# Strathbogie Health and Community Services Consortium Primary Health Care Funding Proposal

*Proposal May 2014*

# Contents

## Background

The Hume Corridor Community Outreach Health Service (HCCOHS) which is based at the Violet Town Bush Nursing Centre was established in 2002 through funding from the Australian Government Rural Primary Health Service Program. The outcomes of this work have been significant for a community that has no State Government funded Primary Health Care Services.

The HCCOHS catchment is based on the now defunct Violet Town Shire boundary incorporating the southern area of the Benalla Rural City LGA and approximately a third of the Strathbogie Shire LGA.

## Service Delivery Issues

Strathbogie Shire has an ageing community with significantly poorer social determinants of health creating vulnerable sub-groups who have poor health literacy, high levels of chronic disease particularly diabetes and experience barriers to accessing services. The significant health issues experienced in Strathbogie Shire align with the National Health Priorities. Strathbogie Shire has the fourth highest percentage of population with diabetes in Victoria and highest level of hypertension for Ambulatory Care Sensitive Conditions in the Hume Region.

There is no public hospital, limited or no access to affordable locally based primary health care services excluding GP's who do not all offer bulk billing. HCCOHS is the only publically funded community health service leaving 2/3's of the Shire without accessible community health services. This is in contrast with surrounding Shires who have substantial publicly funded community health services available to the whole population furthering the health inequity in Strathbogie Shire.

Services from neighbouring Municipalities offer limited in-reach services and often require individuals to travel to larger towns such as Shepparton. This is problematic with limited public transport and can be cost prohibitive.

Research has highlighted distinct gaps in primary health care provision in Strathbogie Shire, such as Speech Pathology and Dietetics on the Western side of the Municipality. In order for residents to have access to services, coordination assistance and dedicated referral pathways must be identified and strengthened.

Research recently conducted in Australia has shown that failing to act on the social determinants of health, which includes our health service system, means people are needlessly suffering long-term health problems (Social determinants of health alliance, www.socialdeterminants.org.au). Whilst it is not financially viable for all primary health care services to be based in the Municipality, any decrease in current service provision would be considered to have catastrophic long-term effects.

## Proposed New Structure

The Strathbogie Health and Community Services Consortium (SHCSC) is proposing the reconfiguration of Primary Health Service within the Strathbogie Shire for the next phase of Commonwealth funding to reduce the health inequity resulting from the current service system and augment the proposed Medicare Local work in chronic disease.

The new strategy and model will increase the capacity of Strathbogie consumers to access the services they require when they require it; while at the same time maximising the capacity of the minimal health infrastructure that exists within the Strathbogie Shire catchment to deliver the right care at the right time for our local communities.

The Consortium consists of the Chief Executive Officers of

- Nagambie Healthcare,
- Euroa Health,
- Violet Town Bush Nursing Centre and
- Strathbogie Shire Council.

It is a **voluntary** structure for joint health and community services planning across the Shire of Strathbogie that explores the existing and future health and community service needs and services of the communities within the Shire of Strathbogie. The Consortium works collaboratively to develop and implement strategies to better meet the identified needs.

The principles underpinning the Consortium are:

**Community Engagement:** The shared communication and problem solving between service providers and community members that occur around the identification of community priorities and implementing actions to achieve those priorities.

**Strathbogie Shire wide approach:** Service planning and development processes will reflect consideration of the shire as a whole.

**Person centred care:** Providers will work alongside the person needing services making sure that that person's priorities and preferences are guiding care.

**Focus on collaborative work:** Service planning, development and provision will occur in consultation with relevant and/or interested individuals and organisations.

**Equity:** Equity is a term which describes fairness and justice in health outcomes. It is not about the equal delivery of services or distribution of resources, but about recognising diversity and disadvantage, and directing resources and services towards those most in need, to ensure equal outcomes for all. (Adapted from Dyson, S (2001) Gender and Diversity Workbook)

**Subsidiarity:** Decisions should be made at the most local level possible.

**Evidence based:** Decisions regarding priorities and strategies should be based on evidence and current best practice.

Through this consortium there will be a management structure to ensure efficient use of funding. The funding will be facilitated in an effective manner as each member of the consortium will utilise their current networks of support to maximise the funding's impacts.

