Victorian Primary Care Partnerships

Submission to the Standing Committee on Health – Best Practice in Chronic Disease Management and Prevention

July 2015

Table of Contents

Purpose

This submission has been prepared to inform the Standing Committee on Health about the work in Chronic Disease Prevention and Management that is undertaken by Primary Care Partnerships in Victoria, and to make some recommendations about areas where further investment could result in improved outcomes for people experiencing, or at risk of, chronic disease.

Primary Care Partnerships (PCPs) are established networks of local health and human service organisations. They work together to find smarter ways to deliver health services, so the health of their communities is improved. Since they were introduced by the Victorian Government in 2000, PCPs have become a vital component of the Victorian healthcare system.

In the 15 years of operation PCPs have grown significantly, in both size and reputation, as more and more health and social services and community groups join them in the quest to deliver better healthcare outcomes for Victorians. Today, PCPs facilitate partnerships with a wide range of health and social service providers and community groups; and they support collaboration and service integration. Most importantly, they play a key role to enhance the wellbeing of people within our local communities.

There are now 28 PCPs around Victoria that connect more than 800 organisations across many different sectors. This includes: hospitals, GPs, local government, universities, community health services, disability services, problem gambling services, women's health and family violence services, mental health services, sports groups, schools, police and many more.

These diverse organisations are working together to plan around the needs of the community, to share their skills and expertise, and align their efforts. In bringing these health and social service organisations together, PCPs find new ways to collaborate and share valuable learnings, research and information. When it comes to the health needs of the community PCPs also enable more effective integrated planning, and develop the service system through co-ordination and integrated care as well as by making better use of data, evidence-informed interventions and a common planning framework.

PCPs are delivering real results – particularly, better health and social outcomes for community members – at the local level. Indeed, a recent evaluation report[1] found that PCPs have:

- Improved integrated planning
- Improved service co-ordination
- Increased organisational capacity and learning for health promotion
- Delivered economic benefits and resource efficiencies
- Contributed to healthier communities

A copy of this report has been attached in the appendices (Appendix 1).

[1] Department of Health (2011) Primary Care Partnerships: Achievements 2000-2010

The Primary Care Partnership platform is used extensively by the Department of Health and Human Services to roll out new initiatives in the areas of service coordination, integration and chronic disease management. The platform is also pivotal in the delivery of prevention and health promotion work across Victoria. This submission has a primary focus on the work that PCPs deliver in chronic disease management and prevention. Service coordination has a significant bearing in this respect and so will also be discussed in some detail.

In preparation for this submission, staff from all 28 PCPs had an opportunity to contribute feedback via electronic survey and web based discussion forum regarding different areas of PCP practice and how they interface with chronic disease management and prevention.

This submission is divided into three key sections. The first section relates to the PCP role in Integrated Chronic Disease Management (ICDM). This is one of the key planks of the PCP platform. The second section of the report will detail Service Coordination. This particular focus has been adopted because the ways in which individuals and communities access, or fail to access, appropriate services (particularly those in disadvantaged communities) has a critical bearing on the outcomes they will experience (such as preventable hospital admissions) and the costs that will be incurred in their care. The third section of this submission covers the area of prevention and explores ways in which activities to prevent the incidence and severity of chronic disease could be enhanced and improved.

In the course of this submission, we also seek to address some of the key areas specifically mentioned in the terms of reference to the Parliamentary Inquiry including:

Key area 1:

Examples of best practice in chronic disease prevention and management, both in Australia and internationally;

Key area 3:

Opportunities for the Primary Health Networks to coordinate and support chronic disease prevention and management in primary health care;

Key area 6:

Innovative models which incentivise access, quality and efficiency in chronic disease prevention and management.

Key area 7:

Best practice of Multidisciplinary teams chronic disease management in primary health care and Hospitals; and

Key area 8:

Models of chronic disease prevention and management in primary health care which improve outcomes for high end frequent users of medical and health services.

Integrated Chronic Disease Management

Key messages in this section:

In Victoria, Primary Care Partnerships provide an existing platform from which to deliver integrated chronic disease management programs and improve systems, processes and partnerships to achieve better health outcomes.

Managing chronic conditions in hospital settings is costly to the health system and often inefficient for the patient. Most chronic diseases can be better managed in community settings leading to enhanced health outcomes and quality of life. Despite this, many people will continue to present at hospitals and many GPs continue to refer patients to hospitals when care in the community is available. On going collaborative work including partnership building and programs to educate the community and health professionals are needed to ensure that people get the right care, in the right place at the right time. PCPs are ideally placed to lead this work.

PCPs welcome the introduction of PHNs and are actively in the process of seeking to establish collaborative relationships with them. PCPs can provide Primary Health Networks with contacts and partnership activities so that they can reach and work with multiple agencies within our catchments. PCPs have regular meetings that PHNs can participate in and be involved with. This will enhance the process of PHNs updating agencies on their work and identifying opportunities to collaborate. In addition, PHNs they can utilise and learn from PCP expertise in areas such as diabetes to support GPs to continuously improve care and self management practices for their patients.

Integrated chronic disease management is key to PCP work. It fits within the program logic 2013–17[2] which has the following strategy goal:

To strengthen collaboration and integration across sectors by 2017, in order to:

- maximise health and wellbeing outcomes
- promote health equity
- avoid unnecessary hospital presentations and admissions.

