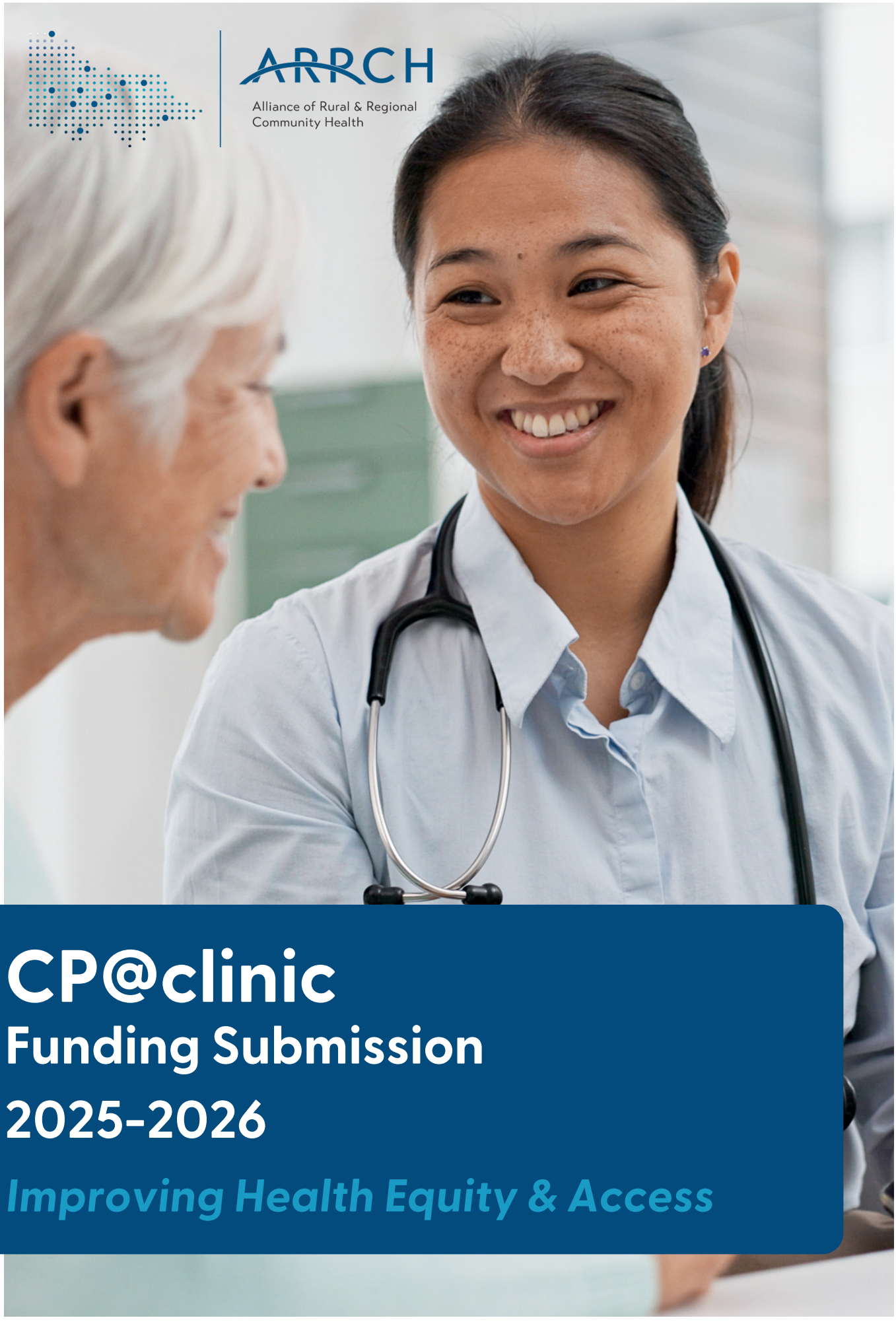
ARRCH

Alliance of Rural & Regional Community Health

ARRCH are proud members of Community Health First



ARRCH
Alliance of Rural & Regional Community Health

CP@clinic
Funding Submission 2025-2026

Improving Health Equity & Access

Contact us:

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What is CP@clinic?

CP@clinic establishes weekly drop-in centres where community paramedics help clients to unpack and work through their complex health and wellbeing needs.

This includes health checks, treating minor conditions, providing health education, and health services navigation.

