Eastern Melbourne
Primary Health Care Collaborative

Eastern Melbourne Primary Health Care Collaborative

Primary Health Strategic Plan 2017–2018

Contents

Executive Summary

The Eastern Melbourne Primary Health Care Collaborative (EMPHCC) was established by a group of primary, community and acute health service providers in the eastern Melbourne region to improve health outcomes for people across their shared catchment areas. The goal of the EMPHCC is to enhance the functions of health systems in the region for people with chronic and complex conditions through better connections among service providers. This will enable people to better navigate the system and receive the care they need in the most appropriate location.

The Eastern Melbourne Primary Health Care Strategic Plan 2017–2018 represents a significant step in the journey for the EMPHCC in the endeavour to undertake shared planning to identify and address primary health care priority areas. This plan deliberately has a short time horizon to facilitate the creation of a solid foundation to take the EMPHCC forward in the future. Key enablers have been identified to provide this platform while priority health areas have also been agreed in the areas of mental health, chronic disease and end of life care.

The EMPHCC is well positioned to achieve the milestones in this plan through a sound governance structure and genuine collaboration among all partners to the shared objective of improving health outcomes for people in eastern Melbourne. The EMPHCC Governance Group is committed to the full implementation of the *Eastern Melbourne Primary Health Care Strategic Plan 2017–2018* in coming months. Indeed, some initiatives have commenced while this plan has been developed.


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Background

The EMPHCC is a region-wide platform of service providers and organisations focused on primary health care system collaboration in order to improve health outcomes for people in eastern metropolitan Melbourne.

The EMPHCC is focused on enhancing primary health care services in community-based settings to support the management of chronic disease and complex conditions for people at risk of poor health outcomes within the EMPHCC catchment, defined by the local government areas of Boroondara, Knox, Manningham, Maroondah, Monash, Whitehorse and Yarra Ranges.

It is intended that the EMPHCC will facilitate the improved alignment of primary and secondary health care service providers across all members of the EMPHCC in order to slow the progression of chronic and complex diseases in the EMPHCC catchment and to reduce avoidable hospital admissions through improved, community-based models of care.

Membership of the EMPHCC Governance Group comprises service providers and organisations that have mandated responsibilities for local health planning and primary health care service delivery. These service providers and organisations consist of Community Health Services, the Department of Health and Human Services, Eastern Health and Eastern Melbourne Primary Health Network. However, established platforms such as Primary Care Partnerships and the Mental Health and Alcohol and Drug Services Planning Council are foundation collaborators and are fundamental to the achievement of the shared goal of improved health care outcomes. To this end, these organisations are embedded within the EMPHCC governance structure and most notably at the Strategic Alliance level.

The EMPHCC acknowledges there are existing collaborations in place across the catchment focused on health promotion, primary prevention and wellbeing initiatives and is not seeking to duplicate the work undertaken within these domains. However, the convergence between prevention, wellbeing and primary health care is recognised and a collaborative approach to ensure alignment between the respective groups will be fostered by the EMPHCC. The integration with local government is a possibility to be considered in future. As the work of the Collaborative evolves, membership will encompass other groups and organisations who are able to i nfluence service system changes.

Partners of the EMPHCC have committed through a Memorandum of Understanding to:

1. Undertake shared planning to identify and collectively address primary health care priority areas through enhanced and sustainable collaboration, efficient use of resources, alignment of service providers and reduced duplication;
2. Work together to improve the health of people in the EMPHCC catchment by developing innovative approaches to effect systemic change;
3. Develop person-centred approaches to deliver measurable improvement in health outcomes using evidence-based strategies;
4. Develop and implement a shared measurement system to support ongoing improvement;
5. Ensure adequate contribution of collaborators and resources to enable the EMPHCC to achieve its identified goals;
6. Foster the values of partnership, excellence and responsiveness in health care; and
7. Formalise the roles and responsibilities of the members of the EMPHCC.

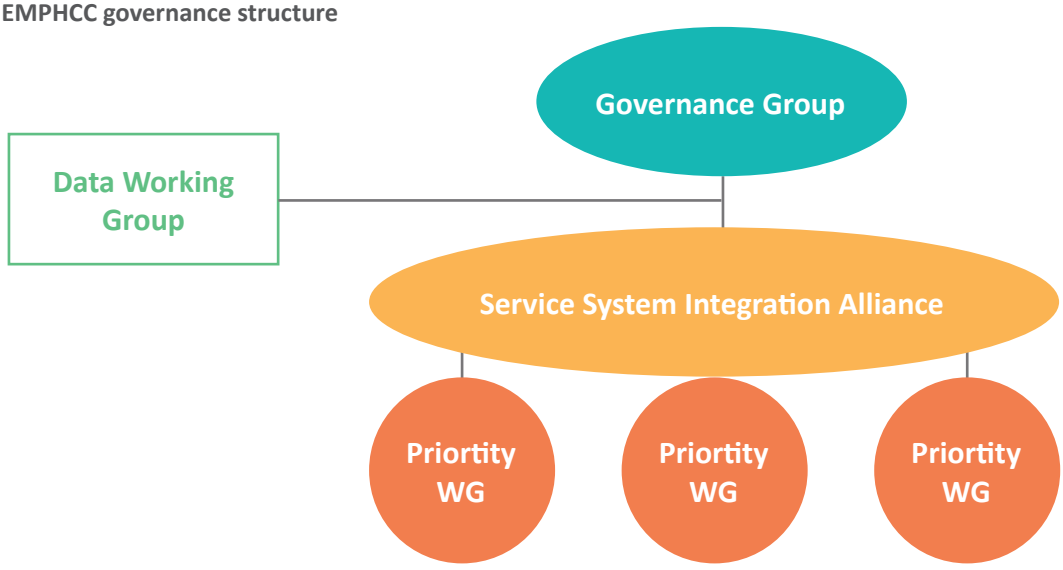
The key activities of the EMPHCC include:

1. Review of available data, needs assessments and relevant information regarding the health of the population in the EMPHCC catchment;
2. Development and oversight of the implementation of a primary health care plan for the EMPHCC catchment to address priority needs with a view to ensuring that the right care is provided in the right place at the right time consistent with current evidence and government policy;
3. Review of available resources and funding to ensure maximum impact; and
4. Ensure an evaluation framework is in place to assess the performance and effectiveness of strategies implemented by the EMPHCC. This should be consistent with current directions related to quality and outcome measures in policy documents from governments and professional bodies such as Targeting Zero published by the Victorian Government and Better Outcomes for People with Chronic and Complex Health Conditions published by the Australian Government.

Governance Structure[1]

The governance structure of the EMPHCC comprises distinct groups at three levels and is represented in Figure 1 below. The structure incorporates the Governance Group that provides strategic direction and oversight for the Service System Integration Alliance, which in turn is supported by the work of Priority Working Groups which will focus on key areas arising from this Primary Health Strategic Plan.

Figure 1: EMPHCC governance structure



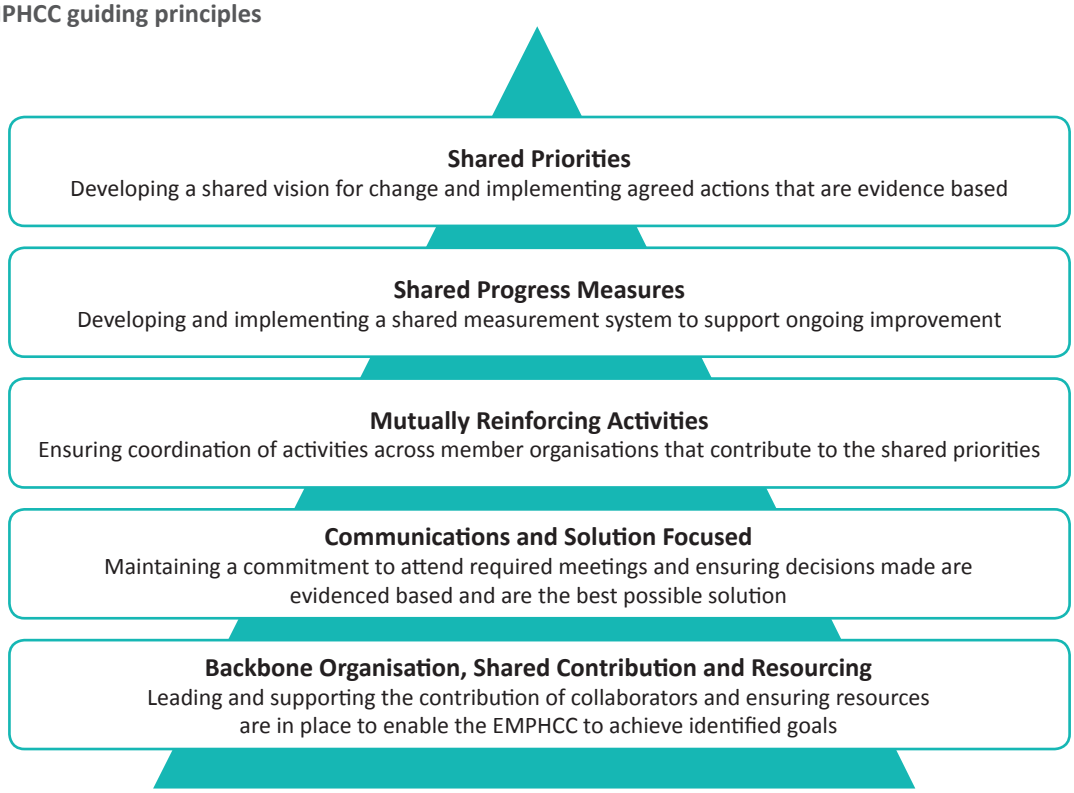
Source: Eastern Melbourne Primary Health Care Collaborative Governance Group Terms of Reference, September 2016

