preparing for isolation at home

Lead Providers will build on community engagement through assertive outreach models that are now well developed through previous HRAR work to support social and economic recovery within the community.

Lead Providers working the Public Housing High Rise Towers will continue to maintain and support the health concierge function which will play a key role in community engagement, promotion of vaccination and active linkages in these settings and offer support to tenants of the towers who are close contacts or COVID cases with an emphasis on social and economic recovery.

**Prevention and preparedness:** Expectations are that efforts in this pillar will reflect actions and outcomes already achieved in previous versions of HRAR. Work in this pillar will move to maintaining awareness and monitoring ongoing readiness and awareness of COVID risks, including any new COVID-19 variants. It is noted that for some facilities, i.e. SRS’, a more concerted effort will be required but is expected to be the minority.

**Active linkage to social supports:** To facilitate access for people in high-risk settings to culturally appropriate support services (including health and social services, food and essential supplies) to meet their needs, particularly at times of heightened risk of COVID-19 infection, transmission or during outbreaks, and to support social recovery efforts at the local level.

As the focus on outbreaks reduces over 2022, active linkages and social supports will grow and become the foundation pillar of the HRAR program. This pillar is expected to leave an indelible legacy - providing a lasting benefit to the vulnerable people receiving HRAR supports and developing community resilience.

**Outbreak support:** Support public health case and outbreak response activities to protect the health and wellbeing of people in high-risk human services settings (residential and non-residential) from COVID-19 infection and its impacts.

## Principles

**Health, safety and wellbeing**

Health, safety and wellbeing for residents, tenants, workers and volunteers are at the centre of all planning, decision making and action.

**Healing and recovery**

Communities will be supported to recover, recognising the ongoing impact of the stress and disruption the pandemic has caused.

**Client voice**

The experience of residents and tenants will be heard and acknowledged with a focus on health outcomes with an emphasis on social and economic recovery.

**Respect and transparency**

The safety, amenity and human rights of residents and tenants, their homes and neighbourhood will be respected. Residents and tenants will know what service response is being proposed, when/how/why this may change and have a chance to input into the ongoing care and support available for their community.

**Accessibility**

Residents, tenants and staff will be empowered to make informed health-related decisions based on clear, accessible, culturally, linguistically and religiously appropriate and authoritative public health and support service information. They will be supported to access clinical and other service needs for the immediate and long term if needed.

**Resilience**

The ongoing risk of COVID-19 will be reflected in future planning, with clear communications and engagement with residents on managing this risk and recognising and building on the strengths and resilience of communities.

**Leadership and community**

Community leaders (where possible, local residents) who reflect the gender, age, cultural and other diversity of residents and tenants will be empowered to be critical agents in supporting communities. There will be a focus on building the community to be stronger and more resilient than before the pandemic.

**Learning and improvement**

There is a commitment to learning and improvement based on the feedback we receive

# Scope

Accommodation settings within scope for the HRAR Extension January 2022 remain the same and continues to include government and non-government managed sites across the state of Victoria, which have been identified as high-risk accommodation.

The range of populations and accommodation-types within scope include:

* High-rise public housing
* Low-and medium-rise public housing – where there are shared facilities (e.g. laundry, kitchen) or access points (e.g. lifts, stairs)
* Residential disability settings
* Supported residential services (SRS)
* Rooming houses (private, community, and unregistered where/as known)
* Community housing
* Caravan Parks with long term residents

COVID-19 outbreaks over late 2021 have been observed in disadvantaged populations that have not previously been supported through HRAR. As such, there will be instances that DFFH will request that providers provide support in new settings. This may include: family violence refuge; out-of-home care for children and young people; non-residential disability settings; or other priority communities.

## Support for outbreak management, vaccination and a focus on social, health and economic recovery

HRAR will continue to focus on outbreak management facilitating access to vaccination and Rapid antigen testing and will also focus on community engagement and active linkages for priority communities and those most at risk, with an emphasis on social and economic recovery​.

The approach to different settings will be guided by risk; tailored to meet people's needs in priority communities, and target engagement to those at risk of adverse health outcomes and social disadvantage.

In an outbreak situation, DFFH HRAR Divisional staff will maintain focus on outbreak response management for highest risk cohorts and settings at the direction of the Department of Health or Local Public Health Unit. They will work with Lead Providers to design and deliver services according to the facility/dwelling risk rating and characteristics of people and their specific situation. Resident isolation support will align with Department of Health directions.

From January 2022, HRAR Divisional staff will work with Lead Providers and other stakeholders to understand how we can best adopt the risk-based approach to determine priority HRAR in scope settings and focus effort through a tailored approach based on identified risk.

Using the current facility/dwelling risk ratings for each setting, the risk approach should be:

1. Identifying settings with individuals and priority communities experiencing ongoing disadvantage that would see continued benefit from community engagement, prevention and preparedness and active linkage activities to support ongoing social, health and economic recovery
2. Identifying settings that remain high risk in the event of an outbreak

If Lead Providers determine a facility/dwelling is a high-risk priority cohort that is not currently listed as a current HRAR in scope settings, it can be included at the discretion of HRAR Divisional staff. Lead Providers are to obtain HRAR Divisional approval before engaging with tenants/residents at the setting.

Conversely, if DFFH HRAR staff determine a facility/dwelling is a high-risk priority cohort that is not currently listed as a current HRAR in scope settings and requires support, DFFH HRAR staff will work with Lead Providers to provide the required support.

Outbreak support management scope settings have changed as described above AND the continued inclusion of homelessness hotels which is noted in Appendix 5 of the Service Specifications. When outbreaks occur, Lead Providers will be deployed as directed by the Department of Health, Local Public Health Unit and the HRAR Division Deputy Agency Commander. This will include isolation support as directed by the DH.

# Catchment approach and boundaries

Catchments cover all in scope accommodation (government and non-government) within a specified geographic area. Catchment boundaries remain as follows:

* For areas with a high density of units, catchments have been defined along the LGA boundaries – ten LGAs fall within this range, including sub-catchments.
* For the remaining areas, to achieve a feasible scale of residents and number of catchments, catchments have been defined in line with the department's Area-based boundaries; 21 catchments fall within this range, including sub-catchments.

## High-risk Accommodation Response catchments

### Local Government Area Catchments

#### North Division

* Moreland
* Yarra (Richmond)
* Yarra (Fitzroy, Collingwood)
* Darebin
* Banyule

#### South Division

* Port Philip
* Stonnington

#### East Division

* Monash

#### West Division

* Melbourne
* Moonee Valley

### DH Area-Level catchments

* Hume Moreland
* Loddon
* North Eastern Melbourne
* Mallee (Mildura)
* Mallee (Buloke, Gannawarra, Swan Hill)
* Outer Gippsland – Wellington
* Outer Gippsland - East Gippsland
* Bayside Peninsula – Middle
* Bayside Peninsula – Lower
* Southern Melbourne
* Inner Gippsland
* Inner Eastern Melbourne
* Outer Eastern Melbourne
* Goulburn
* Ovens Murray
* Western Melbourne
* Barwon
* Brimbank Melton
* Central Highlands
* Wimmera South West – South West
* Wimmera South West – Wimmera

In addition, LPHUs and Disability Liaison Officers, also cover the state but boundaries differ from those used to define the catchments (Appendix 6).

# Service Specifications

The three levels of operations within the HRAR Extension remain, each with a geographic reach:

1. Lead Providers work at the catchment level within the 31 catchments to deliver a local response.
2. The 31 catchments are each allocated to one of the four departmental divisions: North, South, East or West. Divisional staff offer a wider, but still focused perspective on the geographical division in which they operate.
3. RREM provides a state-wide perspective and coordinates operations between the Divisions as well as those services which cross into more than one catchment.

## Roles and responsibilities

### The role of the Lead Provider

Lead Providers will continue to be agile, flexible and creative. The HRAR Extensions are an exercise in partnership – maintaining trusted pathways to ensure an appropriate human services response for those in high-risk accommodation settings when tenants and residents need a helping hand. This iteration of HRAR offers the opportunity for Lead Providers to continue to forge a lasting legacy with some of our most disadvantaged community members.

Lead Providers are aware that not all settings are homogenous across the board. While there may be similarities between most rooming houses, there may be some that are more like an SRS; there may be some blocks of community housing units that feel far more like a high rise. It remains the Lead Provider’s role to identify appropriate activities and methods of engagement based on the characteristics of each setting. The Risk Assessment, which forms part of the suite of reporting tools, will assist in this process (Appendix 5).

Lead Providers may continue to partner with others or defer to overarching mechanisms already in place for the provision of some of the service objectives. This remains a key tool used to avoid duplication of services and allow the Lead Provider to identify and fill service gaps. Where there is a lack of clarity around service provision, it is expected that Lead Providers will action. For example, if it is unclear who will work with residents and staff in a disability setting to help them best apply infection prevention and control principles, the lead provider will offer to action.

In the HRAR Extension (January 2022) disability residential services remain in scope. It is the Lead Providers responsibility to ensure that all HRAR service pillars are offered in these settings and that highest risk settings are identified and offered additional support if required.

### The role of the HRAR Divisional Team

The HRAR Extension Divisional Team remain the key liaison between the Lead Providers and the Department’s Central Team. The Divisional Teams are responsible for ensuring Lead Providers have the tools and supports they need to deliver the contracted work and meet contractual obligations.

### The role of RREM Central Team

The RREM is the link between the Department of Health VIC (DH), interpreting key messages from the Chief Health Officer and that Department, and relaying messaging via the Divisional Teams to Lead Providers.

The RREM is also the liaison between state-wide services and the Divisions. State-wide services include peak bodies such as the Victorian Healthcare Association or Community Housing Industry Association (Victoria), broader regulatory bodies such as the Authorised Officers from both Health and SRS, WorkSafe, Municipal Association of Victoria and Consumer Affairs Victoria. RREM also coordinates service delivery to avoid duplication. This generally occurs when a large entity of one form or another, has multiple settings bridging multiple catchments. Rather than a Lead Provider from each catchment separately coordinating service delivery, this task will be done centrally by RREM in partnership with the Lead Provider.

RREM will also continue to provide overarching guidance to Lead Providers in engagement and communications activities, ensuring that activities by Lead Providers align with those managed by DH, DFFH and other Victorian government departments.

## The tiered approach

The HRAR Extension Operating Model consists of four tiers to assist Lead Providers in planning the intensity, composition, delivery method and extent of service provision and remains unchanged in this HRAR Extension. Tiers do not necessarily reflect ascending or descending risk, but rather reflect variations in risk profile due to differences in setting characteristics.

For example, high-rise housing fits in Tier 1 and represents large numbers of tenants living in close quarters with many shared spaces. To effectively provide HRAR Extension services to the highest number of people living in high-rise housing, staff are on-site via the concierge program. However, that intensity of service is not required to deliver the same program in a five-person rooming house.

Similarly, it is likely that Tier 1 properties will be offered all the HRAR Extension services, including the requirement for a widely known COVIDSafe plan. This same expectation, however, may not apply to a rooming house.

**Tier 1: Public Housing settings**

* all high-rise public housing and high-risk medium-rise public housing
* low-risk medium-rise public housing and all low-rise public housing

**Tier 2: Staffed settings**

* disability residential settings and
* supported residential services (SRS)

**Tier 3: Unstaffed settings**

* community housing
* caravan parks and
* rooming houses

**Tier 4: Other settings**

* disability community-based settings
* other accommodation settings deemed to be in scope on a case by case basis.

# The five service pillars of the HRAR Extension

1. Catchment partnerships
2. Community engagement
3. Prevention and preparedness (including vaccination support)
4. Active linkage to health and social supports
5. Outbreak support

The changes to the five service pillars described below guide the key activities that Lead Providers must supply from January 2022. During this period, it is anticipated that tasks associated with catchment planning, prevention and preparedness and community engagement will be refined, thus reducing supports provided by Lead Providers under these pillars. While outbreak support will initially require considerable resources, as case numbers slow, the expected activities under this pillar will decrease and the future focus will be in activities promoting active linkages to health and social supports. The overall changes are:

**Catchment partnerships** – moving to maintenance of catchment leadership meetings and partnerships

**Community engagement** – build on community engagement through assertive outreach models; continued support for the unvaccinated but expanding to boosters, flu vaccine, health checks, referrals to services, case support for vulnerable residents where required

**Prevention and Preparedness** – targeted focus on priority communities where risk and impact is higher

**Active linkages** – assertive outreach and engagement to most at-risk cohorts and other vulnerable people and communities, linking to broader health and social services to support social and economic recovery

**Outbreak Support** – maintain focus on outbreak response management for highest risk cohorts and settings

\* Revised effort may vary within local catchment area’s depending on local community needs, issues and outbreak support required and issues

## Catchment partnerships (previously ‘catchment planning’)

### Catchment partnership objectives

To provide a local area approach for the delivery of these services, with delineated roles and responsibilities between agencies and government bodies involved in service delivery and governance of the program.

### Catchment partnership goals

It is expected that Lead Providers will maintain existing relationships and leverage established methods of local engagement within catchment areas to continue to inform tailored catchment engagement and service delivery objectives.

* Apply an evidence-based risk framework to identify the level of risk and stratify and tailor responses accordingly.
* Identify and support measures at the catchment level that support and facilitate broader community and social recovery.

These specifications are intended to provide guiding detail but also retain the flexibility to reflect geographical and material differences and the need to allow for local innovation and adaptation based on need.

Lead Providers remain responsible for Catchment Leadership Groups. The catchment leadership group will continue to include local government, local disability liaison officers, LPHU and other identified local service providers.

Catchment Leadership Groups should continue to share local intelligence to inform prioritisation of support for all activities.

A key responsibility of the Catchment Leadership Groups includes the coordination and support of the five pillars of service delivery within the HRAR Extension.

Key Outputs: Catchment Partnerships

|  |  |  |  |
| --- | --- | --- | --- |
| Description  | Trigger and timing  | Led by  | Role of Lead Provider  |
| Ongoing Catchment Partnerships* Catchment leadership group meetings to continue monthly or, at the discretion of each catchment, to drive catchment responses that supports and facilitates broader community and social recovery

\*\* Although catchment plans are not required to be submitted to DFFH, each Lead Provider is expected to utilise the information previously developed such as demographics and Governance.  | Ongoing and dynamic process of partnership, informed by local engagement, site visits and local data and intelligence | Lead Provider  | Lead local catchment partnerships |

## Community engagement

### Community engagement objectives

To continue engaging with people residing in high-risk accommodation settings and their local communities, through a range of community engagement strategies, with a greater focus on promoting a broader social recovery at the local level.

### Community engagement goals

Continue work with community leaders, community health, local councils, community services and other agencies through assertive outreach models to:

* provide information about COVID-19 risks and prevention strategies and supports
* provide information on what to do if you are a case or close contact including preparing to isolate at home
* provide supports which are culturally safe, appropriate for disability clients and families as well as CALD, to meet the presenting health, social, material aid, and other needs of people within high-risk settings and support broader social recovery efforts
* continue the support take up of the COVID-19 vaccination program including booster shots
* provide education on rapid antigen testing and the flu vaccine
* encourage connection between local communities and the broader service system (health and social supports) to help address the needs of people at greatest risk and/or with unmet service needs.

### Community engagement activities

Community engagement activities are to be carried out throughout all stages of the HRAR Extension. Continued early and dedicated efforts to engage residents and community leaders will continue to support prevention and outbreak management activities as well as identify at risk, hard to reach cohorts who require active linkages to health and social supports.

Engagement activities will be aligned with and support outputs through DFFH, DH and other Victorian Government agencies, as required.

Critical to community engagement is the Lead Provider’s knowledge and understanding of:

* residents, community leaders and other key community members
* barriers to engagement
* health and safety risks for residents and staff
* preferred approaches to engagement.

The tables below are excerpts taken from the department’s Community Engagement Toolkit. The full kit contains examples of action logs, terms of reference, newsletters and some detailed guides around the best way to engage with communities, especially in times of crisis. The full kit is available from the Department and can be obtained on request from your HRAR Divisional Director or staff.

Key principles of community engagement

The six principles are based on lessons learned from the public sector response to the outbreak of COVID-19 in public housing and build on the principles of the Public Participation Framework (Department of Human Services; 2019).

| Multi-faceted | Genuine Partnerships | Residents are experts | Place-based | Trauma-informed | Respectful and inclusive |
| --- | --- | --- | --- | --- | --- |
| * Using different ways to engage with community maximises the chances of key messaging on health, safety and supports reaching all residents, including those with diverse needs. For example: Zoom meetings, WhatsApp groups, email bulletins, laminated posters in community buildings, Facebook page, YouTube.
 | * A genuine partnership that empowers residents and community members, and builds mutual trust is the most effective way to prevent the spread of infection.
* Residents and community have a right to be involved in decisions that affect their lives- working together to design solutions is a better way to get things done and to meet everyone’s needs.
* Listening to residents and community members and seeking to understand the barriers to community engagement helps to minimise feelings of intimidation, disengagement and non-compliance.
 | * Residents and the resident voice must be a central focus of community engagement.
* Residents are experts on the experience of living in the community, whether it be public or community housing, a rooming house or specialist residential services. They are best placed to tell us how an emergency and associated responses(s) affects them.
* Contributions of residents and the unique value of the resident voice should be appropriately recognised and remunerated.
* Residents and community members have ideas and solutions about how information can be shared and ways to keep themselves and each other safe.
 | * Community engagement should be targeted and designed at a local level. It should be based on a strong understanding of the values, diversity, dynamics, strengths, needs and priorities of residents and their unique communities.
* Effective community engagement supports and builds on individuals’ and community’s ability to identify and resolve risks and barriers to complying with health advice.
 | * Recognise and build on the cultural strengths of the community.
* Ensure intended and unintended consequences of the community engagement approach do not create harm to individuals or the community.
* Be mindful of historical contexts for groups of individuals.
* Use strategies that encourage engagement and minimise distrust.
* Initiate opportunities for choice, collaboration and connection.
 | * All residents and community members are valued and respected, differences are validated and appreciated.
* Communities have built their own infrastructure and support systems that we need to understand and work with to achieve optimal health, wellbeing and safety outcomes.
 |

Community engagement and planning

Community engagement is a core function of the High-Risk Accommodation Response (HRAR) to support COVID-19 preparedness, prevention and outbreak management. Under the HRAR< lead providers are required to develop a community engagement plan for their catchment. To achieve this, lead providers are expected to engage and partner with residents, community members, community service organisations and government to ensure culturally appropriate and accessible public health messages and COVID-safe practices are in place to reduce the risk of transmission and protect the health, wellbeing and safety of residents.

Community engagement planning should align with public health advice provided by the Department of Health and Human Services (**refer page 25**) and include a focus on safety planning and wellbeing supports for all individuals leading and participating in community engagement activities (**refer page 33**).

|  |  |
| --- | --- |
| Understanding the local community | Engaging everyone in the community, in ways they can understand and that make sense |
| It is critical that HRAR lead providers know the high risk accommodation facilities in their catchments and the residents and communities they are working with. This knowledge will assist lead providers to develop effective engagement strategies for managing risks and optimising health, wellbeing and safety.The checklist on **page 14** in this toolkit guides community engagement planning for COVID-19 preparation for COVID-19 prevention and outbreak management under the HRAR, and provides an opportunity to identify gaps and opportunities, In completing the checklist it is recommended that lead providers use a blended approach to analysis, drawing from available data as well as early engagement with residents, community leaders, proprietors and other key community stakeholders. | The community engagement approach should consider ways to engagement and hear from Aboriginal and Torres Strait Islander people. Culturally and linguistically diverse people, people with a disability, children and young people, the elderly, refugees and asylum seekers, people who are LGBTI, those with low/no-literacy and those without access to the internet or digital devices. It is important to understand the potential barriers to engagement and the associated risks to COVID-19 preparedness, prevents and outbreak management. By understanding barriers, the needs and preferences of everyone can be better supported.Knowing who has established and trusted relationships with residents and the community and how they may be able to support engagement activities is also important. |

Key outputs: community engagement

| Description  | Trigger and timing  | Led by  | Role of Lead Provider  |
| --- | --- | --- | --- |
| * Liaison with RREM through divisional HRAR teams regarding engagement approach and information to be provided about COVID-19 and vaccination including boosters and rapid antigen testing, ensuring that activities are fully aligned with government approaches and outputs.
* Provision of information about COVID-19 risks in a range of formats which meet the needs of the diverse groups identified in catchment leadership groups including accessible communications and in community languages.
* Provision of information about the vaccination program in a range of formats which meet the needs of the diverse groups identified in catchment leadership groups.
* Develop messaging that responds to the identified risks and barriers facing individual site and communities.
* Ensure development of engagement strategies and platforms that are appropriate to each setting and targeted to the individuals/communities residing at each location.
* Development of tools, resources and activities appropriate to community engagement activities in each setting.
* Ongoing engagement with residents, proprietors / landlords and HRAR communities to inform planning and the provision of support.
* Ensure residents are respectfully engaged as members of their community.
* Ensure community engagement activities respect each person’s cultural preferences and their human rights.
 | Ongoing | Lead Provider | To deliver and establish community engagement processes |

## Prevention and preparedness

### Prevention and preparedness objectives

Continue the delivery of COVID-19 prevention and preparedness activities that impart increased understanding of Public Health messages, including infection control and transmission risks and vaccine support with a targeted focus on priority communities where risk and impact is higher.

### Prevention and preparedness goals

* Providing and reinforcing public health messaging in high-risk settings and at the local community level or supporting other agencies to do so, including vaccination support.
* Continue educating residents, staff and proprietors about COVID-19 and how to prevent it harming individuals, families and communities, including vaccination information to support awareness, confidence and readiness.
* Supporting residents, staff and proprietors in high-risk settings to understand and implement strategies that reduce risk of COVID-19 infection and transmission and create “COVID safe” environments.
* Supporting COVID-19 vaccination including proactive engagement, education and promotion.

### Prevention and preparedness activities

The following activities are defined and funded under this pillar:

* Monitor ongoing awareness of COVID risks and readiness to respond if needed, including any new COVID-19 variants
* Evolving the health concierge program in any high-rise tower in response to the changing residents/cohort needs and re-focussing effort to supporting sustainable linkages into broader support services. See Active Linkages for more information.
* Additional surveillance testing as directed by the DFFH HRAR Divisional teams

As per the tier-based operating model, approaches to settings will vary according to risk characteristics, whether settings are staffed, and, most importantly, willingness to accept the support offered. Building on what has been learnt and focussing on the unique and unmet needs of each setting will increase the effectiveness of activities.

Where large organisations are either the proprietor or landlord of multiple properties across several catchments, engagement at that level will be coordinated by RREM. RREM, via HRAR Division Directors will pass on to relevant Lead Providers the activities to be undertaken and task schedule.

