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Snapshots in Primary Care
Connecting Health in the Central Adelaide and Hills Region

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Introduction

Adelaide and Hills Medicare Local (CAHML) it has been underpinned by a strong vision of working in partnership with others, to create connected and comprehensive care, and pathways to long term outcomes.

To improve health and wellbeing in our community by facilitating primary care integration.

CAHML is proud of the successes and outcomes it has achieved in its short time since inception as one of 9 Medicare Locals nationally in October 2011.

Medicare Locals were established as primary care organisations which were tasked with identifying local health needs and driving improvements in primary health care to ensure services are better tailored to meet the community’s needs. They had a broader mandate than the previous Commonwealth-funded Divisions of General Practice, with an expectation that they would work with all primary care providers, including general practice, allied health, aged care and community health providers.

They were specifically funded to:
• Improve the patient journey by developing integrated and coordinated services;
• Provide support to clinicians and service providers to improve patient care;
• Identify the health needs of local areas and develop locally focussed and responsive services;
• Facilitate the implementation and successful performance of primary health care initiatives and programs;
• Be efficient and accountable with strong governance and management.

Key part of CAHML’s work has been to better understand the health needs of our community so that CAHML’s key priorities, strategies and activities address these identified needs. CAHML has not embarked on assessing and addressing these needs in isolation. CAHML has had a strong vision of working in partnership with others to create connected and comprehensive care, and pathways to improve health outcomes. CAHML’s approach has been to listen to community members, health service providers and key stakeholders to understand the enablers and challenges, and then collaborate with them to achieve long term outcomes.

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Our Purpose

CAHML will achieve this by connecting our community, our providers and our members to achieve better health outcomes.

CAHML has undertaken, please refer to the Resources and Publications section.

The snapshots are grouped around the key priority areas for CAHML including:
• Mental health
• Complex and Chronic Conditions
• Positive ageing
• Health Promotion and Prevention Program
• Population Health Planning and Analysis, Research and Evaluation
• Organisational Development and Function
• Aboriginal Health and Wellness
• After Hours Primary Care
• eHealth
• Stakeholder Engagement
• Provider Engagement and Support
• Community Engagement
• Resources and Publications

They outline the approaches, challenges and learnings and provide recommendations for others to continue the great work that CAHML has achieved. For a more comprehensive list of the work that CAHML has undertaken, please refer to the Resources and Publications section.

We look forward to sharing our success and recommendations with you. We hope you find this information useful when considering further opportunities in primary care to address these key priorities.

CAHML is an ageing population profile and associated burden of chronic disease and high levels of mental health co-morbidity. The region has the highest proportion of older adults (65+ years) nationally, with the number of people aged 65 years and over projected to increase until 2030, and forming a larger percentage of the overall CAHML population. By 2030, the increase in numbers over 85 years is more significant. The distribution of older adults (85+ years) across the CAHML region is concentrated more in the western region and the inner north-eastern suburbs.

Younger people (aged 15 to 29 years) also comprise a large percentage of the population and are more highly represented in the Adelaide City, Norwood Payneham and St Peters and Mount Barker Central LGAs.

Central Adelaide and Hills Medicare Local (CAHML) covers the geographical area from the coastal suburbs of western Adelaide through the CBD corridor to the eastern reaches of Norwood and Glenelg in the Adelaide Hills. The region encompasses 12 Local Government Areas (LGAs) and 26 Statistical Local Areas (SLAs). Over 517,000 people, many from diverse cultural and linguistic backgrounds, live in the CAHML, region, in both inner and outer metropolitan and rural settings.

Within the CAHML region, there are a range of acute and primary care settings. The region has a number of public hospitals including the Royal Adelaide Hospital, the Women’s and Children’s Hospital, The Queen Elizabeth Hospital, Hampstead Rehabilitation Centre and St Margaret’s Rehabilitation Hospital. In the Adelaide Hills region, there are the Mount Barker District Soldiers’ Memorial Hospital, Gumeracha District Soldiers’ Memorial Hospital and Stirling District Hospital. Private hospitals within the CAHML region include Ashford, Calvary North Adelaide, Calvary Wakefield, St Andrews, North Eastern Community and a number of others.

From a primary care perspective, there are 245 general practices, with over 800 GP, 45 GP registrars and 205 Practice Nurses working within the region. There are also over 1500 allied health professionals and 156 pharmacies across the region. There are a range of Aged Care providers, supporting both residential and community care options, with 98 Residential Aged Care Facilities with 5735 beds distributed across the region. Other health services available include Mental Health Services, Health Promotion and Prevention services, Non-Government Organisations, Academic training and research institutions, Royal District Nursing Services, Aboriginal Health services and many other primary, secondary and tertiary level health services.

A number of localised challenges have been recognised as a result of our work in primary care to address these key priorities.

The snapshots show significant areas of disadvantage in western Adelaide, the Campbelltown area and Mount Barker regions. Within the CBD of Adelaide there is a concentration of people who are homeless or sleeping rough.

The population of CAHML is expected to increase to 545,000 people by 2030, with the greatest growth anticipated in the age groups of 60-75 years. Additionally the population of Mt Barker and surrounding areas has grown significantly in the last decade with an average annual growth of 3.8% per annum. This high growth rate is expected to continue for at least the next 15 years. This represents a population growth rate that will be between 4.5% and 7.6% per annum each year for the next 15 years, with particular increase in young adults aged 20 to 35 years.

In response to the identified needs for our region from the Comprehensive Needs Assessment (CNA), CAHML sat about developing partnerships to address the identified priorities. CAHML tailored activities to meet the needs of specific populations, age cohorts and sub regions with greatest need.

The following snapshots are CAHML’s reflections on the areas that we focussed our energy and resources.

Key priorities included:
• Mental Health
• Complex and Chronic Conditions
• Positive Ageing
• Health Promotion and Prevention Program
• Population Health Planning and Analysis, Research and Evaluation
• Organisational Development and Function
• Aboriginal Health and Wellness
• After Hours Primary Care
• eHealth
• Stakeholder Engagement
• Provider Engagement and Support
• Community Engagement
• Resources and Publications

The snapshots are grouped around the key priority areas for CAHML including:

CAHML’s key priorities, strategies and activities address these identified needs. CAHML has not embarked on assessing and addressing these needs in isolation. CAHML has had a strong vision of working in partnership with others to create connected and comprehensive care, and pathways to improve health outcomes. CAHML’s approach has been to listen to community members, health service providers and key stakeholders to understand the enablers and challenges, and then collaborate with them to achieve long term outcomes.

CAHML is starting to see the fruits of its success and the difference our work is making in our region, and we are conscious that the national Primary Health Networks and other primary health care organisations and providers will benefit from our experiences and learnings. Our aim for this document is to share with you our successes and challenges, our key learnings and recommendations for future work in primary care and recognise our team’s significant achievements along the CAHML journey.

Chris Seilboth
CEO

The population of CAHML is expected to increase to 545,000 people by 2030, with the greatest growth anticipated in the age groups of 60-75 years. Additionally the population of Mt Barker and surrounding areas has grown significantly in the last decade with an average annual growth of 3.8% per annum. This high growth rate is expected to continue for at least the next 15 years. This represents a population growth rate that will be between 4.5% and 7.6% per annum each year for the next 15 years, with particular increase in young adults aged 20 to 35 years.

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They outline the approaches, challenges and learnings and provide recommendations for others to continue the great work that CAHML has achieved. For a more comprehensive list of the work that CAHML has undertaken, please refer to the Resources and Publications section.

We look forward to sharing our success and recommendations with you. We hope you find this information useful when considering further opportunities in primary care to address these key priorities.

Central Adelaide and Hills Medicare Local - Snapshots in Primary Care

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Central Adelaide and Hills Medicare Local - Snapshots in Primary Care

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Governance

CAHML MEMBERSHIP
- Aboriginal Health Council of South Australia Incorporated
- Adelaide to Outback GP Training Program Incorporated
- Aged and Community Services SA & NT
- Australian Association of Social Workers SA Branch
- Australian Primary Health Care Nurses Association
- Australian Physiotherapy Association SA Branch
- Carers Association of South Australia
- Exercise and Sports Science Australia (ESSA) SA Branch
- GP Partners Adelaide
- Healthfirst Network
- Health Consumers Alliance of South Australia Incorporated
- Multicultural Communities Council of South Australia Incorporated
- Occupational Therapy Australia (SA Division)
- Pharmaceutical Society of Australia
- The Pharmacy Guild of Australia
- The Royal Australian College of General Practitioners
- Royal District Nursing Service of SA Limited
- Sturt Flavours General Practice Education and Training Incorporated
- Summit Health

CAHML BOARD
Professor Justin Bali, Chair
Anne Skipper AM
Juliet Brown
Assoc. Professor Robert Penhall
Dr Michael Taylor
Klaus Zimmerman AM
Yvonne Sneddon
Dr Pasquale Cocciaro
Staphane Millar
Previous Board Member: Dr Rod Pearce

CAHML ADVISORY, WORKING AND REFERENCE GROUPS
CAHML thanks the following individuals and organisations who made up our Advisory, Reference and Working groups, and who contributed their time, skills and expertise to assist us in defining our priorities and achieving our outcomes.

CAHML CLINICAL GOVERNANCE COMMITTEE
Assoc. Professor Robert Penhall
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David Nig
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Donna Page
Mike Baranec
Chris Saiboth
Kirsty Rawlings
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Bill Millotis

Other key individuals involved:
Dan Cox (CAHML)
Meredith Perry (Uniting Care Wesley Port Adelaide)
Flora Kelly (Uniting Care Wesley Bowden)
Jane Longbottom (Life without Barriers)
Andrew Elvin (Salvation Army)
Bryan Atherton (NEAMI National)
Liz Prowse and Alison Pickering (Mental Health Services)
Janice Hogan (Mind Australia)
**Governance**

**HEADSPACE CONSORTIUM**
- Kathy Mickan - CAHML
- Carol Hampton - Mission Australia
- Chris Chaluback - Gotscare
- Mia Vincent - Worksafe
- Kathy Robinson - CAHMS Child and Adolescent Mental Health Services
- Gayle Goodman - Central Adelaide - Mental Health Services
- Neville Phillips - Central Adelaide - Mental Health Services
- Sean Miller - headspace
- Mark Hinton - headspace
- Meredith Perry - Uniting Care Wesley Port Adelaide
- Paul Croddon - Uniting Care Wesley Port Adelaide
- Helen Shaw - Health First Network
- Sonja Walmsley - Western Adelaide Mental Health Services
- Dan Cox - CAHML
- Mary Jane Honner - CAHML

**IMMUNISATION BLITZ – PARENT WORKING GROUP**
- Kahlia Dixon - Community Member
- Nicola Rankine - Community Member
- Talita Haron - Community Member
- Kaashan Khan - Community Member
- Angela Newbound - CAHML
- Nancy Bates - CAHML
- Lorelle Hunter - CAHML

**ABORIGINAL AND TORRES STRAIT ISLANDER WELLNESS GROUP**
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- Meryl Horsell - CAHML
- Kirsty Rawlings - CAHML
- Vanessa Gaston-Gardner - CAHML
- Lorelle Hunter - CAHML
- Nancy Bates - CAHML
- Janelle Lallard - CAHML
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- Fred Graham - CAHML
- Bill Miliotis - CAHML
- Barbara Figueroa - CAHML
- Jackie Sincock - CAHML

**CNA STRATEGIC LEADERSHIP GROUP**
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- Alison King - Country Health South Australia
- Courtney Bartosak - Local Government Association South Australia
- Assoc. Professor John Glover - University of Adelaide: PHDU
- Julie Patterson - South Australian Health
- Leah Trotta - Central Adelaide Local Health Network
- Mary Buckskin - Aboriginal Health Council
- Stephanie Miller - Health Consumers Alliance
- Panny Wonland - District Council of Mount Barker
- Chris Saboth - CAHML
- Kirsty Rawlings - CAHML
- Danielle Grant-Cross - CAHML

**Priority Health Areas**
- **YOUTH MENTAL HEALTH**
- **CENTRAL ADELAIDE AND HILLS PARTNERS IN RECOVERS (CAH PIR)**
- **BEYONDBLUE NEWACCESS**
- **ATAPS**
- **COPD**
- **CLOSING THE GAP**
- **END OF LIFE CARE**
- **HEALTHY AGEING, DEMENTIA AND FALLS PREVENTION**
- **IMMUNISATION**
- **HEALTHY WEIGHT STRATEGY**
- **CITIZEN’S JURY**
Central Adelaide and Hills Medicare Local (CAHML) has had a particular focus on youth mental health as a result of identified need.

Evidence demonstrates that most people with mental health issues experience their first mental health episode as a young person. For this reason CAHML committed resources to service development, service delivery, provider education and service promotion through participation in networks and reference groups.

The development of headspace Woodville has been a significant achievement and the service is now an integral part of the community in Adelaide’s west.

**BACKGROUND**

- One in four young Australians currently has a mental health condition.¹
- Suicide is the biggest killer of young Australians and accounts for the deaths of more young people than car accidents.²
- Evidence suggests three in four adult mental health conditions emerge by age 24 and half by age 14.¹
- Young people constitute 14.2% of the CAHML population.
- CAHML has participated in regional youth sector networks in the west, central, east and hills regions of Adelaide.
- CAHML’s mental health services for young people are delivered through partnerships with contracted providers, consortium partners along with headspace funded staff.

**OBJECTIVES**

1. To improve youth access to mental health services
2. To improve coordination of mental health services for young people
3. To increase primary health care sector awareness about mental health and its impact on young people
4. Increase skills of the primary health workforce in engaging with and supporting young people with mental health issues
5. Improve social recovery of young people experiencing mental health difficulties
6. Increase uptake of services by young people experiencing mental health issues and associated substance use problems

**APPROACH**

Youth Mental Health outcomes have been achieved through a number of strategies. Networking and working collaboratively has enhanced sector awareness of CAHML services and also gives CAHML insight into the needs of the young people and service providers.

CAHML has participated in regional youth sector networks in the west, central, east and hills regions of Adelaide.

CAHML is also a member of the Adelaide Hills Child and Youth Mental Health Working Group and the Mental Health for Learning Reference Group supporting the KidsMatter and MindMatters programs in schools.

headspace Woodville is represented at Western Workers with Youth Network, The Port Adelaide Suicide Prevention Network, Inner West Community Partnership (DECD) and Weaving the Nets.

Education has enhanced the capacity of service providers to engage with and support young people who have mental health needs.

CAHML worked with Dr Jon Jureidini to deliver three ‘Headstart programs’, a Level 1 child and adolescent mental health training program for General Practitioners.

CAHML also engaged a variety of presenters to provide 4 training sessions for general practice and allied health professionals on the use of strategies to support people with anxiety and depression.

Education sessions were also provided to enhance awareness of the referral options available to healthcare providers.

CAHML has invested heavily in youth mental health service development with successful tendering for headspace services in Woodville.

Youth engagement provided opportunity for young people to contribute during service planning. This ensured services are appropriate and youth friendly.

headspace Woodville has an active Youth Reference Group (YRG) providing service feedback, promoting the service along with positive mental health messages.

CAHML and headspace have engaged with young people through consultation and participation in events, forums and expos.

Young people have been specifically targeted for mental health service delivery through headspace Woodville and a partnership with Summit Health.

headspace Woodville has experienced steady increase in service utilisation. There have been 497 referrals received and 1035 occasions of service between May 2014 and January 2015.

Group programs and counselling services provided at a variety of locations across the Adelaide Hills, including Adelaide Hills Vocational College, Mount Barker High School and Oakbank Area School.

**KEY LEARNINGS**

Consulting and collaborating with young people, contractors and other service providers has ensured that our service delivery is youth friendly, meets identified need, is integrated and maximises use of available resources.

Mutually respectful relationships ensure that service providers are happy to work collaboratively or in partnership with CAHML.

**IMPACT**

A key impact of CAHML’s involvement in youth mental health has been the reduction of competition and improved collaboration across the sector: for example: non-government organisations (NGOs) came together to support CAHML tenders rather than competing against each other for the funding. CAHML’s focus on collaboration, education and service integration has resulted in increased information sharing, understanding, referrals and collaboration across sectors.

**IMPLICATIONS FOR PRIMARY CARE**

There are changes occurring in primary health care and mental health care in SA: for example: the introduction of the Primary Health Networks, a youth model of care and the headspace Youth Early Psychosis Program.

The changes will impact on youth mental health service delivery and the relationships across service providers.

Continuing efforts to maintain strong relationships will be critical to the future of youth mental health planning and program development.

**REFERENCES**

1. 3303.0 ABS Causes of Death, Australia, 2012 (2014).
3. Underlying causes of death (Australia) Table 1.3

**RESULTS**

- Increased service integration and coordination
- Increased service provision in the Adelaide Hills and west
- Increased capacity of primary health workers to support young people with mental health difficulties.
- Young people supported by headspace Woodville, including Aboriginal and Torres Strait Islander young people, young people from diverse cultures, same sex attracted or sexually diverse young people.

**Continuing efforts to maintain strong relationships will be critical to the future of youth mental health planning and program development.**
The CAH PIR Model was designed to enable services to be pulled together around people with severe and persistent mental illness who have complex needs. Addressing the needs of people with severe and persistent mental illness requires a complex system of treatment, care and support, often requiring the engagement of multiple areas of service delivery, including health, housing, income support, disability, education and employment.

Central Adelaide and Hills (CAH) PIR commenced on 18 November 2013 with Central Adelaide and Hills Medicare Local (CAHML) as the lead organisation in the Consortium CAH PIR. The CAH PIR Model was designed to enable services to be pulled together around people with severe and persistent mental illness as there can be a lack of inter-agency coordination, resulting in an individual falling through the system gaps and requiring more intensive support to effectively address the complexity of their needs.

In developing the model, the CAH PIR Consortium held underpinning values of perseverance, persistence, recovery, hope, client centredness, no wrong door and strength of relationships as central to attaining quality outcomes for people with severe and persistent mental illness.

**APPROACH**

The CAH PIR model is recognised as consistent with a “collective impact” approach which is designed to address complex social problems through multiple organisations working towards a common agenda, rather than from their own individual organisational agenda. Each of the CAH PIR Consortium members bring identified key partners and existing networks and relationships with other (non-Consortium) service providers. These networks are considered an integral part of assisting in addressing regional service gaps through CAH PIR.

The eight PIR Consortium member organisations are responsible for hosting the Support Facilitator function of CAH PIR, have a central role in system development, establishing relationships and protocols with partner and stakeholder groups, identifying gaps in system response, working with agencies to address these gaps within resources and advising CAHML of the sector and system issues to take forward at a state wide level.

The eight consortium members have equal authority and delegations within CAH PIR, however, their level of participation may vary depending on the client/PIR need.

In addition to CAHML’s internal governance arrangements, CAH PIR implemented oversight and support of PIR through the development of: 1) CAH PIR Management Group, 2) CAH PIR Operational Group and 3) CAH PIR Support Facilitator Group; each with their own Terms of Reference and reporting requirements (Internal to CAH PIR, to CAHML, and to their individual organisation).

**OUTCOMES**

The CAH PIR Consortium has identified the following as key outcomes for CAH PIR:

- People with severe and persistent mental illness experience more integrated approaches to their care and support;
- Stronger partnerships exist across mental health client care and support service providers;
- Increased access to community based primary health care services;
- CAH PIR clients experience improved physical health and social outcomes;
- Systemic change to mental health service delivery is achieved.

As at 31 December 2014, there were 330 clients referred to PIR, with 263 clients then accepted into the program (79.6% of referred clients). The reasons for non-acceptance included the client requiring to be linked into a more appropriate support service, the client residing outside of the CAH PIR region or the client was relocating interstate.

CAH PIR is funded over the life of the program to provide services to 520 clients, therefore the 263 accepted onto the program to date reflects 46.7% of this total.

**OBJECTIVES**

PIR aims to deliver “wrap around support” to meet a range of individual’s needs by providing better coordination of both clinical and non-clinical services.

The overarching objectives of PIR are to improve the system response to, and outcomes for, people with severe and persistent mental illness who have complex needs by:

1. Facilitating better coordination of clinical and other supports and services to deliver ‘wrap around’ care individually tailored to the person’s needs.
2. Strengthening partnerships and building better links between various clinical and community support organisations responsible for delivering services to the PIR target group.
3. Improving referral pathways that facilitate access to the range of services and supports needed by the PIR target group.
4. Promoting a community based recovery model to underpin all clinical and community support services delivered to people experiencing severe and persistent mental illness with complex needs.
5. Adopting a ‘no wrong door’ approach to service access and referral.

The CAH PIR Consortium set a key performance indicator of five days from receipt of referral to first face to face meeting with a Support Facilitator. As at 31 December 2014, CAH PIR was achieving this target 72% of the time.

CAH PIR undertook consumer and carer feedback in November 2014. Overwhelmingly respondents indicated CAH PIR as meeting the initiative to a large degree and the collective impact approach that forms the basis of the CAH PIR model appears to be effectively contributing to the successes achieved to date.

In addition, a recent evaluation of CAH PIR concluded:

**“Overall, CAH PIR is achieving the overarching objectives and guiding principles of the initiative to a large degree and the collective impact approach that forms the basis of the CAH PIR model appears to be effectively contributing to the successes achieved to date.”**

**“I am so glad, ‘cause I was so alone with no light at the tunnel. People won’t be treating me bad no more. People care out there. So grateful.”**

**“It is good to have more help and support”**

**“It helps restore my faith in humanity”**

**Table 1: Average time for CAH PIR client from referral to acceptance and then referral to exit from the program**

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average time from referral to exit</td>
<td>180</td>
</tr>
<tr>
<td>Average time from referral to acceptance</td>
<td>3</td>
</tr>
</tbody>
</table>

**Table 2: Total client summary for CAH PIR (18/11/14 to 31/12/2014)**

<table>
<thead>
<tr>
<th>Action</th>
<th>Pending</th>
<th>Ineligible</th>
<th>Cancelled</th>
<th>Active</th>
<th>Closed</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral</td>
<td>7</td>
<td>51</td>
<td>11</td>
<td>-</td>
<td>-</td>
<td>69</td>
</tr>
<tr>
<td>Assessing</td>
<td>19</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>11</td>
<td>30</td>
</tr>
<tr>
<td>Action</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>51</td>
<td>20</td>
</tr>
<tr>
<td>Planning</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>99</td>
<td>18</td>
</tr>
<tr>
<td>Case</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>117</td>
<td></td>
</tr>
<tr>
<td>Coordination</td>
<td>Monitoring</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>32</td>
<td>11</td>
</tr>
<tr>
<td>Only</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>43</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>26</td>
<td>51</td>
<td>22</td>
<td>182</td>
<td>49</td>
<td>330</td>
</tr>
</tbody>
</table>
Finally, an independent CAH PIR program evaluation was conducted in November 2014. Part of this evaluation focused on the governing structures of CAH PIR. It was determined that the stricture of the consortium model with CAHML as the lead organisation was well received. The CAH PIR Consortium organisations felt that there was an equal partnership and trust across the consortium and lead agency (CAHML). The success to date has been transparency and open communication. It was considered that CAHML’s independence from service delivery provided a separation which resulted in there being no conflict of interest.