It is a requirement that PCP action over 2013–17 is shaped by the following seven guiding principles:

1. Tackling health inequities
2. Person and family centred
3. Evidence-based and evidence-informed decision making and action
4. Cross-sector partnerships
5. Accountable governance
6. Wellness focus
7. Sustainability (including optimal use of technology)

PCP work is underpinned by the knowledge that maximising the health of Victorians requires consolidated action targeting statewide priorities. This strengthens the primary health system

[2] Department of Health (2013) Primary Care Partnership Program Logic 2013-2017. http://docs2.health.vic.gov.au/docs/doc/5E35B44E161AF5C8CA257ACF00762128/$FILE/PCP%20Program%20Logic%202013-17_FINAL_v02.pdf

as well as empowering individuals to live a healthy lifestyle. In order to maximise impact across the state, the significant majority of PCP work in 2013–17 focuses on one to two locally identified early intervention and integrated care priorities and one to two prevention priorities. At least one of the PCP early intervention and integrated care priorities must include a disease that is major and chronic in Victoria. These include:

- Arthritis
- Heart disease
- Cancer
- Osteoporosis
- Stroke
- Diabetes
- Depression or anxiety
- Respiratory conditions (including COPD and asthma)
- Renal conditions

The first PCP program logic domain relates to early intervention and integrated care. The objective of our work in this area is to strengthen the primary health system to deliver person-centred and accessible early intervention and integrated care that aims to keep people as well as possible for as long as possible, particularly people with complex care needs

PCPs have adopted a number of key strategies and accountability indicators in relation to this objective. A number of these are listed below:

Strategies

1. Work with member organisations and Medicare Locals (now PHNs) to strengthen integration and communication practices among providers (including between state-funded and private providers) to facilitate consumer transitions between services and reduce the need for consumers to retell their stories.
2. Facilitate advancement of *Victorian service coordination practice manual 2012* implementation to broader health and wellbeing agencies
3. Work with member organisations to identify and address access barriers, particularly for the identified local priority group
4. Develop and implement local agreements for care planning, care coordination and case conferencing to ensure systemic care planning (including e-care planning) within and across organisations
5. Facilitate implementation of local agreements and systematic interagency care pathways for defined consumer cohorts using evidence-based guidelines
6. Facilitate development and implementation of a robust identification and recall system for people with complex and multiple needs for review and quality control
7. Facilitate continued system improvements for early identification and intervention for priority target groups
8. Continue to strengthen e-health initiatives

These strategies are accompanied by specific accountability indicators, a sample of which are highlighted below:

- Number of member organisations with guidelines and expectations for shared care plans including referral, monitoring, transition and identification of a care/case coordinator
- Number of member organisations that demonstrate evidence of communication regarding the shared care plan of consumers with multiple or complex care needs, with general practitioners (GP)

- Number of member organisations that communicate referral outcomes to referring GPs
- The percentage of consumers whose issues (identified at Initial Needs Identification) have all been responded to with appropriate action
- Improvement against the key domains of the Assessment of Chronic Illness Care (ACIC) Survey – *Integration of Chronic Care Model components scale – Organisational planning for chronic illness care* (additional item)
- Number of member organisations that have a shared care plan in place with consumers using their services
- Improvement against the key domains of the ACIC Survey – *Integration of Chronic Care Model components scale*
- The percentage of consumers with multiple or complex needs with a shared care plan
- Improvement against the key domains of the ACIC Survey – *Integration of Chronic Care Model components scale* and *Organisation of the healthcare delivery system scale*
- Improvement against Part 3c of the ACIC Survey regarding systems for patient follow-up
- Improvement against key domains of the ACIC Survey – *Delivery system design scale* and *Clinical information systems scale*
- Improvement against Part 3d of the ACIC Survey regarding maintenance of registries of patients with specific conditions
- Increase in the number and type of agencies participating in e-referral
- Increase in the number of e-referrals sent
- Increase in the number of e-referrals received
- E-care planning data (localised to those areas where e-care planning projects have been implemented)

The objectives, strategies and accountability indicators highlighted above provide an example of the excellent work that is currently occurring in Victoria as a result of the PCP platform. The fifteen year investment that successive Victorian Governments have made in PCPs has resulted in Victoria being a hub for best practice in this area.

Not withstanding the significant work that must still be undertaken in order to reduce the number of avoidable hospital admissions and ensure that people whose chronic conditions can be managed in the community do not present for care at emergency departments, we believe that Victoria is leading the way when it comes to effective chronic disease management. Increasing numbers of agencies and health services are collaborating to ensure that people with complex and chronic conditions are receiving coordinated care with shared care planning, evidence based models and skilled and confident health professionals.

PCPs have highlighted a number of ways in which our relationships with PHNs may develop and ensure that each platform is able to add value to the other. When the establishment of PHNs was announced, PCPs developed a communique for the sector which highlighted ways in which our relationships may further develop. This document can be found in the appendices. (Appendix 2)

In our consultation process, PCP members also highlighted areas where the Medicare payment system fails to reward and encourage best practice and quality improvement in

chronic disease prevention and management. In particular, access to best practice care may be limited for patients due to current Medicare funding arrangements that restrict rebates for services for allied health. These are subject to referral rules in which the number of services and treatment requirements are pre-specified by the GP. Group therapy is not covered and therefore the benefits of shared experience between patients receiving the same types of restorative or supportive services, is not possible. Group therapy is often an efficient delivery mode for exercise based rehabilitation programs (eg: Heart Failure restorative programs). In addition, the current referral process does not support a multidisciplinary team approach, requiring separate referrals to each service provider which is duplication and repetition for the referring GP.

Multidisciplinary models of care in which medical, allied health and nursing specialists can work collaboratively as a team have been found to provide particularly effective at maximising access and quality and efficiency in chronic disease management. The focus of such teams is on optimising the patient's health, slowing disease progression and maintaining maximum functional capacity and quality of life.

One example of where such best practice can be seen is at Werribee Mercy Hospital. The hospital has a Health Independence Program and newly equipped facilities which utilise an integrated model of care, providing a responsive and flexible link between acute health services, community and social support services.

A number of case studies are included in the appendices to this submission. A summary of case studies that can be found in the appendices is overpage. Each case study contains the contact details of the lead PCP which may be used if the reader has any further questions relating to the case studies. In addition, we have included a number of vignettes that give examples of work that is underway in different PCPs.

Case studies in the appendices include:

Appendix 3: Improving Coordination of Diabetes Care in the North East: *What if we could engage our community earlier in their diabetes care?*

The NEPCP Chronic Disease Collaborative developed and implemented a framework to streamline access and referral to help prevent chronic disease progression a couple of years ago. Living with a Chronic Condition: getting the right help, in the right place at the right time was a great step in improving our consumers' journey and promoting early intervention, but NEPCP decided greater detail and attention to specific chronic diseases was warranted and diabetes was selected to work on first. The aim of the work is to ensure people with diabetes are referred to a service that is able to provide a level of care that best meets their needs.