CP@clinic is delivered in homes, places, and spaces where the most vulnerable populations live, not in clinical settings. Returning to the same locations at the same time each week enables the community paramedics to build trust with clients and support the management of chronic disease.

No appointments are required, and people receive a warm meal and the opportunity for social connection whilst they are having their health needs assessed and supported.

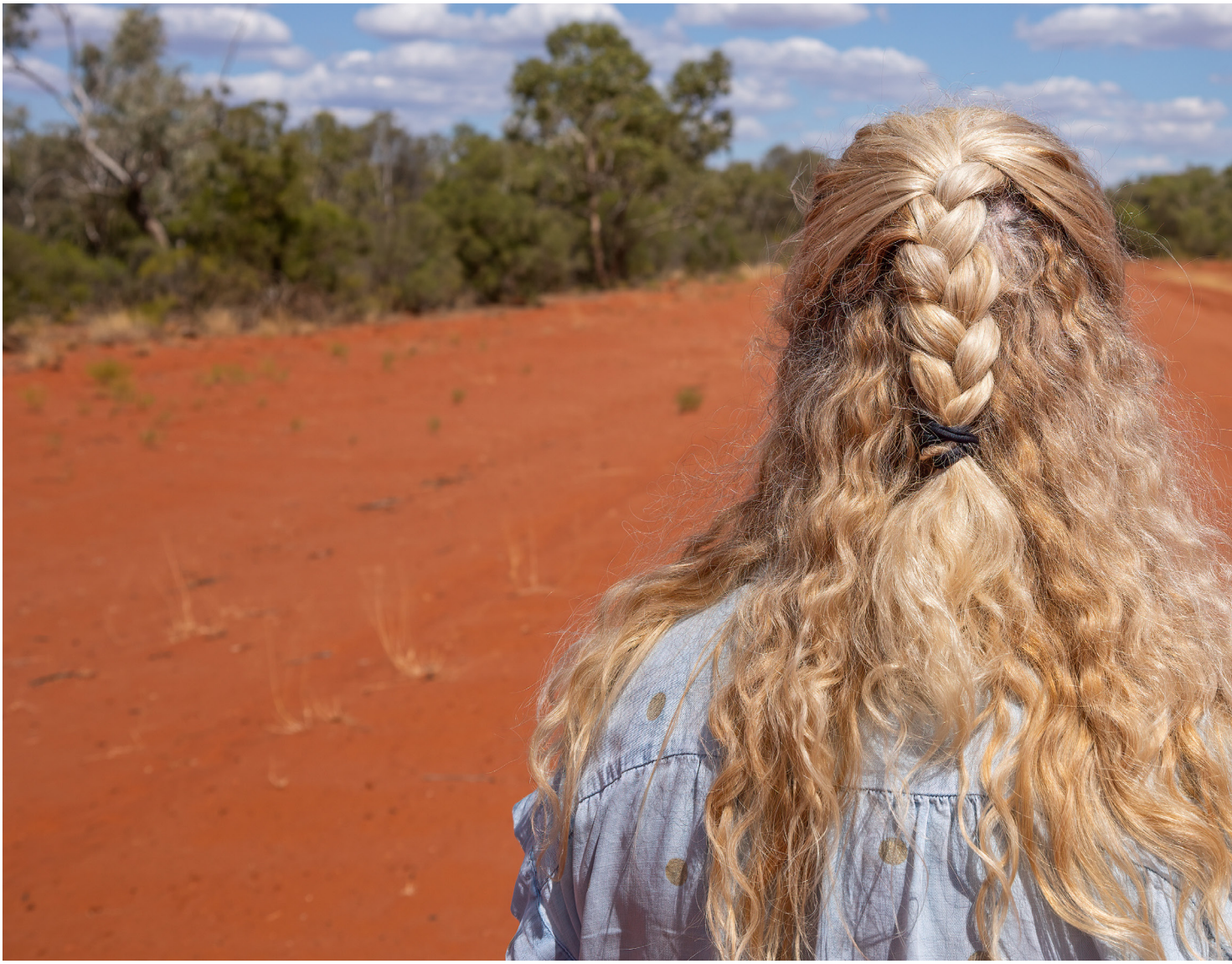
Run by community paramedics, the CP@clinic uses an available workforce, creates new jobs in rural and regional areas, and offers new career paths for paramedics to apply their extensive health knowledge and capability.