KEY LEARNINGS

CAH PIR has made significant progress in enabling a health system to better coordinate care and support people with severe and persistent mental illness. Key program learnings include:

- It is important to have a clear, well communicated and honest discussion regarding understanding and commitment to PIR at all levels of governance;
- Forming a highly functioning Consortium takes time and investment in ensuring all have a valued say/input;
- There is no best model, the choice of model must be driven by local need, be flexible and innovative;
- Change requires stable, committed and strong leadership across all stakeholders;
- In a system that is under pressure/stretched etc. there is a tendency to focus on exclusion criteria rather than inclusion criteria. Services have tended to highlight other services as the ‘issue’ whilst maintaining that they themselves have certain eligibility criteria which will prevent clients from accessing their services;
- Focussing on ‘goals’ as an outcome runs the risk of clients taling and appears time limited, whereas focussing on needs is open-ended and has a better fit with person centred, recovery oriented practice.

IMPLICATIONS FOR PRIMARY CARE

By providing coordinated, integrated and holistic ‘wrap around’ support for people with a severe and persistent mental illness, CAH PIR anticipates the impact on primary health to be:

- Decreased episodes of relapse;
- Reduced service need/relapse;
- Decreased Emergency Department (ED) presentation by people with severe and persistent mental illness;
- Increased access to General Practitioners by people with severe and persistent mental illness;
- Reduced hospital stayishments (length of stay).

To date, CAH PIR is achieving this at individual client level, and our focus in the third year is to consolidate these gains, reform and develop pathways at a broader systems level.

REFERENCES


KEY DOCUMENTS

Australian Government, Department of Health, Operational Guidelines for PIR Organisations, May 2013;
Central and Adelaide Hills Partners in Recovery (CAH PIR) Local Practical Guidelines V10, December 2014

KEY WORDS

beyondblue, NewAccess, Low Intensity Cognitive Behavioral Therapy, anxiety, depression

The communication plan focused on producing collateral (brochures, flyers, wallet size fold outs) aimed at two audiences: GPs and other health professionals, and the local community. A letterbox drop was coordinated which focused on postcode areas highlighted in the Comprehensive Needs Assessment as having high mental health needs. The uptake of the service following this engagement was encouraging. GPs were also targeted with NewAccess information and the Health Provider team promoted the program at practice visits and education events.

NewAccess was also promoted to CAHML’s members through an introduction letter, newsletter adverts for their publications and collateral being sent out. Both CAHML and NewAccess beyondblue promoted the program on respective websites and through CAHML’s fortnightly newsletter. Facebook and Twitter were used regularly to promote NewAccess messages.

NewAccess was formally launched in April 2014 at the WorkSafe SA breakfast by the Hon. Jeff Kennett OAM along with Movember Foundation’s Australian Country Director Jeremy Macvean. Both spoke about the importance of men’s health and raising awareness of mental health. Jeff Kennett said, “If we aren’t leading healthy lives, mentally and physically, then we aren’t in a position to lead others.”

NewAccess is based on a successful, evidence based UK model known as Improving Access to Psychological Therapies (IAPT). NewAccess focuses on the training of a specific coaching workforce. CAHML has five NewAccess Coaches who have been trained and are clinically supervised by Flinders University.

This beyondblue initiative was made possible with funds from the Movember Foundation. The program has provided support for over 260 people since the commencement in late February 2014 until November 2014, when the program was transferred to Uniting Care Wesley Port Adelaide.

OBJECTIVES

Nearly 3 million Australians currently live with anxiety and/or depression.

Only 46% of Australians with anxiety and depression access support. Research in Australia indicated that the NewAccess model would be successful in accessing hard to reach populations, in particular men and people living in regions where access to support is lower. 39% of current clients are male, this is a significantly higher male representation than from traditional models.

APPROACH

The CAHML NewAccess program is accessed via email or phone referral, with the majority of referrals being self-referral (96%) with other referrals coming via community programs and GPs. Coaching is based on low intensity cognitive behavioral therapy. The UK model which was recognised as being successful, achieved a recovery rate of 30%. It is pleasing to see our NewAccess program has exceeded this significantly, with 71.43% recovery rates amongst CAHML clients.

BACKGROUND

NewAccess is an Australian-first beyondblue program, providing free and easy to access coaching for people with mild depression or anxiety who do not usually seek support. CAHML was successfully appointed as one of the three demonstration sites in Australia commencing in February 2014.

PROGRAM STAFF

Melissa Corbett, Conrie van der Kay, Matthew Ragless, Natalie Zيسers, Robert Merrett

MANAGER/S

Tracey Sloan, Simone Thringleton, Mary-Jane Honner, Dan Cox, Danielle Grant-Cross

“if we aren’t leading healthy lives, mentally and physically, then we aren’t in a position to lead others”
The engagement plan focused on CAHML’s 12 local councils, libraries and community centres along with GPs, Allied Health Professionals within the region and CAHML’s 19 Members. The Healthy Workers Healthy Futures program, councils and CAHML members promoted NewAccess to staff as another option to Employee Assistance Programs and also to their clients and the wider community.

OUTCOMES

The following data outlines the client demographics and utilisation of the CAHML NewAccess program. Figure 1 demonstrates that the main age group accessing CAHML NewAccess was the 45 to 55 year olds. This is consistent with the main targeted age group for the NewAccess program.

The gender distribution of clients accessing the program reflected almost 40% identifying as male. This is a higher percentage of males compared to other program sites.

Table 1 outlines the referral and end of care pathway summaries for clients accessing the CAHML NewAccess program. From 264 patients referred during the date range 24/02/2014 to 14/10/2014, 209 clients attended an initial assessment and 171 clients received treatment following initial assessment. From these 171 clients, there were 75 clients who completed all four steps of treatment. Table 2 outlines client attendance and non-attendance figures which demonstrates that the majority of clients attended to Step 2 and on time.

The primary referred problem for NewAccess clients was mixed anxiety and depressive disorders, whereas the primary diagnosis were depressive episode followed by unspecified anxiety disorder. The main other referred problem for NewAccess was relationship issues, followed by family issues and work related problems. The individual client outcomes match or exceed the clinical results of the IAPT program in the UK, on which the CAHML beyondblue NewAccess program is modeled. This UK model achieved a recovery rate of 50% and CAHML beyondblue NewAccess exceeded this with a 71.43% recovery rate reported for CAHML clients. Table 3 highlights change in Patient Health Questionnaire-9 (PHQ-9) and Generalised Anxiety Disorder-7 (GAD-7) scores for CAHML beyondblue NewAccess clients.

Within the catchments of each of the demonstration sites, the effect of the project is demonstrably positive. Aside from the measured benefits to clients, there has been a growing response from the wider community. Whilst many complementary health services are advocates and encourage their clients (patients) to refer, other organisations have also been keen to support the program.

KEY LEARNINGS

NewAccess is complementing other mental health services but also filling a gap in the market, by providing a free service which is targeted towards people with mild to moderate depression and anxiety. Co-locating with other local organisations has been a key factor to reduce barriers to access and to side-step stigma in an effort to reach people who would not otherwise have sought support.

The program is accessing a client group that would not usually seek assistance, with 40% of clients accessing the program being male. This rate of referral is higher than the IAPT benchmark of 30% and demonstrates that this program is able to meet the needs of this group.

The main referral source has been self-referral which reflects the ease of access to and success of the promotion of the program. Other referral sources were allied health professionals, GPs, other CAHML programs and women’s health services.

Services provided by a combination of face-to-face and phone sessions makes it easier for clients to access the program and reduces the stigma associated with accessing support.

IMPLICATIONS FOR PRIMARY CARE

Low level intervention cognitive behavioral therapy programs are effective at assisting clients with mild to moderate anxiety and/or depression access support with managing their condition. The mixed model approach of face-to-face and telephone coaching assists client in accessing services and reduces the stigma associated with accessing support.

The CAHML beyondblue NewAccess program has complemented other mental health services, and appears to be a good fit to provide make with mild to moderate anxiety and/or depression access to services. Co-locating physically with other local organisations has been a key factor to reduce access and stigma-related issues for individuals that would otherwise have not sought support.
ATAPS in the Central Adelaide and Hills Region: A Successful Model

Growth of 35% has occurred within the Access to Allied Psychological Services (ATAPS) program mental health counselling sessions delivered in our region since CAHML first delivered this program in 2012. The merits of this model of delivery of ATAPS and key learnings are highlighted below. It is recommended that delivery of ATAPS via this model is a preferred alternative to the organisation providing both the allied health service model and its management at the same organisation.

BACKGROUND
Access to Allied Psychological Services (ATAPS) is an Australian Government Department of Health funded mental health initiative designed to deliver accessible, high quality services to vulnerable populations. Early identification of mental health needs and responsive services providing early intervention are important in this program.

OBJECTIVES
The ATAPS program enables GPs to refer consumers to ATAPS mental health professionals who deliver focussed psychological services. Services are easy to access and tailored to ensure the mental health needs of people of all ages including children and Culturally and Linguistically Diverse communities are being addressed. This program aims to deliver an agreed number of mental health treatment sessions across each financial year, to continually track this progress and to continually improve quality, and report on key deliverables.

APPROACH
CAHML want to foster for contracted mental health service providers in 2011/2012 and four key providers were successful. These contracted providers included: GP Partners Australia, Healthfirst Network (previously Adelaide Western GP Network), Mind Australia and Summit Health. CAHML administered ATAPS through these providers, and ensured that a diverse group of clients, across the Central Adelaide and Hills Medicare Local (CAHML) region received quality mental health sessions under the following programs within ATAPS Tier 1 and Tier 2 programs:

1. ATAPS Tier 1 / General Mental Health
2. Suicide prevention
3. Child mental health services

PROGRAM STAFF
Natalie Worth ATAPS Program Manager, Simone Thrippleton ATAPS Program Manager, Maryl Horsell, Manager Health Programs

4. Woman with Perinatal Depression
5. Aboriginal and Torres Strait Islander people
6. Homeless people

Refeerrals were directed to the contracted providers who have well established internal processes and appropriately trained staff receiving and triaging referrals. Referrals were received via secure fax or phone and were assessed for ATAPS eligibility, and prioritised (i.e. suicide prevention clients were given priority along with people identified as being affected by past forced adoption). Clients were matched to the most appropriate ATAPS program and clinician based on diagnosis and location. Suicide prevention clients were referred at triage to the After Hours Suicide Support Line for additional counselling as needed. CAHML monitored waiting times, and ensured Tier 2 services were effectively utilised.

Program data shows a decrease in Did Not Attend (DNA) rates, particularly for first appointments. All providers used a ‘no wrong door’ approach and supported referrals and clients. If the client was not eligible, or ATAPS was not clinically appropriate, a referral was made to the most appropriate service ensuring a seamless transition of care for all clients. An Aboriginal Outreach Worker assisted with directing any Aboriginal clients to the most appropriate clinical service and facilitated the client’s journey, improving access and decreasing barriers to services for the Aboriginal community. Demand management and clinical governance processes were the responsibility of the providers with CAHML monitoring this and guidingHaving input as required.

OUTCOMES
In 2012/13, across all ATAPS programs 1442 people received evidence based short-term psychological interventions with a total of 5416 sessions. 77% of target sessions were provided during the 12 month period. In 2013/14 across all ATAPS programs 8264 sessions were delivered out of a target of 9482 (87%) and the infrastructure was built for this to continue with ongoing funding from the Department of Health (DoH). In 2012/13 promotion of referral pathways and services began to develop the ATAPS programs considerably. In 2013/14, well utilised referral pathways and processes ensured that 8264 mental health sessions were delivered by a mix of appropriately qualified psychologists, social workers, mental health nurses, and occupational therapists. Models of session delivery varied with each provider, according to the needs of the clients and the region’s priority areas.

In 2014/15 the program was continuing smoothly and demand management became necessary, demonstrating the success of the promotions, referral pathways and outcomes of the service to date. ATAPS developed from being a little known and much misunderstood in the general public and in the community to becoming a program which was respected and regularly referred to by many hundreds of GPs across our region. Other referral sources include State Mental Health, hospitals, schools, CAPHS and CAMHS and other health and welfare agencies. CAHML created this knowledge through its stakeholder engagement processes, and the ATAPS team maintained and strengthened relationships.

For individual providers, their processes also became smooth and streamlined, allowing for an improved client journey.

KEY LEARNINGS
Having a lead organisation for ATAPS administration provides clarity around ATAPS DoH Guidelines:

• ATAPS clinical guidelines is a key document that guides the parameters of the ATAPS program i.e. referral criteria for clients, clinicians’ qualifications and supervision arrangements, necessary pre and post measures etc.

Strong clinical governance benchmarks:

• CAHML’s Clinical Governance Committee meets with program managers to oversee the clinical governance of each program and to make recommendations to improve quality. A new clinical governance checklist has been developed to standardise reporting of good clinical governance by providers in 2014/15.

Clear, quality driven, processes for gathering reports on ATAPS deliverables:

• Following the outsourced mental health services model, reports are required by providers in advance of the report requirement by DoH. These reports may be data based, financial and written.

Solid reporting to DoH of deliverables: both data and financial reports:

• CAHML’s finance team liaise with the ATAPS manager regularly as to financial progress and reporting to DoH occurs quarterly.

Relationship strengthening and regular communication with Providers via varied means:

• Through written, telephone and face to face contact, both with all providers together and some meetings with each provider individually occur on a regular basis and as required.

Engagement planning needs to be strategic and collaborative with key referring organisations and individuals. Transparency and information sharing that is inclusive of providers.

Promoting providers positively:

Marketing and promotional activities and material is produced electronically and in hard copy.

The establishment, maintenance and enhancement of key partner relationships is crucial:

• Hospitals, Emergency Departments, WCH, CAPHS, CAMHS, community mental health teams, DECD, childcare centres, kindergartens, Helen Mayo House, Nunkuwurr Yunti, Taoudi College, Old Port Rd Primary Health Clinic, local councils, SAPOL, Families SA, amongst many others.

Addressing barriers to healthy working relationships with professionals:

• Meetings on-site with providers

Monitoring of contracts with providers and proactively addressing any issues which were not consistent with these contract terms:

• At times breach of contract had to be identified and addressed and a firm manner obtained the best results here

Representing DoH positively:

• Each staff member within the ATAPS team was taught to promote the DoH and to acknowledge their support for the program. At times due to Government decisions, great transitions in the program occurred and this had to be managed constructively at all levels.

Solutions focused approaches:

• CAHML is a creative, ‘can-do attitude’ type of place and a multitude of approaches were always utilised.

Staff within the ATAPS team shared the motivation and enthusiasm for the ATAPS journey at CAHML and were personally and professionally committed to primary health care for priority groups

• CAHML’s guiding principles are completely in line with ATAPS guiding principles and the commitment of each ATAPS team member at CAHML. Continual feedback is constantly provided and issues as well as successes and achievements at CAHML Board was ongoing.
There has been enhanced clarity of referral pathways and an increase in activities were strategically targeted for maximum benefit to the awareness raising were more the focus in the previous year.

Examples of successful collaborations between the CAHML ATAPS team, stakeholders & ATAPS providers are described below:

- The child mental health program has been enthusiastically taken up in schools, kindergartens, children’s centres, and childcare settings across the region following targeted promotion and information sessions.
- Aboriginal and Torres Strait Islander peoples’ access to ATAPS, especially the suicide prevention program, has been successfully increased due to the appointment of the ATAPS Aboriginal Outreach Worker.
- Strategic population data were used to guide the establishment of Taouln College as a service delivery site for 2 days per week and Port Adelaide as the service delivery location the remainder of the week.
- Mind Australia delivered ATAPS suicide prevention services across the CAHML region.
- Healthfirst network consolidated the service provision of women with perinatal depression.
- There has been an improvement in the ATAPS data reporting and a higher rate of client feedback survey responses representing all providers.

CAHML continued to work closely with service providers, to ensure ATAPS services were easy to access, effective, of high quality, and supported GPs and local primary health care providers to meet the mental health needs of people living within the CAHML region.

KEY DOCUMENTS

- ATAPS Operational Guidelines, Department of Health and Ageing, 2012
- APS Web Based National Training for ATAPS clinicians.
- National Mental Health Strategy, Department of Health and Ageing, 1992

BACKGROUND

Chronic Obstructive Pulmonary Disease (COPD) is a debilitating irreversible disease which can be treated and managed to both support patients to improve their quality of life and to improve their long term health outcomes.

Population health analysis undertaken in 2012 (CAHML Population Health Commissioning Atlas) demonstrated the health impact of COPD on people within the CAHML region.

The annual prevalence of COPD within the CAHML region has been estimated at 12,292 cases or 2.3% of the total population. This is comparable with both the Australian and South Australian rates for COPD (PHIDU data 2011-13). This is considered to be an underestimate of the actual prevalence as under-diagnosis is a recognised issue with determining COPD prevalence.

COPD is the leading cause of Potentially Preventable Admissions (PPA’s) within hospitals in the CAHML region (RAH and TGEH).

OBJECTIVES

The aim of the CAHML COPD Program has been to improve health outcomes for people with COPD through better access to coordinated and multidisciplinary care, and to develop an integrated approach to the management of COPD through increased engagement with key stakeholders.

The COPD Program also aimed to:

- Reduce avoidable hospital admissions and/or length of stay
- Improve COPD management in Primary Health Care through partnerships
- Improve access to integrated health care across health care settings
- Improve self-management support for people with COPD
- Improve management of people with COPD and comorbidities

APPROACH

Staff with skills, knowledge and experience in both COPD and primary care were recruited to CAHML to implement the COPD Project.

The COPD Program included actions directed at improving the management of people with COPD within primary care and community settings. The COPD work program has included:

1. COPD Population Health Analysis – Development of a needs analysis and population profile of respiratory disease across the CAHML region.
2. The COPD Quality Improvement Project including the development of a COPD patient care model and system management package for general practices wanting to better coordinate management of their patients with COPD.
3. Development of the COPD Evaluation Framework. Working in collaboration with the specialist respiratory service in Central Adelaide Local Health Network (CAHNL) to support an integrated approach to COPD care.
4. COPD Education and Training – Provision of evidence based, professional development for general practice and allied health professionals within the CAHML region.
5. Undertaking an active program of stakeholder engagement and communications to promote respiratory health messages and provide information on local respiratory care services and programs.

PROGRAM STAFF

Joanne Teakle, Donna Harrison, Michala Harriot, Emma Jarvis, Cathy Caird

Managers – Lead Meryl Horsell, Kirsty Rawlings

KEYWORDS

COPD, Respiratory disease, Chronic Obstructive Pulmonary Disease, collaboration

IMPLICATIONS FOR PRIMARY CARE

Over the 2-3 year period that CAHML managed ATAPS, these programs have moved successfully from development phases to steady and solid continuous delivery of quality programs.

There has been enhanced clarity of referral pathways and an increase in the collaboration between CAHML’s key organisations and networks.

Expansion has naturally followed this success and demand management has become a focus, whereas promotion and awareness raising were more the focus in the previous year.

Any promotional and stakeholder liaison/relationship building activities were strategically targeted for maximum benefit to the relevant program, and this led to strong increases in programs that had previously had lower than anticipated uptake.

Examples of successful collaborations between the CAHML ATAPS team, stakeholders & ATAPS providers are described below:

- Aboriginal and Torres Strait Islander peoples’ access to ATAPS, especially the suicide prevention program, has been successfully increased due to the appointment of the ATAPS Aboriginal Outreach Worker.
- Strategic population data were used to guide the establishment of Taouln College as a service delivery site for 2 days per week and Port Adelaide as the service delivery location the remainder of the week.
- Mind Australia delivered ATAPS suicide prevention services across the CAHML region.
- Healthfirst network consolidated the service provision of women with perinatal depression.
- There has been an improvement in the ATAPS data reporting and a higher rate of client feedback survey responses representing all providers.

CAHML continued to work closely with service providers, to ensure ATAPS services were easy to access, effective, of high quality, and supported GPs and local primary health care providers to meet the mental health needs of people living within the CAHML region.
The COPD monograph was developed to provide strategic direction to the COPD program and identify areas within the CAHML region with highest prevalence of COPD and highest risk factors. The monograph provides an overview of the health needs of the CAHML population with COPD. The monograph is designed to assist service planners and health care agencies better respond to the needs of local populations. It identifies areas with the highest burden of disease, at risk populations and describes ways in which disease progression and functional decline can be minimised. To complement the monograph, a short form COPD Infographic has also been published. Additionally a detailed COPD needs assessment was undertaken across 26 General Practices to better understand current practice in the management of people with COPD and canvas interest in participating in a quality improvement opportunity aimed at improving COPD patient outcomes.

**MEDICARE LOCAL QUALITY IMPROVEMENT PARTNERSHIP (MLQIP) PROJECT**

The COPD Quality Improvement Project was a 6 month project, undertaken in collaboration with the Improvement Foundation. The project was supported by a COPD Reference Group comprising a GP, Practice Nurse, Pharmacy, and specialist respiratory sector representatives.

The target patient population included patients already diagnosed and appropriately coded as having COPD, as well as patients with a diagnosis of COPD who had not been coded appropriately and thus had a tendency to “fall through the cracks” in regard to targeted population health care initiatives.

The project involved working with four general practices and four pharmacies located in areas of increased COPD prevalence. The range of practices recruited included both small and large practices; as well as practices with dedicated COPD staff, and practices requiring assistance in upskilling their staff in the provision of COPD care.

CAHML’s COPD Care Facilitator worked closely with each practice to support and upskill them in COPD system management. Practices were assisted to make improvements in recorded data quality measures by:

- Developing an accurate COPD register
- Identifying General Practice Management Plans (GPMP) / Team Care Arrangement (TCA) for all patients with COPD
- Recording number of spirometries
- Recording smoking status

Practices were supported to develop their patient management systems and in the use of COPD national guidelines to ensure both appropriate and quality patient care was achieved.

This project was the first formal pharmacy engagement activity to be undertaken at CAHML, with a focus on education and self-managing for people with COPD within the pharmacy setting. CAHML’s Pharmacy Liaison Officer was a core project member and worked closely with participating pharmacies to develop their COPD education capacity.

A practical General Practice COPD Guide that describes the processes for developing COPD management systems within general practice is soon to be released.

**DEVELOPMENT OF A COPD EVALUATION FRAMEWORK**

CAHML and CAUHN have worked together to improve outcomes for people with COPD. The underpinning premise of the collaborative work has been that building a more coordinated and collaborative approach across the continuum of care that involves primary prevention, primary health care, and acute and sub-acute services will help achieve the best care, first time and every time, in the right place.

This collaborative arrangement has culminated in the development of a COPD Evaluation Framework. The Evaluation Framework is designed as a strategic resource to assist health networks, primary health care organisations and others monitor key areas of interest and understand whether health system outcomes are improving.

This will also assist health services to monitor performance in line with national benchmarks.

The COPD Evaluation Framework details the epidemiology of COPD and provides a picture of the patterns of COPD and variations in outcomes. It also identifies 18 performance indicators that together provide a picture of overall progress in relation to COPD prevention, optimum management and system support. The indicators relate to four critical domains; patients and carers; prevention and primary health care providers; sub-acute and acute care providers; and business systems. The indicators can be used to track progress against priorities for action on COPD.

The Evaluation Framework will be published in hardcopy and made available electronically for the Primary Health Network.