Appendix 4: Physical Health Matters Too

Mental health and primary care agencies in the Northern Melbourne area decided to work together to address the physical health needs of people with a serious mental illness. They were responding to the significant evidence indicating that people with a mental illness experience poorer physical health when compared to the general population. In fact the death rate of those with mental illness is 2.5 times greater than that of the general population.

Appendix 5: A Regional approach to Type 2 diabetes care

Over the past four years, Inner East PCP and OEHCSA have supported member agencies including community health and acute services to enact change to improve care through the Improving the Diabetes Journey (ItDJ) project. Inner East PCP and OEHCSA focused on developing objectives and a mix of strategies to address identified gaps based on the Wagner Model of Chronic Care. The results indicated that across the catchment there were improved governance and leadership arrangements and partnerships between community-based primary health care, acute services and Medicare Locals. Inner East PCP's and OEHCSA contribution to the work in diabetes care is strongly focused on system change. Future directions including a continued focus on diabetes education in terms of matching best practice evidence in diabetes education against the provision of education programs across the EMR. This will provide a framework for identifying gaps and for realigning service delivery based on a more informed understanding of the types of education programs that would best suit communities across the EMR. Inner East PCP will also focus on continued promotion and development of the EMR Diabetes Initiatives Steering Group (DISG) and supporting Health Pathways.

Appendix 6: Inner North West PCP Diabetes Services Review Collaborative Project

Increasing prevalence of diabetes and related health complications, combined with growing service demands, were the impetus for Inner North West Primary Care Partnership (INW PCP) member agencies to develop a more coordinated approach to service delivery. An audit of diabetes referrals within two large metropolitan hospitals indicated hospital based clinics were treating people with type 2 diabetes, who could more appropriately receive their care from their local community health service in conjunction with their general practitioner. This is a local inter-agency approach to creating system level change, with the aim that people with type 2 diabetes receive the right service, at the right time, in the right setting.

Vignette: Lower Hume Chronic Illness Care Improvement Plan

Assessment of Chronic Illness Care (ACIC) in 2014 informed the development of a Lower Hume Chronic Illness Care Improvement Plan 2014-2016. Each agency has signed off and works towards the plan with an initial focus on diabetes. This work also aligns with the Hume region chronic care strategy which has an initial focus on diabetes. Lower Hume PCP are collecting consumer feedback on access to, and quality of, current services for those living with diabetes. This will inform a local agreed model of care.

Lower Hume PCP have also put together a Health Literacy Toolkit in response to agencies not knowing where to start when trying to improve organizational health literacy. This is due to be printed by the end of July.

Lower Hume PCP is also working closely with hospitals to implement the Lower Hume Chronic Illness Improvement Plan. This has included staff surveys on diabetes knowledge which has identified that nurses would like some additional training to update their knowledge on diabetes management. This is the first step to supporting holistic care in acute departments to equip patients with knowledge skills and resources to self manage their condition on discharge. Increased referrals to allied health are also being supported through updated forms that prompt nurses to discuss recommended reviews with patients.

A focus on diabetes in the region has also prompted one agency to initiate a diabetes early intervention program that provides access to allied health in a group environment. Evaluation of the pilot phase is producing positive results which will be presented to local GPs to encourage involvement and referrals. This work is aimed at reducing re-admissions to hospitals as nurses support patients to be able to self manage their conditions on discharge. Having information out in the community through local pharmacies will also enable people to manage their diabetes as they will have increased support.

Vignette: Western Self-Management Network

The Western Self-Management Network was established by HealthWest PCP in 2013 and provides opportunities for health professionals to share self-management practices and innovations, network, collaborate and share relevant service information. It also promotes the development of organisational support of self-management within HealthWest member agencies. The network is based on the Wagner Model of Chronic Care. The network is managed by a working group and HealthWest oversees the network and provides administrative support. Participation is open to any clinician or manager interested in developing skills and knowledge of the self-management approach, working in a health and community organisations in the western region of Melbourne. Each network meeting focuses on a particular topic such as mental health, pain or sleep.

Vignette: Working with pharmacies

Lower Hume PCP have coordinated member agencies to engage with their local pharmacies and collect responses to a survey regarding diabetes. The results of the surveys identified the need for local hospitals and community health to partner more closely with their local pharmacies to improve continuity of care for people with diabetes. Pharmacies expressed that they often have people newly diagnosed with diabetes who have a lot of questions about the condition and that they are not confident in their knowledge of diabetes management or local services that could support them. For this reason, agencies will be providing pharmacies with resources that enable them to help customers with their questions, as well as events scheduled for the end of the year which bring together service providers and pharmacies to learn about local services and diabetes management. It is hoped that this is the first step to facilitating all health services to work together to effectively prevent and manage diabetes.

Recommendations – Chronic Disease Management

1. The Commonwealth Department of Health and Ageing should closely examine models for chronic disease management that have developed in Victoria. The fifteen year investment in the PCP strategy in Victoria has resulted in it being particularly well positioned in this area.

2. Primary Health Networks in Victoria should be strongly encouraged to work collaboratively with, and leverage off, the existing PCP platform to achieve enhanced outcomes especially in the area of chronic disease management with a particular focus on reducing avoidable hospital admissions.

3. Invest sufficient resources to ensure that all agencies can meet best practice standards in relation to chronic disease management.

4. Wherever clinically possible, care in the community should be the preferred option and funding models should be directed to ensuring that there are no impediments to this being achieved.

5. The Commonwealth should work with the States to ensure that IT platforms and systems offer interoperability and enable effective care coordination.

6. Tertiary education providers in the health sector should ensure that future health professionals have skills in the areas of care planning, care coordination and case conferencing.

Service coordination

Key messages in this section:

Early intervention is crucial to minimising harm and ensuring better outcomes for people at risk of, or experiencing, chronic disease. Effective and widespread screening is a fundamental building block for earlier intervention.

PCPs have undertaken a significant amount of work and been very successful in consolidating screening processes and referral pathways. However, some on-going connectivity barriers remain to achieving more comprehensive screening.