The budget includes a Core Model Funding Stream for the proposed model and a Secondary Funding Stream for the provision of Physiotherapy, Speech Pathology and Dietetics; all identified allied health service gaps within the Strathbogie municipality.

The Core Model Funding Stream will fund the implementation of:

Two Key Workers

- Chronic Illness focus (1.0 EFT)
- Mental Health focus (1.0 EFT)

Administrative Support Worker (0.2 EFT)

Program Manager (0.2 EFT)

The new model will:

- Reduce inequity across the Strathbogie municipality and allow for individual and area needs to be addressed.
- Provide a whole of municipality approach and utilises the partnerships already developed via the Strathbogie Health and Community Services Consortium.
- Assist in the utilisation of regional services by providing them local key points of contact
- Address local issues regarding access to primary health, including mental health and wellbeing services
- Streamline referral pathways with the provision of local coordinators acting as initial points of access and referral
- Provide positive publicity for the funding body with a new and innovative Shire based funding model
- Take an innovative approach to the provision of primary health care in a financially sustainable manner
- Reduce duplication
- Assist individuals and locally based service providers, such as GP's, in managing the complex service system

This model would involve spreading the current program across the entire Municipality and taking a more pro-active approach to primary health care by building links, providing a local interface and developing referral pathways with external agencies. This model does not allow for the provision of all primary health care services in all areas, but instead focuses on a primary health service which addresses identified gaps and most urgent need using a sustainable partnership approach.

## Objectives

Based upon the objectives of:

- Equitable access for all residents within the Strathbogie Community,

- Efficient and effective use of resources through the integration of services through partnership
- Person Centred Care delivering the right care at the right time

This new structure proposed by the SHCSC will enable the local community the ongoing ability to access the services that they need and build a framework that will support the development of mechanisms that will build higher levels of self-sustainability and resilience across the community. Based upon the health data available in relation to the health and wellbeing of the Strathbogie community this new structure will start the process of overcoming many of the significant barriers faced by the population, these include:

- Access
- Health Literacy

## Operational Structure

This new structure is based upon the very successful and effective Outreach worker model that has been the cornerstone to community engagement through the Violet Town experience for many years. By adding further resources in to this area including a clear pathway into, through and out of the program we will see consumers of the services acquire the level of access required but at the same time build a level of self-management that is sustainable and effective. The program will be implemented by two key workers supported by an administration worker and program manager.

The Key Worker activities will include:

| Key Worker 1: Mental Health (1.0 EFT) | Key Worker 2: Chronic Illness (1.0 EFT) |
|---|---|
| ➢ Engage the community in relation to identifying those at risk of Mental Health issues through:<br>- Face to Face interactions<br>- Engagement of local community groups<br>- Referrals from local organisations<br>- Referral from other programs within the 3 Health services within Strathbogie<br>- Referrals from the community based services delivered by the Strathbogie Council | ➢ Engage the community in relation to identifying those at risk of Chronic Illness through:<br>- Face to Face interactions<br>- Engagement of local community groups<br>- Referrals from local organisations<br>- Referral from other programs within the 3 Health services within Strathbogie<br>- Referrals from the community based services delivered by the Strathbogie Council |
| ➢ Engage those identified with Mental Health and or family breakdown issues | ➢ Engagement of those identified with Chronic Illness issues |
| ➢ Generate and support consumers to action initial referrals to the appropriate services including but not limited to:<br>- GP Clinics within Strathbogie<br>- Area Mental Health Services<br>- Community Health Services<br>- Other services delivered with the 3 Health services within Strathbogie e.g. Day Therapy for Respite | ➢ Generate and support consumers to action initial referrals to the appropriate services including but not limited to:<br>- GP Clinics within Strathbogie<br>- Primary Health Services<br>- Community Health Services<br>- Other services delivered with the 3 Health services within Strathbogie<br>- Support Services delivered by the Strathbogie Shire e.g. HACC |
| ➢ Support consumers in their subsequent care plans e.g. Mental Health Plan through a structured 'follow up' process | ➢ Support consumers in their subsequent care plans e.g. Mental Health Plan through a structured 'follow up' process |
| ➢ Develop referral pathways and processes to support system navigation | ➢ Develop referral pathways and processes to support system navigation |
| ➢ Develop relationships with providers both locally (in particular GP practices) and outside the Shire to provide an interface for funded programs and support service coordination | ➢ Develop relationships with providers both locally and outside the Shire to provide an interface for funded programs and support service coordination |
| ➢ Collect data required to measure impact of the program and inform ongoing evaluation of the program | ➢ Collect data required to measure impact of the program and inform ongoing evaluation of the program |

These two roles will not work in isolation, there will be a number of opportunities based upon the complexity of the consumer(s) to collaborate and ensure where relevant an integrated approach is taken when managing Chronic Illness and Mental Health issues. The key partner in this proposal will be General Practitioners.

