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Report of the Evaluation of HealthOne Mount Druitt

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Abbreviations

ABHI	Australian Better Health Initiative
ACAT	Aged Care assessment Team
AHS	Area Health Service
CHIME	Community Health Information Management Enterprise
COAG	Council of Australian Governments
COPD	Chronic Obstructive Pulmonary Disease
ED	Emergency Department
EPC	Enhanced Primary Care Medicare Benefits Scheme items
GP	General Practitioner
GPLN	GP Liaison Nurse
HIE	Health Information Enterprise
HOMD	HealthOne Mount Druitt
MBS	Medicare Benefits Scheme
MCHP	Menzies Centre for Health Policy
NCDS	National Chronic Disease Strategy
NHHRC	National Health and Hospitals Reform Commission
NSW	New South Wales
SCIPPS	Serious and Continuing Illness Policy and Practice Study
SWAHS	Sydney West Area Health Service
WSLHD	Western Sydney Local Health District

Acknowledgements

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Table of Contents

Tables

Figures

1. Executive Summary

Lack of integration[1] of services and poor coordination of care has been singled out as the largest issue facing health systems (Curry and Ham 2010, Nolte and McKee 2008, Zwar et al. 2006, Van Raak et al. 2005 Blendon et al. 2002). The primary health care sector can play a major role in integrating and coordinating care (Starfield 1998). Strategies to facilitate coordination of care include: improving communication between service providers e.g. case conferencing; systems to support care coordination e.g. care plans, shared decision making, and; providing support for clinicians and structuring relationships between service providers e.g. co-location, case management, multi-disciplinary teams. Successful integration and coordination is more likely if several of these strategies are employed simultaneously (Powell-Davies et al. 2008).

Despite numerous experiments in Australia, going back to the Coordinated Care Trials of the 1990s (Australian Government Department of Health and Ageing, 2007), there is a dearth of solid evidence on the mechanisms needed to improve coordination between fragmented services, and measurement of its effectiveness in improving outcomes for healthcare consumers (Nolte and McKee 2008).

HealthOne

HealthOne is a NSW Health funded program that brings together several of the elements identified as improving integration and coordination. HealthOne aims to increase integration and coordination of primary and community health services by facilitating communication, case conferencing and care planning between GPs, Community Health (including allied health) and other health and social care providers - with care delivered by multi-disciplinary teams. (http://www.health.nsw.gov.au/initiatives/healthonensw/index.asp).

HealthOne has been rolled out in a number of different locations in NSW. By June 2012 there were 15 HealthOne sites in development or operation across five Local Health Districts in NSW. HealthOne Mount Druitt (HOMD) was in development from 2006 and officially opened in 2008. The HOMD 'hub' is located at the Mount Druitt Community Health Centre in a purpose-built facility.

Care for three groups, chronic aged and complex care, children and their families and disadvantaged communities, was introduced using a staged approach. Chronic aged and complex care was addressed first followed 12 months later by children and their families and then disadvantaged communities. The linchpin of the HOMD model of care is the two GP Liaison Nurses (GPLNs) who identify the patient's needs based on referrals received and assessments made and facilitate communication, case conferencing and care coordination between the various health professionals and other providers involved in the patient's care. This may be done in person or by telephone ('virtually') without the GP or other service providers having to be physically present at the hub.

HOMD is delivered through a 'hub and spoke' model of care with some services provided from the hub such as the Wound Clinic, Child and Family Clinic and Antenatal Clinic but others provided through outreach clinics or 'spokes' to locations within the HOMD service area that do not have easy access to GPs and other health service providers. One such spoke at Willmot, on the periphery of the Mount Druitt area, provides on a two part-day per week basis a Child and Family Health Clinic, a Women's Health Clinic and a Mature Aged Person's Clinic.

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1   Kodner and Spreeuwenberg (2002) defined integration as "a coherent set of methods and models on the funding, administrative, organisational, service delivery and clinical levels designed to create connectivity, alignment and collaboration within and between the cure and care sectors."

The HOMD model delivers patient-centred care and is summarised below (Figure 1). The HealthOne Mount Druitt Chronic Aged and Complex Care Model and Child and Family Model are summarised in Figures 2 and 3. Further detail of the HOMD model can be found in Appendix One.

Figure 1: The Patient-Centred HOMD Model of Care[2]
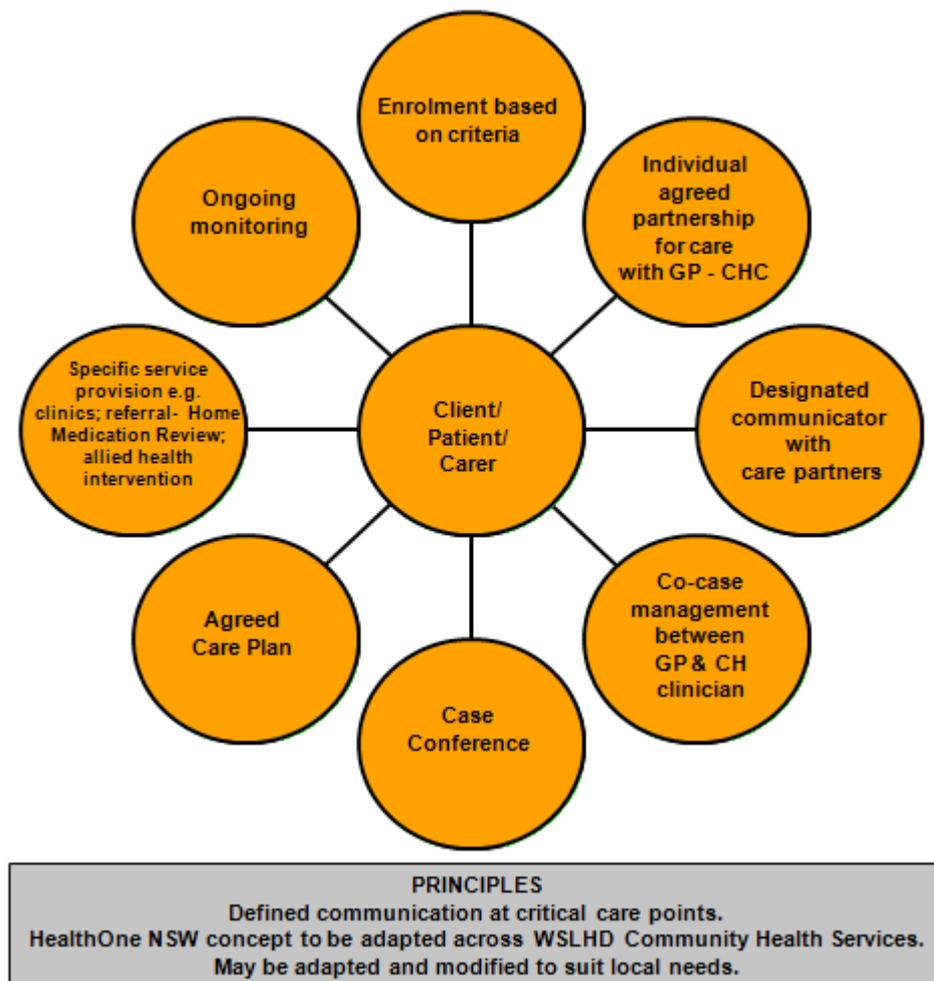
Evaluation of HealthOne Mount Druitt

An evaluation of the Chronic Aged and Complex Care arm of HealthOne Mount Druitt was undertaken by members of the Serious and Continuing Illness Policy and Practice Study (SCIPPS) team based at the Menzies Centre for Health Policy, School of Public Health, University of Sydney.

There were two components to the evaluation of HOMD, a process evaluation and an outcome evaluation. Both components of the evaluation contributed to answering the evaluation questions. The evaluation addressed the following questions:

- In what ways has HOMD resulted in change in patient outcomes?

- In what ways has HOMD resulted in changes in health services?

- In what ways does HOMD make a difference in care provided to patients with chronic and complex conditions in Mount Druitt?

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2 WSLHD Presentation, October 2011.

The SCIPPS evaluation employed both quantitative and qualitative methods for data collection.

Quantitative Data: Patient outcome measures focused on changes in presentations and admissions to the emergency department and/or hospital and were measured one year before patient enrolment in HOMD and one year after enrolment. Organisational and health service delivery measures included changes in referral and service utilisation patterns and were also measured one year before patient enrolment in HOMD and one year after enrolment. A HealthOne Mount Druitt Partnerships Survey was mailed to all service providers (both chronic and complex and child and family arms) with HOMD enrolled patients. The survey aimed to collect data on barriers and facilitators to effective partnerships between GPs and Community Health.

Qualitative Data: Thirty-two semi-structured individual interviews were conducted with NSW Health policy and decision makers, HOMD Steering Committee members and HOMD staff, clients enrolled in HealthOne Mount Druitt and their carers, and local GPs. One focus group with Mount Druitt Community Health Centre staff involved in the care and treatment of chronically ill patients was run during the course of the evaluation.

Research activities for the Evaluation of HealthOne Mount Druitt began in August 2010 and concluded in November 2011.

1.1   Summary of Findings

Changes in Patient Outcomes

- Patient outcome analyses showed that among people with chronic and complex conditions enrolled in the HOMD program the number of emergency department presentations, and length of stay in the emergency department, in the 12 months following enrolment in HOMD was significantly less than in the 12 months prior to enrolment.

- Case studies with HOMD patients showed that quality of life was improved by allowing people to remain in their own homes while receiving care, with assistance and support from their GPs, community health staff and home care services.

Changes in Health Services

- The pattern of service utilisation changed in the 12 months after enrolment in HOMD, with more referrals to allied health services such as physiotherapy, podiatry, occupational therapy, dietetics and psychosocial services.

- Source of the referral changed with fewer referrals from the acute care (hospital inpatient) setting and more from other health service providers and families, friends and neighbours.

- A broader range of multidisciplinary services were able to be delivered to HOMD patients through case conferencing, care planning, and GPLN liaison and information provision.

- For GPs the HOMD GPLNs provided a single point of contact, they were 'user friendly' and tailored their interactions to fit GPs' needs.

- GPLNs organised care that the GP could not through lack of time or because they did not have the knowledge of services available e.g. Home Care, Counselling, other allied health services.

- GPLNs had the local knowledge of service boundaries and criteria for eligibility that GPS did not have.

- GPs valued highly GPLN support through knowledge about referral processes and other relevant information provided to them by fax, telephone, email, or face to face visits.

Difference in Care Provided to Clients

- HOMD clients reported that they felt more supported and less anxious through their involvement with HOMD.

- Support for HOMD clients spanned from 'just being there' – a friendly ear (either on the telephone or by a home visit) to practical assistance for medical and other health and social needs delivered through community health services or arranged by the GPLN to be delivered through other health or social care providers.

- Clients also reported that community health staff, whether GPLNs or other community health staff, spoke to them in an open honest 'truthful' manner about their health and social situations.

- A broader range of multidisciplinary care and services were able to be delivered to HOMD clients not only through the case conferencing and care planning mechanisms of HOMD, but also through liaison and information provided to members of the multidisciplinary team by the GPLNs.

Partnership Between GPs and Community Health

- Facilitating change was a slow and on-going process using the strategy of starting with those who were committed to the HOMD idea and working outwards to the rest of the organisation.

- Building trust between GPs and Community Health was a time consuming and difficult process.

- Partners built trust by acknowledging the history and context of the local setting including previous relations and work experiences between AHS, GP Division/GP, Community Health and any other parties, organisations or individuals participating in the partnership.

- A shared focus on the patient or client assisted in building trust as participants in the partnership had the common value of 'being there for the patients.'

- Developing 'unity of vision' assisted the development of trust especially when members of professional groups involved in the partnership did not initially share a common perspective.

- A small group of GPs already committed to the HOMD idea were engaged to act as leaders to gain the trust of the wider local GP group.

- Leaders from both GP and Community Health groups were already respected and had a reputation for delivering good outcomes for patients and health professionals.

- Leaders had to be committed, passionate and altruistic to initiate change.

- Leadership for change needed to occur at a number of different levels – organisational (GP Divisions/Networks/Associations, Community Health) and governmental (NSW Health and AHS management and policy).

- Community Health embraced new ways of working as a result of the implementation of HOMD and also changes within the Local Health District and the wider NSW health sector – including delivering services through two streams, Chronic Aged and Complex Care and Child and Family.

- Appreciating and respecting different roles, and being flexible in changing traditional organisational views, taking the time to be educated about 'what general practice is', assisted the change process for those involved with HOMD.

- Community Health staff thought that HOMD had significantly improved communication, multidisciplinary involvement and teamwork in case conferencing and care planning within and outside Community Health.

- Community Health staff said GPLNs provided local knowledge, a single point of contact and a known face for other providers – this facilitated more frank and open discussion of care and support issues, and was particularly helpful when dealing with sensitive issues.

Factors for Successful Implementation

- The insight, vision and commitment of the program partners in understanding that 'things could be done better' within the primary health care sector and that HOMD could provide a mechanism through which improvements could be made.

- Community Health's flexibility to allow individual workers to do what they needed to do 'to make it work' at organisational level, the local Community Health Centre and at the program level (flexibility extended to how to work with GPs).

- The AHS (in particular the planning arm and the executive) recognised the key role of Community Health in reviews and restructuring to improve service integration and care coordination systems allowing the planning and implementation of HOMD to proceed more effectively.

- The AHS was seen by GPs to be finally following through on the promise of improving how GPs and Community Health worked together which facilitated GPs involvement in HOMD.

- The diverse membership of the Steering Committee allowed partners to advocate for HOMD across the various levels of the health sector from NSW Health and AHS level to Community Health and local GPs allowing blocks to implementation to be overcome.

- Mapping of GP practices, migrant and Indigenous communities, older and younger populations, Community Health Centres, main public transport routes, local hospitals and various other concentrations of disadvantage and/or lack of services was used to develop a shared commitment to improving access for high risk and disadvantaged groups in the local community, and to developing patient centred, 'wrap around' models of care.

- HOMD provided a single point of contact for GPs to communicate and give and receive information with Community Health with individual, often face-to-face, interaction.

- HOMD's collaborative problem solving and information exchange through an emphasis on the well-being of the patient or client.

- Care planning and case conferencing documents and other support from GPLNs allowed reimbursement of GPs through GP Management Plans and Team Care Arrangements.

- HOMD lightened GPs workloads by providing support to GPs who could then offer better care to their patients.

- The flexible use of public state-AHS funding applied through GPLNs and community nurses to assist general practitioners in small practices with few practice staff, is a key enabler of care for both patients and practices.

- GP Fee-for-Service versus Community Health Salaried Staff – Community Health had the flexibility to attend meetings and carry out other various activities that were relevant to improving integration and coordination of services that often GPs did not have the time or resources to carry out.

- Capital Development Funding – while a physical location was obviously necessary for the operation of HOMD, there was an initial emphasis on only the 'bricks and mortar' hub at Mount Druitt Community Health Centre rather than further developing already existing partnerships, processes and relationships.

- The focus on capital works and lack of adequate funding for planning, development, evaluation and change management was a major barrier.

- The service setting and the type and nature of the partners involved in a HealthOne service was considered an important contextual factor to understand, which, depending on the particulars of the setting and the dynamics of the partnerships involved could be either a positive or a negative influence.

- The perceptions generated from a history of Community Health and General Practice not working closely together (such as past integrative efforts failing or not being sustainable) was a significant barrier that HOMD had to overcome.

- Interacting with setting, the dynamics of the various personalities involved in the partnership could be either a positive or a negative influence.

- Lack of IT capability and an e-health record was considered a barrier to integration/coordination – HOMD overcame this by not allowing the lack of e-health be a barrier to the essential partnership building work that HOMD ultimately relied upon to get up and running.

Sustainability

- HOMD could not continue without the 'driving force' of leadership from key people within the partnership because the current health system is not structured to work in an integrative collaborative manner.

- The sustainability of HOMD requires a wider 'culture change' that would ensure practices and processes relating to working in an integrative multi-disciplinary manner were embedded in partner organisations and established throughout the primary health care sector.

- GPLNs are 'mission crucial' - vital to almost all aspects of the implementation, operation and sustainability of HOMD.

- The seniority and expertise of the individuals in the GPLN roles is also critical – GPLNs have to command the respect not only of their Community Health colleagues, but of GPs, a much harder task, and they must be leaders and change agents.

- Permanent and ongoing GPLN positions would significantly contribute to the sustainability of the program.

- Sufficient funding to increase GPLN numbers and areas of specialisation across the Sydney West region would enhance the sustainability of the program.

- 'Success breeds success' - when the HOMD model is seen to be working successfully, both in terms of the way health professionals work together and better care provided to patients,

then that creates momentum where others may become interested in participating in or implementing a HealthOne model.

Future Directions

- The HOMD model could be extended and refined in the primary health care setting through further improvements to the models of care, greater numbers of GPLNs and more areas of specialisation and a broader range of priority groups targeted.

- A further extension of the HOMD model could be where the working relationships between GP and Community Health become more sophisticated with expanded multidisciplinary practice teams providing a greater range of outreach services, to the point where most services would be delivered outside the hub.

- The hub may change its function and become the centre for provision of more specialised services or perhaps develop into a 'community' hospital, while still retaining its integrative and coordinating functions.

- New community based 'spoke' service models could be developed in private, public and mixed service settings which featured a variety of co-location arrangements and services designed specifically for their local communities.

- There is also potential for HealthOne type models to be rolled out across a range of health and service delivery contexts.

- Lessons learnt from developing the HOMD model could be used to inform, organisationally and structurally, a more integrated coordinated primary health care and acute care sector linked up to a suite of other health and non-health sector partners.

- Governance arrangements of HealthOne services and other programs and initiatives concerned with better integration, coordination and delivery of services could be further consolidated in the Western Sydney area.

HealthOne Policy Objectives

The main aims of HealthOne NSW services are to:

- bring together Commonwealth-funded general practice and state-funded primary and community health care services in order to create a stronger and more efficient primary health care system;

- to increase integration and coordination of primary and community health services by facilitating communication and care planning between GPs, Community Health (including allied health) and other health and social care providers.

- The Evaluation of HOMD has collected evidence that clearly demonstrates HOMD has allowed General Practice and Community Health to work more closely together in the Mount Druitt area.

- The evaluation has shown that integration and coordination of primary and community health services (including allied health and other non-health providers) has been improved by HOMD, and that this improvement has occurred through the GPLNs who have been critical by overcoming and facilitating changes in attitudes and behaviours, and significantly improved communication, information sharing, case conferencing and care planning activities.

NSW Health lists key objectives of HealthOne NSW Services as:

- preventing illness and reducing the risk and impact of disease and disability;

- improving chronic disease management in the community;

- reducing avoidable admissions (and unnecessary demand for hospital care);

- improving service access and health outcomes for disadvantaged and vulnerable groups;

- building a sustainable model of health care delivery.

- HOMD has provided people with a broader range of health and social care services and a better quality of life in their own homes and so has reduced the impact of their illnesses and in some instances the disability associated with these illnesses.

- A broader range of health and social care services in patients' homes and GPLN facilitation of communication, information provision and care planning has improved chronic disease management in the community.

- Fewer Emergency Department presentations and shorter lengths of stay in hospital occurred among people with chronic and complex conditions enrolled in the HOMD program.

- As changes in health outcomes and services available occurred amongst clients living in Mount Druitt, an area known to be disadvantaged, then it can be concluded HOMD has improved the range of services available and health outcomes for disadvantaged and vulnerable people who were enrolled in the HOMD program.[3]

- The evaluation found that the sustainability of the HOMD program was reliant upon: continued leadership and commitment of key partners; a 'culture change' ensuring practices and processes relating to working in an integrative multi-disciplinary manner were embedded within Community Health and other partner organisations; sufficient funding to ensure the continuation of the GPLN positions at an appropriately senior level, and to increase GPLN numbers and areas of specialisation across the Sydney West region.[4]

- Evaluation interviews with policy and decision makers and HOMD Steering Committee members and staff demonstrated that flexibility in how policy objectives were reached and a pragmatic willingness to make it work 'on the ground' allowed local input into how priority groups and service models were developed.

- A common understanding of what HOMD was, and what it was trying to achieve grew out of a flexibility that allowed 'space' for innovation, experimentation and problem solving at the local level.

- Further evaluative work at other HealthOne sites may be able to establish whether these are key elements to the successful implementation and sustainability of HealthOne NSW services across a number of different primary health care settings.

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3   No specific data on the socio-economic status of HOMD clients was available either to the HOMD program or the evaluation.

4   Information about the sustainability of the HealthOne model in other locations in NSW requires further evaluative work as different HealthOne models have emerged in different contexts and settings (urban, regional and rural).

2. HealthOne

HealthOne NSW is a state-wide program that strives to bring together Commonwealth-funded general practice and state-funded primary and community health care services in order to create "a stronger and more efficient primary health care system."