The EMPHCC has key relationships with existing groups such as the Eastern Health Primary Care and Population Health Advisory Committee, Eastern Melbourne Social Issues Council and Eastern Metropolitan Mental Health Community Support Services and Alcohol and Other Drug Services Planning Council. The EMPHCC will maintain effective working relationships with these as well as other groups and organisations committed to improving health and wellbeing outcomes for people in eastern Melbourne. The purpose of these relationships will be to focus on identified priorities, enhance coordination and avoid duplication.

Guiding principles

The guiding principles of the EMPHCC are shared planning to identify and address priority primary health care issues, adopting a person-centred approach, use of evidence-based strategies and collective impact. Analysis of population health will inform the development of strategies including the need to adopt placed based approaches, such as targeting areas of known disadvantage and low health status and increasing equity of access to services. The function of the EMPHCC is to oversee the development and implementation of sustainable collaboration of key service providers and organisations involved in the planning and delivery of primary health services to improve health outcomes as detailed in Figure 2.

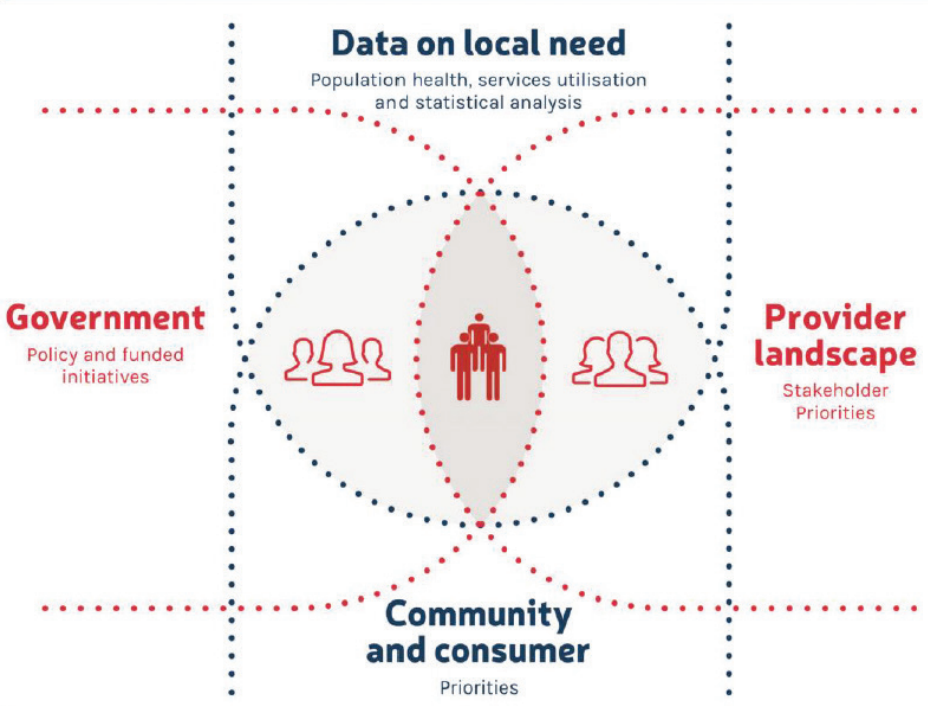
Figure 2: EMPHCC guiding principles



Identification of priorities

Prioritising primary health care needs using a population health statistical analysis has guided the development of a Primary Health Strategic Plan by the EMPHCC. This concept is represented by the image in Figure 3 which shows the four key informants of the Primary Health Care Plan.

Figure 3: Framework for prioritising primary health care needs



The population health statistical analysis undertaken to date by the EMPHCC has been high level data analysis for the EMPHCC catchment including demographics, levels of disadvantage and health needs including rates of avoidable hospital admissions. A summary is provided in Appendix 1.

Ongoing data collection, linkage and analysis is required so that the EMPHCC is able to evaluate and inform prioritisation of primary health care initiatives and to ensure the EMPHCC is agile and responsive to the changing needs of the community. This work will be supported by the EMPHCC Data Management Group. The Priority Working Groups will be also be informed by initiative-specific data working groups.

Australian Government and Victorian Government Policy and Funding guidelines have informed the EMPHCC approach to primary care initiatives. Of significance are the major reforms occurring in mental health, primary care, acute care, aged care and the disability sectors which have major implications for the way services are commissioned within the community. Ultimately, community sentiment, opinion and needs are at the core of the reforms and the co-design approach to planning is intended to incorporate these into the EMPHCC design as reflected in Figure 3.

Purpose of this document

The purpose of this document is to provide the framework for the EMPHCC and guide priority areas in the next two years by outlining a clear framework for specific initiatives to improve primary care service delivery systems and also provide clear direction regarding certain strategic enablers to enhance primary care delivery systems at a more strategic level. The intent is for this plan to be adopted by both the EMPHCC and the Eastern Health Primary Care and Population Health Planning Committee. The EMPHCC will work together to set agreed priorities and strategies under a plan for the Eastern Melbourne Region (EMR) with a focus on primary health system collaboration, efficient use of resources, technology platforms, metrics and methodology to impact system wide change for improving health outcomes and reducing waste.

Primary Health Care Priority Areas

To achieve its purpose of improving health outcomes for clients at an individual and catchment level, the EMPHCC will need to target its attention and select initiatives that align with criteria for project selection. Analysis of data has identified the demographics of the region and common conditions that are amenable to interventions within the primary care setting, refer to Appendix 1. These common conditions have been one component of planning that has informed the priority areas of the EMPHCC.

Criteria for project selection

The EMPHCC has agreed criteria to be used for selecting projects. These are:

- The project will have an outcome focus and be linked to the objectives of the EMPHCC

The project will bring together alignment of the four elements of the framework for prioritising primary health care needs (Figure 3) – population health data; provider landscape; consumer and community expectations; and government priorities

- The project takes into account the social model of health, while considering clinical conditions
- The project considers the whole person and is not solely disease focused that is, it is person focused
- There is a compelling argument for action based on objective data and evidence
- The intervention proposed is evidence-based
- There is a balance between “big and little things” enabling quick / early wins to be built into the project
- The project should be strengthened by the Collaborative and through collaboration
- The project can be clearly differentiated from existing initiatives and does not duplicate effort
- The project uses a consumer lens for design and measurement, ideally with direct participation
- The project should be sustainable or there should be a realistic view of sustainability at the outset

Both the identified common conditions and agreed principles will be applied to select initiatives to be supported by the EMPHCC, called priority areas detailed in Figure 5. Each priority area will progress its work via the establishment of a Priority Working Group comprised of members of relevant stakeholder organisations. Agreed project management and improvement methodology will guide the work, and the scoping and planning for each project will look at solving a problem via the lens of disease classification and / or a place based approach, for example, areas of known disadvantage.

The timelines for each of the projects is still under development and will be confirmed through an annual planning process

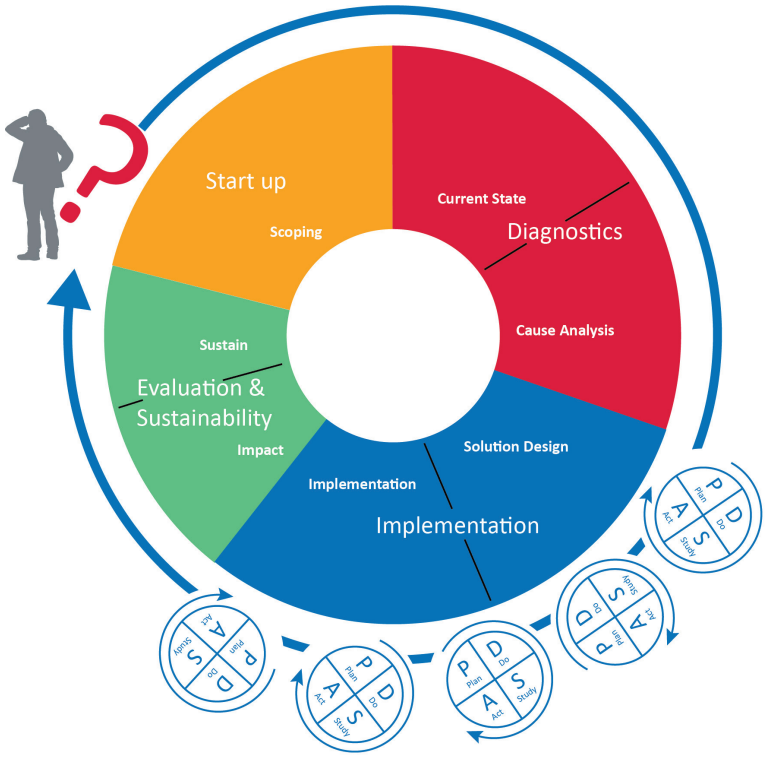
In addition to the agreed projects being undertaken by the Priority Working Groups, the EMPHCC will be responsive to the changing demographics and policy environment and explore new opportunities to ensure the EMPHCC remains relevant to the requirements of the region.

