



HEALTHPATHWAYS MELBOURNE COMMUNITY RESOURCES PROJECT

Final Report – September 2015

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EXECUTIVE SUMMARY

HealthPathways Melbourne (HPM) is a web-based system for General Practitioners (GPs) that helps coordinate patient care across the acute and primary care system and provides guidance for GPs on assessment, management and referral details for common medical conditions. The HealthPathways Melbourne Community Resources project was a collaboration between Inner East Melbourne Medicare Local (IEMML) and Inner East Primary Care Partnership (IEPCP) between February and June 2015.

The aim of the project was to extend HealthPathways Melbourne content to include community resources to meet the needs of patients with chronic and complex health needs, represent the services of community agencies in the Inner East region of Melbourne and provide new material to GPs about the range of services and supports available in their area.

The project involved consulting with consumers with chronic conditions and carers, utilising focus groups, surveys and a phone interview. Feedback provided by these groups was used to inform the community resource information added to the HPM website.

Other key stakeholders were also consulted including local Community Health Services, subject matter experts and service providers working in relevant fields. The Project Officer worked closely with the IEMML HPM team and GP Clinical Editor.

This project resulted in extending existing pathways and creating new pathways relating to aged care assessment, bereavement, grief and loss, carer support, carer stress, community transport, dementia and younger onset dementia and elder abuse and neglect. The existing localised cardiac, diabetes and respiratory pathways on HPM were also reviewed to determine whether there were any missing community resources.

The HealthPathways Melbourne Community Resources Project has demonstrated the complimentary skills and approaches of Primary Care Partnerships and Medicare Locals. Primary Care Partnerships have close working relationships with a wide range of community organisations and this created an opportunity to add “the next layer” to the information provided on HealthPathways.

Recommendations for future actions are:

- Extend the Community HealthPathways work to cover the whole Eastern Primary Health Network catchment
- Increase the number of chronic disease community pathways
- Increase information about local government services on HPM
- Tap into PCP knowledge and skill in community consultation processes
- Expand the range of resource information for GPs and consumers
- Apply the model developed within this pilot project to other Primary Health Network regions across Victoria, in collaboration with local Primary Care Partnerships
- Evaluate the Community Resources component of the HealthPathways project.

BACKGROUND AND CONTEXT FOR PROJECT

HealthPathways is a web-based system for General Practitioners (GPs) that helps coordinate patient care across the acute and primary care system. The pathways provide guidance for GPs when seeing patients in their practice for assessment, management and referral details for common medical conditions. HealthPathways was originally developed in New Zealand by the Canterbury District Health Board and a number of Australian Medicare Locals have subsequently developed local content to meet the needs of GPs in their catchment areas.

HealthPathways Melbourne (HPM) is a website which contains pathways that have been localised or developed for Melbourne's Inner North West and Inner East regions (<https://melbourne.healthpathways.org.au>). HPM is currently managed by Inner East Melbourne Medicare Local (IEMML) (now Eastern Melbourne Primary Health Network) and Inner North West Melbourne Medicare Local (INWMML) (now North Western Melbourne Primary Health Network).

The aims of HealthPathways Melbourne are to:

- Enhance clinical knowledge and promote best practice care
- Build collaboration and reduce fragmentation across the health service network
- Reduce the number of patients referred to specialist care who could be managed in a primary/community care setting.

The HealthPathways Melbourne Community Resources project was a collaboration between IEMML and Inner East Primary Care Partnership (IEPCP). A Project Officer was employed by IEPCP between February and June 2015 working at 0.8 EFT. The project was funded by the Victorian Department of Health and Human Services.

Project Aim and Objectives

The aim of the project was to extend HealthPathways Melbourne content to include community resources to meet the needs of patients with chronic and complex health needs, represent the services of community agencies in the Inner East region of Melbourne and provide new material to GPs about the range of services and supports available in their area.

The objectives of the project were to:

1. Enhance and extend existing pathways to represent a wider range of health and community services.
2. Develop a range of new pathways for GPs on support services for patients with chronic and complex health conditions.
3. Source and/or develop a range of resources for GPs to print out for patients.
4. Document the process of developing these extended pathways for use in future projects.

METHODOLOGY

Review of relevant literature

An informal review of literature was conducted relating to services consumers with chronic illness and their carers find useful. The articles identified informed decision making about the types of community services to include in new HPM pathways and resource pages. The services identified in the literature generally mirrored the information obtained during the consumer and carer consultations about what services were found to be helpful.

Identification of new pathways

Topics for new HealthPathways Melbourne pathways and resource pages relevant to GPs managing patients with chronic and complex health conditions were identified through the following methods:

- Consultation with the IEMML HealthPathways Melbourne team and GP Clinical Editors, Dr Precious McGuire and Dr Sophia Samuel
- Discussion during the IEPCP Members Forum Workshop in October 2014
- Requests from health professionals.

Identification of service types

Service providers at the Eastern Region Service Coordination Practitioners Network and managers of Community Health Services were consulted at the beginning of the project regarding the types of community services people with chronic conditions and their carers may find useful. The following list of service categories was created as a result:

- **Allied health, counselling & nursing:** cardiac rehabilitation/maintenance programs, hydrotherapy, exercise programs, diabetes support services, dental services, speech pathology, physiotherapy, podiatry, occupational therapy, nursing, psychology/counselling, pulmonary rehabilitation, health promotion program.
- **Social support/Activities:** Men's shed, Planned Activity Groups/Clubs, senior citizen's groups, self-management groups, carer/family support, music/art classes and groups, peer support/support groups, volunteer work, education (e.g. University of the Third Age).
- **Information & Advocacy:** support organisations/peak bodies (e.g. Alzheimer's Australia), condition specific programs (e.g. diabetes education), health information/education (e.g. stress management), legal service, advocacy service, peer support, housing service.
- **Practical support:** emergency relief, cleaning, community transport, council/Home and Community Care, gardening, respite, employment/work assistance, aids and equipment.

These categories were utilised to inform construction of the questions in the carer and consumer surveys.

Community consultations

A total of 87 community members were consulted by focus group, survey and phone interview regarding services they found helpful either in their caring role or to manage their chronic condition and remain independent in the community. They were also asked about information, websites or resources they would recommend for people in their situation. Surveys elicited both quantitative and qualitative data and focus groups elicited qualitative data. Fifty participants were carers of someone with a chronic condition and 37 participants were people living with a chronic condition such as heart disease, diabetes, respiratory conditions and musculoskeletal conditions. See Table 1 below for numbers of participants in each group.

Table 1. Number of participants consulted during project

	Focus group	Survey	Phone interview	Total
Carers	6	44	0	50
People with chronic condition	7	29	1	37
Total	13	73	1	87

Consumer consultations

The consumer survey and focus group were promoted to consumers by the Inner East Primary Care Partnership, Inner East Melbourne Medical Local Healthy at Home program, Chronic Illness Alliance, Link Health and Community, Carrington Health, Inner East Community Health Service and the Health Issues Centre by email, social media and by placing hard copies at their locations (Link Health and Community and Carrington Health).

The consumer survey was created using Survey Monkey and distributed by email, social media and hard copy. Before distribution, the consumer survey was reviewed for appropriateness by Alistair Kerr, IEMML reference group consumer representative. Seventy hard copies were distributed with a cover letter and reply paid envelope and twenty-nine responses were received in total, eight of which were hard copy with the rest received online. All respondents had chronic illnesses.

Two focus groups for people with a chronic condition were conducted by the Project Officer and an IEPCP colleague, consisting of seven participants in total, with one person subsequently interviewed by phone as they could not attend the group. One focus group was comprised of members of the Carrington Health Good Life Gym who responded to fliers posted at Carrington Health. Good Life Gym members were chosen as they all have chronic illnesses. The other focus group was comprised of people who responded to an email invitation distributed by the Chronic Illness Alliance. Focus group participants received a \$30 Coles voucher to offset travel expenses.

