Primary Care Partnerships





Ageing populations, increasing rates of chronic disease and spiraling health costs have made the need to keep people healthy a critical goal for western governments.

The Victorian Government took an innovative approach to this challenge almost a decade ago when it recognised the potentially transforming benefits for consumers from increased collaboration between service providers in local communities.

The government understood how local collaboration between agencies, organisations, general practitioners and other health practitioners would facilitate better consumer access to primary health care services, better service coordination and better continuity of care.

This would keep people well as long as possible, out of hospital and reduce duplication within the health system.

The resulting Primary Care Partnership (PCP) Strategy, initiated by the Victorian Department of Human Services in 2000, is now leading the way in health care reform.

It involves 31 partnerships among more than 800 health services and agencies across Victoria and is producing positive health outcomes as well as a more efficient health system.

Partnerships are the key

As the Commonwealth Government recognised in its report on primary health care reform[1], August 2009, the kind of work performed by Primary Care Partnerships is vital to improve the health of the nation.

In Victoria, members of the partnerships are the people at the first point of entry into the health system—the frontline.

They typically include divisions of general practice, hospitals, community health services, local government, aged care assessment services, women's health services, community drug treatment services, ethno-specific health services, mental health services and disability services.

Before partnerships many service providers worked in isolation, often unaware of the range of services that could benefit their clients. Now service providers have support from, and

1 Commonwealth of Australia, 2009, *Primary Health Care Reform in Australia—Report to Support Australia's First National Primary Health Care Strategy.*

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knowledge of, what other providers have to offer.

They work together and share information to enable coordinated service system responses—responses especially important for people with chronic disease or complex care needs who need help from a range of services.

Continuity of care is vital in keeping people out of hospital. General practitioners (GPs) are central to achieving this at the local level, which is why divisions of general practice are core members of the partnerships.

More than 600 GPs have worked with the partnerships on issues ranging from identifying consumer health needs to multi-disciplinary care planning resulting in more comprehensive and timely communication between GPs and other service providers.

The partnerships are building a unified health system, with the various parts working together for the benefit of consumers. Partnerships have enhanced service delivery, making life easier for consumers, improving health outcomes and increasing the efficiency of Victoria's health sector.

Victoria's partnership strategy is working

As early as 2004, a KPMG evaluation report found they had led to earlier identification of client needs, more timely and complete responses to these needs, easier client navigation of the system and better client access to coordinated services.

The report found that the partnerships had resulted in shorter intake and assessment times, better waiting list management, reduced administrative duplication and clearer staff understanding and definition of their roles.

In October 2008, HDG Consulting reported on the impact of partnership collaboration on integrated health promotion, activity involving designing health promotion programs that prioritise and tackle local health and wellbeing issues by harnessing resources across agencies.

HDG found that benefits included improvement in integrated planning, increase in organisational capacity for health promotion and healthier communities.

With every year of partnership activity, the relationships between members of local communities and health professionals have been strengthened, thereby creating more resilient local communities.

The reputation of Primary Care Partnerships is now such that they are expanding to include local non-health agencies such as police, schools, and community and welfare groups seeking a more comprehensive and effective way of reaching people.

They have also been chosen as delivery platforms by other organisations such as the Ministerial Drought Taskforce (mental health initiatives tackling impacts of drought) and the Victorian Department of Justice (Taking Action on Problem Gambling Strategy).

This is all evidence that Victoria's partnership strategy is working.

Better access to services

Victoria's Primary Care Partnerships are ensuring better consumer access to the services they need.

Consumers benefit from partnership initiatives, whether they are integrated health promotion campaigns and programs or improved needs assessment and referral by service providers who communicate with each other.

Better access also improves opportunities for early intervention and health promotion.

One example was collaboration between 16 member agencies in the Portland region on a primary prevention program for 'hard to reach' industry workers with a high-risk of heart disease.

By the end of the program the workers' cholesterol, blood glucose and blood pressure were at healthier levels. They felt less anxious, ate more healthily and had reduced alcohol consumption and smoking. Further, many workers who had not seen a GP for years were now connected with the health system.

Many members of PCP agencies report their satisfaction at being able to better help their clients. As one Drug and Alcohol Worker (Bass Coast Community Health Service) said: *'Now, if I see a client with alcohol issues, I look for related problems that might benefit from the input of another worker, such as poor circulation caused by peripheral vascular disease which may signal foot problems.'*

In a multitude of ways Primary Care Partnerships are improving consumer access to services throughout Victoria.