**GENERAL PRACTICE SUPPORT AROUND COPD**

The COPD program provided a range of support to general practices on any COPD issues. This included advice on spirometry queries, COPD education, and care planning advice. Information technology assistance has also been provided for practice software management systems and clinical audit software to maximise utilisation of the systems for recording and extraction of data.

A significant amount of time and support was provided by the CAHML COPD Care Facilitator to practices participating in the quality improvement project to achieve the project goals. Practices that participated reported improved confidence in managing patients with COPD, QPs and PPIs have an increased understanding of the importance of good quality COPD care in line with best practice guidelines and recommendations. There is also increased understanding of the value of undertaking quality improvement cycles to ensure that the care delivered is tailored in a way that maximises patient health outcomes.

**EDUCATION AND TRAINING**

The COPD program team has provided a COPD professional development education program for primary health care providers to support maintenance of skills and knowledge.

This has included a series of workshops and forums on respiratory care topics. Six education events have been held and attended by GPs, Practice Nurses, Pharmacists and Allied Health professionals. The events covered topics including COPD screening & spirometry, Inhaler Techniques and COPD Best Practice, motivational interviewing in COPD, and Specialist Respiratory services.

**STAKEHOLDER COLLABORATIONS**

Other collaborative work included participating in a University of South Australia (UniSA) research project.

The project involved linking with UniSA and the Royal Adelaide Hospital to support a research project ‘Implementing Care Coordination plus Early Rehabilitation in COPD patients in Transition from Hospital to Primary Care’. The project was a great opportunity to contribute to the knowledge base around developing community based responses to supporting people with COPD.

The COPD Program Coordinator assisted by collecting and providing qualitative and quantitative data from GPs to include in the research findings.

CAHML also facilitated interested stakeholders from the South Australian Ambulance Service and CAUHN in exploring opportunities for linking different care models to minimise the number of Emergency Department attendances for people with COPD when it is appropriate and safe to do so.

**OUTCOMES**

1. The MLQIP – COPD Quality Improvement Project key achievements include:

- 100% retention of involved practices and pharmacies throughout the project.
- All practices achieved improvements in recording data quality measures: increased accuracy of the COPD registers and increased numbers of spirometry recorded, and smoking status recorded.
- Pharmacies delivered opportunistic education on respiratory aids prescribed and purchased by people with COPD within the pharmacy setting.
- Promotion of Lung Foundation Australia (LFA) COPDx guidelines and benefits of pulmonary rehabilitation; spirometry training; and smoking cessation resources.
- The COPD Care Facilitators supported practices with data cleaning to establish current up-to-date registers; care planning; and referral pathways.
- Positive consumer feedback received regarding pharmacy education. A consumer feedback survey was developed and disseminated through pharmacies to consumers regarding inhaler use and smoking cessation. 100% response by consumers found the opportunity to speak with the Pharmacist increased their knowledge about their medications and/or confidence to quit smoking.

The specific data outcomes from MLQIP have been documented in the Australian Primary Care Collaborative ‘footprint’ document. Please refer to this for practice specific data information.

2. COPD Evaluation Framework – COPD resources have been produced to assist in continuing a program of work focused on COPD, including:

- The COPD Evaluation Framework with indicators that can be used to track progress of action on COPD.

A General Practice COPD Management Guide - to assist practices with systems development to support the management of COPD in general Practice.
The COPD program has been successful as a result of having a driver.

A sustained focus on respiratory disease across the continuum along with providing time to General Practice to physically help with what is required to fulfill the project, then it would have been who was leading and driving the project across all practices and pharmacies, was the main reason that the MLQIP was a success.

Successful programs need to have a ‘champion’ who is skilled and knowledgeable in the topic. On the ground support personnel, who have the skills, time and motivation to support any General Practice in key activities has been found to be crucial.

The COPD program has been successful as a result of having a driver. It was generally agreed across the project that the Care Facilitator, who was leading and driving the project across all practices and pharmacies, was the main reason that the MLQIP was a success. Without the key personal to motivate, encourage and support, along with providing time to General Practice to physically help with what is required to fulfill the project, then it would have been far less successful.

**IMPLICATIONS FOR PRIMARY CARE**

COPD represents a significant burden of disease in the central Adelaide and Hills area.

A sustained focus on respiratory disease across the continuum is needed to reduce prevalence and increase early detection and management of COPD, and achieve integration between care providers across the primary, acute and sub-acute sectors.

CAHML’s COPD program has laid a foundation for a continuing focus on COPD that has the potential to have a real impact on the improving outcomes for people with COPD.

There are increasing indications that general practices are adopting more patient centred approaches to care, particularly in relation to caring for people with a chronic disease, such as COPD.

Reducing the prevalence of COPD in our community requires a cross sector collaborative approach. The primary care sector has the potential to be a significant contributor to improving the quality of life of people with COPD, but requires support to be able to maximise their efforts in this regard.

**COPD Population Health Monograph and Infographic**

**KEY LEARNINGS**

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**IMPLICATIONS FOR PRIMARY CARE**

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Reducing the prevalence of COPD in our community requires a cross sector collaborative approach. The primary care sector has the potential to be a significant contributor to improving the quality of life of people with COPD, but requires support to be able to maximise their efforts in this regard.

**The annual prevalence of COPD in the region is estimated at 12,292 cases, or 2.3% of the total population.**

CAHML is committed to improving the health outcomes of Aboriginal and Torres Strait Islander people within our region. Aboriginal and Torres Strait Islander people continue to experience poorer health and greater exposure to risk factors than other South Australians.

The Closing the Gap (CTG) program is part of the Australian Government’s Indigenous Chronic Disease Package (ICDP). The program is an important part of the broad set of initiatives aimed at ‘Closing the Gap’ in life expectancy between Aboriginal and non-Aboriginal Australians. Chronic diseases and related risk factors are responsible for almost two thirds of this gap.

The Closing the Gap program works with Aboriginal people who have a chronic disease to assist them to better self-manage their health and medical needs.

**BACKGROUND**

There are approximately 4,200 Aboriginal and Torres Strait Islander people living in the CAHML region. Aboriginal people carry a high burden of disease compared with the rest of the population and continue to experience poorer health and greater exposure to risk factors than other South Australians.

Aboriginal and Torres Strait Islander people have approximately 17 years shorter life expectancy and a younger age profile than the general CAHML population. Approximately 65% of CAHML Aboriginal and Torres Strait Islander population live in the western suburbs, in areas with poorest index of relative socio-economic disadvantage scores.

CAHML’s Comprehensive Needs Assessment 2014 identified a number of barriers experienced by Aboriginal people in accessing mainstream health services:

- Limited transport options.
- Cost (affordability) of medications and health services.
- Limited number of mainstream services providing a culturally appropriate and welcoming environment. Aboriginal people’s experiences of general practice include impatience of GPs, being rushed or not being listened to, unfriendliness, and racism/judgement.

CAHML has managed the CTG program since July 2012. The program is comprised of 3 elements: care coordination and supplementary services, Indigenous Health Project Officer, and Aboriginal outreach workers. The program structure has enabled the formation of a unified CTG team that works collaboratively to support CTG clients and mainstream services that provide primary health care to Aboriginal and Torres Strait Islander people.

The CTG program works with many of the most disadvantaged people in the region, particularly those residing in areas of disadvantage and high prevalence of psychological distress.

Needs assessment and community profiling has shown that many Aboriginal people are living with one or more chronic diseases.

**OBJECTIVES**

The primary objective of the CTG program is to contribute to improved health outcomes for Aboriginal and Torres Strait Islander people with chronic health conditions, through better access to coordinated and multidisciplinary care. The CTG program aims to:

- Provide care coordination and support for Aboriginal people within the region to assist in the management of their chronic condition and make best use of available health care services.
- Improve access to culturally appropriate primary health care services for Aboriginal people.
- Support general practice in the provision of culturally appropriate health care services.
- Improve the integration of care for complex conditions and complex co-morbidities for Aboriginal people.
- Engage with the local Aboriginal community and organisations linking in with significant events and activities.

**KEY DOCUMENTS**

CAHML COPD Population Health Monograph, 2014
CAHML COPD Infographic, 2014
Lung Foundations COPDx Guidelines
Australian Primary Care Collaborative program is available from the APCC website. http://apcc.org.au/
CAHML COPD Evaluation Framework, 2015
GP COPD Management Guidelines, 2015

**PROGRAM STAFF**

Alexandra Stevens, Karen Atkinson, Donna Harrison (Care Coordinators); Annette Miller, Warwick Wallace, (Outreach Workers); Karlia Miller-Koncz (CTG Program Support); Penny Bates (Aboriginal Community Engagement).

Past team members: Penny Angus, Fred Graham, Ros Miles, Siney Day, Lorella Hunter.

Manager: Meryl Horsell

**KEYWORDS**

Closing the Gap, care coordination, outreach worker, supplementary services, chronic disease
The CTG team has been based in Port Adelaide since January 2014. Being located in Port Adelaide has been a significant step in strengthening the profile of the CTG program, both with other Aboriginal service providers and also with the local Aboriginal community. Most client contact is provided in the client’s home and via telephone follow-up with the client, the referring agency, and other service providers involved in the client’s care. The team has two CTG cars that allow them to be mobile and are an invaluable asset in supporting client transport.

Client referrals to the program are received from many GPs and GP practices, particularly those in the western and central areas of the CAHML region. Referrals are also made from other health and support agencies including Nunkuwarrin Yunti, Port Adelaide Community Health Service, Domiciliary Care, Aboriginal Home Care, and hospitals including The Royal Adelaide Hospital and The Queen Elizabeth Hospital. Clients or family members also self-referral to the program. The CTG program also collaborates with other Medicare Local CTG teams to support clients when they move between regions, or when a referral is made for a client outside of the region. CTG clients have access to care coordinators, support from outreach workers to attend appointments, and assistance with purchasing the range of medical aids and allied health services needed to assist them manage their health care needs. Having access to a flexible funding pool (supplementary services) is an invaluable resource in assisting Care coordinators facilitate access to urgent and essential allied health or specialist services, pharmacy, purchase medical aids pertinent to their chronic disease and provide transport access services where this is not readily available.

Outreach workers also work directly with clients, as well as providing community liaison. This allows strong links to be made within the local Aboriginal communities to encourage the use of health services. The care coordinators and outreach workers work hand in hand to provide the best possible support for the clients who are a part of the Closing the Gap program. Care coordination means working collaboratively with patients, general practice, Aboriginal health services and other service providers to assist in the management of coordinated care for patients with chronic disease. Services provided by the team include education, clinical care and support, arranging required medical appointments and the appropriate transport, supporting clients to have regular reviews by their healthcare providers, assisting clients to adherence to prescribed medical regimes, develop chronic disease self-management skills and empowering clients to make links to community-based services in order to access support.

In 2014, the CAHML CTG team worked in partnership with SA Health and CALHN to implement a cervical screening project for Aboriginal women living in the western suburbs. Local Aboriginal women were assisted to attend a Nunga Womens Wellness clinic in Port Adelaide and have a woman’s wellbeing check that included having a Pap smear.

Outreach workers have been very active in linking clients into services and programs provided by other Aboriginal support organisations such as elders groups, lifestyle group and men’s groups. Promotion of the CTG program has particularly focused on local cultural events. Wherever possible, collaborative approaches with other stakeholders are utilised. For example, in partnership with Local Health Networks, SA Health, and other Medicare Locals, CAHML facilitated a CTG event at Spirit Festival 2014.

**KEY LEARNINGS**

Achieving effective client outcomes for Aboriginal people with chronic disease requires all three elements of the CTG program: care coordination and supplementary services, outreach workers and an Aboriginal health project officer.

The collaborative team approach that incorporates the components of CTG activity is a model that works very well. Team members provide each other with collegial support, provide leave cover and offer team approach to care. Having a male outreach worker is an important aspect of engaging with men and supporting them on their health care pathway.

Establishing a culturally safe and friendly workplace for the CTG team, particularly for the Aboriginal members of the team, has been an important part of the CTG program. Having a designated office in Port Adelaide has been a major achievement in establishing a culturally friendly workspace. The office displays Aboriginal and Torres Strait Islander flags and Aboriginal artwork is on display in the work area.

Being very proactive in engaging with clients is a feature of the program. Communication with clients is often difficult due to limited phone connections, movement within family locations, etc. Being prepared to persist, use community links and engage with extended family when appropriate are all required to maintain contact.

CTG care coordination model has been deliberately kept open and flexible to allow the team to design care planning approaches that are individualised to clients’ needs and family circumstances. The efficacy of the CTG program is achieved by ensuring that the CTG service model and clinical governance protocols are designed using cultural competency principles. It is important to have a program profile that visually reflects Aboriginal art to facilitate community engagement. All CAHML’s CTG program resources include artwork designed by local Kaurna-ngarrindjeri man Allan Sumner.

**IMPLICATIONS FOR PRIMARY CARE**

The ongoing road for the Closing the Gap program is significant if the generational goal of reducing the gap in life expectancy for Aboriginal people is to be achieved.

CTG clients tend to be the most socially and economically disadvantaged and do not have the capacity to access services, medical supports that give them the best chance of improving their health status.

There are no alternative community-based CCSS options available for Aboriginal people with chronic disease. Many CTG clients operate from a very low health literacy base and require significant investment of time, support and education to achieve the ability to self-manage their condition.

The work to develop trust and engagement with Aboriginal community has been very successful and it is important that this engagement and trust is maintained.

**OUTCOMES**

The program and service delivery model has been very successful. The impact of activities to increase awareness of the CTG program is demonstrated by the increasing number of referrals. Since CAHML assumed management, the CTG program has directly supported 234 clients.

Effective community links have been developed, particularly since the move to Port Adelaide.

Collaborative relationships with other service providers are enabling more integrated care approaches to client management. Effective working relationships, which have streamlined referral pathways, exist with other health care agencies including Port Adelaide Community Health Care Services, Nunkuwarrin Yunti, RAHI Aboriginal Cancer Care team, as well as CTG teams in other regions.

Client outcomes that have been achieved include:

- Greater attendance by clients to GP/Specialist and allied health appointments.
- Greater adherence to GP Management plans, medications and prescribed treatment plans by health professionals.
- Easier access to allied health services including podiatry, physiotherapy, audiology, dental, pharmacy and optical.
- Improved mobility, which has reduced social isolation for many clients allowing much greater interaction with local community.
- Male CTG clients have been linked into and supported to attend various local Aboriginal men’s programs. Links were also created for Aboriginal men without a regular GP to attend a clinic run by a local male GP.
- A Nunga women’s fitness (swimming) group has been coordinated by the outreach worker.

As well as working with clients individually, the CTG program has also been able to partner with other services to extend support provided to CTG clients. In 2014, the CTG team ran three Nunga Women’s Wellness clinics at Port Adelaide Community Health Service that included health promotion, educational sessions and provided the opportunity for a well-woman’s checkup with a female GP and nurse. Diabetes and cancer prevention were integral aspects for each of the clinics. The women also gained information and practical knowledge in ways to take care of their own health and social and emotional wellbeing and felt better able to share health messages with other family members.

Promotion of the CTG program has particularly focused on local cultural events. Wherever possible, collaborative approaches with other stakeholders are utilised. For example, in partnership with Local Health Networks, SA Health, and other Medicare Locals, CAHML facilitated a CTG event at Spirit Festival 2014.
Improving Access to Coordinated End of Life Care within the Community

The term 'end of life care' is used to describe care that is provided to a person at the end of their life. Palliative care refers to specialty clinical practice and service delivery. Central Adelaide and Hills Medicare Local (CAHML) has an ageing population profile and the older aged population - especially those over 65 years - is set to increase significantly in the next decade. Associated with our older age population is a high burden of chronic disease. Meeting the health care needs of an older aged population includes improving access to end of life care options.

BACKGROUND

17% of people living in the CAHML region are over 65 years of age. 96% of people over 65 years live in a private dwelling and over 25% live alone. Many older people are supported by home and community care (HACC) programs and for many, the desire to remain at home for as long as possible extends into the end of life period. Supporting people at home during their end of life period, and to die at home if that is their preference, requires an integrated approach from primary care providers and palliative care specialists.

OBJECTIVES

CAHML's palliative care work has involved undertaking an active program of stakeholder engagement and communications to promote quality end of life and care, and provide information on local palliative care services and programs. Through this work, CAHML has aimed to:

- Contribute to enabling people living within the CAHML region who are dying, and their families, to have better access to a range of quality end of life and palliative care options.
- Build capability of primary care providers to provide end of life care for people at home.

APPROACH

Palliative care work has been undertaken by a team of CAHML staff working together to link with a range of key stakeholders from primary care, specialist and NGO sectors to promote shared care end of life care models and improve access to primary care options. CAHML has also facilitated professional development opportunities for the primary care sector in end of life care. This has included promoting the South Australia’s Advance Care Directives Act 2013 and Advance Care Directive form.

An End of Life Care monograph has been developed to identify areas within the CAHML region with highest prevalence of COPD or highest risk factors.

The monograph builds on the CAHML Comprehensive Needs Assessment (2014) and the CAHML Population Health Commissioning Atlas™ which identified an ageing population with associated high levels of chronic disease and multi-morbidity.

The monograph provides an overview of end of life care across the CAHML region and is designed to assist service planners and health care agencies better respond to the needs of local populations.

CAHML has worked with Central Adelaide Local Health Network to improve pathways to end of life care. A Connecting Palliative Care Forum was held in May 2014 to provide opportunity for GPs to connect with the specialist palliative care sector and improve referral pathways.

- This forum was attended by GPs and practice nurses.
- Dr Joan Murray presented on the Advance Care Directives and the implications for GPs.
- Clare Shuttleworth, Service Manager from Central Adelaide Palliative Care Service CAPCS ran an interactive session on how GPs can connect and collaborate with the CAPCS to support their palliative patients to remain at home for as long as possible.
- Paul Tait, Advanced Practice Pharmacist with Southern Adelaide Palliative Services, spoke of his work in community pharmacy and increasing timely access to medicines for palliative patients within the community.
- The forum concluded with a panel discussion on some of the clinical challenges faced including ceasing medications and dealing with difficult questions around ceasing active treatment.

CAHML region and is designed to assist service planners and health care agencies better respond to the needs of local populations.

Outcomes

The collaborative relationship between CAHML and Central Adelaide Local Health Network (CALHN) to improve the coordination of end of life care is a demonstration of the effectiveness of cross sector partnerships in developing systems level responses that can improve health care outcomes.

The CAHML End of Life monograph will be a valuable resource in progressing integrated approaches to coordinated end of life care.

KEY LEARNINGS

Supporting community based end of life care is a time intensive process. Many GPs may only have one or two patients a year needing end of life care. Timely access to specialist knowledge and advice is important if the primary care sector is to increase the number of people supported with community based end of care.

CAHML’s stakeholder engagement capability has strengthened the connections between primary care and specialist sectors.

CAHML’s role in developing integrated approaches to improving health care outcomes has been an important factor in improving referral pathways and developing shared care models that better respond to population health need.

Following the enactment of new SA legislation Advance Care Directives Act 2013, CAHML participated in SA Health’s planning to disseminate information about the new Act and the implications for general practice and the community on the new advance care directives form.

- Advanced care directives information was distributed to all practices within CAHML region.
- Staff member Nathanael Brown who had clinical experience in advance care planning and recent in-depth training in the new legislation provided education sessions on the new laws and using the new form.

OUTCOMES

The collaborative relationship between CAHML and Central Adelaide Local Health Network (CALHN) to improve the coordination of end of life care is a demonstration of the effectiveness of cross sector partnerships in developing systems level responses that can improve health care outcomes.

The CAHML End of Life monograph will be a valuable resource in progressing integrated approaches to coordinated end of life care.

IMPLICATIONS FOR PRIMARY CARE

Providing quality end of life requires collaboration between primary care providers and specialist palliative care providers. GPs are essential providers in supporting people to remain at home for as long as possible.

The primary care sector is a significant contributor to enabling people to maintain quality of life during terminal phases of illness and at end of life.

There is an ongoing need to further build primary care capability in end of life care.

Program Staff

Cathy Caird, Kelly Quinlan, Jackie Sincock, Managers – Lead Meryl Horsell, Cathy Zezers, Kirsty Rawlings

KEYWORDS

End of life, palliative, quality of life

KEY DOCUMENTS

CAHML Health Profile: A population health needs assessment of the Central and Adelaide Hills region 2015
CAHML Population Health Commissioning Atlas™ 2011
CAHML End of Life Monograph 2015
SA Health Palliative Care Services Plan 2009-2016
South Australia Advanced Care Directives Act 2013

PHN SOCIAL HEALTH ATLAS OF AUSTRALIA. FEBRUARY 2014

25.2% of older people live alone

"The CAHML End of Life monograph will be a valuable resource in progressing integrated approaches to coordinated end of life care."
Healthy Ageing, Dementia Care and Falls Prevention

Central Adelaide and Hills Medicare Local (CAHML) and the Health Provider team have committed to supporting healthy ageing by Supporting improved connections between health providers that lead to optimal coordination of care for older people.

PROGRAM STAFF
Nathanael Brown, Janeen Lallard, Health Provider Team Manager - Cathy Ziess

KEYWORDS
Healthy ageing, Dementia, Falls prevention, Hospital avoidance.

BACKGROUND
Healthy ageing is one of CAHML’s key priority areas and includes enhancing older people’s access to services that support them to lead healthy lives, remain active and connected to their communities. The CAHML region has one of the largest populations of older persons, including the highest proportion of people aged 85 years and over nationally. The federal electorate of Hindmarsh within the CAHML region also has the highest prevalence of dementia nationally. Additionally, fall prevention has been a key area of focus as one in every 10 days spent in hospital by a person aged 65 years and older (2000–10) was directly attributable to an injurious fall.

OBJECTIVES
The objectives of healthy ageing as a focus area for CAHML have been:

• To develop and strengthen networks of providers from aged care, general practice, allied health and hospital sectors, to better coordinate the care of older people with a range of health conditions.
• To streamline the health care journey for older people as they move between community, hospital and aged care settings.
• To optimise the utilisation of older person’s health assessments in general practice in order to enhance outcomes through early identification, early intervention and the provision of holistic care.
• To enhance the capacity of older people to effectively partner with professionals in their health care through increased health literacy.
• To promote the uptake of evidence based practice in the health care of older people among health professionals in the CAHML region.

APPRAOCH
Various engagement options were implemented and included the following:

• Connecting with stakeholders such as Older People Clinical Network, the regional Memory Clinic advisory group, Cahml Falls Prevention Committee and Western Linkages.
• Establishing a Healthy Ageing Community of Practice, as a vehicle for health professionals from both public and private sectors to promote evidence-based practice and clinical innovation, develop professional relationships, identify and strengthen referral pathways, solve identified problems and address barriers to access and gaps in health and aged care systems.
• Promoting evidence based practice in the primary health care sector through the provision of continuing professional development for GPs, PHC nurses, allied health providers and pharmacists.
• Facilitating a Falls Prevention Forum providing information to health professionals from general practice, hospital, community and aged care settings regarding the components of an integrated falls prevention system. This was held six times as part of the April Falls Awareness month in 2014 and was attended by health professionals from a range of disciplines and sectors.
• Collaborating with the University of Adelaide, South Australian Dental Service (SADS), CAHML and SADPM to develop a peer education program, using a peer education model - Pills and Spills peer education program.