All focus group participants had chronic illnesses; four had cardiac conditions, three had diabetes and two had respiratory conditions. Some had more than one condition. Participant responses were recorded on a digital audio recording device and by hand written notes.

Information and themes were extracted by the Project Officer and separated into information relating to services for people with cardiac, diabetes and respiratory conditions, in order to inform a review of the existing localised cardiac, diabetes and respiratory pathways on HPM to identify gaps in community resources.

See Appendix 1 for consumer focus group and survey questions.

Carer consultations

The carer survey was created using Survey Monkey and distributed by email, social media and hard copy. One hundred and thirty hard copy surveys with a cover letter and reply paid envelope were distributed to local carer support groups meeting at Uniting Age Well (Strathdon Community and Elgin Street Centre), UnitingCare East Burwood Centre and Whitehorse City Council. The Chronic Illness Alliance, Health Issues Centre and IEPCP promoted the survey by email and newsletter. Forty-four responses were received, 31 of which were hard copy and 13 online.

A focus group was conducted with six members of the mecwacare Bowen Street Carer Support Group, Malvern East during their usual meeting time. All members were carers of a person with a chronic illness or who were frail aged. Conditions of those being cared for by group members included cancer, osteoporosis, acquired brain injury, epilepsy, depression, dementia, younger onset dementia and stroke.

The information collected during the carer consultation process led to the addition of resources and support services to the following new pathways and resource pages:

- Carer stress
- Carer resources and support services
- Dementia resources and support services.

See Appendix 2 for carer focus group and survey questions.

Consultations with key stakeholders

Consultations were conducted with key stakeholders who work with people with chronic illness and carers to establish the services and supports stakeholders were aware of that consumers found most helpful to enable them to maintain their health and independence.

GP Clinical Editors

The Project Officer worked closely with IEMML GP Clinical Editors during this project who approved all new pathway topics, drafted and reviewed clinical information, gave input into and signed off on all completed pathways. Clinical Editors were also consulted on the type of information they require when referring patients to community services (e.g. location, business hours, feedback from service to GPs, transport options) and their preference for presentation of information on HPM. This information was taken into account when collating information for the HPM website.

Service providers

Engagement with service providers working in fields relevant to the new pathways took place in order to obtain information on relevant services and resources for consumers and carers. Service providers were identified through existing IEPCP and IEMML networks and contacts, including peak bodies and relevant agencies.

The Project Officer and IEMML HealthPathways Coordinator gave a presentation to the Eastern Region Service Coordination Practitioners Network in March 2015, outlining the project and asking attendees to complete an Expression of Interest (EOI) form indicating their interest in providing feedback on draft HPM pathways and their area of expertise. Members of the Eastern Region Dementia Network were also emailed the EOI form. Service providers were subsequently contacted to review relevant pages.

Community Health Services

The four Community Health Services within the Inner East region of Melbourne (Link Health and Community, Carrington Health, Inner East Community Health and Manningham Community Health) were targeted, given their provision of a wide range of services to people with chronic and complex illness in the region.

Managers of Community Health Services identified appropriate community health staff for interview during a presentation on the project to the Eastern Metropolitan General Managers Community Health Services meeting in March 2015 by the Project Officer and IEMML HealthPathways Coordinator.

Service coordination and management staff from the four Community Health Services within the Inner East were interviewed by the Project Officer to gather the following information:

- Services they provide for carers and people with chronic/complex medical conditions.
- Referral process for GPs.
- Programs they run or recommend that might be of value to someone who is a carer or has a chronic/complex medical condition.
- Other relevant services they were aware of.

Making these contacts also paved the way for the IEMML HPM team to contact community health staff regarding clinical services they provide relating to pathways which were not part of this project.

[Subject matter experts](#)

Twenty nine service providers and subject matter experts were invited to review draft HPM pathways. These included staff from:

- IEMML HPM Older Person's Working Group (comprising medical specialists, allied health professionals, General Practitioners and other service providers)
- Aged Care Assessment Services
- Community Health Services
- Eastern Community Legal Centre
- Inner East Melbourne Medical Local
- Seniors Rights Victoria
- Chinese Cancer Society of Victoria
- Uniting Care Life Assist.

These experts and service providers provided feedback and suggested resources through the feedback function on the HealthPathways Melbourne website. This enabled all feedback to be recorded, collated and actioned by the IEMML HPM team.

At the conclusion of the project all contacts developed during the project were emailed links to the completed pathways on the live HPM site and invited to provide feedback and provide advice regarding new or updated resources in future.

[Desk top analysis](#)

Desktop analyses on the internet were also conducted to identify community resources and services relevant to patients with chronic diseases and complex needs in the inner east Melbourne catchment. The Project Officer also utilised her previous experience in working with carers, older people and people with chronic conditions to inform some of the resources selected for inclusion.

KEY DELIVERABLES

The following key deliverables were completed during the project.

Creation of new Clinical, Referral and Resource pathways

Table 2 lists the new pathways which were created during the project, the pathway type and the date the pathway was uploaded to the live HPM website.

Pathway types are defined as follows:

- **Clinical pathway** – summarised guidance on the assessment and management of a presenting condition in general practice
- **Referral** – information on a range of community and hospital specialist services, referral requirements and contact details
- **Resource** – additional reference material relating to the clinical pathway and speciality services.

Table 2. New pathways created during Community Resources Project

Name of Pathway	Pathway Type	Date live on HPM website
Elder Abuse and Neglect	Clinical	20 May 2015
Aged Care Assessment Service (ACAS)	Referral	29 May 2015
Carer Stress	Clinical	30 Jun 2015
Dementia Resources and Support Services	Referral	1 Jul 2015
Younger Onset Dementia Resources and Support Services	Resource	1 Jul 2015
Community Transport Providers	Resource	1 Jul 2015
Carer Resources and Support Services	Resource	1 Jul 2015
Bereavement, Grief, and Loss	Clinical	17 Jul 2015
Bereavement, Grief and Loss Resources and Support Services	Resource	17 Jul 2015

Resources for GPs to print out for patients

A Carer Services Patient Information sheet was created in a PDF format which can be printed and given to patients. This resource lists Victorian and national support services with phone numbers and websites which are relevant to carers. The information sheet was attached to the following pathways:

- Carer Resources & Support Services
- Carer Stress.

Links to brochures and other printed information about services were added to pathways where appropriate.

Review of cardiac, respiratory and diabetes pathways

The existing localised cardiac, diabetes and respiratory pathways on HPM were reviewed by the Project Officer to determine whether there were any missing community resources that had been mentioned by consumers with these conditions as being helpful. Seventeen cardiac, 21 diabetes and 11 respiratory pathways were reviewed.

The Project Officer extracted responses given by consumers with cardiac, diabetes and respiratory conditions from the consumer focus groups and consumer survey to determine which services were most helpful for them. Table 3 shows numbers of consumers with each condition.

Table 3. Number of consumers with each condition

	Focus group/ Interview	Survey	Total
Cardiac	4	4	8
Diabetes	3	6	9
Respiratory	2	4	6

NOTE: Several consumers had more than one condition.

The review found that many of the resources already on HPM were identified as useful services by consumers with cardiac, diabetes and respiratory conditions. Recommendations were made to localise some pathways, add resources which were seen as useful and ensure any missing links to these resource pages were added. Comments were made regarding which of these services consumers with these three conditions reported as helpful. The Project Officer provided a report to the IEMML HPM Team and HPM Operations Group (see Appendix 3) on this review.

[Review of Inner North West community resource information](#)

Due to limited timeframes for the project and IEPCP's Inner East catchment area, only some community resource information for the Inner North West region was added to HPM. To assist INWMML to determine gaps in services in their region in the resource pages created during this project, the Project Officer reviewed each pathway developed within the project to indicate the regions covered (see Appendix 4).