Supporting Rural and Regional Victorians

$7 million
Invested in year 1 and scaling up in subsequent years

7,000
Emergency callouts avoided

2,300
Emergency presentations avoided



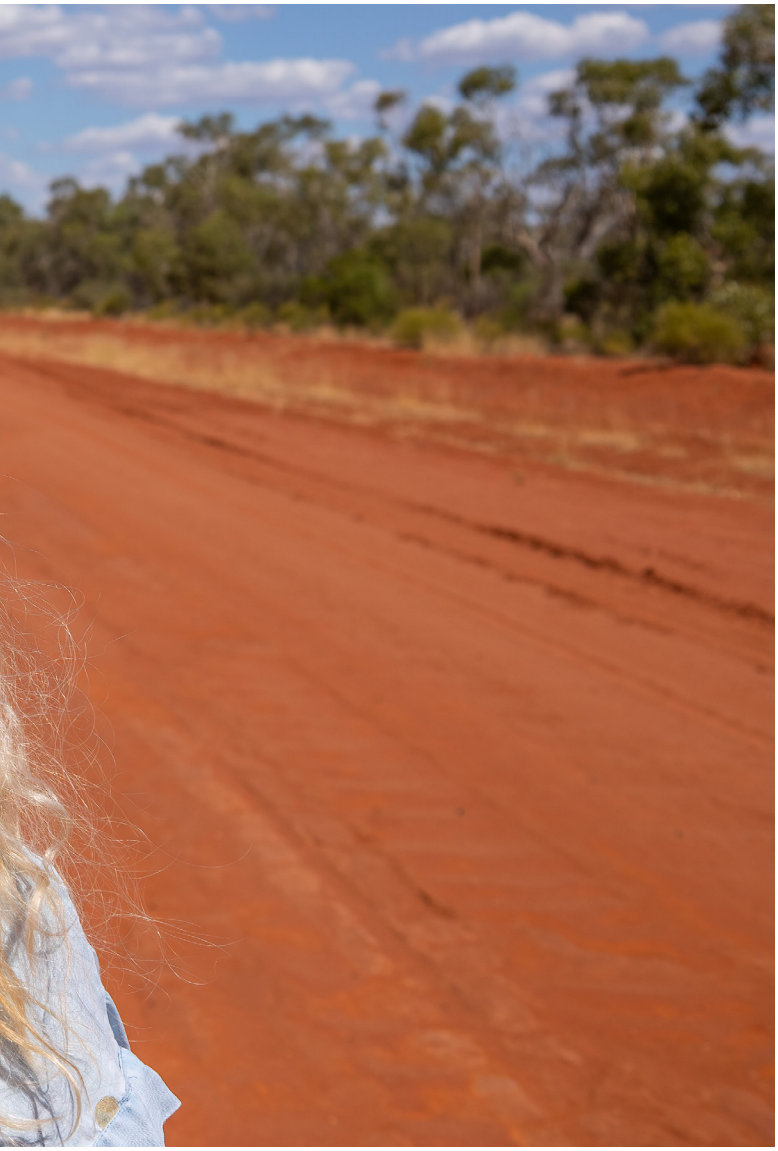
The problem CP@clinic can address

Nearly one-quarter of all Victorians live in regional and rural areas, and many have no or limited access to affordable healthcare close to home.

The clients that CP@clinic would support live in towns or areas where there are often no GPs or specialists, and where there are, the wait times are long (many practices have closed their books to new clients) or services are unaffordable as there are no bulk billing practices. Accessing medical support for this cohort often involves travelling long distances. The care is further complicated by thin markets in disability and aged care services.

The healthcare system in rural and regional Victoria is experiencing unique challenges that place significant strain on delivering timely care. Lack of accessible, affordable primary care services in many rural and regional communities means that demand for hospital services is significantly higher than in metropolitan communities as demonstrated by higher rates of preventable hospitalisation and emergency department presentations.

Emergency department presentation rates in inner and outer regional communities are 1.45 times higher than in metropolitan areas. Not only are rural and regional hospitals the most expensive setting to treat primary healthcare conditions, but hospitals are struggling to manage demand given the sustained challenges of attracting and retaining a skilled health workforce.



CP@clinic helps to ensure appropriate referrals reach primary and acute services.

Lack of accessible primary care treatment options leads to worse health and wellbeing outcomes, higher rates of cancer, chronic disease, mental ill health, and substance abuse in regional areas. These are reflected in potentially avoidable death rates for regional Australians which are 2.5 times higher than for metropolitan areas.