Enablers

The success of any strategic plan and implementation of related priorities is dependent upon key enablers, which are included in Figure 5 to demonstrate their integral role in the progression and sustainability of these initiatives. Collaboration and an agreed way of working are supported by clearly defined governance structures including roles and responsibilities and decision making processes. The EMPHCC has agreed to use common tools for project management and improvement methodology.

The improvement methodology is based on Lean Methodology for healthcare which ensures that resources and processes are targeted appropriately and that effective and sustainable outcomes are achieved. The phases of this approach include scoping and diagnostics, planning, implementation and evaluation, and within that, smaller iterative cycles of change, Figure 4.

Figure 4: Redesign Model Adopted by EMPHCC



Meaningful data to inform initiatives and evaluation of outcomes including avoidable hospitalisation, use of technology and timely communication of client level information is vital. The view of the EMPHCC is that the health care system in eastern Melbourne is currently data rich but information poor due to multiple information systems being used both within and across the sectors. The EMPHCC believes a significant opportunity exists to explore how meaningful information and technology can be used more effectively to model and plan strategies to increase care outside the hospital walls. The first steps include a shared view of data and what it means, and then exploring the capability to share and link such data. Opportunities include exploring access to data through existing platforms, such as POLAR and data held by Eastern Health and also, the establishment of the Department of Health and Human Services' Victorian Agency for Health Information, which has the brief for managing the Department's health data collections including, improving access to clinical data by clinicians, boards, departmental staff and academic researchers.

The importance of accurate data to inform planning priorities is well understood. While the EMPHCC has undertaken a broad review of data from a catchment perspective, there is further analysis required to ensure a thorough understanding of primary care needs and the impact of initiatives to be overseen by the EMPHCC. In addition, the ability to link data at a patient level between service providers as a key enabler to ensure effective coordination of service providers based around patient need is required to ensure effectiveness and efficiency of the service system. It is understood this will be a challenge but equally so is an agreed priority area for the EMPHCC. Indeed, this has informed the need to further develop one of the key enablers related to data and information which is discussed later in this plan.

The EMPHCC also views the development of a consistent approach to engaging consumers, carers and key stakeholders, especially general practitioners, will ensure that the projects selected are well informed, relevant and make a difference to clients, their families and GPs in the region.

Funding models need to be considered to support new ways of working and providing services across the region. A defined and agreed method needs to be developed by the EMPHCC to support this approach.

Priority Areas

The EMPHCC Governance Group and Strategic Alliance have held a number of meetings to develop an evidence base to inform the development of priority areas for action to slow the progression of chronic and complex diseases in the EMPHCC catchment and to reduce avoidable hospital admissions through improved, community-based models of care. The progression is summarised in Figure 5 below including the process undertaken through the establishment phase of the EMPHCC which culminated in a Governance Group Workshop in January 2017 where priority areas were agreed based on the criteria for priority area selection detailed above. These priority areas were informed by the data provided in Appendix 1. Underpinning the priority areas is a set of enablers that are required to facilitate implementation of the priority areas and importantly, provide the architecture for the next iteration of the EMPHCC Strategic Plan.

Quite deliberately, the EMPHCC Primary Health Strategic Plan is time limited through to conclude in the year 2018. This is because the Governance Group considers the enablers detailed below are strategic in their nature and are required to be in place in order to better inform the development of subsequent priority areas. To this end, there are initiatives underway that will support these endeavours both from a service provision and enabling perspective.

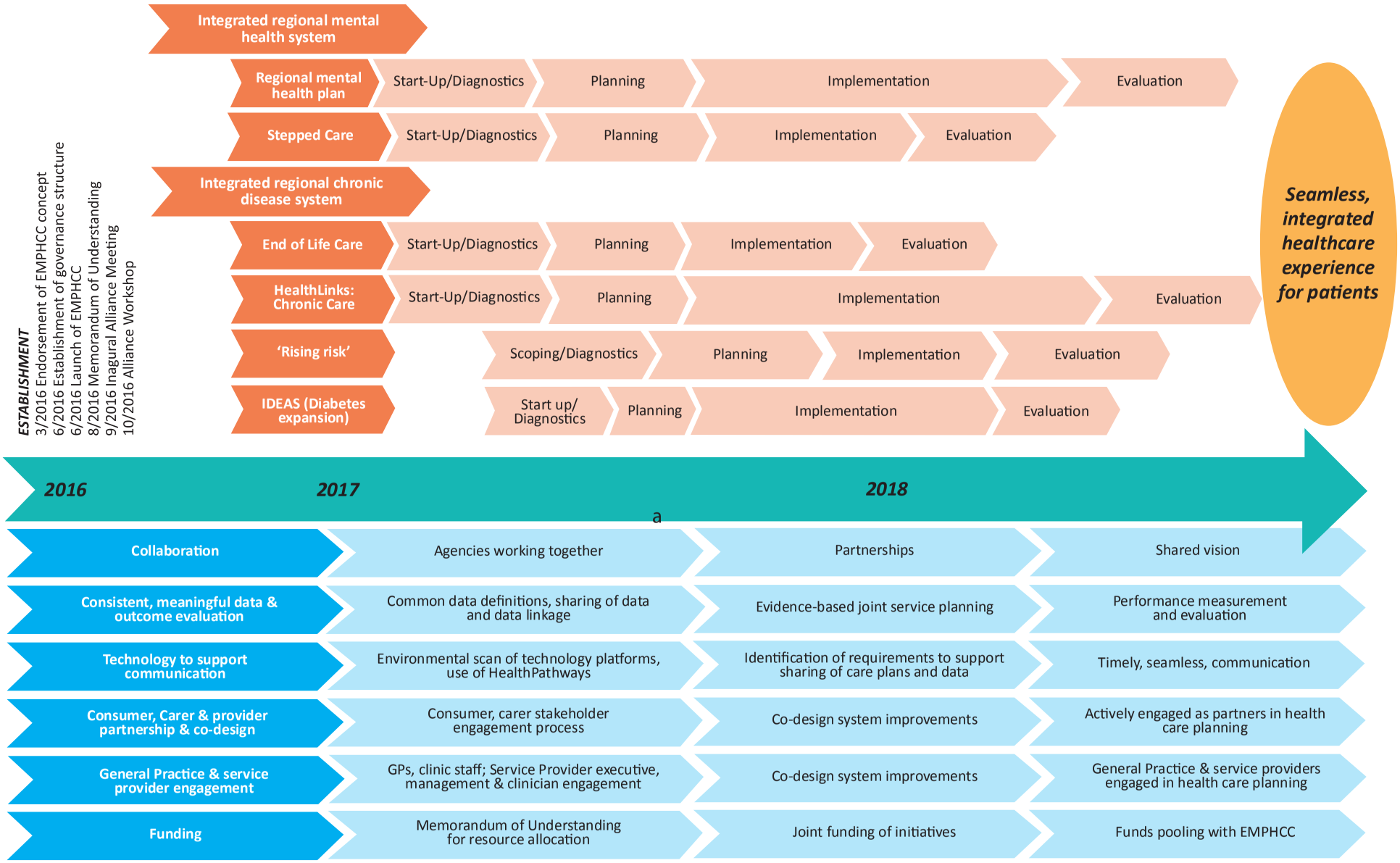
Priority areas and process to determine

The EMPHCC Governance Group led planning processes during late 2016 and early 2017 to identify short and medium term priorities for the EMPHCC. This process was undertaken utilising the information detailed above and also through further discussion and prioritisation by the Service System Integration Alliance.

In each case, the Service System Integration Alliance first reviewed existing models as a start point (such as the Stepped Model of Care model from the Eastern Melbourne PHN, or the End of Life Standard from Eastern Health, included in subsequent pages), to ensure that we are building on and adding to existing approaches. The Governance Group then considered where and how to add value in building linkages, partnerships and / or service systems through specific projects in these areas that will enhance the patient journey.

A detailed implementation plan including key milestones will be developed and overseen by the EMPHCC Governance Group to ensure the full implementation of the EMPHCC Primary Health Strategic Plan.