[Regular reporting to HPM Operations Group and Working Groups](#)

The Project Officer attended the following meetings to provide regular reports, both informal and formal:

- Weekly IEMML HPM Coordinators Huddle – all meetings
- Fortnightly IEMML HPM Team Meeting – all meetings
- Monthly HPM Operations Group (comprising IEMML and INWMML staff, GP Clinical Editors and hospital staff) – presented at the February and June 2015 meetings
- Monthly IEMML/INWMML and Eastern Melbourne Medicare Local HPM Coordinators teleconference – attended once at beginning of project
- HealthPathways Melbourne Strategic Group meeting – Report provided to Manager, Medicare Local Integration and Hospital Engagement for February 2015 meeting.

[Documented process for creating community resources](#)

The following process was developed to create pathways relating to community resources and can be utilised in future to create similar pathways:

1. Identify new pathway or existing pathway requiring additional community resources.
2. Identify subject matter experts and service providers relevant to pathway through HPM team, collegial networks and desktop analysis.
3. Obtain consumer and carer input on relevant resources through:
 - a. Consumer/carer representative (e.g. reference group member, Health Issues Centre consumer)
 - b. Consumer/carer survey
 - c. Consumer/carer focus group (See Appendix 1 and 2 for survey and focus group questions).
4. Follow established HPM protocols for drafting pathways, taking into account consumer input.
5. Send draft pathways to relevant service providers and subject matter experts working in the field for review.

OUTCOMES

The HPM Community Resources project has achieved the following outcomes:

- A successful collaborative partnership between Inner East Melbourne Medicare Local and Inner East Primary Care Partnership, sharing expertise and working on a common goal.
- Provided GPs and health professionals in the Inner East with access to a wider range of services for their patients and access to information on health and community resources.
- Added value to an existing e-health system that is utilised by GPs.
- Engaged local Community Health Services in the updating of current information and addition of new information on HPM.
- Incorporated consumer input into a resource which aims to improve patient outcomes.
- An increase in traffic on the HPM website to the new pathways created during this project in June 2015.

RECOMMENDATIONS

The HealthPathways Melbourne Community Resources Project has demonstrated the complimentary skills and approaches of Primary Care Partnerships and Medicare Locals. Primary Care Partnerships have close working relationships with a wide range of community organisations and this created an opportunity to add “the next layer” to the information provided on HealthPathways.

Participating in the project enabled IEPCP to deliver on two of its core deliverables: improving the coordination of services and chronic disease management. At the same time, it provided a very practical way to strengthen the relationships and working partnership with Inner East Melbourne Medicare Local.

There is potential to build on this work, with a range of benefits:

Increase geographic reach

- Extending the HealthPathways Community Resource work to cover the whole Eastern Primary Health Network catchment would provide a practical opportunity for the newly formed Eastern Melbourne PHN to work closely with the PCPs in their catchment and gain a better understanding of both the PCPs and the local community organisations.

Increase the number of chronic disease community pathways

- There is potential to look at a wider variety of chronic illnesses and the supports available in the community and replicate the extended pathways for these client groups.

Increase information about local government services

- Including more information about the services provided by local Councils would give GPS access to an increased range of community resources, in particular: aged, disability, carer, maternal and child health, youth and multicultural services.

Tap into PCP knowledge and skill in community consultation processes

- When creating pathways with community resources, consult with consumers and carers of people with conditions relevant to each pathway, as well as local community services who provide services to this group.

Expand the range of resource information for GPs and consumers

- Consider the following pathways for future development (based on recommendations discussed during this project by the IEMML HPM team and IEPCP Members Forum):
 - Dementia patient information sheet
 - People with chronic and complex illness
 - Homelessness/Housing
 - Volunteer services
 - Social inclusion
 - Chinese speaking people
 - Culturally sensitive services
 - Child protection
 - Gambling
 - Drug and Alcohol
 - Disability.

Future directions

In the long term there is an opportunity to apply the model developed within this pilot project to other Primary Health Network regions across Victoria, in collaboration with local Primary Care Partnerships.

It is recommended that the Community Pathways component of the HealthPathways project be evaluated as part of the overall project evaluation. Measures could include:

- Monitoring website traffic to HPM pathways relating to community resources to determine usage rates.
- Evaluating the usefulness of community resource information by obtaining feedback from GPs.

APPENDICES

APPENDIX 1 - CONSUMER FOCUS GROUP AND SURVEY QUESTIONS

Consumer focus group questions

1. What are the most challenging aspects of managing your condition(s)?
2. What services or supports have made the biggest difference to your health & independence?
3. How did these services or supports make a difference?
4. What information have you/would you have found helpful from your GP to help you manage your condition?
5. Are there any websites, information or resources you could recommend for other people with chronic illness?

Consumer survey questions

1. Which suburb do you live in?
2. What is your age?
3. What condition(s) do you have?
4. What condition(s) does the person you care for have?
5. What are the most challenging aspects of managing your condition(s)?
6. What services, resources or other supports have made the biggest difference to your health and independence and why?
7. How helpful have the following services been in helping you manage your condition?
 - a. *A list of allied health, counselling and nursing services was provided*
 - b. *A list of social support/activities was provided*
 - c. *A list of information and advocacy services was provided*
 - d. *A list of practical support services was provided*
8. What information, websites or resources could you recommend help other people with ongoing health conditions?
9. In what way has your GP supported you in managing your condition?
10. How else might GPs be able to support people with ongoing health conditions?
11. Please provide any other comments or feedback

APPENDIX 2 - CARER FOCUS GROUP AND SURVEY QUESTIONS

Carer focus group questions

1. What are the most challenging aspects of your caring role?
2. What services or supports have made the biggest difference to your health & wellbeing as a carer?
3. What information have you/would you have found helpful from your GP related to your caring role?

Carer survey questions

1. Which suburb do you live in?
2. What is your age?
3. What is the age of the person you care for?
4. What condition(s) does the person you care for have?
5. What are the most challenging aspects of your caring role?
6. Which of the following services have you used that helped the person you care for OR you in your caring role?
 - a. *A list of allied health, counselling and nursing services was provided*
 - b. *A list of social support/activities was provided*
 - c. *A list of information and advocacy services was provided*
 - d. *A list of practical support services was provided*
7. Which 3 services have made the biggest difference to your health and wellbeing as a carer?
8. What information, websites or resources could you recommend for other carers?
9. What information have you (or would you have) found helpful from your GP as a carer?
10. In what way has your GP supported you as a carer?
11. How else might GPs be able to support carers?
12. Please provide any other comments or feedback

APPENDIX 3 - COMMUNITY RESOURCE REVIEW OF CARDIAC, DIABETES AND RESPIRATORY PATHWAYS

Cardiac services

Pathway	Existing Community Resource/Service	Notes/Recommendations
Absolute Cardiovascular Disease Risk Assessment	<p>Clinical resources:</p> <ul style="list-style-type: none"> National Heart Foundation <p>Patient information:</p> <ul style="list-style-type: none"> Heart Foundation – Know the risks (available in 10 different languages) 	Consumers valued the Heart Foundation.
Atrial Fibrillation (AF)	<p>Patient Information</p> <ul style="list-style-type: none"> Arrhythmia Alliance Australia Heart Rhythm Society – Patient resources Heart Foundation – Atrial fibrillation summary National Stroke Foundation Australia – Living with atrial fibrillation 	Consumers valued the Heart Foundation.
Cardiac Catheterisation Complications (live)	N/A	
Cardiac Drugs and Monitoring	Patient information section links to My Dr website information about specific cardiac drugs	Consumers valued medication information and medication management.
Cardiac Rehabilitation	<p>Lists private and public cardiac rehab & HARP services</p> <p>Clinical resources:</p> <ul style="list-style-type: none"> Australian Cardiovascular Health and Rehabilitation Association <p>Patient information:</p> <ul style="list-style-type: none"> National Heart Foundation – Cardiac rehabilitation The Royal Melbourne Hospital – Rehabilitation Ward Royal Park Campus 	<p>Consumers valued cardiac rehab.</p> <p>Consumers valued the Heart Foundation.</p>
Exercise Physiology Referrals	N/A	Consumers valued exercise programs.