Lead providers will maximise existing linkages between health services, community resources and the various settings, including but not limited to: Area-based Public Housing Teams, the local Disability Liaison Officer, the Community Capacity Building Initiative, Local Government and Public Health Units. In the disability context, facilitating a partnership approach when undertaking prevention and preparedness activities will continue to be important.

All parties must ensure that prevention and preparedness assessment/implementation of strategies is conducted with respect to human rights, the privacy of residents and tenants and relevant legislation.

Residents are moving more freely through daily life and may have different patterns of movement. Lead Providers are encouraged to be innovative in their service offerings and availability to continue to maximise connection with the broad base of residents.

### Vaccination support

There remain three distinct areas of vaccination support. The examples provided are indicative only; the outcome Lead Providers are to strive for is vaccination and boosters of those in the HRAR Extension cohort. Lead Providers to continue to use creative ways to provide vaccination support listed below:

1. the provision of accurate, timely, culturally appropriate and up to date information about vaccination and the vaccination program including boosters
2. continue the promotion of vaccination. This may include supporting the resident to visit their GP for a consultation about their suitability for the vaccine or simply ensuring that the resident is ready, willing and able (has a viable plan) to attend their vaccination appointment
3. accessing vaccination. Services in this area could range from hiring a bus and transporting groups of residents to a vaccination centre, facilitating appointment-based vaccinations in some settings, or supporting them to make an appointment for vaccination that they will attend independently.

Key Outputs: Prevention and Preparedness

| Key activities | Trigger and timing  | Led by  | Role of Lead Provider  |
| --- | --- | --- | --- |
| **Monitor ongoing awareness of COVID and readiness to respond if needed*** Ensure in scope proprietors/landlords and residents have clear information on COVID status and access to vaccinations and boosters.
* Ensure in scope proprietors/landlords and residents have clear understanding of the isolation requirements as directed by the Department of Health
 | Core business | Lead Provider | Facilitate information |
| **Community engagement and education strategies that support prevention and preparedness** * Ensure proprietors/landlords and residents have clear information on COVID-safe requirements.
* Provision of appropriate infection control training and/or guidance and support to follow public health directions and implement COVID-safe strategies. May include hosting community events and forums.
* Communication with residents supported by staff and service providers where available.
* Strategies delivered in easy read English and diverse languages as required.
 | Ongoing | Lead Provider | Documentation |
| **Health Concierge** * Health concierge/information services are established in high risk public housing settings to ensure appropriate and sustainable public health measures and adequate service supports and community engagement strategies are in place and that these services are flexible to meet the movement and availability of residents [[1]](#footnote-1).
 | Ongoing | Lead Provider or during vaccination DH / C19 | Provision of information and support to residents |
| **Vaccination support**Continue to promote uptake of vaccination program including boosters by:* Provision of factual, culturally appropriate and current information,
* Promotion and encouragement of vaccine uptake,

Facilitating vaccine access (e.g. organise transport). | Pre vaccination availability | DH / C19RREM central team to provide comms | Supporting the residents to get vaccinated |
| **Supporting residents to test** * Lead Providers to support residents who may have symptoms of COVID-19 to local testing options or access to the Rapid Antigen Test (RAT).
 | Resident displaying symptoms or advising of possible contact with the virus | Lead Provider / Resident / Support Staff | Facilitate testing and quarantine until test result is known and further if positive |
| **Surveillance testing*** Stand up of additional surveillance testing as a prevention strategy where required\*\*
* Support staff and, in specific circumstance residents, in understanding and assisting them with rapid antigen testing

\*\* Note: It is acknowledged that not all Lead Providers undertake this activity | Provided in response to an identified need | RREM | Additional surveillance testing site and staff |

Where staff are at the service at least daily

|  |  |  |  |
| --- | --- | --- | --- |
| Key activities | Trigger and timing  | Led by  | Role of Lead Provider  |
| **COVIDSafety and Fit for work**Ensure staff double vaccinated and have had a booster shot as per Public Health recommendations | High risk, staffed facility | Lead Provider | Ensure the need for vaccination is understood |
| **Workforce/champions training*** Where there are identified capability gaps in prevention and preparedness (including in vaccination support) training may be developed or sourced from existing resources and training providers.
 | High risk, staffed facility | Lead Provider | Assist to upskill workforce |

## Active linkage to health and social supports

### Active linkage to health and social supports objectives

To facilitate access for people in high-risk settings to culturally appropriate and accessible support services (including health and social services, food and essential supplies) to meet their needs (particularly at times of heightened risk of COVID-19 infection, transmission or during outbreaks). To support connections between people in high-risk settings and the broader service system and maximise social recovery efforts at the local level.

### Active linkage to health and social supports goals

* At times of heightened risk of COVID-19 infection, transmission or during outbreaks support making culturally safe, accessible and appropriate health and support services readily available to clients, staff and proprietors across in-scope settings, either through targeted social supports or connecting to existing services in other settings.
* Encourage connection between people in high-risk settings and the broader service system (health and social supports) to help address the needs of vulnerable people who may be disconnected from services.
* This includes increased focus for health concierge programs to link residents to broader health and social services.
* Promote connection between local community and broader service system to maximise opportunities for social recovery and community resilience.

Leveraging upon the depth and strength of resident engagement and local relationships and trust developed between residents and Lead Providers, the HRAR Extension activities in this space will continue to focus on proactively creating linkages to health and social services. This activity will leverage supportsthat are best matched to presenting needs with the aim of building connection between settings, cohorts, and individuals (where relevant and appropriate) and the broader service system. The continued aim is to support immediate and sustained physical, mental, and social well-being and maximise social recovery and community resilience opportunities. This may include active linkage to general practitioners, mental health, alcohol and drug supports, community services (including family violence, child and family services, community programs etc), financial aid, food relief and other supports, exercise programs, health promotion, and social connection supports, along with the provision of infection prevention advice.

It is known that from 2020 and 2021, fear, in addition to lock downs, has kept people indoors and isolated and many neglected regular health check-ups and appointments or failed to have health concerns investigated.

In addition, the isolation during lock downs, has been seen to trigger or escalate episodes of mental health illness, many of which have also gone untreated.

It must also be acknowledged, though, that prior to 2020 and COVID-19, the HRAR resident cohort often felt excluded and/or ineligible for service provision. For many, their most likely health presentation was during a crisis and through emergency services and the emergency department at their local hospital. Similarly, social groups and support networks are not always well known, understood or utilised by this group.

During contact with in-scope residents, Lead Providers continue to have an opportunity to work with a person to identify services that are available to them, encourage them to seek advice and support, join groups of interest to them and generally assist this vulnerable group to reconnect with their community.

Key outputs: **Active linkage to health and social supports objectives**

| Key activities | Trigger and timing  | Led by  | Role of Lead Provider  |
| --- | --- | --- | --- |
| Use existing relationships between providers and through the Catchment Leadership Group to provide referrals for people into appropriate services | Based on resident need | Lead Provider | Facilitate service |
| Advice and information about health, support and social services that may be of interest to residents and tenants | Based on resident need | Lead Provider | Provision of accurate and up to date information |
| Where required, provide advocacy and referrals for service. | Based on resident need | Lead Provider | Facilitate service |
| Assist and encourage participation.  | Based on resident need | Lead Provider | Support |
| Utilise the health concierge program to link residents to broader health and social services | Based on resident need | Lead Provider | Facilitate service |

Further details on expected work within the five service pillars of the HRAR Extension, including active linkage to health and social supports are provided in Appendix 2.

## Outbreak Support

### Outbreak support objectives

Support public health case and outbreak response activities to protect the health and wellbeing of people in high-risk human services settings (residential and non-residential) from COVID-19 infection and its impacts.

NB: Non-residential settings, e.g. disability day services, homeless service providers, will be included on a case-by-case basis as determined by DFFH HRAR Divisional team.

### Outbreak support goals

Work with DH and DFFH to respond to COVID-19 outbreaks and positive COVID-19 cases at the local level, including as part of Incident Management Teams, Outbreak Management Teams or other forums established to manage the outbreak response.

An outbreak in an in-scope HRAR setting will be declared as determined by the Public Health Directions at the time.

Care must be taken at all times to respect privacy considerations and ensure only those who need to know receive any personal information about the case.

The Lead Provider is required to have an up-to-date understanding of their capacity and that of their partners so they can confirm agreement of the functions they can take on with DFFH or DH.

The Lead Provider will provide local intelligence to inform the plan and will feed up-to-date information to the outbreak response over the life of the outbreak to inform changes in risk. In many cases, the Lead Provider is our eyes and ears on the ground and is the key conduit between health directions and the residents or tenants involved.

The Lead Provider’s local knowledge and early intervention at the dwelling level is an invaluable tool during an outbreak. It is anticipated that Lead Providers will be called upon to provide information on several fronts and will be instrumental in utilising and building on existing networks to deliver services during the outbreak. Local intelligence gained through the valuable role of HRAR in responding at times of heightened risk of COVID-19 infection and transmission has created the flexibility to respond to priorities and needs as they evolve and this will be heightened in any outbreak or even potential outbreak situation.

In the latter part of 2021, outbreaks have increased to the extent that a bespoke and staff intensive response must be limited to only those settings where the risk of community exposure and spread is high. In addition, isolation support for residents to be reduced in line with the Department of Health directions and as directed by the HRAR Divisional staff.

When outbreaks are detected, actions to be taken will be directed by Public Health via the relevant Public Health Unit and may be based on a risk assessment undertaken by HRAR Divisional staff. Within this framework action may incorporate any or all of those actions identified above.

Key outputs: **Outbreak Support**

| Key activities  | Trigger and timing | Led by | Role of Lead Provider |
| --- | --- | --- | --- |
| **Outbreak response planning*** Participate as required in outbreak management forums:
* Forums are led by either the DH or DFFH,
* Lead Providers contribute to developing actions plan designed to eliminate or mitigate the risk of disease transmission and effect recovery of any positive cases,

Lead Providers will agree to undertake actions that are within their scope and complete all actions within agreed timeframes. | In response to an outbreak as determined by the DH or DFFH | Public Health (LPHU)DFFH | Participate in relevant outbreak management forum. Requested to deliver key parts of the Incident Management Plan or related plans |
| **Health service delivery and clinical governance**Depending on requirements set out in the incident action plan or other relate plans, this could include:* Support community engagement, health promotion,
* Deliver onsite testing in line with agreed testing strategy and timeframes,
* In some cases, deliver case and close contact management – including making daily calls to positive cases and close contacts (only if required),

Be an escalation point if residents have complex health (and support) needs. Link residents into existing health services | In response to an outbreak – as set out in Incident Action Plan or related plans  | DH/DFFH | Deliver health services including proactive contact management, active case management and proactive case finding as agreed in the Incident Action Plan or related plans. |
| **Social Services and Relief**Leverage existing local service networks, be the escalation point for positive cases and close contacts who have complex needs. Establish referral pathways to existing and new supports for residents and to undertake case planning for complex clients. | In response to an outbreak – as set out in Incident Action Plan or related plans | DH/DFFH | Escalation point for people with complex needs. Deliver case planning and referral. |
| **Material Aid**Where agreed in the relevant outbreak management forums or the Incident Controller, identify food and aid needs of residents (including any culturally specific requirements) and refer to the appropriate provider for sourcing and distribution.These include, but may not be limited to, food, sanitary items, pharmaceuticals, medical and nursing care and water.In some rare cases, where the need is immediate, the request may be to purchase and provide items immediately. | In response to an outbreak – as set out in Incident Action Plan or related plans | DH/DFFH | As agreed in the Incident Action Plan or related plans. |

# Reporting requirements

## Required Reporting

Reporting requirements remain largely the same:

* Acquittals
* Prevention and Preparedness report (HRAR Extension reporting template)
* Risk Rating

Catchment planning templates no longer need to be provided, however, reporting on catchment leadership and partnerships, including the activities described in the catchment partnerships section, will need to be added in the HRAR Extension reporting template monthly under the qualitative data section:

* Key achievements
* Issues/risks
* Community engagement

In addition to the above, as part of the HRAR Extension monthly reporting template in the qualitative fields, requirement to provide good news stories demonstrating the change in residents/tenant’s life as a result of the HRAR program.

Potential matters of concern to raise with HRAR Division Director:

* Adherence to public health directions, including failure to have a COVIDSafe Plan in place where applicable
* General matters that are not COVID-19 specific (e.g. related to resident or worker safety or quality of accommodation)
* Limited level of engagement by proprietor or landlord to engage or cooperate
* Level of regulatory compliance (whether or not related to COVID safety)

## Data and Reporting Framework

To demonstrate achievement of the program objectives and the impact of the activities undertaken, the reporting domains, activities, outcome measures and metrics are noted in the tables on the following pages.

The data output will both be in a qualitative and quantitative format to enable comparative data analysis, enable commentary about key matters to be provided and ensure good news stories and case studies are captured.

## Reporting frequency and governance

All Lead Providers will continue to undertake required end of month reporting for submission on or by the 14th of each month. This will enable clarity in reporting requirements, promote consistency in reporting practices and ensure that robust data analysis is able to be undertaken through comparison of like data sets and timeframes. Data and reporting will provide the capacity to understand how the program is progressing and to identify and resolve issues that may arise during its operation.

Reporting Schedule

|  |  |
| --- | --- |
| Report | Due for submission by Lead Provider |
| Acquittal Template | 14 February 202214 March 202214 April 202216 May 202214 June 202214 July 2022 |
| Prevention and Preparedness Report\* Including catchment partnership activities | 14 February 202214 March 202214 April 202216 May 202214 June 202214 July 2022 |
| Risk RatingNB: it is not expected that the risk rating for all facility/dwellings will reduce to low risk  | Any change to the rating already provided for each facility/dwelling to be provided monthly:14 Feb 202214 March 202214 April 202216 May 202214 June 202214 July 2022 |

State-wide data representation and analysis can be used for program evaluation and provision of advice to key stakeholders and government around program progress, outcomes and impact, and determine whether program objectives are being achieved. This will support client, community and stakeholder confidence in the efficacy and safety achieved through the initiatives of the program.

## Evaluation

The Data and Reporting Framework will enable data collection and reporting over time that will support an evaluation of the future program should it be endorsed and implemented. The future evaluation will ascertain the efficacy and efficiency of the program in meeting its core goals and objectives. The evaluation process will be further supported by independent research and capture of the client voice.

## Reporting Metrics

Catchment Partnership

|  |  |  |  |
| --- | --- | --- | --- |
| Activity | Outcomes | Metrics | Method of collection |
| To provide a local area approach for the delivery of these services, with delineated roles and responsibilities between agencies and government bodies involved in service delivery and governance of the program. | Catchment partnerships are maintained using established methods of local engagement within catchment areas to inform tailored catchment engagement and service delivery objectives. | * Catchment leadership groups maintained with diverse range of stakeholders
* Catchment leadership group meetings continue on a regular basis
 | * Prevention & Preparedness reporting template
 |
|  | The broader biopsychosocial needs of culturally diverse communities and vulnerable cohorts in high risk settings are met through a holistic approach to engagement and service delivery  | * Demographics in each catchment have been identified and catchment leadership groups continue to ensure all types of communities have been considered
 | * Prevention & Preparedness reporting template
 |
|  | Catchment Leadership Groups record all high-risk accommodation addresses, including an assessment of overall facility risk which facilitates tailored prevention approaches and quick, effective responses to potential outbreaks  | * All facilities on the master address list have been provided with a risk rating
 | * Risk assessment - in scope property list
 |
|  | Activities are undertaken to support social recovery, community resilience and economic recovery  | * Improvement in community recovery and resilience of COVID 19
 | * Independent research
 |
|  |   | * Key achievements since last reporting period
* Any issues, risks and mitigating actions taken
 | * Prevention & Preparedness reporting template
 |

Community Engagement

|  |  |  |  |
| --- | --- | --- | --- |
| Activity | Outcomes | Metrics | Method of collection |
| Engaging with clients, staff and proprietors to inform planning and the provision of support; developing and delivering culturally appropriate and accessible communication and engagement strategies that support residents to practice COVID-safe routines, and, in the event of an outbreak, work alongside DFFH/DH to support testing access and ability to safely isolate. Supporting initiatives for social recovery at the local level.  | Engagement strategies and tailored prevention and preparedness activities are based on local community needs and demographics | * Demographics in each catchment have been identified
* Strategies demonstrate prevention and preparedness activities that have been tailored to ensure the needs of local communities have been considered
 | * Prevention & Preparedness reporting template
 |
|  | Increased community awareness of and connection with the broader health and social support systems | * Activities in place support community awareness.
* Cross section of residents demonstrates awareness of how to connect with health and support systems.
 | * Independent research
 |
|  | Diverse groups within the local community are actively engaged and included in catchment/local planning and service provision  |  | * Independent research
 |
|  | Communications and language is inclusive and accessible for people with disability, people from diverse cultures and non-English speaking backgrounds | * Demographics in each catchment have been identified
* Strategies have been developed to ensure all types of communities have been considered
 | * Prevention & Preparedness reporting template
 |
|   |   | * Strategies they have implemented
* Key achievements since last reporting period
* Which diverse groups have they engaged, and the outcome
* Any issues/risks identified
 | * Prevention & Preparedness reporting template
* Case Studies
 |

Prevention and Preparedness

| Activity | Outcomes | Metrics | Method of collection |
| --- | --- | --- | --- |
| Including, where relevant, provision of infection control advice, provision of masks, sanitiser and guidance for their use, education and support to follow public health directions and implement COVID-Safe strategies, general resident information collection, enabling facility safety and support for the continued COVID-19 vaccination roll-out and booster program. Depending on evolving needs, support for the vaccination and booster programs may range from reiteration of existing public health messaging to direct vaccination service delivery. **Monitor current prevention and preparedness strategies** | Clients/staff of high-risk settings understand and can put into practice prevention and preparedness strategies  | * How many tenants/residents in the property?
* No of individual residents/tenants engaged in the property (ensure the same person is not counted twice)
 | * Prevention & Preparedness reporting template
 |
|  | Applicable facilities have on hand COVID Safe plans, and prevention strategies with stocks of appropriate equipment including PPE available – SRS’, Disability, high rise PH, Comm Housing providers | * No of properties in tiers 1 and 2 where staff are aware of:
	+ COVID safe plans
	+ Prevention strategies
* Outbreak management plan
* Appropriate levels of PPE in stock
* Simple yes/no – if no, support can be offered to achieve these outcomes but staff, landlords and proprietors are not obliged to cooperate.
* Is an organisational partner working in this space? For example, a Disability Provider may already be working with associated partners and there is clear agreement this will continue.
 | * Prevention & Preparedness reporting template
 |
|  | Support is provided to all clients/residents who require COVID-19 testing (this will usually be via linkage to testing sites) | * No of people Lead Providers supported to test in each tier, the support could be with either resident/tenant or manager/proprietor
 | * Prevention & Preparedness reporting template
 |
| **Vaccine and booster program promotion and support** | Residents/tenants/staff provided with vaccination and booster health information in language they require, including accessible communications for people with a disability | * No of residents/tenants engaged in the property:
* vaccine readiness and support / facilitate access
* identify most appropriate way for vaccine to occur (e.g. outreach support)
 | * Prevention & Preparedness reporting template
 |
|  | Residents/tenants/staff are aware of and are supported to receive ongoing vaccination including booster shots | * Good understanding of vaccine benefits and health info
 | * Independent research
 |
| **Capture consumer voice and experience** | Clients/tenants/residents/staff are confident that they understand COVID infection control practices and are able to implement if needed or know who will support them to do soClients/tenants/residents/staff have a good understanding of the benefit and positive outcomes attached to COVID vaccinations and will seek to get vaccinated when the vaccine in available to them.Client/consumer’s now have a better understanding of who can help and where to go to get help around health and social concerns. | * Improved understanding of COVID 19 prevention practices
* Feel empowered to obtain assistance if required
* Good understanding of vaccine benefits and health info
* Improved understanding of community services available to them
 | * Independent research
 |
|  |  | * Key achievements since last reporting period
* Security risks/barriers associated with entering properties
* Any other issues/barriers identified preventing completion of this work
 | * Prevention & Preparedness reporting template
* Case Studies
 |
| **All** |  | * Key achievements since last reporting period
* Security risks/barriers associated with entering properties
* Any other issues/barriers identified preventing completion of this work
 | * Prevention & Preparedness reporting template
* Case Studies
 |

Active Linkages

|  |  |  |  |
| --- | --- | --- | --- |
| Activity | Outcomes | Metrics | Method of collection |
| Where clients’ presenting needs are holistically assessed and there is proactive linkage to required health and social supports, with the aim of building connection between the individual and the broader service system to address any immediate or ongoing issues. Individual support needs will be variable and require a tailored approach to support-linkage based on initial assessment of presenting issues. This may include active linkage to general practitioners, mental health, alcohol and drug supports, financial aid, food relief and other supports, along with the provision of infection prevention advice.  | Client presenting needs are identified and met through active linkage to the broader system supports | * No. of people identified as requiring additional supports and what services
* No. of people showing interest in additional supports and what services
* No. of referrals to alternate LP servicesNo. of referrals to external providers
* Advocacy needed to address barriers to participation
 | * Prevention & Preparedness reporting template
* Case Studies
 |
|  | Increase client and local community connection to the broader health and social service system | * After visit from LP, do they feel more informed about services available in the community?
 | * Independent research
 |
|  |  | * Key achievements since last reporting period
 | * Prevention & Preparedness reporting template
* Case Studies
 |

Other

|  |  |  |  |
| --- | --- | --- | --- |
|  Activity | Outcomes | Metrics | Method of collection |
|   | People are employed for the HRAR program in community engagement and communications roles where possible/appropriate (e.g., concierge roles, advocacy roles)  | * No. of people employed as a result of the HRAR program
 | * Prevention & Preparedness reporting template
 |

Outbreak

|  |  |  |  |
| --- | --- | --- | --- |
| Activity | Outcomes | Metrics | Method of collection |
| As part of an Outbreak Management Team led by the Department of Health (DH) and/or Incident Management Teams led by DFFH, support confirmed cases and outbreaks which may include facilitating access to testing or to safe, alternate accommodation, reiterating public health messaging and enabling access to food, material aid and other health and social supports for people with heightened or complex needs.  | Provide support to confirmed cases as directed by DH and/or DFFH which may include:* facilitating access to testing
* reiterating public health messaging
* enabling access to culturally appropriate food, material aid and other health and social supports for people with heightened or complex needs.
 | Documented process for deploying resources in the event of an identified transmission and/or outbreak, include need for diverse culture and accessible communication plan:* Engagement activity (following assessment of outbreak and resident/community needs)
* Resources distributed and received
* On the spot covid-19 testing for residents (only if able to test)
* Hotel quarantine or other forms of temporary accommodation during isolation period
* Relief support
* Non-Compliance
* Workforce/plans for service continuity to meet needs of residents
 | * Prevention & Preparedness reporting template
 |

# Other requirements

## Funding model

Lead providers continue to be funded for the delivery of the five service pillars of the HRAR Extension (January 2022) across all in-scope properties at unit cost. Unit costs assume an average length of engagement.