(http://www.health.nsw.gov.au/initiatives/healthonensw/index.asp).

Since 2006/07, the NSW Government has funded HealthOne NSW services to the tune of $46 million for capital development of integrated services across the state $3.3 million per annum of that has been made available to Local Health Districts for nursing, allied health and service integration positions within HealthOne NSW and other primary and community health services.

(http://www.health.nsw.gov.au/initiatives/healthonensw/index.asp).

HealthOne NSW initiatives aim to increase integration and coordination of primary and community health services. The program fosters local initiatives to improve communication and care planning between GPs, Community Health (including allied health) and other health and social care providers – such as pharmacists, public dental services, private allied health professionals, other government agencies and non-government organisations – developing improved models of care focused on homes and communities.

(http://www.health.nsw.gov.au/initiatives/healthoneNSW/whatis.asp)

The key objectives of HealthOne NSW Services are:

- Preventing illness and reduce the risk and impact of disease and disability

- Improving chronic disease management in the community

- Reducing avoidable admissions (and unnecessary demand for hospital care)

- Improving service access and health outcomes for disadvantaged and vulnerable groups

- Building a sustainable model of health care delivery (http://www.health.nsw.gov.au/initiatives/healthonensw/index.asp).

NSW Health describes the key features of HealthOne NSW services as:

- Integrated care provided by general practice and community health services

- Organised multidisciplinary team care

- Care across a spectrum of needs from prevention to continuing care

- Client and community involvement

- Co-located services, hub and spoke, virtually integrated services (http://www.health.nsw.gov.au/initiatives/healthoneNSW/whatis.asp).

HealthOne Locations

HealthOne Mr Druitt was the first HealthOne to be established and implemented in an urban setting and remains the most advanced HealthOne service working in a metropolitan environment and developing a corresponding model of care.

HealthOne has also been rolled out in a number of different locations in NSW. In 2006, the following HealthOne sites were under development or in early operation: Mount Druitt, Molong, Rylstone, Corowa, Cootamundra, and Manilla.

By June 2012 there were 15 HealthOne sites in development or operation across five Local Health Districts in NSW: in the Murrumbidgee Local Health District Cootamundra and Corowa; in the Western Local Health District Blayney, Coonamble, Gulgong, Molong and Rylstone; in the Hunter New England Local Health District Forster Tuncurry, Manilla, Raymond Terrace and Quirindi; in the Northern Local Health District Pottsville, and; in the Western Sydney Local Health District Auburn, Rouse Hill and Mount Druitt.

2.1 HealthOne Mount Druitt (HOMD)

Mount Druitt and its surrounding suburbs are in Sydney's outer west and with a population of approximately 100,000, together making up one third of the Blacktown Local Government Area (LGA). The HealthOne Mount Druitt service area includes Bidwill, Blackett, Dharruk, Emerton, Hebersham, Lethbridge, Minchinbury, Mount Druitt itself, Shalvey, Tregear, Whalan and Willmot. Mount Druitt was selected for the establishment of a HealthOne service because of its long-term high levels of socio-economic disadvantage[5] and associated health needs. The Blacktown LGA is culturally diverse with large Aboriginal and Torres Strait Islander and migrant communities. (http://www.health. nsw.gov.au/Initiatives/HealthOneNSW/s1_mt_druitt.asp)

One hundred and thirty GPs work in the HealthOne Mt Druitt catchment area. Seventy-one per cent of practices are sole practices with the remaining practices being either group or corporate. There are very few practice nurses working in these practices compared to other areas with the majority being registered nurses. Many practices have compromised financial viability with low accreditation and high bulk billing rates.[6]

HealthOne Mount Druitt was in development from 2006 and officially opened in 2008. The HOMD 'hub' is located at the Mount Druitt Community Health Centre in a purpose-built facility. The Mount Druitt Community Health Centre has approximately 120 staff with a multidisciplinary profile (nursing, therapy, counselling). The capacity of the Centre to meet the increasing service needs of an expanding population is an ongoing challenge.

The HOMD Steering Committee obtained local demographics and canvassed local issues with both GPs and Community Health staff members before determining target groups. Three priority groups (chronic aged and complex care, children and their families and disadvantaged communities) were introduced using a staged approach. Chronic aged and complex care was addressed first followed 12 months later by children and their families and then disadvantaged communities. Potential HealthOne participants are identified by GPs, community health workers, GP Liaison Nurses, other SWAHS service providers, government and non-government agencies and family members. The HOMD model of care is client/patient/carer centred with enrolment based on criteria, agreed partnership and co-case management between community health and GPs, case conferencing, agreed care planning, and specific service provision and referral – including allied health and social care (Figure 1). The HealthOne Mount Druitt Chronic Aged and Complex Care Model and Child and Family Model are summarised in Figures 2 and 3. Further detail of the HOMD model can be found in Appendix One.

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5   "Weekly income for 38 per cent of the population is below the poverty line. Lower education levels and higher crime levels (especially juvenile crime) than Sydney. Public housing rates of 45-50 per cent, compared to the Sydney average of 5.7 per cent, and a reported incidence of domestic violence 28 per cent higher than the next Area Health Service, as well as high levels of child protection notifications to social services." (http://www.health.nsw.gov.au/ Initiatives/HealthOneNSW/s1_mt_druitt.asp)

6   Data provided by WentWest, June 2012.

Table 1: Total HOMD Enrolments for Chronic and Complex/Child and Family to August 2011

	Chronic and Complex	Child and Family
Total number of referrals:	322	366
Total number of active clients:	125	177
Total number of GPs referred to:	90	85 *(June 2011 figure)*

Enrolment into HOMD was via either the Chronic Aged and Complex Care arm or Child and Family arm. Patients are eligible for enrolment into the chronic and complex arm if they had: a diagnosis of a chronic and complex illness; readmission into hospital within 28 days of discharge; risk factors such as being 75 years old and over, a risk of falls, cognitive impairment or reduced nutritional status; four or more ED/Hospital presentations in the past year, acute exacerbation of chronic condition(s); lack of social support; major life event, and; severe end stage illness.

Eligibility for enrolment into the child and family arm includes "any child and family where the case manager identifies that they require further support including collaboration, joint care planning and partnerships for ongoing care" with possible referral sources or eligibility identified as including: children in out of home care; children with chronic and complex conditions; children living in a family with identified complex psychosocial issues, and; maternal/paternal mental health issues impacting upon the health and development of the child.

The linchpin of the HOMD model of care is the two GP liaison nurses who identify the patient's needs based on referrals received and assessments made and facilitate communication, case conferencing and care coordination between the various health professionals and other providers involved in the patient's care. This may be done in person or by telephone ('virtually') without the GP or other service providers having to be physically present at the hub.

HOMD is delivered through a 'hub and spoke' model of care with some services provided from the hub such as the Wound Clinic, Child and Family Clinic and Antenatal Clinic but others provided through outreach clinics or 'spokes' to locations within the HOMD service area that do not have easy access to GPs and other health service providers. One such spoke, HealthOne Willmot, on the periphery of the Mount Druitt area, was opened in May 2009 after consultation with stakeholders and the local community and provides on a two part-day per week basis a Child and Family Health Clinic, a Women's Health Clinic and a Mature Aged Person's Clinic. The HOMD GP Liaison Nurses also participate in outreach and health promotional activities in disadvantaged communities in the Mount Druitt service area. The outreach aspect of HOMD continues to evolve.

The HOMD GPLNs were also involved in a structured ongoing program 'Medicine in Context' run from the School of Medicine, University of Western Sydney. Third year medical students undertook a five week placement at HOMD and, mentored by the GPLNs, carried out a HOMD based project. This gave the opportunity for the GPLNs to disseminate the philosophy of HealthOne and to educate future GPs about the importance of working collaboratively in order to enhance health outcomes for patients. It also gave the GPLNs the opportunity to inform medical students about the role and services provided by Community Health, some of whom had no knowledge of community health services. Local GPs engaged with HOMD also supported the Medicine in Context program by allowing students to visit their practices, educating them about the role of the GP in the community and encouraging them with their studies**.**

Figure 2: HealthOne Complex, Aged and Chronic Care Model

HealthOne Complex, Aged and Chronic Care Model

Mt Druitt Community Health
- Individuals with needs that impact upon quality of life
- Individuals recognised by GP's, Case Managers or Hospital as in need of co-ordinated healthcare

GP Liaison Nurse receives referral to Health One Sorts referrals with reference to entry criteria for Community Health

GP Liaison Nurse HealthOne intervention
- Level 1 Intervention (Doesn't meet Community Health criteria)
- Level 2 Intervention (Meets criteria)

Outcomes
- Level 1 Improved GP & service provider satisfaction
- Level 2 Enrolment to HealthOne & care coordination

Figure 3: HealthOne Child and Family Model

HealthOne Child and Family Model

All families with children
- Families with needs that impact on child's health and life-chances
- Families recognised by GP's, Case Managers or Hospital as in need of co-ordinated healthcare

GP Liaison Nurse receives referral to Health One Sorts referrals with reference to entry criteria for Community Health

GP Liaison Nurse HealthOne intervention
- Level 1 Intervention (Doesn't meet Community Health criteria)
- Level 2 Intervention (Meets criteria)

Outcomes
- Level 1 Alternate referral pathways identified
- Level 2 Enrolment to HealthOne & care coordination

Figure 4: The HOMD External Referral Pathway

HealthOne MT DRUITT   **NSW** GOVERNMENT | **Health** Western Sydney Local Health District   **medicare local** WESTERN SYDNEY *Connecting health to meet local needs*

HealthOne Mt Druitt Model of Care Flowchart
Service Providers External to Western Sydney Local Health District (WSLHD)

Preliminary Discussion	GP / community based organisation contacts the GPLN to discuss possible HealthOne client and Community Health eligibility	GPLN provides information and alternative support options external to Community Health

Yes   **No**

Referral	For appropriate referrals, GPs and community based organisations gain client's consent to make referral and complete other relevant documentation such as GP Management Plan to send to Central Referral Service (CRS)
	GP faxes referral and other documentation to CRS and flags client as HealthOne
Registration	CRS registers and forwards referral to Community Health Clinical Coordinator / Clinical Senior
Identification	Community Health completes a telephone triage and allocates case manager.
Assessment	Assessment and necessary referrals with written feedback to GPs completed. If additional support is required, client is considered for HealthOne enrolment

Does the client have multiple service providers involved in their care or need to be involved?	Has the client had multiple recent readmissions to hospital?	Does the client have increasingly complex health issues requiring multiple medications?	Children in out of home care - automatic enrolment	Chronic Disease Management clients	Child & Family clients

Enrolment	HealthOne program and benefits discussed with client by GPLN or case manager. Client consent is received and documented in CHIME. Client entered into GPLN HealthOne database
GP Feedback	GPLN or case manager liaises with GP regarding HealthOne enrolment and client care coordination and provides GP with a copy of the client assessment
Case Conference	GPLN contacts the GP and other service providers to offer community case conference and assist with the development of a multidisciplinary care plan
Case Review	GPLN or case manager can review the care plan with the GP and other service providers
Discharge	Case manager continues care with frequent written feedback to GP until client is discharged

For **HealthOne Mt Druitt Internal Referrals** the process would begin at Enrolment. If at any time the Community Health Case Manager feels the client would be appropriate for a HealthOne enrolment, they can have this discussion with the appropriate GP Liaison Nurse

May 2012
Page 1 of 1

13

Figure 5: HOMD Wound Clinic

2.2 Evaluation of HealthOne Mount Druitt

The Menzies Centre for Health Policy (MCHP) is committed to promoting, through research and scholarship, the development of policy for the care of people with chronic conditions. The Serious and Continuing Ilness Policy and Practice Study (SCIPPS) is a six-year NHMRC funded research program running from 2006 to the end of 2012 and designed to assess and gather evidence on patient-centred policy and health system interventions that improve the care and management of individuals with chronic illness. SCIPPS has a long-term objective to describe current chronic disease management strategies (phase one) and evaluate new and innovative interventions designed to enhance the quality of life for people with chronic conditions (phase two).

In phase one of SCIPPS fifty-two patients and 14 carers were interviewed (Jeon et al 2009). A further study consisting of focus groups with 88 health professionals – including GPs, allied health, specialists and pharmacists – was conducted with the aim of investigating this group's reaction to patients' perceptions of chronic health issues (Yen et al 2011). Common problems for people with chronic illness identified by health professionals, patients and carers included competing demands in self-management, financial pressure and co-morbidity. These studies also found that while patients and carers tended to focus on their personal challenges, health professionals often saw the patient experience as a series of failures relating to compliance or service fragmentation. These studies also confirmed that improved integration and coordination of health services was essential if the various

constituent parts of the health system are to work in more cooperative, flexible manner to plan and deliver a continuity of appropriate care to those with chronic illnesses.

Phase two of the SCIPPS program was to evaluate programs such as HOMD that are designed to address problems of fragmentation. Building on previous SCIPPS work, and to further explore how integration and coordination of services may be improved for people with chronic illnesses, SCIPPS partnered with SWAHS to evaluate the chronic and complex conditions arm of HOMD.

There were two components to the evaluation of HOMD, a process evaluation and an outcome evaluation. Both components of the evaluation contributed to answering the evaluation questions. The evaluation addressed the following questions:

- In what ways does HOMD make a difference in care provided to patients with chronic and complex conditions in Mount Druitt?

- In what ways has HOMD resulted in change in patient outcomes?

- In what ways has HOMD resulted in changes in health services?

According to the Mount Druitt HealthOne Implementation Plan (August 2008) expected change in health services include that care will be:

patient focused and flexible, with patients as active participants in care planning and management;

continuing, coordinated and comprehensive, both in the community and across the primary care – hospital interface;

delivered in the most appropriate setting(s) e.g. home, GP, other health facility, community outreach or community hub;

provided by multi-disciplinary teams.

Final approval for the Evaluation of HealthOne Mount Druitt was gained from the Human Research Ethics Committee (HREC) – Westmead Campus and the Westmead Research Governance Officer in March 2010.

Research activities for the Evaluation of HealthOne Mount Druitt began in August 2010 and concluded in November 2011.

2.3   Evaluation Methods

Consultation

A consultative approach has been taken by the evaluation throughout all phases of research planning and evaluative activity. This process was led by the HOMD Steering Committee in partnership with the SCIPPS team based at MCHP, University of Sydney.

Anonymity

As per HREC approval, research undertaken for this evaluation protected the anonymity of participants. In some instances the views and opinions of the people interviewed are available on the public record because of their profile as public sector employees, but this is not the case for many interviewees, including HOMD staff members, patients and local GPs. For these reasons, and for consistency, generic identifiers have been used for all participants throughout this report and any information that could easily identity interviewees has been removed from quoted interview material.

2.4 Outcome Evaluation

The outcome evaluation determined what changes, if any, had occurred in patient outcomes and health service utilisation and referral patterns.

Patient Outcome Measures

Patient outcome measures focused on changes, if any, in presentations and admissions to the emergency department and/or hospital. The Health Information Enterprise (HIE) database which includes FirstNet (Emergency Department database) and hospital data provided the evaluation with these patient outcome measures. Emergency Department presentations and hospital admissions were measured one year before patient enrolment in HOMD and one year after enrolment (see following chapter for further detail).

Organisational Outcome Measures

The type of data required to measure organisational and health service delivery changes included changes in referral and service utilisation patterns. The Community Health Information Management Enterprise (CHIME) of SWAHS database provided the evaluation with these organisational outcome measures. Organisational and health service delivery outcomes were measured one year before patient enrolment in HOMD and one year after enrolment (see following chapter for further detail).

HealthOne Mount Druitt Partnerships Survey

A partnerships survey (Appendix Three) was mailed to all service providers (both chronic and complex and child and family arms) with HOMD enrolled patients in August/September 2011. The survey aimed to collect data on barriers and facilitators to effective partnerships between GPs and Community Health. An unmarked return envelope addressed to HOMD was enclosed to ensure anonymity of respondents. A covering letter briefly explaining the purpose of the survey was also enclosed (Appendix Three).

2.5 Process Evaluation

The process evaluation supplemented the outcome study by describing the process of implementing HOMD. It uses qualitative data to track changes over time, and to identify the mechanisms that produced the process of changes. This approach is sometimes referred to as realistic evaluation (Pawson and Tilley 1997). Realistic evaluation explores the relationship between 'context' (e.g. the organisational setting, external factors and relevant chronic disease management policies), 'mechanisms' (HOMD Steering Committee members and policy and decision makers' ideas about how change will be achieved), and 'outcomes' (the intended and unintended consequences of HOMD).

Four groups were interviewed for the process evaluation: policy and decision makers (mainly at central office or AHS level); HOMD Steering Committee members; local area GPs; and patients and their carers. Qualitative data was collected through individual interviews and one focus group. Interview schedules varied from group to group and were semi-structured with broad topic areas specified to focus discussion but still allowing space for participants to pursue relevant topics of discussion not initiated by the researcher. Semi-structured schedules were used to maintain consistency of issues covered for the above groups interviewed but were modified according to each group and their differing roles within HOMD or chronic disease management more broadly (Appendix Two).

In addition to interviews and a focus group, policies, documents and Mount Druitt Community Health Service files pertaining to HOMD were reviewed in order to clarify the processes of implementation and service delivery.

These interviews and document studies were supplemented with direct observation of HOMD GP liaison nurse networking, health promotion and other community related activities during the course of the evaluation.

Qualitative data was analysed thematically using text coding software QSR NVivo Version 8. Broad subject areas and specific questions from the interview and focus group guides assisted in forming an initial coding frame. Transcribed interview data was coded using this framework. Analysis proceeded from categories derived from the coding framework. Findings are discussed in subsequent chapters.

Thirty-two semi-structured individual interviews were conducted with policy and decision makers; HOMD Steering Committee members and HOMD staff; patients; and local GPs (see Appendix Two for further detail and interview schedules).

Table 2: Evaluation Interviews

Policy and Decision Makers	5
HOMD Steering Committee Members and HOMD Staff	11
Patients	10
Local GPs	6
Total	**32**

3. Patient Admissions, Community Health and Survey Data

This chapter reports on the results of the outcome evaluation. Two outcome measures were collected, patient outcomes and organisational outcome measures. Analysis of these measures will contribute to answering the evaluation questions - in what ways, if any, has HOMD resulted in change in patient outcomes and in how health services are utilised.

3.1   ED Presentations and Ward Admissions for HOMD Patients

A before-after comparison of health service utilisation among people with chronic and complex conditions enrolled in the HOMD program and living in Western Sydney was carried out.

A total of 245 people were enrolled in the chronic and complex arm of HOMD program from its inception in September 2007 to 30 June 2010. Ninety three people of the 245 were excluded from the analysis as they did not have 12 months of data post enrolment in HOMD available for analysis.[7] Of the remaining 152 people, a further 27 people were excluded from the sample as they were no longer participating in HOMD due to entry into a nursing home, no longer living in the HOMD service area, or death. This made a total sample of 125 people.

A before and after study of 125 individuals compared their utilisation of health services in the 12 months preceding enrolment in HOMD with service utilisation in the 12 months following enrolment in the program. The period of enrolment for these 125 patients was from the 19/10/2007 to the 18/6/2010. Data was collected from six hospitals in Western Sydney.

Exploring changes in patient outcomes and how health services were utilised, the outcome evaluation also asked:

- Did the number of emergency department presentations decrease in the 12 months following enrolment in HOMD, compared to the 12 months prior to enrolment?

- Did the length of stay in the emergency department decrease in the 12 months following enrolment in HOMD, compared to the 12 months prior to enrolment?

- Did the number of referrals to community health practitioners increase in the 12 months following enrolment in HOMD, compared to the 12 months prior to enrolment?

This section details the results relating to the first two questions while the following section (3.2) reports results for the third of these questions.

Analyses

Descriptive data are presented as means and standard deviations, or frequencies and percentages. The main questions of the outcome evaluation are assessed using a non-parametric Wilcoxon Rank-Sign test. All analyses were conducted in SAS v9.2. Only patients that survived 12 months after recruitment were included in these analyses.

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7   It was decided that a minimum of 12 months of ED presentations and ward admissions before and after enrolment in HOMD was required per patient in order to calculate meaningful change.

Results

Table 3: Demographic characteristics of patients enrolled in the Health One Mt Druitt program for 12 months

Total	n		125
Age at referral	mean(SD)		68.4 (14.3)
	range		17 - 93
Sex of patient	n(%)	Male	51 (40.8)
		Female	73 (58.4)
		Not Known	1 (0.8)
Country of Birth	n(%)	Australia	35 (28.0)
		Other	30 (24.0)
		Not Known	60 (48.0)

Table three summarises the demographic details of patients in the evaluation. Of the 125 participants in HOMD, the mean age was 68.4 years, and the majority were female (58.4%). Death following completion of the 12 month follow-up was recorded for 13.6% of participants. Nearly half of participants did not have any data recorded on ethnicity (48%). In addition to the 125 patients who completed 12 month follow-up on HOMD eight eligible patients died before follow-up could be completed.