Pathway	Existing Community Resource/Service	Notes/Recommendations
Exercise Programs	Private: Find: <ul style="list-style-type: none"> • An accredited fitness instructor or business. • An exercise physiologist • A physiotherapist Physical Activity and Life Style Modification Programs: <ul style="list-style-type: none"> • Active Ageing <ul style="list-style-type: none"> • The HEAL Program (delivered by Merri Community Health Services) • Heart Foundation Walking • Heartmoves • Life! • Lift for Life • Lungs in Action • Council directories Community Health Programs	Consumers valued exercise programs. Consumers valued the Heart Foundation. Consumers valued services provided by CHS.
Funny Turns	N/A	
Holter Monitoring	Patient Information <ul style="list-style-type: none"> • Heart Foundation 	Consumers valued the Heart Foundation.
Immediate Cardiology Assessment or Admission	N/A	
Infective Endocarditis Prophylaxis	N/A	
Palpitations	Patient Information <ul style="list-style-type: none"> • Better Health Channel – Heart arrhythmias and palpitations • myDr – Palpitations • Patient.co.uk: <ul style="list-style-type: none"> ○ Supraventricular Tachycardia (SVT) ○ Arrhythmias • iTunes – Cardiograph Application: Heart Rate Pulse Measurement using your iPhone & iPad Camera 	
Percutaneous Coronary Intervention (PCI) Follow Up	N/A	
Stress Testing	Patient Information <ul style="list-style-type: none"> • Heart Foundation 	Consumers valued the Heart Foundation.
Urgent or Routine Cardiology Assessment	N/A	
Urgent or Routine Cardiology Assessment	N/A	

Pathway	Existing Community Resource/Service	Notes/Recommendations
Warfarin - Starting and Monitoring	Patient Information <ul style="list-style-type: none"> • Anticoagulation.com.au: <ul style="list-style-type: none"> ○ One page guide to warfarin treatment ○ Warfarin consumer information ○ Warfarin overview ○ Warfarin self-monitoring (Models) • Atrial Fibrillation and Anticoagulation • Melbourne Pathology – Warfarin Care Patient Guide • NPS Medicinewise – Living well with Warfarin 	Recommend link to medication management once localised.

NOTE: 'N/A' indicates no community resource information was available on that pathway. Clinical resources may have been present.

Recommendations for addition of community resources to cardiac pathways:

1. Link the following pages to cardiac pathways, as these were services consumers with cardiac conditions found helpful:
 - Cardiac Rehabilitation
 - Community Health Services
 - Dental services (once localised)
 - Dietetics Referrals
 - Exercise Physiology Referrals
 - Exercise programs.
 - Home and Community Care
 - Nutrition
 - Pain Management Referrals
 - RDNS - Royal District Nursing Service
 - Referrals to Podiatry Services and Foot Clinics – Adults
 - Smoking Cessation Advice.

2. Localise the Medication Management pathway, as medication management is an issue for people with cardiac conditions.

3. Add missing information on Carrington Health exercise programs to Exercise Programs pathway.

4. Add the following community resources to the Cardiac related pathways:

Baker IDI Heart and Diabetes Institute [hyperlink - www.bakeridi.edu.au] - Education and clinical programs for people with diabetes and cardiovascular disease and health professional training - Phone: **(03) 8532-1111**

- Cardiovascular disease brochure – [hyperlink - http://www.bakeridi.edu.au/Assets/Files/Baker%20IDI%20Cardiovascular%20Disease%20DL%20brochure_4.pdf]
- Healthy Hearts Clinic [hyperlink - http://www.bakeridi.edu.au/healthy_hearts_clinics/] - free service to the community to identify and address a person's risk of developing cardiovascular disease.

Cardiomyopathy Australia [hyperlink - <http://www.cmaa.org.au/>] - organisation supporting people with all forms of cardiomyopathy, and their families.

- Support meetings [hyperlink - <http://www.cmaa.org.au/support-meetings.html>]
- Phone **1300-552-622**

Carrington Health - Heart Health Program [hyperlink - <http://www.carringtonhealth.org.au/services/groups/physical-activity-groups-and-programs/hospital-admission-risk-program>]

- Supports people in the management of cardiac conditions, including heart failure and other chronic medical conditions.
- Brochure [hyperlink - <http://www.carringtonhealth.org.au/services/groups/physical-activity-groups-and-programs/201501HeartHealthBrochureDL.pdf>]
- Referral required from GP or Cardiologist.
- Box Hill location.
- Fees apply based on income and ability to pay.
- Contact the Heart Failure Case Manager at Box Hill Hospital on **(03) 9895-3333** or Carrington Health on **(03) 9890-2220**.

Carrington Health – Good Life Gym [hyperlink - <http://www.carringtonhealth.org.au/services/groups/physical-activity-groups-and-programs/good-life-gym>]

- Aims to establish good exercise patterns for clients with long term conditions.
- To join, patients need to attend a Physical Activity Information Session and complete an application/screening form.
- Brochure [hyperlink - <http://www.carringtonhealth.org.au/for-health-practitioners/201501GoodLifeGymBrochureDL.pdf>].
- Box Hill location.
- Fees apply based on income and ability to pay.
- Phone: **(03) 9890-2220**.

Carrington Health – Good Life Club [hyperlink - <http://www.carringtonhealth.org.au/services/chronic-disease-management/chronic-disease-management>]

- Self-management program that aims to support people diagnosed with long term health conditions with information, support and resources to manage their chronic disease and improve and maintain their health and well-being.
- Includes health coaching, allied health, education and exercise.
- Self or GP referral
- Brochure [hyperlink - <http://www.carringtonhealth.org.au/services/chronic-disease-management/201501GoodLifeClubBrochureDL.pdf>]
- Box Hill location.
- Fees apply based on income and ability to pay.
- Phone: **(03) 9890-2220**

Inner North West Primary Care Partnership – Physical Activity Directory for Older Adults [hyperlink - <http://inwpcp.org.au/resources/physical-activity-directory/>]

- Search for registered Exercise Programs that are specifically targeted to or cater for adults aged 55 years and over.
- Covers the LGAs of Melbourne, Moonee Valley, Moreland and Yarra.
- The directory is targeted at the general community, hospitals, community and primary health services, General Practitioners, HACC services, allied health and other professionals. [*Could be added to Exercise Programs page*]

Heart Foundation [hyperlink - www.heartfoundation.org.au]

- Support for a healthy heart and access to quality services for people with risk factors for heart disease, or who have had a cardiac event.
- Health Information Service - free personalised information and support on heart health, nutrition and a healthy lifestyle.
 - Phone: **1300-362-787**
- Heart disease resources for Aboriginal and Torres Strait Islander peoples [hyperlink - <http://www.heartfoundation.org.au/your-heart/Pages/Resources-for-Aboriginal-health.aspx>]
- Heart Foundation Walking [hyperlink - <http://walking.heartfoundation.org.au/>] - Find a local walking group
- Heart Foundation Heartmoves [hyperlink - <http://www.heartmoves.org.au/>] - a low to moderate intensity exercise program developed by the Heart Foundation for people who are living with health conditions.
 - Locate a local program by using interactive map or Phone **(03) 9693-9777**.

