# Better Health
North East Melbourne

# Strategic Plan 2018-2023

## Connected Healthcare for Community Wellness

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# Chair's Message

I am delighted to present the Better Health North East Melbourne (BHNEM) Strategic Plan 2018–2023. This Strategic Plan outlines our vision, values and the role BHNEM will play in order to realise our strategic goals.

Formulating this Strategic Plan has allowed us to take stock of what we have achieved since commencing in 2016. I am proud of the successes we have achieved to date and am grateful for the drive, commitment and determination of all participants. Our Strategic Plan has been developed recognising the challenges ahead, but also how much more we can do together as partners.

We aspire to an integrated, connected, accessible, responsive and consumer-focused health system.

This Strategic Plan articulates our unique contribution to its creation. Our vision is set into achievable goals, with clear objectives and measurable outcomes.

Over the next five years we look forward to working with and alongside you and the communities we serve in North East Melbourne, to ensure better health for all.

**Penny Anderson**
Chief Executive Officer, Your Community Health
Chair, Better Health North East Melbourne

## Better Health North East Melbourne

In 2018, the membership of BHNEM comprises:

- Austin Health
- Banyule Community Health
- Victorian Government Department of Health and Human Services
- Eastern Melbourne Primary Health Network
- healthAbility
- North Western Melbourne Primary Health Network
- Your Community Health

# Our Vision...

## Connected healthcare for community wellness.

A connected healthcare system is one that understands and meets the needs of all the people who use it: patients, carers, families, volunteers and staff.

In this system no one has to retell their story because the diverse healthcare partners across the system are able to confidentially and safely share critical information when and where it is needed.

Trust between these partners is high. Upon this trust they collaborate on projects that build bridges across previously siloed activities. In doing so they create a better care experience for everyone.

When everyone in our community is able to access the healthcare they need in efficient and effective ways they are healthier and are able to live well.

# Our Role...

## We are influential leaders who design and deliver integrated services together.

Delivering healthcare is a complex business.

The way health is funded and the diversity of organisations that deliver healthcare has created gaps and inconsistencies that are detrimental to the wellbeing of the people who receive care.

As a collaboration of high level health leaders across the north eastern region of Melbourne we play a unique role in working closely together to create an integrated, connected, accessible, responsive and consumer focused health system.

We work together to influence all levels of the system including policy, strategy and operations.


Leaders from Better Health North East Melbourne member organisations signed a memorandum of understanding in June 2018 agreeing to work together towards connected healthcare for community wellness.

*Clockwise from left: Mick Geary, CEO, Banyule Community Health, Sean Spencer, healthAbility, Anne Lyon, standing in for Robin Whyte, CEO, Eastern Melbourne Primary Health Network, Christopher Carter, CEO, North Western Melbourne Primary Health Network, Jane Foley, Department of Health and Human Services, Penny Anderson, CEO, Your Community Health (and Chair of BHNEM), Sue Shilbury, CEO, Austin Health.*

# Our Values...

## We are **Ambitious.**

We imagine better ways and we confidently and pragmatically go about making them happen. We have the courage to challenge the status quo, inertia and limiting beliefs that so often slow down or stop better approaches from flourishing. We inspire others to join us in our ambition of collaborating to create a more connected health system.

## We are **Persuasive.**

We are listened to by politicians, funders and clinicians and so are able to influence the critical decisions being made across the system that have a significant impact upon our community's wellness.

We tell our story well, we see sharing our successes with others as an important way to amplify the good work we do by encouraging others to look across the system and work together.

## We are **Focused.**

We are clear what success is and work persistently to achieve it, refusing to be distracted by 'the noise' that threatens to derail our progress. We are resilient in the face of roadblocks and set-backs, always returning to our bigger vision and asking ourselves... what would we do next to move in that direction?

## We are **Trustworthy.**

We take care of each other's best interests. We appreciate the complexity of collaborating across diverse organisations. We are honest with each other about the challenges we face and how we can turn them into opportunities. We do the things we say we are going to do. We build trust at all levels because we understand how it is a platform upon which our partnerships grow.