Figure 5: EMPHCC Priority Areas



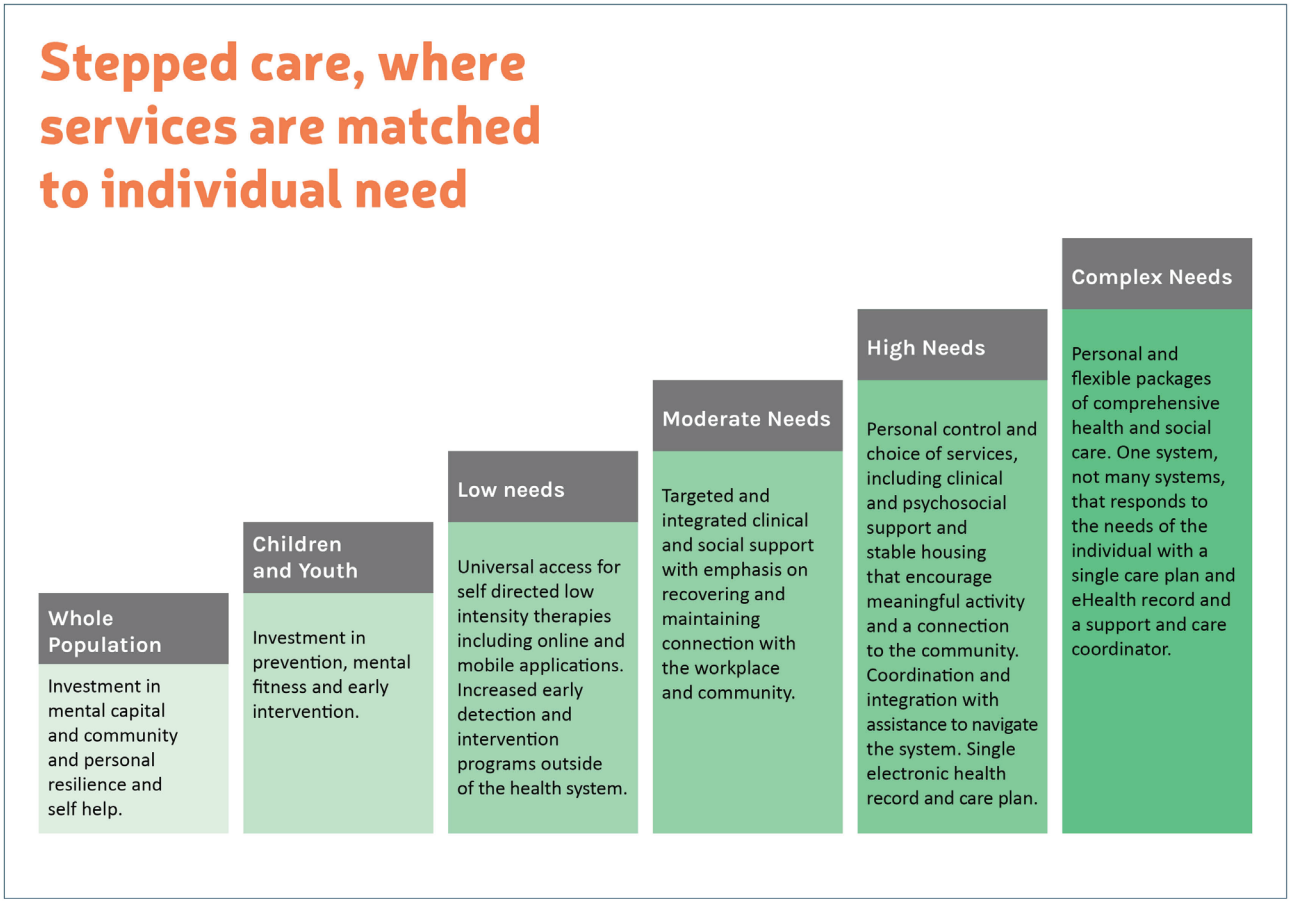
The following sections outline these priorities which will form the basis of the EMPHCC Primary Health Strategic Plan. Each of these priority areas will have a Priority Working Group established as detailed in the governance section above, to oversee and coordinate initiatives relevant to the respective area. There may be the need to have two priority areas under the remit of one Priority Working Group to ensure consistency of effort and to prevent duplication.

Stepped Care approach

A "stepped care model" has been in place within the mental health service sector for some time and can be defined as an evidence-based, staged system comprising a hierarchy of interventions, from the least to the most intensive, matched to the individual's needs. While there are multiple levels within a stepped care approach, service providers do not operate in silos or as one directional steps, but rather offer a spectrum of service interventions (PHN Primary Mental Health Care Flexible Funding Pool Implementation Guidance). The benefit of this approach is to clearly define the role each service/practitioner occupies for the person, at which time and for what purpose.

The model is valuable as it clearly outlines the role service providers have across the care continuum and therefore across the system more broadly. A stepped care approach is represented in Figure 6. The intention is to adapt the stepped care approach currently used in mental health services to other chronic conditions and priority areas identified by the EMPHCC where patients are moving between primary, secondary and tertiary level care to reduce duplication and ambiguity for service providers. This approach will provide the consumer with a seamless, integrated experience when navigating the healthcare system.

Figure 6: Stepped Care concept



Source: Eastern Melbourne PHN presentation, Mental Health Stepped Model of Care, December 2016

Mental Health

Primary Health Networks are tasked to develop and commission region-specific services, using existing service providers, to provide early intervention to support children and young people with, or at risk of, mental illness. The approach will maintain current service delivery and improve the integration of broader primary mental health services, physical health services, drug and alcohol services, and social and vocational support services.

The Eastern Melbourne PHN currently has a range of funding for various initiatives around mental health and is mapping the "steps" of care and services available. The EMPHCC platform will be used as a collaborative platform to facilitate this work around low intensity and high prevalence mental health issues within the primary care sector and assist general practitioners to navigate the system.

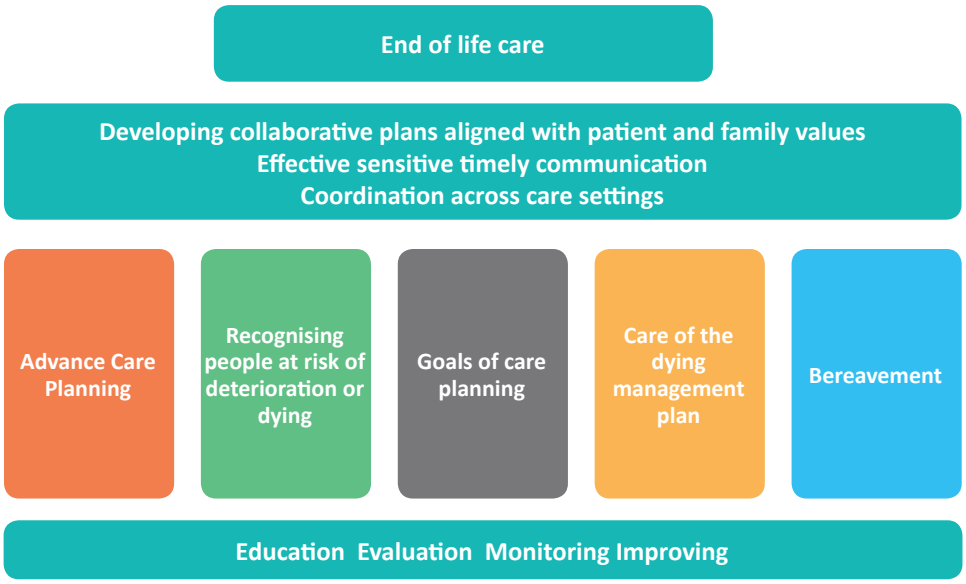
Innovative service models developed by the EMPHCC will support the integration of physical and mental health care systems. Physical and mental health are closely interconnected and affect each other in a variety of ways. Compelling evidence shows there are high rates of mental health conditions among those with long-term physical health problems, poor management of "medically unexplained symptoms", reduced life expectancy among those with severe mental health issues attributable to poor physical health, and limited support for the wider psychological aspects of physical health and illness[1]. An integrated approach will slow the progression of chronic and complex illnesses and improve health outcomes.

End of Life Care

Over fifty per cent of Australians die in hospitals or other institutions; however the majority would prefer to die at home. The concept of "End of Life Care" (EOLC) focuses on the quality of life over the last twelve months of life, recognising the importance of establishing goals of care for people who are dying. The EOLC framework's vision is for "all Victorians and their families to receive the best possible end of life care that places them at the centre where preferences, values, dignity and comfort are respected and quality of life matter most (Department of Health and Human Services). The framework for the Eastern Health EOLC standard is display in Figure 7 and is the basis for work to be undertaken by the EMPHCC, with a focus on the health care sector working together to identify and share information and care plans for people who are at the end of life. It is important for the Collaboration to work together on EOLC initiatives to ensure services are in place across the primary, secondary and tertiary sectors to support people to die in their place of choice.