**Baseline funding**

Covers the cost of activities under the five pillars that is to be undertaken by Lead Providers with an increased focus on the broader social recovery of individuals and communities. Specific funding amounts for Lead Providers under this funding platform were considered in the High-Risk Accommodation Response Extension Service Specifications and amounts calculated as part of that body of work.

Activities related to assisting those required to isolate due to status as a close contacts and additional surveillance testing are also covered.

**Outbreak funding**

Costs to providers of supporting DH and DFFH to respond to COVID-19 outbreaks (where positive COVID-19 case(s) are directly involved) including activities arising from Incident Management Teams, Outbreak Management Teams or other forums established to manage the outbreak response.

The costs deployed to provide agreed outbreak services are now included in the baseline funding and to be recorded as part of the monthly expenditure acquittal process (separate invoice to be funded retrospectively is no longer required).

## Information Sharing and Privacy

The department is committed to safeguarding privacy and confidential information. Lead Providers will only collect, use and disclose confidential information (including personal and health information):

* In line with relevant laws, including the Privacy and Data Protection Act 2014 (Vic) and the Health Records Act 2001 (Vic) and the Health Services Act 1988 (Vic),
* That is relevant to the service the HRAR Extension provides,
* In line with the Department’s Privacy Policy.

### Roles and responsibilities

Lead Providers are expected to engage with residents in in HRAR in-scope settings (alongside owners/ proprietors) to help residents’ practice COVID-safe routines and prevent outbreaks. Although Lead Providers are experienced at client-facing work, working with residents of high-risk accommodation settings, some of whom may have multiple and complex needs or present with other vulnerabilities, may be a new context for some Lead Providers. The range of resident needs in in-scope settings reinforces the importance of this response in supporting Victorians who live in accommodation with increased COVID-19 transmission risks. Lead Providers should apply their organisation’s existing privacy and data security policies and procedures in these settings when working with residents if they collect personal and health information.

Lead Providers should note that some residents in high-risk accommodation settings may present with multiple and complex needs and therefore may consider their personal and health information as sensitive. If Lead Providers are having significant difficulties engaging with residents and proprietors due to their privacy and data security concerns, this should be captured in relevant Department reports. Lead Providers need to consider the need for consent and privacy issues in the disability space (especially where person may have a guardian and/or using different methods of communication to express wishes).

Providers should manage their data collection, storage, and record-keeping according to existing policies, systems and processes, relevant legislation, and the Department Privacy Policy.

### Tools and supports

If Lead Providers have general questions about privacy and data security, they should refer to their organisation’s policies and procedures. Specific questions or concerns about privacy and data security in the context of HRAR Extension activities, are to be discussed with their relevant HRAR Division Director or staff, who may escalate as appropriate.

## Incident Reporting

Incident Reporting should be conducted when there is any near miss, actual minor or major incident to staff or clients, and when Health, Safety and Wellbeing (HSW) hazards have been identified. For the purpose of the HRAR model and this document, we have included the client incident reporting frameworks below and within Appendix 4.

Staff incidents should continue to be reported as per the Lead Providers’ internal policies and procedures.

Other important incidents for the lead agency to consider are the department’s privacy incidents and reportable conduct scheme policies, which can be provided on request.

There are two systems the lead agency may need to access to report client incidents and site hazards (see Appendix 4); however, it should be noted all staff-related incidents should continue to be reported as per the employer policy and procedures.

The [Client Incident Management System (CIMS)](https://providers.dhhs.vic.gov.au/client-incident-management-summary-guide-word) <https://providers.dffh.vic.gov.au/client-incident-management-summary-guide-word> is a reporting system that focuses on the safety and wellbeing of our clients by outlining the approach and key actions service providers are required to undertake to manage client incidents. For a full description of CIMS and which agencies this reporting system is in scope for, please see [here](https://providers.dhhs.vic.gov.au/sites/default/files/2020-01/Client%20incident%20management%20guide_0.docx) <https://providers.dhhs.vic.gov.au/sites/default/files/2020-01/Client incident management guide\_0.docx>.

The [Victorian Health Incident Management System (VHIMS)](https://www.bettersafercare.vic.gov.au/our-work/incident-response/VHIMS) <<https://www.bettersafercare.vic.gov.au/our-work/incident-response/VHIMS>> is a standardised dataset for the collection and classification of clinical, occupational health and safety (OH&S) incidents, near misses, hazards and consumer feedback. VHIMS is a system used to monitor the identification and mitigation of [clinical risk](https://www2.health.vic.gov.au/hospitals-and-health-services/quality-safety-service/clinical-risk-management) <https://www.health.vic.gov.au/quality-safety-service/clinical-risk-management>.

## Service agreement and Statement of Priorities arrangements

Providers are funded under a departmental service agreement or Statement of Priorities.

The service agreement and Statement of Priorities funding arrangements include a range of requirements set out in the terms and conditions and schedules.

DFFH monitors and reviews compliance with the requirements of the service agreement and funding arrangements.

Monitoring of compliance is driven by the performance monitoring framework. As a critical part of DFFH's quality assurance approach, the monitoring framework also supports responses to identified performance issues.

Providers delivering services are accountable for using departmental funding appropriately and for delivering services in line with the service agreement. To support accountability, funded organisations must regularly report on their services through existing mechanisms.

A collective approach to accountability will be implemented in each catchment. Data on performance will be shared within the governance model to support practice governance and continuous improvement.

Reporting allows organisations and DFFH to undertake periodic reviews of progress and to adjust targets as required. It also allows for local and state-wide monitoring by DFFH.

## Accreditation

Accreditation and independent review processes support strong organisational management, administration and service delivery and a continuous improvement philosophy. Providers will be assessed against the Human Services Standards.

[**Human Services Standards Policy**](https://providers.dhhs.vic.gov.au/sites/default/files/2020-07/Human-Services-Standards-Policy-202007.doc)

<<https://providers.dhhs.vic.gov.au/sites/default/files/2020-07/Human-Services-Standards-Policy-202007.doc>>

[**Policy, procedures and forms for the registration of disability service providers and community services**](https://providers.dhhs.vic.gov.au/sites/default/files/2020-07/Policy-procedures-forms-for-registration%20072020.docx)

<https://providers.dhhs.vic.gov.au/sites/default/files/2020-07/Policy-procedures-forms-for-registration%20072020.docx>

[**Coronavirus Case and Contact Management Guidelines: Health Services and General Practitioners**](https://www.dhhs.vic.gov.au/coronavirus-case-and-contact-management-guidelines-health-services-and-general-practitioners)

<<https://www.dhhs.vic.gov.au/coronavirus-case-and-contact-management-guidelines-health-services-and-general-practitioners>>

[**Apartments and Multi-Dwelling properties Guidelines: COVID-19**](https://www.dhhs.vic.gov.au/multi-dwelling-properties-shared-facilities)

<<https://www.dhhs.vic.gov.au/multi-dwelling-properties-shared-facilities>>

[**Coronavirus (COVID-19) information for Aboriginal and Torres Strait Islander communities**](https://www.dhhs.vic.gov.au/coronavirus-information-aboriginal-and-torres-strait-islander-communities)

<<https://www.dhhs.vic.gov.au/coronavirus-information-aboriginal-and-torres-strait-islander-communities>>

### Human Services Standards

The [Human Services Standards](https://providers.dhhs.vic.gov.au/human-services-standards) <<https://providers.dffh.vic.gov.au/human-services-standards>> represent a single set of service quality standards for DFFH-funded service providers and DFFH-managed services, summarised as:

* Empowerment: People’s rights are promoted and upheld
* Access and Engagement: People’s right to access transparent, equitable and integrated services is promoted and upheld
* Wellbeing: People’s right to wellbeing and safety is promoted and upheld
* Participation: People’s right to choose, decision making and to actively participate as a valued member of their chosen community is promoted and upheld.

The Human Services Regulator is responsible for administering legislation (*Children Youth and Families Act 2005* and *Disability Act 2006*) that aims to protect the Victorian community and those accessing human services. Under these Acts, registered entities are required to meet the Human Services Standards.

For more information, see [Human Services Standards Policy – updated July 2020 <https://providers.dhhs.vic.gov.au/sites/default/files/2020-07/Human-Services-Standards-Policy-202007.doc>.](file:///C%3A/Users/vicw474/AppData/Local/Microsoft/Windows/INetCache/Content.Outlook/9SY3YVY4/Human%20Services%20Standards%20Policy%20%E2%80%93%20updated%20July%202020%20%3Chttps%3A/providers.dhhs.vic.gov.au/sites/default/files/2020-07/Human-Services-Standards-Policy-202007.doc%3E)

## Applicable guidance

Providers are required to understand and comply with a range of Victorian Government policies, frameworks and procedures as well as legislative requirements as part of their service agreements. In addition, providers are required to understand the operating model of the HRAR and their roles and responsibilities under the HRAR.

### DH COVID-19 resources

The [DH Coronavirus website](https://www.dhhs.vic.gov.au/coronavirus) <<https://www.dhhs.vic.gov.au/coronavirus>> is the central repository of information and resources created by DH on COVID-19, for both individuals and organisations. All providers are to refer to this website for the latest information and resources for their sector.

# Appendices

|  |  |
| --- | --- |
| Appendix 1 | Sample formats for Catchment Leadership Group Terms of Reference, Agendas and Minutes |
| Appendix 2 | Tier based operating model |
| Appendix 3 | Contract specifications |
| Appendix 4 | Incident reporting systems |
| Appendix 5 | Data Reporting Templates and Metrics |
| Appendix 6 | Mapping Catchments, Department Areas and Divisions, LPHUs, DLOs |
| Appendix 7 | Glossary |

## Appendix 1: Sample Terms of Reference, Agenda Template and Minutes Format for a Catchment Leadership Group

|  |
| --- |
| Terms of referenceHigh Risk Accommodation Response*<insert catchment name>* Catchment Leadership Group |
| Terms of reference  |
| **OFFICIAL** |

Please note: while Terms of Reference for Catchment Leadership Groups are required under the HRAR specifications, the use of **this template is optional** and is provided to give an indication of likely membership and content. Lead Providers may wish to use their own formats and membership arrangements, in line with the specifications. For those who wish to use this template, this paragraph should be deleted.

### Background

The Victorian Department of Families, Fairness and Housing (DFFH) provides a range of services that prevent, prepare for, and rapidly respond to the risk of COVID-19 infection in communities involved with (or who may benefit from) human services supports. The High-Risk Accommodation Response (HRAR) program is one of these services. It responds to COVID-19 risks in settings including high-risk public housing, community housing, supported residential services, rooming houses and caravan parks.

The HRAR program is funded and supported through the Human Services COVID-19 Readiness and Response Centre (HSCRRC) within the Readiness, Response and Emergency Management Division within DFFH. The program commissions community health lead providers, working with HSCRRC divisional teams backed by central support, to carry out readiness and response activities in in-scope settings.

HRAR’s overarching objectives are:

1. **Catchment partnerships:** To provide a local area approach for the delivery of these services, with delineated roles and responsibilities between agencies and government bodies.
2. **Community engagement:** To engage with people in high-risk settings and their local communities to provide information, reduce risks and promote social recovery.
3. **Prevention and preparedness:** To run activities that increase understanding of and response to public health messages, including the development and implementation of COVID-safe plans.
4. **Active linkage to social supports:** To support people in high-risk settings to access culturally appropriate support services to meet their needs and support social recovery efforts.
5. **Outbreak support:** Support outbreak response activities to protect the health and wellbeing of people in high-risk settings from COVID-19 infection and its impacts.

### Purpose

The <insert catchment name> Catchment Leadership Group is responsible for local area coordination and support of the five pillars of service delivery within the HRAR Extension. The Catchment Leadership Group will not have a formal decision-making capacity but will act as a mechanism for collaboration, strategic direction and relationship building.

### Scope

Discussion topics will focus on, but are not limited to:

* sharing local intelligence to inform prioritisation of properties for new or additional prevention and preparedness activities (including vaccination support).
* identification and support of social and economic recovery and community resilience activities.
* collaboration and engagement.

Accommodation settings within scope for the HRAR Extension include government and non-government-managed sites across the state of Victoria, which have been identified as high-risk accommodation.

The range of populations and accommodation types within scope include:

* High-rise public housing
* Low-and medium-rise public housing – where there are shared facilities (e.g. laundry, kitchen) or access point (e.g. lifts, stairs)
* Residential disability settings
* Supported residential services (SRS)
* Rooming houses (private, community, and unregistered where/as known)
* Community housing
* Other high-risk or high-density settings including caravan parks on a case-by-case basis.

### Membership

|  |  |  |
| --- | --- | --- |
| Organisation  | Title   | Name  |
| Lead Provider  | CEO (Chair)  |   |
| Lead Provider  | HRAR Manager  |   |
| Department of Families, Fairness and Housing  | Director, <insert Division>  |   |
| Department of Families, Fairness and Housing  | HRAR COVID Lead Manager <insert catchment>  |   |
| Department of Families, Fairness and Housing  | Manager, Client Support and Housing Services  |   |
| Department of Justice and Community Safety  | General Manager, Community Services  |   |
| Local Public Health Unit   |   |   |
| Local Public Health Service  |   |   |
| Local Public Health Cluster  |   |   |
| Community Services  |   |   |
| Local Government  |   |   |
| Local Commonwealth Disability Liaison Officer  |   |   |
| Primary Health Network  |   |   |
| Primary Care Partnership  |   |   |
| CALD representative organisation  |   |   |
| Aboriginal and Torres Strait Islander representative organisation  |   |   |

\* Individuals may be co-opted to the group as appropriate to provide expert knowledge and address issues.

### Group tenure

The tenure of the group begins from 16 April 2021 to 30 June 2021. Any extension will be decided by the department and is subject to review.

### Meeting frequency

The group will meet monthly. Meeting frequency and scheduling is subject to change following review and agreement by members. Such review may be discussed during a meeting or out of session.

### Meeting venue

Meetings will be held online. The meeting link will be sent out by the Secretariat.

### Meeting agenda, action log and papers

The Secretariat will provide the meeting agenda, action log and papers three business days prior to the meeting.

### Out-of-session papers

When an issue arises that, in the opinion of the Chair, requires provision or resolution by the group before the next scheduled meeting, the Chair may seek to provide an out-of-session paper.

### Confidentiality

All papers are to be treated as confidential and should not be circulated beyond members’ organisations.

### Seniority

Membership is for Chief Executive Officers, senior executives or their delegate.

### Proxy

Members are required to notify the Secretariat when there is an intention for a proxy or substitute to represent the member at any meeting or to undertake any delegate role or responsibility.

### Declaration of conflict of interest

Members must declare any conflict of interest during the standing items agenda item at the start of any meeting or as soon as they become aware of the conflict of interest.

### Sitting fee and travel reimbursement

All paid employees of an organisation will be attending as representatives of their organisation and as such, will not receive payment or reimbursement.

### Secretariat

Secretariat support will be provided by the Catchment Lead Provider.

### Contact details

**Secretariat**

HRAR Catchment Leadership Group

Catchment Lead Provider

Email:

### Agenda template and minutes

|  |
| --- |
| *<insert catchment name>* Leadership Group   |
| Meeting agenda **OFFICIAL**  |

#### Meeting overview

|  |  |
| --- | --- |
| **Time and date** |   |
| **Chairperson** | CEO Lead Provider  |
| **Location** |   |
| **Attendees** | Lead Provider, CEO (Chair) Lead Provider, HRAR Manager Director, HRAR <insert Division>, Department of Families, Fairness and Housing,  Manager HRAR COVID Lead, Department of Families, Fairness and Housing,  **Representatives from:** *<suggestions not exhaustive>* Client Support and Housing Services, Department of Families, Fairness and Housing  Community Services, Department of Justice and Community Safety Local Public Health Unit   Local Public Health Service  Local Public Health Cluster  Community Services  Local Government  Local Commonwealth Disability Liaison Officer  Primary Health Network  Primary Care Partnership  CALD representative organisation Aboriginal and Torres Strait Islander representative organisation   |
| **Apologies** |   |
| **Purpose** | To facilitate local area coordination and support of the five pillars of service delivery within the High-Risk Accommodation Response Extension: 1. Catchment partnerships
2. Community engagement
3. Prevention and preparedness
4. Active linkage to social supports
5. Outbreak support.
 |
| **Papers** |   |

#### Agenda items

|  |  |  |  |
| --- | --- | --- | --- |
| No.  | Time  | Description  | Presenter  |
|  |   | Acknowledgement of Country  | Chair  |
|  |   | Actions from previous meetings  | Chair  |
|  |   | Catchment partnerships: * Changes to master list
* Changes to risk profile
* Other catchment matters
 | All  |
|  |   | Prevention and preparedness: * Recent activities
* Other matters
 | Lead Provider  |
|  |   | Community engagement: * Vaccination engagement
* Engagement with CALD communities
* Engagement with people with disabilities
* Engagement with Aboriginal and Torres Strait Islander communities
* Other engagement matters
 | Lead Provider  |
|  |   | Active linkage to social supports: * Recent activities
* Other matters
 | Lead Provider  |
|  |   | Outbreak support: * Matters arising from recent outbreak activity, if applicable
 | Lead Provider  |
|  |   | Collaboration and engagement: * Gaps and duplication
* Share success stories
* New opportunities
 | All  |
|  |   | Impact, legacy and opportunities for improvement  | All  |
|  |   | Other business  | All  |

#### Your action record

|  |  |  |  |
| --- | --- | --- | --- |
| Item  | Action  | Deadline  | Person responsible  |
|   |   |   |   |
|   |   |   |   |
|   |   |   |   |

#### Your notes

|  |
| --- |
|   |

## Appendix 2: Tier based operating model

The operating model for settings which were in scope for the first phase of HRAR (all except residential disability) remains largely the same. Approaches to settings will vary according to risk characteristics and whether settings are staffed. In staffed settings, approaches may focus on empowering staff with relevant skills and knowledge to guide and work with residents to create a COVIDSafe environment. In unstaffed settings, approaches are likely to focus on more direct face-to-face engagement with residents. Key differences to the previous operating model include:

* The identification of ‘active linkage to health and social supports’ as a program objective to build connection to the broader health and social support systems
* The inclusion of COVID-19 vaccine promotion and engagement as a component of the prevention and preparedness objective
* The support to foster relationships with local public health units
* Expansion of scope to include disability settings

Residential disability settings have been brought into scope to the HRAR Extension model. For more information on in scope Residential disability settings, see ‘Scope’ section on page 9

The program operates across a range of settings. These are briefly described in the table below:

Table 1: Settings

| Setting type | Description | Planning considerations |
| --- | --- | --- |
| **High-rise and high-risk medium-rise public housing** | High rise towers with multiple floors and shared amenities. Large number of residents living on site in separate residences Multiple shared areas including foyers, lifts, stairs, hallways, laundries and playgroundsConsistent tenants/residentsNot staffedLists of registered tenants/residents may be available | These are accommodation only settings and do not have support staff to leverage quick engagement with residents. (although individual residents may receive support services).Resident names and contact details may not be quickly available in these settings and there is a possibility the names on the lists and tenancy agreements may not be the people living at the premises, or there may be additional people living onsite. High-rise and high-risk medium rise may require health concierge, community services, community leaders to establish contact with residents which may delay the critical early stages of outbreak management. High numbers of people from CALD communities means that a range of communication methods may be required. |
| **Low-rise public housing** | Buildings with few floors or may be single dwellings. Buildings may have multiple apartments and have shared facilities such as laundries, stairs, hallways, foyers and gardens.Single dwellings unlikely to have shared amenities.Consistent tenants/residentsNot staffedLists of registered tenants/residents may be available | These are accommodation only settings or single dwellings and do not have support staff to leverage quick engagement with residents (although individual residents may receive support services).Resident names and contact details may not be quickly available in these settings and there is a possibility the names on the lists and tenancy agreements may not be the people living at the premises, or there may be additional people living onsite. Community service providers may need to door knock to establish contact with residents which may delay the critical early stages of outbreak management. May include many people from CALD communities, range of communications required. |
| **Supported Residential Services SRS** | Facilities are privately owned and operated Most have shared bedrooms and bathrooms and all SRS have shared dining and lounge areas. Some SRSs that accommodate older residents have individual bedrooms with ensuites.Low staffing levels (legislation requires 1:30), 24 hours a dayLow-medium resident turnover | Settings are staffed and therefore information about who is living at the facility can be quickly obtained, including any support and communication needs. Staff are enablers for the sustainability of IPC measures within the facility.In the event of an outbreak SRS and disability staff can quickly provide necessary information about residents and their health and support needs. Staff can also support residents to comply with testing requests and public health directions and be a conduit for information flow between residents and who is this referring to Resident support plans record health and support needs and provider contact information.  |
| **Disability residential accommodation** | Shared accommodation for people with disability (average 5 residents) Residents have their own bedroom but share all other areas (kitchen, bathrooms etc)Staffing:* Specialist Disability Accommodation has full time staffing
* Staffing for properties registered for Supported Independent Living depends on the needs of residents and may not be 24/hr

Low resident turnover | Settings are staffed and therefore information about who is living at the facility can be quickly obtained, including any support and communication needs.Staff are enablers for the sustainability of IPC measures within the facility.In the event of an outbreak, disability staff can quickly provide necessary information about residents and their health and support needs. Staff can also support residents to comply with testing requests and public health directions and be a conduit for information flow between residents and public health directions. Note that issues of consent need to be consideredMany residents have impacted cognitive functionNDIS and transferred accommodation have client care and behaviour support plans |
| **Caravan Parks** | Some caravans or movable dwellings will be fully self-contained although many long stay residents will live with basic amenities (kitchenette) and use shared site amenities (toilets, bathrooms, showers, BBQs, seating, gardens and grounds).Not staffed- accommodation only – staff provide park management (no support staff)Some long-term residents, some short term, vacationers. | These are accommodation only settings with an onsite proprietor. They do not have support staff (although individual residents may receive support services) to leverage quick engagement with residents.Residents may be a mix of long term and short term/vacationers. Resident names and contact details may not be quickly available in these settings and there is a possibility the names on the lists and tenancy agreements may not be the people living at the premises, or there may be additional people living onsite. Community service providers may need to door knock to establish contact with residents which may delay the critical early stages of outbreak management. Focus would be on engaging with longer term residents and proprietors |
| **Community Housing** | Operated by not-for-profit community housing organisationsResidents live in separate dwellingsOften tenanted by large families (5 or more people) or by people not registered on the leaseCan be multi storied with shared corridors, lifts, laundries, playgrounds, yards and BBQs. Not staffed. Low resident turnover | These are accommodation only settings or single dwellings therefore they do not have support staff (although individual residents may receive support services) to leverage quick engagement with residents.Resident names and contact details may not be quickly available in these settings and there is a possibility the names on the lists and tenancy agreements may not be the people living at the premises, or there may be additional people living onsite. Community service providers may need to door knock to establish contact with residents which may delay the critical early stages of outbreak management.May include many people from CALD communities, range of communications required. |
| **Rooming Houses** | Privately owned and operated or operated by Community Housing Associations Some unregistered people may also live at the premises Residents may have their own bedrooms, but, in general, all other rooms are sharedNot staffed but may have proprietors or onsite managersMedium to high resident turnover | These are accommodation only settings and do not have support staff (although individual residents may receive support services) to leverage quick engagement with residents.Resident names and contact details may not be quickly available in these settings and there is a possibility the names on the lists and tenancy agreements may not be the people living at the premises, or there may be additional people living onsite. Community service providers may need to door knock to establish contact with residents which may delay the critical early stages of outbreak management. |
| **Backpacker accommodation, Private Hostels, Disability Community Settings, Other** | Inclusion of these facilities is on a risk basis and must be approved by HRAR Division Director.Key risks that will support inclusion will be consideration of the ability of the residents to safely apply infection control principles, resident turnover (short turnover may require ongoing evaluation of the risk) and the ability of the cohort to safely quarantine or isolate if required to do so (ie physical environment). | Other Accommodation settings - Includes backpacker accommodation and private hostels. Settings do not have support staff who might be able to assist in communicating with residents. Information about residents’ needs are unknown. Residents may be short term and move between a range of accommodation facilities. |