Continuity of care

Since the partnerships were established, Victorians are experiencing improved continuity of care.

Using standard statewide agreed business rules outlined in the partnerships' Victorian Service Coordination Practice Manual, staff in member agencies are collecting consumer information, identifying consumer health care needs, making multiple referrals and receiving referral feedback in a more consistent way.

By 2008, more than 90 percent of PCPs had partly or fully integrated these agreed rules, including obtaining consumer consent for disclosure of information, responding to urgent and routine referrals, monitoring people between referrals and providing referral feedback.

Since the PCP strategy, service providers have gained a better understanding of the local primary health care system and access to detailed information about health services throughout the state using electronic service directories. With consumer consent, providers also share client information through secure electronic systems.

Rather than simply look at what each agency can do for a person, health workers now look beyond the consumer's immediate health issue to consider other services from which they would benefit. The health workers then engage in all-important referral feedback.

For consumers, this means no longer having to retell their story every time they see someone new, or find their own way around a service system that may seem confusing. More people now experience various parts of a system that work together.

For the health system, this has reduced duplication and made more efficient use of existing resources.

Chronic disease prevention and management

Since 2000 the Primary Care Partnerships have led the way with planned and integrated approaches to chronic disease, re-orientating health and human services to manage the increasing demands of chronic disease in our communities.

Tackling chronic disease requires a mix of prevention strategies to keep healthy people in good health for as long as possible and management strategies to help people with chronic disease lessen the impact of their condition.

Recognising that preventing chronic disease is most effectively achieved through a system that's proactive and promotes good health practices, member agencies work together to plan and implement shared heath promotion programs.

At the local level this has ranged from better access to fresh fruit and vegetables in public housing estates by providing transport to community gardens and markets, to blood pressure checks at community events to increase early detection of high blood pressure.

Member agencies also work together on the management of chronic disease. People with chronic disease or complex care needs often require a number of different services, and it's now very clear that those services work most effectively when they're coordinated.

Banyule Nillumbik Primary Care Alliance PCP created a general practice liaison role which resulted in more than 50% of the region's GPs making referrals to early intervention programs targeting medical conditions such as Type 2 diabetes and heart and respiratory disease. This meant that clients received services earlier which prevented or delayed disease progression.

Another example, from the Wimmera partnership, was service providers articulating their roles and responsibilities within a local plan to improve support for people with chronic disease, resulting in consumers having a hand-held record and benefitting from improved transition between services.

The positive outcomes of partnership collaboration have included more client care plans, more coordination of self management support programs and more information sharing between service providers.

The electronic revolution to support better care

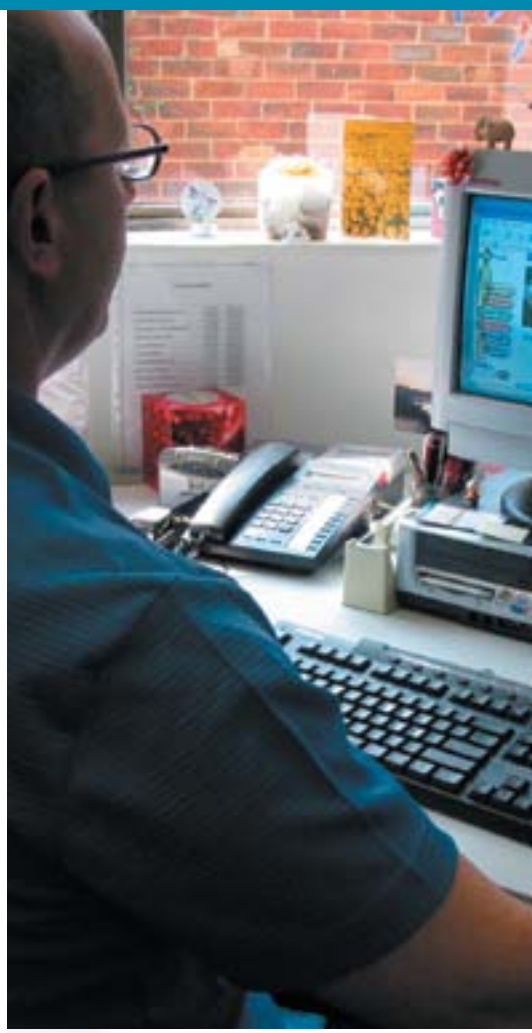
Secure electronic communication to share consumer health and care information assists Primary Care Partnerships improve consumer care.