To support both workers a day a week will be funded to create an administrative role, their focus will be:

- Collation of data
- Support Governance committee with requirements such as
    - Minutes
    - Correspondence
    - Reporting to funding bodies
    - Administering referrals
- Support Key workers with Administrative requirements

The role of the Program Manager will be to supervise the two key workers and support them in their roles.

## Impact Measures & Evaluation Process

To be managed by the governance structure of the program i.e. SHCSC; the following will be the measures used to determine the effectiveness of the program.

### Rural Outreach Worker (mental health key worker)

**Outcome 1: Early intervention**

The Rural Outreach Worker model will provide earlier intervention for people with undiagnosed or existing mental illness with a priority focus on those who are faced with elements of further disadvantage such as isolation, both social and geographical, and minimal access to services

Measures

- Response time to referral
- Existing health service support for presenting issue
- Documented referral pathways, including number and variety of referrals
- Clients geographical location

**Outcome 2: Improved access to services**

The Rural Outreach Worker model will facilitate access to services by supporting health literacy for people with mental health issues who are isolated and not linked into services for their presenting issue

Measures

- Number of interventions required to link client into a service e.g. phone calls, representations, case conferences
- Consumers response to action plan e.g. referrals undertaken and outcomes

**Outcome 3: Improved outcomes for clients**

The Rural Outreach Worker model will facilitate sustained improved mental health outcomes through a structured 'follow up' program

Measures

- Triage in 'follow-up' demonstrates transition to a lower risk category
- Qualitative data from 'follow up' program
- Consumer adherence to mental health care plan
- 'Follow up' program monitors risk stratification to minimise risk of crisis and re-entry into mental health service sector
- Improved community connections as relevant

## Chronic Disease Key Worker

**Outcome 1: Early intervention**

The Chronic Disease Key Worker model will provide earlier intervention for people at risk or early stages of chronic disease with a focus on cardiovascular disease and diabetes not currently linked into services

Measures

- Number of people screened for diabetes risk and blood pressure through outreach risk factor screening program
- Number of referrals to GP resulting from outreach risk factor screening program
- Number of outreach risk factor screening program clients referred to LIFE program based on GP data

**Outcome 2: Improved access to services**

The Chronic Disease Worker model will facilitate access to services by supporting health literacy for people at risk or early stages of chronic disease with a focus on cardiovascular disease and diabetes not currently linked into services through an outreach risk factor screening and education program

Measures

- Number of interventions required to link client into a service e.g. phone calls
- Consumers response to action plan e.g. referral undertaken, compliance with agreed actions
- Number of referrals to GP resulting from outreach risk factor screening program

**Outcome 3: Improved person centred chronic illness care**

The Chronic Disease Key Worker model will improve person centred chronic illness care through a GP Chronic Disease Management Plan support program, providing a program of one on one sessions to support consumers action their plan.

Measures

- Improvement in pre and post program Patient Assessment of Care for Chronic Conditions scores

**Outcome 4: Improved health behaviours**

The Chronic Disease Key Worker model will support improved health behaviours through a GP Chronic Disease Management Plan support program, providing a program of one on one sessions to support consumer's action their plan and a structured 'follow up' program

Measures

- Number of people adhering to GP Chronic Disease Management Plan
- Number of people achieving their goals as per the GP Chronic Disease Management Plan
- Number of people achieving their goals as per the GP Chronic Disease Management Plan at 6 month review

Note: The PACIC tool and scoring chart (Assessment of Care for Chronic Conditions) will be utilised as a measure.