HEART Online – Heart Education Assessment Rehabilitation Toolkit – [hyperlink - <http://www.heartonline.org.au/Pages/default.aspx>]

- Web resource for health professionals seeking evidence based information and tools that support delivery of quality cardiovascular disease prevention and rehabilitation and heart failure management services. [Clinical resource]

Heart Support-Australia [hyperlink - <http://heartnet.org.au/>]

- Not-for-profit organisation committed to helping people affected by heart conditions through peer support, information and encouragement.
- Phone: **(02) 6253-0097**

Stroke Foundation [hyperlink - <http://strokefoundation.com.au>]

- Support for stroke survivors, carers, health professionals, government and the public to reduce the impact of stroke on the community.
- StrokeLine [hyperlink - <https://strokefoundation.com.au/about-stroke/help-after-stroke/strokeline>] - information and advice on stroke prevention, treatment and recovery, including support services for stroke survivors, carers and family members. Phone: **1800-787-653**
- Post-stroke checklist of common problems people might have after a stroke:
http://strokefoundation.com.au/site/media/Interactive_PostStrokeCHECKLIST_2013.pdf
- Local stroke support groups and choirs [hyperlink - <https://strokefoundation.com.au/about-stroke/help-after-stroke/local-stroke-support-groups-and-choirs>] Phone: **1800-787-653**

5. Add equivalent information on Inner North West Community Health Service programs if applicable.

HealthPathways Melbourne community resource review - Diabetes services

Pathway	Existing Community Resource/Service	Notes/Recommendations
Diabetes Cycle of Care	N/A	
Diabetes Education	<ul style="list-style-type: none"> • CHS (general referral info only) • Self-management: • IDEAS • HARP • Diabetes Australia (Vic) • FlexIT (Baker IDI) • OzDAFNE self-management program 	<p>Consumers valued CHS programs.</p> <p>Consumers valued Diabetes Education programs.</p> <p>Consumers valued Diabetes support groups.</p> <p>Recommend adding specific info re CHS programs & support groups.</p> <p>OzDAFNE self-management program – link broken</p>
Diabetes Medication Management	N/A	Recommend adding patient info on medication
Diabetes Referrals	<p>In This Section</p> <ul style="list-style-type: none"> • Immediate Endocrinology Assessment or Admission (Diabetes) • Urgent or Routine Endocrinology Assessment (Diabetes) • Diabetes Education • Diabetes High Risk Foot Assessment <p>See Also</p> <ul style="list-style-type: none"> • Dietetics Referrals for Adults • Exercise Physiology Referrals • Optometry Referrals • Physiotherapy Referrals • Referrals to Podiatry Services and Foot Clinics - Adults • Wound Care Referrals • RDNS - Royal District Nursing Service • HARP - Hospital Admission Risk Program • Immediate Ophthalmology Assessment or Admission • Urgent or Routine Ophthalmology Assessment • Immediate Nephrology Assessment or Admission • Urgent or Routine Nephrology Assessment 	<p>Consumers valued exercise programs.</p> <p>Consumers valued podiatry services.</p> <p>Consumers valued dental services.</p> <p>Consumers valued nursing services.</p> <p>Consumers valued community transport services.</p> <p>Recommend adding support groups here.</p> <p>Recommend link to Exercise programs page.</p> <p>Recommend link to Dental services page once localised.</p>
Eye Disease Screening in Diabetes	<p>Patient Information</p> <ul style="list-style-type: none"> • Diabetes Victoria – Diabetes and your Eyes • INWMML – Diabetes and Your Health 	
Foot Screening in Diabetes	Patient Information	

Pathway	Existing Community Resource/Service	Notes/Recommendations
	<ul style="list-style-type: none"> • Baker International Diabetes Institute – Taking care of your feet. • North East Valley Division of General Practice – Diabetic Foot Disease • INWMML – Diabetes and Your Health 	
Glycaemic Control	Patient Information <ul style="list-style-type: none"> • Diabetes Australia – Translated Resources • Diabetes NSW: <ul style="list-style-type: none"> ○ What is hypoglycaemia (Indigenous) ○ For Indigenous Australians • Diabetes Victoria: <ul style="list-style-type: none"> ○ Diabetes Resources ○ Hypoglycaemia ○ Hypoglycaemia & diabetes (PDF) ○ Sick day management ○ Travel & Diabetes • NDSS: <ul style="list-style-type: none"> ○ Blood Glucose Monitoring ○ Information Sheets ○ Multicultural Diabetes Portal • INWMML – Diabetes and Your Health 	Recommend adding CALD & ATSI symbols to Patient Information section
Hypoglycaemia	Patient Information <ul style="list-style-type: none"> • Baker IDI – Hypoglycaemia • Diabetes Australia – Translated Resources • Diabetes Victoria – Hypoglycaemia and Diabetes • INWMML – Diabetes and Your Health • National Diabetes Services Scheme – Multicultural Diabetes Portal 	Recommend fixing typo: “Diabetes Victoria – Hypoglycaemia and Diabetes”
Immediate Endocrinology Assessment or Admission (Diabetes)	N/A	
Insulin Education	Diabetes Dietary advice: <ul style="list-style-type: none"> • National Health and Medical Research Council – Healthy Eating For Adults • Diabetes Australia (Vic): <ul style="list-style-type: none"> ○ Food Choices for People with Diabetes ○ Aboriginal and Torres Strait Islander Nutrition and Type 2 Diabetes • Diabetes Resources • Baker IDI: <ul style="list-style-type: none"> ○ Diabetes Resources and Fact Sheets ○ Hypoglycaemia 	Consumers valued assistance to inject insulin correctly. Recommend adding CALD & ATSI symbols to Patient Information section

Pathway	Existing Community Resource/Service	Notes/Recommendations
	<ul style="list-style-type: none"> • EatForHealth.gov.au – Australian Dietary Guidelines Patient information: <ul style="list-style-type: none"> • Diabetes Australia <ul style="list-style-type: none"> ○ Managing Type 1 Diabetes (Insulin) ○ Diabetes and Sick Days ○ Translated Resources • Diabetes NSW: <ul style="list-style-type: none"> ○ What is hypoglycaemia (Indigenous) ○ For Indigenous Australians • Diabetes Victoria: <ul style="list-style-type: none"> ○ Hypoglycaemia ○ Hypoglycaemia & diabetes (PDF) ○ Sick day management ○ Travel & Diabetes • National Diabetes Services Scheme: <ul style="list-style-type: none"> ○ Diabetes and Driving ○ Multicultural Diabetes Portal • NSW Government – Driving and your health 	
Insulin in Type 2 Diabetes - Assessment and Management	N/A	
Insulin Pump Breakdown and Troubleshooting	Patient Information <ul style="list-style-type: none"> • Diabetes Australia - Vic – Information for people with type 1 diabetes 	
Managing Type 2 Diabetes	Patient Information <ul style="list-style-type: none"> • INWMML - Diabetes and Your Health • Diabetes Australia: <ul style="list-style-type: none"> ○ Translated Resources • For Indigenous Australians • National Diabetes Services Scheme: <ul style="list-style-type: none"> ○ Multicultural Diabetes Portal 	Recommend adding CALD & ATSI symbols to Patient Information section
Newly Diagnosed Type 1 Diabetes - Adults	Patient Information <ul style="list-style-type: none"> • Diabetes Australia – Translated Resources • Diabetes Victoria: <ul style="list-style-type: none"> ○ Newly Diagnosed with Type 1 Diabetes ○ Type 1 Diabetes • NDSS – Multicultural Diabetes Portal 	Recommend adding CALD symbol to Patient Information section
Renal Disease Screening in Diabetes	Patient Information <ul style="list-style-type: none"> • Diabetes Australia – Translated Resources • Kidney Health Australia: <ul style="list-style-type: none"> ○ Blood Pressure and Your Kidneys ○ Diabetic Kidney Disease • INWMML – Diabetes and Your Health 	Recommend adding CALD symbol to Patient Information section

Pathway	Existing Community Resource/Service	Notes/Recommendations
	<ul style="list-style-type: none"> • NDSS – Multicultural Diabetes Portal 	
Screening and Detection of Diabetes and Pre-diabetes	Patient Information: <ul style="list-style-type: none"> • Diabetes Australia: <ul style="list-style-type: none"> ○ Translated Resources ○ Understanding Diabetes • Diabetes NSW – For Indigenous Australians • Diabetes Victoria – Diabetes Resources • INWML – Diabetes and Your Health • Life! – About the Life! program • NDSS – Multicultural Diabetes Portal 	Recommend adding CALD & ATSI symbols to Patient Information section Recommend link to Exercise programs page as indicated in DOT on 10/4/15. Diabetes Victoria – Diabetes Resources link broken.
Self-Monitoring Blood Glucose (SMBG)	Patient Information <ul style="list-style-type: none"> • Diabetes Australia: <ul style="list-style-type: none"> ○ Blood Glucose Monitoring ○ Insulin and Tablets information sheet ○ Translated Resources • Diabetes NSW – For Indigenous Australians • Diabetes Victoria: <ul style="list-style-type: none"> ○ Blood Glucose Monitoring ○ Hypoglycaemia • INWML – Diabetes and Your Health • National Diabetes Services Scheme: <ul style="list-style-type: none"> ○ Diabetes and Driving ○ Multicultural Diabetes Portal 	Recommend adding CALD & ATSI symbols to Patient Information section
Starting Insulin in Adults	N/A	
Surgery, Contrast, and Bowel Preparation	Patient Information <ul style="list-style-type: none"> • Diabetes NSW: <ul style="list-style-type: none"> ○ Going to hospital - Type 1 diabetes ○ Going to hospital - Type 2 diabetes 	
Types of Insulin	N/A	
Urgent or Routine Endocrinology Assessment (Diabetes)	<ul style="list-style-type: none"> • IDEAS 	

NOTE: 'N/A' indicates no community resource information was available on that pathway. Clinical resources may have been present.