Across PCPs there is a clear understanding that some services deliver tertiary responses whilst others are better placed to assist people in the community. Our focus on improving service coordination is to make sure that those experiencing, or at risk of, chronic disease will have an increased / improved support and referral pathways, thereby ensuring that they get the right care, in the right place at the right time.

Many people with chronic diseases come into contact with numerous health and community agencies in addition to GP and hospital services. To minimise duplication and ensure most appropriate care, mainstream health and community service providers need to be equipped to adequately identify and respond to chronic disease.

Effective partnerships are crucial to ensure that all people who experience chronic disease receive the right care, in the right place at the right time.

PCPs are well placed to work with stakeholders to develop a more integrated service system and strive towards a more consistent, coordinated and timely responses that result in enhanced care and improved outcomes for people with chronic diseases.

What is service coordination?

Service coordination places consumers at the centre of service delivery to maximise their opportunities for accessing the services they need. Service coordination enables organisations to remain independent of each other, while working in a cohesive and coordinated way to give consumers a seamless and integrated response.

Primary Care Partnerships have 15 years of expertise in service coordination having worked extensively in this area to ensure better access to services across a range of health and community services. Our experiences have taught us that improvements in service coordination practices are critical to reducing the burden that chronic disease places on individuals, families and the community. Timely access to appropriate services is the key to ensuring better outcomes for people with chronic disease.

The service coordination context

Service coordination stems from *Better Access to Services: A Policy and Operational Framework* (DHS, 2001). Implementation of service coordination is supported by policy, practice standards, training and other resources.

What are the benefits of service coordination?

Service coordination can offer many benefits to consumers and service providers.

The benefits for consumers include the following:

- Provision of up-to-date information about local service availability and support options to contact the most appropriate service
- No wrong door – every door in the service system can be the right door for consumers to access services
- Clear entry points, plus transparent and consistent referral pathways and processes that are easy to navigate
- Improved and timely identification of needs through the initial needs identification process
- Improved response times to requests for information, referral and provision of service.
- Confidential transfer of information without collecting or storing client data for referral purposes in a way that does not require the consumer to repeat their information
- Improved access to assessment and coordinated shared care/case planning clarity regarding who is involved in service provision and what their responsibilities are to meet the consumer's goals
- Reduced duplication of assessments and services as well as identification of service gaps
- Increased knowledge of the local service system and access to resources that support service coordination, such as the National Health Services Directory (NHSD)
- Consistent service standards from each service provider through the use of regional protocols and memorandum of understandings between service providers.
- A positive experience of the service system that puts the consumer at the centre of care.

The benefits for service providers include the following:

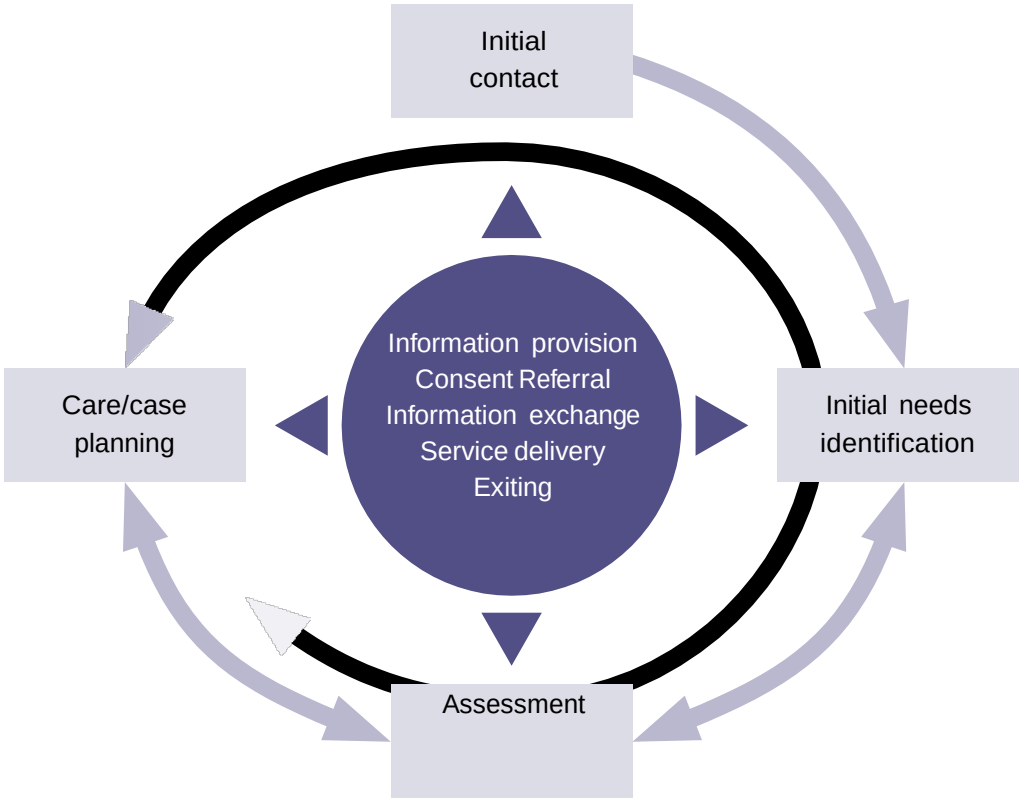
- Practices, processes, protocols and systems that set out clear guidelines and expectations around key areas of work and inter-organisation practice, including continuous quality improvement strategies aligned with accreditation standards
- Documented practice standards for the elements of service coordination including; initial contact, initial needs identification and shared care/case planning, providing a common language between services
- Improved consistency and quality of consumer information through the use of common tools such as **the Service Coordination Tool Templates which have increased efficiency by combining over 300 different versions of templates**.
- More efficient use of resources through improved information and feedback from referrals, fewer inappropriate referrals and less duplication of services
- Streamlined services through the provision of a consistent, agreed, standardised way for practitioners within and across organisations to identify consumer needs, identify appropriate services, make referrals, provide feedback, communicate and coordinate

care, leading to improved operational efficiency and a reduction in the demand on the service system through more effective client / consumer outcomes.