In addition, many “frequent flyers” (four or more visits to ED) have been shown to have more psychiatric, psychosocial, and substance abuse issues than the general population and tend to be complex to manage. These patients are more effectively managed and treated in the community. [1]

1 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2729222/

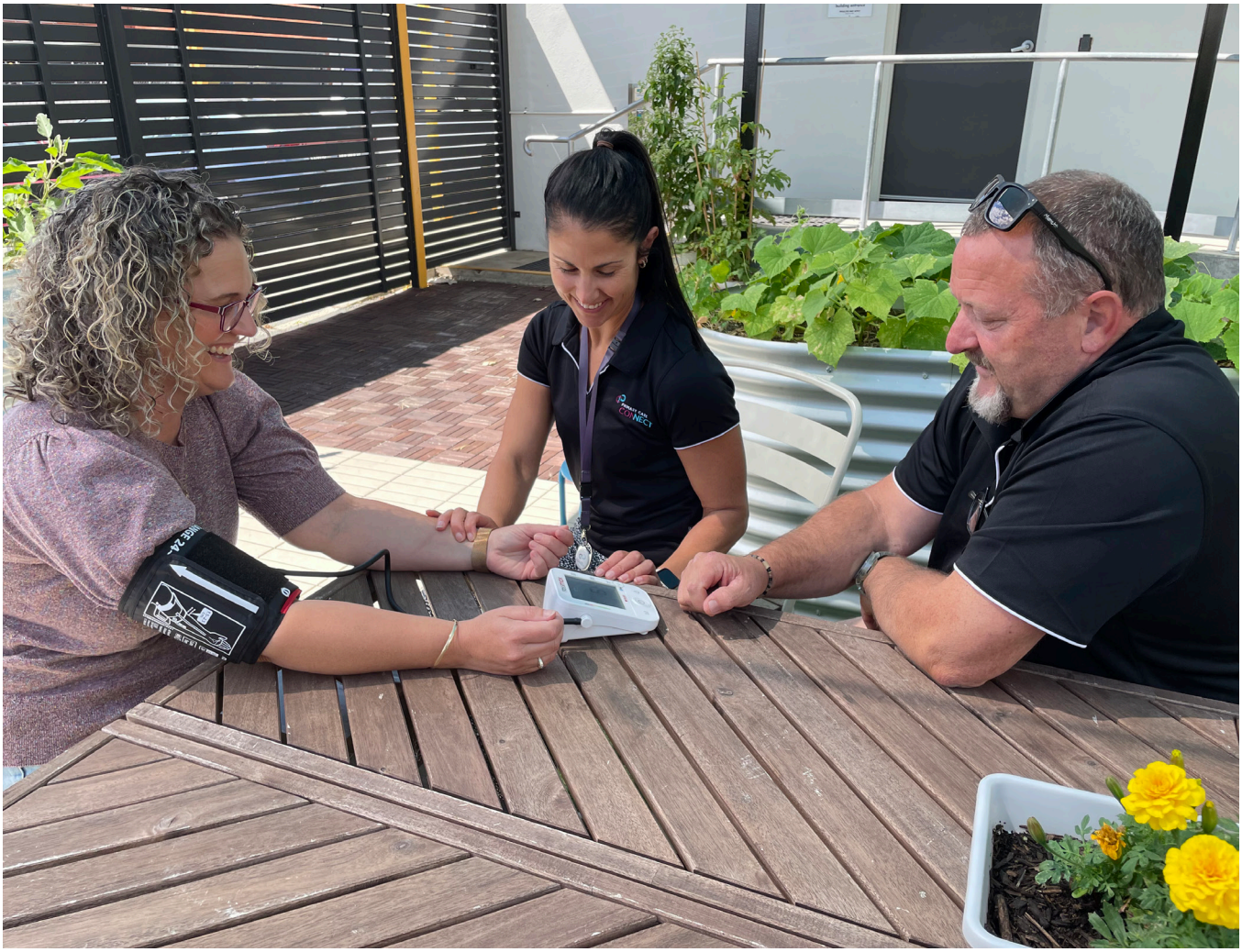
Geographical focus area

Rural and Regional Victoria

Our target client groups

People living in rural and regional Victoria who have the greatest health inequity. This includes those who have no, or limited access to health care, live with complex chronic health conditions, are socially or geographically isolated, and are unable to navigate the health system.