[1]Naylor C et al (2016) The King's Fund. Bringing together physical and mental health. A new frontier for integrated care.

Figure 7. End of Life Care Framework Representation



HealthLinks: Chronic Care

HealthLinks: Chronic Care is a Department of Health and Human Services led initiative to determine if flexible funding enables health services to develop and implement alternative models (to inpatient acute care) that provide better experiences and outcomes for clients with chronic conditions i.e. those at risk of repeat presentation / admission for acute care. The project commenced in 2016 and eligible clients are identified by the department using an algorithm that predicts the risk of multiple unplanned admissions to hospital and/or presentations to the emergency department. Eastern Health has been participating by shadowing the Department's data to identify opportunities to intervene with a subset of enrolees. A pilot intervention model will be developed for implementation in mid-2017 and will create an opportunity to work with EMPHCC partners to develop an appropriate model of care that increases access to community based services.

Rising Risk Group: Chronic Care

The HealthLinks: Chronic Care algorithm identifies clients at risk of repeat presentation / admission to acute care, including those that have not yet been enrolled in HealthLinks. This group, "the rising risk", are amenable to early intervention to prevent their enrolment in HealthLinks. A stepped care model of care will be developed for this group of clients, with a view to ensuring they are engaged with appropriate primary care services to manage and prevent further deterioration of their health status.

Diabetes

Type 2 Diabetes Mellitus (T2DM) is increasing at epidemic proportions, and it is estimated that by the year 2031, 3.3 million Australians will have the condition. Within the EMPHN catchment T2DM effects 4.6% of the population, representing over 70,000 individuals. IDEAS, an Integrated Diabetes Education and Assessment Service, brings together specialist medical and allied health services to provide integrated multidisciplinary team based care in a community setting, with the person with diabetes supported to be an active participant in the management of their own health. Team based care is provided by specialist endocrinology from Eastern Health and integrated chronic disease management expertise within community health services in the one place, at the one time. Following trial and implementation within a small number of community health services, this project will now expand locations, offering delivery at a total of 5 different service sites across the Eastern Region. The outcome will be to reduce pressure on hospitals by providing eligible patients with integrated wrap-around support in community settings.

Conclusion

The EMPHCC has now established its governance structure formalising roles and responsibilities of the member organisations. The governance structure is underpinned by guiding principles and processes that enable the targeting of resources to support collaboration around improving health outcomes for people in eastern metropolitan Melbourne. The Collaboration has worked together to scope and plan a range of initiatives aimed at enhancing primary health care services in the short to medium term. The immediate step is to refine and implement the work plan, along with allocating resources and setting timelines. Integral to this work will be the measurement and evaluation of the impact of these initiatives to identify improvement in health outcomes as well as the development of a reporting and monitoring framework.

Appendix 1

Overview of High Level Data on Local Need and Emerging Areas of Focus and EMPHCC Analysis of Population Needs

Introduction

The EMPHCC has undertaken data analysis to better understand the catchment population and areas of need. The launch of the EMPHCC and inaugural planning workshop was held on 17 June 2016. This was a significant event that represented an important milestone for the EMPHCC particularly from a partnership engagement point of view and planning perspective. The data detailed below was presented to over 80 delegates from EMPHCC member organisations, service providers and consumer representatives. The following pages provide an overview of this information including a brief description of the emerging areas of focus.

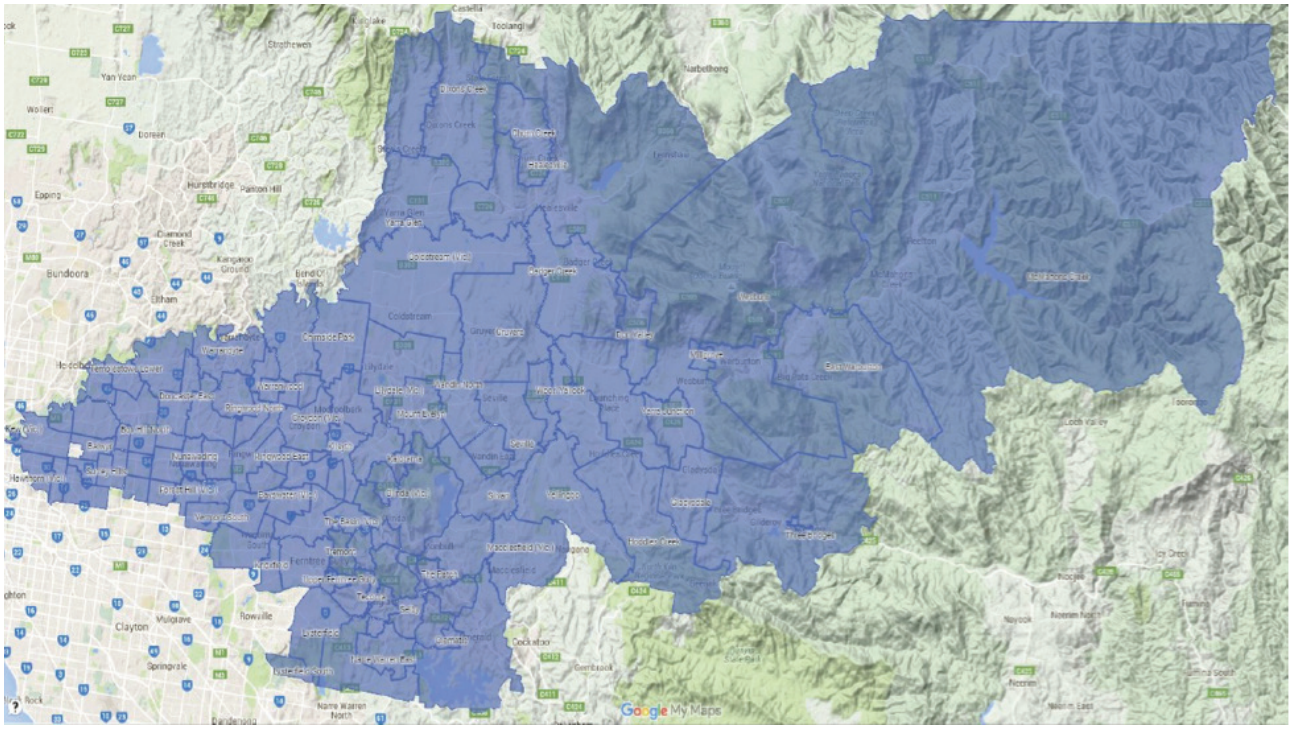
Prioritising Primary Health Care Needs

Prioritising primary health care needs using a top down population health statistical analysis will support the development of a Primary Health Care Plan by the EMPHCC. This concept is represented by the image in the Primary Health Care Strategic Plan at figure 3 which represents the four key informants of the Primary Health Care Plan currently being developed by the EMPHCC. The findings of population health and planning data analysis to date generated by the EMPHCC are of value in informing the Primary Care & Population Health Advisory Committee now and into the future.

Catchment

The EMPHCC catchment area is defined as the LGAs within the Eastern Health catchment comprising Boroondara, Knox, Manningham, Maroondah, Whitehorse and Yarra Ranges as displayed in Figure 1 below.

Figure 1: EMPHCC Catchment Area



Population

Table 1 shows the current population for the catchment by LGA, the percentage projected population change and the projected population by 2031[i]. The catchment population is currently 886,917, with Boroondara having the highest population (174,899) followed by Whitehorse (167,600) and then Knox (159,541). By 2031 the catchment population is projected to have grown to 1,028,379, with the highest growth areas being Boroondara (20.57%) and Maroondah (18.3%).

Table 1: Current Catchment Population Projected Change to 2031

LGA	Population 2016	Annual % change 2011 – 2021	Annual % change 2021 – 2031	Change 2016 – 2031	Projected Population 2031
Boroondara	174,899	1.0%	0.6%	20.57%	210,876
Knox	159,541	0.7%	0.8%	15.85%	184,828
Manningham	121,500	0.9%	0.8%	15.04%	139,774
Maroondah	112,901	0.9%	1.1%	18.27%	133,528
Whitehorse	167,600	1.2%	0.6%	11.20%	186,371
Yarra Ranges	150,476	0.5%	0.9%	14.97%	173,002
Total	**886,917**				**1,028,379**

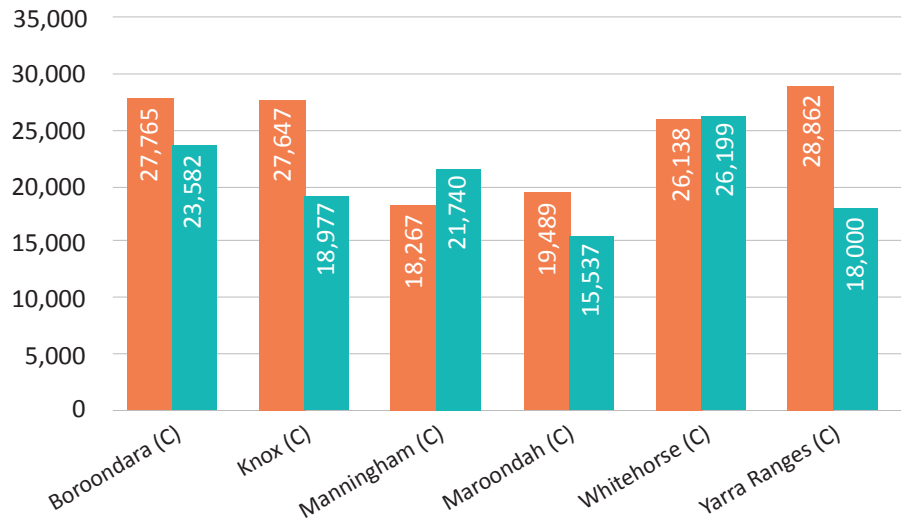
Demographics of the Catchment

The demographics of the EMPHCC catchment have been identified using the Australian Bureau of Statistics (ABS) 2011 Census of Population and Housing data.