What is the Service Coordination Framework and what are the elements?

The operational elements of service coordination, as described in the *Better Access to Services: A Policy and Operational Framework* are depicted in the figure below. Initial contact, initial needs identification, assessment and care/case planning are the key service coordination elements. Additional processes such as information provision, consent to share information, referral, information exchange, service delivery and exiting can occur at any stage.

Service coordination elements are implemented in a range of ways according to the consumer, the service provider and context in which services are provided. For example, in some services, initial contact and initial needs identification are carried out by the same person and assessment is conducted by a different person; in other services, one person may conduct both initial needs identification and assessment processes at the same time.



Service Coordination in Victoria is documented in the *Victorian Service Coordination Practice Manual* (VSCPM). The manual and associated resources were designed for managers and service providers involved in the implementation of service coordination. We recommend this resource to the Commissioners. Initially developed in 2006 by the Statewide Primary Care Partnership (PCP) Chairs' Executive, with funding from the formally known Department of Health, the resources aim to provide an overarching service coordination framework applicable to a range of sectors and services including:

- Aboriginal community-controlled organisations (ACCO)

- Ambulance Victoria
- disability services
- family violence services
- general practice
- health
- housing
- mental health
- multicultural and ethno-specific services
- welfare and community services
- youth and family services

Vignette: Western Intake Network Group (WING)

The Western Intake Network Group (WING) provides a forum for Intake and Access Support Workers from health and other related services in the western metropolitan region to network, learn, share and deliver quality improvement strategies together in a spirit of collaboration and respect. Intake workers who met at the HealthWest PCP Active Service Model Intake Forum (November 2011) identified a need for an Intake focused networking group. This initiative is a response to that need, and is supported by the ten HACC agencies involved in the HealthWest Active Service Model Project. This network is a natural initiative from the HealthWest previous strategic plan: 'Healthy Communities Healthy Lives Framework' which was based on the Expanded Chronic Care Model. The meetings are coordinated and facilitated by the WING Leadership Group, with the support of HealthWest.

Explanation of different service coordination areas of practice

Initial contact

Initial contact is the consumer's first contact with the service system. It is an important function of every service provider and usually includes the provision of accurate, comprehensive service information and facilitated access to initial needs identification. It may or may not include the completion of a screening tools for chronic disease which some agencies will undertake at a later date.

Initial needs identification

Initial needs identification is a brief, broad, screening process to uncover underlying and presenting issues. Initial needs identification canvasses the consumer's needs as well as opportunities for intervention and information provision early in their contact with the service system. The service provider engages in a broad conversation to identify these needs. It is not a diagnostic process, but includes identification of the consumer's health risks, eligibility and priority for service. Initial needs identification involves a whole-of-person, consumer-centred approach.

The Service Coordination Tool Templates (SCTT) were developed to collect client information and undertake initial needs identification, referral and information sharing processes. These templates have been adopted by hundreds of agencies across the state

replacing over 300 different screening and referral forms. This has led to greatly improved consistency in screening, referral and data collection. The templates have been regularly updated since they were first introduced.

Assessment

Assessment is a decision-making methodology that collects and interprets relevant information about the consumer. Assessment is not an end in itself, but part of an ongoing process of delivering services. It is an investigative process using professional and interpersonal skills and in-depth enquiry to identify relevant issues that will guide a responsive intervention. It is often service specific.

Consultation with PCPs revealed that in some cases, inadequate staff training and poor understanding of local service systems can impede timely and effective assessment.

As with initial needs identification, electronic client management systems need to enable agencies to undertake comprehensive standard assessments. These systems should also have built in alerts and prompts to ensure consumers get access to the full range of services which might assist in the management

Care/case planning

Care/case planning is a dynamic process that incorporates assessment coordination, care/case management, referral, information exchange, review, reassessment, monitoring and exiting. Care/case planning involves balancing relative and competing needs, and helping consumers make decisions appropriate to their needs, wishes, values and circumstances. Care/case planning may occur at an individual provider level and both within and across agencies.

Coordination of care can be difficult for people with chronic diseases. Often when a person has a chronic disease, they come into contact with multiple services including GPs, specialists, hospitals, allied health professionals and community nurses. A system of case management that is shared in real time across agencies would provide a streamlined service thereby improving care coordination. Clear communication and referral pathways would assist in this regard. A time poor, resource constrained workforce is more likely to experience poor understanding of local service systems outside of their own.

Care coordination is greatly enhanced where there are high levels of IT connectivity which comply with the National E-Health Transition Authority (NEHTA) Standards. There are a number of electronic client management systems that enable better connectivity for supporting services. S2S and Connecting Care are the ones that are used by the majority of PCP member agencies in Victoria. S2S and Connecting Care enable secure messaging between agencies. s2s also has the capacity to have an interactive shared support plan between agencies supporting a consumer.

PCPs are well placed to assist local health providers to become more e-referral literate.

Additional processes

Information provision

Providing information that is relevant to the consumer's needs may be undertaken at any and all stages of the service coordination process. When choosing the type and complexity of information to provide, service providers will be receptive to and guided by the consumer's needs, learning styles and their capacity to understand information (taking into account issues such as preferred language and visual or cognitive requirements). Service providers will check that consumers have understood and, importantly, are able to utilise the information that is being provided.

PCPs have identified that the availability of bi-lingual staff and CALD resources are critical in this respect. However, other factors such as health literacy must also be taken into account. People require information in safe, easily understood formats including through verbal, written and electronic means.

The National Health Services Directory (NHSD) is a key resource within this area it has been expanded from the Victorian Human Services Directory and is now nationwide. It underpins directories such as Nurse on Call, the better health Channel and Connecting Care among others. It is on-line and is regularly updated by agencies. PCPs encourage all member agencies to populate and update the NHSD. The Department of Health and Human Services encourages use of the NHSD but it would be helpful to issue stronger directives in this regard and provide funding and or incentives to make it more accessible and increase the functionality and develop this technology further

Consent to share consumer information

Privacy legislation requires the protection of an individual's personal information and their right to decide how the information is used, disclosed to or shared with others. Consumer consent is a compulsory part of the information exchange process. The primary purpose of information collection is the purpose for which the information was originally provided. The secondary purpose is any additional use that is not directly related to the consumer's original disclosure. Consumers must agree to the disclosure of information for secondary purposes.