Table 4: Number of emergency department presentations and ward admissions among 125 HOMD patients in the 12 months before and after enrolment in HOMD

	Before HOMD	**After HOMD**	**Total**
Emergency Department Presentations	365	289	654
Ward Admissions	66	46	112

Across the 125 participants (over 24 months), there were 654 emergency department presentations and 112 hospital admissions (Table 4). There were more emergency department presentations in the 12 months prior to enrolment in HOMD than after (365 vs. 289). There were also more hospital admissions in the 12 months prior to enrolment in HOMD than after (66 vs. 46).

Table 5: Location of hospital presentation for participants enrolled in the Health One Mt Druitt program for 12 months

Hospital (ED presentation)	**Before HOMD** n (%)	**After HOMD** n (%)
Auburn Hospital	1 (0.8)	2 (1.6)
Blacktown Hospital	11 (8.8)	18 (14.4)
Mt Druitt Hospital	87 (69.6)	61 (48.8)
Nepean Hospital	4 (3.2)	2 (1.6)
Westmead Hospital	8 (6.4)	5 (4.0)
No presentations	14 (11.2)	37 (29.6)
Total	125	125

Table five shows that the majority of participants in the evaluation presented to Mount Druitt hospital when they required emergency treatment (69.6% before HOMD enrolment; and 48.8% after HOMD enrolment). Almost 30% of participants did not have any hospital presentations after enrolment in the program.

Table 6: Average number of ED presentations, hospital admissions and time in the ED for 125 patients in the Health One Mt Druitt (HOMD) program for 12 months before and after HOMD registration

Mean (95% confidence interval)*	12 Months Before HOMD	12 Months After HOMD	Difference (After-Before)	p-value
Average number of ED presentations per patient	3.1 (2.7-3.4)	2.3 (2.0-2.7)	-0.76	0.006
Average time patient spent in the ED (hours)	12.5 (9.9-15.6)	6.6 (5.0-8.8)	-5.80	0.009
Average number of ward admissions per patient	1.4 (1.3-1.5)	1.2 (1.2-1.3)	-0.12	0.082
Average time patient in hospital (ED and Ward) (hours)	6.3 (4.0-9.8)	3.7 (2.5-5.1)	-15.78	0.041

*All values of mean and CI in Table 2 are back-transformed from the log-scale

Table six shows descriptive statistics and significance tests to compare health service utilisation in the 12 months before enrolment in HOMD with the 12 months following enrolment. There were significantly more average emergency department presentations per patient in the 12 months prior to enrolment in HOMD than after (p=0.006), with an average of 3.07 visits per patient before HOMD and 2.31 visits after HOMD. There was significantly more time spent in the emergency department per patient in the 12 months prior to enrolment in HOMD than after (p=0.009), with an average of 12.44 hours before HOMD and 6.64 hours after HOMD. There was no significant effect of the HOMD program on the number of ward admissions.

3.2   Community Health Information Management Enterprise (CHIME) Data

This section details the results relating to the third question of the outcome evaluation, did the number of referrals to community health practitioners increase in the 12 months following enrolment in HOMD, compared to the 12 months prior to enrolment?

Table 7: Number of referrals to community health services, with service type and referral source, among 125 HOMD patients in the 12 months before and after enrolment in HOMD

		Total	Before HOMD	After HOMD
			n (%)	n (%)
Total number of referrals		580	297 (100)	283 (100)
Service Requested	Community Home Nursing	218	188 (63.3)	30 (10.6)
	Adult Physiotherapy	70	8 (2.7)	62 (21.9)
	Podiatry Service	68	24 (8.1)	44 (15.5)
	Adult Occupational Therapy	56	22 (7.4)	34 (12.0)
	Cancer/Palliative Care	39	22 (7.4)	17 (6.0)
	Adult Psychosocial	38	0 (0.0)	38 (13.4)
	Aged Day Care	36	14 (4.7)	22 (7.8)
	Community Dietetics Adult	34	5 (1.7)	29 (10.2)
	Continence Service	14	10 (3.4)	4 (1.4)
	Other	7	4 (1.3)	3 (1.1)
Referral Source	Acute care (hospital inpatient)	198	164 (55.2)	34 (12.0)
	Health service provider	182	73 (24.6)	109 (38.5)
	Client	99	32 (10.8)	67 (23.7)
	Family/friend/neighbour	30	7 (2.4)	23 (8.1)
	Community/Aged Care Package	27	1 (0.3)	26 (9.2)
	Community Options Program COPS)	17	0 (0.0)	17 (6.0)
	Domiciliary nursing	6	3 (1.0)	3 (1.1)
	General practitioner (GP, LMO)	5	5 (1.7)	0 (0.0)
	Other	16	12 (4.0)	4 (1.4)

Across the 125 participants in HOMD (over 24 months), there were 580 referrals to community health services. There were more referrals made in the 12 months prior to enrolment in HOMD than after (297 vs. 283). The majority of community health referrals were for community home nursing services (218 referrals). The number of these referrals decreased from 188 (63.3%) before HOMD enrolment to 30 (10.6%) after enrolment. Most referrals were made in an acute hospital inpatient setting, or by a health service provider. The number of referrals made in a hospital inpatient setting decreased substantially after HOMD enrolment, from 164 (55.2%) to 34 (12.0%). The number of referrals made by health service providers increased from 73 (24.6%) to 109 (38.5%).

Table 8: Average number of referrals to community health services for patients in the Health One Mt Druitt (HOMD) program for 12 months before and after HOMD registration

	12 Months Before HOMD	12 Months After HOMD	Difference (After-Before)	p-value
Average number of referrals per patient	2.5	2.4	-0.1	0.02

Table eight shows descriptive statistics and significance tests to the average number of referrals to community health services for patients in HOMD with the 12 months following enrolment. There were significantly fewer number of community referrals per patient in the 12 months prior to enrolment in HOMD than after (p=0.02), with an average of 2.5 referrals per patient before HOMD and 2.4 referrals after HOMD.

3.3 Changes in Patient Outcomes and Health Service Utilisation

Outcome evaluation questions included whether emergency department presentations and length of stay decreased in the 12 months following enrolment in HOMD compared to the 12 months prior to enrolment. This study found that among people with chronic and complex conditions enrolled in the HOMD program the number of emergency department presentations, and length of stay in the emergency department, in the 12 months following enrolment in HOMD was significantly less than in the 12 months prior to enrolment. Almost 30% of participants had no hospital presentations after enrolment in the program.

The outcome evaluation also asked whether the number of referrals to community health practitioners increased in the 12 months following enrolment in HOMD, compared to the 12 months prior to enrolment. Health service utilisation analyses showed that the number of referrals to community health for people with chronic and complex conditions fell considerably following enrolment in the HOMD program. This was part of a change in pattern of service utilisation in the 12 months after enrolment. Referrals to allied health services such as physiotherapy, podiatry, occupational therapy, dietetics and psychosocial services rose but there were fewer referrals to community home nursing. This result suggests that clients enrolled in HOMD were already linked with Community Health nurses, and the process of care coordination through HOMD identified a range of service needs and facilitated additional allied health referrals. The sources of referrals also shifted, with fewer from the acute care (hospital inpatient) setting and more from other health service providers and families, friends and neighbours. The assumption is that clients enrolled in HOMD were already linked with Community Nurses. However the process of care coordination through HOMD identified a range of service needs and facilitated the additional allied health referrals

From these results it is clear that changes in patient outcomes and health service utilisation have occurred among people with chronic and complex conditions enrolled in the HOMD program. However, it is less clear whether these changes are the result of the activities of HOMD, as the before-after study design, and the absence of a comparison group, create some difficulties in distinguishing between program efficacy and a confounding temporal effect.

3.4 HOMD Partnerships Survey Data

Ninety-five surveys were sent to GPs and 68 to other providers. Fifty-six surveys were returned, 24 from GPs and 32 from other disciplines. This yielded response rates of 25% for GPs, 47% for other providers and 34% for both groups overall.

Figure 6: Survey Respondents
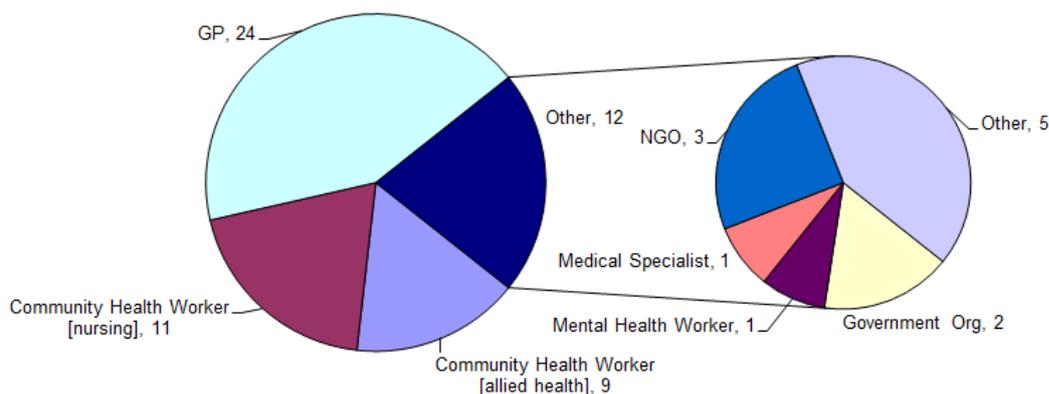
Involvement with HOMD

GPs and other health professionals responding to the survey were involved in HOMD by receiving information, making referrals and participating in case discussions and conferences (Figure 7). Three quarters of GPs and 78% of other health professionals surveyed had received information from HOMD. Three quarters of other health professionals made referrals through HOMD compared to half of GPs responding to the survey. Both groups had high rates of participation in case conferences with 17 GPs out of the 24 (71%) and 28 out of the 32 other health professionals (87%) indicating that they had participated in a HOMD case conference. Lower numbers of those participating in case discussions (53%), particularly GPs (37%), is probably due to the fact that this was a more informal mechanism of case conferencing with the majority of HOMD cases receiving formal case conferencing when further case management was required. Other ways of being involved in HOMD included attending HOMD Steering Committee meetings (two GP respondents), attending a GP meeting (one GP respondent) and consultation with HOMD for ongoing care coordination (one respondent).

Figure 7: Level of Involvement in HOMD
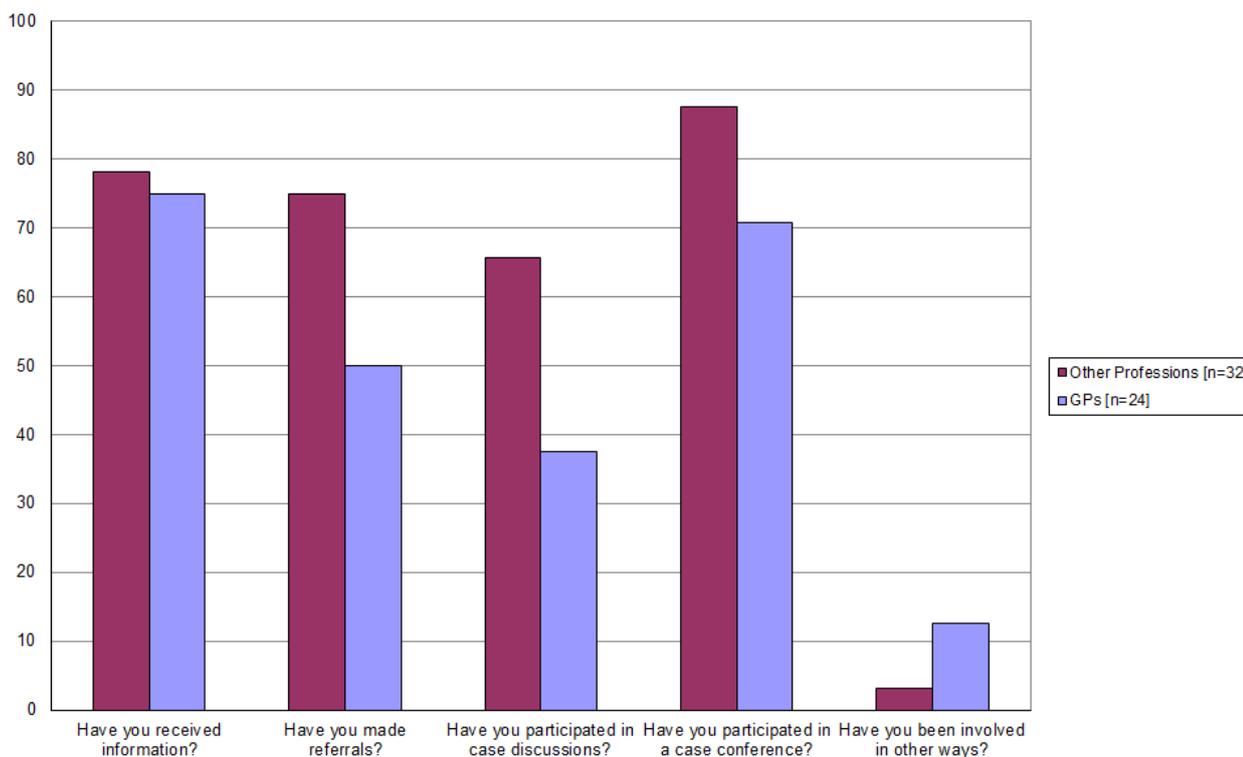
Goal Clarity, Commitment and Need for Partnership

All respondents agreed or strongly agreed that there was need for a partnership approach. The majority of respondents agreed or strongly agreed that HOMD had a clearly stated goal (87%) with two GPs indicating they were unsure about this. Two other health professionals also indicated they were unsure about this with a further two disagreeing that HOMD had a clearly stated goal. The majority of respondents, including all GPs answering the question, either agreed or strongly agreed that they were committed to the HOMD goal (90%). Four health professionals indicated they were unsure about their commitment.

The GP Liaison Nurse Role

Almost all respondents (n=54, 96%) either agreed (n=37, 66%) or strongly agreed (n= 17, 30%) that the GPLN role facilitated effective communication and information exchange between clients and service providers with only one person disagreeing and another being unsure about this (Figure 8). All GPs surveyed either agreed (n=18, 75%) or strongly agreed (n=6, 25%) with this statement.

The majority of respondents (n=47, 84%) also agreed (n=33, 59%) or strongly agreed (n=14, 25%) that the GPLN role crossed traditional boundaries to enhance care coordination between clients and service providers (Figure 8). Three GPs disagreed with this and six people were unsure (three GPs and three other health professionals). Ninety per cent of health professionals (n=29) agreed (n= 20, 62%) or strongly agreed (n=9, 28%) that GPLNs enhanced coordination while 75% of GPs (n=18) agreed (n=13, 54%) or strongly agreed (n=5, 21%).

Figure 8: The GP Liaison Nurse Role
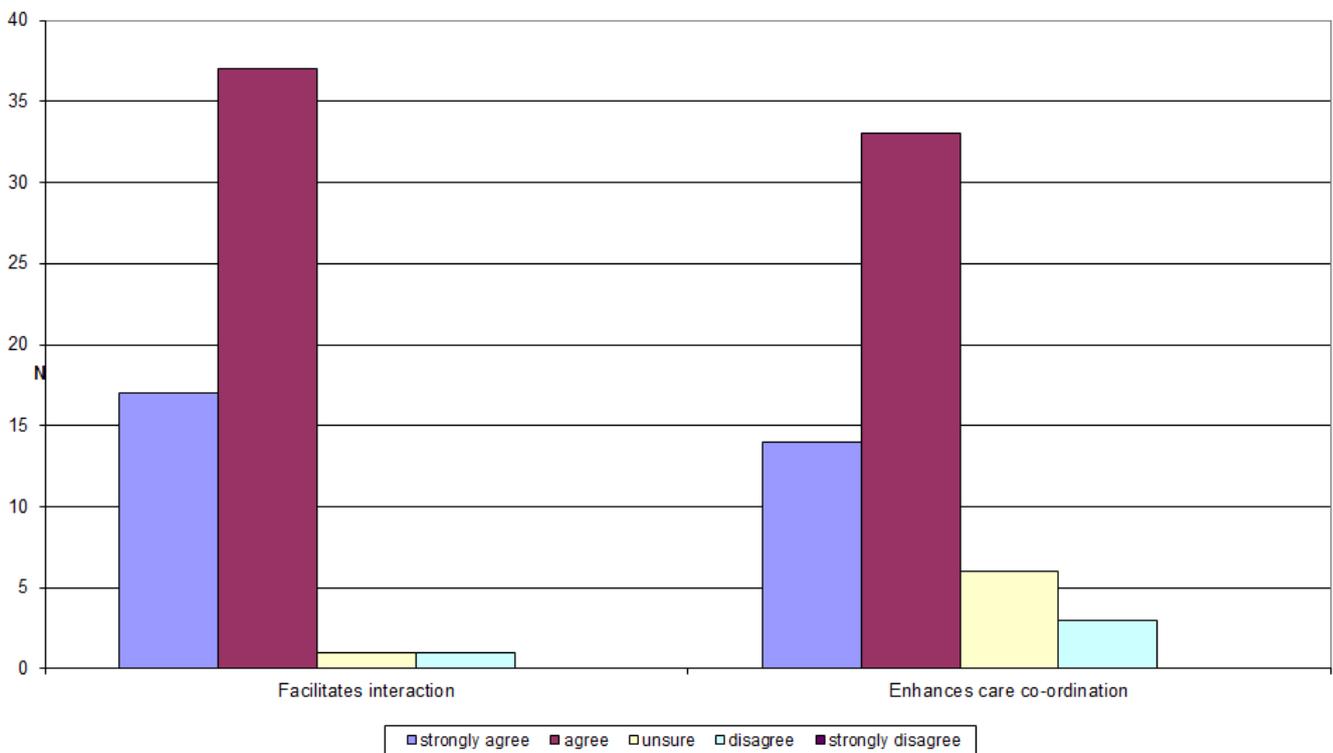
Almost all respondents (n=53, 95%) indicated that the GPLN role was important (n=24, 43%) or very important (n=29, 52%) to the functioning of HOMD. Only three people were unsure about this (Figure 9). Ninety-six per cent of GPs (n=23) thought the GPLN role was important (n=14, 58%) or very important (n=9, 38%) with one GP unsure. Ninety-four per cent of other health professionals (n=30) thought the GPLN role was important (n=10, 31%) or very important (n=20, 63%) to the functioning of HOMD with two people unsure. No one thought the GPLN role was unimportant or very unimportant.

Figure 9: The Importance of the GPLN Role to the Functioning of HOMD
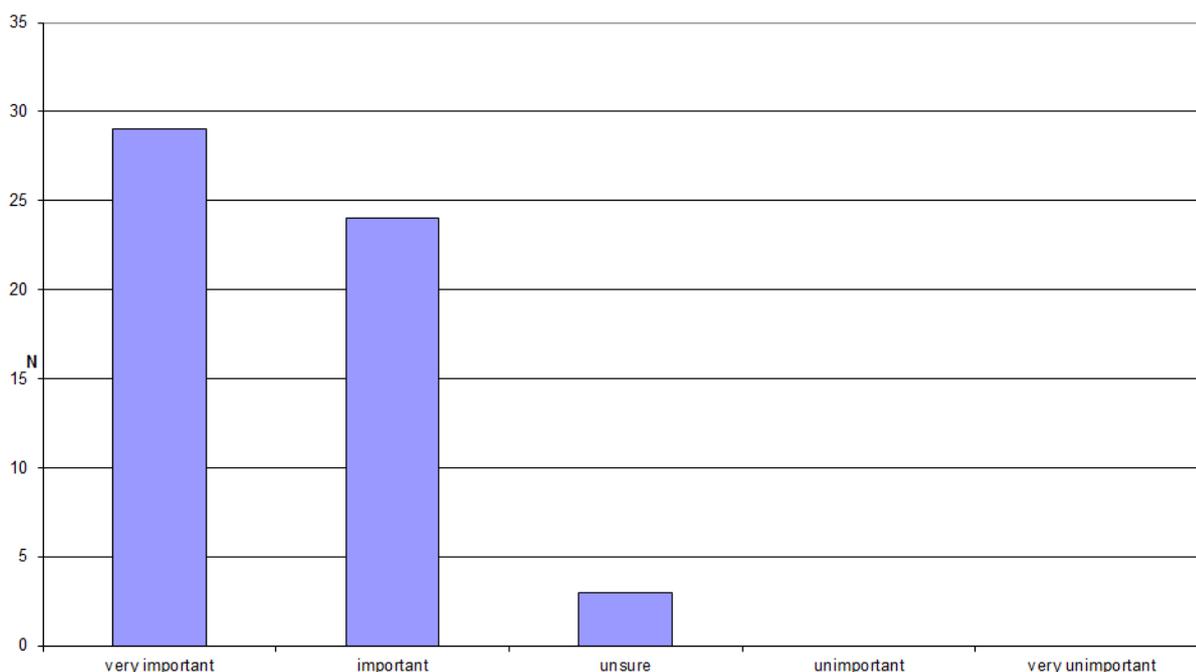
Systems and Processes

The majority of people responding to the survey reported they understood HOMD referral processes (82%) with seven people indicating they did not understand (12%) and a further seven (four GPs and three other health professionals) indicating they were unsure about HOMD referral processes. Seventy-nine per cent of GPs and 84% of other health professionals reported they understood referral processes of HOMD.