OUTCOMES
Positive outcomes were achieved across the various healthy ageing engagement processes and included:

• To build health literacy among older people regarding falls prevention and the safe use of medicines, using a peer education model - Pills and Spills peer education program.
• To enhance the capacity of older people to effectively partner with professionals in their health care through increased health literacy.
• Working in partnership with COTA (Council of the Ageing) to build health literacy among older people regarding falls prevention.
• To enhance the capacity of older people to effectively partner with professionals in their health care through increased health literacy.
• To build health literacy among older people regarding falls prevention and the safe use of medicines, using a peer education model - Pills and Spills peer education program.

KEY LEARNING & IMPLICATIONS FOR PHC
1. Older people frequently receive care from many different health and aged care organisations, often they are not aware of each other’s involvement. It will be crucial for the PHN to establish effective working relationships with general practitioners, aged care providers, allied health and hospital professionals.
2. Accessible and relevant professional development opportunities are consistently well attended. Health professionals highly value these and they provide a platform for health professionals to engage with each other and the PHN.
3. Inter-professional learning opportunities that bring together a range of providers from aged care and health settings have the potential to strengthen referral pathways and working relationships between providers.
4. The uptake of health assessments is relatively low in general practices across the region. Projects such as the Better Health Connections Project have the potential to engage PHC nurses and GPs sufficiently to increase the uptake as they provide feedback in the form of perceptible patient care outcomes. There have been valuable opportunities to link the 75+ assessment to referral options such as under the Oral Health for Older Person’s research project.
5. Peer education is a powerful and well-received method of communicating with older people and increasing health literacy.
6. Websites are an effective means of disseminating information to health professionals and consumers regarding referral pathways and service provision.

KEY DOCUMENTS

REFERENCES
Immunisation Program

The Central Adelaide and Hills Medicare Local (CAHML) Immunisation Program has supported providers to implement strategies to increase childhood immunisation rates across the region.

PROGRAM STAFF
Angela Newbound: Immunisation Program Coordinator, Lorelle Hunter, Nancy Bates, Managers – Lead Meryl Horsell, Danielle Grant-Cross

KEYWORDS
Immunisation, Vaccination

BACKGROUND
The CAHML region has had the lowest immunisation rates for children < 7 years of age in South Australia, and the lowest for Aboriginal and Torres Strait Islander children at 2 years of age, according to the National Health Performance Authority (NHPA) report and reports generated through the Australian Childhood Immunisation Register (ACIR). Approximately 6,000 children <7 years who resided in the CAHML region were not fully vaccinated. The greatest majority of these children live in the western suburbs of Adelaide. Under-vaccinated children are at risk of acquiring vaccine preventable diseases which could lead to severe illness, hospitalisation, disability or death.

The cessation of the designated immunisation incentive for GPs and incorporation of this resource into the Practice Nurses payment has reduced the focus within some GP practices on maintaining an active vaccination program in the face of many competing needs. Many GP practices under-prioritise immunisation in relation to other health care services required.

OBJECTIVES
CAHML’s aim has been to advocate for and promote the benefits of immunisation to reduce the prevalence of vaccine preventable illnesses within the community, as well as support providers in the delivery of these programs.

OBJECTIVES
The CAHML Immunisation Program has the objective of maximising access to expert immunisation advice to the primary care sector and providers across the region. To lead the program, CAHML employed an experienced Immunisation Coordinator, who utilised support from the Stakeholder Engagement and Communications, Provider Support, Closing the Gap, and Planning and Research teams. This has ensured that a strong promotional capability has been maintained.

Activities undertaken:
- Delivery of a robust immunisation education program for GPs, Primary Care Nurses, Local Council Immunisation Nurses and Aboriginal Health Workers
- Development and/or distribution of appropriate vaccination information and resources to the community
- Tracking and mapping immunisation rates across CAHML and maintaining a current, accurate database of relevant ACR data
- Identification of postcode areas with the highest number of children reported as not fully vaccinated
- Engagement with providers, childcare centres and Aboriginal and non-Aboriginal community members in the identified postcode areas
- Liasing with other relevant stakeholders e.g.: SA Health, Aboriginal Health Council SA and Department of Human Resources (ACIR) to assist in identification of hard to reach groups
- Provision of a staff flu vaccination program for CAHML employees

Working as an integrated team has enabled connecting with key members of the Aboriginal community, developing appropriate resources for Aboriginal and non-Aboriginal communities and facilitating the culturally appropriate coordination of education events for immunisation providers.

Establishing relationships with providers and community members was seen as the first step in improving vaccination coverage rates. This allowed CAHML to be better positioned to understand the reasons why children were not fully immunised.

Frequent immunisation information was communicated to providers and up to date (topical) immunisation education sessions were delivered.

- Participation in community events provided opportunities to engage with the community, and raise immunisation awareness and acceptance.
- The establishment of an Aboriginal Young Mother’s Group assisted with directing resource development and communication with the Aboriginal community with the aim of improving awareness, rates and access to appropriate vaccination services for the Aboriginal community.
- ACIR “Overdue Children” reports were scrutinised to understand the specific postcode areas most affected and if there was a trend to a particular vaccine not received by the child.
- Resources such as Immunisation Reminder fridge magnets were developed for the Aboriginal and non-Aboriginal communities. The magnets have been distributed at education sessions, practice visits, community events and through the Child and Family Health Service (CAHLS) and Aboriginal Cultural Consultants (ACCs).
- Child care centres in identified postcode regions were recruited to participate in an Immunisation Blitz. The Blitz included seeking permission from parents for ACIR record checks to be performed on their child(ren). Parents who consented were contacted with information about overdue vaccines, vaccines next due and changes to the scheduling points on the immunisation schedule. This also gave CAHML the opportunity to correct missing or incorrect data. A total of 18 child care centres participated in the Blitz.

OUTCOMES
CAHML has gained knowledge about immunisation awareness, attitudes and practices through provider and community engagement. This has enabled a positive, trusting and reliable relationship to be established with providers and community members.

Immunisation providers have:
- Been supported in streamlining their recall/reminder processes, ACIR notifications and in monitoring their practice vaccination rates.
- Received best practice clinical support, relevant education and current (topical) immunisation information in a timely manner.

The community has been:
- Given the opportunity to receive information to increase awareness about the importance of vaccination and the importance of the timeliness of immunisation.
- Through the strategies implemented from mid-2014, CAHML has reduced the number of children not fully immunised by 9%.

KEY LEARNINGS
- Build, maintain and strengthen relationships with all providers and key stakeholders through regular communication via varied means.
- Written newsletter articles, reports and web page information.
- Telephone support for a variety of program issues (clinical, ACIR reporting, cold chain management).
- Face to face contact through practice visits, meetings and education sessions.
- Engagement is needed to implement a successful immunisation program. Relevant stakeholders CAHML has linked with include the local councils within the region, SA Health and particularly the Women’s and Children’s Health Network, and the Department of Education and Childhood Development.
- Promoting key messages to providers and communities assists in increasing immunisation awareness.
- Address parents’ concerns and barriers to vaccination with professionalism and respect.
- “Action” approach: providers valued the creative, ‘can-do’ attitude of CAHML and felt supported in areas of the program where time pressures impeded their ability to deliver.
- The process to access immunisation data at the SLA level, and to identify Aboriginal children, is overly cumbersome. This concern has been addressed through constant liaison with ACIR and SA Health, but remains a major issue.
- The ability to track and map rates across the region and maintain an accurate and up-to-date database of relevant ACIR data is difficult. As CAHML is not a Registered Provider, only limited data is available and this impacts on the ability to comprehensively target areas of low immunisation.
- ACIR records have been discovered to be frequently inaccurate, compounding the difficulty to target activity to achieve best outcomes.
- Immunisation Program oversight has also been provided by CAHML’s clinical governance protocols. Immunisation Program team members meet with program managers to oversee the clinical governance and to make recommendations to improve quality.
The CAHML Immunisation Program activities have escalated during 2014 and the momentum gained has resulted in steady and solid continuous delivery of quality programs. The expertise of the Immunisation Coordinator and having an immunisation program team with a range of complementary skillsets has been a critical factor in driving improvements in vaccination rates.

All promotional and stakeholder engagement and relationship building activities were strategically targeted for maximum benefit to the immunisation program going forward, and has led to a decrease in the number of children identified as not fully immunised.

CAHML continues to work closely with immunisation providers to ensure immunisation services are accessible, effective, of high quality and sustainable to meet the aim of increasing rates and decreasing the risk of vaccine preventable disease in the CAHML region.

**KEY DOCUMENTS**

- When do I get baby immunised? Immunisation schedule reminder magnet (Aboriginal and Torres Strait Islander specific and Diverse Community specific)
- Diverse Community specific)

**BACKGROUND**

Central Adelaide and Hills Medicare Local (CAHML) identified overweight and obesity as a priority area of concern as a result of population health profiling in 2012.

Overweight and obesity are major issues in Australia with 63% of the adult population either overweight or obese.

In 2012 the Population Health Commissioning Atlas™ identified that the highest levels of overweight and obesity were present in the western suburbs and a pocket in Campbelltown.

CAHML’s aim was to have a Healthy Weight Strategy that was responsive to local need. This need was consolidated following the Comprehensive Needs Assessment completed in 2014.

The result would be the production of a Healthy Weight Population Health Monograph capturing knowledge gained from extensive consultation with stakeholders and community members.

**OBJECTIVES**

1. To clarify and document care pathways to aid general practice in the management of overweight and obesity.
2. To complete a document designed to inform future direction and management of overweight and obesity across the CAHML region through primary health care.

**APPROACH**

CAHML’s approach to developing the Healthy Weight Strategy was based on the IAP2 principles captured in the CAHML Community Relations Policy. This included identifying best practice, knowing the issue, knowing the community and building collaborative partnerships.

In developing the Healthy Weight Strategy key stakeholders were identified as:

- External stakeholders - general practice, pharmacy, allied health professionals, specialists, education and community.
- Internal stakeholders - CAHML staff and Board.

It was identified early in the engagement process that stakeholders wanted action not rhetoric.

**IMPLICATIONS FOR PRIMARY CARE**

The CAHML Immunisation Program activities have escalated during 2014 and the momentum gained has resulted in steady and solid continuous delivery of quality programs.

All promotional and stakeholder engagement and relationship building activities were strategically targeted for maximum benefit to the immunisation program going forward, and has led to a decrease in the number of children identified as not fully immunised.

CAHML continues to work closely with immunisation providers to ensure immunisation services are accessible, effective, of high quality and sustainable to meet the aim of increasing rates and decreasing the risk of vaccine preventable disease in the CAHML region.

86.3% of children in our region are fully immunised by age 5 compared with 90% nationally.

CAHML has reduced the number of children not fully immunised by 9%.

**ENGAGEMENT STRATEGIES**

Citizen’s Jury on Obesity

The Citizen’s Jury on Obesity was held in May 2013. This process explored community viewpoints in relation to bariatric surgery access, treatment and management. Participating were interested community members and experts in the area of surgery and management of obesity.

Understanding Obesity Workshops

A series of three workshops were delivered to primary health care nurses and allied health workers exploring the key issues with managing obesity. Presenting at these workshops were expert allied health workers in the field of obesity management.

Healthy Weight Week

Aimed at general practice, CAHML supported Dietitians Association of Australia’s Healthy Weight Week in February 2014 and 2015. The aim was to raise awareness of healthy weight and the value of using dietitians in managing obesity.

Workplace Wellness

With the evidence around sedentary behaviors and poor health, CAHML introduced the annual staff walking challenge. This aimed to promote physical activity, reduce sedentary behavior and to encourage team building.

Healthy Weight Practice Grants

Practices were encouraged to look at how obesity prevention, treatment and management could be addressed in the general practice setting. This was done by introducing healthy weight practice grants. The grants aimed to provide seed funding to practices to either introduce a new program or to evaluate an existing program.

In order to establish relationships and to gain feedback, it was necessary to meet external stakeholders and community in a manner that was mutually beneficial.

For internal stakeholders (CAHML staff) gaining an insight into their roles and priority areas provided an opportunity to identify those who were best placed to take the healthy weight message to providers and engage as part of CAHML priority areas.

For external stakeholders it was essential to build the relationships, learn about their priority areas, gain an understanding of what being involved in any consultation or collaboration would mean for them, and consider what level of support is required.

**Central Adelaide and Hills Medicare Local (CAHML)**

identified overweight and obesity as a priority area of concern as a result of population health profiling in 2012.

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- Internal stakeholders - CAHML staff and Board.

It was identified early in the engagement process that stakeholders wanted action not rhetoric.

**PROGRAM STAFF**

Lead Vanessa Gaston-Gardner, Senior Project Officer

Healthy Weight (Program Lead), Stakeholder and community Engagement Team

Manager – Danielle Grant-Cross


The communication plan also included social media as a mechanism to engage with the Aboriginal community:

• Attending cultural events.
• Sharing information.
• Completing cultural competency training.
• Providing training for aboriginal health workers to deliver the Healthy Eating and Lifestyle Program (HEAL™).

Women’s Health CALD

The aim of engaging with the CALD community was to increase health literacy and engage women from Hispanic, Italian and Vietnamese origin in health education.

Healthy Eating Activity and Lifestyle (HEAL™) Program

The HEAL™ Program was delivered to a group of community members over a period of six months. The program, a nationally accredited Healthy Lifestyle Program, provided opportunity to consult with community and identify needs.

Communication

CAHML developed an effective communication plan that included a healthy lifestyle webpage for community and one for professionals that provided valuable resources and links to research.

Regular communication via the CAHML newsletter kept stakeholders informed and provided an opportunity for feedback.

The communication plan also included social media as a mechanism for sharing and gathering information.

OUTCOMES

All of the strategies used were designed to:

• Build relationships and trust
• Identify gaps
• Identify needs
• Build skills and knowledge
• Identify best practice
• Inform the development of the healthy weight monograph

The outcome of the process is the development of two key documents:

The Healthy Weight Population Health Monograph includes:

• Current obesity trends
• Regional profiles
• Recommendations
• General practice support
• Pathway document supporting GPs in managing overweight and obesity. This document is a simple flow chart summary of the NHMRC Clinical Practice Guidelines for the Management of Overweight and Obesity (2013).

The frustration has been evident when engaging with both GPs and PHC nurses.

• Choosing the right environment and activity can be effective in engaging community and can be used to gather knowledge on gaps in services, access to health care and health literacy. For example delivering a lifestyle program to community in order to engage and gather information.
• Obesity rates have continued to increase over the last 10 years. The trend of shift from overweight to obesity in many regions, particularly the West, is alarming.
• Obesity prevention, treatment and management is a multi-sectoral responsibility, not just that of health. Everyone knows it is a problem but there is no one solution.

A number of learnings arose from this process:

• A good communication plan is essential in being able to gather and share information. It is also a valuable mechanism in building relationships and engaging across a number of community groups in a safe, equitable and timely manner.
• Obesity generates a number of emotions. Community acknowledge the need to do something about obesity but are struggling to find the solution.
• Changing behaviors is difficult to attain and maintain without support. At individual levels, within communities in greatest need, eating healthy food is not the easy choice and is certainly not a priority.
• General practice are sick of being consulted with, they want action on obesity.

For general practice the constant loss of programs and defunding of services has made managing obesity in this primary health setting a difficult task.

The format allowed information to be gathered to identify the gaps in current service provision and the areas of greatest need.

The area of public interest was ‘Publically Funded Bariatric Surgery’ and guidelines for assessment and access to such procedures.

BACKGROUND

CAHML collaborated with the Griffith University Research Team and Flinders University which provided an opportunity to engage the community and inform the development of the Healthy Weight Strategy.

The theme considered access to weight loss surgery, pathways for non-surgical treatment, and management and best practice.

The format allowed information to be gathered to identify the gaps in current service provision and the areas of greatest need.

The area of public interest was ‘Publically Funded Bariatric Surgery’ and guidelines for assessment and access to such procedures.

OBJECTIVES

The objective for the day was:

• to review the evidence for surgical intervention (bariatric surgery) for weight loss.
• to develop a set of new criteria that best identified surgical inclusion and exclusion as perceived by the jurors after hearing all the expert witnesses.

APPROACH

The Citizen’s Jury on Obesity was conducted as part of a larger research project. CAHML Citizen’s Jury was the second conducted by Griffith University having delivered a similar event in NSW.

Professional facilitators with broad experience in Citizen’s Jury were engaged to conduct the CAHML event.

The Jury

Twelve jury members were selected. The selection process involved advertising using local media where potential jurors self-nominated to be considered for selection.

Nominees were randomly selected. This resulted in a jury from a cross section of backgrounds, education, ages, gender and understandings.

Each juror completed a questionnaire to gather a base line on understanding and attitudes to obesity and healthy lifestyles.

The Witnesses

Experts in the field of obesity management and bariatric surgery were invited to provide testimony and face cross examination from the Jury.

As well as expert clinicians, consumers from across the community with experience in navigating the health care system in order to access bariatric surgery were also invited to provide testimony.

Questions for the Jury

1. What should be the criteria for patient access to publicly funded obesity surgery?
2. What should be the criteria for prioritising people for bariatric surgery?
3. What about patients who don’t meet the above criteria?
4. Should surgery for obesity be given a lower priority for resourcing/ funding than other elective surgeries?

The Verdict

As with a legal jury, the Citizen’s Jury:

• Heard the evidence from witnesses
• Cross examined witnesses through questioning; and
• Clarified information
• Deliberated and discussed the evidence
• Reached consensus and made recommendations.
OUTCOMES
A number of key findings were reached:

• Public surgery should not be restricted to only those under 45 years of age.
• BMI criteria should be 35 with comorbidities such as Type 2 Diabetes.
• BMI in excess of 50 without comorbidities, should be offered surgery.
• People who have had Type 2 Diabetes up to 5 years should be eligible for surgery.
• Before being eligible for surgery, patients should demonstrate commitment to behaviour change.
• Considerations need to be given to individuals living with mental illness.
• Multi-disciplinary teams should be available to assist patients not eligible for bariatric surgery.
• Public Health Policy needs to change e.g. taxes on soft drinks.
• Bariatric surgery to have the same priority rating as other elective surgery.
• Increased funding should be allocated to bariatric surgery in the public health system.

IMPLICATIONS FOR PRIMARY CARE
The use of a Citizen’s Jury as a means of engaging community in the development of health policy assists to identify public perception and understanding of important health issues.

The process engaged community and providers, and demonstrated the effectiveness of bringing together community and clinicians to discuss topics of importance across sectors.

It has long been recognized that listening to the views of consumers can enhance health care decision making, inform policy and provide an equitable and relevant approach to health care.

KEY LEARNINGS
The process of planning and implementing a Citizen’s Jury is time consuming. Ideally a Citizen’s Jury would run for 1½ to 2 days to allow time to gather enough information to deliberate and reach consensus.

Key learnings from the jurors were:

• Important to hear what the public thinks.
• Citizen’s Jury is a useful process.
• Works well and a good platform.
• Good to have the opportunity to openly discuss and reach an agreement on a taboo subject.
• Politicians may not have been able to come up with a better outcome in the same length of time.
• Many components to a complex issue
• Today has increased my knowledge of obesity
Health Planning and Analysis

BACKGROUND
A key part of Central Adelaide and Hills Medicare Local (CAHML) work has been to better understand the health and service system needs of our community so that CAHML’s key priorities, strategies and activities address these identified needs.

This has been undertaken by utilising population health needs analysis and planning methods, and has been conducted in conjunction with consumers, health providers and key stakeholders to develop locally focused and responsive primary health care services.

OBJECTIVES
CAHML has a commitment to understanding the health needs of its region through a rigorous population health analysis process.

This includes:
- identifying the social determinants of health and any associated trends;
- understanding the service provision and capacity within its region; and
- using this information to assist in developing, either individually or jointly with key stakeholders, appropriate primary health care service provision within the CAHML region.

APPROACH
To understand the health needs of the region and assist in developing appropriate solutions, CAHML has:
- Identified and documented the health profile of the catchment population.
- Identified the health needs and gaps in services within the region.
- Examined opportunities for better targeting of services.
- Established formal and informal linkages with key stakeholders to assist in the development of strategic priorities and joint planning for the region. This includes the acute, mental health and aged care sectors, and other services in the primary health care sector.

CAHML has not embarked on assessing and addressing these identified needs in isolation. CAHML’s approach has been to listen to community members, health service providers and key stakeholders to understand the enablers and challenges, and then collaborate to achieve long-term outcomes.

ONGOING ENGAGEMENT WITH COMMUNITY
Health providers and key stakeholders was planned to gather detailed qualitative data to assist in program and service development further.

Needs Assessment
CAHML conducted an Interim Needs assessment in 2011-12 and a further Needs Assessment in 2012-13. This allowed the production initially of a Population Health Commissioning Atlas™ with Healthfirst Network, which was an initial snapshot of the health needs for the CAHML region and helped shape CAHML’s key priority areas.

CAHML also conducted a number of Needs Assessments to better understand the issues and delivery of After Hours primary health care within the region. The information gained from these processes helped shape the CAHML After Hours Incentive and Grants programs.

Population Health Monographs
The key priority areas of Chronic Obstructive Pulmonary Disease, Positive Ageing, Healthy Weight, Palliative Care and Health Screening were examined in more detail, resulting in the production of Population Health Monographs. These monographs looked more closely at the demographics of the CAHML population, risk factors and prevalence, current service provision and suggested further activity that needed to occur within the region to address these health issues.

Research and Analysis
The Health Planning, Research and Organisational team supported CAHML through further data analysis and planning to support the development of key activities, services and programs. This has enabled greater specificity in planning of program outcomes, and identification of specific geographic regions and populations.

Comprehensive Needs Assessment
CAHML’s understanding of the health needs of the region was expanded significantly with the undertaking of the Comprehensive Needs Assessment (CNA) process in 2013-14. This process identified the health characteristics and health needs across the region, the current profile of services and programs, the gaps in service options and enablers and barriers for consumers accessing services.

It involved a detailed analysis of the quantitative and qualitative data for the region at the Statistical Local Area and CAHML level, including analysis of social determinants of health and a range of health indicators. Detailed analysis of specific populations also occurred, including Aboriginal and Torres Strait Islander people, established migrant groups and recent refugees, older people and carers.

Mapping of current health provider and service provision and capacity also occurred to help form a picture of service availability and access across the region.

CAHML established a Strategic Leadership Group (SLG), which was comprised of a range of stakeholders from across the region. The SLG’s role was to oversee and provide input into the process of the CNA, and assist in shaping the key priorities for CAHML. The SLG included representatives from Central Adelaide Local Health Network, Country Health SA, SA Health, Aboriginal Health Council SA, Health Consumers’ Alliance, Adelaide University, the Local Government Association (LGA) and local LGA representatives.

The SLG was committed to continuing to work together post the CNA process to assist in shaping a joint response to addressing health needs within the region. Due to the decision by the Australian Government to defund Medicare Locals, this did not progress further, but it was encouraging to see the openness demonstrated by key stakeholders to this approach.

One of the key outcomes from the CNA process has been disseminating the information learned from this process for the many health providers, organisations and stakeholders that each play a role in keeping people well. They have subsequently used this information to plan and resitent service provision.