Table 2: Risk Tiers and setting type(s) - Service Expectations and interventions

\* Tiers do not necessarily reflect ascending or descending risk, but rather reflect variations in risk profile due to differences in setting characteristics

### 2.1 Catchment partnerships

**Tier and setting type(s)\* service expectations and intervention**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **All Tiers – Catchment Wide** | **Tier 1a: Public Housing – High- Risk settings**All high-rise public housing and high-risk medium-rise public housing | **Tier 1b – Public Housing low-risk settings** Low-risk medium-rise and low-rise public housing | **Tier 2: Staffed Accommodation facilities**Residential disability and Supported Residential Services (SRS) | **Tier 3: Unstaffed Accommodation facilities**Rooming houses, community housing and caravan parks | **Tier 4: Other Settings**Disability community-based settings, and other accommodation settings (including private hostels and backpacker accommodation) |
| * Establish governance and catchment leadership group – led by Lead Provider
* Perform risk-assessment of in-scope settings to develop targeted plans
* Catchment partnerships consider:
* outbreak responses,
* prevention and preparedness activities,
* vaccination preparation / support,
* ongoing communication mechanisms,
* local community engagement strategies, and
* social recovery activities at local level during periods of low/no cases of infection in broader community.
 | * Assess facilities with no active cases and develop plan for outreach support and assessment
* Risk Assessment required for all facilities in this tier
* Onsite Health Concierge model – supports communications and community engagement
 | * Catchment partnership activities will be conducted at these settings on an as needs basis, encompassing approaches as detailed in all catchment approach.
* Not every facility or setting will require a full risk assessment and development of COVID safe plan (given many are individual dwellings), focus will be on settings accommodating multiple people on site with shared amenities, rather than single dwellings.
 | * Risk Assessment required for all facilities in this tier
* Develop approach that includes specific detail to support people with disability (for outbreak and preparedness and social recovery initiatives)
* Note any sub-contractual arrangements with providers to enable tailored responses/activities
* Consider mobility and isolation challenges for people with high support needs and complex needs
* Consider role of staff in supporting people in residential disability and SRS settings
* Consider linkages / interface with NDIA, NDS, mental health services and disability service providers
 | * Develop plan for outreach support and assessment
* Risk Assessment required for facilities in this tier, with varied approaches and levels of intervention
* There may be difficulty in pre-planning approaches due to type of setting (no staff) and inability to access key information around residents and types of needs at each location/facility/ individual residence
 | * Develop plan for outreach support and assessment
* Risk Assessment on a needs or case by case basis in this tier
* Consider mobility issues
* Consider communication challenges and language barriers
* For centre-based services (disability day centres) there may be staff who can be engaged to assist with COVIDsafe planning and communication with centre participants
* For backpacker accommodation and private hostels – focus on working with proprietors around prevention and preparedness strategies
 |

### 2.2 Community engagement

**Tier and setting type(s)\* service expectations and intervention**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **All Tiers – Catchment Wide** | **Tier 1a: Public Housing – High- Risk settings***All high-rise public housing and high-risk medium-rise public housing* | **Tier 1b – Public Housing low-risk settings** *Low-risk medium-rise and low-rise public housing* | **Tier 2: Staffed Accommodation facilities***Residential disability and Supported Residential Services (SRS)* | **Tier 3: Unstaffed Accommodation facilities***Rooming houses, community housing and caravan parks* | **Tier 4: Other Settings***Disability community-based settings, and other accommodation settings (including private hostels and backpacker accommodation)* |
| * Catchment wide health promotion:
* Engage with residents and proprietors to help residents practise COVID-safe routines, prevent outbreaks and to lead local social recovery initiatives.
* Facilitate community engagement with diverse populations, access to interpreters and/or bi-cultural staff
* Deliver accessible communication and engagement strategies that support testing and help residents practise COVID-safe routines and information about vaccine roll out.
 | * Onsite Health Concierge to support engagement:
* Supports delivery of key messages and infection control strategies and information around vaccination
* Delivery of culturally appropriate and accessible communication and engagement strategies that support access to testing\* and help residents to practice COVID-safe routines
* Engagement/employment of local community members in prevention and preparedness and/or social recovery initiatives where possible
* Supports provision of information about vaccination roll out when available
 | * Community Engagement activities will be conducted at these settings on an as needs basis, encompassing approaches as detailed in all catchment approach.
 | * Engage with residents, proprietors, staff and disability service providers and Peaks to help residents practice COVID-safe routines, prevent outbreaks and to lead local social recovery initiatives.
* Deliver accessible communication and engagement strategies that support access to testing and vaccination
* Consider complex needs and ways to increase links with local community
 | * Facilitate community engagement with diverse populations, access to interpreters and/or bi-cultural staff
* Caravan parks – focus on engagement with longer term residents and park proprietors
* Hostels – focus on engagement with proprietors and longer term residents
* Consider opportunities to engage residents through onsite incentives/ activities that encourage residents to seek out the service – e.g. free coffee (coffee van) as initial engagement tool
 | * Facilitate community engagement with diverse populations, access to interpreters and/or bi-cultural staff
* Group living settings (e.g. hostels) – focus on engagement with longer term residents and proprietors
* Consider opportunities to engage residents through onsite incentives/activities that encourage residents to seek out the service – e.g. free coffee (coffee van) as initial engagement tool.
 |

### 2.3 Prevent and preparedness (including vaccination support)

**Tier and setting type(s)\* service expectations and intervention**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **All Tiers – Catchment Wide** | **Tier 1a: Public Housing – High- Risk settings***All high-rise public housing and high-risk medium-rise public housing* | **Tier 1b – Public Housing low-risk settings** *Low-risk medium-rise and low-rise public housing* | **Tier 2: Staffed Accommodation facilities***Residential disability and Supported Residential Services (SRS)* | **Tier 3: Unstaffed Accommodation facilities***Rooming houses, community housing and caravan parks* | **Tier 4: Other Settings***Disability community-based settings, and other accommodation settings (including private hostels and backpacker accommodation)* |
| * Assess infection prevention and control processes and provide information about vaccine roll out
* Implement infection prevention and control education strategies - communications in easy read English and diverse languages as required
* Establish / review outbreak management plan – document the plan and any changes to the plan, monitor for quality improvement etc
* Undertake active case finding, report on status of agreed actions and escalate as required
* Support access to PPE and education around use of PPE as required
 | * Communications around infection prevention, education and information strategies supported via Health Concierge model
* Health Concierge supports provision of information about vaccine roll out and planning
 | * Preparedness and Prevention activities will be conducted at these settings on an as needs basis, encompassing approaches as detailed in all catchment approach.
 | * Implement infection prevention and control education strategies for staff and residents – communications with residents is supported by staff and service providers
* Ask whether they have an accessible outbreak plan and COVIDSafe plan
* Consider vaccine roll out and planning
* Undertake active case finding, report on status of agreed actions and escalate as required
* Support access to PPE and education around use of PPE for staff and residents (including disposal of PPE)
* Establish processes for isolation in event of community outbreak
* Consider any potential workforce risks (e.g. high workforce mobility)
* For larger Disability Providers operating multiple disability residential sites, engagement may occur through central and a specific site may be selected for assessment and planning (with support of catchment Lead Provider) and strategies implemented across all other sites operated by the proprietor.
 | * For larger Community Housing proprietors, engagement may occur through central and a specific site may be selected for assessment and planning (with support of catchment Lead Provider) and strategies implemented across all other sites operated by the proprietor
 | * Work with proprietors and longer term residents for backpacker and private hostel settings
* Disability day centres may have staff who can be engaged around COVID safe planning
 |

### 2.4 Active linkage to health and social supports

**Tier and setting type(s)\* service expectations and intervention**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **All Tiers – Catchment Wide** | **Tier 1a: Public Housing – High- Risk settings***All high-rise public housing and high-risk medium-rise public housing* | **Tier 1b – Public Housing low-risk settings***Low-risk medium-rise and low-rise public housing* | **Tier 2: Staffed Accommodation facilities***Residential disability and Supported Residential Services (SRS)* | **Tier 3: Unstaffed Accommodation facilities***Rooming houses, community housing and caravan parks* | **Tier 4: Other Settings***Disability community-based settings, and other accommodation settings (including private hostels and backpacker accommodation)* |
| Note initial presenting needs for residents/clients Use opportunities to create linkages for residents/clients with broader health and social systems to meet their needs (facilitate referrals and information provision)Leverage existing local service networksConsider local initiatives / opportunities to promote social recovery at local level. | Consider strategies to build trust and enable provision of information about local support servicesUse Health Concierge model to support linkage work and broader community social recovery approaches | Active linkage activities will be conducted at these settings on an as needs basis, encompassing approaches as detailed in all catchment approach. | Strive to improve connection between disability service providers and local health providers to increase access to local health services and drive improved health outcomes for residents with disabilityConsider social recovery at local level and improved connection between residents and local providers, focus on accessibility of services and venues |  |  |

### 2.5 Outbreak support

**Tier and setting type(s)\* service expectations and intervention**

|  |
| --- |
| **All Tiers – Catchment Wide** |
| * Support the DDH and DFFH to respond to COVID-19 outbreaks and cases at the local level, including as part of Incident Management Teams and Outbreak Management Teams.
* Identify need for support to self-isolate & facilitate as required
* Identify need and facilitate access to food and essential supplies (connect to relief supports).
 |

\*NB: **Access to COVID-19 testing** will generally be through supporting residents/clients to attend Department of Health operated testing sites, or through Rapid Response Testing facilitated by DH. There may be circumstances where Lead Providers have capacity to offer individual onsite tests to residents/clients, at the discretion of the Lead Provider (some Lead Providers have this capability but not all)

## Appendix 3: Contract Specifications

### Legal obligations to employees and contractors

Employers and employees of organisations operating in Victoria must comply with the workplace directions pursuant to section 200(1)(d) of the *Public Health and Wellbeing Act 2008 (Vic).*

The department has an obligation under the [*Occupational Health and Safety Act,* 2004](https://www.legislation.vic.gov.au/in-force/acts/occupational-health-and-safety-act-2004) <<https://www.legislation.vic.gov.au/in-force/acts/occupational-health-and-safety-act-2004/038>> to provide and maintain a working environment for its employees that is, so far as is reasonably practicable, safe and without
risks to health.

Provision of a safe working environment includes:

1. Providing and maintaining safe plant/equipment and systems of work
2. Making arrangements for the absence of risks in connection with the use, handling, storage or transport of plant
or substance
3. Maintaining each workplace under the employer's management and control in a condition that is safe and without risks to health
4. Providing adequate facilities for the welfare of employees at any workplace under the management and control
of the employer
5. Providing such information, instruction, training or supervision to employees as is necessary to enable those persons to perform their work in a way that is safe and without risks to health
6. Monitoring the health of employees
7. Monitoring conditions at any workplace under the employer's management and control.

Important note:

1. A reference to an employee includes a reference to an independent contractor engaged by an employer and any employees of the independent contractor.
2. The duties of an employer extend to the independent contractor engaged, and any employees of the independent contractor, in relation to matters over which the employer has control or would have control if not for any agreement purporting to limit or remove that control.

### Health, safety and wellbeing considerations when engaging personnel

1. Establishment of a clear point of control for the operation with clear reporting lines to the point of control and clarity around who is sourcing and engaging the workforce for the operation.
2. Position descriptions/job cards that clearly outline what the roles are including tasks, working hours and location. This should include the skills, knowledge, qualifications and training required of personnel to enable them to perform the roles and tasks to be undertaken.
3. An assessment of the HSW risks associated with the role, tasks, working hours and location and implementation of risk control measure to address identified risks that affords the highest level of protection that is reasonably practicable. The HSW team or other expert advice may be contacted to support this.
4. Use or establishment of systems, procedures, instructions and fact sheets to support work to be conducted safely – both physically and psychologically.
5. In addition to the provision of general HSW orientation, information on how personnel will be informed/trained/instructed in relation to the systems, procedures, instructions and risk control measures specific to their role, tasks and location.
6. Information on how and by whom personnel will be supervised to monitor safe working practices and that working conditions support physical and psychological health and wellbeing.

### Health, safety and wellbeing considerations when outsourcing operations:

1. Where the department is outsourcing an operation, it must still demonstrate its due diligence on the entity the operation has been outsourced to. Ideally this should be done before the operation commences, and if not practicable to do so, shortly after commencement. This includes:
2. ensuring that the entity has personnel with appropriate skills and qualifications to conduct the operation
3. being satisfied that the entity has appropriate safety protocols in place (as per points 2-6 above)
4. requesting at minimum that relevant risk assessments are conducted and documented.
5. In an outsourced model, the department has HSW obligations in relation to matters over which it has control. Whilst the department may not control the day to day operations it will be deemed to have control over:
6. Which entity it selects to run the operation (due diligence that shows the entity could safely run the operation)
7. How the entity is engaged (a contract/agreement setting out the scope of work/roles/responsibilities)
8. Monitoring that the entity is doing what is required in relation to health and safety matters.

The contractor shall provide the department with a health and safety management plan that will, as a minimum, address the following topics in line with the scope of services to be provided:

1. The organisation’s hierarchy (such as an organisation chart) showing key roles in senior management and allocation of duties for health and safety
2. Roles and responsibilities at different levels of the organisation for health and safety including details of the suitably qualified personnel who are advising the organisation on health and safety matters
3. Policies that address health and safety and related matters
4. Consultation and communication processes in place for health and safety matters (including issue resolution processes)
5. Identification of hazards
6. Risk assessment and risk control
7. Monitoring of controls (such as an audit and inspection program for frontline activities)
8. Instruction, training and supervision of staff (including risk-based justifications for the levels of instruction, training and supervision provided)
9. Mechanisms in place for the selection, engagement and management of subcontractors (subordinate to the contract in place with DFFH)
10. [Incident reporting, management and investigation](https://fac.dhhs.vic.gov.au/incident-reporting). <<https://fac.dhhs.vic.gov.au/incident-reporting>>
11. Hazardous substances and Dangerous Goods
12. Reporting and monitoring of health and safety performance
13. Emergency management
14. Record keeping and archiving of information.

The plan must be submitted on request to the departments HSW Unit. Elements of the plan can then be verified by the HSW unit at frontline locations.

#### Media engagement

Media engagement must be authorised through DFFH. Lead Providers should contact their Divisional Directors in advance of undertaking media engagement.

## Appendix 4: Incident reporting systems

### Victorian Health Incident Management System (VHIMS)

[The Victorian Health Incident Management System (VHIMS)](https://www.bettersafercare.vic.gov.au/our-work/incident-response/VHIMS) <https://www.bettersafercare.vic.gov.au/our-work/incident-response/VHIMS> is a standardised dataset for the collection and classification of clinical, OH&S incidents, near misses, hazards and consumer feedback.

VHIMS was established in 2009 by the Department of Health and Human Services (the Department). The Victorian Agency for Health Information (VAHI) took over responsibility for VHIMS in 2017. VAHI now coordinates VHIMS in collaboration with the Department, Safer Care Victoria (SCV) and importantly, Victorian public health services.

Incident and feedback information collected in VHIMS helps to drive local and statewide improvements in quality, safety and patient experience. Providers should be aware of the VHIMS policies and guidelines on [adverse patient safety events](https://www.bettersafercare.vic.gov.au/sites/default/files/2019-08/Policy%20-%20Adverse%20Patient%20Safety%20Events.pdf) <[https://www.bettersafercare.vic.gov.au/sites/default/files/2019-08/Policy - Adverse Patient Safety Events.pdf](https://www.bettersafercare.vic.gov.au/sites/default/files/2019-08/Policy%20-%20Adverse%20Patient%20Safety%20Events.pdf)>, including the [Victorian Health Incident Management System (VHIMS) Minimal Dataset PDF](https://www.bettersafercare.vic.gov.au/sites/default/files/2019-06/190530-1%20VHIMS_Minimum%20dataset_June_2019.pdf) <[https://www.bettersafercare.vic.gov.au/sites/default/files/2019-06/190530-1 VHIMS\_Minimum dataset\_June\_2019.pdf](https://www.bettersafercare.vic.gov.au/sites/default/files/2019-06/190530-1%20VHIMS_Minimum%20dataset_June_2019.pdf)>.

Staff training on VHIMS can be found [here](https://www.bettersafercare.vic.gov.au/vhims-central) <<https://www.bettersafercare.vic.gov.au/vhims-central>>.

Information Systems and Customer Experience support, including software integration with existing software solutions can be found [here](https://www.bettersafercare.vic.gov.au/our-work/incident-response/VHIMS/localsolution) <<https://www.bettersafercare.vic.gov.au/our-work/incident-response/VHIMS/localsolution>>.

Victorian Health Incident Management System (VHIMS) is designed for public health services such as(ambulance Victoria, bush nursing services, Forensicare, public sector residential aged care facilities, hospital in home services, private day surgery facilities.) For more information on VHIMS, please email the VHIMS team <vhims2@vahi.vic.gov.au>.

### Client incident management system (CIMS)

The CIMS will be the reporting pathway for the catchment lead to input client incidents and site concerns which impact clients and their accommodation. The CIMS Information system focuses on the safety and wellbeing of clients by outlining the approach and key actions to manage client incidents.

**For NDIS providers:** Victoria's quality and safeguards arrangements will remain during transition to full scheme roll-out in 2019. This means that NDIS providers are required to comply with the CIMS.

**Find out more about the CIMS**

The [CIMS webpage](http://providers.dhhs.vic.gov.au/cims) <<http://providers.dhhs.vic.gov.au/cims>> has more information about the CIMS, including the policy, link to the incident report webform and client incident register, fact sheets, implementation guidance, learning and development materials and IT requirements.

For assistance with the CIMS, refer to resources within the CIMS webpage or email CIMS <CIMS@dhhs.vic.gov.au>. Stakeholders using their own IT reporting system and submitting incidents via the application program interface should continue to speak with their IT vendor.

CIMS is a [client management system](https://cims.vic.gov.au/#/introduction) <<https://cims.vic.gov.au/#/introduction>> will assist the Lead Provider to apply:

* The [management](https://providers.dhhs.vic.gov.au/sites/default/files/2020-01/Client%20incident%20management%20guide_0.docx) <[https://providers.dhhs.vic.gov.au/sites/default/files/2020-01/Client incident management guide\_0.docx](https://providers.dhhs.vic.gov.au/sites/default/files/2020-01/Client%20incident%20management%20guide_0.docx)> of client incidents and tracking the management through to continuous improvement
* The management of client incidents while receiving [out of home care](https://providers.dhhs.vic.gov.au/sites/default/files/2020-02/Client%20incident%20management%20guide%20addendum%20out-of-home%20care_0.docx) <[https://providers.dhhs.vic.gov.au/sites/default/files/2020-02/Client incident management guide addendum out-of-home care\_0.docx](https://providers.dhhs.vic.gov.au/sites/default/files/2020-02/Client%20incident%20management%20guide%20addendum%20out-of-home%20care_0.docx)>
* Conducting [Root Cause Analysis reviews](https://intranet.dhhs.vic.gov.au/working-at-dhhs/about-you/training/cims-root-cause-analysis-rca-review) <https://intranet.dhhs.vic.gov.au/working-at-dhhs/about-you/training/cims-root-cause-analysis-rca-review>

## Appendix 5: Data Reporting Templates

### Prevention and Preparedness Reporting Template

|  |  |
| --- | --- |
| The Tiered Approach | Definitions |
| The HRAR Extension Operating Model identified four tiers which can be used by Lead Providers to assist in planning the intensity, composition, delivery method and extent of service provision. Tiers do not necessarily reflect ascending or descending risk, but rather reflect variations in risk profile due to differences in setting characteristics. | **Dwellings:** Dwelling is a self-contained unit of accommodation such as a house/rooming house, apartment or caravan. |
| **Tier 1: Public Housing settings**\* all high-rise public housing and high-risk medium-rise public housing \* low-risk medium-rise public housing and all low-rise public housing **Tier 2: Staffed settings**\* disability residential settings\* supported residential services (SRS) **Tier 3: Unstaffed settings**\* community housing\* caravan parks\* rooming houses **Tier 4: Other settings**\* disability community-based settings \* other accommodation settings deemed to be in scope on a case by case basis | **Potential matters of concern to raise with HRAR Divisional Director:**\* Adherence to public health directions, including failure to have a COVID-Safe Plan in place where applicable\* General matters that are not COVID-19 specific (e.g. related to resident or worker safety or quality of accommodation)\* Limited level of engagement by proprietor or landlord to engage or cooperate\* Level of regulatory compliance (whether or not related to COVID safety) |

|  |
| --- |
| Quantitative Data |
| Total in scope facility sites - from master accommodation list  |
| Total in scope dwellings (see glossary for definition) - from master accommodation list  |
| **Monitoring the current prevention and preparedness strategies / vaccine promotion and support** |
| Number of dwellings engaged (at least 1 tenant/resident) |
| Number of accommodation settings engaged (at least 1 tenant/resident) |
| Total number of residents/tenants residing in these accommodation settings (approx. numbers) |
| Number of individual residents/tenants and/or proprietor/managers engaged - prevention and preparedness activities, including vaccination support (interaction at accommodation settings and all other, e.g. pop up tents, concierge) |
| Number of residents/tenants requiring practical support to access vaccination, e.g. transportation, booking |
| No of people Lead Providers supported to test (the support could be with either resident/tenant or manager/proprietor) |
| **For Tier 1 (high/med rise if applicable) and Tier 2** |
| Number of accommodation settings that have:\* Prevention strategies maintained\* Outbreak support plan in place\* Approp. levels of PPE in stock |
| Number requiring additional support to reach compliance with above section |
| **Resident/tenants presenting needs are identified and met through active linkage to the broader system supports** |
| No. of people showing interest in additional supports or advocacy services  |
| No. of referrals to internal Lead Provider services (excluding referrals for vaccination) |
| No. of referrals to external services (excluding referrals for vaccination) |
| **Concerns** |
| Number concerns escalated HRAR Division Director (see glossary for definition)  |

|  |
| --- |
| Qualitative Data |
| Key achievements since last reporting period. For example, review of Governance arrangements completed, community survey completed, review of action plans, additional supports for residents/tenants |
|
|
|
|
| Any issues, implementation risks and mitigating actions taken, e.g. risks/barriers to entering properties / preventing completion of this work, and barriers to vaccination access |
|
|
|
|
| Community engagement activities based on local community needs and demographics, ensuring all types of communities in HRAR accommodation settings have been considered. For example, pop ups in response to community need, vaccination program advice provided  |
|
|
|
|

Qualitative Data listed above

Quantitative Data listed above





|  |  |  |  |
| --- | --- | --- | --- |
| Early Intervention and Outbreak Response Reporting | Exposure site and close contact intervention  | Outbreak Response |  |
| **Engagement activity (following assessment of outbreak and resident/community needs)** | **Number** | **Number** | **Comments (if required)** |
| Number of dwellings/accommodation settings contacted |  |  |  |
| Number of communication engagement strategies, eg social media, flyers, posters, handouts  |  |   |  |
| **Resources distributed and received** |  |   |  |
| Number of dwellings / accommodation settings / (residents - concierge only) provided with resource material/signage (including culturally appropriate) |  |   |  |
| Number of dwellings / accommodation settings / (residents - concierge only) provided with hand sanitisers |  |   |  |
| Number of dwellings / accommodation settings / (residents - concierge only) provided with face masks |  |   |  |
| **On the spot covid-19 testing for residents (only if able to test)** |  |   |  |
| Number of COVID-19 test bookings made |  |   |  |
| Number of COVID-19 tests undertaken |  |   |  |
| Number of COVID-19 tests refused |  |   |  |
| **Hotel quarantine** |  |   |  |
| Number of positive residents assisted to move to hotel quarantine |  |   |  |
| **Relief support** |   |   |  |
| Number of dwellings/accommodation settings where isolation/emergency relief support provided (eg. laundry, food, medicine etc.) |  |   |  |
| **Non-compliance** |  |   |  |
| Number of dwellings/facilities referred to authorised officers or police for non-compliance of health directions |   |   |  |

### Acquittal Template



### Risk Assessment

**Purpose**

To provide an overall risk rating to each dwelling within your catchment to represent the associated risk in the event of an outbreak. This will support planning an approach for high risk accommodation settings in the event of a potential or confirmed COVID 19 case.