Over half of the people responding to the survey reported HOMD did not duplicate services and processes already available in the Mount Druitt area (62%) but over a quarter (27%) of respondents were unsure about this. Six people (11%) thought HOMD did duplicate services available. Among health professionals 69% thought HOMD did not duplicate services while over half of GPs also thought this (54%). However, over a quarter of GPs (29%) and a quarter of other health professionals were unsure whether HOMD duplicated services or not.

Almost half of respondents (46%) disagreed that the day to day administrative processes of HOMD were cumbersome although a third of respondents were unsure. GPs were more ambivalent about this than other health professionals with almost half of GPs being unsure (42%) and 21% agreeing that processes were cumbersome. Over half of other health professionals (53%) did not think HOMD processes were cumbersome but a quarter were unsure and almost another quarter (22%) agreed HOMD processes were cumbersome.

Case Conferences

Almost all respondents (n=44, 94%) agreed (n=31, 66%) or strongly agreed (n=13, 28%) that case conferences improved planning and coordination for HOMD clients/patients. Two people (GPs) were unsure about this. Ninety per cent of GPs (n=19) agreed (n=15, 71%) or strongly agreed (n=4, 19%). Almost all other health professionals (n=25, 97%) agreed (n=16, 62%) or strongly agreed (n=9, 35%) that case conferences improved planning and coordination. One health professional disagreed that case conferences had improved planning and coordination for HOMD clients/patients (Figure 10).

Figure 10: Case Conferences Improved Planning and Coordination
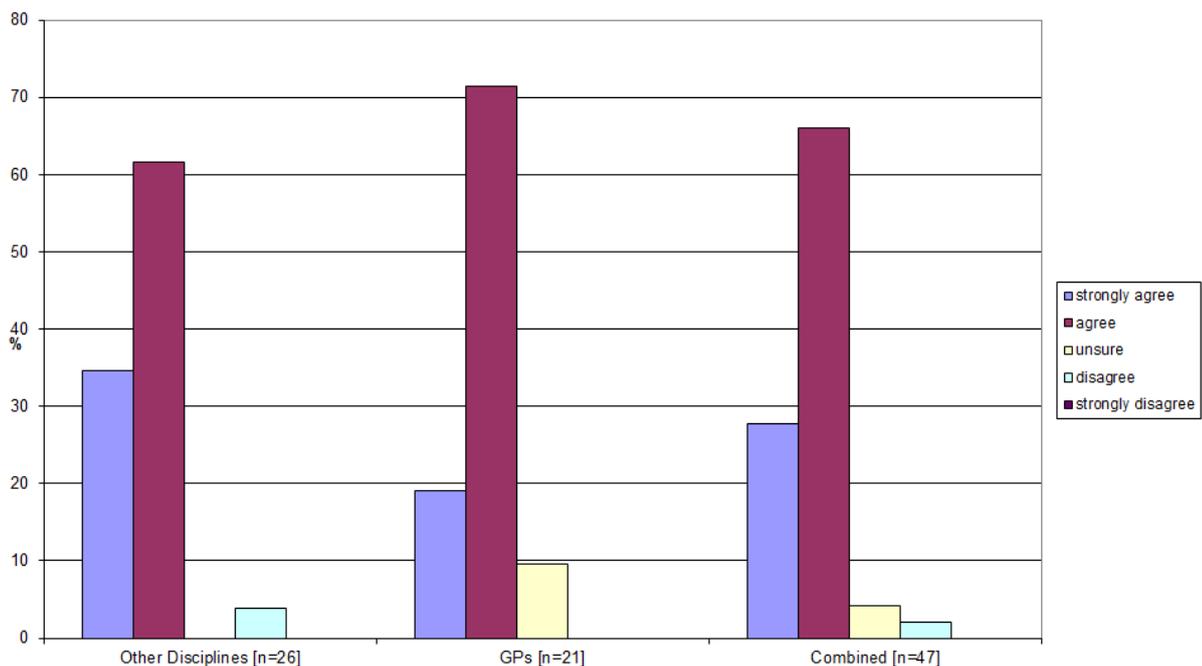
Benefits and Drawbacks of HOMD

Overall, almost all survey respondents (90%) indicated the benefits of being involved with HOMD were either greater than the drawbacks (49%) or far outweighed the drawbacks (41%). Three people thought the benefits and drawbacks were 'about equal' and two people indicated the drawbacks were greater than the benefits. No-one thought the drawbacks far outweighed the benefits (Figure 11). Ninety per cent of GPs thought the benefits of being involved with HOMD far outweighed (38%) or were greater than the drawbacks (52%). Two GPs thought the benefits and drawbacks were 'about equal.'

Figure 11: Benefits and Drawbacks of Being Involved in HOMD
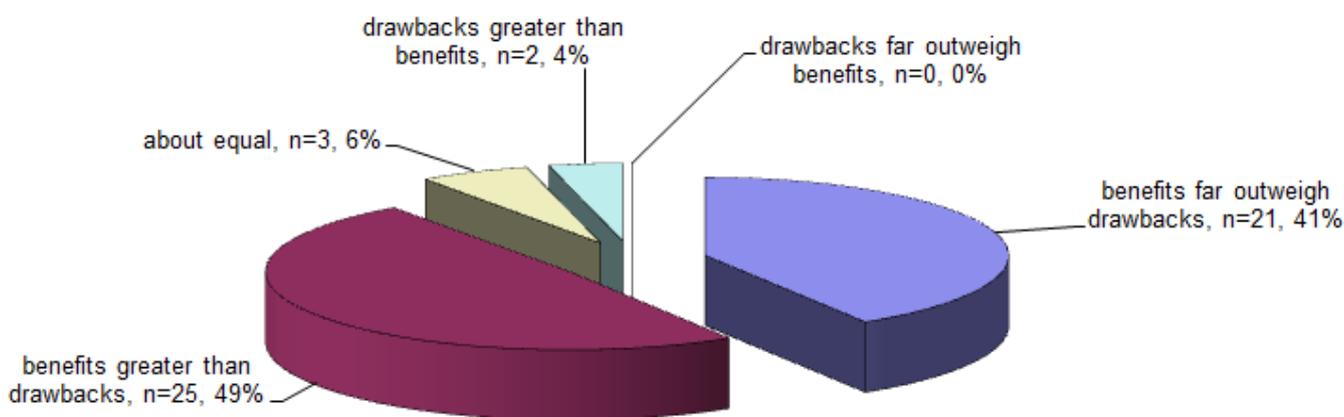
Survey respondents selected from a list of potential benefits and drawbacks from working in a partnership those which they considered applied to HOMD. Table nine shows proportions (expressed as percentages) of respondents who endorsed each of the listed benefits. Overall, respondents identified the top five benefits of HOMD as: more comprehensive planning for clients; closer working links with other organisations; better service coordination for patients with multiple needs; enhanced relationships with health workers and other areas for collaboration opened up/ improved the range of health services in Mount Druitt.

GPs identified the top five benefits of HOMD as: improved the range of health services in Mount Druitt; closer working links with other organisations/more comprehensive planning for individual clients; and, enhanced relationships with health workers/better service coordination for patients with multiple needs.

Other health professionals identified the top five benefits of HOMD as: more comprehensive planning for individual clients; closer working links with other organisations/better service coordination for patients with multiple needs; and, enhanced relationships with health workers/ better service coordination for patients with multiple needs.

Table 9: Benefits of HOMD

Benefits of HOMD	GPs (%)	Other Health Professionals(%)	Combined (%)
access to knowledge about community	52	69	62
access to a wider range of services	61	69	65
enhanced relationships with health workers	70	75	73
closer working links with other organisations	74	78	76
more comprehensive planning for individual clients	74	88	82
other areas for collaboration opened up	65	72	69
improved the range of health services in Mt Druitt	87	56	69
assists in the development of personal skills.	30	44	38
it provides a single point of contact	65	47	55
better service co-ord. for patients with multiple needs	70	78	75

Table ten shows proportions (expressed as percentages) of respondents who selected each of the listed drawbacks they considered applied to HOMD. Overall, respondents identified the top five drawbacks of HOMD as: participation by individual practitioners is variable; involvement in HealthOne makes more work; progress is sometimes too slow in moving towards objectives; frustrations with different personalities or conflicting points of view, and; power tends to be usurped by the bigger players.

GPs identified the top five drawbacks of HOMD as: participation by individual practitioners is variable; progress is sometimes too slow in moving towards objectives/ involvement in HealthOne makes more work, and; power tends to be usurped by the bigger players/ frustrations with different personalities or conflicting points of view.

Other health professionals identified the top five drawbacks of HOMD as: participation by individual practitioners is variable; involvement in HealthOne makes more work; progress is sometimes too slow in moving towards objectives, and; frustrations with different personalities or conflicting points of view/HealthOne patient priorities conflict with other priorities.

Table 10: Drawbacks of HOMD

Drawbacks of HOMD	GPs (%)	Other Health Professionals(%)	Combined (%)
the partnership is inefficient in its use of resources	9	16	13
progress is sometimes too slow in moving towards objectives	39	31	35
power tends to be usurped by the bigger players	17	19	18
less control over own agendas	9	13	11
frustrations with different personalities/conflicting points of view	17	22	20
involvement in HealthOne makes more work	39	41	40
individual contributions are not sufficiently acknowledged	13	6	9
reputation adversely affected by the reputation of others	9	6	7
HealthOne patient priorities conflict with other priorities	9	22	16
participation by individual practitioners is variable	61	63	62

4. Patients and General Practitioners (GPs)

Interviews with patients, their carers and GPs formed part of the process evaluation of HOMD. This qualitative data complements the outcome evaluation and addresses the evaluation questions by providing in-depth detail of processes and activities associated with the implementation of the program and clarifying how outcomes occurred.

Ten individual interviews were undertaken with patients (and conjointly with one carer who was available and consenting) and focused on changes in experience of chronic illness and its management as a result of HOMD. Where possible, paired interviews were carried out with the patient's GP, if available and willing, to gain a fuller picture of care and management of illness from the points of view of care providers and care recipients (see for example Kendall et al. 2009). Six patients' GPs were interviewed. In some instances GPs interviewed had more than one patient enrolled in the HealthOne program. Only one GP declined to be interviewed for the evaluation.

These interviews were supplemented with the HOMD Partnerships Survey (Appendix Three). The survey was mailed to all service providers (both chronic and complex and child and family arms) with HOMD enrolled patients in August/September 2011. The survey aimed to collect data on barriers and facilitators to effective partnerships between GPs and Community Health. An unmarked return envelope addressed to HOMD was enclosed to ensure anonymity of respondents.

Nine-five surveys were sent to GPs. Twenty-four surveys were returned giving a response rate of 25%.

All GPs responding to the survey reported they were committed to the HOMD goal. Three quarters of GPs surveyed had received information from HOMD. Seventy-one per cent of GPs had participated in a HOMD case conference with most agreeing that case conferences improved planning and coordination. All GPs surveyed agreed or strongly agreed that the GPLN role facilitated effective communication and information exchange between clients and service providers. Three quarters of GPs agreed or strongly agreed that GPLNs also enhanced coordination. Seventy-nine per cent of GPs said they understood HOMD referral processes but over a quarter were unsure whether HOMD duplicated services or not.

GPs identified the top five benefits of HOMD as: improved the range of health services in Mount Druitt; closer working links with other organisations/more comprehensive planning for individual clients; and, enhanced relationships with health workers/better service coordination for patients with multiple needs. They identified the top five drawbacks of HOMD as: participation by individual practitioners is variable; progress is sometimes too slow in moving towards objectives/ involvement in HealthOne makes more work, and; power tends to be usurped by the bigger players/ frustrations with different personalities or conflicting points of view.

4.1   General Practitioners

Providing Care for People with Chronic Illnesses before HOMD

GPs who have patients enrolled in HOMD were interviewed to provide detailed accounts of their experiences of providing care for people living with chronic illnesses prior to their involvement with HOMD. They were also asked about what problems or difficulties they encountered in providing care as well as what issues they felt their patients faced before their enrolment in HOMD.

GPs talked about of number of issues they believed impacted on their patients' ability to manage their own chronic illnesses. These ranged from difficulty in getting transport to appointments, programs and health services (see also Corcoran, McNab, Girgis and Colagiuri, 2012) to cost of medications, particularly for those with multiple illnesses and so corresponding cost of multiple medications, even with pharmaceutical subsidies eg Healthcare card (Essue et al. 2011). GPs also described the

difficulties patients faced in being motivated to change unhealthy behaviours relating to their chronic illnesses. One GP complained of the frustrating time consuming barriers that restrict access to COPD, cardiac rehabilitation and other health and exercise programs. Long waiting lists were exacerbated by poor information on available services. GPs lacked the time to search out the appropriate person or service organisation.

One GP was concerned at inadequate support in the home for people with chronic illnesses, sometimes leading to unnecessary hospital presentations or admissions: "… support at home is lacking greatly. I think [community health] nursing is helpful but unfortunately [there are] not enough nurses to go around and there's not enough support at home. Often people call ambulances for attention and treatment at home… or get taken to hospital and admitted for 24 hours sometimes."

For another GP, a particular difficulty was the need to repeatedly explain treatment, care and/or medications even with a relative or carer present to assist. As this GP put it "I get surprised by how much misunderstanding can happen sometimes and it has to be clarified once, or twice, or three times with complicated patients." Limited time to give explanations further exacerbated this difficulty. This was further complicated by a need for more than one healthcare professional, for example specialists or allied health professionals as well as the GP, to explain different aspects or options of a person's treatment or care, as the differing perspectives of different healthcare professionals can assist in the process of understanding and clarifying information given.

Information Provision, Referral and Feedback without HOMD

Referring to Hospitals and Community Health Services

GPs also spoke about the difficulties in providing care for people with chronic illnesses because of information blocks within the health sector. The most common comments were about a lack of information provision from other providers such as difficulty in getting information about patients, including poor referral and feedback processes.

One GP commented that before HOMD was implemented and the GPLN was available to liaise with other service providers and assist with information concerning referrals "I did everything myself" which in this case meant referring only to those services that were known about, with a known contact person. For this GP that meant referring chronically ill patients mainly to the hospital – generally the dietician or the diabetic educator. This GP described this situation as "not very satisfactory" continuing that "we would get some feedback from the hospital but not a lot, you know, very scanty, if we [got] anything at all." When asked about communication and referral to community health services (home nursing or allied health) for this GP difficulty in reaching busy and often unavailable community health staff hindered the referral process:

> … we did have the community centre with the community nurses who would help us or who would see the patients, but they were also understaffed, yeah. You'd ring up – when we can get them … we [would] ring up and nobody will answer the phone ….

Another GP described a similar situation when it came to referring chronically ill patients to other health services "I really didn't know much what to do, you know … I really tried to get the patient to see me more than once … but really I didn't have [many] resources to help them … I struggled with that actually." When asked about organising home help for patients without spouses or carers when they were discharged from hospital this GP responded "I didn't have [any] idea what to do." When asked about referring to community health this GP said they knew community health services were available "but the waiting list is so long and so hard to get [patients] in" adding "it was very hard to know who to ring up or talk to."

Communication within the health sector remains patchy and ad hoc. Where information provision,

feedback and referral works it is more the result of luck and personal relationships. In much of the system, no communication occurs at all.When asked about communication with community health outside the operation of HOMD a third GP said "I think there is an abyss with respect to communication between me and community nurses." However, this GP has forged a close relationship with a local Aged Care Facility and describes the situation there as very different. Nursing staff provide ongoing and constant communication about patients; this relationship works well "because we're looking after the patient, I'm respecting her [aged care nurse's] professionalism, she's respecting mine and the patient, and I know that she's not an idiot."

A fourth GP interviewed described "trouble with ringing hospital-based services" and went on to discuss the difficulty a GP can face "isolated from the loop" of information and feedback about their patients, receiving little information about the care received by a patient. :

> ...it isn't helpful and you see after we've been here for 37 years or something … we know these people very well and not only do we know the patient very well, we also know the relatives very well, so we have patients that I know the cousins, the uncles, the grandparents, the grandchildren, you name it right, and so if there are social issues involved, which often there are as well, then to be honest we often know who to go to for that … And so I do think that from both the patient's perspective and from ours that if we have better communication with the hospital then that is going to make a big difference to patient care and it's going to mean that [it is] less frustrating for our job and … also for the community health people's job to be honest, yeah.

This GP added that the complex issues involved in providing care for an ageing population of the chronically ill makes improving communication even more pressing:

> Because people – our practice population is aging and – although we still have a lot of kids coming through the doors, by and large we have a lot of middle aged people now. We don't at this stage have a lot of geriatric patients. We have some … and for those people it's terribly important that we have this sort of communication. And of course people are cared for longer now. They have more chronic illnesses than they had in the past. They're living longer. They're on lots more medications and there are lots and lots more issues but as I said, I still think of us as the linchpin of the service and I think that really, that our knowledge should be useful to these people [hospital and community health staff] as well. You know, there should be things that they can give to us but there should also be a lot that we can communicate to them …

Discharge Summaries

Inconsistent practices in providing discharge summaries to patients on their departure from the hospital recurred as an issue of concern in the GP interviews. Although most GPs interviewed said they received discharge summaries from patients at their first appointment after discharge from hospital, it was not uncommon that a patient would not bring the summary, or was confused over whether they had received a summary and about the treatment or medication they received in hospital. This could lead to the GP being unclear about treatment, medications and care that had been provided in the acute setting. As one GP explains:

> Mostly we get discharge summaries. Sometimes we don't and we have to chase around to get discharge summaries and I will do that maybe more than once a week I'm chasing around looking for a discharge summary because someone comes in here and doesn't really understand exactly what they're meant to be on [medications] or exactly what happened to them … Discharge summaries are essential and I do think that if someone has a very serious problem that it would be better to communicate directly to us.

When GPs were asked what they did when a patient arrived at an appointment without a discharge summary many responded that their support staff, usually their receptionist, had to follow up and get the summary (or to follow up on other patient and service/referral information) as they were under too much time pressure to be able to do it themselves.

Time Pressure

The subject of time pressure was also brought up by the GPs interviewed in other contexts of caring for the chronically ill. One GP commented that "it's very hard for me to make time or have time to arrange home care" adding that although home visits were valued by the practice they were often very time-consuming both from the point of view of providing care and travel times to and from the patients' homes. Another GP remarked "the chronically ill are very, very time-consuming" continuing "we do our best to give them the time but I wonder … how elderly people can get through a clinic in five minutes because to me it's a Pandora's box, one thing leads to another."

4.2   GPs' Views of HealthOne Mount Druitt

GPs made a number of comments about their interaction with HOMD and its impact on the care of their chronically ill patients, in particular that it had improved considerably information flow, feedback and referral processes between hospital, community health (including allied health) and GPs. The HealthOne Mount Druitt GP Liaison Nurse (HOMD GPLN) was pivotal to these processes and central to liaising with and supporting GPs (see also HOMD Partnership Survey results section 3.4).

One GP described his interactions with hospitals before HOMD in the following way, "30 years ago there was nobody helping us so if the patient was sick we'd send them to the hospital and the hospital would try and fix them up and send them home, sometimes with a letter, sometimes with nothing at all." When asked about whether HOMD had made a difference to this situation this GP responded:

> … see if my patient is admitted I ring up [the HOMD GPLN] and say, "So and so is admitted, can you find out what's happening" … So that's where [the GPLN] comes in, and then she'll ring me up and say, [the patient] is in what ward, who's looking after her, what's the problem … Yes, and then when [patient is] going to be discharged we have discharge conference if necessary, and so the patient knows that I know what's happened to her and she's getting support, yeah. Or if I'm not aware the patient has been admitted sometimes [the GPLN] will ring me and tell me.