Mixed methods analysis (or triangulation) was used to increase the validity of the CNA by deliberately drawing on evidence from a wide range of perspectives and methods, and comparing findings. Qualitative and quantitative data were brought together to ascertain agreement between different sources of data to “build a case” for the need/issue, and develop a shortlist of needs. These were then prioritised in consultation with the CNA SLG, the CAHML Board and staff. Priority needs were used to inform the CAHML Strategic Plan for 2014-17 and the Annual Plan for 2014-15, including key activities, desired outcomes/outcomes and appropriate key performance indicators to monitor progress.

CAHML concentrated heavily on ensuring specific outcomes were built into the planned approach to enable evaluation of the effectiveness of its activities. It was planned that this information would then guide future recommendations and activities within the region.

OUTCOMES
The data analysis conducted in the CNA processes, including the production of the Population Health Commissioning Atlas™, initially identified a number of key priorities for CAHML. These included:
- Aged care coordination
- Young people and mental health
- Mental health
- Aboriginal health
- Child (hood) immunisation
- Obesity
- Health promotion and screening
- Health service system integration with a focus on Chronic Obstructive Pulmonary Disease
- After hours
- E-health
- Primary Health Care quality improvement activities
- End of life and palliative care
- Culturally and Linguistically Diverse populations.

The CNA supported further the key priorities identified and provided more detail regarding the key issues and areas, and highlighted an appropriate response.

The key health issues and contributing factors identified in the CNA are summarised below.

Chronic Disease Prevalence
Within the CAHML region, particularly in the west of the region, Campbelltown and Mount Barker, the prevalence of chronic disease, and complex co-morbidities is very high compared to the greater metropolitan area of Adelaide and nationally. This includes Type 2 Diabetes, cardiovascular disease, Chronic Obstructive Pulmonary Disease, Osteoarthritis, and musculoskeletal disorders. This is combined with risk factors of overweight/obesity, smoking, hypertension, high cholesterol, physical inactivity and poor nutrition.

The prevalence of these risk factors correlates with chronic disease prevalence in the western suburbs, Campbelltown and Mount Barker.

Mental Health
There is a high prevalence of mental health issues and psychological distress particularly for the western region and Campbelltown and Norwood Payneham and St Peters LGAs, and this is also evident for older adults, youth and early childhood age groups. There is a high prevalence of mental health issues and psychological distress, particularly in the west of the region, Campbelltown, Norwood Payneham and St Peters Local Government Areas (LGAs), and this is also evident for older adults, youth and early childhood age groups.
Immunisation and communicable disease

Immunisation rates across the CAHML region are very low for children aged 1 to 5 years, and particularly within the Aboriginal and Torres Strait Islander community. Within the culturally and linguistically diverse (CALD) and Aboriginal and Torres Strait Islander population groups in the western region, there is a high prevalence of Hepatitis B.

End of life and Palliative care

There is minimal data at a CAHML region level. In patient palliative care separations and average length of stay in South Australia (SA) is similar to the Australian statistics. Central Adelaide Local Hospital Network has the highest number of separations in SA. Data for the Central Adelaide Palliative Care Service demonstrates that the number of people receiving support to die at home is increasing, and is projected to continue to increase.

Older adults

The health issues for older adults within the CAHML region are wide-ranging and complex, and include complex co-morbidities, high prevalence of risk factors for chronic disease, mental health issues and psychological distress, dementia, palliative care and falls prevention. There is also a significant prevalence of older adults from CALD backgrounds or with a profound or severe disability across the region.

There are issues for older adults around access to transport, social isolation, coordination of health and social services, capacity to navigate the health system, and coordination of end of life and palliative care.

Culturally and Linguistically Diverse populations

Analysis of the data has demonstrated CALD communities tend to demonstrate higher rates of social disadvantage, chronic diseases, lower English proficiency, and lower rates of screening and preventative activities. The recent refugee population has its own distinct health needs around unknown current immunisation status, blood borne viruses, such as Hepatitis B, and psychological trauma.

Aboriginal and Torres Strait Islander communities

Health needs identified for Aboriginal and Torres Strait Islander people include immunisation, particularly for young children, maternal and child health, diabetes, renal health, cardiovascular health, respiratory disease and mental health.

Youth health

Given the high prevalence of younger people aged 15 to 29 years within parts of the CAHML region, there is a corresponding need to address the correlating health needs of youth mental health, sexual health and drug and alcohol use.

The key focus areas for CAHML that have been shaped by the findings from the CNA are reflective of these challenges and include:

- Integrating care for mental health, particularly youth mental health
- Integrating care for chronic and complex conditions
- Integrating care and implementing strategies for older adults to assist with positive and healthy aging
- Health promotion and preventative strategies.

KEY LEARNINGS

Using an evidence base to determine an appropriate response in primary care is essential. This allows for detailed planning regarding key activities for specific populations or sub-regions within the region.

It also allows for the planning and monitoring of key outcomes and an evaluation of the effectiveness of the approach and activities. This information is then crucial for future planning of services and activities.

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KEY DOCUMENTS

CAHML Health Profile: A population health needs assessment of the Central Adelaide and Hills region, March 2015.

CAHML COPD Monograph, November 2014.

CAHML Health Screening Monograph, November 2014.


CAHML Healthy Weight Population Health Monograph, March 2015.

CAHML End of Life Care Monograph, March 2015.


BACKGROUND

CAHML undertook a Comprehensive Needs Assessment (CNA) to identify health needs in the region and inform health planning. Analysis of quantitative data forms a key part of population health needs assessment.

OBJECTIVES

The objectives of the quantitative components of the CNA were to:

- Understand the demographic characteristics of the CAHML population.
- Assess the health status of the population and identify the key health issues/needs for the region, including the prevalence of disease and associated risk factors.
- Identify health inequalities that exist between geographic areas and population groups and gain understanding of the contributing social determinants.
- Assess the utilisation of existing health services, including hospitalisation rates.
- Review the current capacity of the primary health care system and workforce to identify access gaps and barriers to health care.

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- Review the current capacity of the primary health care system and workforce to identify access gaps and barriers to health care.

KEY LEARNINGS

Using an evidence base to determine an appropriate response in primary care is essential. This allows for detailed planning regarding key activities for specific populations or sub-regions within the region.

It also allows for the planning and monitoring of key outcomes and an evaluation of the effectiveness of the approach and activities. This information is then crucial for future planning of services and activities.

Analysis of the CNA-enabled CAHML, to develop relationships with community, health providers and key stakeholders to ensure their voice was heard in consideration of the data and planning of key priority areas.

The SLG enabled CAHML to build constructive relationships with key stakeholders within the region that also had a vested interest in addressing the health needs identified. The SLG was an appropriate format for enabling discussion and commitment to a joint response to address these health needs, and further deepened the understanding of the work already occurring by these organisations within the region.

IMPLICATIONS FOR PRIMARY CARE

It is essential that Primary Health Networks (PHNs) continue to use a population health analysis and planning approach utilising both quantitative and qualitative data methods to identify the health characteristics of their regions and key health priorities and respond accordingly.

This will enable PHNs to build relationships with community, health providers and key stakeholders whilst also gaining a very detailed understanding of the health and service system needs across the region, and plan appropriate activities.

Applying a population health analysis and planning approach will also enable the establishment of constructive relationships with other key stakeholders who plan and deliver services across the region to ensure that any response is enhanced and not duplicated, and will also allow collaborative planning and at times, a joint response to address an issue.

KEYWORDS

Quantitative data analysis, demography, needs assessment, health services research, health planning

PROGRAM STAFF

Alicia Windle, Kelly Quinlan, Simona Champion, Kylie Cocks, Justin Reeves, Bronwyn Knight

Manager - Lead Kirsty Rawlings

APPRAOCH

Data from the Public Health Information Development Unit (PHIDU) at the University of Adelaide was used as the premium source of quantitative data. PHIDU data is mainly drawn from ABS Census (2011) data and National Health Survey (2007-08, 2011-13) data. PHIDU data on a large range of indicators were compared at Statistical Local Area (SLA) level. Data was presented on ‘heat maps’ to highlight sub regional prevalence rates within CAHML. To further contextualise the data on each indicator, each SLA was given a rating based on its comparison against Australian and Adelaide metropolitan benchmarks, and its quintile rating within CAHML.

These ratings were plotted on a matrix to give a clear indication of which geographic areas had higher need on the different indicators.

There were some limitations in the approach to gathering quantitative data such as; (please dot point these) a large range of data was only available at the Medicare Local level data did not align with Medicare Local boundaries data was only available at a state or national level. This could not be meaningfully compared using the matrix method described above, however it was still analysed and appropriate comparisons made to determine whether any health needs of the CAHML region could be identified. Where available, data of disease/ risk factor prevalence for specific population groups (e.g. Aboriginal and Torres Strait Islander people) were compared with overall CAHML prevalence, to give approximate rate ratios.

Mixed method analysis (or triangulation) was used for increasing the validity of findings by deliberately drawing on evidence from a wide range of perspectives and methods and comparing findings. Quantitative and qualitative data was brought together to ascertain agreement between different sources of data.

OUTPUTS AND FINDINGS

A detailed report has been prepared which presents the analysis and findings of the CNA for the CAHML region. This includes the matrix of comparative analysis by SLA. There is also a summary list of identified needs, and an infographic which illustrates key findings.
Quantitative analysis of a range of population health data has shown that the western suburbs of Adelaide in the Port Adelaide-Enfield and Charles Sturt council areas (with the exception of coastal Charles Sturt) have relatively high levels of need in most of the health and social issues analysed. The LGA’s of Adelaide City, West Torrens, Campbelltown and Mt Barker also had relatively high levels of need on a number of issues. There are further ‘hotspots’ of high need in respect to particular health issues in the Prospect and Norwood, Playford and St Peters council areas. The Adelaide Hills, Burnside, Unley and Walkerville areas had the lowest evidence of health need.

The health and social issues with the highest quantitative evidence of need were childhood immunisation, overweight and obesity (particularly in males), Aboriginal and Torres Strait Islander people’s health, cardiovascular disease, diabetes, disability and carers, culturally and linguistically diverse people with low English language proficiency, unemployment, mental health, chronic obstructive pulmonary disease (particularly in males), Aboriginal and Torres Strait Islander people. There are further ‘hotspots’ of high need in respect to particular health issues in the Prospect and Norwood, Playford and St Peters council areas. The Adelaide Hills, Burnside, Unley and Walkerville areas had the lowest evidence of health need.

The development of the matrix tool has proven to be a very useful resource in enabling rapid, visual assessment of a range of health issues across the region.

The key strength of the CNA is the wealth of data that has been analysed in detail. We have developed a comprehensive understanding of health needs in our region, which has been valuable to CAHML and continues to be valuable to our stakeholders. The development of the matrix tool has proven to be a very useful resource in enabling rapid, visual assessment of a range of health issues across the region.

The findings from this analysis, in combination with the qualitative components of the CNA, serve to inform health service and program planning by enabling targeting of specific high need populations and issues.

**Key Learnings and Strengths**

The key strength of the CNA is the wealth of data that has been analysed in detail. We have developed a comprehensive understanding of health needs in our region, which has been valuable to CAHML and continues to be valuable to our stakeholders.

**Implications for Primary Care**

The findings from this analysis, in combination with the qualitative components of the CNA, serve to inform health service and program planning by enabling targeting of specific high need populations and issues.

**Key Documents**

- CAHML Comprehensive Needs Assessment – Infographic
- CAHML Comprehensive Needs Assessment – List of Identified Needs

**Background**

Engagement was undertaken with community members, health providers and key stakeholders to gather qualitative data on the needs within the CAHML region to provide a full range of views and perspectives. The qualitative data collected was used to support and inform the overall CNA process. Utilising both quantitative and qualitative data provides an in-depth picture of the health characteristics and health service needs of the region.

**Objectives**

The aim of the qualitative data collection was to obtain information about the ‘felt’ need of people within the CAHML community and provide insight into:

- experiences of health and health services
- perspectives on how primary health care should be improved and where it is working well.

The qualitative data collection was a way to get ‘behind the numbers’ of the quantitative analysis, to provide insights that could not be obtained from data alone.

**Approach**

**Data Collection**

Using the stakeholder engagement strategy, developed for the CNA, sampling for the qualitative data was determined in a systematic way to ensure that community, stakeholders and health professionals provided an indicative sample. The following activities were implemented using a range of methods and data was collected across a three month period.

**Primary qualitative data sources:**

- Online surveys utilising the UEngage system: survey link sent via email and through external communication mechanisms as determined by the stakeholder engagement strategy.
- Face-to-face surveys administered at CAHML events.
- Face-to-face focus groups - to explore service users’ views.
- Focus groups - to understand the perspectives on how primary health care should be improved and where it is working well.
- Key stakeholder interviews, and an environmental scan – a review of stakeholder, community and provider needs captured through existing external consultations and published by secondary sources.

**Data Analysis**

The dataset developed from surveys, focus groups and stakeholder interview responses was reviewed, coded and then collated to identify important themes within the data. The coded and collated data was then examined to identify significant broader patterns of meaning. Each theme was then collated and reviewed for a second time against the main dataset to check that the ‘story’ of the data was accurate. As part of the overall CAHML communication and engagement strategy, further engagement was planned to continue to consult and further validate data and shape key priority areas.
OUTCOMES

The following table provides a summary of the type and total number of responses received as part of the engagement process.

<table>
<thead>
<tr>
<th>Engagement mechanism</th>
<th>Number of responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Online survey</td>
<td>169</td>
</tr>
<tr>
<td>Face to face survey</td>
<td>87</td>
</tr>
<tr>
<td>Focus group participation</td>
<td>76</td>
</tr>
<tr>
<td>Key stakeholder interviews</td>
<td>3</td>
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<tr>
<td>Environmental scan documents reviewed</td>
<td>32</td>
</tr>
<tr>
<td><strong>Total Responses</strong></td>
<td><strong>335</strong></td>
</tr>
</tbody>
</table>

CAHML has compiled a population profile which outlines the key health needs within the region based on qualitative and quantitative evidence. A detailed report has been prepared which presents the analysis and findings of the CNA for the CAHML region.

KEY LEARNINGS

Capturing the qualitative data added a unique perspective to the CNA process and allowed the project team and the organisation to ‘hear the voices’ of the community and build a story around the data. The short timeframe available to undertake the consultation for the CNA did not allow for planned follow-up consultations to delve further into the key needs that were identified. This would have allowed a greater level of detail and validation of the existing findings.

IMPLICATIONS FOR PRIMARY CARE

The findings from the CNA inform health service and program planning by enabling targeting of specific high need populations and issues.

A snapshot of the key primary health care needs that were identified across the CAHML region include:

**Health priorities**
- Mental health, anxiety and depression, stress youth mental health, and relationship issues
- Chronic disease management, particularly diabetes, heart disease/cardiovascular disease, respiratory disease/COPD/ Asthma and obesity
- Healthy ageing; dementia, dental care, physical mobility and falls prevention

**Access issues**
- Access to service providers; long wait times for GPs and specialist services
- Access to affordable services; cost of consultations, medications, gap payments for allied health and limited access to bulk billing
- Access to transport; lack of public transport, distances between services and lack of appropriate transport corridors, the cost of owning/maintaining a motor vehicle or the inability to drive

**System issues**
- Being able to navigate the health system
- Being aware of services and how to access them
- Lack of integrated/to-located services
- Care coordination; support services to link people with appropriate services and increased collaboration between services.

IMPACT Research Program: South Australia

The ‘Improving Models Promoting Access-to-Care Transformation’ (IMPACT) research program aims to transform primary health care (PHC) structures to improve access to appropriate care for vulnerable populations.

**BACKGROUND**

The IMPACT program is funded by the Australian Primary Health Care Research Institute and Canadian Institute of Health Research for a Canadian and Australian CIHR Community-based Primary Healthcare Team Grant.

IMPACT is a five year international research program (2013-2018), which has developed a network of partnerships (Local Innovation Partnerships (LIP)) to trial, evaluate and co-create innovative models of care that enhance access to primary health care for vulnerable populations.

A LIP is a community of stakeholders who share a common concern around vulnerable populations that are at increased risk due to limited access to care. LIPs serve as forums for meaningful engagement, knowledge exchange and collaboration among stakeholders.

Six Local Innovation Partnerships have been established in three Canadian provinces (Quebec, Ontario and Alberta) and three Australian states (New South Wales, Victoria and South Australia).

**OBJECTIVES**

Through this program, we aim to transform PHC organisational structures to improve access to appropriate care for vulnerable populations resulting in reduced unmet need, avoidable emergency department visits and avoidable hospitalisations for vulnerable populations.

**KEY DOCUMENTS**

- CAHML Comprehensive Needs Assessment List of identified needs.
- CAHML Comprehensive Needs Assessment Infographic.

**PROGRAM STAFF**

SA LIP IMPACT Core Team: Principal Investigator: Professor Nigel Stocks (University of Adelaide), LIP Lead: Kirsty Rawlings (CAHML), LIP Coordinator: Simone Champion (CAHML)

**KEYWORDS**

IMPACT, primary health care, vulnerable populations, access to health care, service design, health care intervention, innovation, program evaluation

IMPACT has four main objectives:

1. To develop a network of partnerships between decision makers, researchers, clinicians and members of vulnerable communities to support the improvement of access to PHC for vulnerable populations;
2. To identify organisational, system level Community Based Primary Health Care interventions designed to improve access to appropriate care for vulnerable populations, and establish the effectiveness and scalability of the most promising organisational innovations;
3. To support the selection, adaptation and implementation of organisational innovations which align with our regional partners’ local population needs and priorities; and
4. To evaluate the effectiveness and efficiency and further scalability of these organisational innovations.

**GOVERNANCE**

The SA LIP IMPACT Team comprises the IMPACT Principal Investigator, LIP Lead, and LIP Coordinator.

There is also a SA LIP Advisory Group comprising decision makers, researchers, clinicians and members of vulnerable communities.

Thirdly, a LIP Network is established by a broader group of organisations and individuals representing, championing and servicing vulnerable communities.
The program is based on a mixed methods approach in which qualitative and quantitative methods are combined in order to achieve the various objectives of the program. The IMPACT program of research involves four interconnected projects over five years:

**Project 1** – Scoping of organisational innovations

A detailed analysis of local data was conducted using both within Greater Metropolitan Adelaide.

**Project 2** – Syntheses of effectiveness and implementation

To build a local picture of access to health care and vulnerability, a detailed analysis of local data was conducted using both quantitative and qualitative data sources.

**Project 3** – Mixed method analysis of surveys

**Project 4** – Implementation and evaluation of organisational innovations

To address access issues within local contexts and across diverse contexts.

**OUTCOMES**

1. To produce a set of innovations that can be tailored, implemented and robustly evaluated for effectiveness and feasibility;
2. Facilitated dialogues which engage local community and decision makers across sectors in designing organisational innovations to improve access to PHC for vulnerable populations;
3. Connection with colleagues across provincial, national and international contexts. Sharing of lessons learned across contexts will further inform future practice innovations for vulnerable populations;
4. Support for analysis of local data related to needs and access gaps for vulnerable populations;
5. Consolidation and appraisal of evidence-related strategies currently used to address access issues;
6. Identification of leading practices that address access issues within local contexts and across diverse contexts.

**IMPLICATIONS FOR PRIMARY CARE**

A scalable system level Community-Based Primary Health Care intervention tested locally, designed to improve access to appropriate care for vulnerable populations.

**KEY DOCUMENTS**


**Central Adelaide and Hills Medicare Local** was responsible for direct and indirect clinical and health service delivery programs, including headspace and Closing the Gap programs. Establishing a clinical governance and clinical improvement program demonstrated CAHML’s commitment to the accountability for clinical services and to continuously improve the quality and safety of clinical care.

**BACKGROUND**

As defined by Scally and Donaldson (1998, as cited by the Australian Commission on Safety and Quality in Health Care), clinical governance is:

“A system through which organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care; achieved by creating an environment in which there is transparent responsibility and accountability for maintaining standards and by allowing excellence in clinical care to flourish.”

Central Adelaide and Hills Medicare Local embarked on the process of developing and implementing a clinical governance framework in July 2013.

**OBJECTIVES**

To establish accountability and responsibility for the safety, quality and continuous improvement of clinical services provided (directly and indirectly) by CAHML.

**APPROACH**

A Clinical Governance Sub-Committee of the Board was established and met quarterly to provide clinical governance oversight on behalf of the Board.

Clinical governance and clinical management were defined within CAHML and the appropriate structures to support both were developed and implemented within the organisation.

The Clinical Governance Framework document was developed through collaboration and review to provide direction for the monitoring, reporting and improvement of services. Five critical elements were identified to ensure robust governance could take place.

Staff were trained in the content and implementation of the framework. Further training of ten staff occurred in the process of Root Cause Analysis, to be utilised in the event of a serious adverse event.

The CAHML Clinical Review and Improvement Committee (CRIC) was established to operationalise the Clinical Governance Framework through items such as: program reports, clinical incident management, clinical risk assessment and clinical audit. The CRIC met monthly and were convened on a further two occasions to conduct critical incident reviews.

Clinical services were supported in these quality and safety activities by the Health Planning, Research and Organisational Development team.

**PROGRAM STAFF**

Jackie Simcoke, Chris Saboth, Associate Professor Robert Prentail, Manager – Lead Kirsty Rawlings

**KEYWORDS**

clinical governance, clinical improvement, quality, safety, root cause analysis, clinical incidents
OUTCOMES
Achievements in clinical governance are:

- The establishment of clinical governance and clinical management structures, and associated policies and processes, to support oversight and management of safety, quality and continuous improvement of clinical services.
- The implementation of the Clinical Governance Framework across all CAHML services and programs, with consideration of how CAHML can monitor clinical governance of sub-contracted providers.
- The adaptation of the framework in the development of the headspace Woodville Clinical Governance Framework.
- Risk assessments being undertaken of all CAHML clinical programs and an internal audit and reporting schedule developed as a result.
- The formation of an internal Clinical Review and Improvement Committee to provide internal oversight of clinical incident management, clinical audit activities and provide recommendation from a quality improvement perspective to ongoing clinical management.

KEY LEARNINGS
The process of developing and implementing a framework for clinical quality, safety and improvement assisted CAHML with understanding:

- Where clinical governance sits in regard to sub-contracted clinical services. This has resulted in CAHML building into its funding agreements with service providers the requirement for them to have clinical governance structures and processes in place and report on these to CAHML.
- Clinical risk assessment can be useful to inform and plan the clinical audit schedule.
- Everyone involved in service delivery needs to have a commitment to quality improvement.
- The Clinical Governance Framework document informed program reporting templates, timeframes and key performance indicator measures.

IMPLICATIONS FOR PRIMARY CARE
Clinical governance is an integral part of an organisation’s quality agenda to ensure the services they provide, or sub-contract, are safe and of a high quality.

Primary Health Networks will need to consider how to implement clinical governance in a commissioning framework.

Support for primary health care providers in the development and implementation of a clinical governance framework needs to be considered, with a focus on education and training, as well as tools and templates.