Recommendations for addition of community resources to diabetes pathways:

1. Link the following pages to diabetes pathways, as these were services consumers with diabetes found helpful:
 - Adult Weight Management and/or Older Adult's Weight and Nutrition (once localised)
 - Community Health Services
 - Community Transport
 - Diabetes Education
 - Dietetics Referrals
 - Dental services (once localised)
 - Exercise programs
 - Medication management
 - Multi-Purpose Taxi Program (MPTP)
 - Nutrition
 - Physiotherapy Referrals for Adults
 - RDNS - Royal District Nursing Service
 - Referrals to Podiatry Services and Foot Clinics – Adults
 - Smoking Cessation Advice
2. Add CALD & ATSI symbols to Patient Information sections where these resources relate to these groups.
3. Add the following community resources to the diabetes related pathways:

Baker IDI Heart and Diabetes Institute [hyperlink - www.bakeridi.edu.au] Education and clinical programs for people with diabetes and cardiovascular disease and health professional training

- Diabetes and your health brochure [hyperlink - http://www.bakeridi.edu.au/Assets/Files/Baker%20IDI%20Diabetes%20and%20your%20health%20DL%20brochure_5.pdf]
- Education programs for people with diabetes [hyperlink - http://www.bakeridi.edu.au/diabetes_services/education/]
- Diabetes resources and fact sheets [hyperlink - http://www.bakeridi.edu.au/Diabetes_Resources_Fact_Sheets/]
- Specialist Diabetes Clinic [hyperlink - http://www.bakeridi.edu.au/diabetes_services/] - medical care and support services for the management of diabetes and its complications. Comprehensive service for people with type 1 and type 2 diabetes, Pre-diabetes and Gestational diabetes.
- Melbourne location.
- Phone: **(03) 8532-1111**

Carrington Health – Good Life Gym [hyperlink - <http://www.carringtonhealth.org.au/services/groups/physical-activity-groups-and-programs/good-life-gym>]

- Aims to establish good exercise patterns for clients with long term conditions.
- To join, patients need to attend a Physical Activity Information Session and complete an application/screening form.
- Brochure [hyperlink - <http://www.carringtonhealth.org.au/for-health-practitioners/201501GoodLifeGymBrochureDL.pdf>].
- Box Hill location.
- Fees apply based on income and ability to pay.
- Phone: **(03) 9890-2220**.

Carrington Health – Good Life Club [hyperlink - <http://www.carringtonhealth.org.au/services/chronic-disease-management/chronic-disease-management>]

- Self-management program that aims to support people diagnosed with long term health conditions with information, support and resources to manage their chronic disease and improve and maintain their health and well-being.
- Includes health coaching, allied health, education and exercise.
- Self or GP referral
- Brochure [hyperlink - <http://www.carringtonhealth.org.au/services/chronic-disease-management/201501GoodLifeClubBrochureDL.pdf>]
- Box Hill location.
- Fees apply based on income and ability to pay.
- Phone: **(03) 9890-2220**

Carrington Health – Diabetes support group [hyperlink - <http://www.carringtonhealth.org.au/services/groups/diabetes-groups-and-services/diabetes-support-group>]

- Monthly meeting providing people living with Type 2 diabetes a place to get together to share their self-management, discuss problems, form friendship and learn from one another.
- Improvement of diabetes knowledge
- Social outings.
- Self or GP referral
- Box Hill location.
- Fee: voluntary gold coin donation.
- Phone: **(03) 9890-2220**

Carrington Health – Diabetes Nurse Education [hyperlink - <http://www.carringtonhealth.org.au/services/diabetes-services/diabetes-nurse-education>]

- A credentialed diabetes nurse educator is available to assist people newly diagnosed with Type 1 Diabetes, Type 2 Diabetes and Pre Diabetes. Includes:
 - Help with blood glucose monitoring
 - Managing medications
 - General advice about managing diabetes
- Self or GP referral
- Brochure [hyperlink - <http://www.carringtonhealth.org.au/services/diabetes-services/201501DiabetesEducationBrochureDL.pdf>]
- Box Hill location.
- Fees apply based on income and ability to pay.
- Phone: **(03) 9890-2220**

Carrington Health – “Step by Step” Diabetes Series [hyperlink - <http://www.carringtonhealth.org.au/services/diabetes-services/diabetes-education>]

- This series of four sessions with a Diabetes Educator is for people with type 2 diabetes (whether newly diagnosed or not) to develop skills to manage their condition.
- The program complements the information and care provided by the patient’s GP.
- Self or GP referral
- Brochure [hyperlink - http://www.carringtonhealth.org.au/services/diabetes-services/copy_of_201501StepbyStepBrochureDL.pdf]
- Box Hill location.
- Fee: Fees apply.
- Phone: **(03) 9890-2220**

Diabetes Australia – Vic – [hyperlink - <http://www.diabetesvic.org.au/>]

- National body for people affected by diabetes and those at risk.
- Provide education programs and health professional training, diabetes information line providing advocacy, counselling and support
- Locate Type 1 and Type 2 Diabetes support groups [hyperlink - <http://www.diabetesvic.org.au/how-we-help/support-groups>]
- Phone: **1300-136-588**

Inner East Community Health – Diabetes Group Education [hyperlink - <https://iehealth.org.au/service/diabetes-program/>]

- Six week course on managing diabetes facilitated by Credentialed Diabetes Educator and Dietitian
- To attend Diabetes Group classes patients need:
 - GP Management Plan or GP Management Plan Review (item 721 or 732)
 - Referral from a GP to our Diabetes Educator or Dietitian for an Initial Assessment (using a Referral form for Group Allied Health Services under Medicare for patients with type 2 diabetes that has been issued by the Department of Health).
- Brochure [hyperlink - <https://iehealth.org.au/wp-content/uploads/2014/07/Brochure-Diabetes-Group-Programs.pdf>]
- Ashburton, Hawthorn and Richmond locations.
- Fees apply unless patient is healthcare cardholder and pensioner with a GP management plan (Item 721 and 732).
- Phone: **(03) 9429-1811**

Inner East Community Health - Diabetes Private Education [hyperlink - <https://iehealth.org.au/service/diabetes-private-education/>]

- For people with Type 1, Type 2 or Gestational Diabetes
- Diabetes Educator will develop an individual plan for the patient. Includes education in blood glucose monitoring, meal planning, exercise, medications and problem solving to improve diabetes control and reduce risk of complications.
- Ashburton, Hawthorn and Richmond locations.
- Fees apply unless Team Care Arrangement from GP and patient has a Healthcare / Pension Card.
- Phone: **(03) 9429-1811**

Inner North West Primary Care Partnership – Physical Activity Directory for Older Adults [hyperlink - <http://inwpcp.org.au/resources/physical-activity-directory/>]

- Search for registered Exercise Programs that are specifically targeted to or cater for adults aged 55 years and over.
- Covers the LGAs of Melbourne, Moonee Valley, Moreland and Yarra.
- The directory is targeted at the general community, hospitals, community and primary health services, General Practitioners, HACC services, allied health and other professionals. [*Could be added to Exercise Programs page*]

Manningham Community Health – Diabetes Program [hyperlink - http://www.mannchs.org.au/services/s_diabetes.php]

- Group and individual education and advice sessions to help people with Type 2 diabetes or pre-diabetes manage their condition
- The team includes:
 - Diabetes Nurse Educators
 - Dietitians
 - Podiatrists
 - Physiotherapists
 - Health Coaches and Key Workers
- Doncaster location
- Anyone can refer to this service but GP referral may be required to access some funding streams (e.g. Medicare Benefits Schedule).
- Fees apply based on income and ability to pay.