This GP also commented that "HealthOne helped us coordinate, yeah, and get feedback from the allied health providers and from hospitals." This GP was particularly enamoured with the fact that because of HealthOne "I don't have to do everything myself now" continuing that "… before I had to do everything myself and my secretary would ring up and book the appointment, or there was just no service available, no physiotherapy, very few dieticians …"

Another GP discussed the GPLNs' familiarity with allied health services and their applicability to situations and patients that a GP would not necessarily think of, being less familiar with these services, saying that the GPLN had "a very good grasp" of allied health and what it had to offer continuing that "I tend not to even think of OTs, dieticians, whatever." This GP was also of the view that the GPLN had "every aspect" of a HealthOne patient's care covered, from organising appropriate nursing staff to see the patient (such as cardiac or respiratory nurse specialists) to organising assessments (such as Aged Care Assessment Team assessments) to ensuring communication occurred between the hospital and GP for patients being admitted or discharged. A third GP placed considerable value on the GPLN being a single point of contact for GPs, a face and/or voice that was known and that an ongoing relationship of mutual trust could be built up over time:

> I mean it's probably very selfish of us, we like to have one or two people that we can communicate with. It's no good us having a whole 10 different sections. It's better if [it's] one person … [the GPLN] was the one that we could say now [GPLN] what can we do here and she would know which one of these [health professionals/service providers] that needed to phone us or we need to phone them or whatever … It does help me to know the person and [the GPLN] would call in at the practice, we would phone her. It was all relatively easy. It made a big difference.

Several GPs also commented on the benefit of the GPLN's local knowledge, which allowed more efficient and effective liaison than GPs were able to carry out, not only because they did not have the detailed local knowledge of health and non-health sector service providers required (including service areas/boundaries, eligibility criteria etc) but also because they did not have the time to "have to spend my day on the telephone" as one GP put it. This GP described the liaison and coordination that the GPLN provided as "very valuable", also commenting that it made "a huge difference" to providing care and support for chronically ill patients beyond the GP's surgery.

> And we did use [the HOMD GPLN] for a lot of that liaison work because to be perfectly honest, it's a minefield trying to find the right telephone number or the right service sometimes … then all these other services, they're the ones that I'm not able to keep tabs on because they seem to change all the time. And so I found it very, very useful for [the GPLN] to visit and to then - if I said well, we need, you know, the OT to assess to put a ramp in or to get the shower adjusted or we need Meals on Wheels or we need all of these things, then [the GPLN] had the contacts to be able to mean that I didn't have to spend my day on the telephone … or to spend hours going from one service to the other because your patient might live a street away and therefore they're in Blacktown, or they're covered by Penrith or whatever, that makes a huge difference … but it does require someone with a lot of local knowledge.

Another GP pointed out that the HOMD GPLN was dedicated, hard working, and committed to the role, commenting "I think she put a lot of herself into it, and I don't think you find that very often." This raises the question of leadership – committed people in the HOMD roles driving its success – and whether HOMD can continue its success by enshrining successful systems and procedures in ongoing processes. It also raises the issue of appropriate qualifications, training and continuing resources and support for not only existing GPLNs, but also for new people coming to the role, or for the expansion of the role into other areas or services.

Some GPs also commented on the sustainability and continuation of HOMD into the future with one GP musing "I suppose all my patients should be in HealthOne … why should I [not] make use of HealthOne if the patient needs it, yeah, so all my patients are potential HealthOne patients, I would put it that way, yeah." In a similar vein, another GP remarked "we would certainly have more people that this service would be appropriate for" concluding "[s]o I'm hoping that that sort of service will continue and expand actually."

4.3 HealthOne Mount Druitt Patients

GPs were also asked about HealthOne in the context of providing care to a specific patient enrolled in HOMD. Many of the general points made about HOMD in the previous section are illustrated in more detail in the following section which describes GPs experiences of providing care for their chronically ill patients in partnership with the HOMD program.

HOMD patients were also interviewed about their experiences of HOMD. Their views are also incorporated into the following section.

<u>Mrs N.</u>

Mrs N. was 56 years old at the time of the evaluation interview in 2011. She had been diagnosed with lung cancer some years previously, and had undergone surgery in 2007 to remove a tumour. She had received chemotherapy treatment at the time but the cancer had since returned. She also suffered from severe COPD. She was enrolled in HOMD in 2008. At the time of the evaluation interview Mrs N. knew she did not have long to live and would soon require palliative care, but wished to continue living at home as long as she could, assisted by her husband (who was also her carer).

The GP caring for Mrs N. described how HOMD assisted him by liaising with and coordinating hospital and palliative care services as he did not have the time to do this himself. As he put it, "I need HealthOne to do the coordination for me because I don't have the time to ring around the hospitals and palliative care" continuing "I'll tell [the GPLN] what I need, what's my problem, and she'll do whatever she can … she rings me or she drops in a letter." This GP said he did not always have the time to make home visits to Mrs N. and that he got support from HOMD who provided nursing community health staff to do home visits when he was not able.

> I don't have the time to go and visit her, I do home visits but it's very helpful if somebody else can come to her – when she rings up and I can't go, you know? Now I call [the GPLN] if it's important, you know? So [Mrs N.] feels there's always somebody she can turn to, yeah …

He also said that along with him as GP, and the hospital-based cancer care team, Mrs N. also felt supported by HOMD, which was important to Mrs N. while she was being cared for at home. As he explained:

> [Mrs N.] has done very well. I'm very happy for her because I think the support was very important other than from me, you know, or from the cancer care team which is hospital based … I think she felt in the beginning – especially in the beginning – that people were there to help her, you know …

Another important aspect of the support and care provided by HOMD was the case conference arranged by the GPLN and attended by the patient, the patient's husband, the GPLN, and the GP to ascertain the patient's needs. Apart from the more obvious clinical needs, a perhaps less obvious outcome of this case conference was the social dimension of support required for the patient to remain at home, in Mrs N.'s case some assistance with housework and accommodation needs. As Mrs N.'s GP explains:

> Yeah, we had a case conference… I was there once at least, you know, with [the GPLN], the community nurse, with the husband, and the whole team, yeah. I think [the GPLN] has been there a few times at home … We were trying to see what she needed, you know? Yeah, maybe how we're going to help her with the accommodation and housework.

An outcome of this assistance was that Mrs N. was able to move to new public housing for the last years of her life, something she had very much wanted to do before she died. HOMD assisted Mrs N. in reaching this goal and in so doing improved the quality of her last years of life.

Mrs N. was also asked about her situation and about her experience of receiving HOMD services. When asked what the hardest thing was for her, living with and dealing with her illness, she responded "[n]ot being able to talk anyone about my condition … loneliness, because you just can not get out at all. Loneliness. Frustration of not being able to do anything." For Mrs N. her situation was further complicated by her terminal illness. As she explained "they told me that I had eight weeks to live, and not knowing 'Oh my god is it nearly time or what?' It was scary."

HOMD organised and coordinated Mrs N.'s care in the home through visits by Mount Druitt community nursing staff but also including housework and personal care support when needed. Along with practical advice and support for her medical condition, it was Mount Druitt community nursing staff's ability to listen that was equally important, given Mrs N.'s isolation and loneliness, and fear of her terminal illness. As Mrs N. put it:

> Yeah yeah I think they're wonderful. They're very nice women. They listen to you – they don't want to just sit there and chatter, they want to talk about, you know, about me type of thing and how I'm feeling. I can't fault them at all.

When asked how HOMD and community health services had changed things for her she continued that knowing they were close and easily contactable gave her a sense of security:

> Knowing that they're around. [laugh] Yeah. Security. I've got phone numbers for them, they're nice and close…and if I did need them, like if I needed [community health staff member] I can ring her or, you know, down at the health place. They're there for me, yeah and it's what the security is yeah and they'll do anything in the world for you ….

Perhaps summing up both his and Mrs N.'s relationship with HOMD, the GP said "I think it helped the patient and if it helps the patient I suppose it helps me. [Mrs N.] had more support from health professionals other than myself and I think that helped her a lot, you know". Mrs N. had not been admitted to hospital since her chemotherapy treatment and had not visited the ED after her enrolment in HOMD.

Mrs A.

Mrs A. was 66 years old when she was interviewed having been enrolled in HOMD in April 2010. She had suffered from COPD for many years but in more recent times her condition had become increasingly debilitating. Her grand-daughter, who also lived with her, helped with housework and caring. Mrs A. had led an active life and enjoyed walking. She had worked as long as her condition allowed but eventually had had to give up work because of her worsening COPD. At the time of the interview, not being able to do things without becoming breathless had begun to take its toll on Mrs A. and she had begun to feel depressed at times. She had also developed leg ulcers because of poor circulation related to her COPD. As section 2.1 outlined, some HOMD services were provided from the hub such as a Wound Clinic. Mrs A. attended this clinic to receive care for her chronic leg ulcers, which her GP described as her "main need." Mrs A. went to the hospital ED twice in the year after her enrolment with HOMD with problems relating to her leg ulcers but was not admitted to hospital on either occasion.

When Mrs A. was asked about her experiences of HOMD she said she had learned to ask for help and information when she needed it because of her interactions with receptive community health staff, "I've sort of got to learn sometimes to ask for help, that's where my problem is … I think I get embarrassed, and just finding out things." She also valued community health staff's ability to do home visits. As she said, "And by having the community nurses, if you're unwell they will arrange and they can come to the house so you don't have to panic and get up and get dressed."

Mr K.

Mr K. was 63 years old and had lived in Australia many years after emigrating from Greece as a young man. His wife was his long term carer and his teenage daughter also lived at home with them. Mr K. was suffering from a number of debilitating medical conditions – morbid obesity, hypertension, COPD, congested cardiac failure and renal function impairment – at the time of the evaluation interview. In the past, Mr K. had been admitted to hospital frequently because of his poor health.

Mr K. was first referred to HOMD by his GP in 2007. The GPLN had visited the GP's surgery to discuss HOMD the day after Mr K. had been admitted to a Hospital Intensive Care Unit in respiratory distress. As the GP said, "… they [the GPLNs] came and told me about themselves … and I had Mr K. in the hospital at that time so I told them about him and, yeah, through that I found a very good service." The GP felt Mr K. should be enrolled in HealthOne as it could provide technical support to maintain the medical equipment he used at home such as his supplementary oxygen but more importantly assist him with his long term problems of poor diet, overeating and consequently difficulty in losing weight – the source of many of his medical problems.

Along with the GP and GPLN, a dietician, an exercise physiologist, a chronic illness management nurse and a clinical nurse specialist (cardiac failure) were also involved in Mr K.'s care. A case conference was held at the GP's surgery in March 2008 where a care plan was developed, including supporting Mr K. in changing his diet, walking (sometimes the community health nurses or the GPLN accompanied Mr K.) and doing other regular exercises. A further case conference was held in December 2008. Mr K.'s GP thought that this continuing multidisciplinary support beyond the care she could provide as his GP, coordinated by HOMD and the GPLN, was vital not only in Mr K. achieving his weight loss and diet change goals but also in his continued survival. As she put it :

> … unless for HealthOne I don't think he would – he could achieve anything … it's like assisting, telling him and, you know, observing him, repeating, and educating, and showing him that there's someone to care and not just doctors that are there and hurrying their medicine and go home, you know, that was really very, very important to him staying alive I think.

This multidisciplinary mix of healthcare workers also allowed for the psychosocial dimensions of the patient's care to be addressed in the case conferences, in particular Mr K.'s fear of becoming incapacitated while away from the home, either through breathing difficulties or cardiac distress. As his GP explained "[w]e talked about diet, and weight and, you know, and his fear … he was … terrified going out." She continued HOMD and the multidisciplinary team approach "made all the difference" in addressing the complexity of Mr K.'s weight issue and motivating him to lose weight:

> It made all the difference. I couldn't do much for him, I mean losing weight was the best thing that he was ever offered, and no matter what I can say in the consultation here [it] is not effective … [The team could] weigh him, and show him, and when the weight start to drop he …keep[s] motivated …. So it made all the difference, yep.

When Mr K. was asked about the case conferences and the discussion of his weight and diet he said "Yes, I remember, I was going good. I was losing weight." Apart from the technical support for medical appliances and the practical support of the nurses walking with him and motivating him to keep to his weight and diet goals, Mr K. particularly appreciated the direct honest way the community health staff talked to him about his weight and health problems. As he put it "[t]hey're talking true …. it was true, everything, I know that …"

Mr K. had been admitted to hospital with shortness of breath and chest pains once in the year before his enrolment in HOMD and once in the year after.

Mr E.

Mr E. was 68 years old at the time of the evaluation interview and had been presenting with chest pains and breathing difficulties to hospital emergency departments in the Sydney West area many times (up to eight visits a month at one stage) as well as a large number of presentations to his GP's surgery, sometimes up to three or four times a week. As his GP took up the story, Mr E. had "multiple presentations for non-consequential medical indications and multiple presentations to the GP, multiple presentations to casualty and there [were] a lot of psychosomatic complaints." This

GP said that he was aware from very early on in Mr E's visits to his practice that Mr E was suffering from "an anxiety issue", as the GP explained it, "[Mr E.] would get very tight in the chest and get chest pains and, because he's worked up or something … but he hasn't actually linked the two together. So his symptoms are pretty much genuine, to him anyway, but when you do all the tests and investigations, there's not much to find."

Mr E. was enrolled in HOMD in September 2008. The GP got HOMD and the GPLN involved, as he described it, "to enrol the help of other specialists and [a] psychiatrist" because "sometimes it's hard for them [patients] to actually want to see a [mental health professional] when they don't think that there is a problem there." The GP felt that HOMD liaised well with the patient to overcome this barrier. In Mr E.'s case the GPLN supported Mr E. in his decision to go to a psychologist in order to address his anxiety problem. The psychologist gave him a protocol and relaxation CD to assist him in calming his breathing and so ease his feelings of anxiety. A case conference was also held where a staff member from one of the hospital EDs Mr E. frequented could explain to him directly (and not at the time of presentation when he was distressed) why it was not necessary for him to attend the ED every time he felt anxious or was having a panic attack. As the GP said:

> So HealthOne is very good in liaising and actually getting him to understand why he has all the symptoms. He doesn't have to push a panic button straight away, and that he has got this little protocol that he goes through and he knows how to sort of wind himself down. So that buys him breathing space … he is actually quite good now.

HOMD is able to put in the time to do the 'behind the scenes' work that the GP often does not have the time, resources or support to do on their own. The theme of the patient feeling like they are being supported beyond the GPs practice also came up again. As Mr E.'s GP said "Yeah, yeah that he's not being ignored, if you, you know, take twenty breaths and do this protocol and things might calm down and if he's still not calm by then, by all means present here [at GP's practice]. But I think he learned quite well."

As a consequence of HOMD working with the GP and Mr E presentations to EDs and the GP decreased. In the year before Mr E. was enrolled in HOMD he made 46 visits to the ED and in the year after 41 visits. This does not seem to indicate a marked decrease in ED visits. However, examining Mr E.'s ED visits from May 2008 to his enrolment in HOMD in September of that year reveals that on eight occasions he visited hospital EDs four or more times within one month (eight times in one month on three occasions, seven times on one occasion, five times on two occasions, and four times on two occasions). In the period from his enrolment in HOMD in September 2009 to April 2011 Mr E. only visited hospital EDs four or more times within one month on three occasions (six times in a month on two occasions and four times on one occasion). From April 2010 to April 2011 Mr E. was not visiting the ED more than two times on any given month, often visiting only once a month or not at all (Figure 8).

Figure 12: Number of Patient E's Visits to the Emergency Department by Month
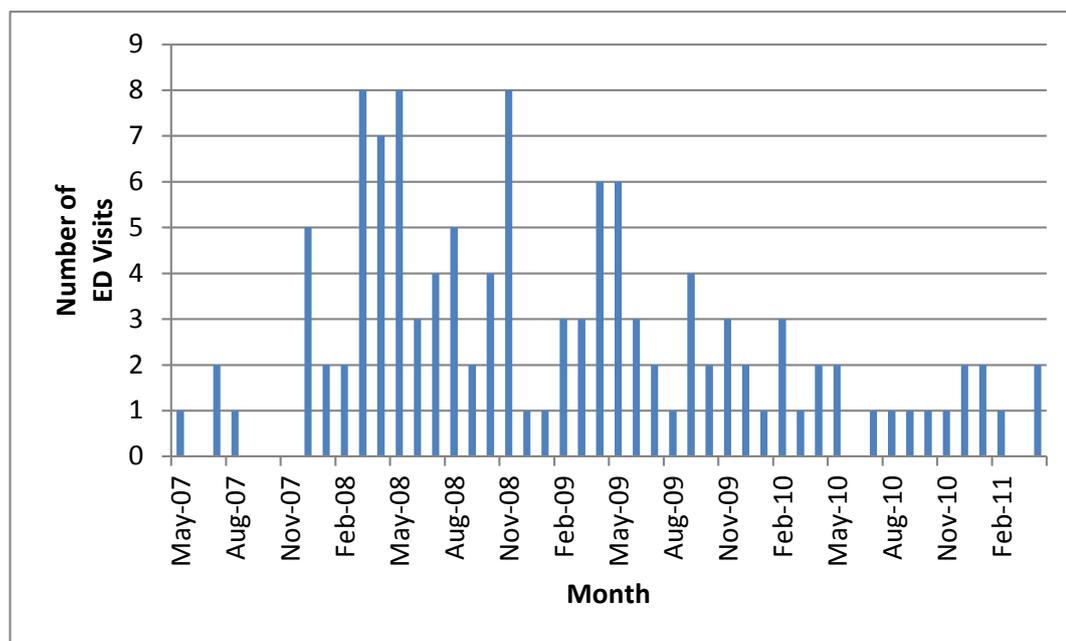
While information on frequency of Mr E.'s visits to his GP was not available to the evaluation, his GP was able to confirm that visits had decreased markedly. As the GP said, "[y]es, yes [Mr E.'s visits] dramatically decreased maybe from twice a week to maybe once a month now … it's good, yeah it's a good outcome from Health One … one of its success stories. I didn't think that we would see the light at the end of the tunnel … I think it's one of the best success stories so far."

Mr E.'s views were also canvassed in an evaluation interview with him. He valued the ongoing contact and continuity of care he received from HOMD and the GPLN, as he put it "…[the GPLN] ringing me up and seeing how I was or even someone else even, when [the GPLN] wasn't (there), like sick or anything like that they'd notify me and ask how I was going and everything …"

To deal with the loneliness and social isolation Mr E. faced living alone, the GPLN arranged that he go to a local aged day care centre two days a week for social interaction and to do odd jobs and gardening to make use of his home handyman skills. As Mr E. described it:

> Yeah, [I] go down … and have a good talk down there [to a local aged day care centre] and we play dominoes … do all our fricken fitness exercises each time, you know … Yeah, I get out there and I do a bit of gardening … they've only got pots growing at the present moment now, but before they used to have the veggies and all that and I'd go there and just, water the plants and all that … [Researcher: Do you enjoy talking to the people there?] Oh, yeah. Talk to them, yeah. They're good, yeah. Oh yeah, we have a good time. [Researcher: Does it get your mind off other things, does it?] Oh yeah. Yeah. It does. That's right, yeah.

Mr E. enjoyed visiting the psychologist HOMD and his GP had suggested he see saying "that's been going very well … I'd like to go back and see her [again], you know." He was also very happy with the relaxation exercises and CD the psychologist had given him, and found it was very effective in easing his anxiety. As he said when asked if he was not going to the hospital ED so much, "[y]eah, well as I said, everything's like fricken, like really settled, like settled down now, you know … every now and again I might get a little bit of a, a little bit of that, attack … I put the tape on that I got … listen to that." In addressing the psychosocial dimensions of Mr E.'s health HOMD and the GP managed his care without the need for frequent hospital or GP visits.

<u>Mr G</u>.

Mr G. was a 69 year old Indigenous man, and at the time of the evaluation interview was suffering from many debilitating health problems including chronic back pain, Type 2 diabetes, ischaemic heart disease, asthma, hypertension, peptic ulcer disease and chronic cellulitis. He had also had multiple hernia repairs in the years preceding his enrolment in HOMD in October 2009. Mr G. was referred to HOMD by the Mount Druitt Community Health Centre dietician (with involvement from Mount Druitt Community Health nursing staff). Mr G. had been receiving podiatry care from Mount Druitt Community Health Centre but had not been responding to letters sent by the service. Mr G. had also presented to hospital at the time as he had become confused about his multiple medications and may have been suffering from adverse interactions. The HOMD GPLN liaised with the hospital pharmacy to assist with Mr G.'s medications. Subsequently, a referral was made by the GPLN to Mount Druitt community nursing for case management.

Mr G. had two GPs at the time of the evaluation. One GP had been his doctor for over 30 years but as Mr G. had no means of transport and this GP's practice was some distance away, he had also begun seeing a nearby GP for several years. When asked what he thought HOMD's role was with Mr G. this GP said, "[h]e lives by himself, I think it's just to outline a little structure around him so that if there's anything that happens after hours I suppose, to … write out a little plan for him, a little protocol if he gets all the pains and problems again. Just to follow the protocol before he jumps in the ambulance I suppose, yeah."