Prioritisation of place is based on both population health data and regular consultations with communities.

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How does CP@clinic work?

Service model

Nearly one-quarter of all Victorians live in regional and rural areas, and many have no or limited access to affordable healthcare close to home.

The CP@clinic program and supporting materials were developed, evaluated, and provided by the McMaster community paramedicine research team, led by Dr. Gina Agarwal from the Department of Family Medicine at McMaster University, Ontario, Canada.

The model has been adapted to the Australian setting by Sunraysia Community Health Services in Mildura, and research partners McMaster University and La Trobe University's, Violet Vines Mashman Centre for Rural Health Research in 2021.

In Canada, the model is operated within an ambulance jurisdiction. It was agreed in Victoria, the model fitted well with community health where there is an existing primary health and chronic disease focus, and the opportunity to facilitate access to other primary health services.

The CP@clinic supports the hardest to reach communities to:

- Manage chronic disease in the community.
- Access the right healthcare and wellbeing care and pathways to stop, slow, or treat their chronic disease.
- Address social isolation and loneliness.
- Access primary health care where the health workforce is unavailable, including navigation of primary care and community services.

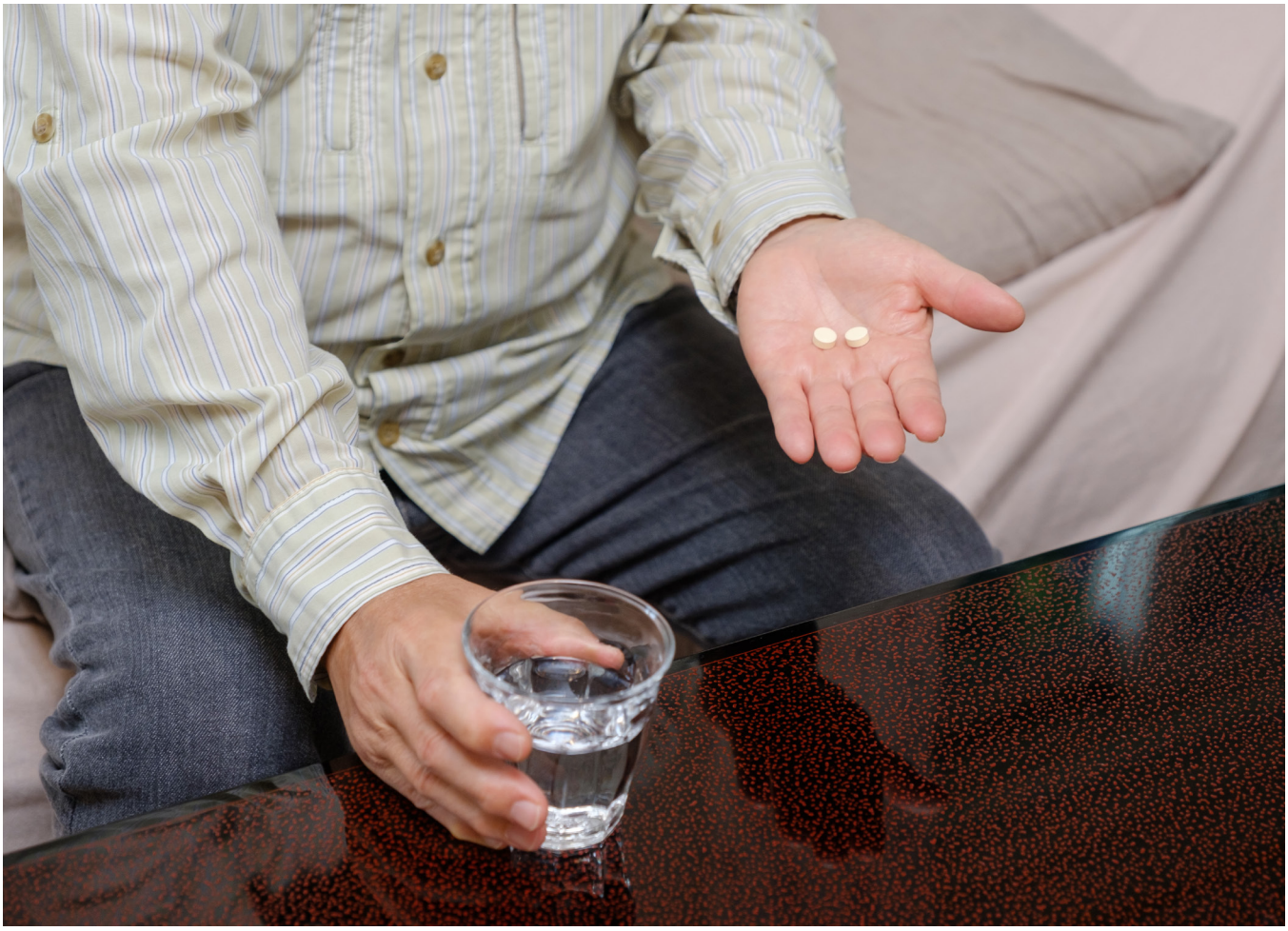
CP@clinic community paramedics utilise:

- A consistent set of evidence-based, chronic disease assessment tools.
- A standardised electronic database with built-in algorithms to analyse an individual's data and calculate the person's risk rating.
- Risk ratings aligned to a robust clinical pathway framework that prescribes the best course of action ranging from health literacy and education to urgent treatment. There is capacity and interest for these pathways to be aligned with the Primary Health Network (PHN) in the future.

CP@clinic© McMaster University | Family Medicine

LA TROBE UNIVERSITY | Violet Vines Marshman Centre For Rural Health Research

Case Studies



Case Study 1

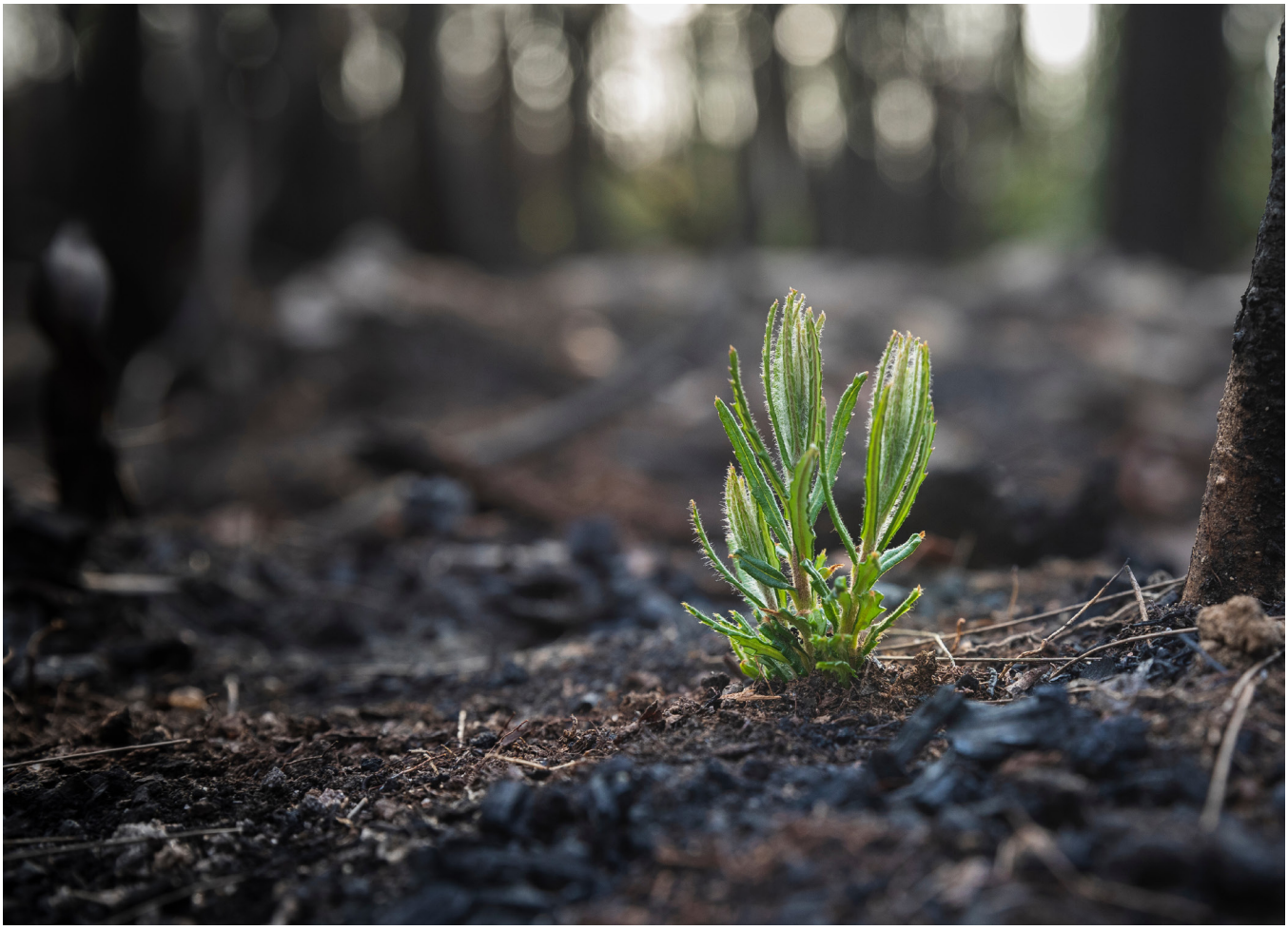
Tony is 38, living in a caravan park because he cannot find permanent housing and is unable to work due to a complex medical history that includes mental ill-health and other co-morbidities.

