phn VICTORIAN ALLIANCE

An Australian Government Initiative

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Victorian PHN Alliance Festival of Ideas - Our Collective Ideas so far

Our Forum Purpose:

How can we further evolve our collective approach to realising high performing primary care across Victoria over the next 3 years?

OUR SAY

This report is a summary of the ideas we collectively generated over the past few weeks in our OurSay online platform. We remained open to all ideas. The ideas below are ideas are as they were submitted to us.

Our Ideas so far

001 Find ways to integrate care across PHN boundaries for patients who live close to these boundaries. Many people use health services in more than one PHN region.

002 Yes this really needs to be managed across PHNs please. PHN boundary issues create problems for clients, service providers and PHN staff alike. It would be great if PHNs could reach agreements about sharing services and resources across boundaries, otherwise patients are the ones to suffer. The aim to provide the right service, to the right person in the right place at the right time becomes compromised when there is failure to address this issue.

003 Fund consortia of diverse service types to contribute specialist staff to multi-disciplinary teams. This would provide wrap-around services for consumers, create more in-depth understanding across the partner services and also improve referral pathways between the different service types.

004 As demonstrated by PiR services which function with a consortia of diverse services and the local PHN in governance. This has possibly been one of the unique and innovative concepts underling the susses of PiR and the idea could be developed further to enhance service delivery and great consumer outcomes.

005 Addressing smoking rates

Smoking is the single leading cause of preventable death and disease in Australia. The annual health toll of tobacco includes hundreds of thousands of preventable illnesses being treated in our health system, leading to an economic burden of more than $2.4b per annum in Victoria alone.

Smoking rates are higher in marginalised groups, but all people who smoke can be supported to quit and become tobacco free. Reinforcing messages and supporting quitting attempts through general practice should be a priority to reduce the burden on the health care system and improve the lives of those affected.

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Evidence shows that 1 in 33 conversations between a general practitioner and a patient will result in a successful quit attempt. Evidence also shows that a general practitioner asking about smoking and not providing advice to stop and an offer of support or a referral decreases the chance a person will stop smoking. There are fast, effective ways to help people become tobacco-free. For every 100 patients advised to stop smoking and provided with a referral to Quitline, 22 people are expected to stop smoking. Add combination NRT (a patch plus a fast acting form, such as gum, mouth-spray or a lozenge) and the success rate increases to one in three stopping smoking.

006 Great suggestion. Pharmacists and dental practitioners are among the other health professionals that can effectively reinforce the messages of the GP, provide brief interventions and other advice and also make referrals to the Quitline, to support the patient to quit.

007 Integrated secure messaging that enables consumers and clinicians to safely and securely exchange information so we minimise waste and significantly improve health outcomes.

008 We know that high performing primary health care, and effective commissioning of services, both require engaged clinicians willing and able to lead and champion change. PHNs should be actively seeking to build and support clinical leadership across the health sector.

009 How do we encourage small rural hospitals and health services to engage in prevention and primary care activities when doing so may compromise their financial viability? (i.e.. keeping people out of hospital and aged care dampens demand for acute and aged care services). The debate we have to have!

010 What unifies our collective interest in primary care is how we maximise the contribution of our health workforce. Regardless of whether we are looking at secondary prevention, supportive care for those with cancer, or working with individuals affected by alcohol. The confidence, skills and knowledge of the whole primary care workforce is key.

011 We need to look at enhancing the incentives and structures to facilitate a shared focus on patient and community outcomes within a catchment, with a focus on quality. We should be working towards the same outcomes, regardless of whether we are local primary, community and acute services.

012 Measuring outcomes of treatment of patients with chronic diseases.

013 How can PHNs best deliver primary care in rural and remote Australia — giving thought to having multidisciplinary teams to provide best practice care? Often small rural and remote communities cannot support a full time multidisciplinary primary care team. What funding models could be put in place to —...share— allied health professionals across acute, primary and aged care to make this model more viable in rural and remote Australia?

014 How can PHNs focus on health prevention and promotion activates which will impact on reducing avoidable hospitalisations?

015 How can PHNs work to integrate and collaborate with small rural and remote hospitals as well as aged care facilities in rural and remote communities?

016 Health Consumers NSW and the WentWest PHN have developed a fabulous model for Consumer and Community Engagement that could be adopted in Victoria for use across all PHNs. Check it out at: http://www.hcnsw.org.au/pages/consumer-and-community-engagement-model.html

Dental Health Services Victoria is considering adopting this model for our organisation. Great consumer and community engagement leads to safer services and improved health outcomes.

017 Establish formalised structures and arrangements to support shared approaches to epidemiological analysis, and integrated service planning.

018 Work with dental health agencies to fully address the health needs of the Victorian population.

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019 Plan ahead to address the potential impact of increasing automation, robotics, computerisation and digital health developments on the health sector workforce. CSIRO and CEDA both say that around 40 to 50 percent of existing jobs are likely to disappear over the next 10-15 years due to technological advancement.

http://www.csiro.au/en/Research/D61/Areas/Data-for-decisions/Strategic-Foresight/Tomorrows-Digitally-Enabled-Workforce

http://www.ceda.com.au/research-and-policy/policy-priorities/workforce

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020 Establish common approaches to measurement, monitoring, and evaluation. This may include shared primary care data standards which align with our agreed collective outcomes. This will help us know - how well are we tracking?