Age groups

Figure 2 shows the breakdown of the population by age groups less than 15 years old and greater than 65 years old by LGA. Yarra Ranges has the highest number of young people (less than 15 years) (28,862), closely followed by Boroondara, Knox and Whitehorse. Whitehorse has the highest number of people aged over 65 years (26,199), followed by Boroondara (23,582).

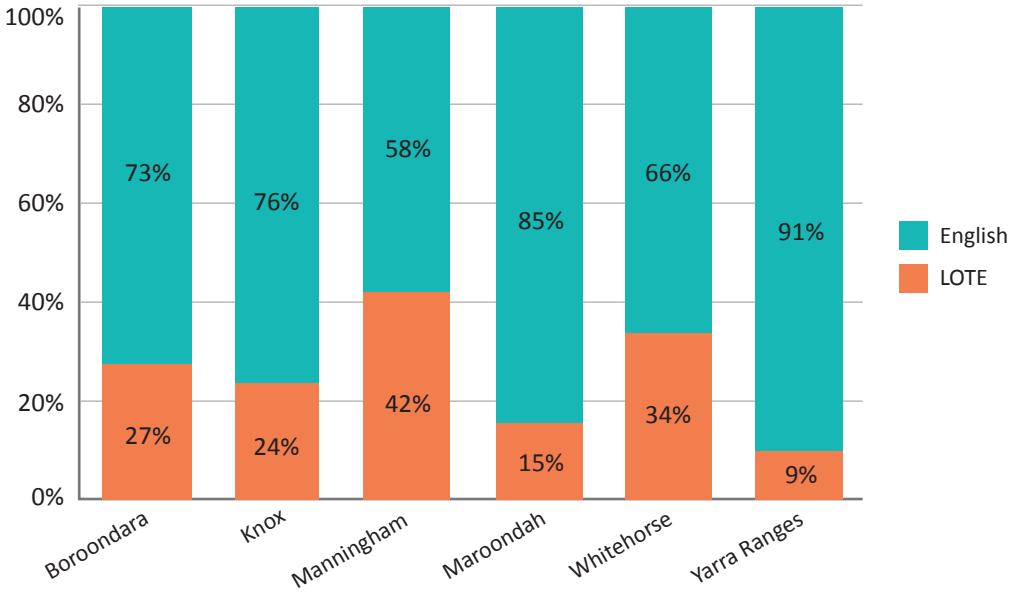
Figure 2: Number of People Aged Less Than 15 Years and Greater Than 65 years



Languages spoken

Figure 3 shows the percentage of languages other than English (LOTE) spoken at home compared with English by LGA. Manningham (42%) has the highest proportion of languages other than English being spoken at home, followed by Whitehorse (34%). Yarra Ranges has the highest proportion of English being spoken at home (91%).

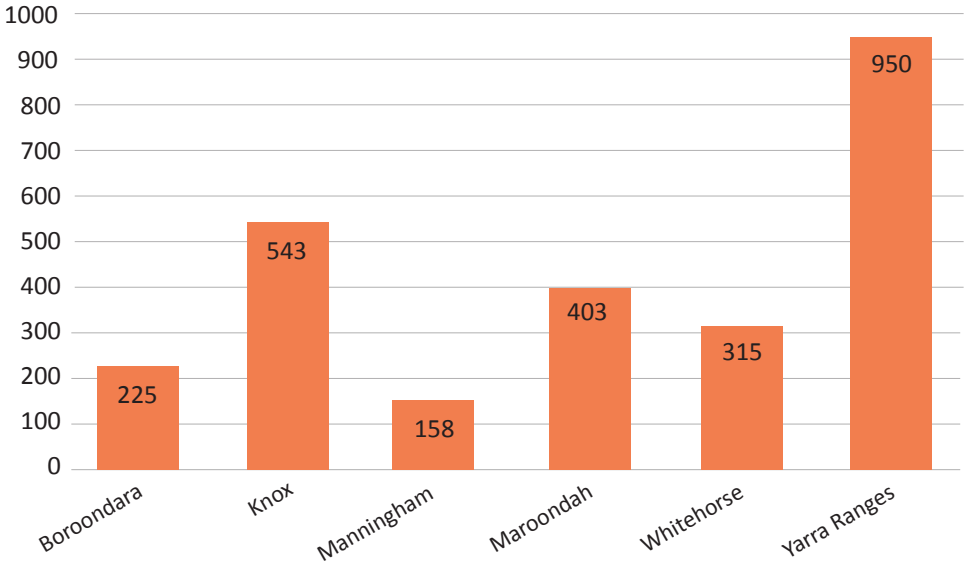
Figure 3: Languages Other Than English Spoken at home by LGA



Indigenous people

Figure 4 shows the number of people who identify as indigenous by local government area. Yarra Ranges has the highest number of indigenous people (950) within the EMPHCC catchment.

Figure 4 The Number of Indigenous People by LGA



Inequities

Inequities within the EMPHCC catchment have been identified using the Socio-Economic Indexes for Area (SEIFA), which are derived from the 2011 Census of Population and Housing, specifically the Index of Relative Socio-economic Advantage and Disadvantage (IRSAD). The Index of Relative Socio-economic Advantage and Disadvantage (IRSAD) is a general socio-economic index that summarises information about the economic and social conditions of people and households within an area, including both relative and disadvantage measures. A lower score indicates greater disadvantage and a lack of advantage in general, for example, an area could have a low score if there are (among other things):

- Many households with low incomes, or many people in unskilled occupations, and
- Few households with high incomes, or few people in skilled occupations[ii].

Figure 6 displays the Index of Relative Socio-economic Disadvantage (IRSAD) by LGA and Figure 7 single parent families with children less than 15 years. Figure 5 shows Knox and Whitehorse have the widest inequities and Yarra Ranges has the lowest overall IRSAD, indicating greater disadvantage. Figure 6 shows Yarra Ranges has the highest proportion of single parent families and largest number of children living in single parent families.

Figure5: SEIFA Index of Relative Socio-economic Disadvantage (IRSD) Profile by LGA

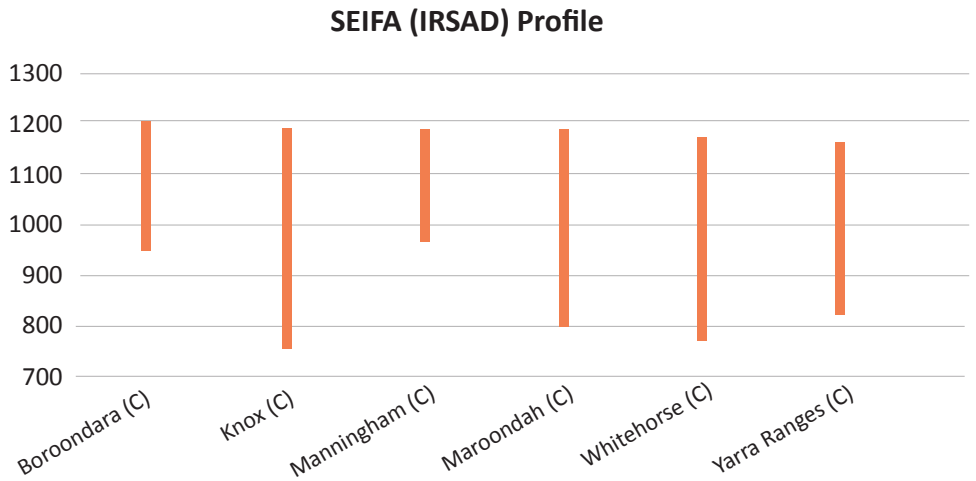
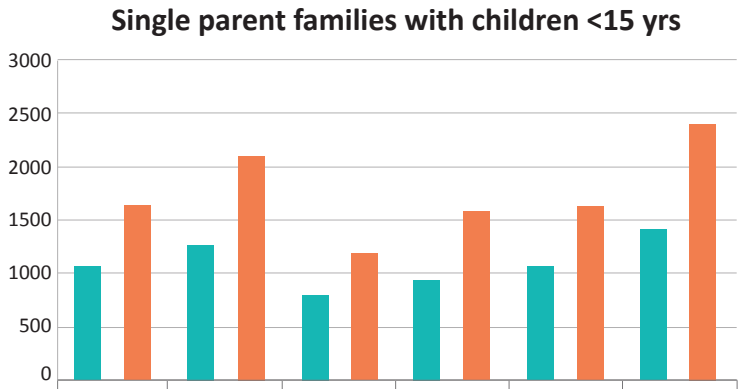