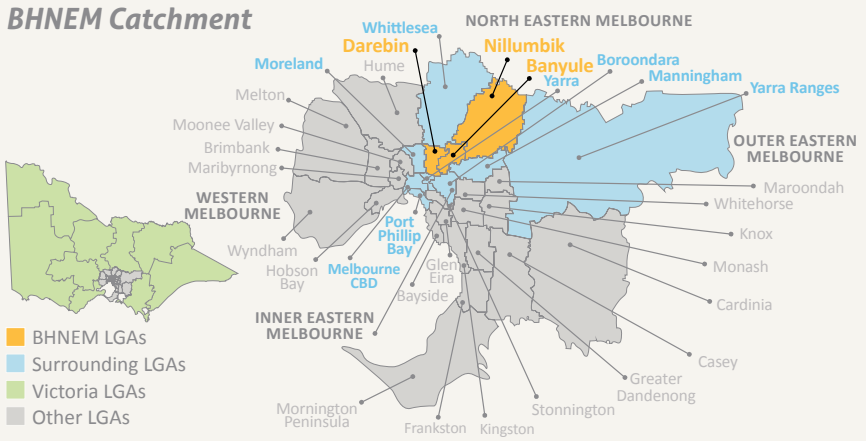
# Our Community...

Australia's health and community services policy landscape is not static; it continues to change and reform. Australia's population is ageing, and there is a relative reduction in people of traditional working age.[1] This impacts on national income, which is used for such areas as 'health'. At the same time, health service costs are rising, and there is an increasing burden on the system from chronic diseases and ill health.[2]

Better Health North East Melbourne (BHNEM) is a collaboration of health leaders whose individual focus is primary and/or secondary health care planning and provision. BHNEM has a catchment that covers the Local Government Areas (LGAs) of Darebin, Banyule and Nillumbik. The conduit to primary care (GPs) is the Primary Health Network. Two of these – Eastern Melbourne Primary Health Network and North Western Melbourne Primary Health Network are BHNEM members. Three Community Health Services – Your Community Health (Darebin), Banyule Community Health, and health Ability (Nillumbik) – are BHNEM members and are key to maintaining a focus on people and health service delivery in communities.

The main secondary care provider for the catchment - Austin Health - and the Department of Health and Human Services – North Division are also BHNEM members.

***BHNEM Catchment***




[1] https://static.treasury.gov.au/uploads/sites/1/2017/06/02_Exec_summary.pdf
[2] https://www.strategyand.pwc.com/media/file/Reimagining-health-reform-in-Australia.pdf

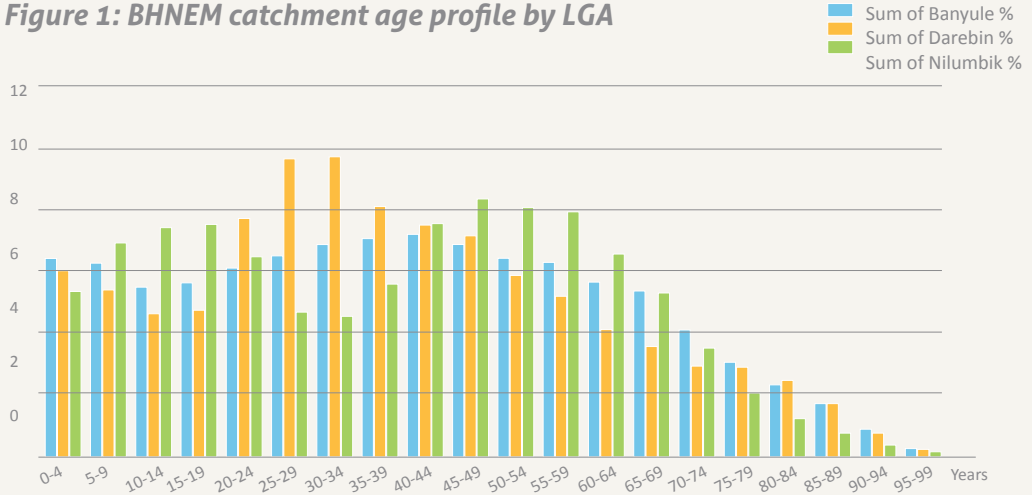
The BHNEM catchment has significant areas of 'advantage' but also areas of 'disadvantage'. The LGA of Darebin has areas of disadvantage, particularly at its northern 'border', and Banyule has disadvantage in Heidelberg West – Bellfield, in particular, but also in Heidelberg Heights and Watsonia. The total population for the three LGAs within BHNEM is 329,865 people (2016 ABS Census) comprising Darebin (146,722), Banyule (121,869) and Nillumbik (61,274). There is heterogeneity in terms of age profile across the three LGAs, with Darebin having an over representation of people aged 25-44 and 85 plus and Nillumbik having an under representation of people aged 25-44 and 65 plus compared to the Melbourne average.