He is on a disability pension and needs to manage his type 2 diabetes and epilepsy, problems further complicated by a lack of access to a GP or diabetes educator. Tony turned to CP@clinic for help after suffering several seizures.

He was using his medications sparingly because, due to not having a GP, he was forced to go to his local Emergency Department for medication scripts. The hospital only provides a script for one week's medication, prompting Tony to reduce his dose below therapeutic levels to try to make his supply last longer. As a result, Tony would have seizures resulting in regular hospital presentations.

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

(Sunraysia Community Health Service)



Case Study 2

Following the devastating 2024 and 2025 bushfires in the Grampians region, the CP@ clinic paramedics became a crucial element of post-disaster support.

Partnering closely with local recovery agencies, the CP@clinic embedded themselves in affected communities, serving as a vital link to healthcare services that were often inaccessible due to geographic isolation and the immediate survival needs post-fire. In this role, they not only provided immediate medical care but also identified and addressed long-standing health issues exacerbated by the crisis. Through proactive in-reach, they offered a compassionate presence, engaging in meaningful conversations that alleviated stress, addressed immediate health needs and provided crucial referrals for ongoing care.

This initiative proved instrumental in restoring community resilience, focusing not just on physical ailments but also on the psychological toll of the disasters. By fostering trust and continuity of care, the CP@clinic program not only responded to acute health needs but also laid the foundation for long-term recovery and rebuilding within these resilient communities.

The program's success underscores the importance of community health strategies in disaster recovery efforts, setting a benchmark for future emergency response models in rural and remote settings.

(Grampians Community Health)