Since the partnerships were established member agencies have agreed on how to coordinate their services, leading to significant growth in sharing consumer health and care information through secure electronic systems.

E-referral allows, with consent, a standard set of consumer health and care information known as the Service Coordination Tool Templates to be shared securely between services. The templates were established by the Department of Human Services in collaboration with the partnerships.

This electronic communication has made life easier for consumers by reducing the time required for collecting their registrations, identifying their health care needs and receiving multiple referrals. They also benefit from not having to repeat their story every time they see someone new.

In 2006–07, more than 34,000 e-referrals were made between 450 services using secure electronic systems, nearly double the previous year. In 2007–08, more than 95,000 e-referrals were made.



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In the words of an emergency care coordinator from Eastern Health: *'E-referral, and the agreed common practices that underlie it, has supported us to link in more strongly with other services. When we e-refer we know that we will get good quality and quick referral feedback and as a result we feel confident to refer more broadly than before.'*

Benefits have included reduced administrative duplication, improved waiting list management, more timely and relevant information for service providers and freeing up time for service providers to dedicate to meeting consumer needs.

Responding to specific community needs

Every community has its own set of circumstances, demographics, and particular health and care needs. This is why Primary Care Partnerships are made up of local people and organisations working together for the benefit of their own communities.

One example of a community containing vastly different health needs is Melbourne's western suburbs. Here, two partnerships have been working on improving access to, and coordination of, services for people from a refugee background.

Participants include people from local government, hospitals, community health centres, divisions of general practice, district nursing, psychiatric disability support services and rehabilitation services, as well as a range of other local, regional and statewide agencies.

This has resulted in reduced duplication of services, more efficient service coordination, better understanding of referral pathways and integrated approaches to health promotion practices.

Another example is tackling depression in small communities in drought-affected rural areas where partnerships have helped bring Mental Health First Aid training to members of the community—including training tailored to youth and Indigenous people—at no cost.

This has led to broader community understanding of the condition, and better access for people with depression to the services that can help them.

Better access has also arisen from an integrated health promotion program involving Upper Hume Primary Care Partnership members, Mungabareena Aboriginal Corporation and Women's Health Goulburn North East. They developed cultural awareness training and a resource kit to help local service providers.

As one Indigenous participant said: *'This approach has made a difference to our community members accessing generalist health.'*

Many examples—from the inner city to rural areas—demonstrate how the flexibility of local Primary Care Partnerships lead to effective responses to local community needs.

Benefiting the whole community

A range of government departments and associated authorities are coming to recognise the success of Victoria's Primary Care Partnerships in tackling issues common to all communities.

The partnership system is robust and flexible, and can be readily applied in situations beyond the primary health sector.

Early recognition came in October 2006 when the partnerships were selected by the Ministerial Drought Taskforce as a platform for delivering comprehensive mental health initiatives to respond to the impacts of drought.

Since 2006 the Victorian Department of Justice has invested in Primary Care Partnerships to deliver on more systematic approaches to service coordination and promoting healthy communities as part of the Taking Action on Problem Gambling Strategy.

There are many examples of how the partnerships—as a network of health services intersecting with the non-health sector—have the capacity to coordinate and implement responses to a broad range of community issues.

Changing the face of health services

As populations age, the demand for health services will increase. Every aspect of health care is becoming more complex and more expensive.

The rate of change is placing increasing pressure on our health system. It's not simply a matter of building more hospitals or training more health workers.

It's a matter of finding new ways to use existing resources more effectively, ways of keeping people healthier and out of hospital, and having the ability to bring resources together to make the community healthier.

Its collaborative approach to prevention of illness and the coordination of services has placed Primary Care Partnerships at the cutting edge of national health reform.

The Primary Care Partnership Strategy is one that aims at keeping Victorians healthier. At the same time, it's helping the people who work in Victoria's health system by keeping it healthier as well.

Other brochures on Primary Care Partnerships are available at **www.health.vic.gov.au/pcps** and include:

- *Electronic revolution supports better care*
- *Promoting healthy communities*
- *Better access to services*
- *Chronic disease prevention and management*