Generally, PCP member agencies and their staff have good knowledge of consent and privacy issues. This is especially the case where they use SCTT because this system has high standards for compliance in this area.

Referral

Referral may occur at or result from any stage of the service coordination process. Referral is the transmission, with consent, of a consumer's information from one service provider to another for the purpose of further assessment, or service provision.

Ideally, interagency or service referral should occur via a secure messaging platform. It is acknowledged that secure messaging is currently limited by inconsistent uptake of systems that have this functionality. Interoperability issues between different agency referral systems

are also a factor. There are two messaging platforms that are used by PCP agencies both of which enable secure transmission of client referrals, including consent.

Information exchange

Information exchange is essential to provide consumers with a seamless, coordinated service delivery. Information exchange includes: acknowledgement that a referral has been received and the subsequent action to be taken, provision of summary information to other service providers at key points in the consumer's pathway, such as following assessment, care/case planning, review or change in service delivery, handover, transition, exiting, or at other points in the consumer's service delivery pathway as appropriate.

The barriers to effective information exchange are similar to those experienced with referrals. As highlighted earlier they include:

- use of non secured pathways for information exchange
- lack of interoperability between IT systems and platforms where secure messaging has not been mandated. (An effective solution here requires pressure from government on vendors for interoperability.)
- concerns regarding privacy and confidentiality
- inadequate processes for acknowledging referrals and providing feedback to the referring agency
- knowledge barriers among the existing workforce (A solution here might lie in education at university for practitioners on the service system and IT systems. New graduates could be well positioned to mentor older workers in this area.)

Service delivery

Service delivery is generally undertaken in accordance with local protocols and in keeping with the needs of the consumer and the level of skill of the person providing the service. Within local PCPs, all work is underpinned by core service coordination principles as outlined in the Victorian Service Coordination Practice Manual[3]:

- Central focus on consumers
- Partnerships and collaboration
- The social model of health and the social model of disability
- Competent staff
- Duty of care
- Protection of consumer information
- Engagement with a broad range of service sectors
- Consistency in practice standards

Further detail about each of these principles can be found in the Manual.

This submission does not focus on service delivery as we expect that agencies working directly with consumers are in in the best position to do this. However, we do note that effective service delivery requires adequate resourcing.

[3] Victorian Service Coordination Practice Manual 2012, http://www.health.vic.gov.au/pcps/downloads/sc_pracmanual2.pdf

Exiting

Exiting can occur at any stage of the service coordination process and is generally managed in accordance with local protocols.

Before exiting, a case closure plan should be put in place particularly in cases where support provided has been complex and extensive. Effective planning once again requires good communication to internal and external staff and agencies. It should be secure, timely and include processes to ensure all service providers are informed. The use of secure message delivery should be expanded across sectors to enable best practice in this area.

PCPs acknowledge that management of chronic disease can be a complex and protracted issue. In many instances, clients who have "exited" will require further services in the future. Improved connectivity with client management systems and secure means of transferring client data will ultimately lead to more efficient and effective service delivery.

Recommendations – Service Access and Coordination

1. **Implement the Service Coordination framework across all funded health agencies and resolve issues with connectivity to ensure secure and efficient practice in relation to all aspects of service coordination:**

- SCTT frameworks, guidelines and templates should be mandated for a broader range of agencies.
- The Commonwealth should collaborate with the Department of Health and Human Services (Vic) and other State authorities to ensure that all future upgrades to referral processes (such as the SCTT tools) are included in software products and that interoperability exists between secure messaging platforms. Furthermore, future developments should occur in consultation with vendor providers' development teams to enable implementation of the upgrades in a timely manner.
- Continue to support the ongoing development of platforms to enable interoperability of CMS in future developments that align with NEHTA standards.

2. **Ensure a well trained and competent workforce**

- Implement minimum compulsory training standards for all existing staff in privacy and confidentiality and the transfer of client information. This should include information about secure messaging.
- Ensure that Service Co-ordination is included within the curriculum at university to all medical, health and social students with some detail about the secure messaging, privacy and systems.

3. **Invest sufficient resources to ensure that all agencies can meet best practice standards in relation to service coordination**

- Resource and strengthen existing partnerships and platforms. New initiatives should not be introduced independently of existing structures, as it can be counterproductive to create new partnerships, governance structures and organisations.
- Consider promoting and enhancing co-location arrangements so that more workers from different disciplines can be seen from one location thereby decreasing the need for consumers to juggle multiple appointments in different locations.

Access and Service Coordination Project

The Access and Service Coordination Project (AASCP) was a Victorian government Youth Partnerships initiative, funded by the Department of Education and Early Childhood Development. It built on the findings of the Victorian State Government Better Youth Services Pilot (2009), and the work of the Child and Youth Pathways (CYP) project in Wyndham. The CYP (June 2010-June 2013) project focused on child and youth mental health and identified barriers and enablers for the children and young people of Wyndham in accessing appropriate mental health services. The CYP project produced a package which included a mental health referral pathways roadmap tool, a map of available mental health services in Wyndham, a list of child and youth mental health networks in Wyndham, a mental health training calendar and options for service coordination and e-referrals. The chronic disease roadmap tool developed collaboratively by HealthWest PCP and its members in 2008 was crucial to the development and design of the tools in the CYP package.

The aim of the AASCP was to provide the young people of Wyndham and Hobsons Bay, their parents and/or other adults and the professionals they work with, with online Youth Directories (http://youth.wyndham.vic.gov.au/ysd & http://hobsonsbayyouthdirectory.com) that guide them to the most appropriate service, including information about how to access these services. The project has also developed a community communication strategy which has led to promotion of the Youth Directories in over 45,000 homes, 16 schools, 12 community organisations, 4 police stations, 4 libraries, 12 medical clinics and 6 community centres in the Wyndham and Hobsons Bay areas. Additionally, the collaboratively developed Initial Needs Identification (INI) tool has also been trialled in 37 multi sectorial agencies in Wyndham and Hobsons Bay who are working with young people. The INI was based on the Victorian Department of Health Service Coordination Initial Needs Identification tool templates.