Figure 6 Single Parent Families With Children Less Than 15 Years Old

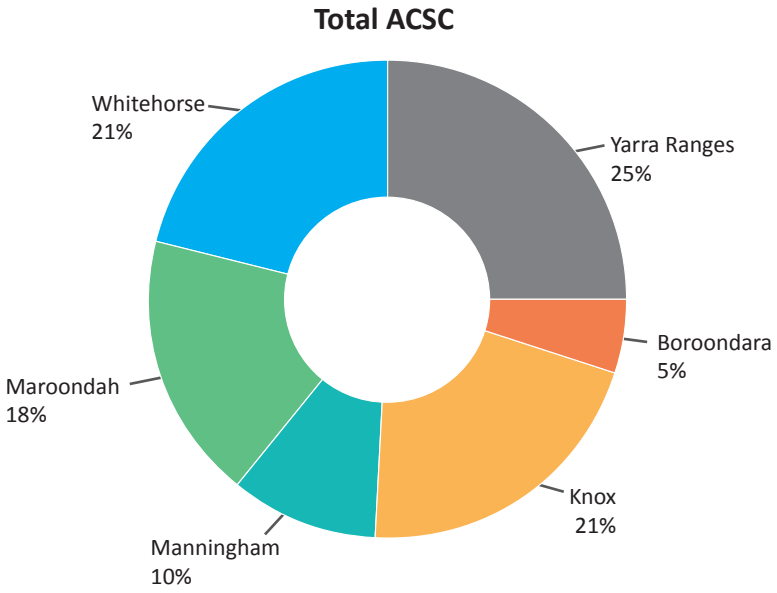


	Boroondara	Knox	Manningham	Maroondah	Whitehorse	Yarra Ranges
Number of families	1053	1266	787	939	1053	1400
% of total population	7.1%	8.0%	7.5%	8.6%	7.1%	9.0%
Total number of children	1639	2101	1196	1579	1639	2410

Ambulatory Care Sensitive Conditions

Ambulatory Care Sensitive Conditions (ACSCs) are those for which hospitalisation is thought to be avoidable with the application of public health interventions and early disease management, usually delivered in an ambulatory setting such as primary care. High rates of hospital admissions for ACSCs may provide indirect evidence of problems with patient access to primary healthcare, inadequate skills and resources, or disconnection with specialist services[iii]. ACSCs conditions are thought to be avoidable and reflect inequities and are amenable to early intervention and disease management. Figure 7 displays the percentage of ACSCs by local government area[iv], Yarra Ranges (25%), Whitehorse (21%) and Knox (21%) have the highest percentage of ACSCs avoidable admissions.

Figure 7: Ambulatory Care Sensitive Conditions (ACSCs) Avoidable Admission By LGA



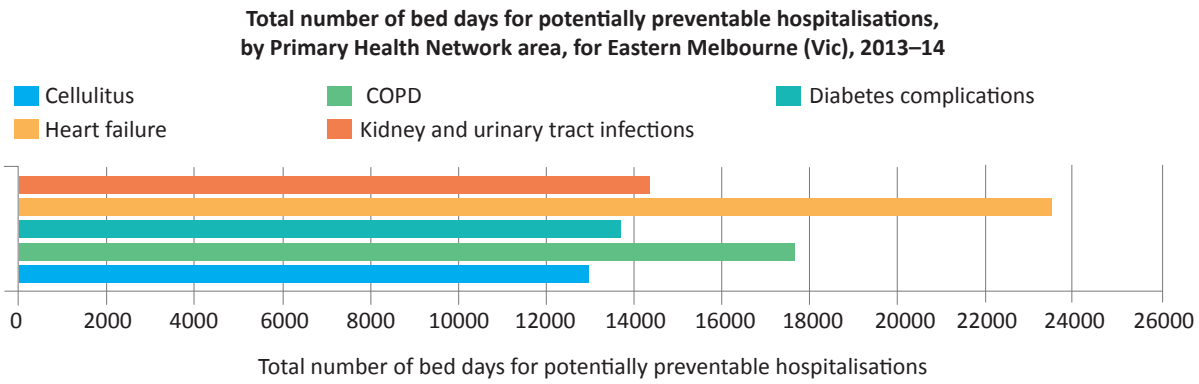
The top ACSCs classified as avoidable admissions by conditions or disease type in the EMPHCC catchment in 2014/2015[v] including and ranked bed days used are displayed in Table 2.

Table 2: EMPHCC Top ACSC Avoidable Admissions 2014/2015

Condition	Bed Days
Diabetes complications	31,806
Hypertension	32,371
Pyelonephritis (Kidney / UTI)	21,642
Dehydration & Gastroenteritis	13,587
Congestive Heart Failure (CHF)	18,655
Chronic Obstructive Pulmonary Disease (COPD)	13,141
Iron Deficiency Anaemia	5,979
Cellulitis	12,235
Asthma	2,892
Ear, Nose & Throat Infection	2,343
Total	**154,651**

The most common ACSCs being hospitalised in the Eastern Melbourne PHN during 2013/2014 are displayed by bed days in Figure 8[vi]. Heart failure and Chronic Obstructive Pulmonary Disease (COPD) are the two highest potentially preventable hospitalisations across the EMPHN in terms of bed days. Kidney infections and urinary tract infection (UTI), diabetes complications and cellulitis potentially preventable hospitalisations also have high utilisation in terms of bed days.

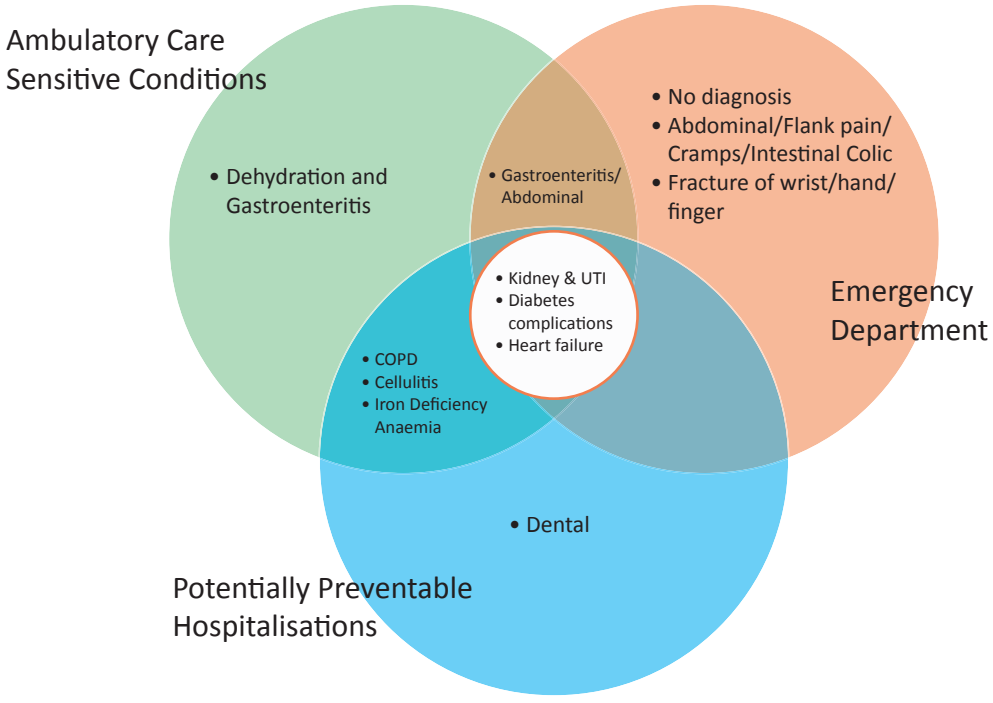
Figure 8 Total Bed Days By Diagnosis For Potential Preventable Hospitalisations EMPHN



EMPHCC Areas of Focus

Figure 9 diagrammatically represents the ACSC priority areas, potentially avoidable hospital admissions and an emergency department presentation identified by the EMPHCC and informs the work plan for the Collaborative.

Figure 9 Ambulatory Care Sensitive Conditions priorities



HealthLinks: Chronic Care

A new Department of Health and Human Services (DHHS) initiative, HealthLinks: Chronic Care (HLCC), is to be piloted at Eastern Health in 2016/2017. The DHHS has identified the initial target group of patients through the development of an algorithm that predicts the risk of multiple unplanned admissions to hospital and/or presentations to the emergency department over a 12 month period. HLCC will focus on people with chronic and complex disease that are at risk of frequent presentations to an Emergency Department and subsequent admission to inpatient units.