Mr G.'s GP of many years thought that HOMD had "helped a hell of a lot as far as managing him at home" and in so doing took the time pressure off the GP to travel to Mr G.'s house for a home visit. HOMD also supported the GP in addressing Mr G.'s basic literacy matters (Mr G. had very limited reading and writing skills) and its impact on his ability to communicate which medication he was running out of at any given time. These issues were discussed at a case conference at the patient's home in February 2010 attended by Mr G.'s long time GP and a multidisciplinary team consisting of the GPLN, an occupational therapist, a home care worker, a dietician and two Aboriginal health workers. The GP discussed these issues in the evaluation interview and when asked if Mr G.'s transport problems were a difficulty said "[c]ertainly prior to the help he's getting now [from HOMD and the multidisciplinary team], it was impossible, and I was the one providing the transport by going to see him." When asked about the discussion at the case conference the GP continued:

> Oh well, we talked about the issues he had as far as transport, literacy which, literacy is a big problem because he doesn't know what medication to ask for when he rings, he doesn't know which medication he's out of almost, the pain ones you know or the, the stomach ones, or the heartburn ones or whatever.

When asked what he found most helpful about the case conference the GP said it had made him more aware of the support available for Mr G. in the community, as organised through HOMD, and that this support had not been available in the past, continuing that HOMD had "been very good for him [Mr G.] in some respects and taken some pressure off me perhaps you know…" This GP also commented that since Mr G. has been enrolled in HOMD the GP had received much more information about him and his care through both faxes and telephone calls. When asked if he would get this information for patients who were not enrolled in HOMD he replied "I don't think so, no."

When Mr G. was asked about the HOMD service and his interactions with the various care and health workers who came to his home he said "[e]verybody's been great, you know, bloody great." When asked why he said this he continued "… you know just by talking and explaining things to me afterwards, I can't really write real good, you know, and they explain things to me …"

Mr G. visited the hospital ED on three occasions in the year before he was enrolled in HOMD. On each of these occasions he was admitted for treatment of his cellulitis. Mr G. also had four ED visits

the year after his enrolment in HOMD, being admitted on two of these occasions with circulatory problems. One of these visits was when Mr G. was suffering from adverse reactions/interactions of his medications as previously discussed. He was not admitted on this occasion.

Mr H.

Mr H. was 84 years old and a diabetic who had also had a heart attack several years before the evaluation interview. Mr H. lived by himself but had a large family who visited him often, with some family members living nearby. He was referred to HOMD in August 2010 by a visiting Mount Druitt community nurse after it became apparent he was having difficulties keeping up with his housework because of tiredness and shortness of breath relating to his heart condition. At the time, Mr H. had said he might prefer to live in an aged care facility because of the difficulties he was having living alone.

After enrolment in HOMD and a case conference attended by Mr H.'s GP, the HOMD GPLN and a clinical nurse consultant (cardiac failure) it was suggested that Mr H. attend a cardiac rehabilitation group. Mr H. had initially been "a bit iffy", as he put it, about becoming involved in the group because he had been feeling unwell and thought he might not be able to do the exercises. But, after speaking to a friend who had been going to the group for some time, changed his mind and decided to attend. Mr H. spoke positively about his attendance at the group and noticed his health improving. As a result Mr H. decided he did not need to go into an aged care facility. When asked why he said, "[w]ell because I started getting better, I started feeling better" Soon after Mr H. began walking around his neighbourhood which further improved his health and fitness.

Mr H.'s GP also noticed the improvement in Mr H.'s health, "I'm telling you now after HealthOne came into his life his weight dropped, so he got rid of fluid, and he was actually, he was a picture of health …" Mr H. died of natural causes at his home in November 2011. His GP felt that Mr H. had had a better quality of life in the final months of his life in part due to improved health from his participation in a cardiac rehabilitation program. As he said "… for people living by themselves, I think, I was very happy with [Mr H.] until he just decided to go, but I think that [Mr H.] couldn't have looked better, couldn't have looked better, he was much happier and certainly died happy."

Mr H. had visited the hospital ED three times in the year before his enrolment in HOMD, suffering from chest pain. He was admitted to hospital on two of these occasions. In the year after being referred to HOMD, Mr H. had no further ED visits or hospital admissions.

Mrs C

Mrs C. was 64 years old at the time of the evaluation interview in 2011. She had been a diabetic for many years but more recently also suffered from COPD and cardiac failure. Mrs C. was enrolled in HOMD in August 2010 as she needed more support to remain living at home because her health was deteriorating and she was becoming more debilitated while she continued to live with and care for her elderly mother, with whom she had a very close relationship. Mrs C. and her mother, who had dementia, lived in an annex to the main house where one of Mrs C.'s children and grandchildren resided. While Mrs C.'s family assisted in caring duties, Mrs C. remained the primary carer for her mother.

Mrs C.'s GP explains why she felt her patient could benefit from the HOMD program, "I always felt confident that [Mrs C.] was caring for her [mother] to the best of her ability and also that generally the mother was well cared for. It's just that with [Mrs C.'s] failing health we needed some extra things … that would have been the initial thing." The HOMD GPLN assisted in arranging home care services for Mrs C.'s mother and also ensuring Mrs C.'s medical requirements were addressed when she came out of hospital such as the cardiac and respiratory rehabilitation nurses visiting. The GPLN also liaised with the rest of the patient's family and Occupational Therapists to improve access to bathroom

facilities from the annex in which Mrs C. and her mother lived.

When asked how HOMD and the GPLN had assisted in the care and management of Mrs C. her GP responded, explaining all the various services and activities that needed to be arranged and coordinated by the GPLN:

> [The GPLN] helped us certainly to put in place all of the things that we had in place for the mother. You know, the day care, the nurse to help with the showering, all those things. [Mrs C.] had a lot of hospital admissions as well … she was in and out of hospital constantly … it was the chest, the emphysema … and also latterly with the cardiac failure. So [the GPLN] had the cardiac nurse visit. [Mrs C.] is on a protocol, you know, she weighs herself daily and we have that in place. So [the GPLN] was able to help us … as [Mrs C.] came out of hospital having the - liaising with the cardiac people and also with - liaising with the family, the other family members and sorting out some of the problems at home.

When asked whether there was a benefit to having HOMD and the GPLN involved in the care of her patient, Mrs C.'s GP said, "… the [GPLN] was definitely very useful in helping … to keep [Mrs C.'s] chest in as good a condition as possible and to take as much pressure off [Mrs C.] as we could." The liaison and coordination skills of the GPLN were particularly helpful in this case as Mrs C. was described by her GP as "a very independent person" continuing that Mrs C. "really didn't want to accept too much help in the beginning but I think then she realised that if her health was better she would be able to continue to care for her mother which is what she wants to do." The GPLN brought all the various parties – family members, general and specialist nursing, allied health professionals and home care service providers – together to achieve a positive outcome for Mrs C. Mrs C.'s GP went on to say that she would not have had the knowledge of all the various service providers or the time to achieve a similar outcome in a timely manner:

> Without [the GPLN] it would have been very difficult to organise, yes, that's right. Without me making dozens of phone calls and probably then waiting a lot longer to get the help that they needed, whereas it seemed to happen very quickly … so that really did make a difference. They were all integrated. She knew the right person to talk to and it all sort of happened, yeah.

However, it still took several case conferences at the GP's practice with Mrs C. and the general and specialist nurses attending to reach a satisfactory arrangement. At these case conferences Mrs C.'s day to day care, particularly with respect to her cardiac and respiratory management, were discussed along with the more difficult issues of Mrs C.'s deteriorating health and her desire to continue to care for her mother as long as possible. As the GP described the situation:

> I think [Mrs C.] is very defensive about her mother because I think she thinks that if - see, they're very, very close. And I think that she feels very responsible for mum's care and she would be afraid that maybe someone is going to say she is no longer capable of the care … Because she knows and I know that in the fullness of time her mother will need more care than she is able to provide and that ultimately she may well require nursing home care. But that's not going to come easily to her.

The GP went on to describe the ongoing difficulty of the situation, explaining that although HOMD had assisted her in managing Mrs C. at home and so allowed Mrs C. to continue to care for her mother due to improved health and as a consequence, fewer hospital admissions, it was only a matter of time before Mrs C.'s chronic and complex conditions meant she would not be able to care for her mother any longer. As the GP put it:

… we'll need to talk to the extended family at that point, because right now [Mrs C.] hasn't been in hospital for a while … and a lot of it of course depended on how [Mrs C.'s] own health has gone and this year she's had a particularly good year. A lot less hospital admissions, so that's made mum's care easier because there wasn't the need for respite or anything like that …

Although Mrs C. made five visits to the hospital ED in the year before being enrolled in HOMD, and four visits in the year following, none of these visits resulted in her being admitted to hospital.

Mr S

Mr S. was 72 years old at the time of the evaluation interview and suffering from pancreatitis and osteoporosis. He had had numerous hospital admissions over the past 13 years including spinal surgery in 2007. He lived with his wife and carer, Mrs S., who was very active in the care partnership using mobile phone and email to receive appointment information and updates for Mr S. and also using a computer to access health information relevant to Mr S.'s chronic conditions. As Mr S.'s carer, Mrs S. was interviewed at the same time as Mr S. Mr S.'s GP did not wish to be interviewed for the evaluation.

Mr S. had attended the Mount Druitt Community Health Centre's Wound Clinic since September 2008 for management of an ulcer and related bone infection on his foot. While originally enrolled in HOMD in October 2009 through the Mount Druitt Community Health Chronic Illness Management Nurse, Mr S. did not have close contact with HOMD until Mrs S. contacted the GPLN because she and Mr S. were not satisfied with the care Mr S. was receiving in hospital. The GPLN continued her involvement with Mr and Mrs S. when it became apparent Mr S. would soon be requiring palliative care services as his pancreatitis was becoming life threatening. Indeed, Mr S. had one stay in palliative care but recovered sufficiently to be discharged.

Mr and Mrs S. were very happy with the services HOMD, the GPLN and Mount Druitt Community Health staff provided. As Mr S. put it "[t]hey are absolutely fantastic. There's nothing that you can't ask and you don't get an answer to. They're brilliant … you can ring up and say 'Hey'[and they say] 'I'll be there'." In fact, it could be said Mr S. was an impassioned supporter of HOMD and the Mount Druitt community health team. Mr S. also felt strongly that the HOMD program should continue:

> If I could have [Mr S.'s GP] and the team down here [GPLN and Mount Druitt Community Health staff], I wouldn't need anybody else [laughter]. There you go, that's how, I am absolutely rapt in them. And if the government, and if that goes back to the government, if the government ever stops it, look out, I'll be on your door step [laughter].

When asked what difference HOMD and the community health team made to him, Mr S., as with many other HOMD clients already discussed, said it was not having to travel to services for care, and also just knowing that someone else was there to provide care, advice and support besides GPs and the hospital:

> It's changed my outlook, it's changed, the fact that I don't have to travel down to [hospital] all the time to see anybody, if - they're [GPLN and community health staff] just there. You know, they're there for you and that's in the back of your mind … It feels as though, I feel for myself, as though I've got somebody. … somebody that I can trust, go to, be happy with, you know. Yeah. They do a lot for me. They do a hell of a lot for me. Just being there.

When asked the same question, Mrs S. simply said "[i]t's given him peace of mind."

Mr S. also mentioned that if his wife should be away from the house for any length of time, particularly

if out of the state, he knew HOMD and community health staff would keep in contact with him (either by telephone or visiting him at home) to "… say hi and see if everything's alright."

Mr S. also thought that his contact with and support from the service reduced his hospital and GP visits. As he put it "… saves you going to hospital, going to doctors a lot of times. Like, I'd have to go to [the GP] more often if it wasn't for HealthOne." In the year before his enrolment in HOMD Mr S. visited the ED twice and was admitted on one of these occasions due to his pancreatitis. Mr S. had one visit to the ED in the year after but was not admitted to hospital on that occasion.

Ms K.

Ms K. was 44 years old and had a number of complex and interrelated social, psychological and medical problems when interviewed. Ms K. was schizophrenic but also suffered from depression and had ongoing drug and alcohol problems. She was hypertensive and obese having also had a myocardial infarction in 2007. Ms K. had a fractured left arm at the time of the interview, the result of a minor motorised bike accident. She also had difficulty walking because of her weight and problems with her knees. She lived with a housemate who did odd jobs about the house and was also her carer but limited in what he could do due to a back injury. Ms K. had a 12 year old son who visited regularly but did not live with her permanently. Ms K.'s GP was not able to be interviewed for the evaluation.

Ms K. was referred to HOMD by her GP who requested support for the management of Ms K.'s multiple and complex medical and psychosocial problems. She was enrolled in HOMD in October 2010. A community case conference was held with Ms K.'s permission in November 2010. While Ms K. did not wish to attend, her family support care worker who assisted her with the care and schooling of her son, home care worker and social worker (also Ms K.'s case manager) did attend along with the HOMD GPLN and Ms. K's GP. Because of her pain and restricted mobility referrals to a pain clinic, an occupational therapist and physiotherapist were made and a walker provided as a result of the case conference along with the provision of lawn mowing services through a local council's community care program. Ms K.'s inability to mow her lawns was an issue that had been concerning her for some time. Ms K. began receiving home care services and also began regularly visiting a psychologist who assisted her with her psychosocial and addiction issues as a result of her involvement with HOMD.

Ms. K. described how the HOMD GPLN coordinated the various workers that assisted her, both those within the health system and those from other agencies. When asked what difference, if any, the HOMD GPLN and the various health and other workers had made to her life Ms K. summed up the support and services provided in the following way:

> I'm not so stressy … So yeah … they've done like a lot for me like if I didn't have the help I wouldn't have the grass done and the walker. I wouldn't be talking about my problems. I probably would've had a heart attack by now you know like they've … helped me out a lot …. [the GPLN] was the first one and she … helped me talk to, get a physiotherapist … [the GPLN] started the ball rolling you know and like helped me with the physio and the psychologist otherwise I probably would've had a nervous breakdown by now.

Ms K. also mentioned she was drinking less alcohol as a result of her visits to the psychologist. Ms. K had not visited hospital EDs or been admitted in the year before her enrolment with HOMD, or the year after.

Mrs D.

Mrs D. was 62 years old when interviewed and suffering from COPD, anaemia, rheumatoid arthritis and congestive cardiac failure. She was fitted with a prosthetic heart value having also had a heart

attack in 2009. She continues to suffer from atrial fibrillation (irregular heart beat). Mrs D. lives with her partner and carer.

Mrs D. was referred to HOMD in August 2010 after a fall and consequently being admitted to hospital. The GPLN attended a discharge case conference and became more involved after Mrs D. returned home when it became clear she would need some help in the home with housework – mainly cleaning and vacuuming. At times when Mrs D. was more debilitated by complications related to her rheumatoid arthritis she also needed assistance with personal care. The GPLN arranged for Mrs D. to receive home help and personal care services.

In the evaluation interview Mrs D. said she was initially "so embarrassed, absolutely embarrassed" that she needed help in the home that she was reluctant to accept assistance. However, with the support of her sister, to whom she was very close, she realised she needed to "give in and stop being stubborn." Still, this was difficult for Mrs D. as she had "always been an independent person" as she put it. Having accepted help Mrs D. described the change that HOMD had made in her life as "absolutely fantastic" continuing "… I feel more relaxed, more comfortable in myself that I don't have to sort of mop and vacuum." When asked if she worried when she could not carry out household chores due to ill health she responded "Oh yeah, very much so."

Mrs D. had visited the hospital ED four times in the year before her enrolment in HOMD and was admitted on one of these occasions due to myocardial infarction (heart attack). Mrs D. visited the ED seven times in the year after her enrolment with HOMD and was admitted once because of complications related to her rheumatoid arthritis.

Figure 13: HOMD client with Community Health Staff member

5. Policy Background

Prevention, management and treatment of chronic non-communicable diseases are major challenges facing governments this century (Jeon et al 2010; World Health Organisation 2002; Nolte and McKee 2008). Furthermore, the social and economic burden of chronic conditions is set to increase in western societies over the coming decades due to ageing populations, an increase in numbers of those with multi-morbid chronic conditions, and associated escalating health costs. In 2002 approximately 59 per cent of global death was due to chronic diseases and this percentage is projected to increase to 66 per cent by 2030 (Mathers and Loncar 2005). In western societies approximately 86 per cent deaths are estimated to be due to chronic disease (Jeon et al 2009; Lopez and Murray 1998).

5.1 Australia

In Australia, chronic non-communicable diseases make up 80 per cent of the total burden of illness and injury in the ageing population (NHPAC 2006) and account for 70 per cent of health expenditure (AIHW 2004). Because of this situation, formulating appropriate policy responses and cost effective treatment, care and management of chronic conditions has become central to the sustainability of health systems. Adding to the challenge, most formal health care is organised around the delivery of acute and episodic care rather than the complex, long-term care that is necessary for people with multi-morbid chronic illness (Jeon et al 2010; World Health Organisation 2002; Nolte and McKee 2008).

Improved management of chronic disease has been the subject of policy-making since the mid 1980s (Jeon et al 2010; Yen et al 2011). The most commonly proposed solutions involve greater service integration, coordination, flexibility and continuity, along with policy and health system changes to improve the management of chronic disease (Zwar et al. 2006; Nolte and McKee 2008). In Australia disease specific and population level health policies for chronic illness were formulated at Commonwealth Government level in the 1980s and the 1990s, and more recently at state and territory level (Jeon et al 2010).

In 1995 the Council of Australian Governments (COAG) initiated the Coordinated Care Trials which ran from 1997 to 1999 and attempted to provide more integrated and coordinated care at various selected locations throughout Australia and with several different target populations, including chronically ill people. A second round of trials ran from 2002 to 2005. The evaluations of these national initiatives suggested that collectively these trials led to individuals' improved access to services, a sense of security about their health and interventions, and health related empowerment (Australian Government Department of Health and Ageing, 2007).

More recently, the *National Chronic Disease Strategy* (NCDS) has guided policy approaches to chronic disease care and management Australia-wide by specifying four key priority areas for action: prevention across the continuum; early detection and early treatment; integration and continuity of prevention and care, and; self-management (National Health Priority Action Council, 2006: 13 - 40). An emerging theme in health policy is an emphasis on what is now referred to as 'patient-centredness' (see for example Luxford, Safran and Delbanco 2011, Lindsay and Vrijhoef 2009) – the reorientation of health services with the patient as the focus rather than the service provider as the centre of the care delivery system. This approach is becoming increasingly common in chronic disease management (Coulter et al. 2008; Nolte and McKee 2008) and is apparent in the four key priority areas for action of the NCDS.

Other national chronic disease policy initiatives include the National Service Improvement Frameworks for Asthma, Diabetes, Musculoskeletal and Arthritis, and Heart, Stroke and Vascular Disease (2006) that complement the NCDS and COAG's Australian Better Health Initiative (ABHI), a four year national program launched in 2006 which aimed to strengthen the focus of the health system on prevention, health promotion and the management of chronic disease. Like the NCDS, ABHI specified

priority areas for action which were: promoting healthy lifestyles; supporting early detection of risk factors and chronic disease; supporting lifestyle and risk modification; encouraging active patient self management of chronic conditions, and; improving the communication and coordination between care services. Also at national level, the Medicare Benefit Scheme (MBS) assists GPs and other health professionals in chronic disease management by including items that allow payment for preparing and reviewing management and care plans and coordinating and reviewing team care arrangements.

In 2008 the Rudd/Gillard Government established the National Health and Hospitals Reform Commission (NHHRC) with a mandate to consider major structural reforms to the health system. Several policy documents have been launched to drive this, including the National Primary Health Care Strategy and the report of the NHHRC: *A healthier future for all Australians*. Both emphasise the important role that general practitioners, nurses and other health professionals working within the primary and community health sector play in providing integrated, comprehensive primary health care. Both further emphasise the importance of this sector in the delivery of patient centred care to those with chronic and complex care needs. For example, the recommendations of the final report emphasise redesigning health care services through such things as the introduction of Comprehensive Primary Health Care Centres and Services, voluntary client enrolment with a 'health care home' and Regional Primary Health Care Organisations (now referred to as Medicare Locals).

The Federal Department of Health and Ageing has also distributed funds to General Practice Networks Australia-wide within the area of chronic disease management, for example, diabetes management strategies and lifestyle modification programs such as the Chronic Disease Self-Management/Lifestyle and Risk Modification Grants program. These programs are continuing under the Medicare Locals that are being developed to replace and extend the GP Networks at the centre of primary medical care.