KEY DOCUMENTS
CAHML Clinical Governance Framework November 2013
CAHML headspace Clinical Governance Framework December 2014
Medicare Local Accreditation Standards 2013
National Mental Health Standards 2010
National Quality and Safety in HealthCare Standards 2012

A number of strengths contributing to the ongoing development of CAHML were identified by the review team. Fourteen suggestions for improvement were given across six of the twelve mandatory standards. Quality improvement plans were put in place to address these suggestions.
KEY LEARNINGS
The path to accreditation highlighted for CAHML that:
• Implementing accreditation is more than a one-off process and requires a commitment to a quality agenda
• Project and change management skills are essential
• Regular contact with the accrediting agency enables being appropriately prepared
• Balancing the workload and expectations across the teams is critical
• The need to support staff in the writing process is essential
• Accreditation is not one person’s role. It is organisation-wide and everyone needs to understand it and prepare for it
• Starting early in the process is crucial for a comprehensive and coordinated approach.

Post accreditation, CAHML learnt to:
• Provide opportunities to celebrate
• Give people time to reflect and summarise their experiences
• Build on the momentum to pursue improvement.

Despite the decision to defund Medicare Locals by the Australian Government after June 2011, continuous quality improvement has remained a priority for the organisation.

IMPLICATIONS FOR PRIMARY CARE
Although achieving accreditation is not currently a requirement for the Primary Health Networks (PHNs), supporting primary care providers in their efforts to pursue and achieve a quality, safety and improvement program is critical. Accreditation is a part of this process.

Accreditation against the National Mental Health Standards 2010 is recommended for services delivering mental health care.

KEY DOCUMENTS
Department of Health Medicare Local Accreditation Standards 2013
Department of Health National Mental Health Standards 2010

Developing and Implementing a Reconciliation Action Plan

In 2014 Central Adelaide and Hills Medicare Local’s Aboriginal Wellness Group (AWG) commenced the process of developing a nationally recognised Reconciliation Action Plan (RAP). The plan was developed as an opportunity to recognise and acknowledge the prolific work that was occurring to improve the health and wellness of the Aboriginal and Torres Strait Islander community; as well as to elevate the awareness and understanding of the organisation and its staff in the culture and needs of the community.

BACKGROUND
Reconciliation is about unity and respect between Aboriginal and Torres Strait Islander people and non-Aboriginal people. Reconciliation is the respect for Aboriginal and Torres Strait Islander heritage and of valuing justice and equity for all Australians. (http://www.australia.gov.au/about-australia/australian-story/reconciliation)

A Reconciliation Action Plan (RAP) is an organisation’s business plan that documents what will be done to influence and contribute to Reconciliation in Australia. RAPs outline practical actions that build strong relationships and enhance respect between Aboriginal and Torres Strait Islander peoples and other Australians. A RAP sets out the aspirational plans to drive greater equality by pursuing sustainable opportunities. (http://www.reconciliation.org.au/raphub/about/)

In February 2014, CAHML embarked on the process of building and implementing a RAP, through Reconciliation Australia.

OBJECTIVES
• To develop and implement an approved RAP across CAHML to improve the cultural competence of staff
• Embed Aboriginal Wellness into all CAHML programs.
• To provide opportunities for personal growth and development through understanding and sharing.
• To improve the health and wellness of the Aboriginal and Torres Strait Islander people within the region.

APPROACH
From the outset, the pursuit of a RAP was driven from the CAHML leadership team and embraced by the members of the AWG and CAHML staff.

PROGRAM STAFF
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KEYWORDS
Reconciliation, action plan, Aboriginal wellness
OUTCOMES

Of the 23 actions outlined in the RAP, all will be achieved by the end of June 2015. Of these, the significant achievements were:

- CAHML has achieved a recruitment rate for Aboriginal people of 12.5% of total staff.
- Development and implementation of cultural protocols including Welcome to Country and Acknowledgment of Country.
- 97.5% of staff have completed the cultural competency training with projected completion rate of 100% by June 2015.
- Aboriginal Wellness, as a priority focus area was embedded into all CAHML teams and programs.
- Connecting Pharmacy and Allied Health with Aboriginal and Torres Strait Islander Communities Cultural Awareness Package developed and trialed with community pharmacy.
- Development of a cultural competency audit tool for General Practice.
- Staff participation in cultural activities, including cultural walks, screening of Aboriginal and Torres Strait Islander stories/ documentaries, culturally significant events NAIDOC Week and Spirit Festival.
- Participation in Reconciliation SA’s Anniversary of the Apology, and Reconciliation Breakfasts 2014/15.
- Sponsorships for SA Netball and Football Carnival 14/15 and Spirit Festival 14/15.
- Partners in Recovery staff training in Psychological Assessment of Aboriginal and Torres Strait Islander people.
- Support and utilisation of Aboriginal and Torres Strait Islander business Cultural Connections, Australian Bushwattle Catering, Crankeine Creations, Warnippiings Living Kaurna Cultural Centre, Tandanya Cultural Institute, Tribes United, Summer Arts and Nharla Photography.
- Newsletter Yarnin’ Health and Wellbeing disseminated to the Aboriginal and Torres Islander community.
- Innovative engagement with the Aboriginal and Torres Strait Islander community to conduct Community Needs Assessment.

KEY LEARNINGS
Developing a RAP has been a worthy pursuit for CAHML and is recommended for other primary health care organisations to capture and demonstrate their work and commitment to Aboriginal and Torres Strait Islander health and wellness.

In the journey toward a RAP, CAHML’s key learnings included:

- Engage with and focus on the organisation’s Aboriginal and Torres Strait Islander workforce. Their contribution and influence positively affects the direction of the RAP.
- Provide opportunities for people to reflect, both personally and as a group, on their thoughts and ideas about reconciliation which brings about growth, development and collaboration.
- Provide people with the time and resources to learn about Aboriginal and Torres Strait Islander history, with follow up support for discussion and debriefing.
- Actions speaking louder than words. A RAP is beyond a document and is a real, action driven, measurable commitment to improving the health and wellness of the Aboriginal and Torres Strait Islander community.
- Applying and working within Reconciliation Australia’s guidelines and the RAP templates as early on in the process assists in the RAP development and approval.

IMPLICATIONS FOR PRIMARY CARE
Ongoing, meaningful engagement with the community is essential for the future of primary health care to understand needs and to develop actions that affect real change. An endorsed RAP provides the structure and support to demonstrate this commitment.

According to the 2012 RAP Impact Statement by Reconciliation Australia, organisations with a RAP:

- Increase employment and retention rates of Aboriginal and Torres Strait Islander people.
- 66% of organisations with a RAP have frequent contact with Aboriginal and Torres Strait Islander communities.
- Have a greater appreciation for the place of Australia’s First People.
- Create culturally safe working environments.
- Support two-Way learning opportunities that build trust.
- Provide people with the time and resources to learn about Aboriginal and Torres Strait Islander communities, with greater impact of relationships between people, and their stakeholders.
- Are able to broaden their markets and community reach to the Aboriginal and Torres Strait Islander community.

KEY DOCUMENTS

BACKGROUND
After hours primary care is accessible and effective care for people whose health condition is urgent and cannot wait for treatment until regular services are next available. CAHML administrators funding for AH primary health services to further improve access to AH care so that communities across the region have suitable AH services in place.

The AH period is defined as:

- Before 8:00am and after 6:00pm weekdays;
- Before 8:00am and after 12:00pm Saturdays; and
- All day Sundays and public holidays.

The AH period can be further categorised into the following periods:

- The regular AH period, between 6:00pm and 11:00pm and 7am and 9am; and
- The unsociable AH period, between 11:00pm and 7:00am.

During this time it is difficult for people to access AH primary care, for providers to be sustainable in operating their AH services and there is a burden on health professionals’ work-life balance.

Feedback from the initial CAHML GP After Hours consultation forums (early 2013), highlighted concerns with the previous system of PIP payments; those delivering a large number of hours per week believed they were not being incentivised fairly.

OBJECTIVES
- Access to AH GP telephone advice when needed.
- Local AH primary care services are planned, coordinated and appropriate to community needs.
- Services are accessible when needed in both the sociable and unsociable AH periods, including for disadvantaged groups, residents of aged care facilities, the house-bound aged and palliative patients.
- Patients are directed to the most appropriate point of care for their condition.
- Health professionals are supported in the arrangement and/or provision of AH care for patients.

PROGRAM STAFF
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KEYWORDS
After Hours, after-hours care, after-hours period

APPRAOCH
The CAHML AH Program has been implemented in two phases:

Stage One (establishment of CAHML to 30 June 2013):

- AH primary care needs assessment.
- Plan to address priority gaps in AH care during the stage one period.

Stage Two (1 July 2013 – 30 June 2014):

- Re-direction of funding through CAHML to administer funds to support AH providers.
- Support for locally appropriate AH services.
- Encouragement of AH services to provide accurate, up to date service information to the National Health Service Directory (NHSD).
- Other initiatives:
  - Integration with AH GP helpline and other eHealth initiatives.
  - CAHML established two pools of funding to provide financial support to AH primary health care services:
    - Pool 1 (PIP replacement): incentive to provide AH services to GP patient populations, based on the weighted combination of AH service components being delivered by the practice.
    - Pool 2 grants program replaced the Australian Government GP After Hours Grant to provide AH services to the wider community. Pool 2 supports providers to implement innovative models of care and address gaps identified through the CAHML needs assessment.

CAHML has implemented a tiered system incorporating six levels of funding: the tiers reflect volume and comprehensiveness of care. Levels are based on the number of hours provided within the clinic and number of on-call hours, including to residential aged care facilities (RACFs). The model accounts for the size of the practice and the MBS Standardised Whole Patient Equivalent (SWPE) data.

The CAHML After Hours (AH) Program provides Australian Government funding for the provision of after hours primary health services within the CAHML region and replaced the General Practice After Hours Program and the Practice Incentive Program (PIP) After Hours Incentive from June 2013.
OUTCOMES
The Stage 1 Needs Assessment identified five priority gaps which were used to plan stage 2 implementation:
1. Consumer knowledge of what AH services exist and how to access them.
2. RACFs in the Adelaide Hills.
3. RACFs in the metropolitan area.
4. Mount Barker and surrounding region.
5. Recent migrants.

The 2013-2014 funding year practice reports indicate an increase in access to services, through awareness and extended hours thus providing a valuable service to the local community.

Key successes include:
- More than 60% of funded practices report being open ‘After-Hours’, 80% are on-call AH for general patients and approximately 70% on call for RACFs.
- An 11.2% increase in GP non-urgent AH and a 23.29% increase in urgent AH services since the commencement of the program.
- A 26.35% increase in total services to RACFs (non-urgent).
- Total services for the 2013-2014 year include 131,700 clinic consults, 28,283 services to RACFs and more than 29,690 home visits attended.
- Over 139,266 urgent AH MBS item number (sociable hours) and more than 41,056 (unsociable hours) were claimed.
- Over 75% of funded practices have details recorded on the NHSD.
- Practices have increased access to culturally and linguistically diverse communities and clients of RACFs.

IMPACT
Current analysis has highlighted the need for the provision of equitable access to AH funding to ensure community needs are met. Positive feedback from service providers funded for after-hours service provision includes:
- Enabled extended coverage of care in the after-hours period for residents of RACFs as well as phone support for nursing staff.
- Continuity of care; consumers are able to see their regular GP who knows their medical history.
- Reduced unnecessary attendance at emergency departments and ambulance transfer to hospitals for residents of RACFs.
- Increased ability to recruit and retain GPs and provide a more comprehensive service to cover community need.

DISCUSSION
The increase since the commencement of the project and further results show that the AH Program is delivering out of hours care to an increasing number of providers and consumers across the CAHML region.

KEY DOCUMENTS

“...The Medicare Local needs to ensure that the after-hours needs of the Adelaide Hills residents are not being neglected, the trend is that the after-hours availability of safe and adequate services is at increasing risk”... health provider
Stakeholder Engagement - A Critical Element

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KEYWORDS
Stakeholder Engagement, Collaboration, Inclusion, Communication, Partnerships/Relationships, Community Engagement

BACKGROUND
CAHML was committed to ensuring our key stakeholders had input into the development of our key strategic priorities and our program and service delivery. Our initial engagement work was guided by the initial Population Health Commissioning Atlas™, and recognised the vital role of engaging our stakeholders in the development of our health service delivery and health outcomes. Our 13 Foundation members provided a base initially to roll out our engagement plan that focused on improving the community’s health literacy as well as their understanding and ability to navigate the health system, especially within Aboriginal, Culturally and Linguistically Diverse (CALD) and new migrant populations.

The 2013-2014 Comprehensive Needs Assessment (CNA), which provided more detailed data on our key focus areas enabled CAHML to target its engagement. CAHML’s Engagement and Management Plan provided a consistent overarching structure to guide and support the process of engagement with communities and consumers, including wider engagement with the local health networks, health and community sectors, health providers and with Local, South Australian and Australian Governments.

OBJECTIVES
1. Ensure stakeholder engagement is embedded in the culture and core function of CAHML.
2. Inform planning, service provision and program development through a bottom up approach to service improvement.
3. Enhance collaboration, strengthen partnerships and increase linkages across CAHML’s region.
4. Identify opportunities to improve the organisation’s communication and linkages within local communities.

APPROACH
CAHML’s approach to its Stakeholder Engagement Strategy was based on the Stakeholder Engagement and Management Plan and Policy and the Communication Plan. This identified a best practice approach, including knowledge the idea, knowing the stakeholders and community, and building collaborative partnerships.

Staff worked on strengthening partnerships, enhancing collaboration and increasing linkages across the region, increasing CAHML’s presence and footprint.

In developing the Stakeholder Engagement Strategy we identified the following groups:
- External Stakeholders - community and consumers, Local Health Networks, health and community sectors, health providers, Local, South Australian and Australian Governments.
- Internal stakeholders - CAHML Board, members and staff.

It was identified early that engagement was a two way process that needed to be responsive and reciprocal. Inclusivity was crucial for all CAHML activity especially those harder to reach due to language, culture, age and mobility. It was important that information was accessible, transparent, impartial and objective. Participation and communication needed to be meaningful with a culture of sharing ideas encouraged. Lastly, stakeholders were valued and respected and their input was used to improve policy and outcomes.

CAHML was committed to improving the health of people living in our region and we acknowledged that we could not do it alone. CAHML recognised and understood that a lot of good work was already being done by external organisations in our region. We therefore partnered with our stakeholders and further advanced and enhanced this good work.

We recognised the importance of approaching stakeholder engagement in a unique manner. Being a true start up organisation we created our initial strategies listed below.

Pivotal to this success has been the relationships with members, partner organisations, Local Health Networks, Local Government Associations, service providers and community who have identified shared priorities for joint engagement.

ENGAGEMENT STRATEGIES
Central Adelaide Local Health Network (CAHNL)

A close working partnership was developed with CAHNL to progress joint health priorities. CAHNL was part of the Strategic Leadership Group for our Comprehensive Needs Assessment. We assisted the communication and distribution of information for the Advance Care Directives and changes to cervical screening procedures. We were part of the Women’s and Children’s Governing Council, CAHNL’s Strategic and Operational Executive and CAHNL’s Executive Research Committee.

We worked closely with CAHNL clinicians to develop the patient journey and referral pathways for COPD. This included working with clinicians in the hospital sector to assist with touchpoints and integration with primary care for management of COPD. We have provided input into primary service provision by CAHNL for vulnerable populations within our community, including recent arrivals, established migrants and refugees, and homeless and sleeping rough members of our community. We have provided data and been involved in discussions regarding the re-orientation of hospital outpatients and primary care services.

Collaborating in Complex Times Workshop

This externally facilitated workshop was the first wave of a strategy to collaborate with our stakeholders; an opportunity for us to have some preserved time to map out shared interests, shared planning and ultimately shared activities to reach our collective objectives of a healthy community. From here ‘Working Together Agreements’ were established with organisations mapping out joint work and objectives.

"First of all thank you for the opportunity to be invited, it was a privilege to be part of a dynamic and forward thinking group. The workshop was so informative and I will be reporting this back to our Board." Roosetta Rosali General Manager, COTA SA.

Membership/Partners in Health/Community Connectors

We have developed strong, sustainable engagement/partnership strategies underpinned by increasing membership, stakeholder partnerships, working together agreements, Community of Practice models, Partners in Health and Community Connectors groups. This provided an opportunity for sharing of communication, knowledge and involvement in education and community events.

Health Provider Engagement

Health Provider engagement and support was a critical piece of our work and was integrated across the organisation and program areas.

The mission to improve the health journey of the CAHNL community includes general practice and a range of health provider inputs along all stages of the planning to implementation and evaluation. The CNA, a range of surveys, event evaluation and provider engagement feedback has enabled strong program support, including education to best suit provider and health priorities. Effective engagement with health providers was supported by work with professional bodies and lead agencies.

Mental Health Think Tank

One major highlight of our work was this event facilitated by Dr Norman Swan that brought key stakeholders from the mental health sector together to discuss mental health, health and social sector collaboration and how to best support people with severe and persistent mental illness.

Sector representation, engagement and commitment were highly demonstrated and many positive actions and work forward have been identified. CAHML embraced the opportunity of bringing the sectors together and addressing systemic challenges whilst also consolidating systemic strengths.

Aboriginal Engagement

CAHML’s commitment to improving the health of Aboriginal and Torres Strait Islander people has taken each of us on a journey which has been both provoking both professionally, and personally. Reflecting upon the work done as an organisation, it is clear we have forged ahead and maintained our presence within the Aboriginal community and stakeholder sector by supporting community health initiatives whilst observing culturally significant events. Development of our Reconciliation Action Plan, its ratification and then implementation has set the bar for primary health organisations.

CALD Engagement

The aim of this strategy was to increase health literacy and engage in health education and promotion with women from Hispanic, Italian and Vietnamese origin. Underpinning our success in this area was the effective engagement and partnerships developed with peak bodies and lead agencies, including Multicultural Communities Council of South Australia (MCCSA) and Multicultural Rural Aged Care, MAC, Migrant Health Service, local government authorities and community groups.

Comprehensive Needs Assessment

CAHML conducted a comprehensive needs assessment in 2013-14 to better understand the health status, needs and priorities of our region. This process built on our previous Internal Needs Assessment and Population Health Commissioning Atlas™.

Over 300 consumers, health providers and key stakeholders provided information about the state of health in their local health networks, health and community sector, accessibility to and utilisation of health services and health priorities. This information was gained in a number of ways, including by on-line and face to face surveys, participation at stakeholder and community events, key stakeholder interviews and targeted focus groups.
The Hon. Jeff Kennett OAM said, "The beyondblue roadshow came to Adelaide and provided CAHML the relationship with headspace National, the Australian Governments, Aboriginal community, CALD community, new and emerging communities and media."

The beyondblue and NewAccess relationship with beyondblue and Movember culminated in a dedicated consortium with a common goal to support young people. Consistent and equitable communication via the website, fortnightly specific targeted communication plans. We have provided clear, underpinned by the CAHML Communications Policy and program sustainability across multiply sectors.

CAHML has developed and implemented strategies to manage, maintain and update effective communication within the organisation, to clients, the community, stakeholders and media. This was underpinned by the CAHML Communications Policy and program specific targeted communication plans. We have provided clear, consistent and equitable communication via the website, fortnightly e-newsletters, quarterly Yarrin Health & Wellbeing newsletter, social media (Facebook and Twitter) and the development of resources. During this period significant and extensive work has been undertaken with the Comprehensive Needs Assessment, suite of monographs and other publications.

**OUTCOMES**

All of the strategies used were designed to:

- Build relationships and trust
- Identify gaps
- Identify needs
- Build skills and knowledge
- Identify best practice

In the development of the specific engagement strategies targeting stakeholders, members, health providers, Local, State and Australian Governments, Aboriginal community, CALD community, new and emerging communities and media.

**KEY LEARNINGS**

A number of learnings arose from this process:

- True collaborative partnerships are the key to successful and sustainable stakeholder engagement.
- Working Together Agreements and Memorandum’s of Understanding identifying joint strategies and re-visioning them is a foundation to progress significant pieces of work, along with identifying the right lead person within an organisation.
- A good communication plan is essential in being able to gather and share information. It is also a valuable mechanism in building relationships and engaging across a number of sectors in an equitable and timely manner.
- Choosing the right environment and activity for effective engagement, including the use of external providers and facilities can make the difference in positive collaboration.
- Board and staff understanding and support of Stakeholder Engagement strategies ultimately drives successful collaboration and sustainable relationships across multiply sectors.

**IMPLICATIONS FOR PRIMARY CARE**

Continuing on the relationships with these identified Stakeholder groups and building on these engagement strategies will assist the transition into the new Primary Health Networks. There is joint responsibility across the sector to collaborate and find solutions with reduced resources, recognising each stakeholder’s individual worth and contribution, and committing to true collaboration will lead to better health outcomes for the community.

**KEY DOCUMENTS**

- Stakeholder Engagement & Management Plan
- Stakeholder Engagement & Management Policy
- Communication Plan
- Comprehensive Needs Assessment Infographics 2014
- CAHML Health Profile: A population health needs assessment of the Central Adelaide and Hills region 2015
- 2013 Annual Report
- 2014 Annual Report

**BACKGROUND**

Engaging with GPs provided the mechanism to build on existing good relationships and to expand the networks required to ensure a collaborative and co-ordinated approach to primary health care. CAHML recognised that general practice was imperative to primary care and we aimed to support and strengthen general practice across the region.

Medicare Locals aligned with local health networks and facilitated efforts to integrate primary health services and service providers with a greater population health focus. CAHML physical territory aligned closely with the Central Adelaide Local Health Network boundaries and to three former Divisions of General Practice.

**OBJECTIVES**

CAHML’s objectives aligned with those at a national level and specific projects focused on local priorities.

Invoking GPs in various ways assists the work of primary health organisations by:

- Increasing credibility within and outside of the profession;
- Enhancing an evidence-based practice;
- Introducing new policy initiatives such as locally focussed afterhours program and the Personally Controlled Electronic Health Record;
- Identifying the business issues faced by general practices, supporting quality improvement including practice accreditation;
- Advocacy of vulnerable patient groups who may not represent themselves.

**KEYWORDS**

general practice, primary care, engagement, clinical, advice, liaison, representation

**PROGRAM STAFF**

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**APPROACH**

A Provider Support Team was established to focus on GP engagement. However, GP engagement was embedded across all CAHML programs as part of Stakeholder Engagement.

Methods included:

- Regular communication in the form of newsletters, bulletins, and other media;
- Practice visits;
- Education events;
- Surveys, focus groups, and advisory group meetings;
- Clinician input and representation on groups and committees; for example, Clinical Governance Committee, Quality Committee, and GP Advisory group;
- GP representation at a management level on the CAHML Board;
- GPs on staff to provide ready access to GP advice and liaison to provide the link to GPs as stakeholders.

Locally, GP engagement aimed to achieve:

- A comprehensive data base and an understanding of the local workforce and population health needs;
- Tailoring of proposed activities: for example, to better meet local need or fit within general practice workflow;
- Assistance for external agencies to better tailor their activities to general practice;
- Increased use of health services for both existing and new programs;
- Greater involvement in Local Health Network outpatient reforms;
- An opportunity for GP views and perspectives to be represented.
OUTCOMES

CAHML achieved a great deal:

- More than 3200 real contacts (practice visits, meetings) with general practice staff in the 2013/2014 financial year.
- Within 12 months, CAHML more than doubled the GP reach of its communications, with 88% of general practices receiving newsletters or GP bulletins.
- Communications were largely well received.
- Education events attracted more than 1000 attendees in 2013/2014 with strong positive feedback.