A key objective of the pilot is to promote flexible use of funding and increase access to community services preventing avoidable hospital admissions and presentations. The Eastern Health cohort has been identified as 3,336 eligible patients, with many of these patients experiencing Ambulatory Care Sensitive Conditions. Eastern Health will choose to enrol a subset, for example, based on geography, co-morbidity and functional assessments, or all of the HLCC eligible pool in an intervention. The pilot will create an opportunity to work with EMPHCC partners to develop an appropriate model of care that increases access to community based services.

Mental Health

In 2014/2015, mental health conditions accounted for 2,392 admissions involving 22,636 bed days[vii] in the EMPHCC catchment. Anxiety, schizophrenia, Borderline Personality Disorder (BPD) and bipolar disorders were the most common mental health conditions presenting to Emergency Departments. The area of mental health requires more detailed data analysis to fully understand the services provided by general practitioners, emergency departments and community mental health services.

Alcohol & Pharmaceutical Presentations

Data provided by Turning Point identifies the following trends in relation to Emergency Department presentations in the EMPHN in 2012/2013:

- People from the City of Whitehorse accounted for the highest number of alcohol presentations
- The highest number of alcohol presentations by 15-24 year olds were from the City of Knox
- The highest number of pharmaceutical presentations were from the City of Monash (EMPHN), while Knox had the highest number in relation to the EMPHCC catchment.

This data are shown in Figure 10, Figure 11 and Figure 12. These data need to be explored further to understand opportunities for preventative interventions.

Figure 10 Emergency Department Alcohol Related Presentations in the EMPHN 2012/2013

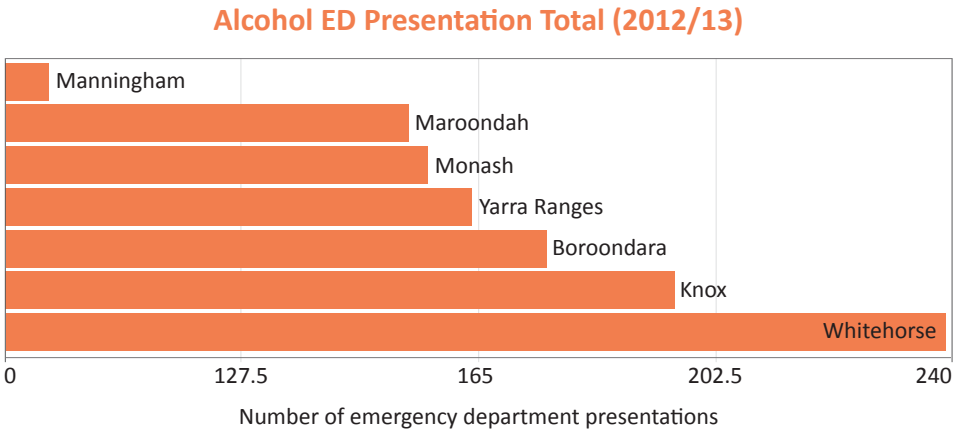


Figure 11 Emergency Department Presentations Related to Alcohol for 15 - 24 Year Olds 2012/2013

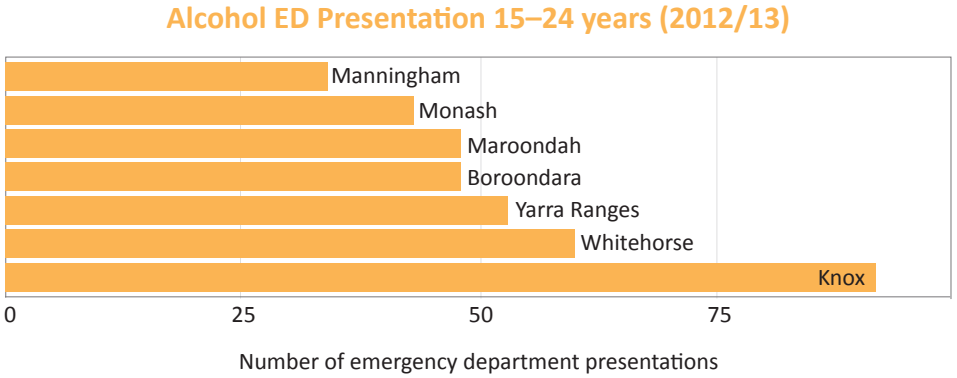
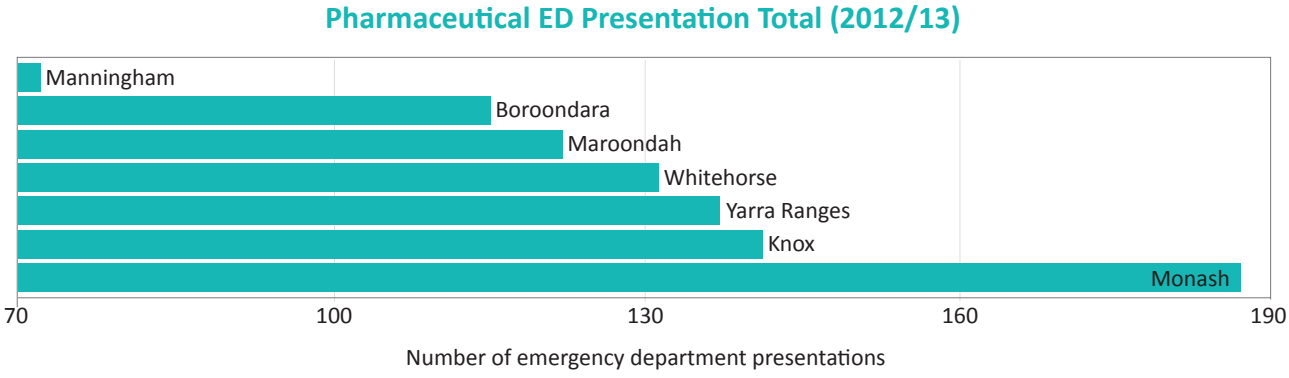


Figure 12 Emergency Department Presentations Related to Pharmaceuticals 2012/2013



Emerging Areas of Focus for the Primary Health Care Plan

As noted above, the EMPHCC held its launch and inaugural planning workshop on 17 June 2016. The planning items covered in the workshop focused on areas for improvement and emerging opportunities for the EMPHCC. Participants considered this from the perspectives of individual consumers, health service providers, the primary health system and the health system more broadly.

The report from the planning workshop is currently being finalised and will be a key information source to the EMPHCC Primary Care Plan. However, the emerging areas of focus are detailed in table 3 below. The emerging themes are across key areas of disease classifications/patient groups, place or location based approaches, the enablers required and collaboration.

Table 3: Emerging Areas of Focus to be Considered in the Primary Health Care Plan

Area of Focus	Theme/Priority
Disease classifications/patient groups on a catchment wide basis	• Diabetes • Heart Failure • COPD • Mental Health • Alcohol & Other Drugs
Place / location based approaches and targeted initiatives	• Address areas of known disadvantage • Concentrate on locations with low health status • Increase equity of access to services
Enablers	• Consistent and meaningful data to assess outcomes • Effective information and communication technology platforms • Timely communication regarding patient level information and available system capacity
Collaboration in care	• New or enhanced models of care • Increasing collaboration among service providers

The EMPHCC will be undertaking further planning processes in the coming weeks and this will be discussed at the first meeting of the Governance Group on 30 June 2016. Importantly, there is general agreement on the importance of selecting a smaller and more manageable number of high impact priorities rather than a larger number of priorities which could represent a risk to the implementation of service system change on a broad level.

SUMMARY

The nature of inequities across the local government areas of the EMPHCC varies by age group and locality, indicating the need for careful design and targeting of initiatives. There is also recent data indicating that the emerging areas of focus regarding primary health care for the EMPHCC, and indeed Eastern Health, diabetes, heart failure, COPD as well as kidney/urinary tract infections.

This information and the emerging priorities generated from the inaugural EMPHCC planning workshop on 17 June 2016, indicates the need for higher treatment levels for targeted populations, more effective care and treatment such as focused secondary prevention and better compliance with care plans, and improved use of resources, particularly through the community sector and better coordination of patient care and information sharing across the health care system as a whole.

[i] Source: EMPHN data id source

[ii] http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/2033.0.55.001~2011~Main%20Features~IRSAD~10004

[iii] https://hns.dhs.vic.gov.au/3netapps/vhisspublicsite/ViewContent.aspx?TopicID=1&SubTopicID=10

[iv] Source: Victorian Admitted Episodes Dataset (VAED)

[v] Source: Victorian Admitted Episodes Dataset (VAED)

[vi] Souce: National Health Pricing Authority (NHPA)

[vii] Source: Turning Point

Eastern Melbourne
Primary Health Care Collaborative