Victorian Primary Care Partnerships

Submission to the Review of new arrangements for the delivery of Mental Health Community Support Services and Alcohol and Drug Treatment Services

August 2015

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Purpose

This submission has been prepared to inform the Review of new arrangements for the delivery of Mental Health Community Support Services and Alcohol and Drug Treatment Services about the work in service coordination and chronic disease prevention and management that is undertaken by Primary Care Partnerships (PCPs) in Victoria. The intention of informing the Review of this work is to ensure that any changes made to current operating arrangements take into account existing best practice in these areas and remedy some of the impacts that have been felt by PCP partner agencies which are delivering or have an interface with Mental Health and Alcohol and Drug Services.

Primary Care Partnerships (PCPs) are established networks of local health and human service organisations. Funded by the Department of Health and Human Services, 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. Over the past 15 years, 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. PCPs now 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 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, alcohol and drug treatment 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 2011 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 service coordination because this is the key area which has been impacted by the reforms and new arrangements. Over the past 15 years, PCPs have worked extensively with service delivery agencies across a range of sectors to ensure best practice in service coordination, recognising that efficient and effective access to services is critical to achieving good health outcomes. Some new providers of services under the new regime have been unfamiliar with past work in this area. As a result, practices that are inconsistent with Service Coordination have emerged in some areas. We consider this to be an area where solutions are available and collaborative work through the PCP platform can ensure that all services meet best practice standards in these areas.

This submission is divided into two main sections. The first section relates to the PCP role in Service Coordination. This is one of the key planks of the PCP platform. 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 second section of the report will report on the work of PCPs in Integrated Chronic Disease Management (ICDM). Finally, this submission includes a comprehensive case study and some shorter vignettes to highlight the type of work that PCPs are able to deliver.

The Terms of Reference for the Review being undertaken by is focussed on the following areas:

1. Identifying what is working well with the new system;
2. Exploring any gaps or issues with the new arrangements, and identify potential solutions to address these;
3. Listening to clients, carers, service providers and referrers about how the functioning of the system can be further improved;
4. Identifying where further work may be required to address any outstanding system functioning or implementation issues; and
5. Providing a basis for future planning and strategic service development, including but not limited to development of the new ten-year mental health plan and preparation for transition to the National Disability Insurance Scheme.

This submission will primarily focus on areas two and four. Furthermore, it does not seek to offer specific feedback in relation to particular programs operating within the community. This is better done by Mental Health and Alcohol and Drug Treatment Services themselves, many of which are active members of PCPs. Rather, general feedback from PCPs has been that some of the gains made in service coordination practice over the past fifteen years have been disrupted by the new arrangements. New agencies have entered the arena which have not previously signed up to Service Coordination principles. However, we are confident that all agencies will be able to achieve best practice in this area if they are encouraged to subscribe to existing principles and protocols as outlined in the Victorian Service Coordination Practice Manual.

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, mental health and alcohol and drug issues. 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, mental health and drug and alcohol issues 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 mental health and alcohol and drug issues 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 these issues and refer appropriately to specialist funded agencies.

Effective partnerships are crucial to ensure that all people who experience mental health and alcohol and drug issues 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 in the community.

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:

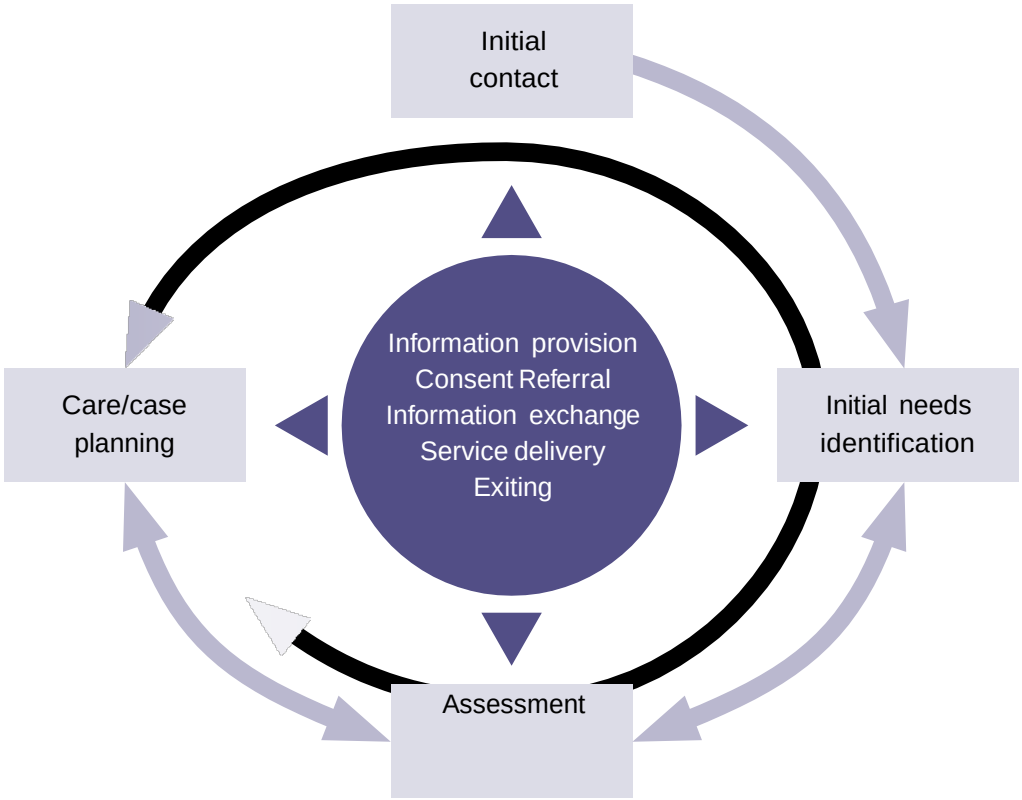
- Practices, processes, protocols and systems that set out clear guidelines and expectations around key areas of work and inter-organisation practice, including continuous quality improvement strategies aligned with accreditation standards
- Documented practice standards for the elements of service coordination 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

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 complex mental health and drug and alcohol issues. In these casse, people often 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[2]:

- 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.

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 mental health and drug and alcohol issues 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

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

secure means of transferring client data will ultimately lead to more efficient and effective service delivery.

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.

Mental health conditions and protracted alcohol and drug issues present particularly complex chronic disease issues which tend to be exacerbated when not identified and addressed early.

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.

Integrated chronic disease management is key to PCP work. It fits within the program logic 2013–17[3] 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 as well as empowering individuals to live a healthy lifestyle. In order to maximise impact

[3] 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

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 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.

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.

Examples of PCP work

Physical Health Matters Too

Physical Health Matters Too is an excellent example of work that a PCP has facilitated which has had very real impacts of work practice in the area of health needs screening. 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. People accessing mental health services in this catchment are now far more likely to receive comprehensive health screens and have better access to health services. More details about this initiative can be found in Appendix 2.

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

1. **Implement the Service Coordination framework across all funded mental health community support services and alcohol and drug treatment services 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 including all agencies funded under this reform.
- All agencies funded under these reforms should be encouraged to be memebrs of their local PCP.
- 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.

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. Physical Health Matters Too Case Study