The three LGAs have a very similar proportion of their population in the 40-44 years age group, and a similar proportion of their individual LGA population in the 0-4 years age group and in the age groups over 75 years. *(See Figure 1)*.

Just over 15% of the BHNEM catchment are people aged 65 and over. Frailty is associated with ageing and is common in the elderly. Frailty is related to "an increased risk for poor health outcomes including falls, incident disability, hospitalization, and mortality".[3]

At the other end of the age range, children aged 0-4 account for 6% of the BHNEM catchment's population. Although these children are, on average, less developmentally delayed than the Melbourne average, there is still room for improvement. Darebin has the most vulnerable children of the BHNEM catchment at 7%. (Vulnerable is defined here as children who are delayed in two or more domains of the Australian Early Development Census). This is more than Banyule (6%) and Nillumbik (3%). Improving health outcomes in the early years improves outcomes for people into the future.

***Figure 1: BHNEM catchment age profile by LGA***




[3] Qian-Li Xue, The Frailty Syndrome: Definition and Natural History, accessed at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3028599/

The BHNEM catchment has a small Indigenous population (less than 1%). As elsewhere across Australia, outcomes for Indigenous Australians are poor compared to outcomes for non-Indigenous Australians.

The rates of chronic disease vary across the BHNEM catchment, with the highest rates being for 'high cholesterol' and 'musculoskeletal diseases'. Out of the three LGAs in the BHNEM catchment, Darebin has a noticeably higher rate for 'type 2 diabetes', 'cardiovascular diseases' and 'arthritis'.

Across the catchment, and whilst Darebin's rate is higher than Banyule's and Nillumbik's, there is noticeable premature mortality from the chronic diseases of 'circulatory system diseases' and 'ischaemic heart disease'.

In terms of preventable admissions for chronic conditions, Darebin has the highest rates, many of which exceed the Greater Melbourne average rate. Preventable admissions for 'chronic congestive cardiac failure' and 'iron deficiency anaemia' are relatively high, followed by preventable admissions for 'chronic COPD' and 'chronic diabetes'.

**While overall the BHNEM catchment has good health outcomes, there is room for improvement in some areas, and there is a need to maintain and extend good health outcomes across the catchment.**

In the absence of new money, it is recognised that more has to be done with less, and there needs to be greater efficiency in service delivery.[4] Collaborative or partnership arrangements, such as BHNEM, are one way to do this.

[4] https://www.kingsfund.org.uk/sites/default/files/field_publication_file/Place-based-system-of-care-Kings-Fund-Nov-2015_0.pdf

# Our Current State...

Maintaining and improving the health outcomes for people in the BHNEM catchment requires better connection between the parts of the health system.

As elsewhere in Australia, across the BHNEM catchment the health system and services are siloed and fragmented. This includes how each part is funded. Each sector has its own 'turf' with the consumer/patient 'journey' being one of stops and starts at the interfaces between services. At times there is duplication. The person using the health system often has to repeat their story to each provider they see; the data and necessary information do not flow optimally between providers along the consumer/patient 'journey'.

There is a disparity in terms of health outcomes and disease prevalence. There is a focus on 'illness' and the treatment or management of individual conditions (diagnoses) rather than focussing on the whole person who might have multiple morbidities. Care tends to be 'episodic', whereas chronic conditions are enduring, requiring a plan for long term management.

There are opportunities to improve both the effectiveness and the efficiency of the health system across BHNEM's catchment. This is necessary to respond to a growing population and to increased health costs. While individual provider organisations appropriately focus on effectiveness, and quality and safety within their organisation, it is at the interface between providers that gaps appear. This is where improvements can be made.

Each provider has its own funding and management systems. Accountability and rules around expenditure, and the stipulation for discrete (organisation-specific) outcomes and outputs have, to date, limited the creation of innovative solutions and the development of truly integrated models.