The AASCP was a collaboration comprising the Department of Education and Early Childhood Development (DEECD), Wyndham City, Hobsons Bay City Council and HealthWest. It was the first time that service coordination and integrated chronic disease management principles have been used in a project in the West outside the health sector. 37 services were engaged in the designing and trialling of the tools (Youth Directory, INI, and associated protocol). Of these, 20 schools (both secondary and alternative settings, public, private and catholic) and 17 agencies (including mental health, housing, family, outreach, counselling, generalist youth, employment and education placement as well as other not-for-profits) work in some way with young people in Wyndham and Hobsons Bay.

An evaluation framework using a combination of qualitative and quantitative evaluation measures has been developed with regular reporting against the aims and objectives of the AASCP. The Project has created two Youth Directories which enable education providers, youth services, young people and parents/carers to easily access information on local services and have better knowledge of available services. The directories have been widely promoted and up-take has been high. Feedback indicates that the Service Directories are easy to navigate, user friendly and contain relevant information. In addition other local government areas replicated the service directory.

Prevention

Key messages in this section:

Most chronic disease are preventable.

Evidence is clear that the determinants of chronic disease are tied up with social, economic and health inequalities. Effective upstream prevention work needs to address these issues.

New initiatives should not be introduced independently of existing structures, as it can be counterproductive to create new partnerships, governance structures and organisations. Such approaches tend to drain funds and resources away from existing work and partnerships.

Preventing chronic disease saves money and improves quality of life.

An introduction to prevention and integrated health promotion in PCPs

In Victoria, the term 'integrated health promotion' refers to:

> 'Agencies and organisations from a wide range of sectors and communities in a catchment (local area) working in collaboration using a mix of health promotion interventions and capacity building strategies to address priority health and wellbeing issues.' [4]

In order to achieve effective integrated health promotion program delivery in the current Victorian context, PCPs apply the following elements:

- Effective partnerships
- A mix of interventions and common planning framework
- A broad range of sectors

In recent years, there has been a shift in language towards wider use of the term “prevention” to cover a broad range of health promotion activities intended to keep populations healthy. Sometimes language around “public health approaches” may also be used interchangeably as a public health approach denotes all organised measures (whether public or private) that might be undertaken to prevent disease, promote health, and prolong life among the population as a whole.

Documents relating to IHP can be found on the Department of Health/PCP website. In particular, the **Primary Care Partnerships: Integrated Health Promotion Report 2011** draws on findings from an evaluation conducted in 2008 on the impact of the PCP IHP strategy.

[4] IHP Resource Kit (2012) Department of Health http://docs.health.vic.gov.au/docs/doc/Integrated-health-promotion-resource-kit--Entire-practice-guide

Victorian Health Promotion Priorities

Each PCP's IHP Catchment Plan generally has between one to three health promotion priorities which align with the priorities of the Victorian Pubic Health and Well-Being Plan 2011-2015. The priorities are as follows:

1. increasing healthy eating
2. increasing physical activity
3. controlling tobacco use
4. improving oral health
5. reducing misuse of alcohol and drugs
6. promoting sexual and reproductive health
7. promoting mental health
8. preventing injury
9. preventing skin cancer.

The Victorian government is currently developing a new Pubic Health and Well Being for 2015-2019.

The Department of Health and Human Services (DHHS) has specific requirements of PCPs for their planning activities and documents, which are linked to PCP funding and service agreements with DHHS. Total funding to PCPs across Victoria to undertake Integrated Health Promotion is modest and is in the vicinity of $2 million.

PCPs work to prevent chronic diseases by…

1. Participating in, and promoting, partnerships
2. Building the capacity of PCP member agencies to undertake prevention work
3. Developing and implementing evaluation strategies
4. Participating in awareness raising work

What enablers exist that facilitate effective prevention work?

PCPs have reported that the following existing factors support effective prevention work:

1. The fact that most chronic diseases are now widely recognised as preventable conditions that contribute significantly to burden of disease.
2. Commitment by many organisations to work in partnership to address the determinants of chronic disease.
3. A competent and committed health promotion workforce across a range of organisations that is able to plan and implement prevention activities.
4. The availability of an increasing number of evidence based frameworks that emphasise action on the determinants of chronic diseases to guide planning and implementation of primary prevention activities.

These are the features of the system that are currently working quite well to support prevention initiatives. However, many of the drivers of ill health sit outside of the health sector and there is not always sufficient buy-in from external stakeholders to ensure that prevention activities are successful.

PCPs recognise the important role of government in preventing chronic disease and in particular highlight the stunning success of successive Australian and state governments in reducing tobacco consumption. Tobacco is perhaps the greater contributor to preventable chronic disease and PCPs urge all levels of government to continue to work together to

further reduce smoking rates. Australian success in this area is a reminder of how effective governments can be as enablers of effective prevention work.

What barriers do PCPs encounter to effective prevention work?

The most significant challenge that PCPs have identified to more effective prevention work relates to limitations with federal and statewide strategy to reduce the drivers of chronic disease. Whilst we have been very successful as a nation in reducing tobacco consumption, the same cannot be said for obesity prevention. Overweight and obesity are major contributors to chronic disease. As a nation, we have failed to make significant inroads in this area. This situation may not shift much until such time as governments are willing to intervene to better regulate the food and beverage industries. Alongside sedentary lifestyles, increasing consumption of energy rich / nutrient poor food and beverages is a major contributor to chronic disease, particularly diabetes.

PCPs identified a number of additional barriers to more effective prevention work including:

- Duplication of partnership structures across the catchment and region – prevention work is taking place at local government, PCP catchment and regional levels. In some cases, these different partnership structures draw on the same pool of professionals who then experience “partnership fatigue”, being pulled into too many meetings and planning forums and finding little additional time to actually undertake much work. As one PCP respondent wrote, “too many meetings in relation to tiny available resources.”
- PCPs have also identified challenges in maintaining the focus of member agencies on primary prevention activities, rather than being drawn to intervention and service delivery activities.
- Influencing stakeholders who are not in health promotion/prevention roles to understand and focus on activities to prevent chronic diseases can be difficult.
- Some PCPs identified challenges in working with Local Government due to approaches that operated in silos and difficulties getting broader catchment and / or regional agreement. The role of local government in planning and the construction of the built environment could have a major bearing on activities to reduce the prevalence of chronic disease.