# Appendix 1

## Strathbogie Shire Population Health Profile – Comparison with neighbouring Local Government Areas

| | **STRATHBOGIE** | **MURRINDINDI** | **MITCHELL** |
|---|---|---|---|
| Size | area of approximately 3302 sq. kilometres | Area of approximately 3889 sq. kilometres | Area of approximately 2862 sq. kilometres |
| Population | 9504 | 13058 | 36,244 |
| Median Age | 50 | 45 | 37 |
| Avg Household income | $834 | $917 | $1,170 |
| SEIFA Score | 970 | 977 | 996 |
| Victorian Rank for Disadvantage | 23rd | 45th | 38th |
| Hume Region Rank for Disadvantage | 4th/16 | | |
| Victorian Funded Health Services | **No public hospitals**<br>**No State Government funded Allied Health**<br>HACC Service visit from Shepparton upon request and for specific target group. | Two Community Health Centres (2) with Community Health and<br>HACC funded Allied Health<br><br>Two Public Hospitals | Two Public hospitals<br>One Community Health Service |
| Services that exist | **Euroa.**<br>No Community Health funded services based there<br><br>Euroa Health-<br>Occupational Therapy-Private and via Day Therapy | Services available<br>• Dietician<br>• Occupational Therapist<br>• Diabetes Educator<br>• Wound Consultant<br>• Continence Nurse<br>• Access Worker | COMMUNITY HEALTH SERVICE provides<br>• Counselling<br>• Dietetics<br>• Physiotherapy<br>• Podiatry<br>• Continence Nurse Advisor<br>• Occupational Therapist |

| | | | |
|---|---|---|---|
| | Visiting Private Podiatrist<br>Visiting Private Physiotherapist<br>Visiting Counsellor via Primary Care Connect-book through PCC<br><br><u>Euroa GP</u><br>Visiting Podiatrist-Private and EPC<br>Visiting Physiotherapist-Private and EPC<br>Visiting Psychologist-Private and EPC<br>Visiting Dietitian-RPHS | • Psychologist<br>• Women's Health<br>• Physiotherapist<br>• Speech Pathology<br><br>Note: Services provided across the Municipality including Marysville and Eildon.<br><br>They also have a Private Physiotherapists in the community. | • Speech Pathologist<br>• Community Health Nursing<br>• Diabetes Education<br>• Psychology<br>• Social Work<br>• Family Violence Support |
| | **Nagambie.**<br>Visiting Podiatrist-Private and EPC<br>Physiotherapist-Private<br>Mental Health Nurse-GP funding<br>Diabetes Educator-GVH | | |
| | **Violet Town**<br>Diabetes Educator-visits from GVH<br>RPHS-Physiotherapist, Counselling, Rural Outreach, Speech Pathologist, Dietitian<br>Podiatrist-Private | | |

# Appendix 2

## Strathbogie Shire Current Health Environment

Strathbogie has gone from being the 12th highest in 2010 to the **fourth highest LGA in Victoria** for the percentage of population with **Diabetes** in 2011 and the highest in the Hume Region. Between 2001 and 2011 the incidence of Diabetes in Strathbogie increased by **160%.** (Diabetes Aus Vic.)

VicHealth Indicators 2011 identified that Strathbogie was **significantly less** than Victorian average for having **Internet Access at Home**.

**20.7%** of Strathbogie residents live near public transport compared with 72.6% of Victorians.

Percentage of families with children in households with income less than $650 per week-Strathbogie is **ranked 13** out of the 79 LGA's in Victoria.

Information from the Victorian Population Health Survey indicated at Strathbogie was
Ranked **2nd highest LGA** in Victoria for people at risk from **short-term harm from alcohol consumption**,
**Ranked 15th** for percentage of **males who do not meet fruit and vegetable dietary guidelines**,
**Ranked 13th** for the percentage of **females 18+ who are current smokers**,
**Ranked 7th** for the **percentage of females who are overweight or obese**
**Ranked 5th** for the **percentage of persons aged 75+ who live alone**
(2010 Local Government Area Statistical Profiles-Department of Health)

**14.3% of children** in Strathbogie Shire in their first year of school were **developmentally vulnerable** on two or more domains. (Change and Disadvantage in the Hume 2011, Victorian Government)

AMBULATORY CARE SENSITIVE CONDITIONS DATA (2012-13)
**Diabetes Complications**-Strathbogie was the **18th highest** LGA across all ages in the State. In the 70-74 age group Strathbogie was the 2nd highest municipality in the Hume Region and the 12th highest in the State. In the 75-79 age group Strathbogie was the 2nd highest municipality in the Hume Region and the 7th highest in the State.
**Hypertension-**Strathbogie was **11th** highest LGA across all ages in the State. In the 70-74 age group Strathbogie was the 2nd highest in the State and the Highest in the Hume Region. In the 85+ age group Strathbogie was the 5th highest Municipality in the State and the highest in the Hume Region.