#### Instructions

**Risk**

The attached Risk Matrix (see tab 'risk') identifies and describes risk factors under three themes to assist in identifying an overall rating.

\* Select the most appropriate under each of the three themes

\* To achieve an overall rating, please use either of the two risk matrix's provided

\* Record the associated overall risk rating against the dwelling in your facility list

**Risk Identification**

This tab provides further details on the risk factors listed in each risk theme

**Accomm Settings**

The table in this tab describes the characteristics and considerations across different accommodation settings which may assist in the determination of a risk rating

#### Frequency of reporting

Completion of the initial risk rating for all dwellings is required.

\* Any change to the rating is to be provided monthly

#### Risk themes

|  |  |  |
| --- | --- | --- |
| Environment and infrastructure  | Systems, governance and leadership  | Resident/tenant characteristics |
| Strong indication of:\* ability for residents/tenants to isolate\* quality and nature of facility structure\* staffing/proprietor presence, training, understanding and minimal mobility (if applic) | Strong indication of:\* leadership/management onsite\* external regulatory bodies oversight\* COVID safe plan compliance (if applic)\* in the event of an outbreak, can access resident information quickly\* adequate supply of PPE\* compliance with public health directions | Strong indication of:\* Residents/tenants being equipped, engaged and informed (taking into consideration CALD and literacy)\* Residents with low complex needs\* Residents having minimal requirements for additional supports |
| Some indication of:\* ability for residents/tenants to isolate\* quality and nature of facility structure\* staffing/proprietor presence, training, understanding and minimal mobility (if applic) | Some indication of:\* leadership/management onsite\* external regulatory bodies oversight\* COVID safe plan compliance (if applicable)\* in the event of an outbreak, can access resident information quickly\* adequate supply of PPE\* compliance with public health directions | Some indication of:\* Residents/tenants being equipped, engaged and informed (taking into consideration CALD and literacy)\* Residents with complex needs\* Residents having requirements for additional supports |
| Minimal indication of:\* ability for residents/tenants to isolate\* quality and nature of facility structure\* staffing/proprietor presence, training, understanding and minimal mobility | Minimal indication of:\* leadership/management onsite\* external regulatory bodies oversight\* COVID safe plan compliance (if applicable)\* in the event of an outbreak, can access resident information quickly\* adequate supply of PPE\* compliance with public health directions | Minimal indication of:\* Residents/tenants being equipped, engaged and informed (taking into consideration CALD and literacy)\* Residents with low complex needs\* Residents having minimal requirements for additional supports |

#### Assignment of rating based on above criteria

2 different risk metrics to assist with assignment of an overall rating - if you use either one, the overall risk will be the same.

|  |  |
| --- | --- |
| High | **Automatic rating – high**\* For those properties that refuse access/engagement\* High rise public housing |
| Medium | \* No high risk ratings and majority are medium |
| Low | \* No high risk ratings and at least 2 are low risk |

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  | Risk Rating |
| Low | Low | Low | **Low** |
| Low | Low | Medium | **Low** |
| Medium | Low | Low | **Low** |
| Low | Medium | Low | **Low** |
| Medium | Low | Medium | **Medium** |
| Low | Medium | Medium | **Medium** |
| Medium | Medium | Low | **Medium** |
| High | Low | Medium | **High** |
| Medium | Low | High | **High** |
| High | Low | High | **High** |
| Low | Medium | High | **High** |
| Low | High | Medium | **High** |
| Low | High | High | **High** |
| High | Medium | Low | **High** |
| Medium | High | Low | **High** |

#### Risk identification

Environment and infrastructure

| Risk factors | Example |
| --- | --- |
| Shared physical environment  | Settings with shared amenities and spaces may heighten risk of transmission |
| Quality and nature of facility structure | Buildings with good ventilation can help reduce the concentration of airborne contaminants indoors. Indoor spaces are more risky than outdoor spaces where it might be harder to social distance. |
| Staffing presence and training | Trained staff can contribute to adherence to COVIDSafe practises and contribute to preventing and minimising transmission |
| Staff mobility | Staff moving between facilities creates an incursion and transmission risk, as does the use of casual workers. |
| Staff characteristics (SES, CALD, literacy) | Staff in these settings tend to have lower incomes and are more likely to be part of a casualised, mobile workforce |

Systems, governance and leadership

| Risk factors | Example |
| --- | --- |
| Leadership/management | Organisational leadership and management are important enablers to ensure the sustainability of prevention and preparedness activities and readiness to respond in the event of an outbreak. |
| Regulatory oversight | Regulation and compliance monitoring are enablers for sustained action. Risks arise in non-regulated settings because of lack of oversight. |
| COVIDSafe Plan | Certain settings are required to develop COVIDSafe plans which may contribute to prevention and preparedness activities and readiness to respond in the event of an outbreak |
| Resident information | In the event of an outbreak, delays in contacting residents may lead to delays in testing and quarantining. Delays in accessing information about resident support needs risks effectively managing residents supports in the early stages of an outbreak response. |
| Access to PPE | Inadequate supply and unclear pathways for rapid access may heighten risk of transmission |
| Compliance with public health Directions | For example, in times of low community transmission there is a risk that the focus on staff and visitor attestations and other Directions may lessen |

Resident or client characteristics

| Risk factors | Example |
| --- | --- |
| Population size, density and age distribution | Higher resident density and crowding may heighten risk of transmission. Older populations are at heightened risk of negative consequences from COVID-19 infection |
| Socio-economic status (SES) | People on low incomes are more likely to be part of a casualised, mobile workforce which is less likely to have the option of working from home |
| Cultural and linguistic background (CALD) | People from a CALD background have had higher rates of infection. This may be due to a range of reasons including English and health literacy and level of trust in government. |
| Health literacy | Low health literacy impacts the ability to understand and act on health messages. This may include knowledge of effective infection control practises (e.g. handwashing and wearing a face-covering) |
| Health and social support needs | People with pre-existing comorbidities or require other intensive social supports may be at higher risk of negative consequences from COVID-19 infection |
| Cognitive abilities of residents/clients and compliance capability | People with cognitive impairment may not understand public heath directions and require a high level of support to adhere to advice |

#### Accommodation settings

|  |  | Characteristics | Considerations |
| --- | --- | --- | --- |
| **High rise public housing towers, mid and low-rise public housing**  | Physical environment  | \* Large number of residents living on site in separate dwellings \* Some shared areas including foyers, lifts, hallways, laundries and playgrounds | These are accommodation only settings therefore they do not have support staff (although individual residents may receive support services) to leverage quick engagement with residents.Resident names and contact details may not be quickly available in these settings and there is a possibility the names on the lists and tenancy agreements may not be the people living at the premises, or there may be additional people living onsite. High risk - Requires health concierge, community services, community leaders or the outbreak management team to establish contact with residents which may delay the critical early stages of outbreak management. |
|  | Residents and staffing | \* Lists of registered residents are maintained but, unregistered residents may also live onsite \* Higher proportion of people from CALD communities\* No staffing\* Information about resident support needs is not readily available\* Low resident turnover |  |
| **Community housing** | Physical environment  | \* Operated by not-for-profit community housing organisations\* Residents living in separate dwellings | These are accommodation only settings therefore they do not have support staff (although individual residents may receive support services) to leverage quick engagement with residents.Resident names and contact details may not be quickly available in these settings and there is a possibility the names on the lists and tenancy agreements may not be the people living at the premises, or there may be additional people living onsite. Community service providers may need to door knock to establish contact with residents which may delay the critical early stages of outbreak management. |
|  | Residents and staffing | \* Often tenanted by large families (5 or more people) or by people not registered on the lease\* Higher proportion of people from CALD communities\* No staffing \* Information about residents’ support needs is not readily available\* Low resident turnover |  |
| **Rooming houses** | Physical environment  | \* Privately owned and operated or operated by Community Housing Associations \* Some unregistered people may also live at the premises \* Residents usually have their own bedrooms, but all other rooms are shared |  |
|  | Residents and staffing | \* Higher proportion of people from CALD communities\* No staffing but may have proprietors or onsite managers involved\* Information about residents’ support needs is not readily available\* Medium-high resident turnover |  |
| **SRS & Disability Residential Settings** | Physical environment  | \* SRS’ privately owned and operated \* Some SRS’ and Disability Residential Settings have shared bedrooms and bathrooms, and all have shared dining and lounge areas. \* Some SRS and Disability Residential Settings will have individual bedrooms with ensuites | Settings are staffed and therefore information about who is living at the facility can be quickly obtained. Staff are enablers for the sustainability of IPC measures within the facility.In the event of an outbreak, SRS and disability staff can quickly provide necessary information about residents and their health and support needs. Staff can also support residents to comply with testing requests and public health directions and be a conduit for information flow between residents and the outbreak response team. |
|  | Residents and staffing | \* Low staffing levels in SRS’, 24 hours a day\* Staffing levels in disability homes determined under an NDIS SIL Plan according to resident need (usually staffed 24 hrs)\*Both SRS and Disability Homes maintain support plans which record support needs. \* Low-medium resident turnover |  |
| **Caravan parks** | Physical environment | \* Some caravans or movable dwellings will be fully self-contained although many long stay residents will live with basic amenity and some shared areas. | Including caravan parks, backpacker accommodation and private hostels.Settings do not have support staff who might be able to assist in communicating with residents. Information about residents’ needs are unknown. |
|  | Residents and staffing | \* Staff to manage and operate the park are on site\* Information about residents’ support needs is not quickly available |  |
| **Backpacker hostels** | Physical environment | \* Mostly shared bedrooms, bathrooms and all other facilities |  |
|  | Residents and staffing | \* Operational staff but not support staff \* Information about residents’ support needs is not quickly available |  |