5.2   New South Wales

Informed by and running parallel (and often prior) to these national initiatives NSW Health, from the 1990s, developed its own policies and programs to assist in the care, treatment and management of chronic illnesses including: *Improving Health Care for People with Chronic Illness: A Blueprint for Change 2001 -2003; NSW Chronic Disease Prevention Strategy; Framework for Integrated Support and Management of Older People in the NSW Health Care System; NSW Chronic Care Program* (Phase One 2000 - 2003, Phase Two 2003 - 2006, Phase Three 2006 -2009), and most recently; Connecting Care. Relevant Community Health policy includes *Integrated Primary and Community Health Policy 2007 – 2012* and *Integrated Primary and Community Health Policy 2007 – 2012 Implementation Plan.*

The NSW Chronic Care Program was a major initiative of the NSW Government Action Plan in the early 2000s. It moved from the development of guidelines for disease management and prevention to a greater focus on health service delivery. This shift took it from a more top down directive approach, to more innovative experiments in encouraging local initiative and coordination between health professionals.

The *NSW Chronic Care Program Phase One* was informed by *Improving Health Care for People with Chronic Illness: A Blueprint for Change 2001 -2003* which set out the original aims, principles and scope of the program. As with the NCDS and the National Service Improvement Frameworks, Phase One of the NSW Chronic Care Program was complemented by Clinical Service Frameworks setting out standards in three priority areas: respiratory disease, cardiovascular disease and cancer. These were developed along with 60 local priority health care programs aimed at enhancing care provided

for people with chronic illnesses and implemented across 17 Area Health Services[8] and focussing on respiratory disease (18 programs); cardiovascular disease (25 programs); cancer (13 programs); and four generic chronic disease programs. Other initiatives of Phase One of the Program included: initiating chronic care forums bringing together clinicians, program managers and consumers to discuss chronic disease management; establishing the *NSW Aboriginal Chronic Disease Service Standards* in recognition of the poor health of Aboriginal people with chronic diseases, and; introducing *My Health Record* – a patient-held record containing all relevant health information aimed at improving communication and enhancing continuity of care, Phase Two of this program built on this experience by improving the governance, coordination and delivery of health services

A third phase included a tighter focus on prevention – preventing or delaying the onset of chronic disease and reducing progression and complications, as well as striving to achieve best practice in prevention, detection and ongoing management of chronic disease. Like its predecessors, the *NSW Chronic Care Program Phase Three 2006 - 2009: NSW Chronic Disease Strategy* continued to emphasise 'person- centred' integrated, coordinated multidisciplinary care, equitable and timely access to services, active self management, and effective organisational, governance and leadership but with the addition of more explicit detail on working in partnership with 'all relevant stakeholders across government, non-government and community sectors, with emphasis on the crucial role of general practitioners in providing chronic care' (NSW Department of Health 2006) – a policy directive particularly relevant to the development of NSW HealthOne initiatives.

The current NSW Health chronic disease strategy is *NSW Chronic Disease Management Program - Connecting Care in the Community* which builds on its predecessors. The program prioritises those people with diabetes, congestive heart failure, coronary artery disease, chronic obstructive pulmonary disease or hypertension who are at high or very high risk of unplanned emergency department or hospital presentation and admission. The program aims to enrol 43,000 people over four years and deliver integrated multidisciplinary patient focussed 'whole person' care with proactive coordination and identification, assessment, enrolment and monitoring (http://www.health.nsw.gov.au/cdm/severe_chronic_disease_managment_program.asp)

The following section details how these various chronic disease policies, guidelines and initiatives at both federal and state level informed both the development of NSW HealthOne services in general and HOMD in particular.

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8   Seventeen Area Health Services (AHS) were amalgamated by the NSW State Labor Government into eight larger regional AHS in 2004/2005. In 2010, AHSs were renamed Local Health Networks (LHNs) in NSW in line with the Rudd/Gillard Labor Government Health Reforms. In 2011 the NSW State Liberal Government rebadged LHNs Local Health Districts (LHDs).

6. Development and Implementation of HealthOne Mount Druitt

The process evaluation was built on the interviews with patients, their carers and GPs, supplemented by interviews with policy and decision makers, and with HOMD Steering Committee members. This qualitative data provided in-depth detail of processes and activities associated with the implementation of the program.

Sixteen individual interviews were carried out with the HOMD Steering Committee members (eleven) and with policy and decision makers (five). Interviews focussed on the history and development of chronic disease management policies including HOMD, perceived barriers and facilitators to the implementation of HOMD and sustainability of the program.

6.1 General Issues and Background

Federal and State Context

Many factors at both federal and state level influenced the development of chronic disease policy, management, and service delivery initiatives in NSW. However, policy development and implementation does not necessarily proceed in a linear fashion (Gillespie, Yen and Wells, 2008). Influences and evidence can be wide ranging and drawn from a number of both formal and informal processes throughout the policy cycle (Althaus, Bridgman & Davis 2007) i.e. policy initiation, refinement and implementation may all be subject to a subtle interplay of factors. HealthOne is a good example of the creative use of conflicting initiatives from Commonwealth and state levels that crossed the same policy space.

Policy and decision makers were in general agreement that the acknowledgement of the 'problem' of chronic disease, as outlined in section five, was one of the main drivers at the broadest level for policy initiatives and programs in the area. One decision maker described it in the following way:

> They [governments] were trying to control the constant rise in the health budget. What's the rise in the health budget? Chronic disease. Hospital beds. Overloading emergency departments. That's the message so it was a driver that came from government saying we've got to do it … But beforehand no it's not such a big issue. Now it is a big issue. (decision maker)

The broader policy aspects of chronic disease management were well understood and canvassed by policy and decision makers and the HOMD Steering Committee members interviewed. They all saw HOMD as part of a more general move to strengthen the capacity of the primary health care sector and enhance its integration and coordination with acute health and non-health sectors (home care and support services etc), building on patient-centred approaches. There was also consensus support for electronic health record (ehealth) and Emergency Department presentation and hospital admission initiatives and programs aimed at reducing unnecessary or inappropriate admissions for frequent flyers (typically patients with chronic illnesses who have multiple hospital admissions in a year). HOMD Steering Committee members tended to frame these aspects of chronic disease management within discussions about the development of the HOMD model while policy and decision makers discussed these aspects in a more general context. For example, one policy maker summed up the need to strengthen the primary health care sector to reduce unnecessary hospitalisations in the following way:

> … looking at the impact of having coordinated primary health care on that person's stability and condition management and if that's stopping them bouncing in and out of hospital. I mean it's no good for the patient and it's certainly not the most efficient use of resources in terms of hospital care versus if we can provide that care in the community. So I mean we are premised on providing care in the community as generally

a better alternative to acute care. I mean clearly there are places and times when people do need a hospital admission. But by and large if people's conditions can be managed, being out of hospital is a better place to be. (policy maker)

Policy and decision makers focused on system-level change, arguing that structural change and financial incentives were required to fully integrate the acute sector with the primary health care sector, and that further capacity building in the primary health care sector, particularly care and support services provided in the home, was also required if the goal of full integration between and within sectors was to be reached.

So some structural change is required … At the moment our systems don't reward [financially] in any way to try and keep someone out of hospital … I mean I think part of the problem that all of us are faced with dealing with chronic disease is that we haven't necessarily had the right structural organisational elements to look after chronic disease. Most of our health system is designed to look after, particularly our hospital-based system, is designed to look after acute illness. It doesn't have good organisational structures … within the organisation to reflect the needs of those with chronic illness so some fundamental revision is required to the way we run health as well as the way we run hospitals. (decision maker)

Projects for electronic patient health records (ehealth) have emerged in response to the episodic nature of care provided in the health care system. People with chronic illness find they repeatedly provide the same information to different providers or sectors within the health system, or sometimes even within the same organisation. This is inefficient, time-consuming, frustrating for both patient and health professional, and can be inaccurate. It can also detract from patient satisfaction with care provided (Jeon et al. 2010,Yen et al. 2011). Continuity, accuracy and accessibility of up-to-date general health, medical and pharmaceutical information is of particular relevance to people with multi-morbid chronic illnesses as they tend to be referred to a wide range of providers both within and outside the health system, many of whom currently do not have access to electronic information from other sectors. This has long been recognised as a problem within the health system not only for the chronically ill, but patients in general. Several interviewees raised this as a significant issue to be addressed if integration and coordination of services – and so the treatment, management and care of the chronically ill – is to be improved.

Several policy and decision makers also mentioned the federal government's recognition of the increasing incidence of chronic disease as a policy issue and their response to this situation, many of the same policy responses as mentioned above and in section five, but particularly the Council of Australian Government's (COAG) Australian Better Health Initiative (ABHI) health reform agenda of 2006, a four year national program which aimed to strengthen the focus of the health system on prevention, health promotion and the management of chronic disease (as outlined in section five). At NSW state and AHS level policy makers were well aware of the ABHI initiative and its focus on what was termed 'integrated primary health care' – the Commonwealth funding a spectrum of initiatives from prevention to self management that were implemented through state-based organisations such as Divisions of General Practice. As one policy maker recalls the situation:

Integrated primary health care was actually one of their six domains of the Australian Better Health Initiative and the Commonwealth were going to do certain things, MBS items for cancer care and some - from memory investing in training of allied health staff in chronic disease management. I think from memory they pulled out of that one. And the States and Territories were to do other things and there were other areas where it was a matched funding, social marketing, school canteen guidelines in terms of the preventive end of the spectrum, [these] were joint initiatives … (policy maker)

However, Commonwealth initiatives did not necessarily translate neatly and clearly over to the state context. In this case, each level of government brought quite different understandings and interpretations of the meaning of 'integrated' primary health care. As a policy maker and a decision maker explain:

> … [at the] integrated primary health care end of the spectrum the Commonwealth funded through the Divisions of General Practice network initiatives … to promote integrated primary health care as the Commonwealth understood it. Not quite how we understand it and we did our own thing which was HealthOne, what is now branded as HealthOne in NSW. (policy maker)

> I think the Commonwealth tends to know what they want and they tell people what they want but that may not be the best necessary product at the end point. (decision maker)

These different meanings became a major issue with the implementation of the ABHI funding formula:

> But the Commonwealth really wanted to - and I think it's part of the way they have to work through the Divisions' network- they determined a funding formula so each Division got money to do its thing. And, you know, some of the small Divisions … got a tuppence out of that bucket which they can do very little with. (policy maker)

Another consequence of this funding model, which had implications for the evolution of the HealthOne initiative in NSW, was a creativity and flexibility at local level to interpret and respond to perceived local priorities, context and need. However, this advantage came at the expensive of systemic change:

> And others looked at IT so there was a flowering of ideas and nothing was systematised … Other states did it differently but that was the decision of what's now GP NSW to do the funding formula and let Divisions prioritise and I understand that each area has got local priorities but we never got any systematic, systemic changes out of that. So that's the history of ABHI … (policy maker)

Two members of the HOMD Steering Committee discussed the influence of the ABHI project in their organisation, because of the flexible nature of the ABHI funding where priorities at the local level could determine the nature and outcomes of the project. Commonwealth funding specifically earmarked to improve 'integration' was used to develop communication processes between the acute sector, community health and GPs, particularly for dissemination of discharge summaries.

Another factor that strongly influenced the development of HealthOne was support from the then Premier of NSW Morris Iemma and Reba Meagher the state Health Minister at the time. Iemma was a great supporter of the integration of primary health care. In this instance, he was also responding to a recommendation from his General Practice Council to establish a state-wide integrated primary health care new models program. GP Council members were heavily involved in the development of the HealthOne concept at state level via the HealthOne Steering Group (these initiatives predate ABHI and GP Super Clinics by some years). This support, and the Commonwealth funding for integrated primary care, led to the funding of the HealthOne initiative. As one policy maker put it "and that was where we got money from, [NSW] Treasury, to actually make this thing [HealthOne] fly."

HealthOne and Other Similar Chronic Disease Management Initiatives

There was general agreement amongst the policy and decision makers interviewed that limited thought and planning had been given as to how HealthOne would operate in a connected way with other similar initiatives in the area of chronic disease management aimed at improving patient care and integration and coordination of services which were evolving at the same time. The most often mentioned of these being Care Navigation[9] and the emerging impact of the role of the Medicare Local.

There was general consensus was that there was an important connection between Care Navigation and HealthOne as improved integration and coordination of services was required both within the hospital and primary health sectors and between the two sectors. Several policy and decision makers commented that linking Care Navigation, which operates primarily within the hospital system by linking to community health and other services, and HealthOne, which operates in the primary care sector, was vital if the goal of providing patient centred-connected care across sectors was to be achieved.

The question as to how the role of the new Medicare Local would work with programs like HealthOne or Care Navigation proved more vexing for policy and decision makers. Some were of the view that it was very much dependent on the people involved in these organisations, whether they had an interest in the management of chronic illness, and in particular whether they had prior experience working with the HealthOne or Care Navigation programs, or whether they had been part of organisations who had been partners in these or similar programs and initiatives aiming to improve integration and coordination of the acute and/or primary health care sectors. As one decision maker put it:

> Now, the integrated models are certainly the attractive ones obviously, because it's about how to integrate the hospital and the community and I think that's where we get the best value of the superclinics. Otherwise they just become large private - large organisations of GPs. (decision maker)

Another concern for those interviewed was the announcement of a Superclinic for the Blacktown area. GPs working with local initiatives felt their livelihoods were under threat as unlike HOMD:

> … the Federal Government has identified the locations and … there was no consultation with Area Health Services or the Department [NSW Health] … Here we are developing this model for HealthOne and I hadn't heard about that [superclinics] … So they're done without consultation and it really puts GPs, puts their noses out of joint seriously because you know they're [superclinics] attractive to corporates who can write a beautiful plan and come in and get the work force and potentially put local general practitioners out of business rather than working with the providers that you've got in your community and saying how can we work better and more efficiently together. (policy maker)

The NSW Health Chronic Disease Management Program has had a significant impact on program and service development, particularly as, in its most recent stages, The Connecting Care phase of the Chronic Disease Management Program has focused on service delivery issues at both the state and local level. The introduction of the Connecting Care Program within the Sydney West region has significantly raised the profile of chronic disease management and related service provision issues in the region.

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9   Care Navigation is was an initiative of the then SWAHS at Auburn, Blacktown, Mount Druitt and Nepean Hospitals. Care Navigation aimed to decrease unnecessary Emergency Department and Hospital admissions for those with chronic illness.

As one decision maker said of this latter phase of the Chronic Disease Management Program "it did make people think about their service provision." A policy maker recalls the impact of Phase One at the Area level commenting that while it was largely single disease focussed and "very tied-up or focused on specialist care so looking at … specialists largely within a hospital setting" there was also "outreach to the community" in the form of cardiac and respiratory rehabilitation programs, some of which continue to operate out of the larger hospitals in the region. This interviewee was of the view that Phase Two of the Chronic Disease Management Program allowed the shift towards a "focus on the HealthOnes and the GPs." This shift was also influenced by the GP Council and their discussion paper critiquing Phase One – a paper which was ultimately taken into account by those rethinking the program. Phase Two Program development involved multiple reports to, and consultations with, the GP Council. Consultation with the GP council continues under the NSW Agency for Clinical Innovation's stewardship.

A decision maker added "what became obvious is that we needed to think not only [of] the diseases but for managing chronicity of any problem and how you bring your components of the needs together … focusing much more … [on] integrated care and trying to provide a greater centrality", what some term 'patient-centred care'. This interviewee warned that the goal of a patient-centred health system is still elusive, hindered in large part by a lack of an electronic patient record.

Another aspect of chronic disease management that shaped the development and implementation of HOMD in the Sydney West Area was the emergence of Clinical Networks.[10] Arising out of a restructuring of work groups and re-distribution of budgets across the Sydney West Area, clinical networks linked the established specialities of acute care in surgery and cardiology and acute intervention medicine which included renal and respiratory medicine. New clinical networks were also established with an aged care, chronic and complex group which obtained equal status. As a decision maker explained it:

> So for the first time you actually had a massive organisational, clinical network, power block if you want to use that term, equivalent in terms of budget to a cardiology group or a surgical group and they had an equal standing and equal decision making at the decision making table. (decision maker)

Further reinforcing this organisational change was the merging of the Primary Care and Community Health, Mental Health and Drug and Alcohol services under a single 'Integrated Health Cluster' (reporting through clinical operations direct to the Chief Executive) which the same decision maker described as "designed to sort of draw those elements together even more between hospital, community health, primary health."

At the same time there were pressures from the broader context of aged care and chronic disease management contributing to this period of re-organisation and self reflection throughout SWAHS. Central government agencies were beginning to grasp the threat posed by an ageing population and associated increasing incidence and numbers of the chronically ill on both acute and primary health care services and health budgets. This resulted in what one Community Health Steering Committee member described as "… a siege mentality at the time in terms of demand is increasing, resources are diminishing, we can't meet the needs of all people" which in turn led to "…conversations about [how] things have to start happening in the community because the hospital system can't do it anymore. So there [were] a lot of imperatives for us to change." This change was to take the form of strengthened capacity of the primary health care sector and reduction in unnecessary or inappropriate Emergency Department admissions, policy imperatives also discussed at length by policy and decision makers in this evaluation as previous sections have illustrated.

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10   The Clinical Networks were formed to provide strategic and program planning and service coordination across all hospital facilities and community based services in the SWAHS region.

Care Navigation was one initiative that arose out of this context. Another was the SWAHS *Promoting Integrated and Timely Care in the Community and Hospital* (PITCCH) Clinical Redesign initiative. PITCCH resulted in close scrutiny and modification of a number of processes and procedures within the acute setting in order to improve patient flow and reduce access blocks. PITCCH had a knock on effect on Community Health and subsequently the development of HOMD as one of the consequences of the clinical redesign process was a requirement from the AHS that there be no waiting times for community health services, particularly community nursing for the aged and the chronically ill. One Community Health Steering Committee member described the effect on both acute and community health services in the Western Sydney region "… we all started to think system and better outcomes for people, so we all had to move out of our defensive bunkers and be exposed and change what we were doing."

The impetus for this collaborative and integrated approach to service delivery was SWAHS's CareFirst strategic direction, introduced by the then Chief Executive which emphasised the patient at the centre of all service planning and care coordination processes and required a routine monitoring of patient experience of the health service and implementation of a constant quality improvement approach. The CareFirst approach led to further review and refinement of how community health services were delivered.' A new community health service delivery model was developed in which services were organised into two multidisciplinary streams of service priority, HomeFirst focusing on the health needs of vulnerable older people and people with the chronic and complex care needs and ConnectFirst, focusing on child and family health needs. A Community Health Steering Committee member explained the rationale for Care First in the following way:

> … so we basically wanted to link everything that we were doing into the total health care provided by the Area Health Service, and for people to understand our business … so the concept of HomeFirst and ConnectFirst emerged out of that … [to] have the sort of objectives, have our eligibility criteria, have what can be expected, be very clear about what we're delivering and that people can think, oh HomeFirst, I know what that is, or ConnectFirst, I know what that is. Whereas before Community Health had all those things but it was 20 different bits and pieces, like we do speech pathology or we do occupational therapy or the nurse goes out. People couldn't understand that as a package or a model or how it all linked and connected or how people traversed through our services or anything like that. (Community Health Steering Committee member)

The review of Community Health organisational arrangements and shaping of the HomeFirst and ConnectFirst service delivery model was to have a major influence on the developing HOMD model. Through joint planning with general practitioners and GP Division representatives as part of the HOMD development (as described elsewhere in this report), these common areas of priority emerged as a shared theme. The subsequent establishment of the HOMD GP Liaison Nurse positions fell naturally to each of these priority streams.

Put together then, it was all these various factors coming together and interacting that impacted on the reconfiguration of community health service delivery more broadly, which had knock on effects and created a particular context within which the HOMD model developed and was implemented.

All of these different initiatives created some confusion at local level as new programs overlapped or were poorly documented (and understood). Steering Committee members agreed with policy and decision makers that not enough thought or planning had gone into how the various chronic disease initiatives and programs would integrate with each other at federal or state level, with one Steering Committee member going so far as to say "the whole thing's a dog's breakfast … how they are all supposed to fit together really escapes me." However, as with their policy and decision maker colleagues, some Steering Committee members also argued that this confusion had creative elements: synergies developed as initiatives at AHS level enabled new ways of thinking about service

provision to emerge across the whole health sector, and for services to the chronically ill in particular. This information exchange was helped when the AHS devoted a staff position to disseminating information about how programs such as *NSW Chronic Disease Management Program - Connecting Care in the Community*, *Care Navigation* and *HealthOne* integrated and interacted. During the course of the evaluation, the AHS employee in this role gave presentations on this subject to a number of work and professional groups in the acute and primary health care sectors in the Sydney West region.