# Appendix 3

## Research support

### SOCIAL DETERMINANTS OF HEALTH ALLIANCE

According to **the World Health Organisation**, the social determinants of health are the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. The social determinants of health are mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between countries.

As the **2011 World Conference on the Social Determinants of Health** outlined, structural mechanisms that affect the differential social positions of individuals are the root cause of health inequities.

Inequities in health arise because of the circumstances in which people grow, live, work, and age, and the systems put in place to deal with illness. The conditions in which people live and die are, in turn, shaped by political, social, and economic forces. Closing the health gap requires concerted action across sectors by national governments, the World Health Organisation, United Nations agencies and civil society organisations. Better health and its fair distribution should be adopted as shared goals

www.socialdeterminants.org.au

### WORLD HEALTH ORGANISATION

As stated at Alma Ata Conference: "Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination."

Health equity is the absence of unfair and avoidable or remediable differences in health services and outcomes among groups of people. Data that are presented according to social, demographic, economic or geographical factors can help to identify vulnerable populations and target health interventions. Disaggregated data are useful to track progress on health goals, revealing differences between sub-groups that overall averages may mask. Health equity data provide an evidence base for equity-oriented interventions, and are a key component of mainstreaming gender, equity and human rights as well as equity-oriented progress towards universal health coverage.

Health equity depends vitally on the empowerment of individuals to challenge and change the unfair and steeply graded distribution of social resources to which everyone has equal claims and rights. Inequity in power interacts across four main dimensions – political, economic, social, and cultural – together constituting a continuum along which groups are, to varying degrees, excluded or included.

## AUSTRALIAN INSTITUTE OF HEALTH AND WELFARE (AIHW)

Health outcomes, as exemplified by higher rates of death, tend to be poorer outside major cities. The main contributors to higher death rates in regional and remote areas are coronary heart disease, other circulatory diseases, motor vehicle accidents and chronic obstructive pulmonary disease (e.g. emphysema). These higher death rates may relate to differences in access to services, risk factors and the regional/remote environment.

Clear differences exist in health service usage between areas. There are, for example, lower rates of some hospital surgical procedures, lower rates of GP consultation and generally higher rates of hospital admission in regional and remote areas than in major cities…people from regional and remote areas tend to be more likely than their major cities counterparts to smoke and drink alcohol in harmful or hazardous quantities. It is also likely that environmental issues such as more physically dangerous occupations and factors associated with driving (for example. long distances, greater speed, isolation, animals on roads and so on) play a part in elevating accident rates and related injury death in country areas.

www.aihw.gov.au

## A SNAPSHOT OF MENS HEALTH IN REGIONAL AND REMOTE AUSTRALIA-AIHW-2010

Men in rural regions of Australia may face distinct health issues because of their location, work and lifestyle. Overall, men in rural areas are more likely than their urban counterparts to experience chronic health conditions and risk factors. For example, they: are more likely to report daily smoking and risky drinking behaviour; are less likely to possess an adequate level of health literacy; have higher mortality rates from injury, cardiovascular disease and diabetes.

There is a strong relationship between poor health and social and economic disadvantage. Compared with urban areas, rural regions of Australia contain a larger proportion of people living in areas of socioeconomic disadvantage.

Cardiovascular diseases were responsible for nearly a third of the elevated male death rates outside *Major cities*.

Male death rates from diabetes were 1.3 times as high in *Inner regional* areas and 3.7 times as high in *Very remote* areas as compared with *Major cities*.

### *Alcohol and other drugs*

Men living outside *Major cities* were more likely to report daily smoking and risky or high-risk alcohol use than their counterparts in *Major cities*. They were also more likely to have experienced a substance use mental disorder throughout their lifetime. The incidence of head and neck cancers and lip cancers, two groups of cancers associated with increased smoking and alcohol consumption, was also higher outside *Major cities*.