## Appendix 6: Service Mapping

| LGA | Suburbs  | DFFH Area | DFFH Division | HRAR Catchment | Lead Provider  | LPHU | Health Cluster | DLO based in region |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Alpine Shire | Abbeyard, Barwidgee, Bogong, Bright, Buckland, Buffalo Creek, Buffalo River, Cobungra, Coral Bank, Dandongadale, Dargo, Dederang, Dinner Plain, Eurobin, Falls Creek, Freeburgh, Gapsted, Germantown, Glen Creek, Gundowring, Harrietville, Havilah, Hotham Heights, Kancoona, Kergunyah South, Merriang, Mongans Bridge, Mount Beauty, Mount Buffalo, Mount Hotham, Mudgeegonga, Myrtleford, Nug, Ovens, Porepunkah, Rosewhite, Running Creek, Selwyn, Smoko, Tawonga, Tawonga South, Upper Gundowring, Wandiligong, Wongungarra And Wonnangatta. | Ovens Murray | East | Ovens Murray | Gateway Health | Albury Wodonga Health  | Hume - Goulburn Valley Health | Yes |
| Ararat Rural City | Ararat; Armstrong; Ballyrogan; Bayindeen; Black Range; Bornes Hill; Buangor; Carranballac; Cathcart; Chatsworth; Crowlands; Denicull Creek; Dobie; Dunkeld; Dunneworthy; Elmhurst; Eversley; Glenlogie; Glenthompson; Great Western; Halls Gap; Lake Bolac; Langi Logan; Mafeking; Maroona; Middle Creek; Mininera; Mount Cole; Mount Cole Creek; Moyston; Narrapumelap South; Nerrin; Norval; Pomonal; Pura Pura; Rhymney; Rocky Point; Rossbridge; Stavely; Stoneleigh; Streatham; Tatyoon; Warrak; Westmere; Wickliffe; Willaura; Willaura North; Woorndoo; Yalla-Y-Poora | Central Highlands | West | Central Highlands | Ballarat Health Services | Barwon Health | Grampians - Lead - Ballarat Health | Yes |
| Ballarat City | Addington; Alfredton; Ascot (Ballarat); Bakery Hill; Bald Hills; Ballarat Central; Ballarat East; Ballarat North; Black Hill; Blowhard; Bo Peep; Bonshaw; Brown Hill; Buninyong; Bunkers Hill; Burrumbeet; Canadian; Cardigan; Cardigan Village; Chapel Flat; Coghills Creek; Creswick; Delacombe; Durham Lead; Ercildoune; Eureka; Glen Park; Glendaruel; Glendonald; Golden Point (Ballarat); Gong Gong; Invermay; Invermay Park; Lake Gardens; Lake Wendouree; Learmonth; Lucas; Magpie; Miners Rest; Mitchell Park; Mount Bolton; Mount Clear; Mount Helen; Mount Pleasant; Mount Rowan; Nerrina; Newington; Redan; Scotchmans Lead; Scotsburn; Sebastopol; Smythes Creek; Soldiers Hill; Sulky; Tourello; Warrenheip; Wattle Flat; Waubra; Weatherboard; Wendouree; Windermere | Central Highlands | West | Central Highlands | Ballarat Health Services | Ballarat Health | Grampians - Lead - Ballarat Health | Yes |
| Banyule City | Bellfield, Briar Hill, Bundoora (Part), Eaglemont, Eltham North (Part), Greensborough, Heidelberg, Heidelberg West, Heidelberg Heights, Ivanhoe, Ivanhoe East, Lower Plenty, Macleod (Part) Montmorency, Rosanna, St Helena, Viewbank, Watsonia, Watsonia North, Yallambie | North East Melbourne  | North  | Banyule | Banyule Community Health | NEPHU | North Metro - Lead - Austin Health | Yes |
| Bass Coast Shire | Almurta, Anderson, Bass, Dalyston, Glen Forbes,Inverloch | Inner Gippsland Area (IGA) | South | Inner Gippsland  | La Trobe Community Health Service | La Trobe Health | Gippsland - Lead - La Trobe Regional Health | Yes |
| Bass Coast Shire | Adams Estate, Archies Creek, Blackwood Forest, Cape Paterson, Cape Woolamai, Churchill Island, Corinella, Coronet Bay, Cowes, Dudley South, Glen Alvie, Grantville, Harmers Haven, Jam Jerrup, Kernot, Kilcunda, Kongwak, Krowera, Lance Creek, Lang Lang, Loch, Newhaven, Outtrim, Pioneer Bay, Pound Creek, Powlett River, Queensferry, Rhyll, Ryanston, San Remo, Silverleaves, Smiths Beach, St Clair, Summerlands, Sunderland Bay, Sunset Strip, Surf Beach, Tenby Point, The Gurdies, Ventnor, Wattle Bank, West Creek, Wimbleton Heights, Wonthaggi, Wonthaggi North, Woodleigh And Woolamai | Inner Gippsland Area (IGA) | South | Inner Gippsland  | La Trobe Community Health Service | SEPHU | Gippsland - Lead - La Trobe Regional Health | Yes |
| Baw Baw Shire | Aberfeldy, Ada, Allambee, Allambee Reserve, Allambee South, Amor, Athlone, Baw Baw, Baw Baw Village, Bona Vista, Boola, Brandy Creek, Bravington, Buln Buln, Buln Buln East, Caringal, Childers, Cloverlea, Coalville, Coopers Creek, Crossover, Darnum, Delburn, Driffield, Drouin, Drouin East, Drouin South, Drouin West, Ellinbank, Erica, Ferndale, Fumina, Fumina South, Gainsborough, Gentle Annie, Glengarry North, Hallora, Hallston, Heath Hill, Hernes Oak, Hill End, Icy Creek, Jacob Creek, Jericho, Jindivick, Labertouche, Lardner, Lillico, Loch Valley, Longwarry, Longwarry North, Mirboo South, Modella, Moe, Moe South, Moondarra, Mountain View, Narracan, Nayook, Neerim, Neerim East, Neerim Junction, Neerim North, Neerim South, Nilma, Noojee, Nyora, Piedmont, Poowong East, Poowong North, Rawson, Ripplebrook, Rokeby, Seaview, Shady Creek, Strzelecki, Tanjil, Tanjil Bren, Tanjil South, Tetoora Road, Thaloo, Thomson, Thorpdale, Thorpdale South, Toombon, Toongabbie, Toorongo, Trafalgar, Trafalgar East, Trafalgar South, Trida, Vesper, Walhalla, Warragul, Warragul South, Warragul West, Westbury, Willow Grove, Yallourn North, Yarragon And Yarragon South | Inner Gippsland Area (IGA) | South | Inner Gippsland  | La Trobe Community Health Service | La Trobe Health | Gippsland - Lead - La Trobe Regional Health | Yes |
| Bayside City | Beaumaris, Black Rock, Brighton, Brighton East, Cheltenham, Cromer, Dendy, Hampton, Hampton East, Highett, Moorabbin And Sandringham | Bayside Peninsula Area (BPA) | South | Bayside Peninsula Middle | Connect Health | SEPHU | South Metro - Lead - Alfred Health | Yes |
| Benalla Rural City | Archerton, Benalla, Boweya, Boxwood, Wangandary, Broken Creek, Bungeet, Bungeet West, Chesney Vale, Devenish, Glenrowan, Glenrowan West, Goomalibee, Goorambat, Lima, Lima East, Lurg, Major Plains, Molyullah, Moorngag, Mount Bruno, Myrrhee, Samaria, Stewarton, Swanpool Taminick, Tarnook, Tatong, Thoona, Upper Lurg, Upper Ryans Creek, Warrenbayne, Winton | Ovens Murray | East | Ovens Murray | Gateway Health | Goulburn Health | Hume - Goulburn Valley Health | Yes |
| Boroondara City | Ashburton, Glen Iris | Outer Eastern | East | Outer Eastern | EACH | SEPHU | North Metro - Lead - Austin Health | Yes |
| Boroondara City | Balwyn, Balwyn North, Burwood, Camberwell, Canterbury, Deepdeene, Glenferrie South, Greythorn, Hawthorn, Hawthorn East, Kew, Kew East, Mont Albert, Surrey Hills | Outer Eastern | East | Outer Eastern | EACH | NEPHU | North Metro - Lead - Austin Health | Yes |
| Borough of Queenscliffe | Point Lonsdale; Queenscliff; Swan Island | Barwon | West | Barwon | Barwon Health | Barwon Health | Barwon South West - Lead agency: Barwon Health | Yes |
| Brimbank City | Albanvale; Albion; Ardeer; Brooklyn; Cairnlea; Calder Park; Deer Park; Delahey; Derrimut; Hillside (Melton); Kealba; Keilor; Keilor Downs; Keilor East; Keilor Lodge; Keilor North; Keilor Park; Kings Park; St Albans; Sunshine; Sunshine North; Sunshine West; Sydenham; Taylors Lakes; Tullamarine | Brimbank Melton | West | Brimbank Melton | IPC Health | WEPHU | West Metro - Lead - Melbourne Health | Yes |
| Buloke Shire | Ballapur; Banyan; Barrakee; Berriwillock; Bimbourie; Birchip; Birchip West; Boigbeat; Buckrabanyule; Bunguluke; Carron; Charlton; Chirrip; Cokum; Coonooer Bridge; Cope Cope; Corack; Corack East; Culgoa; Curyo; Donald; Dooboobetic; Dumosa; Gil Gil; Glenloth; Glenloth East; Granite Flat; Jeffcott; Jeffcott North; Jeruk; Jil Jil; Kalpienung; Karyrie; Kinnabulla; Laen; Laen East; Laen North; Lake Marmal; Lake Tyrrell; Lawler; Litchfield; Marlbed; Massey; Morton Plains; Myall (Sea Lake); Nandaly; Nareewillock; Narraport; Ninda; Nine Mile; Nullawil; Nyarrin; Pier Milan; Reedy Dam; Rich Avon; Richmond Plains; Sea Lake; Springfield (Swan Hill); Straten; Sutton; Teddywaddy; Teddywaddy West; Terrappee; Thalia; Tittybong; Towaninny; Towaninny South; Turriff East; Tyenna; Tyrrell; Tyrrell Downs; Wangie; Warmur; Warne; Watchem; Watchem West; Watchupga; Whirily; Wilkur; Willangie; Wooroonook; Woosang; Wycheproof; Wycheproof South; Yawong Hills; Yeungroon; Yeungroon East; | Mallee | North  | Southern Mallee | Swan Hill District Health | Ballarat Health | Grampians - Lead - Ballarat Health | Yes |
| Campaspe Shire | Ballendella; Bamawm; Bamawm Extension; Bonn; Burnewang; Burramboot; Carag Carag; Colbinabbin; Cornella; Corop; Diggora; Echuca; Echuca Village; Echuca West; Fairy Dell (Campaspe); Girgarre; Gobarup; Gunbower; Kanyapella; Kotta; Koyuga; Kyabram; Kyvalley; Lancaster; Lockington; Milloo; Mitiamo; Moora; Muskerry; Myola; Nanneella; Patho; Pine Grove; Redcastle; Rochester; Roslynmead; Runnymede; Rushworth; Stanhope; Strathallan; Tennyson; Terrick Terrick East; Timmering; Tongala; Toolleen; Torrumbarry; Wanalta; Waranga Shores; Wharparilla; Whroo; Wyuna; Wyuna East; Yambuna; | Loddon | North  | Loddon | Bendigo Community Health Service | Goulburn Health | Loddon Mallee - Bendigo Health | Yes |
| Cardinia Shire | Avonsleigh, Menzies Creek | Southern Melbourne Area (SMA) | South | Southern Melbourne (EACH) | EACH | NEPHU | South and East Metro - Lead - Monash  | Yes |
| Cardinia Shire | Bayles, Beaconsfield, Beaconsfield Upper, Bunyip, Bunyip North, Caldermeade, Cardinia, Catani, Clematis, Cockatoo, Cora Lynn, Dalmore, Dewhurst, Emerald, Garfield, Garfield North, Gembrook, Guys Hill, Heath Hill, Iona, Koo Wee Rup, Koo Wee Rup North, Lang Lang, Lang Lang East, Longwarry, Maryknoll, Modella, Monomeith, Mount Burnett, Nangana, Nar Nar Goon, Nar Nar Goon North, Nyora, Officer, Officer South, Pakenham, Pakenham South, Pakenham Upper, Rythdale, Tenby Point, Tonimbuk, Tooradin, Tynong, Tynong North, Vervale And Yannathan | Southern Melbourne Area (SMA) | South | Southern Melbourne (EACH) | EACH | SEPHU | South and East Metro - Lead - Monash  | Yes |
| Casey City | Beaconsfield, Berwick, Blind Bight, Cannons Creek, Clyde, Clyde North, Cranbourne, Cranbourne East, Cranbourne North, Cranbourne South, Cranbourne West, Devon Meadows, Doveton, Endeavour Hills, Eumemmerring, Fountain Gate, Hallam, Hampton Park, Harkaway, Junction Village, Lynbrook, Lyndhurst, Lysterfield South, Narre Warren, Narre Warren North, Narre Warren South, Pearcedale, Tooradin, Warneet | Southern Melbourne Area (SMA) | South | Southern Melbourne (EACH) | EACH | SEPHU | South and East Metro - Lead - Monash  | Yes |
| Central Goldfields Shire | Adelaide Lead; Alma; Amherst; Archdale; Archdale Junction; Bealiba; Bet Bet; Betley; Bowenvale; Bromley; Bung Bong; Campbelltown; Caralulup; Carisbrook; Cotswold; Craigie; Daisy Hill; Dunach; Dunluce; Dunolly; Eddington; Emu; Flagstaff; Glengower; Golden Point (Maryborough); Goldsborough; Havelock; Inkerman; Joyces Creek; Lillicur; Majorca; Maryborough; Moliagul; Moolort; Moonlight Flat (Maryborough); Mount Cameron; Mount Glasgow; Mount Hooghly; Natte Yallock; Rathscar; Red Lion; Simson; Stony Creek (Central Goldfields); Strathlea; Talbot; Timor; Timor West; Wareek; | Loddon | North  | Loddon | Bendigo Community Health Service | Ballarat Health | Grampians - Lead - Ballarat Health | Yes |
| Colac Otway Shire | Aire Valley; Alvie; Apollo Bay; Balintore; Barongarook; Barongarook West; Barramunga; Barunah Plains; Barwon Downs; Beeac; Beech Forest; Birregurra; Bungador; Cape Otway; Carlisle River; Carpendeit; Chapple Vale; Colac; Colac East; Colac West; Coragulac; Cororooke; Corunnun; Cressy; Cundare; Cundare North; Dreeite; Dreeite South; Elliminyt; Eurack; Ferguson; Forrest; Gellibrand; Gellibrand Lower; Gerangamete; Glenaire; Grey River; Hordern Vale; Irrewarra; Irrewillipe; Irrewillipe East; Jancourt East; Johanna; Kawarren; Kennett River; Larpent; Lavers Hill; Marengo; Mount Sabine; Murroon; Nalangil; Ombersley; Ondit; Pennyroyal; Petticoat Creek; Pirron Yallock; Separation Creek; Simpson; Skenes Creek; Skenes Creek North; Stonyford; Sugarloaf; Swan Marsh; Tanybryn; Warncoort; Warrion; Weeaproinah; Weering; Whoorel; Winchelsea; Wingeel; Wongarra; Wool Wool; Wye River; Wyelangta; Yeo; Yeodene; Yuulong | Barwon | West | Barwon | Barwon Health | Barwon Health | Barwon South West - Lead agency: Barwon Health | Yes |
| Corangamite Shire | Alvie; Ayrford; Berrybank; Bookaar; Boorcan; Bostocks Creek; Bradvale; Brucknell; Bullaharre; Camperdown; Carlisle River; Carpendeit; Chapple Vale; Chocolyn; Cobden; Cobrico; Cooriemungle; Cowleys Creek; Cressy; Cundare North; Curdies River; Curdievale; Darlington; Derrinallum; Dixie; Dreeite; Dreeite South; Duverney; Ecklin South; Elingamite; Elingamite North; Foxhow; Garvoc; Gellibrand Lower; Glenfyne; Glenormiston North; Glenormiston South; Gnotuk; Heytesbury Lower; Jancourt; Jancourt East; Kariah; Kennedys Creek; Koallah; Kolora; Larralea; Leslie Manor; Lismore; Mingay; Mount Bute; Naroghid; Newfield; Nirranda East; Noorat; Noorat East; Paaratte; Peterborough; Pirron Yallock; Pittong; Pomborneit; Pomborneit East; Pomborneit North; Port Campbell; Princetown; Scotts Creek; Simpson; Skibo; Skipton; South Purrumbete; Stonyford; Tandarook; Taroon; Terang; Tesbury; Timboon; Timboon West; Vite Vite; Vite Vite North; Waarre; Wattle Hill; Weerite; Werneth; Wool Wool | Wimmera South West | West | WSW - South West | South West Health Care | Barwon Health | Barwon South West - Lead agency: Barwon Health | Yes |
| Darebin City | Coburg | North East Melbourne  | North  | Darebin | Your Community Health | WEPHU | North Metro - Lead - Austin Health |  |
| Darebin City | Bundoora (Part), Kingsbury, Macleod (Part), Fairfield, Alphington, Northcote, Preston, Reservoir, Thornbury  | North East Melbourne  | North  | Darebin | Your Community Health | NEPHU | North Metro - Lead - Austin Health |  |
| East Gippsland Shire | Anglers Rest, Bairnsdale, Bairnsdale East, Bellbird Creek, Bemm River, Benambra, Bendoc, Bengworden, Bete Bolong, Bete Bolong North, Bindi, Bingo Munji, Bonang, Boole Poole, Broadlands, Brodribb River, Brookville, Bruthen, Buchan, Buchan South, Buldah, Bullumwaal, Bumberrah, Bundara, Butchers Ridge, Cabanandra, Cabbage Tree Creek, Calulu, Cann River, Cape Conran, Cassilis, Chandlers Creek, Clifton Creek, Club Terrace, Cobbannah, Cobberas, Cobungra, Combienbar, Corringle, Dartmouth, Deddick Valley, Delegate River East, Dellicknora, Deptford, Doctors Flat, Double Bridges, Eagle Point, Ellaswood, Ensay, Ensay North, Erinunderra, Fairy Dell, Fernbank, Flaggy Creek, Forge Creek, Gelantipy, Genoa, Gipsy Point, Glen Valley, Glen Wills, Glenaladale, Goon Nure, Goongerah, Granite Rock, Haydens Bog, Hillside, Hinnomunjie, Hollands Landing, Iguana Creek, Jarrahmond, Johnsonville, Kalimna, Kalimna West, Lake Bunga, Lake Tyers, Lake Tyers Beach, Lakes Entrance, Lindenow, Lindenow South, Lochend, Lucknow, Mallacoota, Manorina, Maramingo Creek, Marlo, Marthavale, Melwood, Merrijig, Metung, Mitta Mitta, Mossiface, Mount Taylor, Murrindal, Nariel Valley, Newlands Arm, Newmerella, Nicholson, Noorinbee, Noorinbee North, Nowa Nowa, Nungurner, Nunniong, Nurran, Nyerimilang, Ocean Grange, Omeo, Omeo Valley, Orbost, Paynesville, Raymond Island, Reedy Creek, Sarsfield, Shannonvale, Simpsons Creek, Stirling, Suggan Buggan, Swan Reach, Swifts Creek, Tabberabbera, Tambo Crossing, Tambo Upper, Tamboon, The Fingerboards, Timbarra, Tom Groggin, Tonghi Creek, Tongio, Toorloo Arm, Tostaree, Tubbut, Uplands, W Tree, Wairewa, Wallagaraugh, Walpa, Wangarabell, Waterholes, Waygara, Weeragua, Wingan River, Wiseleigh, Wombat Creek, Woodglen, Wroxham, Wuk Wuk, Wulgulmerang, Wulgulmerang East, Wulgulmerang West, Wy Yung And Yalmy | Outer Gippsland Area (OGA) | South | East Gippsland | Gippsland Lakes Complete Health | La Trobe Health | Gippsland - Lead - La Trobe Regional Health | Yes |
| Frankston City | Carrum Downs, Frankston, Frankston North, Frankston South, Karingal, Langwarrin, Langwarrin South, Sandhurst, Seaford And Skye. | Bayside Peninsula Area (BPA) | South | Bayside Peninsula Lower  | Peninsula Health | SEPHU | South Metro - Lead - Alfred Health |  |
| Gannawarra Shire | Appin, Appin South, Bael Bael, Beauchamp, Benjeroop, Budgerum East, Burkes Bridge, Cannie, Capels Crossing, Cohuna, Cullen, Daltons Bridge, Dingwall, Fairley, Gannawarra, Gonn Crossing, Gredgwin, Horfield, Keely, Kerang, Kerang East, Koondrook, Koroop, Lake Charm; Lake Meran; Lalbert; Leitchville; Macorna; Macorna North; Mcmillans; Mead; Meatian; Meering West; Milnes Bridge; Mincha West; Murrabit; Murrabit West; Myall (Kerang); Mystic Park; Ninyeunook; Normanville; Oakvale; Pine View; Quambatook, Reedy Lake; Sandhill Lake; Teal Point; Tittybong; Towaninny; Tragowel; Wandella; Wee Wee Rup; Westby | Mallee | North  | Southern Mallee | Swan Hill District Health | Bendigo Health | Loddon Mallee - Bendigo Health | Yes |
| Glen Eira City | Bentleigh, Bentleigh East, Brighton East, Carnegie, Caulfield, Caulfield East, Caulfield North, Caulfield South, Coatesville, Elsternwick, Gardenvale, Glen Huntly, Hopetoun Gardens, Mckinnon, Murrumbeena, Ormond, Patterson and St Kilda East | Bayside Peninsula Area (BPA) | South | Bayside Peninsula Middle  | Connect Health | SEPHU | South and East Metro - Lead - Monash  | Yes |
| Glenelg Shire | Allestree; Bahgallah; Bessiebelle; Bolwarra; Branxholme; Breakaway Creek; Brimboal; Cape Bridgewater; Carapook; Cashmore; Casterton; Chetwynd; Clover Flat; Condah; Corndale; Dartmoor; Dergholm; Digby; Drik Drik; Drumborg; Dunrobin; Dutton Way; Gorae; Gorae West; Grassdale; Greenwald; Heathmere; Henty; Heywood; Homerton; Hotspur; Killara (Glenelg); Lake Condah; Lake Mundi; Lindsay; Lyons; Merino; Milltown; Mount Richmond; Mumbannar; Muntham; Myamyn; Nangeela; Nareen; Narrawong; Nelson; Paschendale; Portland; Portland North; Portland West; Sandford; Strathdownie; Tahara; Tahara Bridge; Tahara West; Tyrendarra; Wallacedale; Wando Bridge; Wando Vale; Warrock; Winnap | Wimmera South West | West | WSW - South West | South West Health Care | Barwon Health | Barwon South West - Lead agency: Barwon Health | Yes |
| Golden Plains Shire | Anakie; Bamganie; Bannockburn; Barunah Park; Batesford; Berringa; Berrybank; Cambrian Hill; Cape Clear; Corindhap; Cressy; Dereel; Durdidwarrah; Durham Lead; Enfield; Garibaldi; Gheringhap; Grenville; Haddon; Happy Valley (Ballarat); Hesse; Illabarook; Inverleigh; Lethbridge; Linton; Mannibadar; Maude; Meredith; Morrisons; Mount Bute; Mount Mercer; Murgheboluc; Napoleons; Newtown (Ballarat); Nintingbool; Piggoreet; Pitfield; Pittong; Rokewood; Rokewood Junction; Ross Creek; Russells Bridge; Scarsdale; She Oaks; Shelford; Smythes Creek; Smythesdale; Springdallah; Staffordshire Reef; Steiglitz; Stonehaven; Sutherlands Creek; Teesdale; Wallinduc; Werneth; Willowvale; Wingeel | Central Highlands | West | Central Highlands | Ballarat Health Services | Barwon Health | Barwon South West - Lead agency: Barwon Health | Yes |
| Greater Bendigo City | Argyle; Ascot (Bendigo); Avonmore; Axe Creek; Axedale; Bagshot; Bagshot North; Barnadown; Bendigo; Big Hill (Bendigo); California Gully; Costerfield; Derrinal; Drummartin; Eaglehawk; Eaglehawk North; East Bendigo; Elmore; Emu Creek; Eppalock; Epsom; Flora Hill; Fosterville; Golden Gully; Golden Square; Goornong; Harcourt North; Heathcote; Hunter; Huntly; Huntly North; Ironbark; Jackass Flat; Junortoun; Kamarooka; Kangaroo Flat; Kennington; Kimbolton; Knowsley; Ladys Pass; Lake Eppalock; Leichardt; Lockwood; Lockwood South; Long Gully; Longlea; Lyal; Maiden Gully; Mandurang; Mandurang South; Marong; Mia Mia; Mount Camel; Myers Flat; Myrtle Creek; Neilborough; North Bendigo; Quarry Hill; Ravenswood; Raywood; Redcastle; Redesdale; Sailors Gully; Sebastian; Sedgwick; Shelbourne; Spring Gully; Strathdale; Strathfieldsaye; Toolleen; Wellsford; West Bendigo; Whipstick; White Hills; Wilsons Hill; Woodvale; | Loddon | North  | Loddon | Bendigo Community Health Service | Bendigo Health | Loddon Mallee - Bendigo Health | Yes |
| Greater Dandenong City | Bangholme, Dandenong, Dandenong North, Dandenong South, Keysborough, Lyndhurst, Noble Park, Noble Park North, Springvale And Springvale South | Southern Melbourne Area (SMA) | South | Southern Melbourne | EACH | SEPHU | South and East Metro - Lead - Monash  | Yes |
| Greater Geelong City | Anakie; Avalon; Balliang; Barwon Heads; Batesford; Bell Park; Bell Post Hill; Bellarine; Belmont; Breakwater; Breamlea; Ceres; Clifton Springs; Connewarre; Corio; Curlewis; Drumcondra; Drysdale; East Geelong; Fyansford; Geelong; Geelong West; Grovedale; Hamlyn Heights; Herne Hill; Highton; Indented Head; Lara; Leopold; Little River; Lovely Banks; Manifold Heights; Mannerim; Marcus Hill; Marshall; Moolap; Moorabool; Mount Duneed; Newcomb; Newtown (Geelong); Norlane; North Geelong; North Shore; Ocean Grove; Point Lonsdale; Point Wilson; Portarlington; Rippleside; South Geelong; St Albans Park; St Leonards; Staughton Vale; Swan Bay; Thomson (Geelong); Wallington; Wandana Heights; Waurn Ponds; Whittington | Barwon | West | Barwon | Barwon Health | Barwon Health | Barwon South West - Lead agency: Barwon Health | Yes |
| Greater Shepparton City | Arcadia, Ardmona, Boxwood (Part), Bunbartha, Byrneside, Caniambo, Congupna, Cooma, Coomboona, Cosgrove, Cosgrove South, Dhurringile, Dookie, Dookie College, Gillieston, Girgarre East, Gowangardie, Grahamvale, Harston, Karramomus, Katandra, Katandra West, Kialla, Kialla East, Kialla West, Kyabram (The Rural Part Not The Town), Kyabram South, Lancaster (Part), Lemnos, Major Plains (Part), Marionvale, Marungi (Part), Merrigum, Moorilim (Part), Mooroopna, Mooroopna North, Mooroopna North West, Mount Major, Murchison, Murchison East, Murchison North, Nalinga (Part), Orrvale, Pine Lodge, Shepparton, Shepparton East, Shepparton North, St Germains, Stanhope South, Stewarton (Part), Tallygaroopna, Tamleugh North, Tatura, Tatura East, Toolamba, Toolamba West, Undera, Violet Town (Part), Waranga, Wyuna (Part), Zeerus | Goulburn  | East | Goulburn  | Primary Care Connect | Goulburn Health | Hume - Goulburn Valley Health | Yes |
| Hepburn Shire | Allendale; Bald Hills; Basalt; Blampied; Broomfield; Bullarook; Bullarto; Bullarto South; Cabbage Tree; Campbelltown; Clunes; Clydesdale; Coomoora; Creswick; Creswick North; Daylesford; Dean; Denver; Drummond; Drummond North; Dry Diggings; Dunach; Eganstown; Elevated Plains; Evansford; Fern Hill; Franklinford; Glengower; Glenlyon; Guildford; Hepburn; Hepburn Springs; Invermay; Kingston; Kooroocheang; Korweinguboora; Langdons Hill; Lawrence; Leonards Hill; Little Hampton; Lyonville; Malmsbury; Mollongghip; Mount Beckworth; Mount Cameron; Mount Franklin; Mount Prospect; Musk; Musk Vale; Newbury; Newlyn; Newlyn North; North Blackwood; Porcupine Ridge; Rocklyn; Sailors Falls; Sailors Hill; Shepherds Flat; Smeaton; Smokeytown; Spring Hill; Springmount; Stony Creek (Central Goldfields); Strangways; Sulky; Taradale; Tarilta; Trentham; Trentham East; Tylden; Tylden South; Ullina; Wattle Flat; Waubra; Werona; Wheatsheaf; Yandoit | Central Highlands | West | Central Highlands | Ballarat Health Services | Ballarat Health | Grampians - Lead - Ballarat Health | Yes |
| Hindmarsh Shire | Albacutya; Antwerp; Big Desert; Broughton; Crymelon; Dimboola; Gerang Gerung; Glenlee; Jeparit; Kaniva; Kenmare; Kiata; Little Desert; Lorquon; Netherby; Nhill; Rainbow; Tarranyurk; Yanac; | Wimmera South West | West | WSW - Wimmera | Grampians Community Health | Ballarat Health | Grampians - Lead - Ballarat Health | Yes |
| Hobsons Bay City | Altona; Altona Meadows; Altona North; Brooklyn; Laverton; Newport; Seabrook; Seaholme; South Kingsville; Spotswood; Williamstown; Williamstown North | Western Melbourne | West | Western Melbourne | Cohealth | WEPHU | West Metro - Lead - Melbourne Health | Yes |
| Horsham Rural City | Arapiles; Blackheath; Brimpaen; Bungalally; Clear Lake; Dadswells Bridge; Dooen; Douglas; Drung; Duchembegarra; Grass Flat; Haven; Horsham; Jilpanger; Jung; Kalkee; Kanagulk; Kewell; Laharum; Longerenong; Lower Norton; Mckenzie Creek; Mitre; Mockinya; Murra Warra; Natimuk; Noradjuha; Nurrabiel; Pimpinio; Quantong; Riverside; St Helens Plains; Telangatuk East; Tooan; Toolondo; Vectis; Wail; Wartook; Wonwondah | Wimmera South West | West | WSW - Wimmera | Grampians Community Health | Ballarat Health | Grampians - Lead - Ballarat Health | Yes |
| Hume City | Campbellfield, Craigieburn, Greenvale, Oaklands Junction, Somerton | Hume Moreland | North  | Hume Moreland | DPV Health | NEPHU | North Metro - Lead - Austin Health | Yes |
| Hume City | Gladstone Park, Melbourne Airport, Fawkner, Diggers Rest, Sunbury | Hume Moreland | North  | Hume Moreland | DPV Health | WEPHU | North Metro - Lead - Austin Health | Yes |
| Hume City | Attwood, Broadmeadows, Bulla, Campbellfield, Clarkefield, Coolaroo, Craigieburn, Dallas, Greenvale, Jacana, Kalkallo, Keilor (Part), Meadow Heights, Mickleham, Oaklands Junction, Roxburgh Park, Somerton, Tullamarine (Part), Westmeadows, Wildwood And Yuroke. | Hume Moreland | North  | Hume Moreland | DPV Health | Bendigo Health | North Metro - Lead - Austin Health | Yes |
| Indigo Shire | Allans Flat, Barnawartha, Beechworth, Brimin, Browns Plains, Bruarong, Carlyle, Charleroi, Chiltern, Chiltern Valley, Cornishtown, Gooramadda, Great Northern, Gundowring, Huon, Indigo, Indigo Valley, Kergunyah, Kiewa, Lilliput, Mudgegonga, Norong, Norong Central, Osbornes Flat, Prentice North, Red Bluff, Rutherglen, Sandy Creek, Staghorn Flat, Stanley, Tangambalanga, Wahgunyah, Woolshed, Wooragee, Yackandandah | Ovens Murray | East | Ovens Murray | Gateway Health | Albury Health | Hume - Goulburn Valley Health | Yes |
| Kingston City | Aspendale, Aspendale Gardens, Bonbeach, Braeside, Carrum, Chelsea, Chelsea Heights, Cheltenham, Clarinda, Clayton South, Dingley Village, Edithvale, Heatherton, Highett, Mentone, Moorabbin, Moorabbin Airport, Mordialloc, Oakleigh South, Parkdale, Patterson Lakes And Waterways | Bayside Peninsula Area (BPA) | South | Bayside Peninsula Middle (Glen Eira, Kingston, Bayside) | Connect Health | SEPHU | South and East Metro - Lead - Monash  | Yes |
| Knox City | Lysterfield, Rowville, Upper Ferntree Gully, Wantirna | Outer Eastern | East | Outer Eastern | EACH | SEPHU | South and East Metro - Lead - Monash  | Yes |
| Knox City | Bayswater, Boronia, Ferntree Gully, Knoxfield, Sassafras, Scoresby, The Basin, Wantirna | Outer Eastern | East | Outer Eastern | EACH | NEPHU | South and East Metro - Lead - Monash  | Yes |
| Latrobe City | Balook, Boola, Boolarra, Boolarra South, Budgeree, Callignee, Churchill, Cowwarr, Darlimurla, Delburn, Driffield, Flynn, Flynns Creek, Glengarry, Glengarry North, Glengarry West, Grand Ridge, Hazelwood, Hazelwood North, Hazelwood South, Hernes Oak, Jeeralang, Jeeralang Junction, Jumbuk, Koornalla, Loy Yang, Maryvale, Mid Valley, Mirboo, Moe, Moe South, Moondarra, Morwell, Mount Tassie, Narracan, Newborough, Tanjil South, Toongabbie, Traralgon, Traralgon East, Traralgon South, Tyers, Yallourn, Yallourn North, Yinnar And Yinnar South | Inner Gippsland Area (IGA) | South | Inner Gippsland  | La Trobe Community Health Service | La Trobe Health | Gippsland - Lead - La Trobe Regional Health | Yes |