The system as a whole is inefficient. This signs and symptoms of this inefficiency include:

- increased waiting times and lists. (And more than 10% of outpatient costs can be avoided if integrated care pathways and models are used).[5]
- people not attending appointments that are necessary (DNAs, no shows) or people delaying or not getting prescribed medications. (10% of the most disadvantaged of the population have delayed or not got prescribed medications due to cost).[6]
- people presenting to an Emergency Department when they should have accessed primary care or other non-hospital care. (30% of patients presenting to EDs could be managed in primary care settings).[7]
- people being admitted to hospital for a chronic condition when they should have been managed in primary care or in the community.
- people being readmitted to hospital within a short period of time after discharge.
- children not being 'school ready'.
- poor literacy and poor health literacy.
- people not taking responsibility for their own health, including in changing behaviour to prevent ill health and illness. (Chronic disease accounts for 80% of the burden of disease and more than 30% of that is preventable).[8]
- people not dying in their preferred place of death.

A coordinated/integrated approach is needed so that the costs/problems do not just get passed 'downstream' or onto another provider – or do not get addressed at all.

**In many cases it is not a lack or absence of services that is the problem but a lack of understanding in the community and amongst providers of what services are available.**

In addition, there is often poor navigation of these services and a lack of coordination between the services.

Technological solutions to the costs/problems are relatively under explored and underutilised. There is room for innovative technological solutions.

[5] https://www.strategyand.pwc.com/media/file/Reimagining-health-reform-in-Australia.pdf
[6] https://theconversation.com/australias-health-system-is-enviable-but-theres-room-for-improvement-81332
[7] https://www.strategyand.pwc.com/media/file/Reimagining-health-reform-in-Australia.pdf
[8] Ibid

# Our Future State...

**"A viable health reform strategy for Australia must necessarily take a systemic view that addresses both demand and supply at a catchment area/health network level and a wider health system level."**[9]

We desire a health system across the BHNEM catchment that is:

- Integrated
- Coordinated
- Efficient
- Connected
- Able to deliver a seamless consumer experience
- Technology enabled – leveraging the opportunities provided by new technologies
- Planned, developed and shaped by data
- Measured and evaluated using data
- Accessible, with clear navigation points
- Focused on wellness
- Focused on early intervention, improving quality of life, and 'living well'.

In addition, the future state will have:

- No duplication
- No gaps

The future state will deliver improved health outcomes for everyone in the catchment, but particularly for the more vulnerable and disadvantaged. The future state will be led by visionary leaders who understand the issues, foster innovative solutions, and take bold steps.

Funding for health services will be joined up so that there can be coordination in planning and delivery of services at the provider level, and innovative solutions can be implemented.

[9] https://www.strategyand.pwc.com/media/file/Reimagining-health-reform-in-Australia.pdf

# Our Strategy...

Better Health North East Melbourne is a collaboration of diverse organisations that are critical to the delivery of health care across the North East of Melbourne. As a collective the group has identified the potential of working closely together to deliver better healthcare outcomes for its constituents. However, it also acknowledges (from lived experience) that doing so successfully is a complex and difficult task.

Embedded inside its Strategic Plan are some key strategic choices that aim to set the collaborative up for success. These choices were developed through a conscious process, which considered:

- What data are available?
- What do the data tell us?
- What can BHNEM (as a collaborative) influence?
- How many things should BHNEM focus on in order to do them well?
- What can BHNEM do that no one else is doing?
- What can BHNEM do that builds on, extends, or uses what others are doing?
- How can BHNEM create the biggest 'bang' for the 'buck'?

In terms of specific and priority projects or pieces of work for the collaborative, the process and line of enquiry taken by the collaborative led to a decision to focus on two distinct cohorts for the period of this Strategic Plan. BHNEM wants to improve the connectedness of the health system for these cohorts, and, through its work, BHNEM wants to improve the outcomes and experience of care for people in these cohorts.

The first cohort is 'frail aged'. Frailty is important because of the health system utilisation and costs to the individual, to their families and communities, and to the 'system'. Frailty is common in the elderly and is related to an increased risk for poor health outcomes including falls, disability, hospitalisation and death. Improvements in care require more joined up effort, and BHNEM is committed to being the vehicle to drive this.

The second cohort is 'children under the age of 5 with developmental delay'. Health system improvements for this cohort will not only improve these children's health and outcomes now, but also into the future. Data and literature describe the link between literacy, socio-economic factors, and health outcomes. BHNEM is committed to making a difference for this vulnerable cohort to effect long term health and wellbeing gains.