Case Study 3

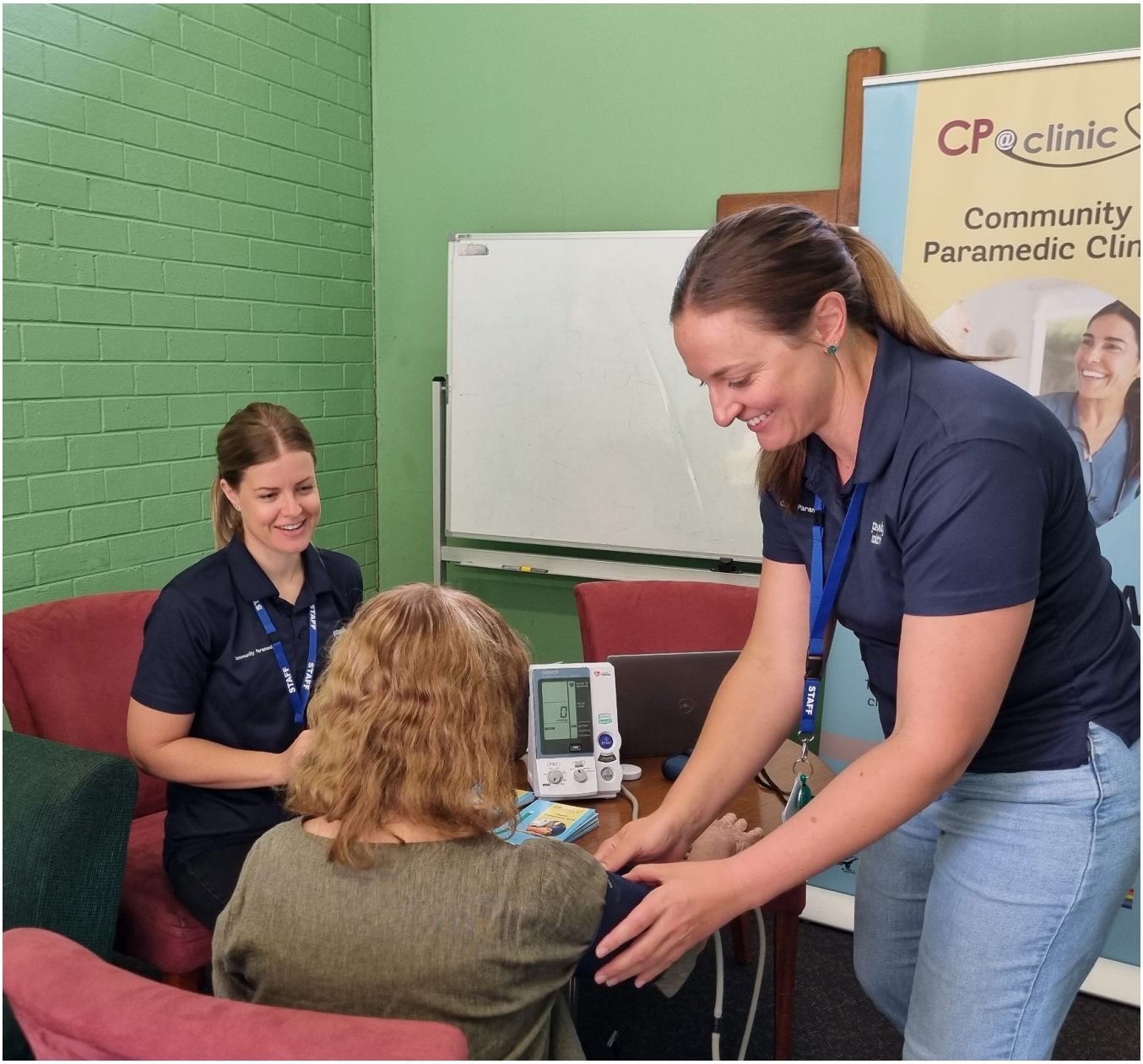
Mary, a 70-year-old female with a history of multiple falls, has recently called for an ambulance on several occasions for assistance to get off the floor overnight.

When she visited the local CP@clinic, the community paramedics carried out multiple assessments and sent a referral to the physiotherapist. Due to the nature of the referral, Mary was triaged as high-risk and was reviewed the same week. She had been on an allied health waiting list but was deemed a low priority on a generic referral from the aged care team.

Within 2 weeks, Mary was fitted for a four-wheel mobility walker and had her furniture at home moved to ensure safe access from her bedroom to the toilet overnight. Since the modifications were made, Mary has not had a fall in 4 weeks.

She reported to the CP@clinic community paramedics that her outlook on getting out and about has changed dramatically, and she is already talking about attending the strength and balance class at NCN Health in the future.

(Primary Care Connect)



Workforce

CP@clinic draws on an available paramedic workforce. More paramedics graduate from university each year than are being employed by Ambulance Victoria. In addition, the nature of work in ambulance services exposes the paramedics to consistently demanding conditions and workplace hazards that, for many, are unsustainable. CP@clinic could provide an opportunity to extend the careers of paramedics.

Evidence base

CP@clinic is based on a well-established and proven Canadian model developed by McMaster University. The model has been in operation for over a decade and seen a 19-25% reduction in emergency call-outs . This model is currently unfunded and being piloted at a small scale in four independent community health organisations in rural and regional Victoria - Sunraysia Community Health, Gateway Community Health, Primary Care Connect and Grampians Community Health. Whilst early days, the pilots have proven to reach high-risk community members, reduce emergency department presentations, and improve health outcomes.

CP@clinic has gained strong partner support from local hospitals, Aboriginal community controlled organisations, councils and other community service providers.

Sunraysia Community Health Services CP@clinic

Primary Care Connect CP@clinic

Grampians Community Health CP@clinic

Grampians Health commenced in February 2025 and has the support of local Aboriginal organisation Budja Budja Neighbourhood House.

About ARRCH

The 11 partner organisations of the Alliance of Rural and Regional Community Health cover 87% of rural and regional Victoria, working from over 80 sites and have more than 2,217 staff and volunteers.

Each of these community health organisations is deeply embedded in its local community with expert, local knowledge of those within its reach.