| Loddon Shire | Appin South; Arnold; Arnold West; Auchmore; Barraport; Barraport West; Bealiba; Bears Lagoon; Berrimal; Boort; Borung; Brenanah; Bridgewater; Bridgewater North; Bridgewater On Loddon; Buckrabanyule; Burkes Flat; Calivil; Campbells Forest; Canary Island; Catumnal; Cochranes Creek; Coonooer Bridge; Derby; Dingee; Dunolly; Durham Ox; Eastville; Eddington; Emu; Fentons Creek; Fernihurst; Fiery Flat; Gladfield; Glenalbyn; Glenloth East; Goldsborough; Gowar East; Gredgwin; Horfield; Inglewood; Inkerman; Jarklin; Jungaburra; Kamarooka; Kamarooka North; Kingower; Kinypanial; Korong Vale; Kurraca; Kurraca West; Kurting; Laanecoorie; Lake Marmal; Lake Meran; Leaghur; Leichardt; Leitchville; Llanelly; Loddon Vale; Logan; Macorna; Marong; Mcintyre; Meering West; Milloo; Mincha; Minmindie; Mitiamo; Moliagul; Mologa; Murphys Creek; Mysia; Newbridge; Nine Mile; Painswick; Pompapiel; Powlett Plains; Prairie; Pyramid Hill; Raywood; Rheola; Richmond Plains; Salisbury West; Sebastian; Serpentine; Shelbourne; Skinners Flat; Slaty Creek; Sylvaterre; Tandarra; Tarnagulla; Terrappee; Terrick Terrick; Waanyarra; Wedderburn; Wedderburn Junction; Wehla; Woodstock On Loddon; Woodstock West; Woolshed Flat; Woosang; Wychitella; Wychitella North; Yando; Yarraberb; Yarrawalla; Yeungroon East; | Loddon | North  | Loddon | Bendigo Community Health Services | Bendigo Health | Loddon Mallee - Bendigo Health | Yes |
| Macedon Ranges Shire | Ashbourne; Baynton; Baynton East; Benloch; Bolinda; Bullengarook; Bylands; Cadello; Carlsruhe; Cherokee; Chintin; Clarkefield; Cobaw; Darraweit Guim; Denver; Drummond; Edgecombe; Fern Hill; Gisborne; Gisborne South; Goldie; Greenhill; Hesket; Kerrie; Kyneton; Kyneton South; Lancefield; Lauriston; Macedon; Malmsbury; Monegeetta; Mount Macedon; New Gisborne; Newham; Pastoria; Pastoria East; Pipers Creek; Riddells Creek; Rochford; Romsey; Sidonia; Spring Hill; Springfield (Macedon Ranges); Tantaraboo; Taradale; Toolern Vale; Trentham East; Tylden; Woodend; Woodend North; | Loddon | North  | Loddon | Bendigo Community Health Services | Goulburn Health | Grampians - Lead - Ballarat Health | Yes |
| Manningham City | Bulleen, Doncaster, Doncaster East, Donvale, Nunawading, Park Orchards, Ringwood North, Templestowe, Templestowe Lower, Warrandyte, Warrandyte South, Wonga Park | Outer Eastern | East | Outer Eastern | EACH | NEPHU | North Metro - Lead - Austin Health |  |
| Mansfield Shire | Ancona, Barjarg, Barwite, Bonnie Doon, Boorolite, Bridge Creek, Delatite, Gaffneys Creek, Goughs Bay, Howes Creek, Howqua, Howqua Hills, Howqua Inlet, Jamieson, Kevington, Lake Eildon, Nillahcootie, Piries, Sawmill Settlement, Tolmie, Woodfield, Woods Point | Ovens Murray | East | Ovens Murray | Gateway Health | Goulburn Health | Hume - Goulburn Valley Health | Yes |
| Maribyrnong City | Braybrook; Footscray; Kingsville; Maidstone; Maribyrnong; Seddon; Tottenham; West Footscray; Yarraville | Western Melbourne | West | Western Melbourne | cohealth | WEPHU | West Metro - Lead - Melbourne Health | Yes |
| Maroondah City | Bayswater North, Croydon, Croydon Hills, Croydon North, Croydon South, Heathmont, Kilsyth, Kilsyth South, Park Orchards, Ringwood, Ringwood East, Ringwood North, Vermont, Warranwood, Wonga Park | Outer Eastern | East | Outer Eastern | EACH | NEPHU | South and East Metro - Lead - Monash  | Yes |
| Melbourne City | Docklands; Flemington; Kensington; North Melbourne; Parkville; South Wharf; Southbank; West Melbourne | Western Melbourne | West | Melbourne | cohealth | WEPHU | North Metro - Lead - Austin Health | Yes |
| Melbourne City | Carlton; Carlton North; East Melbourne | Western Melbourne | West | Melbourne | cohealth | NEPHU | North Metro - Lead - Austin Health | Yes |
| Melbourne City | Melbourne; Port Melbourne; South Yarra | Western Melbourne | West | Melbourne | cohealth | SEPHU | North Metro - Lead - Austin Health |  |
| Melton City | Brookfield; Burnside; Burnside Heights; Caroline Springs; Diggers Rest; Exford; Eynesbury; Hillside (Melton); Kurunjang; Melton; Melton South; Melton West; Mount Cottrell; Parwan; Plumpton; Ravenhall; Rockbank; Taylors Hill; Toolern Vale; Truganina | Brimbank Melton | West | Brimbank Melton | IPC Health | WEPHU | West Metro - Lead - Melbourne Health | Yes |
| Mildura Rural City | Big Desert; Birdwoodton; Boinka; Cabarita; Cardross; Carina; Carwarp; Colignan; Cowangie; Cullulleraine; Hattah; Iraak; Irymple; Koorlong; Kulwin; Lindsay Point; Linga; Merbein; Merbein South; Merbein West; Meringur; Merrinee; Mildura; Mittyack; Murray-Sunset; Murrayville; Nangiloc; Neds Corner; Nichols Point; Ouyen; Panitya; Patchewollock; Red Cliffs; Tempy; Torrita; Tutye; Underbool; Walpeup; Wargan; Werrimull; Yelta; | Mallee | North  | Northern Mallee | Sunraysia Community Health | Ballarat Health | Loddon Mallee - Bendigo Health | Yes |
| Mitchell Shire | Avenel, Beveridge, Broadford, Bylands, Clonbinane, Dysart, Emu Flat, Flowerdale, Forbes, Glenaroua, Glenhope, Glenhope East, Heathcote Junction, Heathcote South, High Camp, Highlands, Hilldene, Kilmore, Kilmore East, Kobyboyn, Mangalore, Mia Mia, Moranding, Northwood, Nulla Vale, Puckapunyal, Pyalong, Reedy Creek, Seymour, Sugarloaf Creek, Sunday Creek, Tallarook, Tarcombe, Tooborac, Trawool, Tyaak, Upper Plenty, Wallan, Wandong, Waterford Park, Whiteheads Creek, Willowmavin | Goulburn  | East | Goulburn  | Primary Care Connect | Goulburn Health | Hume - Goulburn Valley Health | Yes |
| Moira Shire | Almonds, Barmah, Bathumi, Bearii, Boomahnoomoonah, Boosey, Boweya North, Bundalong, Bundalong South, Burramine, Burramine South, Cobram, Cobram East, Drumanure, Esmond, Invergordon, Kaarimba, Katamatite, Katamatite East, Katunga, Koonoomoo, Kotupna, Lake Rowan, Lower Moira, Marungi, Muckatah, Mundoona, Mywee, Naring, Nathalia, Numurkah, Peechelba, Pelluebla, Picola, Picola West, St James, Strathmerton, Telford, Tungamah, Ulupna, Waaia, Waggarandall, Wilby, Wunghnu, Yabba North, Yabba South, Yalca, Yarrawonga, Yarroweyah, Yielima, Youanmite, Youarang, Yundool. | Goulburn  | East | Goulburn  | Primary Care Connect | Goulburn Health??? Northeast Health  | Hume - Goulburn Valley Health | Yes |
| Monash City | Ashwood, Burwood, Huntingdale, Notting Hill, Oakleigh, Oakleigh East, Oakleigh South, Pinewood, Syndal And Wheelers Hill | Inner Eastern | East | Monash | La Trobe Community Health Service | NEPHU | South and East Metro - Lead - Monash  | Yes |
| Monash City | Chadstone, Clayton, Glen Waverely, Hughesdale, Mount Waverley, Mulgrave | Inner Eastern | East | Monash | La Trobe Community Health Service | SEPHU | South and East Metro - Lead - Monash  | Yes |
| Moonee Valley City | Aberfeldie; Airport West; Ascot Vale; Avondale Heights; Essendon; Essendon Fields; Essendon North; Essendon West; Flemington; Keilor East; Moonee Ponds; Niddrie; Strathmore; Strathmore Heights; Travancore | Western Melbourne | West | Mooney Valley | cohealth | WEPHU | West Metro - Lead - Melbourne Health |  |
| Moorabool Shire | Ballan; Barrys Reef; Bungal; Dales Creek; Gordon | Central Highlands | West | Central Highlands | Ballarat Health Services | Ballarat Health | Grampians - Lead - Ballarat Health | Yes |
| Moorabool Shire | Bacchus Marsh; Balliang; Balliang East; Barkstead; Beremboke; Blackwood; Blakeville; Bolwarrah; Bullarook; Bullarto South; Bunding; Bungaree; Buninyong; Cargerie; Clarendon; Claretown; Clarkes Hill; Coimadai; Colbrook; Darley; Dunnstown; Durham Lead; Elaine; Fiskville; Glen Park; Glenmore; Greendale; Grenville; Hopetoun Park; Ingliston; Korobeit; Korweinguboora; Lal Lal; Leigh Creek; Lerderderg; Long Forest; Maddingley; Meredith; Merrimu; Millbrook; Mollongghip; Morrisons; Mount Doran; Mount Egerton; Mount Wallace; Myrniong; Navigators; Parwan; Pentland Hills; Pootilla; Rowsley; Scotsburn; Spargo Creek; Springbank; Trentham; Wallace; Warrenheip; Wattle Flat; Yendon | Central Highlands | West | Central Highlands | Ballarat Health Services | WEPHU | Grampians - Lead - Ballarat Health | Yes |
| Moreland City | Brunswick, Brunswck East, Brunswick West, Coburg, Coburg North, Fawkner, Fitzroy North (Part), Glenroy, Hadfield, Oak Park, Pascoe Vale, Pascoe Vale South, Tullamarine (Part) | Hume Moreland | North | Moreland | Merri Health | WEPHU | North Metro - Lead - Austin Health |  |
| Mornington Peninsula Shire | Arthurs Seat, Balnarring, Balnarring Beach, Baxter, Bittern, Blairgowrie, Boneo, Cape Schanck, Crib Point, Dromana, Fingal, Flinders, Hastings, HMAS Cerberus, Kunyung, Main Ridge, Mccrae, Merricks, Merricks Beach, Merricks North, Moorooduc, Mornington, Mount Eliza, Mount Martha, Pearcedale, Point Leo, Portsea, Red Hill, Red Hill South, Rosebud, Rosebud West, Rye, Safety Beach, Shoreham, Somers, Somerville, Sorrento, St Andrews Beach, Tootgarook, Tuerong And Tyabb | Bayside Peninsula Area (BPA) | South | Bayside Peninsula Lower (Frankston, Mornington Peninsula) | Peninsula Health | SEPHU | South Metro - Lead - Alfred Health |  |
| Mount Alexander Shire | Barfold; Baringhup; Baringhup West; Barkers Creek; Bradford; Campbells Creek; Campbelltown; Carisbrook; Castlemaine; Chewton; Chewton Bushlands; Drummond North; Eastville; Eddington; Elphinstone; Faraday; Franklinford; Fryerstown; Glenluce; Golden Point (Castlemaine); Gower; Green Gully; Greenhill; Guildford; Harcourt; Harcourt North; Irishtown; Joyces Creek; Langley; Lockwood South; Maldon; Malmsbury; Mckenzie Hill; Metcalfe; Metcalfe East; Moolort; Moonlight Flat (Castlemaine); Muckleford; Muckleford South; Myrtle Creek; Neereman; Newstead; Nuggetty; Ravenswood; Ravenswood South; Redesdale; Sandon; Shelbourne; Strangways; Strathlea; Sutton Grange; Taradale; Tarilta; Tarrengower; Vaughan; Walmer; Welshmans Reef; Werona; Yandoit Hills; Yapeen; | Loddon | North  | Loddon | Bendigo Community Health Service | Bendigo Health | Grampians - Lead - Ballarat Health | Yes |
| Moyne Shire | Allansford; Ayrford; Ballangeich; Bessiebelle; Breakaway Creek; Broadwater; Brucknell; Bushfield; Byaduk; Caramut; Chatsworth; Codrington; Condah Swamp; Crossley; Cudgee; Curdievale; Darlington; Dennington; Dundonnell; Ecklin South; Ellerslie; Framlingham; Framlingham East; Garvoc; Gazette; Gerrigerrup; Glenormiston North; Grassmere; Hawkesdale; Hexham; Heytesbury Lower; Illowa; Killarney; Kirkstall; Knebsworth; Kolora; Koroit; Laang; Lake Condah; Macarthur; Mailors Flat; Mepunga; Mepunga East; Mepunga West; Minhamite; Minjah; Mortlake; Nareeb; Naringal; Naringal East; Nerrin Nerrin; Nirranda; Nirranda East; Nirranda South; Noorat; Nullawarre; Nullawarre North; Orford; Panmure; Penshurst; Peterborough; Port Fairy; Pura Pura; Purdeet; Purnim; Purnim West; Rosebrook; Southern Cross; St Helens; Taroon; Tarrone; Terang; The Cove; The Sisters; Toolong; Tower Hill; Tyrendarra; Tyrendarra East; Wallacedale; Wangoom; Warrabkook; Warrnambool; Warrong; Willatook; Winslow; Woodford; Woolsthorpe; Woorndoo; Yambuk; Yangery; Yarpturk | Wimmera South West | West | WSW - South West | South West Health Care | Barwon Health | Barwon South West - Lead agency: Barwon Health | Yes |
| Murrindindi Shire | Acheron, Alexandra, Buxton, Cathkin, Castella, Caveat, Devils River, Dropmore, Eildon, Fawcett, Flowerdale, Ghin Ghin, Glenburn, Gobur, Granton, Highlands, Homewood, Kanumbra, Kerrisdale, Killingworth, Kinglake, Kinglake Central, Kinglake West, Koriella, Limestone, Maintongoon, Molesworth, Murrindindi, Pheasant Creek, Rubicon, Strath Creek, Taggerty, Taylor Bay, Terip Terip, Thornton, Toolangi, Whanregarwen, Yarck, Yea | Goulburn  | East | Goulburn  | Primary Care Connect | Goulburn Health | Hume - Goulburn Valley Health | Yes |
| Murrindindi Shire |  Marysville, Narbethong | Goulburn  | East | Goulburn  | Primary Care Connect | NEPHU | Hume - Goulburn Valley Health | Yes |
| Nillumbik Shire | Eltham, Diamond Creek, Arthurs Creek, Bend Of Islands, Christmas Hills, Cottles Bridge, Doreen (Parts), Kangaroo Ground, Panton Hill, Kinglake (Parts), Kinglake West (Parts), North Warrandyte, Nutfield, Plenty, Research, Smiths Gully, Research, Strathewen, Watsons Creek, Wattle Glen, Yan Yean, Yarrambat. | North East Melbourne  | North  | North East Melborne | DPV Health | NEPHU | North Metro - Lead - Austin Health | Yes |
| Northern Grampians Shire | Archdale; Archdale Junction; Avon Plains; Banyena; Barkly; Beazleys Bridge; Bellellen; Bellfield (Grampians); Black Range; Bolangum; Brimpaen; Bulgana; Callawadda; Campbells Bridge; Carapooee; Carapooee West; Cherrypool; Concongella; Coonooer Bridge; Coonooer West; Cope Cope; Crowlands; Dadswells Bridge; Dalyenong; Deep Lead; Dunneworthy; Emu; Fyans Creek; Germania; Glenisla; Glenorchy; Gooroc; Gowar East; Grays Bridge; Gre Gre; Gre Gre North; Gre Gre South; Great Western; Greens Creek; Halls Gap; Illawarra; Joel Joel; Joel South; Kanya; Kooreh; Laen; Laharum; Lake Fyans; Lake Lonsdale; Landsborough West; Ledcourt; Logan; Lubeck; Marnoo; Marnoo East; Marnoo West; Mokepilly; Moolerr; Morrl Morrl; Mount Dryden; Moyreisk; Natte Yallock; Navarre; Paradise; Pomonal; Redbank; Riachella; Rich Avon East; Rich Avon West; Roses Gap; Rostron; Rupanyup; Shays Flat; Slaty Creek; St Arnaud; St Arnaud East; St Arnaud North; Stawell; Stuart Mill; Sutherland; Swanwater; Swanwater West; Tottington; Traynors Lagoon; Tulkara; Wal Wal; Wallaloo; Wallaloo East; Wartook; Wattle Creek; Winjallok; York Plains; Zumsteins | Wimmera South West | West | WSW - Wimmera | Grampians Community Health | Ballarat Health | Grampians - Lead - Ballarat Health | Yes |
| Port Phillip City | Albert Park, Balaclava, Elwood, Garden City, Melbourne, Middle Park, Port Melbourne, Ripponlea, South Melbourne, Southbank, St Kilda, St Kilda East, St Kilda West And Windsor | Bayside Peninsula Area (BPA) | South | Port Phillip | Star Health | SEPHU | South Metro - Lead - Alfred Health |  |
| Pyrenees Shire | Amphitheatre; Avoca; Barkly; Beaufort; Bo Peep; Brewster; Buangor; Bung Bong; Burnbank; Burrumbeet; Carngham; Carranballac; Chepstowe; Chute; Cross Roads; Crowlands; Elmhurst; Ercildoune; Evansford; Eversley; Frenchmans; Glenbrae; Glenlofty; Glenlogie; Glenpatrick; Hillcrest; Homebush; Lake Goldsmith; Lake Wongan; Lamplough; Landsborough; Landsborough West; Langi Kal Kal; Lexton; Lillicur; Linton; Main Lead; Mena Park; Middle Creek; Moonambel; Mount Emu; Mount Lonarch; Natte Yallock; Navarre; Nerring; Nowhere Creek; Percydale; Pittong; Raglan; Rathscar; Rathscar West; Redbank; Shays Flat; Skipton; Smythesdale; Snake Valley; Stockyard Hill; Stoneleigh; Streatham; Tanwood; Trawalla; Wareek; Warrenmang; Waterloo; Wattle Creek; Waubra | Central Highlands | West | Central Highlands | Ballarat Health Services | Ballarat Health | Grampians - Lead - Ballarat Health | Yes |
| South Gippsland Shire | Agnes, Allambee Reserve, Allambee South, Arawata, Baromi, Bena, Bennison, Berrys Creek, Binginwarri, Boolarong, Boolarra, Boolarra South, Boorool, Buffalo, Darlimurla, Delburn, Dollar, Dumbalk, Dumbalk North, Fairbank, Fish Creek, Foster, Foster North, Gunyah, Hallston, Hazel Park, Hedley, Hoddle, Inverloch, Jeetho, Jumbunna, Kardella, Kardella South, Kongwak, Koonwarra, Koorooman, Korumburra, Korumburra South, Krowera, Lang Lang, Leongatha, Leongatha North, Leongatha South, Limonite, Loch, Mardan, Meeniyan, Middle Tarwin, Mirboo, Mirboo East, Mirboo North, Mount Best, Mount Eccles, Mount Eccles South, Mountain View, Moyarra, Nerrena, Nyora, Outtrim, Poowong, Poowong East, Poowong North, Port Franklin, Port Welshpool, Pound Creek, Ranceby, Ruby, Sandy Point, Stony Creek, Strzelecki, Tarwin, Tarwin Lower, Thorpdale, Thorpdale South, Tidal River, Toora, Toora North, Trida, Turtons Creek, Venus Bay, Walkerville, Walkerville South, Waratah Bay, Welshpool, Whitelaw, Wild Dog Valley, Wilsons Promontory, Wonga, Wonyip, Woorarra West And Yanakie | Inner Gippsland Area (IGA) | South | Inner Gippsland  | La Trobe Community Health Service | La Trobe Health | Gippsland - Lead - La Trobe Regional Health |  |
| Southern Grampians Shire | Balmoral; Bellfield (Grampians); Bochara; Branxholme; Brit Brit; Buckley Swamp; Bulart; Byaduk; Byaduk North; Caramut; Carapook; Cavendish; Cherrypool; Clover Flat; Coleraine; Coojar; Croxton East; Culla; Dunkeld; Englefield; Gatum; Gazette; Glenisla; Glenthompson; Grampians; Gringegalgona; Gritjurk; Hamilton; Harrow; Hensley Park; Hilgay; Karabeal; Konongwootong; Melville Forest; Mirranatwa; Mooralla; Morgiana; Mount Napier; Moutajup; Muntham; Nareeb; Nareen; Penshurst; Pigeon Ponds; Purdeet; Rocklands; Strathkellar; Tabor; Tahara; Tarrayoukyan; Tarrenlea; Tarrington; Vasey; Victoria Point; Victoria Valley; Wando Vale; Wannon; Warrayure; Woodhouse; Wootong Vale; Yatchaw; Yulecart | Wimmera South West | West | WSW - South West | South West Health Care | Barwon Health | Barwon South West - Lead agency: Barwon Health |  |
| Stonnington City | Armadale, Glen Iris, Hawksburn, Kooyong, Malvern, Malvern East, Prahran, South Yarra, Toorak And Windsor | Bayside Peninsula Area (BPA) | South | Stonnington | Star Health | SEPHU | South Metro - Lead - Alfred Health | Yes |
| Strathbogie Shire | Arcadia South, Avenel, Baddaginnie, Bailieston, Balmattum, Boho, Boho South, Creek Junction, Creighton, Creightons Creek, Earlston, Euroa, Gooram, Goulburn Weir, Graytown, Kelvin View, Kirwins Bridge, Kithbrook, Koonda, Locksley, Longwood, Longwood East, Mangalore, Marraweeny, Miepoll, Mitchellstown, Moglonemby, Molka, Moorilim, Moormbool West, Nagambie, Nalinga, Pranjip, Riggs Creek, Ruffy, Sheans Creek, Strathbogie, Tabilk, Tamleugh, Tarcombe, Upotipotpon, Upton Hill, Violet Town, Wahring, Whroo, Wirrate | Goulburn  | East | Goulburn  | Primary Care Connect | Goulburn Health | Hume - Goulburn Valley Health | Yes |
| Surf Coast Shire | Aireys Inlet; Anglesea; Bambra; Barrabool; Bellbrae; Bells Beach; Benwerrin; Big Hill (Lorne); Birregurra; Boonah; Breamlea; Buckley; Connewarre; Deans Marsh; Eastern View; Fairhaven; Freshwater Creek; Gherang; Gnarwarre; Inverleigh; Jan Juc; Lorne; Modewarre; Moggs Creek; Moriac; Mount Duneed; Mount Moriac; Ombersley; Paraparap; Pennyroyal; Torquay; Wensleydale; Winchelsea; Winchelsea South; Wurdiboluc | Barwon | West | Barwon | Barwon Health | Barwon Health | Barwon South West - Lead agency: Barwon Health | Yes |
| Swan Hill Rural City | Annuello; Bannerton; Beauchamp; Beverford; Bolton; Boundary Bend; Bulga; Castle Donnington; Chillingollah; Chinangin; Chinkapook; Cocamba; Fish Point; Gerahmin; Goschen; Gowanford; Happy Valley (Swan Hill); Kenley; Kooloonong; Kunat; Lake Boga; Lake Powell; Liparoo; Manangatang; Meatian; Miralie; Murnungin; Murrawee; Murraydale; Narrung; Natya; Nowie; Nyah; Nyah West; Nyrraby; Pental Island; Piangil; Pira; Polisbet; Robinvale; Robinvale Irrigation District Section B; Robinvale Irrigation District Section C; Robinvale Irrigation District Section D; Robinvale Irrigation District Section E; Speewa; Swan Hill; Swan Hill West; Tol Tol; Towan; Tresco; Tresco West; Turoar; Tyntynder; Tyntynder South; Tyrrell; Ultima; Ultima East; Vinifera; Waitchie; Wandown; Wemen; Winlaton; Winnambool; Wood Wood; Woorinen; Woorinen North; Woorinen South; | Mallee | North  | Southern Mallee | Swan Hill District Health | Bendigo Health | Loddon Mallee - Bendigo Health | Yes |
| Towong Shire | Bellbridge, Berringama, Bethanga, Biggara, Bullioh, Bungil, Burrowyne, Colac Colac, Corryong, Cudgewa, Dartmouth, Eskdale, Georges Creek, Granya, Guys Forest, Huon, Jarvis Creek, Koetong, Lucyvale, Mitta Mitta, Mount Alfred, Nariel Valley, Old Tallangatta, Pine Mountain, Shelley, Talgarno, Tallandoon, Tallangatta, Tallangatta East, Tallangatta South, Tallangatta Valley, Thologolong, Thowgla Valley, Tintaldra, Tom Groggin, Towong, Towong Lower, Walwa | Ovens Murray | East | Ovens Murray | Gateway Health | Albury Health | Hume - Goulburn Valley Health | Yes |
| Wangaratta Rural City | Archerton, Bobinawarrah, Boorhaman, Boorhaman East, Boorhaman North, Boralma, Boweya, Bowmans Forest, Bowser, Byawatha, Carboor, Cheshunt, Cheshunt South, Docker, Dockers Plains, Edi, Edi Upper, Eldorado, Everton, Everton Upper, Glenrowan, Greta, Greta South, Greta West, Hansonville, Killawarra, King Valley, Laceby, Londrigan, Lurg Upper, Markwood, Meadow Creek, Milawa, Moyhu, Murmungee, Myrrhee, Oxley, Oxley Flats, Peechelba, Peechelba East, Rose River, Springhurst, Tarrawingee, Tatong, Tolmie, Wabonga, Waldara, Wangandary, Wangaratta, Wangaratta East, Wangaratta North, Wangaratta South, Whitfield, Whitlands, Whorouly, Whorouly East, Whorouly South, Yarrunga. | Ovens Murray | East | Ovens Murray | Gateway Health | Goulburn Health | Hume - Goulburn Valley Health | Yes |
| Warrnambool City | Allansford; Bushfield;Dennington;Illowa;Warrnambool;Woodford;Yangery | Wimmera South West | West | WSW - South West | South West Health Care |  | Barwon South West - Lead agency: Barwon Health | Yes |
| Wellington Shire | Airly, Alberton, Alberton West, Arbuckle, Balook, Billabong, Binginwarri, Blackwarry, Boisdale, Briagolong, Budgee Budgee, Bundalaguah, Buragwonduc, Bushy Park, Callignee North, Callignee South, Calrossie, Carrajung, Carrajung Lower, Carrajung South, Castleburn, Cherrilong, Christies, Clydebank, Cobains, Coongulla, Cowa, Cowwarr, Crookayan, Crooked River, Dargo, Darriman, Dawson, Denison, Devon North, Dutson, Dutson Downs, Fernbank, Flamingo Beach, Flynn, Flynns Creek, Fulham, Gelliondale, Giffard, Giffard West, Gillum, Glen Falloch, Glengarry, Glenmaggie, Glomar Beach, Golden Beach, Gormandale, Grand Ridge, Greenmount, Hawkhurst, Hedley, Heyfield, Hiamdale, Hiawatha, Hollands Landing, Howitt Plains, Hunterston, Jack River, Johnstones Hill, Kilmany, Koorool, Lake Wellington, Langsborough, Licola, Licola North, Llowalong, Loch Sport, Longford, Macks Creek, Madalya, Maffra, Maffra West Upper, Manns Beach, Mcloughlins Beach, Meerlieu, Mewburn Park, Miowera, Monomak, Montgomery, Moornapa, Moroka, Mount Buller, Munro, Myrtlebank, Nambrok, Nap Nap Marra, Newry, Nuntin, Ocean Grange, Paradise Beach, Pearsondale, Perry Bridge, Port Albert, Reynard, Riverslea, Robertsons Beach, Rosedale, Sale, Sale East, Sargood, Seacombe, Seaspray, Seaton, Snake Island, Staceys Bridge, Stockdale, Stradbroke, Stratford, Tamboritha, Tarra Valley, Tarraville, The Heart, The Honeysuckles, Tinamba, Tinambra West, Toolome, Toongabbie, Toora North, Valencia Creek, Walhalla, Walhalla East, Waterford, Willung, Willung South, Winnindoo, Won Wron, Wongungarra, Wonyip, Woods Point, Woodside, Woodside Beach, Woodside North, Woolenook, Woorarra, Worrowing, Wrathung, Wrixen, Wurruk, Yangoura And Yarram. | Outer Gippsland Area (OGA) | South | Wellington | Central Gippsland Health Service | La Trobe Health | Gippsland - Lead - La Trobe Regional Health | Yes |
| West Wimmera Shire | Apsley; Benayeo; Big Desert; Bringalbert; Broughton; Charam; Chetwynd; Connewirricoo; Dergholm; Dorodong; Douglas; Edenhope; Goroke; Grass Flat; Gymbowen; Harrow; Kadnook; Kaniva; Karnak; Langkoop; Lawloit; Lillimur; Miga Lake; Minimay; Miram; Mitre; Neuarpurr; Nurcoung; Ozenkadnook; Patyah; Peronne; Poolaijelo; Powers Creek; Serviceton; Tarrayoukyan; Telopea Downs; Ullswater; Wombelano | Wimmera South West | West | WSW - Wimmera | Grampians Community Health | Ballarat Health | Grampians - Lead - Ballarat Health | Yes |
| Whitehorse City | Blackburn, Blackburn North, Blackburn South, Box Hill, Box Hill North, Box Hill South, Burwood, Burwood East, Forest Hill, Mitcham, Mont Albert, Mont Albert North, Nunawading, Surrey Hills, Vermont And Vermont South | Inner Eastern | East | Inner Eastern | Access Community Health | NEPHU | South and East Metro - Lead - Monash  | Yes |
| Whittlesea City | Beveridge (Part), Bundoora (Part), Donnybrook, Doreen (Part), Eden Park, Epping, Humevale, Kinglake West (Part), Lalor, Mernda, Mill Park, South Morang, Thomastown, Whittlesea, Wollert, Woodstock And Yan Yean (Part). | North East Melbourne   | North  | North East Mebourne | DPV Health | NEPHU | North Metro - Lead - Austin Health | Yes |
| Wodonga City | Bandiana, Baranduda, Barnawartha North, Bonegilla, Castle Creek, Ebden, Gateway Island, Hume Weir, Huon Creek, Killara, Leneva, Staghorn Flat, Wodonga And Wodonga West  | Ovens Murray | East | Ovens Murray | Gateway Health | Albury Wodonga Health | Hume - Goulburn Valley Health | Yes |
| Wyndham City | Cocoroc; Eynesbury; Hoppers Crossing; Laverton; Laverton North; Little River; Mambourin; Mount Cottrell; Point Cook; Quandong; Tarneit; Truganina; Werribee; Werribee South; Williams Landing; Wyndham Vale | Western Melbourne | West | Western Melbourne | cohealth | WEPHU | West Metro - Lead - Melbourne Health | Yes |
| Yarra City | Abbotsford, Alphington (Part), Burnley, Carlton North (Part), Clifton Hill, Collingwood, Cremorne, Fairfield (Part), Fitzroy, Fitzroy North (Part), Princes Hill And Richmond. | North East Melbourne  | North | Yarra, (Fitzroy Collingwoo) | cohealth | NEPHU | North Metro - Lead - Austin Health | Yes |
| Yarra City | Richmond | North East Melbourne | North | Yarra, (Richmond) | North Richmond Community Health | NEPHU | North Metro - Lead - Austin Health | Yes |
| Yarra Ranges Shire | Narree Warren East | Outer Eastern | East | Outer Eastern | EACH | SEPHU | South and East Metro - Lead - Monash  | Yes |
| Yarra Ranges Shire | Badger Creek, Beenak, Belgrave, Belgrave Heights, Belgrave South, Big Pats Creek, Cambarville, Chirnside Park, Chum Creek, Clematis, Coldstream, Dixons Creek, Don Valley, Emerald, Fernshaw, Ferny Creek, Gilderoy, Gladysdale, Gruyere, Healesville, Hoddles Creek, Kallista, Kalorama, Kilsyth, Launching Place, Lilydale, Lysterfield, Macclesfield, Matlock, Mcmahons Creek, Menzies Creek, Millgrove, Monbulk, Montrose, Mooroolbark, Mount Dandenong, Mount Evelyn, Mount Toolebewong, Olinda, Powelltown, Reefton, Sassafras, Selby, Seville, Seville East, Sherbrooke, Silvan, Steels Creek, Tarrawarra, Tecoma, The Patch, Three Bridges, Toolangi, Toorongo, Tremont, Upper Ferntree Gully, Upwey, Wandin East, Wandin North, Warburton, Warburton East, Wesburn, Woori Yallock, Yarra Glen, Yarra Junction, Yellingbo, Yering | Outer Eastern | East | Outer Eastern | EACH | NEPHU | South and East Metro - Lead - Monash  | Yes |
| Yarriambiack Shire | Areegra; Aubrey; Bangerang; Beulah; Boolite; Brim; Cannum; Crymelon; Dimboola; Hopetoun; Jung; Kellalac; Kewell; Laen; Lah; Lascelles; Lawler; Longerenong; Lubeck; Minyip; Murra Warra; Murtoa; Patchewollock; Rainbow; Rosebery; Rupanyup; Sheep Hills; Speed; Tempy; Turriff; Wallup; Warracknabeal; Watchem West; Wilkur; Willenabrina; Woomelang; Yaapeet | Wimmera South West | West | WSW - Wimmera | Grampians Community Health | Ballarat Health | Grampians - Lead - Ballarat Health | Yes |