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021 Move from short-term collective plans to longer-term collective plans. What is our collective vision for the next 20 years?

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022 Meaningfully and collectively explore our community stories.

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023 Oral health is important for general health. Poor oral health impacts on chronic disease and quality of life. Only 30 % of Victorian adults (aged 18-64) eligible for public dental care attend community dental clinics over a 2-year period. Few of these people will be receiving care in the private sector. Many are NOT receiving any dental care at all. PHNs can support primary health care in promoting good oral health, early identification of disease and referral to care in the public sector to eligible people. This will improve health outcomes for Victorians.

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024 Address skin cancer in general practice

It has been calculated that the total cost of NMSC (diagnosis, treatment and pathology) was $511 million in Australia in 2010. Non melanoma skin cancer accounts for over a million patient encounters in general practice in Australia and this number is increasing.

Upskilling and enabling GPs to provide early stage treatment of non-melanoma skin cancer will:

- Reduce hospitalisations
- Reduce costs to the health system
- Improve patient outcomes"

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025 Overweight and obesity issues in the primary health sector

Two thirds of Australians are overweight or obese. Evidence shows that routinely weighing patients is not standard practice, despite evidence that this improves adherence to weight loss efforts.

GPs and other primary health workers should be supported to incorporate evidence based strategies such as livelighter.com.au to help patients lose weight.

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026 Bowel cancer screening in general practice

Bowel cancer is the second most common cause of cancer-related death yet it is a highly curable cancer if detected early. Participation in the National Bowel Cancer Screening Program (NBCSP) is low for the general population, and lower still in those from social-economically disadvantaged backgrounds. GPs should be supported to endorse the NBCSP to increase participation in this lifesaving program.

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027 Chronic hepatitis B (CHB) disproportionally affects vulnerable populations in Victoria, including Aboriginal and culturally and linguistically diverse communities, and if left untreated can lead to cirrhosis and liver cancer. CHB can be effectively managed in general practice, but GPs frequently refer to tertiary services and patients face long delays for routine monitoring. Supporting and upskilling general practices to monitor people with CHB can increase patient outcomes and prevent avoidable liver cancer diagnoses.

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028 Changes to the cervical screening

PHNs must support health professionals across Victoria to be up to date on the latest recommendations and guidelines for cervical screening in Australia which will be introduced from May 2017 as part of the National Cervical Screening

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Program renewal. The PHNs can play a key role ensuring practices are ready for the changes by supporting a range of professional development opportunities and promotion of available resources and online training modules to support cervical screening providers and practice staff to be upskilled, knowledgeable and confident in cervical screening changes.

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029 Building relationships with Aboriginal and Culturally Diverse Communities

If GPs and Primary Health Professionals are to make positive impacts on prevention, immunisation, smoking cessation and screening to reduce the burden of cancers and provide relevant, timely support for people with cancer, then engagement with these communities and a foundation of strong relationships is essential. A level of trust in health practitioners and the health system needs to be present so that the barriers around communication, cultural competence and entering an institutionalised health system can be reduced.

Health professionals require cultural competence training, workers of the same culture of the target community need to be engaged to work on projects.

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030 A whole-of-life approach to immunisation and not just the standard childhood immunisation focus is necessary. A whole of life approach is necessary as identified in many forums with the Aboriginal community. Strategies need to consider the continuum and not one element along it. So a coordinated approach to know that when focusing on screening, prevention, immunisation, we are also discussing access to treatment and treatment itself, support services and palliative care.

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031 Increase cancer screening participation

A joint Aboriginal Health Worker role with a pap nurse to coordinate improved cancer screening and HPV immunisation rates at each of the Aboriginal Co-operatives. This coordinated position can look at data cleaning, inputting missing cancer screening history for each patient and from this information identify people who are overdue or have never participated in cancer screening, coordinate services such as group breast screen bookings, and provide opportunistic and outreach cervical screening that evidence shows, works for the community to increase cancer screening participation.

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032 Patient navigator

We know that whilst there is a lower participation rate in cancer screening in the Victorian Aboriginal community, there is also a higher incidence of positive FOBT. We also know that there is a lower rate of Aboriginal people attending for colonoscopy, breast assessment and colposcopy. Whilst a focus on increasing cancer screening participation is important, we need to provide the appropriate support mechanisms so people attend specialist appointments after receiving a result requiring further investigation.

The care coordinator role for chronic disease is a step in the right direction; however we also need the interface between primary and tertiary services.

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033 Models of care are moving from centralised and treatment orientated, towards more community based and co-designed service models. Can opportunities for innovation to take place occur in new service configurations (ie working within organisations) or do we need to develop these outside the system to radically produce new solutions? In this context, how do you see health technologies being leveraged to facilitate active consumer participation or health literacy? if people from indigenous or CALD communities can co-design models of care what would the enablers to this be?