The establishment of a GP Advisory Group was successful and regular meetings achieved the following benefits:

- Policy refinement that provided greater incorporation of the GP perspective, GP work processes and capability were better accounted for, patient safety improved, and policies better informed by available evidence.
- Practical assistance to general practices in the region on a variety of matters, eg Ebola, Accreditation.
- Attracting RACGP QI&CPD points for education events and tailoring of content and format to suit the needs of general practice.
- Established a positive reputation for the organisation and demonstrated a need for GP advisory and liaison services.
- Increased knowledge of and referral to, various services, contributing to increased patient numbers using mental health services.

KEY LEARNINGS

The three most important lessons from CAHML’s GP engagement experience are:

1. Change agendas can be a lengthy process to implement. It takes time to generate support and leverage that support for system improvement.
2. General practitioners wish to be represented but are difficult to persuade to be involved directly. Financial incentives are required to recompense lost consulting time.
3. For mass communication, faxes are still often more acceptable to general practice than emails.

IMPLICATIONS FOR PRIMARY CARE

Improvement efforts by Primary Health Networks (PHNs) are likely to be similar in many respects, with some of the same long-range work. Gaining support from GPs can be hard when the work is often invisible, behind-the-scenes work, with slow progress.

There are many areas of mutual interest to GPs and primary health organisations.

Opportunities exist for priority issues to be addressed during the PHN establishment phase. These priority issues are:

- Long outpatient waiting times for particular clinical specialties.
- GP-hospital communication, in both public and private sectors.
- Lack of providers of CPD/education that are not reliant on pharmaceutical company sponsorship.
- Transparent and meaningful GP engagement.
- MBS item number interpretation assistance.

BACKGROUND

The practice mapping activity was designed to identify the practices within CAHML, to better provide programs and supports for general practice. This strategy was also undertaken to identify and subsequently build connections with practices that CAHML had not previously engaged with. This increased the stakeholders database which was a useful tool to inform ongoing engagement with general practices within the CAHML region.

OBJECTIVES

The objectives of the practice mapping activity included:

- Strengthening relationships with general practice in the CAHML region.
- Promoting CAHML programs and activities.
- Informing practices of supports provided by CAHML, and building a stakeholder database for future targeted engagement.

APPROACH

The general practice engagement strategy was implemented in three phases, outlined below:

Mapping Exercise (April 2014)

- Practices in the CAHML stakeholder database were grouped by Local Government Area (LGA).
- Practice information was updated, adding and amending practice information where necessary by internal staff knowledge and information from other databases including:
  - National Health Services Directory (NHSD)
  - SA Directory of Community Services
  - Adelaide Medical Practitioners Directory
  - Yellow Pages.

Effective engagement with General Practice is critical to establish ongoing, mutually beneficial partnerships to inform the planning, development and delivery of CAHML programs. One of the most effective tools for targeted communications is a comprehensive database, therefore an engagement strategy was put in place to refine and further develop CAHML’s stakeholder database for General Practice.

PROGRAM STAFF

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Manager – Lead Cathy Zesers

KEYWORDS

general practice, database, planning, communication, connections

DATABASE MANAGEMENT (MAY-JULY 2014)

- Throughout the strategy, staff refined CAHML’s stakeholder database and added additional information from consenting practices for future engagement.

OUTCOMES

The following outcomes were identified:

- Staff were able to inform a number of practices in our region about various CAHML programs and practice supports.
- Throughout the engagement strategy the numbers of:
  - GPs recorded in our stakeholder database grew from 400 to 650, an increase of 63%.
  - Practice Health Care (PHC) Nurses recorded in our stakeholder database grew from 55 to 77, an increase of 22%.
  - Practice staff recorded in our stakeholder database grew from 71 to 114, which is an increase of 61%.
  - CAHML was able to collect information on practitioners in the region that consult in a language other than English.
- Areas of interest were recorded against 65 additional GPs, which has enabled us to promote programs and educational events that align with these interests.
The increase in data capture for GPs, PHC Nurses and practice staff over the course of the engagement strategy can be seen in the graph below:

**DISCUSSION**

The general practice engagement strategy was a useful exercise to identify practices, GPs, practice nurses and practice staff, to further develop and strengthen connections with general practice in the region. Increased knowledge allowed further planning to promote CAHML programs, and offer a range of practice specific supports. The strategy also enabled CAHML to further enhance the stakeholder database that has assisted in subsequent communications, and promotion of programs and events with general practice.

**BACKGROUND**

CAHML offers education to support CPD for allied health professionals, GPs, primary health care nurses and practice staff, to assist them to deliver high quality primary health care. Education and CPD events are an important means by which health providers maintain knowledge and skills related to their professional lives. The provision of quality CPD seeks to build the capacity of health providers to ensure their practice is relevant and up to date.

**OBJECTIVES**

CAHML CPD activities were provided in a planned and systematic way to update or extend knowledge, skill or assessment in a health area. Key objectives are to enable providers to:

- Maintain specialised competence,
- Retain and enhance effectiveness in the workplace,
- Be able to help, influence and lead others,
- Successfully deal with changes in a particular area, and
- Better assist and support the community to ensure improved health outcomes.

**APPROACH**

Events were organised and coordinated across programs within CAHML according to the events schedule. The key event organiser for each liaised with the CAHML Education Coordinator to confirm dates, venue, health provider focus, and if RACGP points were required. Planning documents and checklists were used to ensure the smooth running of events and regular meetings were held with all internal and external staff involved. All events were added to an internal events calendar and website.

Education events were evaluated by attendees and post event debriefing was conducted to ensure that quality improvements (QI) were noted and actioned. A log of QI suggestions was also maintained.

**PROGRAM STAFF**

Lizsa Myers, Cathy Zesers, Janean Lillard, Emma Jarvis, Madeline Collins, Dr Brownyn Knight, Dr Danny Byrne, Nathanael Brown, Cathy Caird.

Manager - Cathy Zesers

**KEYWORDS**

Education, Quality, CPD

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**GPs recorded in our stakeholder database grew from 400 to 650, an increase of 63%**

**Practice Nurses recorded in our stakeholder database grew from 55 to 77, an increase of 29%**

**Practice staff recorded in our stakeholder database grew from 71 to 114, which is an increase of 61%**

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**42 provider education events**

**1550 attendees to education events**

"Excellent programs, definitely focused for the primary care professionals - PRACTICAL. Thankyou..."
OUTCOMES
In 2014, 42 education events were run with over 1,550 attendees. Of these, nine events had RACGP points attached to the activity. Events ranged from small workshop styles sessions and standard CPD evening sessions to large scale forums and events of over 170 attendees i.e. Ebola virus update (pictured) which was in response to outcomeS
CAHML also produced high quality short videos to enhance health provider engagement and knowledge in areas such as cultural awareness, primary care nursing and the needs of culturally and linguistically diverse communities.
Some positive feedback from events included:
“Speaker was absolutely fantastic. I can’t wait to use these strategies personally and at work with clients...”
"Well organised, diverse and interesting topics"
"Overall it was a well organised education session, because it is hard to meet everyone’s needs. Thanks for organising and all the presenters."
“....Thank you very much for last weekend’s seminar, I enjoyed it very much and found it useful. Thank you for all your effort...”

KEY LEARNINGS
It is important to consider the needs of the target audience with regard to logistical considerations; including car parking options and comfort to structure and content; what is the event trying to achieve and what are the key learning objectives? Sessions that have had a practical application have been well received. In order to best target an event, needs analysis of provider needs at the beginning of each year to inform content for planning has been valuable. Choosing topics that relate to the needs of the CAHML population as well as health providers within the region has been critical to achieving good attendance rates.
The value of networking and communication opportunities between providers shouldn’t be underestimated.
Invest in coordination and administration support for events, as administration and documentation can be time consuming and requires a team effort, especially for large scale events. Knowing who needs to do what and when including budget considerations, staff capacity, planning and timing makes all the difference.

IMPLICATIONS FOR PRIMARY CARE
Having the RACGP QMCPD points does add an externally validated measure of quality to education events. Working with new areas where there is a need can be exciting and produce rewarding outcomes.

KEY DOCUMENTS
RACGP QMCPD program 2014-2016 Triennium.
http://www.racgp.org.au/education/qicpd-program/

Practice Managers’ Network: Supporting Leaders in Quality Health Care

The following is an outline of the development and implementation of the Central Adelaide and Hills Medicare Local (CAHML) Practice Managers’ Network. This Network formed the basis of the work undertaken by the Health Provider Liaison Officer, and was one of the key engagement activities employed by the Provider Support Team.

BACKGROUND
CAHML undertook a general practice needs assessment in early 2013 that guided planning for essential Practice support for local providers. As Practice Managers (PMs) are often considered a gateway into general practice, it was obvious that the development and coordination of a Practice Managers’ Network (PMN) would be a key step towards the provision of this support.

OBJECTIVES
The PMN was established in order to meet organisational objectives around engagement, innovation and collaboration. The objectives of the PMNs have been:
• To provide assistance, support and guidance for those PMs undertaking preparation for Accreditation against the Royal Australian College of General Practitioners (RACGP 4th standards).
• To provide a forum for discussion and networking opportunities.
• To provide opportunities for PMs, such as training, scholarships, education and project participation opportunities.
• To provide a quality education on topics that meet an expressed need.
• To assist PMs to develop connections with colleagues and external providers.

APPROACH
An engagement strategy and a toolkit of resources and information were created by CAHML. A PM Needs Assessment and Liaison visits were undertaken, and included some “cold-calling”. Some PMs were asked what they felt was lacking in service provision in the local region, and relationships began to form. Whilst initially a slow process, over time these relationships have grown.

Engagement strategies employed for PMs included:
• Delivery of education and networking events focused on needs, with a feedback loop maintained.
• Quarterly email communication to the PM email distribution list with relevant sector news and updates. Positive feedback from these email communications was frequently received.
• Provision of opportunities for PMs, such as training, scholarships, education and project participation opportunities.
• Communication support service – PMs contact CAHML via phone or email and receive a prompt response and support from any query, from MBS item questions, through to business planning, HR management and Accreditation support.

PROGRAM STAFF
Emma Jervis, Health Provider Liaison Officer,
Manager – Lead Cathy Zesers

KEYWORDS
Practice Manager (PM), network (PMN), engage, educate, opportunity, quality, improvement
The provision of accreditation support was a successful undertaking. The PMN events continue to be well received, with high rates of participation. The PMN grew exponentially through 2013 and 2014, culminating in almost 110 PM contacts by the end of the latter. This connection enables information and relevant opportunities to be communicated to the network.

The PMN events continue to be well received, with high rates of completion and a high frequency of requests by PMs outside of our region due to a lack of local support in their area. Comments from participants in the PMN regarding the Network events include:

- Attendance continued to grow at these events, with average numbers approaching 40 attendees at each session. On average, 91% of participants rated attendance at the Network events to be relevant and useful to their day to day work.
- Another significant outcome of the PMN was the roll out of a package of support for general practices requiring help in gaining accreditation. The provision of accreditation support package was a successful undertaking. The reputation of the accreditation support package grew. Comments from PMs who have received accreditation support include:

  - The value of engagement. It is important to engage the correct people to be involved in Network events.
  - Responding appropriately and efficiently to feedback, and being flexible and willing to improve as a result of this feedback is vital.
  - Meaningful and relevant information must be provided in a concise and useful way.
  - It is important to ensure communication is frequent, responses are prompt and information is disseminated efficiently and effectively.
  - Interactions work best when based on a reciprocal relationship. General Practices, although busy, have a willingness to participate and volunteer time and energy towards assisting the Network.
  - Collaboration with organisations such as AAPM provides sustainable network options.

**KEY LEARNINGS**

With the growth of the PMN came a number of key learnings:

- PMs are a driving force in General Practice. They maintain, monitor and improve the working environment, having a substantial impact on the quality of care that is delivered in this primary care setting. Continuing to support PMs through the provision of a successful PMN will enhance the systems and outcomes for primary care.

**OUTCOMES**

The PMN events continue to be well received, with high rates of participation. There have been numerous requests by PMs outside of our region due to a lack of local support in their area.

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  - Meaningful and relevant information must be provided in a concise and useful way.
  - It is important to ensure communication is frequent, responses are prompt and information is disseminated efficiently and effectively.
  - Interactions work best when based on a reciprocal relationship. General Practices, although busy, have a willingness to participate and volunteer time and energy towards assisting the Network.
  - Collaboration with organisations such as AAPM provides sustainable network options.

**IMPLICATIONS FOR PRIMARY CARE**

PMNs are a driving force in General Practice. They maintain, monitor and improve the working environment, having a substantial impact on the quality of care that is delivered in this primary care setting. Continuing to support PMs through the provision of a successful PMN will enhance the systems and outcomes for primary care.

**KEY DOCUMENTS**

For more information about the role of the Practice Manager, please visit the Australian Association of Practice Management website: [http://www.aapm.org.au/](http://www.aapm.org.au/)

**BACKGROUND**

CAHML was established in 2011 and since its inception, engagement and connection with and between a broad range of primary health care providers has occurred. PHC Nurses are at the forefront of primary health care and share the characteristic of being part of the first level of contact within the health system. Nurses working in general practice can experience autonomy and independence, and at the same time express peer isolation.

**OBJECTIVES**

- To provide support and increase the number of PHC Nurses connecting with CAHML and the PHC Nurse Network.
- To collaborate, provide a CAHML PHC Nurse and multi-disciplinary professional development program.
- Identify and support innovative practice opportunities for nurses working within a range of settings including Aboriginal health, schools, prison health, aged and community and schools.
- To advocate for recruitment and retention of nurses within the region, with a focus on general practice.
- To increase engagement of multi-cultural PHC Nurse groups.

**APPROACH**

CAHML’s quality face-to-face professional practice events has provided a valuable nurse networking opportunity that cannot be underestimated. Broadening a network to include nurses from all primary care settings has been a trademark initiative of CAHML.

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**OUTCOMES**

To engage a wide network of primary health care nurses and grow a vibrant network between members, offering support from nurses to nurses.

According to CAHML data, there were 205 PHCs working in the region in August 2013. CAHML is connecting with 168 nurses in February 2015!
• 14 PHC Nurse specific education/network events were offered 2013-2014, and many other multidisciplinary events for nurses to attend were also offered.
• Many nurses from other regions outside of CAHML made contact and connected with the CAHML education and support program.
• More than 50 One-on-One support visits to nurses working in General Practice.

Participant comments following a variety of PHC Nurse network events:

“Really worthwhile event to –increase profile of MLs role and capacity, offer opportunity for nurses to network, education.”

“Really informative, will definitely increase quality of care for our patients”

“Very informative and interactive, Presented at a pace that is easy to take in. Thank you”

“Really enjoyed the format and atmosphere of the day”

“Extremely valuable workshop”

Working with Allied Health - Connecting Care

Allied health significantly contribute to the health and wellbeing of our local community, and Central Adelaide and Hills Medicare Local (CAHML) recognises that allied health professionals (AHPs) in private, public and community sectors are key partners in the delivery of integrated primary health care.

KEY LEARNINGS

• Nurses are networkers! Spread the word and nurses will connect.…..
• Nurses in primary health care need a local support body, this is expressed time and time again.
• Listen to the nurses, their needs, ‘what are the gaps’ – they will inform you! Plan ways to obtain feedback from the network and use the information in any planning.
• Be approachable and supportive, this is all that’s asked! CAHML did not have the answer to all the queries, though we always responded and were supportive.

BACKGROUND

CAHML has worked in collaboration with allied health professionals and peak bodies across a range of programs including Access to Allied Psychological Services (ATAPs), Healthy Weight, Chronic Obstructive Pulmonary Disease (COPD) and Healthy Ageing. These partnerships have been integral to these programs and enhance the delivery of health services to consumers in the region. AHPs are continually seeking ways in which to better connect with the system to support the patient journey. Building connections with a range of public and private AHPs is an integral part of the connecting care function of CAHML.

OBJECTIVES

The key objectives of connecting with allied health were to:

• Actively engage with the allied health sector to build the capacity of services and to improve the delivery of coordinated care with a focus on priority areas identified via the Comprehensive Needs Assessment (CNA).
• Identify and address training/education opportunities for allied health providers, increasing competence and capacity of the sector and improving the links between different points of care.
• Respond to identified consumer health needs that would benefit from allied health involvement such as chronic disease management, pre- and post-acute care (including hospital avoidance) and co-ordination.
• Work closely with individuals and groups to promote and advise the allied health sector of specific initiatives such as eHealth, data management, quality initiatives and business development opportunities (such as MBS item utilisation, private health insurance models etc.).
• Work in conjunction with the Central Adelaide Local Health Network (CALHN) and the allied health sector to support access for Aboriginal people and special needs group e.g. people who are homeless or sleeping rough, people with disabilities).
• Undertake an active program of stakeholder engagement and communications to promote access to allied health care, and provide information on local allied health services and programs.

APPROACH

CAHML has focused on building relationships with peak bodies, AHP services and individual service providers, developing a communication strategy, and building a functional AHP data base to understand allied health services within our region. Active engagement has also occurred through key strategies such as AHP specific education and events and through progressing a Community of Practice (CoP). The CoP brings together AHPs from both public and private sectors across the region to:

• Share evidence and information,
• Promote evidence-based practice and clinical innovation,
• Share ‘out-of-the-box’ knowledge,
• Develop professional relationships,
• Identify and strengthen referral pathways,
• Solve identified problems and address barriers,
• Strengthen multi-disciplinary partnerships and networks.

Reference groups with AHP representation have also included the COPD Reference Group, and the CAHML Clinical Governance Committee. The interest and involvement in these groups stemmed from specific AHP events hosted by CAHML. The opportunity to invite participation in allied health and pharmacy grants was also provided.

PROGRAM STAFF

Janeen Lallard, Nathaniel Brown, Lizza Myres, Madeline Collins, Cathy Caird, Dr Bronwyn Knight, Dr Danny Byrne and Emma Jarvis (Health Provider Team)
Manager – Lead Cathy Zesers

KEYWORDS

Allied Health, Allied Health Providers (AHPs)
OUTCOMES

AHP specific events:
More than 350 AHPs have registered for CAHML events including topics such as COPD, healthy ageing (including falls prevention), chronic pain and healthy weight. These events have allowed opportunities for capacity building and education, pathways exploration and design and communication and linkage strategies.

AHPs were involved in the comprehensive needs assessment (CNA) process and were also linked into the feedback sessions at the CNA completion which allowed for further opportunities to identify needs and support them to utilise local level information in their own planning activities.

Two allied health forums were run in consecutive years (2013 and 2014) and involved more than 150 allied health and pharmacy providers. The first forum in 2013 focused on ehealth and the second on building a healthy business, incorporating marketing, working effectively with general practice and consumer engagement. The second forum also introduced cultural competency training to this group of private providers, something that is quite a new initiative for AHPs.

Communities of practice:
A CoP specific to healthy ageing was a combined activity of allied health and ageing programs and included a multi-disciplinary group coming together regularly to discuss topics of importance in aged and community care.

Program collaboration:
AHPs have also contributed to programs including ATAPs, COPD, Healthy Weight, and Closing the Gap. Liaison and shared work group opportunities with CALHN have also involved multi-disciplinary and multi-sector collaboration to address improvements and redesign of services such as falls prevention, memory clinics and outpatient services.

Six grants for allied health projects were also provided, addressing COPD, diabetes, social integration, falls and chronic pain.

KEY LEARNINGS

AHPs are keen to collaborate with general practice to provide better connected care. Improved and more viable business models for AHPs are continually sought with providers keen to support clients and further integration with general practice, yet funding models have been a common challenge. Specific learnings include:

- Team based patient centered care i.e. AHPs connecting and communicating in a two way or shared record with general practice, produce optimal outcomes for patients. Positive examples include APCC models around COPD, the Coordinated Veterans Care Program and anecdotally, the Diabetes Care Project.
- AHPs are keen to be involved in shared advisory/ reference groups e.g. Clinical Governance and educational opportunities.
- Collaboration around key topic areas such as ageing are critical to improve outcomes and respectfully acknowledge professional input and skills that each member of the team can bring.
- Funding opportunities that encourage AHP integration and acknowledge their key role in the health care team are vital, particularly with our ageing population.
- Consumer engagement and a continued understanding of the allied health patient journey should continue to be fostered into the future.

KEY DOCUMENTS

- CAHML Guide to MBS item numbers
- MBS online - www.mbsonline.gov.au

Nurses Supporting Nurses …across Primary Health Care

A CAHML priority has been to support health professionals who are at the forefront of primary health care (PHC). The PHC Nurse Mentor Panel and the broader nurse network coordinated by the Health Provider Clinical Liaison role have been key to the successful engagement with nurses across the region.

BACKGROUND

CAHML recognised that there are primary health care nurses with a wealth of knowledge, enthusiasm and who show leadership and innovation, and therefore the idea of a PCH Nurse Mentor Panel was born!

OBJECTIVES

- For CAHML to receive feedback regarding current gaps and needs in supporting nurses working in various primary health care settings.
- Provide a supportive network opportunity and mentorship to primary health care nurses, as identified and appropriate.
- Provide expertise in health care areas according to qualifications and experience.
- Contribute to, and be involved in continuing professional development activities for nurses.
- Participate in the development of health care initiatives focused on patient health care outcomes that would potentially be integrated into PCH Nurse Practice.

PROGAM STAFF

Janeen Lallard, Litza Myers
Manager – Lead Cathy Zesers

KEYWORDS

Nurse Mentor, Primary Health Care Nurse Network

APPROACH

It was time for a fresh approach to provider support. CAHML welcomed the experience, but we wanted to do it differently... so we spread the word...

We asked?... And they came... from General Practice, the LHN, Aged care and GP Training Organisations.

A response to a simple Expression of Interest indicating areas of interest/ experience and areas for growth, was all that was needed to get the “ball rolling” on this innovative initiative!

The nurses were looking for a network, for updates, for leadership opportunities, to supervise students... And to continue their learning. The nurses found a group of like-minded professionals to network with!
OUTCOMES
A panel of experienced PHC Nurses continued to engage and work with CAHML on primary health care initiatives and to gain from the network in their own career pursuits. Ten (10) members constitute the Nurse Mentor Panel from a range of settings:

- Practice Nurse/Nurse Manager role; Associate Professor – Lecturer in Nursing; Nurse Practitioner Candidate; Nurse Liaison – GP Training Organisation; Nurse/Practice Manager; and State Health Policy Advisor – Chief Nurse Office.

Panel initiative outcomes included:

- 9 Nurses completed the Leadership & Mentoring training
- 5 nurses applied and were all successful in receiving a small CPD scholarship promoting capacity building
- Production of a film piece promoting PHC nursing
- National Conference for PHC nurses abstract presentation

WHAT HAVE THE NURSES SAID?

“I feel very fortunate to be part of such an enjoyable and professional group.”

“Although I have attended other leadership training, this has been the most relevant to practice and has demonstrated the application of principles so well.”

“I have very much appreciated being involved; it has challenged my thinking, and caused me to reflect on my practice. The connections with others, and the benefit of sharing experiences is very valuable. I look forward to opportunities to connect with, and help other primary health care nurses. PHC Nurses can be very isolated – this is a valuable avenue to provide links and connection.”