## Appendix 7: Glossary

| Term | Definition |
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| **Aboriginal** | Aboriginal people are the First Peoples and Traditional Owners and custodians of the land and water on which we rely. In the context of the High-Risk Accommodation Response the Aboriginal community is a high-risk group requiring specialised medical and cultural considerations in the application of COVID-19 prevention and treatment. |
| **Aboriginal Community Controlled Organisation (ACCO) officer** | An ACCO is an independent, not-for-profit organisation, that is incorporated as an Aboriginal organisation. An ACCO has been initiated by and is controlled and operated by Aboriginal people; thereby acknowledging the right of Aboriginal peoples to self-determination. ACCOs deliver services that build strength and empowerment in Aboriginal communities and people. |
| **Accessibility** | Clear, accessible, culturally, linguistically and religiously appropriate and authoritative public health and support service information.  |
| **Aged Care Accommodation** | This is accommodation for people who are no longer able to live independently in their own homes. This could be due to a wide variety of causes, including psycho-social needs. This type of accommodation is out of scope for the High-Risk Accommodation Response. Aged Care is regulated by the Commonwealth government. |
| **Auslan** | Auslan is short for Australian sign language, a language developed by, and for, Australians who are deaf or hearing impaired. It’s a visual form of communication that uses hand, arm and body movements to convey meaning. |
| **Backpacker Hostel** | Low-cost, short-term shared sociable lodging where guests rent a bed, usually a bunk bed in a dormitory, with shared use of a lounge and sometimes a kitchen. Rooms can be mixed or single-sex and have private or shared bathrooms.  |
| **Biohazard Waste** | Bodily fluid or tissues which hold the potential to transmit disease. Biohazard waste needs to be disposed of following strict Australian standards. This waste carries the high likelihood of transmitting human pathogens, which also include the COVID-19 virus. |
| **Caravan Park** | An area containing caravans either for holiday rental, holiday use or permanent living. Guests may share multiple amenities including bathrooms, kitchen, BBQ areas, recreational areas and swimming pools. |
| **Case numbers** | The number of residents, or members of the public infected with COVID-19.  |
| **Catchment** | A geographical area sectioned according to the Local Government Area (for areas with a high density of units) or DFFH area boundaries (for remaining areas). Each Lead Provider is responsible for assigned catchment areas. There are 26 in total.  |
| **Catchment Leadership Group** | The Catchment Leadership Group is chaired by the Lead Provider in each of the 31 catchments and is a forum which brings together all partner organisations working to provide HRAR supports in that catchment. |
| **Lead Provider** | Lead Provider and partner agencies delivering HRAR operations.  |
| **Community Capacity Building Initiative** | Non Governmental Organization to contribute to the mitigation of poverty, health, gender and environment related problems by enhancing the capacity of communities to access and utilize knowledge and resources for the benefit of these communities. |
| **Community Engagement** | Written or verbal communication, which keep residents and the community informed of progress and next steps of the HRAR. Community engagement also includes working with community leaders and trusted providers to provide and reinforce public health messaging to residents. Engagement is accessible and includes the use of a translators and culturally appropriate resources. |
| **Community Safety** | A joint response from all parties within the HRAR, including the Victoria Police, to ensure the physical and mental safety of residents and compliance with relevant laws and public health directions.  |
| **Community Transmission** | A type of transition of COVID-19 or any infectious disease where there is no clear origin of the infection in a new community. Community transmission occurs when you can no longer identify who became infected after being exposed to someone who interacted with people from the originally infected communities. |
| **COVID-19** | COVID-19 is a disease caused by a new strain of coronavirus.  |
| **Culturally appropriate** | Communications and responses which are developed with care and insight into residents’ culture and ideally in collaboration with residents. Culturally appropriate communications and responses create a culturally safe environment, where residents feel safe and there is no denial or challenge of their identity.  |
| **Safety Data Sheet (SDS)** | A document which identifies hazardous chemicals. The document includes:* the chemical’s identity and ingredients
* health and physical [hazards](https://www.safeworkaustralia.gov.au/glossary#hazards)
* safe handling and storage procedures
* emergency procedures
* disposal considerations
 |
| **Epidemiology** | The branch of medicine which deals with the incidence, distribution, and possible control of diseases and other factors relating to health.  |
| **Family Violence Refuge** | Confidential and a safe space for women and children escaping family violence. |
| **Food and Aid** | Essential items residents may require meeting their basic needs. These include may not be limited to food, sanitary items, pharmaceuticals, medical and nursing care, and water.  |
| **Health Services** | A service offering in-home or virtual health supports to residents while deploying the HRAR. |
| **High-rise public housing**  | Where there is high density of residents living across a multi-storey public housing estate.  |
| **High-risk shared accommodation** | These accommodation sites are determined by their lay-out, shared facilities and the residents within the dwelling. High-rise towers are automatically a high-risk setting, however medium and low-rise public housing will require a case by case assessment by the Catchment Provider (health lead) in consultation with the department. |
| **Infection prevention and Control (IPC)** | Infection prevention and control (IPC) is a scientific approach and practical solution designed to prevent harm caused by infection to patients and health workers. It is grounded in infectious diseases, epidemiology, social science and health system strengthening. IPC occupies a unique position in the field of patient safety and quality universal health coverage since it is relevant to health workers and patients at every single health-care encounter. |
| **Interpreter** | [The interpreter’s role is to accurately convey the whole spoken message from one language to another while abiding by the Australian Institute of Interpreters and Translators (AUSIT) Code of Ethics.](http://www.ausit.org/) <http://www.ausit.org/> |
| **Leadership and community** | Community leaders (where possible, local residents) who reflect the gender, age, cultural and other diversity of residents will be empowered to be critical agents in supporting communities. There will be a focus on building the community to be stronger, and more resilient than before the pandemic.  |
| **Lead Provider** | Responsible for delivery of HRAR operations aligned to agreed standards. This also includes any partner agencies.  |
| **Learning and improvement** | A commitment to learning that incorporates the experience of residents and responds effectively to those lessons. Public health education and engagement campaigns remain an important part of Government’s overall response. This is particularly true in public housing settings. |
| **LGBTIQ** | Lesbian, Gay, Bisexual, Trans and Gender Diverse, Intersex and Queer/Questioning. |
| **Local Social Support Network** | A support network consisting of: social service navigator(s), and key local community support officers. |
| **Low Density Housing** | Includes a large detached home on a very large residential block, or houses which have their own block of land. This type of accommodation is out of scope for the High-Risk Accommodation Response. |
| **Low-rise public housing (metro and regional)**  | Low-rise public housing potentially has more than one house or unit on the block. There are in-scope for the High-Risk Accommodation Response when there are shared facilities (i.e. laundry, kitchen) or access points (i.e. lifts, stairs). They could also be deemed in-scope when there is identified risks which could be large families living in one house or serious co-morbidities within the housing community, making the residents more likely to transmit COVID-19 and with poorer health outcomes. |
| **National Relay Service (NRS)** | The National Relay Service (NRS) is a government initiative that allows people who are deaf, hard of hearing and/or have a speech impairment to make and receive phone calls. |
| **Non-government** | Non-government and high-risk accommodation with shared facilities (including private providers) covers many types of accommodation. Examples include supported residential services, rooming houses, other high-density settings with vulnerable populations and compliance issues (case by case), for example a backpacker hostel, caravan park or retirement living park. |
| **Outbreak** | Disease outbreaks are usually caused by an infection, transmitted through person-to-person contact, animal-to-person contact, or from the environment or other media.  |
| **Partnerships** | The department and Lead Provider make community partnerships with other organisations and influential members of the community to reach the health and welfare outcomes required within the HRAR model. |
| **Personal Protective Equipment (PPE)** | PPE protects the wearer from infection. Proper use helps keep health workers safe and stops the spread of COVID-19. PPE includes but is not limited to surgical masks, P2/N95 respirators, gloves, goggles, glasses, face shields, gowns and aprons. |
| **Person-centred care** | Must put the needs of the patient (and their family) at the centre of the care model through a community-led approach to ensure their holistic needs are met. |
| **Resident Voice approach** | A key aspect to the community engagement model, which empowers residents to contribute to the decisions regarding their homes and welfare.  |
| **Respect and transparency** | The department defined respect and transparency in the context of the High-Risk Accommodation Response as the safety, amenity and human rights of residents, their homes and neighbourhood will be respected. Residents will know what service response is being proposed, when/how/why this may change and have a chance to input into the ongoing care and support available for their community. |
| **Social Services** | Services which positively impact the wellbeing of the community.  |
| **Stage of restrictions within the community** | Directions issued by the Victorian Chief Health Officer (CHO) to help contain the spread of COVID-19. These directions are made publicly available, and apply to the whole state, including any variations determined to individual Local Government Areas (LGA). |
| **Stand-alone housing** | A dwelling which is on its own block of land. This accommodation type is out of scope for the HRAR. |
| **Student accommodation** | Accommodation privately owned and rented by an organisation or private arrangement for student living. Although these environments may be described as high-density living, these are out of scope for the High-Risk Accommodation Response. Students living in these accommodations will be supported as part of the broader community response, including through mobile testing and engagement through Operation Drasi. |
| **Tourist and Commercial Accommodation** | Accommodation privately owned and rented by an organisation or private arrangement for tourist or commercial purposes. These accommodation types are out of scope for the HRAR. |
| **Translating and Interpreter Service (TIS)** | The Translating and Interpreting Service (TIS National) is an interpreting service provided by the Department of Home Affairs for people who do not speak English and for agencies and businesses that need to communicate with their non-English speaking clients. |

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| **DH** | Department of Health (Vic) |
| **DFFH** | Department of Families, Fairness and Housing (Vic) |
| **HSCRRC** | Human Services COVID Readiness and Response Centre |
| **RREM** | Readiness, Response and Emergency Management (a division of DFFH) |
| **CPRO** | COVID Prevention, Response Operations (a team within the RREM) |
| **PPE** | Policy Planning and Engagement (a team within the RREM) |

1. The health concierge in high rise public housing settings differs in other high-risk non-government settings where the service is generally established in a public health-led response to positive cases. (See outbreak management) [↑](#footnote-ref-1)