- Phone: **(03) 8841-3000**.

Monashlink Community Health – Diabetes Education services [hyperlink - <http://www.monashlink.org.au/index.php/health-menu/community-health/diabetes-education.html>]

- Support for people who have diabetes or at high risk of developing diabetes on understanding, preventing and managing diabetes
- Clayton, Glen Waverley and Batesford locations. (Home visits can be arranged for those who are eligible).
- Fees apply based on income.
- Phone: **1300-552-509**

Monashlink Community Health – Monash Diabetes Support Group [hyperlink - <http://www.monashlink.org.au/index.php/group-menu/groups-activities/support-groups.html>]

- A monthly support group for people [from any area](#) living with diabetes [to share experiences, gain information and improve their diabetes](#).
- Facilitated by Diabetes Educator & Dietitian
- Glen Waverley location.
- Fees apply.
- Phone: **1300-552-509**

Monashlink Community Health – Chinese First Bites [hyperlink - <http://www.monashlink.org.au/index.php/component/content/article/8-monashlink/services/131-chinesefirstbites.html>]

- For Chinese-speaking individuals with elevated blood sugar levels, diabetes or pre-diabetes.
- At this single session, the dietitian leads a discussion on dietary myths, and healthy eating for blood sugar control.
- Delivered in Mandarin and Cantonese
- Glen Waverley location.
- Fees apply.
- For enquiries and registration, phone Tammie Choi (dietitian) on **(03) 8540-6043** or **1300-552-509**.

4. Add equivalent information on Inner North West Community Health Service programs if applicable.

HealthPathways Melbourne community resource review - Respiratory services

Pathway	Existing Community Resource/Service	Notes/Recommendations
Acute Exacerbation of COPD	Patient Information <ul style="list-style-type: none"> Better Health Channel – Lung Conditions: Chronic Obstructive Pulmonary Disease (COPD) Lung Foundation Australia – Patient Area 	Consumers valued the Lung Foundation.
Advanced or End-stage COPD	Patient Information <ul style="list-style-type: none"> Better Health Channel – Lung Conditions: Chronic Obstructive Pulmonary Disease (COPD) Lung Foundation Australia – Patient Area 	Consumers valued the Lung Foundation.
Asthma in Adults AND Asthma in adults – non acute	Patient Information <ul style="list-style-type: none"> Asthma Foundation – What is Asthma? Asthma Australia – Inhalers & spacers 	
Community Acquired Pneumonia (CAP) in Adults	Patient Information <ul style="list-style-type: none"> Better Health Channel – Pneumonia 	
COPD	Management: <ul style="list-style-type: none"> Link to smoking cessation advice Link to Adult weight management (not localised) Referral: If appropriate, consider referral to: <ul style="list-style-type: none"> HARP Home Medicine Review Pulmonary Rehabilitation Palliative Care Services Royal District Nursing Service (RDNS) Other community based support programs provided by councils, community health services and private health insurances Patient Information <ul style="list-style-type: none"> Better Health Channel – Lung Conditions: Chronic Obstructive Pulmonary Disease (COPD) Lung Foundation Australia – Patient Area 	Consumers valued the Lung Foundation.
Differentiating Asthma from COPD	N/A	
Immediate Respiratory Assessment or Admission	N/A	
Lung Function Testing	N/A	

Pathway	Existing Community Resource/Service	Notes/Recommendations
Pulmonary Rehabilitation	<ul style="list-style-type: none"> • HARP Patient Information <ul style="list-style-type: none"> • Lung Foundation Australia – Pulmonary Rehabilitation Fact Sheet 	Consumers valued the Lung Foundation.
Smoking Cessation Advice	Management <ul style="list-style-type: none"> • Link to Quit Referral <ul style="list-style-type: none"> • Link to Quit • tobacco free and smoking cessation clinics Clinical Resources <ul style="list-style-type: none"> • Department of Health (Victoria) <ul style="list-style-type: none"> ○ Supporting patients to be smoke free ○ Tobacco reforms • Smoking cessation applications: <ul style="list-style-type: none"> ○ Quit Now: My QuitBuddy: <ul style="list-style-type: none"> ▪ Android ▪ iPhone ○ Quit for You – Quit for Two (for pregnant smokers): <ul style="list-style-type: none"> ▪ Android ▪ iPhone • RACGP <ul style="list-style-type: none"> ○ Supporting smoking cessation: a guide for health professionals ○ Supporting smoking cessation: treatment algorithm Patient Information <ul style="list-style-type: none"> • Australian Department of Health – The dangers of passive smoking • Better Health Channel – Tobacco • Quitline: <ul style="list-style-type: none"> ○ Aboriginal Quitline Counsellors ○ Smoking and Pregnancy ○ Nicotine patches (Fact Sheet) www.icanquit.com.au	Consumers valued smoking cessation assistance.
Urgent or Routine Respiratory Assessment	N/A	

NOTE: 'N/A' indicates no community resource information was available on that pathway. Clinical resources may have been present.

Recommendations for addition of community resources to respiratory pathways:

1. Link the following pages to cardiac pathways, as these were services consumers with respiratory conditions found helpful:
 - Community Health Services
 - Exercise Physiology Referrals
 - Exercise programs
 - Home and Community Care
 - Multi-Purpose Taxi Program (MPTP)
 - Smoking Cessation Advice
 - Physiotherapy Referrals for Adults
 - Community Transport.
2. Add the following community resources to the respiratory related pathways:

Carrington Health – Good Life Gym [hyperlink - <http://www.carringtonhealth.org.au/services/groups/physical-activity-groups-and-programs/good-life-gym>]

- Aims to establish good exercise patterns for clients with long term conditions.
- To join, patients need to attend a Physical Activity Information Session and complete an application/screening form.
- Brochure [hyperlink - <http://www.carringtonhealth.org.au/for-health-practitioners/201501GoodLifeGymBrochureDL.pdf>].
- Box Hill location.
- Fees apply based on income and ability to pay.
- Phone: **(03) 9890-2220**.

Carrington Health – Good Life Club [hyperlink - <http://www.carringtonhealth.org.au/services/chronic-disease-management/chronic-disease-management>]

- Self-management program that aims to support people diagnosed with long term health conditions with information, support and resources to manage their chronic disease and improve and maintain their health and well-being.
- Includes health coaching, allied health, education and exercise.
- Self or GP referral
- Brochure [hyperlink - <http://www.carringtonhealth.org.au/services/chronic-disease-management/201501GoodLifeClubBrochureDL.pdf>]
- Box Hill location.
- Fees apply based on income and ability to pay.
- Phone: **(03) 9890-2220**

Inner North West Primary Care Partnership – Physical Activity Directory for Older Adults [hyperlink - <http://inwpcp.org.au/resources/physical-activity-directory/>]

- Search for registered Exercise Programs that are specifically targeted to or cater for adults aged 55 years and over.
- Covers the LGAs of Melbourne, Moonee Valley, Moreland and Yarra.
- The directory is targeted at the general community, hospitals, community and primary health services, General Practitioners, HACC services, allied health and other professionals. [*Could be added to Exercise Programs page*]

Manningham Community Health - Phase 3: Chronic Obstructive Pulmonary Disease (COPD) Rehabilitation – [hyperlink - http://www.mannchs.org.au/groups/g_physio.php]

- Long-term group for patients who have completed the Phase 2 COPD program in a hospital or rehab setting in the past 12 months.
- Program focuses on fitness, strength training, breathing exercises and maintenance for COPD sufferers.
- Referral is required from a respiratory physiotherapist or respiratory physician to participate in this group.
- Phone: **(03) 8841-3000**.