Most of the challenges identified related in some way to resourcing issues. Many professionals from within PCPs noted frustrations with lack of time allocation to follow through on prevention activities, lack of staff skill and knowledge in understanding how to tackle the upstream determinants of chronic diseases and lack of resources that would enable follow through on prevention activities and ideas generated by partnerships.

What improvements could be made to maximise prevention benefit?

PCPs identified the following changes that could be made to maximise prevention efforts in Victoria:

- Ensure chronic disease prevention stays on the 'agenda' in health promotion for agencies through adequate resourcing.

- In line with appropriate framing in public health policy, planning and reporting guidelines for PCPs, Community Health and Women's Health should be structured to allow for appropriate prioritisation of chronic disease prevention as a public health issue in its own right, with well established determinants and contributing factors.
- Increase funding of primary prevention activities that specifically address the determinants of chronic disease, as identified in the evidence-base
- Further investment could be made in local government and community health. Across Victoria these two sectors are among the most active members of PCPs. They have many strengths in relation to preventing chronic disease. Their role is both as large employers (org/workforce development), community settings with local employees and providing important services providers (often delivering Early Years, maternal and child health, HACC, health and family support programs, GPs, Youth Services, community & sporting facilities etc). Local government and community health are especially good places to invest in prevention work because:
    - ✓ They know/understand their communities and can develop prevention strategies & initiatives to meet specific local needs and contexts (which we need to if we are to be effective).
    - ✓ They can address determinants – promote healthier lifestyles and create more supportive environments
    - ✓ They can influence contributing factors: for example employment, neighbourhood characteristics, social connections & cohesion - we know that addressing contributory factors is most likely to be successful in reducing chronic disease.
    - ✓ They have influence/relationship with priority settings – for example sport, schools, media, workplaces
    - ✓ They have reach/ relationship with vulnerable groups (those vulnerable to higher rates of chronic disease) – Aboriginal, CALD, people with disabilities, people in rural/remote areas, and older people.
    - ✓ They can work across the continuum – prevention, early intervention and response.
    - ✓ They can take a multidisciplinary approach, bringing together professionals, organisations, individuals and communities from very different backgrounds and with many different skills and experiences.
    - ✓ They can provide leadership and want to lead / play an active role in chronic disease prevention.
    - ✓ If resourced & supported, they can drive whole of organisation / whole of community programs
- Appropriately address issues with data that would enable better measurement of the incidence of chronic disease and better evaluation of prevention activity. To this end:
    - ✓ Address gaps in data collection to measure progress in preventing chronic diseases.
    - ✓ Fund and support existing regional partnership platforms to collect and manage local data.
    - ✓ Promote mechanisms that support more effective sharing of data across a range of services to provide a more comprehensive insight into the prevalence and prevention of chronic disease.

Vignette: Falls Prevention Project

In 2011 the North East PCP received funding to implement a community based project that targeted elderly clients with a history of falls who resided in their own homes and were aged 75 and over. Occupational Therapists (OT's) conducted home hazard assessments and facilitated implementation of relevant recommendations and modifications. Clinical results of the project included assessing 65 eligible clients averaging 82 years of age, the average rate of falls per client in 6 months prior to OT service was 1.86 compared to 0.52 falls per person within 12 weeks post OT assessment. The other aspect of the project had a service coordination flavour with a view to strengthen partnerships and explore opportunities for new referral pathways to Community Health from agencies in the community, such as Austin Falls and Balance Service, Emergency Department, Home and Community Care (HACC) Planned Activity Groups (PAG), Vision Australia and Ambulance Victoria. In addition the role of Occupational Therapists and their contribution to falls prevention was promoted to managers and team leaders of HACC Planned Activity Groups in the NEPCP catchment area.

NEPCP was fortunate to be offered a second year for this project and with this opportunity we continued to support the increase in OT capacity in the three community health services to undertake home hazard assessments. In the second year the project participants had averaged 2.1 fall per person in the 6 month period prior to OT assessment which was reduced to 0.22 falls per person when clients were reviewed at 12 weeks or discharged. During this year we also undertook a schedule of health promotion presentations on falls prevention concentrating on CALD Planned Activity Groups in the catchment including the distribution of a booklet called "Don't fall for it, falls can be prevented" in English and other languages as appropriate to the group.

Recommendations – Preventing Chronic Disease

1. **Recognise and address the determinants of disease**
    - Governments must demonstrate greater willingness to address determinants of obesity and overweight that reside in systems of food production, distribution and marketing. Behaviour lifestyle programs alone will not be sufficient to address rising rates of obesity.
    - Ensure that all work to prevent chronic disease is evidence based
2. **Invest more resources in prevention activities**
    - Adequately fund existing projects and initiatives
    - Recognise that investing in prevention is a long term strategy
    - Focus on children and young people as change may take place over a generation
3. **Build on existing plans and partnerships whilst strengthening statewide leadership**
    - Ensure that prevention has greater focus in commonwealth funding priorities
    - Do not create new structures and partnerships when rolling out new initiatives

Further Information

Prepared by: Dr Susan Rennie

Manager Policy and Strategy

Victorian Primary Care Partnerships

For further information please contact susan.rennie@bchs.org.au, or Susan 0425 706 978

Appendices

The following documents have been attached as appendices:

1. Department of Health (2011) Primary Care Partnerships: Achievements 2000-2010
2. Victorian PCP Communique to PHNs
3. Improving Coordination of Diabetes Care in the North East: *What if we could engage our community earlier in their diabetes care?* Case Study
4. Physical Health Matters Too Case Study
5. A Regional approach to Type 2 diabetes care Case Study
6. Inner North West PCP Diabetes Services Review Collaborative Project Case Study