KEY LEARNINGS
Regular communication with a network supports continued engagement.

- Reach out and find the people, be visible and active!
- Listen to those at the forefront of primary health care – they will engage with an organisation who not only asks but acts on responses
- Nurses supporting nurses – a nurse has the ability to understand nurses and therefore supports where it is needed
- Nurses are a valuable resource to be optimised. Seek input, and learn from these skilled professionals.

IMPLICATIONS FOR PRIMARY CARE
Do not plan from a ‘funding level’ only. Find out what is working well; what the gaps are; and from nurses at the forefront, who, how & when is needing support and resources.

OBJECTIVES

- To increase the number of pharmacies within the CAHML region and beyond that are known by the Aboriginal and Torres Strait Islander community as being friendly, welcoming and knowledgeable places.
- To further extend this training to any Allied Health provider and their staff within the CAHML region.
- To support the CTG measures around Quality Use of Medicine, and increasing access to Allied Health Services.

BACKGROUND
In 2013-2014 Central Adelaide and Hills Medicare Local (CAHML) undertook a Comprehensive Needs Assessment which highlighted the poor health outcomes facing the approximate 4830 Aboriginal and Torres Strait Islander people living within the CAHML area. Alongside this a Reconciliation Action Plan 2014-2015 was created and implemented, outlining CAHML’s vision and commitment to Reconciliation.

Subsequently a survey was sent to all pharmacies within the CAHML area and included questions asking whether pharmacists felt they were seen as Aboriginal and Torres Strait Islander friendly places. The majority of the respondents stated that “they hoped so”, but were “not really sure if they were”, and then were unsure what they needed to do.

In response a training package has been developed following extensive research and consultations with the Aboriginal and Torres Strait Islander Community, CTG Team, pharmacy and allied health practitioners. Five training videos have been designed to bring to life some of the issues facing Aboriginal and Torres Strait Islander people when accessing Community Pharmacy and Allied Health services and to be a practical guide in the provision of services.

PROGRAM STAFF
Nancy Bates, Cathy Caird
Manager – Lead Cathy Zesers, Danielle Grant-Cross, Maryl Horsnell

KEYWORDS
Connecting, Aboriginal and Torres Strait Islander health, Pharmacies

Connecting Pharmacy and Allied Health with Aboriginal and Torres Strait Islander Communities Training Package

Nurses leading the change in Primary Health Care across Central Adelaide and Hills

CONNECTING PHARMACY AND ALLIED HEALTH WITH ABORIGINAL AND TORRES STRAIT ISLANDER COMMUNITIES TRAINING PACKAGE

Increasing the capacity of Pharmacy and Allied Health to build cultural competence and connect with Aboriginal and Torres Strait Islander communities is the purpose of this training package, with a particular focus on supporting the Closing the Gap measures specific to Quality Use of Medicine, and increasing access to Allied Health Services.

BACKGROUND
In 2013-2014 Central Adelaide and Hills Medicare Local (CAHML) undertook a Comprehensive Needs Assessment which highlighted the poor health outcomes facing the approximate 4830 Aboriginal and Torres Strait Islander people living within the CAHML area. Alongside this a Reconciliation Action Plan 2014-2015 was created and implemented, outlining CAHML’s vision and commitment to Reconciliation.

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OBJECTIVES

- To increase the number of pharmacies within the CAHML region and beyond that are known by the Aboriginal and Torres Strait Islander community as being friendly, welcoming and knowledgeable places.
- To further extend this training to any Allied Health provider and their staff within the CAHML region.
- To support the CTG measures around Quality Use of Medicine, and increasing access to Allied Health Services.
Training of this kind can have profound positive implications on outcomeS for primary care.

However what is required is ongoing training and resources made available for the Facilitators to continue to deliver this package at a state and national level.

The funding for the timing of the videos was limited as well as having time constraints. Ideally some of the videos would be filmed again after training at the pilot sites was undertaken.

OUTCOMES
Training has been delivered at three community pharmacy sites, and feedback collated to enhance future delivery. Further training sites have been identified through promotion of the training package with initial feedback being extremely positive about the value of this training package.

KEY LEARNINGS
- There are some excellent resources available regarding the health issues facing Aboriginal and Torres Strait Islander people. However limited resources are available to assist in putting the learnings into practice.
- The response and interest to the training package has been high.
- The response and interest to the training package has been high.

IMPLICATIONS FOR PRIMARY CARE
Training of this kind can have profound positive implications on the health of Aboriginal and Torres Strait Islander people. However what is required is ongoing training and resources made available for the Facilitators to continue to deliver this package at a state and national level.

KEY DOCUMENTS
CAHML’s Connecting Pharmacy and Allied Health with Aboriginal and Torres Strait Islander Communities - Training Package

BACKGROUND
Our initial engagement work was guided by the Population Health Commissioning Atlas™ around improving the community’s healthcare literacy as well as their understanding and ability to navigate the health system, especially within Aboriginal, CALD and new migrant populations. Our aim was to create supportive environments, strengthen community action, and develop the community’s personal health planning and coping skills.

In 2013-14, a Comprehensive Needs Assessment (CNA) gathered information on access to and utilisation of primary health care services to identify the population groups within the region, at the greatest risk of poor health outcomes.

These were:
- Culturally and Linguistically Diverse (CALD) communities;
- Aboriginal and Torres Strait Islander communities;
- New and Emerging Migrants;
- The ageing population; and
- Youth.

CAHML recognised that to achieve a comprehensive, ongoing community relations program it required the active participation and contribution of all Board members, staff, sub-contractors and key stakeholders within our region. Further to this, the commitment to developing relationships and engaging with communities resulted in the development of the Stakeholder Engagement team, including recruitment of specific community engagement and Aboriginal Community Engagement staff.

OBJECTIVES
Community engagement set out to achieve:
1. Engagement with priority communities by building collaborative, trusting partnerships;
2. Improving health literacy and the community’s understanding of the health system;
3. Improving the community’s ability to navigate the health care system;
4. Creating supportive environments, valuing diversity and respecting culture, backgrounds, needs and aspirations;
5. Strengthening community action and developing health planning, disease prevention and coping skills; and
6. Receiving community feedback and suggestions about activities and achievements.

APPROACH
CAHML’s approach to community engagement was based on the International Association of Public Participation’s (IAP2) principles and spectrum for public participation.

This identifies best practice, establishes the mechanisms for analysing appropriate engagement levels for each situation and outlines the suggested goals and methods.

In developing the community engagement strategy, with particular focus on our most vulnerable communities, key stakeholders were identified as:
- External Stakeholders: Community groups and members, CAHML members, health consumer groups, government agencies, Councils, non-government and not-for-profit organisations, cultural organisations
- Internal Stakeholders: CAHML staff and Board.

Engaging with the Community: Count Us In

Effective community engagement enhances service and program planning, informs policy development and improves service delivery and program development. Central Adelaide and Hills Medicare Local (CAHML) has been successful in building community relationships and gathering valuable information from individuals, to identify health priorities and gaps in primary care with a particular focus on those at greatest risk in our region. Paramount to this engagement was ensuring consideration was given to the diversity that exists within our community.

PROGRAM STAFF
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Manager: Danielle Grant-Cross

KEYWORDS
Community engagement, stakeholder relationships, public participation, community relationship, Comprehensive Needs Assessment
CAHML COMMUNITY ENGAGEMENT STRATEGIES

- Invitations and involvement in workshops and focus groups
- Citizen’s Jury
- CAHML fortnightly eNewsletter
- CAHML website: information, resources and feedback pathways
- Production and dissemination of health publications
- Translation of health literature to other languages
- Media activity: local papers and radio
- Social media presence: Facebook and Twitter
- Presence in community newsletters
- Presence at cultural events and community activities.

CAHML COMMUNITY ENGAGEMENT ACTIVITIES

There have been a number of successful engagement activities as outlined below.

Aboriginal Health

Strategies include:

- Presence at cultural events and community awareness days;
- Cultural Competency Training for internal staff and external stakeholders;
- 2014 Immunisation Blitz
- Nunga Women’s Wellness Clinics
- Aboriginal Mums Group
- Healthy Eating Activity and Lifestyle (HEAL™) program facilitator training for Aboriginal Health Workers.

Beyondbus Roadshow – Adelaide, April 2014

CAHML staff members engaged with community at seven locations to raise awareness about mental health and to promote beyondbus NewAccess Program.

CALD Women’s Health Forums

A series of CALD forums were held to engage with women in the CALD community in collaboration with the Cancer Council, SA Cancer Screening, BreastScreen SA and Community Access and Services SA, along with relevant cultural organisations and general practice.

The forums provided specific women’s health promotion, health information and education to women of Hispanic, Italian and Vietnamese origin.

Community Connectors

This group was established to enable the community to receive communication and to be involved with activities, events and focus groups. An electronic database provided the avenue for regular engagement.

Citizen’s Jury on Obesity – May 2013

Community members were invited to take part in this Citizen’s Jury that explored the management of obesity and bariatric surgery and funding. Refer to Healthy Weight Strategy for more information.

Comprehensive Needs Assessment (CNA) Focus Groups – 2013/14

Collaborative partnerships were established with Multicultural Communities Council SA, Multicultural Aged Care and Carers SA to engage with their clients and members around their primary health care experiences and needs.

Focus groups included the established CALD communities and members from the Chinese, Indian, Italian, Greek, Vietnamese, Spanish, Serbian and Croatian communities who expressed their concerns as health consumers, and discussed the programs and services most usable.

New and Emerging Migrant communities included members from the Turkish, Liberian, Sierra Leone/Robb, Burmese, Bangladeshi, Rwandan, Afghani, Sudanese and Ethiopian communities who provided their input with regards to their concerns, needs and barriers experienced.

Engaging with the Ageing 2013/14

Focus was given to the Falls Prevention strategy and specifically the Falls & Falls Education Sessions. A partnership was developed with the Council of the Ageing (COTA) where multiple education sessions were coordinated through their peer education program.

This partnership extended into the sponsorship of the Annual Every Generation Festival in 2013 and 2014 where community members were recognised for their contribution to the older population.

A partnership was also established with Active Ageing Australia through sponsorship of the Annual Forum in 2013 and 2014 and the ‘Will you still need me when I’m 64?’ Community Debate in 2014. This relationship extended into the sponsorship of the Falls Prevention website administered through Active Ageing SA.

CAHML, along with other stakeholders were part of Living Well Expo’s in the Western and North eastern suburbs.

Local Councils

CAHML’s 13 local councils played a significant part in our engagement process. Some were more engaged than others as a reflection of our key priorities. CAHML contributed to the public health planning for many of the councils, and councils were represented on our Strategic Leadership Group. CAHML’s Immunisation Blitz closely connected with councils and assisted their own immunisation strategies and promotion.

Beyondbus’s NewAccess program was also heavily promoted to councils, libraries and community centres.

Mental Health ThinkTank with Norman Swan – August 2014

This event reflected true engagement from the grass roots up. With CAHML Partners in Recovery (PIR) a Mental Health ThinkTank provided service providers in the mental health, health and social sectors along with consumers, carers and peak bodies the opportunity to contribute to building an integrated and collaborative care and systemic change.

OUTCOMES

Community Engagement has been embedded within all CAHML programs and teams. All staff are responsible for this engagement which is part of their daily work. Through effective community engagement, CAHML has been successful in being part of over 70 Community consultations and 33 Community Events.

CAHML:

- Built relationships and trust
- Identified gaps
- Identified needs
- Built skills and knowledge
- Identified best practices.

Through embedding community engagement principles across the organisation, CAHML has undertaken coordinated, collaborative and culturally appropriate approaches to engaging with vulnerable communities within our region.

KEY LEARNINGS

The process of community engagement has provided many opportunities to learn and improve the way subsequent activities have been developed.

The main learnings have been:

- Establishing positive and transparent relationships and allowing for feedback that informs future engagement approaches;
- Engagement is a participatory process;
- Involving community members in decision making entails much more than consulting or providing information;
- Joint planning, monitoring and evaluating creates a shared responsibility and accountability toward shaping health service delivery and improving health outcomes that benefit the community;
- Understanding and respecting the needs and aspirations of community members builds trust and respect; and
- Closing the loop with participants to let them know how their input has contributed shows an appreciation for their effort and increases the chances of them participating again in the future.

IMPLICATIONS FOR PRIMARY CARE

Community engagement must remain a key priority for primary health care, learning from what has occurred previously and creating new opportunities to enhance public participation.

For Primary Health Care to be effective there is a need to:

- Understand the healthcare needs of the community through listening to what they have to say, creating regular opportunities for this to occur.
- Understand where the gaps exist and who is most at risk of falling through the gaps.
- Look at varied engagement activities and work with other stakeholders to achieve this.
- Respond to needs in a timely and culturally appropriate manner.
- Share the learning and understanding in the form of best practice models.
- Work collaboratively with a broad range of providers to ensure a coordinated and relevant health service that addresses the needs of our most vulnerable communities.
- We would encourage continued engagement with councils
- Specific community engagement strategies for the Aboriginal and Torres Strait Islander community.
- Establish Community Advisory Groups that are reflective of the diverse nature of the communities across the region.
- Enable transparent feedback between patients and health professionals.

Acknowledgement of Key Stakeholders

- CAHML Stakeholder Engagement Team
- CAHML Provider Liaison Team
- CAHML Staff and Board
- Active Ageing Australia
- Carers Association of SA
- Council of the Ageing (COTA)
- Health Consumer Alliance
- Lutheran Community Care Refugee Services
- 12 Local Councils within the region
- Migrant Resource Centre
- Migrant Health Service
- Multicultural Community Council of SA Inc
- Multicultural Aged Care
- Uniting Care Wesley Port Adelaide
Connecting with the Aboriginal Community

Genuine engagement with the Aboriginal and Torres Strait Islander community has driven significant health improvements, and fostered culturally competency across Central Adelaide and Hills Medicare Local (CAHML).

**PROPROGRAM STAFF**
Nancy Bates, Lorraine Hunter, Angela Newbound, Tom Cotes
Manager – Lead Danielle Grant-Cross, Maryl Horsal

**OUTCOMES**
Aboriginal employment
CAHML has achieved a high rate of recruitment and retention of Aboriginal staff.
The SA Aboriginal population is approximately 30,000 (ABS 2011) making up 1.9% of the overall population.
CAHML has achieved an employment rate for Aboriginal people of approximately 10%.

Aboriginal agency relationship building
CAHML greatest strength in achieving set targets for improvements in health outcomes has been in the relationships we have built with Aboriginal agencies, and the joint response to those health needs.
- Aboriginal Health Council of South Australia (delivery of Immunisation education to Aboriginal Health Workers and sponsorship of NADDOC Aboriginal Health Awards 13/14, partnership for launch of Keep It Coma campaign).
- Nukkuwarrin Yunti of SA (funding for ATAPS services, HEAL training for Healthy Lifestyle Workers, funding for Care Coordination CTG).
- Kura Yani (Delivery of childhood immunsinations and partnership to connect with Aboriginal families).
- Tandanya National Cultural Institute (sponsorship of Spirit Festival 14/15 and delivery of immunsinations and promotion of CTG and mental health services).
- Kalaya Aboriginal Children’s Centre (Immunisation Days and reminder system developed).

Aboriginal Childhood Immunisation
Tasked with improving rates of childhood immunisation for Aboriginal children in our region, CAHML has been instrumental in reducing the rates of Aboriginal children that have not been immunised.
This has been achieved through partnerships with SA Health, Local Health Networks, Aboriginal Health Council of SA, Local Councils and Immunisation Service Providers.

The establishment of a steering group made up of Aboriginal women from the CAHML region guided strategic directions, communication of immunisation messages, and created greater community reach. This group created an online social media campaign via Facebook Immunisation Blitz to highlight the need for timely childhood immunisation.

**Events and Celebrations**
CAHML’s internal relationship with Aboriginal staff has in turn created opportunities to support and participate in significant events and celebrations. These include:
- National Apology Day (sponsorship and attendance of Reconciliation SA’s Anniversary Breakfast 2013-15).
- Reconciliation Week (Sponsorship and attendance at Reconciliation SA’s Annual Breakfast 13/14/15).
- NADDOC Week (Stall holders at NADDOC Family fun Day 2013/14).
- Close the Gap Day (Health promotion in West and Adelaide Hills).
- Spirit Festival (Sponsorship and health promotion).
- Aboriginal Football and Netball Carnival 2013/14 (event sponsorship, health promotion and immunisation service).

**Uptake of Mental Health Services**
The Partners in Recovery Program have demonstrated that an internal focus on service provision to Aboriginal and Torres Strait Islander people results in a high level of engagement and uptake of services at an average engagement rate of 11%
ATAPS employs an Aboriginal Outreach Worker to support promotion of these services to the Aboriginal and Torres Strait Islander community, and their service providers. This role strengthened referral pathways, established relationships, and promoted the service.

headspace Woodville ensured that young Aboriginal people were engaged with service planning and ongoing delivery as members of headspace youth reference group. This engagement has led to cultural inclusion in the design of the service and communication strategies.

beyondblue’s NewAccess program widely promoted services to the Aboriginal and Torres Strait Islander community at key community events, online, and via our e-newsletter Yarin’ Health and Wellbeing. All NewAccess coaches received cultural competency training.

**Cultural Competency**
CAHML has committed to cultural competency training with the Centre for Cultural Competency Australia which is online and accredited. 87.5% of all staff completed this training.

In addition, CAHML staff have participated in face-to-face training and cultural activities to both complement and build cultural competencies.

CAHML developed a cultural competency training package for...
Connecting with the Aboriginal and Torres Strait Islander people for the purpose of responding to health needs requires genuine engagement underpinned by the following principles:

- **Meaningful engagement begins with an Aboriginal staff recruitment strategy to attract cultural advisors, community connectors, service planners, deliverers, and as experts.**
- **Relationships are key, and taking the time to build trust, demonstrate integrity and create shared goals is essential for reaching targets.**
- **Engagement is a participatory process therefore involving Aboriginal people and agency in decision making is about more than consulting or providing information.**
- **Joint planning, monitoring and evaluation creates a shared responsibility and accountability framework, thus building reputation.**

**IMPLICATIONS FOR PRIMARY CARE**

Best practice in Aboriginal and Torres Strait Islander community engagement requires adopting international frameworks, such as the United Nations Declaration on the rights of Indigenous Peoples, due to the absence of a comprehensive legal framework or treaty that upholds rights for First People in Australia.

International frameworks insist on giving First People significant control through investment in building Aboriginal and Torres Strait Islander governance capability, and the resources to do so, with a commitment to inclusion in decision making.

IAP2 principles are also integral to the engagement process as captured in CAHML’s Stakeholder Engagement & Management Plan, Stakeholder Engagement & Management Policy, Community Relations Policy and Communication Plan. This identified best practices, knowing the issues, knowing the stakeholders and community, and building collaborative partnerships and knowing the importance of collaborative partnerships.

In terms of improving health outcomes, Aboriginal and Torres Strait Islander communities must determine their needs, so that Primary Health organisations establish shared goals through meaningful and frequent participation in service planning, provision and review.

**KEY DOCUMENTS**

Central Adelaide and Hills Medicare Local - Snapshots in Primary Care

2012 Annual Report
2013 Annual Report
2014 Annual Report
CAHML Population Health Profiling + Needs Assessment + Commissioning, an Overview
CAHML Health Profile: A population health needs assessment of the Central Adelaide and Hills region 2015
SA - CAHML fact sheet
What you need to know – CAHML Information Sheet

Monographs:
- Population Screening Profile
- Ageing Population and Associated Needs
- Chronic Obstructive Pulmonary Disease
- Healthy Weight Population Health
- End of life care

Central Adelaide and Hills – Health Profile 2014 Glossy Infographic

Sign up for an eHealth Record for Your Chance to Win – promotional poster

GP Updates – event A5 flyers
Community events – posters and flyers
CAHML Staff – Programs YouTube videos

CLOSING THE GAP
- Are you eligible for Closing the Gap services? - GP Practice poster
- Closing the Gap Information Sheet with list of participating GP practices
- We Support Closing the Gap Prescriptions here – pharmacy poster
- Nunga Health Clinics poster
- Closing the Gap Day Community Event posters
- Closing the Gap brochure
- Quick Jab to Close The Gap brochure

Quick Jab to Close The Gap, It’s never too late. Immunise your Mob - poster

Closing the Gap Care Coordination Service postcard magnet
Do you feel like yarnin about your wellbeing? postcard magnet
Do you feel like yarnin about your wellbeing? brochure
Our Immunisation Blitz needs you postcard magnet

Yamin Health and Wellbeing quarterly Newsletter
When do I get baby immunised? Immunisation schedule reminder magnet
Free Immunisation at Spirit Festival 2014 poster
Connecting Pharmacy and Allied Health with Aboriginal and Torres Strait Islander communities: A practical guide to the provision of Aboriginal and Torres Strait Islander friendly services
Connecting Pharmacy and Allied Health with Aboriginal and Torres Strait Islander communities: YouTube videos
Reconciliation Action Plan
Cultural Walk of Botanical Gardens - Staff flyer

HEALTHY AGEING
- CAHML / COTA Pills & Spills brochure
- 75+ Home Health Assessment flyer

CULTURALLY AND LINGUISTICALLY DIVERSE (CALD)
- Mental Wellbeing Pathways poster – Bilingual: English / Vietnamese
- Mental Wellbeing Pathways poster – Bilingual: English / Spanish
- Need an Interpreter? - Introducing Australian Translating and Interpreting Services (ATIS) resource poster

MENTAL HEALTH
- Mental Wellbeing Pathways poster
- CAHML Access to Allied Psychological Services (ATAPS) information sheet
- Mental Wellbeing Counselling ATAPS brochure
- Healthy Minds throughout the Journey ATAPS services brochure
- Central Adelaide and Hills Partners in Recovery brochure
- Wellbeing Started Early in Life, Child Wellbeing Program newspaper advertisement
- beyondblue National Roadshow & CAHML - Power vs Crows Showdown event poster, Hansen Construction poster, Adelaide University poster, Mt Barker TAFE poster,

HEADSPACE
- Youth Reference Group flyer

HEALTHY WEIGHT STRATEGY
- Engaging with Stakeholders and Community to Identify Gaps in Obesity Services poster
- Management of Overweight and Obesity in Adults – Patient Care Pathway in General Practice resource

IMMUNISATION
- Immunisation Update Day - event A5 flyers
- Development of an Online Pneumococcal Vaccination Algorithm Tool resource poster
- When do I get my child immunised? Immunisation schedule reminder magnet
- Immunisation Blitz GP Practice flyer

CHRONIC OBSTRUCTIVE PULMONARY DISEASE
- Working Together to Tackle Chronic Obstructive Pulmonary Disease (COPD), a Partnership between General Practice, Pharmacy and CAHML - infographic
- Improving integrated COPD Care Across CAHML – “CAHML Collaborator” workshop poster
- COPD Consumer Feedback Survey – Pharmacy Intervention
- COPD Evaluation Framework
- COPD General Practice Resource Kit

Innovative Models Promoting Access-to-Care Transformation - IMPACT
- Posters
- Infographics
- Booklets
- Forum Worksheets