Lung Foundation Australia - COPD Action Plan [hyperlink - <http://lungfoundation.com.au/health-professionals/clinical-resources/copd/copd-action-plan/>]

- Guides the patient in recognising when their symptoms change and what action they should take.
- Should be completed by the clinician and patient together.
- Indigenous COPD Action Plan also available. [Clinical resource]

Lung Foundation Australia – Better living with COPD – A patient guide [hyperlink - <http://lungfoundation.com.au/patient-area/resources/better-living-with-copd-a-patient-guide/>] –

- Booklet to support people with COPD, their families, carers and health professionals caring for those to better understand and manage COPD.

Lung Foundation Australia - Better Living with Lung Cancer [hyperlink - <http://lungfoundation.com.au/patient-area/resources/better-living-with-lung-cancer-a-patient-guide/>] –

- Booklet to help people diagnosed with lung cancer understand more about lung cancer, its diagnosis and treatment.

Lung Foundation Australia – Patient Support Groups - [hyperlink - <http://lungfoundation.com.au/patient-area/patient-support/>]

- Phone: **1800-654-301**

Lung Foundation Australia - Home Oxygen Booklet – [hyperlink - <http://lungfoundation.com.au/patient-area/resources/home-oxygen-booklet/>]

- A resource for those with a chronic lung condition, who have recently been prescribed home oxygen therapy, or may be prescribed it in the near future.

Lung Foundation Australia Information and Support Centre [hyperlink - <http://lungfoundation.com.au/patient-area/>]

- Patient education and support for people with lung conditions
- Phone: **1800-654-301**

State-Wide Equipment Program – Domiciliary Oxygen Program [hyperlink - <http://swep.bhs.org.au/domiciliary-oxygen-program>]

- Provides oxygen equipment for adults and children who qualify under the Thoracic Society Guidelines (TSANZ) and the Victorian A&EP Guidelines [hyperlink - http://swep.bhs.org.au/library/file/189/5_DHS_Guidelines.pdf]
- All applicants must be assessed by a Consultant Physician specialising in respiratory (thoracic) medicine, cardiology or oncology, and the prescription approved by the DHS appointed Respiratory Physician.
- Phone: **1300-747-937**

3. Add equivalent information on Inner North West Community Health Service programs if applicable.

APPENDIX 4 - REVIEW OF INNER NORTH WEST COMMUNITY RESOURCE INFORMATION

The following table outlines each pathway which has been developed within the HealthPathways Melbourne Community Resources Project and whether each page includes community information specific to Inner North West and Inner East regions, as well as whether community information relevant to people living in Melbourne, Victoria or Australia is included. Ticks indicate information is available on the page, whilst crosses indicate information is not available on the page.

HPM Pathway/Page - section	Inner North West specific info	Inner East specific info	Melbourne/ Vic/National info
Aged Care Assessment	✓	✓	✓
Bereavement, Grief & Loss	✓	✓	✗
Referral – Urgent public			
Referral – Non urgent public	✓	✓	✓
Referral – Non urgent private	✗	✗	✓
Referral – Community services	✗ (except INWML Suicide Prevention Service)	✓	✓
Bereavement, Grief and Loss Resources and Support Services	✗	✗	✓
Carer Resources & Support Services	✗	✗	✓
Aboriginal and Torres Strait Islander carers			
Advocacy and complaints	✗	✗	✓
Aids and equipment	✗	✗	✓
Allied health and community health services	✓ (Refer to HPM pages with region specific info)	✓ (Refer to HPM pages with region specific info)	✓
Behaviour management	✗	✗	✓
Bereavement, Grief and Loss	See Bereavement, Grief and Loss pathway		
Case management services	✓	✓	✓
Counselling and psychology services	✗	✓	✓
Culturally and linguistically diverse carers	✗	✗	✓
Financial support	✗	✗	✓
Gardening services	✓	✓	✓
Home care and personal care services	✓	✓	✓
Information and education for carers	✗	✓	✓
Legal services	✗	✗	✓
LGBTIQ carers	✗	✗	✓
Meals and food services	✓	✓	✓

HPM Pathway/Page - section	Inner North West specific info	Inner East specific info	Melbourne/ Vic/National info
Nursing services	x	x	✓
Palliative care	x	✓	✓
Peak bodies	x	x	✓
Planning for the future	x	x	✓
Respite services	✓	✓	✓
Support services	✓	✓	✓
Transport	See Community Transport pathway		
Volunteering	x	✓	✓
Working carers	✓	✓	✓
Carer Resources Patient Information Sheet	x	x	✓
Carer Stress	✓	✓	✓
Community Transport	✓	✓	x
Community transport provided by local councils			
Community transport provided by community health services	x (To be added from DOT feedback)	✓	x
Other community transport services	x	✓	✓
Other transport-related services	x	x	✓
Dementia Resources & Support Services	✓	✓	✓
Aboriginal and Torres Strait Islander services			
Advocacy and complaints	x	x	✓
Aids and equipment	x	x	✓
Allied health and community health services	✓ (Refer to HPM pages with region specific info)	✓	✓
Behaviour management	x	x	✓
Bereavement, Grief and Loss	See Bereavement, Grief and Loss pathway		
Carers	See Carer related pages		
Case management services	✓	✓	✓
Counselling and psychology services	x	✓	✓
Culturally and linguistically diverse services	✓	✓	✓
Driving and dementia	x	✓	✓
Employment and dementia	x	x	✓
Financial support	x	x	✓
Gardening services	✓	✓	✓
Home care and personal care services	✓	✓	✓

HPM Pathway/Page - section	Inner North West specific info	Inner East specific info	Melbourne/Vic/National info
Information and education on dementia	x	✓	✓
Legal services	x	x	✓
Meals and food services	✓	✓	✓
Nursing services	x	x	✓
Palliative care	x	✓	✓
Planning for the future	x	x	✓
Respite services	✓	✓	✓
Support services	✓	✓	✓
Transport	See Community Transport pathway		
Volunteering	x	✓	✓
Working carers	✓	✓	✓
Younger Onset Dementia	See Younger Onset Dementia Resources & Support Services		
Elder Abuse and neglect Referral	x (According to my SME there are no elder abuse specific services in INW region)	✓	✓
Elder Abuse and neglect Patient Information	x	✓	✓
Younger Onset Dementia Resources (YOD) & Support Services Aboriginal and Torres Strait Islander services	✓	✓	✓
Advocacy and complaints	x	x	✓
Aids and equipment	x	x	✓
Allied health and community health services	x	✓	x
Behaviour management	x	x	✓
Bereavement, Grief and Loss	See Bereavement, Grief and Loss pathway		
Case management services	✓	✓	✓
Counselling and psychology services	x	✓	✓
CALD services	✓	✓	✓
Driving and dementia	x	✓	✓
Employment and YOD	x	x	✓
Financial support	x	x	✓
Gardening services	✓	✓	✓
Genetic counselling	x	x	✓
Home care and personal care services	x	x	✓
Information for people living with YOD	x	x	✓

HPM Pathway/Page - section	Inner North West specific info	Inner East specific info	Melbourne/ Vic/National info
Legal services	x	x	✓
Meals and food services	✓	✓	✓
Medication	See Medication management pathway		
Nursing services	x	x	✓
Palliative care	x	✓	✓
Planning for the future	x	x	✓
Respite services	✓	✓	✓
Support services for people with YOD	x	x	✓
Support groups for carers of people with YOD	✓	✓	✓
Transport	See Community Transport pathway		
Volunteering	x	✓	✓
Working carers	✓	✓	✓