The Strategic Plan is summarised on the following pages. The Plan highlights a number of key principles, as follows:

## Being focused

When there is so much to do and so many influential people in the room who are able to direct their organisations to act, the temptation can be to take on too much and become overwhelmed and confused. That is why this Strategic Plan has identified such specific and measurable outcomes. By focusing specifically on two cohorts - the frail aged, and children with developmental issues - it is possible to focus the group's efforts and track its impact, knowing that lessons learned can be applied to other areas.

## Health pathways

Looking at care pathways from the perspective of the people who use the health system is a common aspiration. This collaborative is uniquely placed to actually deliver on this aspiration. This is partly because it has focused very clearly on which pathways it is going to pursue first, and partly because most of the key players who form part of that pathway are represented in the collaborative. Identifying and filling the gaps that occur because organisations are siloed from each other will be critical to the collaborative's success.

## Partnerships

Achievements will be built upon the successful partnerships that the collaborative is able to establish - both within the collaborative and with all other key stakeholders. Being trusted and acting in a trustworthy way, being transparent, and sharing data and knowledge are all key ways the collaborative is able to deliver its ambitious vision.

## Sharing data

The collaborative is under no illusions about the complexity of sharing data across the system. Issues of technology, privacy, legality and habit all play a part in making it difficult for clinicians to access the information they need to access to deliver seamless healthcare. However, solving these problems in the long term is seen as a critical factor for success. So, the collaborative will work pragmatically within the limits it currently faces to create change today whilst working diligently on the bigger, more complex, task of safely sharing patient data so that no one has to retell their story.

# Our Strategic Goals, Objectives and Outcomes: Plan on a Page

Better Health
North East Melbourne

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|---|---|---|---|---|---|
| **OUR VISION...** | **Connected healthcare for community wellness.** | | | | |
| **OUR ROLE...** | **We are influential leaders who design and deliver integrated services together.** | | | | |
| **STRATEGIC GOALS...** | **GOAL 1:**<br>**Seamless healthcare**<br>We create seamless health care pathways for people. | **GOAL 2:**<br>**Sharing information**<br>We share and link data so that we can identify and address our agreed outcomes. | | **GOAL 3:**<br>**Working well together**<br>We work together to achieve high impact outcomes for our community. | |
| **OBJECTIVES...** | **Objective 1:**<br>To work across the health system to provide seamless services to the most vulnerable, marginalised and disadvantaged. | **Objective 2:**<br>To understand the community's needs and expectations. | **Objective 3:**<br>To understand and address the problems & our impact upon them. | **Objective 4:**<br>To create efficiency and impact by connecting our resources, systems, processes and people. | **Objective 5:**<br>To inspire our politicians, funders, health workforce and peers to collaborate across the system to deliver results together. |
| **OUTCOMES...** | **Time frame:** 5 years<br>**Year 1:** In development.<br>**Year 5:**<br>• Reduce avoidable hospital attendances and admissions at Austin Hospital by 10% for the frail aged in our catchment.<br>• Improve the Patient Reported Outcome Measures (PROMs)[10] & Patient Reported Experience Measures (PREMs) [11] by 10% for the frail aged in our catchment.<br>• Reduce the waiting time for children with developmental issues to be assessed by a paediatrician at Austin Hospital from 365 days to 90 days.<br>• Improve the Patient Reported Outcome Measures (PROMs) & Patient Reported Experience Measures (PREMs) by 10% for the parents of children with developmental issues in our catchment. | | | | |

[10] "Patient-Reported Outcome Measures (PROMs) are questionnaires which patients complete. They ask for the patient's assessment of how health services and interventions have, over time, affected their quality of life, daily functioning, symptom severity, and other dimensions of health which only patients can know. PROM's promise to fill a vital gap in our knowledge about outcomes and about whether healthcare interventions actually make a difference to people's lives." See **https://www.strategyandquality.gov/au/our-work/indicators/patient-reported-outcome-measures/**

[11] "PREMs assess the patient's experience and perception of their health care... This information can provide a more realistic gauge of patient satisfaction as well as real-time information for local service improvement and to enable a more rapid response to identified issues."
See **https://www.aci.health.nsw.gov.au/make-it-happen/prms/about-patient-reported-measures**