6.2   Development of HealthOne

Policy and Decision Makers

HealthOne received a strong political commitment at state level, with support from the then Premier of NSW Morris Iemma and Reba Meagher the state Health Minister in 2004/2005. Commonwealth funding for integrated primary care through the COAG Health Reform agenda of 2006 underpinned the funding and implementation of HealthOne. However, one policy maker emphasised difficulties in getting effective cooperation:

> … everyone in Australia for years, if not decades, had talked about the dysfunctions and the disjunctions between Commonwealth subsidised general practice and state funded community health services and the difficulties of bringing the two beasts together. So it [HealthOne] started out as a relatively modest discussion and release of an EOI [Expression of Interest] in late 2005. (policy maker)

For this policy maker, the ideas around integration of the primary and community health sector were well in advance of the COAG reform agenda which later provided funding through the NSW State Treasury to launch the initiative. HOMD was one of the first successful bids in response to the NSW State Treasury EOI for HealthOne services. Some Steering Committee members also commented on an awareness of the need for service integration and coordination that preceded the HOMD initiative, in some instances by many years, describing early initiatives dating back to the mid 1990s that attempted to address the problem.

The NSW Chronic Care Program was also pushing towards better integration of primary health care services. As one decision maker recalled:

> … there was a sense that we should be doing something different in primary care and I think the initial concept was called 'Integrated Primary and Community Health Care Centres' and this was designed to bring together primary care, general practice, community health again to be trying to focus on those with more complex health care requirements. (decision maker)

Another strong advocate for greater integration of the primary health care sector was the Royal Australian College of General Practitioners (RACGP)[11], which lobbied both NSW Health through the NSW Chronic Care Program and the Premier and Health Minister for a more comprehensive integrated approach to primary health care. However, the strongest GP influence on the evolution of not just HealthOne, but of all PHC and community health initiatives over the period 2003 to 2011, was the NSW General Practice Council.

NSW Health had a well-established focus on improving management and care of the chronically ill. The Department's Inter-Government and Funding Strategies branch took the lead in forming

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11   The peak body group GP Unity NSW also had a strong influence, comprising chairs of the RACGP, AMA, ACRRM, GP NSW and others.

Primary Health and Community Partnerships and also took the lead in developing and implementing HealthOne. This branch also supported and worked with the NSW General Practice Council. The initiatives mentioned below came to the Council for review and comment, usually through a series of iterations, so general practice influence was prominent at state level in all these policy and program areas.

NSW Health's *Integrated Primary and Community Health Policy 2007 – 2012* and *Integrated Primary and Community Health Policy 2007 – 2012 Implementation Plan* set out definitions, principles and guidelines within which integrated primary and community health care was to be developed. The *Integrated Primary and Community Health Policy 2007 – 2012* states its aim is to set "the direction for the delivery of comprehensive and well coordinated primary and community health services for the people of NSW." Key concepts in the area are defined such as what constitutes 'primary health care', 'community health' and 'Primary and Community Health' (PaCH) - defined as "the overlapping primary health care and community health sectors and services as a single integrated and cohesive structure" (NSW Department of Health 2006: 1). A range of partners, organisations and services who contribute to the operation of the primary and community health sector are outlined along with key priory areas within which effort will be focussed. These areas include: integrated service planning and delivery; improved models of care; stronger partnerships; improved workforce capacity; and, enhanced information management and research (NSW Department of Health 2006: 13).

The *Implementation Plan* discusses these priority areas in more detail along with outlining how various other federal and state initiatives such as ABHI and NSW clinical redesign programs will interact with new policy and program directives. The Plan also specifically mentions HealthOne in a number of contexts including that the Inter-Government and Funding Strategies branch will work with HealthOne NSW services to identify, trial and test new integrated models of care that will deliver "integrated and effective primary and community health services … that place the patient at the centre of care" and that it will work with individual HealthOne NSW services to locally develop "planning protocols, networks and links" (NSW Department of Health 2007: 9, 3).

These policy directives were specifically written to set the parameters within which HealthOne NSW services could be implemented, but at the same time allowing for local needs, priorities and target groups to be identified and appropriate models of care to be developed at the local level. Discussing the inevitable tension between allowing some discretion at local level, but at the same time defining a set of principles within which the HealthOne services should operate, one policy maker said:

> And I think having some strong principles that travel across – because it's about partnerships. It's about bringing different services together. It's about defining a patient cohort that you're looking after. It's about having the support to allow that particular system to be. It's about setting up your systems and your policies and procedures to make that work. So they're … common principles that you find across [services] but in essence each system has to work for itself. (policy maker)

HealthOne services took shape within these overlapping state and Area contexts. Another policy maker described it as a process of bringing together various elements and resources of other chronic disease programs and initiatives at the same time recognising that GP fee-for-service arrangements would not be "undone any time soon" and that they would need to be integrated with the salaried arrangements of community health staff:

> … we started out thinking that we would like to make complementary the resources not only in general practice … but all the programs the Divisions of General Practice … and some of the chronic disease self management programs and the like. How could we best make use of all our collective resources but still recognising that general practice is going to work within a fee for service model. I mean we never thought that that would be undone any time soon. So … how could we actually bring people together

still recognising you've got a fee-for-service arrangement and a salary arrangement. (policy maker)

This policy maker also described this process with specific reference to the Mount Druitt context, "…for example in Mount Druitt … this is about how do we support the GPs so if we can get them [involved in HOMD] and support them to do team care arrangements and GP management plans and provide the complementary services that are identified for individual patients. That's a starting point." This interviewee continued the organic nature of HealthOne that allowed local level definition of needs, target groups and methods of GP involvement had been successful:

> So while we've got essential critical elements that are common across all of our services now each one is quite different and I think that has been the success of the program. It's been organic, we've allowed people to come to us and say 'this is what our community needs' and Mt Druitt is a point in hand … So they [HOMD] needed to do it their way that would bring on their GP partners with them and that was critical. (policy maker)

Steering Committee Members

The Mount Druitt HealthOne Steering Committee was formed in 2006 to guide all aspects of the development and implementation of HOMD. Key leaders, managers and staff were drawn from the participating partners the SWAHS (through its Community Health Services), the Western Sydney Division of General Practice, and the local GP Associations and the two GP Liaison nurses (see also Appendix Two). Early work performed by the committee included conceptualising an integrated patient-centred model, and facilitating work to determine local need, target groups and appropriate models for service delivery. As HOMD was rolled out in the Mount Druitt area the committee continued to oversee operations meeting monthly (until 2011) to review progress and discuss and implement further refinements and additions to the model. The Steering Committee continues to meet bi-monthly to oversee the operations of HOMD.

As part of the process evaluation, Steering Committee members were interviewed to gain insight into the processes, strategies and mechanisms that were initiated to develop and implement HOMD.

While Steering Committee members tended not to talk about chronic disease management and related concepts such as integration, coordination and patient-centred care in the broader policy context as their state and regional policy and decision maker colleagues did, they still had clearly defined ideas of what an integrated primary care sector should look like, usually from a strongly held personal philosophy developed over long years of experience working within a particular professional group. For example, one GP Steering Committee member had become involved in HOMD because he had "felt very frustrated at times that there was this professional isolation behind a silo, between general practice and community nursing …" hence developing a 'vision', as he puts it: "[f]rom day one at HealthOne I've had this vision of having GPs and nurses who could collaborate and have good working relationships in such a way that continuity of care … became a reality for patients." This was a commonly held view. Indeed, the Steering Committee as a whole was in full agreement of the assessment of 'the problem': lack of coordination of services, not just between community health and GPs but across the whole health sector including acute services; and lack of communication about patients and available resources and services both within and outside the health sector.

Steering Committee members were also very clear about the value of integration in primary health care, the ability of an integrated multi-sectoral team to address complex issues, as one person put it "… because the complexities of the … problems that people bring to primary healthcare are rarely solvable by a single individual or often not even by a single organisation, hence the need for primary healthcare to be multi-sectoral." This committee member also neatly summed up the benefits in terms of patient outcomes when care is delivered through a more integrated multi-sectoral approach by saying simply "… one could expect the benefits to be greater than the sum of the parts."

However, while Steering Committee members had well developed views about many aspects of providing care through a more integrated holistic multi-sectoral system, the details of the HOMD model emerged in the practical process of implementation. In order to 'do it their way' as the policy maker in the previous section opined, HOMD Steering Committee members did not start from a developed blueprint, but thought practically through problems as they arose to develop their own understanding – and practical application – of the concepts of integration and coordination in primary healthcare. Steering Committee members – with strongly held differing individual perspectives and managing the often divergent views of their contributing partner organisations or professional groups – collaborated to crystallise and develop the concept and service delivery model of HOMD.

The first steps towards HOMD were taken through a proposal centred on integrated primary healthcare that had been developed by the interested partners and submitted to NSW Health. Discussions between senior Community Health decision makers, local GPs and the then GP Division in the Western Sydney region had been occurring since the mid 2000s, with an awareness of the need for greater service integration and coordination and early initiatives attempting to address these problems, some with success, dating back to the mid 1990s in the wider area. The GP Liaison Nurse model which would become pivotal to the HOMD model also arose out of this context.

The subsequent proposal responding to the NSW Health EOI for HealthOne services resulted in funding and the building of the HOMD hub. This infrastructure funding provided a focus to draw together the various interested parties under a HOMD Steering Committee governance structure. As one Steering Committee member put it "… there had been a lot of ground work done preparing the possibilities and then it was like serendipity … New South Wales Health got interested and that allowed it to move forward." NSW Health funding allowed for a project officer to be employed initially through SWAHS but later, to provide greater recruitment flexibility than the public health recruitment system at that time, through the local GP Division, which gave the initiative further momentum. This proved to be a positive collaborative move so this arrangement has continued even though SWAHS is no longer experiencing the same level of budgetary and recruitment constraints.

The Steering Committee identified local stakeholders for discussions and ran information workshops with local GPs to engage partners for the new HOMD program. The committee had a strongly held view that local GPs and other potential partners should be consulted in meaningful ways and included in decision making from the beginning of the planning process. Another strongly held position of the Steering Committee was that this engagement of local GPs must be initiated by local GP leaders and Steering Committee members before substantial discussions about HOMD took place. This was a specific strategy to alleviate local GPs' cynicism and fears that HOMD was just another AHS initiative that promised much and delivered little.

This local engagement with GPs shaped the HOMD understanding of its policy goals – especially around integration. This caused some tensions between State Health and the AHS Executive on the one hand, and senior policy advisors and the local level HOMD implementation leaders on the other. The mutual respect and tactful resolution of these differences played a major part in the ultimate success of HOMD. The State Health/AHS Executive were of the belief (informed by the rural model for HealthOne sites) that GPs should be located in the hub, integrating services by physical co-location. HOMD Steering Committee members, with their close links to general practice, were of the view that HealthOne in a metropolitan setting needed to engage with all GPs in the locality and not to set up HealthOne as a competitive service model.

There was also a more philosophical difference emerging over the meaning of service integration. As two Steering Committee members put it, 'co-location does not necessarily mean integration.' One added "if you're in the same corridor it can help but it doesn't make it happen, there's got to be other reasons for you to work together, and other strategies to make that happen." Some Steering Committee members and policy makers were of the view that the physical co-location at the hub was distracting from the more important processes of establishing good working relationships,

partnership building and model development. It also threatened the fragile GP goodwill on which the program depended – in particular, a concern from GPs that services that they provided would be duplicated or in competition with their own practices if GPs were located within the hub.

Other factors occurring at the same AHS level also shaped the development of HOMD. These included a number of reviews and reorganisations of service provision within Western Sydney community health and primary care services. Some of this activity was generated from wider AHS initiatives and some from within Community Health itself in response to these and other outside pressures.

This period of analysis and review in Community Health had its origin in the NSW State Labor Government's amalgamation of Sydney's 17 AHS into eight larger regional AHS in 2004/2005. In the Sydney West region this resulted in the merging of two separate Community Health structures (Wentworth AHS and Western Sydney AHS) and a restructure into three groups of Community Health services. This raised a number of questions regarding the nature of Community Health and the services it provided. As one Steering Committee member reflected "… in doing all of that process, it was what are our drivers, who are our partners, what are the issues, what's our contribution to the health setting, what's our relationship with the acute, what's our relationship with GPs? … We needed to bring it all together and standardise it and sort out what was our reason for being" (Community Health Steering Committee member).

The health needs of young people was also determined as a priority through the HOMD planning process. This priority was subsumed at that time into the emerging headspace program.

6.3   Implementation of HOMD

Policy and decision makers agreed on the factors required to implement a HealthOne service. Physical location was obviously important with a HOMD hub purpose built at Mount Druitt Community Health Centre with the capital funding provided by NSW Treasury. However, the more intangible aspects of HOMD were equally important - more important in local leaders' judgement. As one policy maker put it "[t]here was a very naïve view, I think, that still may persist amongst some, that you build a building and it all would be hunky-dory and it would happen … It's how these bits and pieces are going to work together that you have to thrash out." Another policy maker described the 'bits and pieces' that needed to be thought about before the more specific aspects of the HOMD model of care and target groups could be nutted out.

> … how do you get GPs to the table, what's the role of the [GP] Division … how do we get consent [of patients and GPs], what are the privacy issues, what are the billing arrangements, if they're in our [NSW Health] facility can they bill Medicare still or are we infringing the Health Insurance Act. So all those things, you know, how did you pick that target group, what's your model of care … (policy maker)

Once these more general aspects of HOMD were understood and agreed upon then began the time-consuming and difficult business of working out, "debating and discussing", appropriate priorities, target groups and models of care for the Mount Druitt setting – taking into account population needs, that Mount Druitt is an area of disadvantage, the profile of GPs in the area, and the particular partners committed to HOMD. One policy maker describes the process of arriving at the two streams of service delivery, chronic and complex and children and their families, and the associated model of care:

… so there was quite a lot of debate and discussion around, you know, well who is the target group? Do we just focus on the older age chronic group? Do we focus on young ones? Is it anyone who is young? Do we focus on drug and alcohol, mental health? So we had endless lists that we worked through, and workshops, you know, to come to these two streams. Your older chronic, and then your young and vulnerable that have problems and hence the two GP Liaison officers appointed in those different roles. But that took a while to work that through. It wasn't just an instant thing. And given the level of vulnerability that you see in places like Mount Druitt amongst a lot of the population, the level of disadvantage, you know. Just thinking about how you're going to manage all that as well. (policy maker)

These problems looked quite different from general practice and the AHS offices. One policy maker noted that while management of chronic and complex disease was an AHS priority - and also a priority throughout health services generally because of the impact of increased presentations and admissions – it was not necessarily a priority of the same magnitude for GPs. Indeed, the higher priority for many local GPs was child and family services and support. HOMD responded to this need as detailed in the next section on the HOMD Model of Care.

A decision maker pointed out that the focus on the two streams of chronic and complex and children and their families posed a new way of working for community health staff "… so for them they were still grappling with what was happening internally." Given these complications the HealthOne partners decided to limit the catchment area of the HealthOne service to Mount Druitt which was considered "just huge to tackle as it was." The initial three priority groups (chronic aged and complex care, children and their families and disadvantaged communities) were introduced using a staged approach. Chronic aged and complex care was addressed first followed 12 months later by children and their families and then disadvantaged communities. A Community Health Steering Committee member also commented on this aspect of the implementation, pointing out that it was this "paring back" of the HOMD idea – both of people's expectations and what reasonably could be done in terms of service delivery within the Mount Druitt area with two GPLN positions – that made the whole thing manageable, both psychologically and practically.

6.4 The HOMD Model of Care

The HOMD model of care is client/patient/carer centred with enrolment based on carefully defined and agreed criteria, agreed partnership and co-case management between community health and GPs, case conferencing, agreed care planning, and specific service provision and referral – including allied health and social care (Figure 1). Services are delivered via a hub and spoke and virtual model either through the Chronic and Complex Care or Child and Family Streams of HOMD, facilitated by the GPLNs (see Section 2.1, Figures 2 and 3, and Appendix One for further details).

Views on the Model of Care

The HOMD model of care started from what one policy maker described as the "absolutely essential elements":

> … we determined at the outset that there were certain parameters within which we wanted this model to develop, and the absolute fundamentals [were] that it had to be a partnership between general practice and community health and that the service, the coordinated or integrated service … needed to cover a spectrum of care from prevention and early intervention through to the continuing management of people with chronic and complex conditions. So they were the absolutely essential elements of the model. (policy maker)

However, within these parameters this policy maker explained NSW Health adopted a flexible approach to encourage innovation at the local level, a policy formally enshrined in NSW Health's *Integrated Primary and Community Health Policy 2007 -2012.*

> You know none of us here wanted to be prescriptive to say that you know thou shalt do this because people will come up with innovative ideas and they best know what, well I think, will meet the needs of their population and … they've got to figure out how they're going to work together and if they can decide on this then that's what we're quite happy to support. (policy maker)

This flexibility, while embraced by the HOMD partners, also made it difficult to implement a program at the same time a model of care was being developed. As one decision maker put it, it was first necessary to create structures within which a model could then develop:

> No, there was no model at all. And the model started to evolve and New South Wales [Health] started to evolve what they thought was going to be a model as well. Very initially I think the model was certainly about creat[ing] a structure, put[ting] everyone in the structure and everyone work around it … (decision maker)

This decision maker went on to comment that use of a range of demographic and other data about the local area also inputted into the process of developing a model, and in fact to some extent drove how the final model would look.

> So it became quite apparent because of the work that we had done around the demography of Mount Druitt, where the GPs are, where the people are, how people travel. It just became quite apparent that it would actually be a different model. (decision maker)

GP practices were mapped and classified using data provided by the local GP Division to determine number and distribution of single and multiple GP operated practices and corporate practices throughout the Mount Druitt catchment area. Using census data this mapping process was also used to determine concentrations of local migrant and Indigenous communities, older and younger populations, as well as various other concentrations of disadvantage and/or lack of services. The location of Community Health Centres was also incorporated into these maps as were main public transport routes, car ownership data, and locations of local hospitals and shopping centres. This information was then used by the various HOMD partners to develop an appropriate model of care in relation to these identified needs, communities and population groups. This mapping exercise also provided the evidence for outreach from the HOMD 'hub', the purpose built facility at Mount Druitt Community Health Centre, to communities of need or areas of low service provision or spokes such as Willmot (see also section 2.1).

The introduction of GP Liaison Nurses was identified by most policy and decision makers and Steering Committee members as the key point in establishing the HOMD model of care. As one policy maker explained, the role of clinical or care coordinator was not in itself new in the health sector, but what was specific to the HOMD model was the splitting of the two full time GPLN positions into chronic and complex and child and family arms, thus allowing a more dedicated approach ranging from facilitating information flow between the various players within the acute and primary health care sectors right up to intensive case management for high need clients with multiple service providers both within and outside the health sector.

But in fact as it turned out Area said you know can we use some of that to have a clinical integration position. They might have a clinical caseload but we really need to do the clinical integration and we said absolutely. And they sort of take slightly different names but I think they essentially do the same roles so the GP Liaison Nurses in Mount Druitt, Auburn and Rouse Hill in other locations in NSW they're called clinical integration coordinators, but essentially they do the same thing, they act as that clinical go-between between the community health services, the GPs and any other services that, as you might know, Mount Druitt whether it's Department of Community Services or the Aboriginal Medical Service or Juvenile Justice or any of the NGOs that provide some of the services that would fit into that mix for whatever their target populations are. (policy maker)

Another policy maker saw the GPLNs as the 'glue' of HOMD:

And then the GP Liaison Nurses, their role, coming on board [was] instrumental in getting all this going. If they weren't there, this wouldn't have moved along. So, a very, very fundamental glue, if you will, between how community health does its business, and linking into general practice. So, you know, a really, really important link, and then into the hospital, and what's happening there … We perhaps hadn't quite appreciated when you start out with these things that these were sort of the linchpins of the model in terms of how do you bring disparate parties together to keep them, to keep them working together. (policy maker)

In summing up the implementation of the HOMD program and its associated model, this policy maker thought that it was when the GPLNs and the team began to discuss in detail the needs and circumstances of individual HOMD enrolled patients that "things started to gel":

… but I think where things started to gel and make a difference is where the patients started to come on the table, if you will, not physically for examination [laughter] but just actually starting to talk through for this particular patient. Actually looking at the patient records in Community Health to see who was listed there, who had a GP, who didn't have a GP. What could Community Health do with the patients on their list where there was a GP involved… (policy maker)

This was also the experience of Steering Committee members. One Community Health committee member went so far as to say "…we didn't have the GP Liaison Nurses on for about the [first] two years so we were trying to work through what the model might look like …it just felt like a one armed swimmer, you know, round and round and round and we didn't know where we were going." However, the HOMD model rapidly developed when the hub was built and the GPLNs were employed. While the HOMD hub was the home base for the GPLNs and the HealthOne clinics, the majority of GPLN activity was 'virtual' (see also section 2.1), beyond the physical confines of the building in the form of liaison, information transfer, referral, case conferencing and care planning largely between GPs and Community Health but also including other service providers when relevant to the care of the patient/client (see also section 4.3 HealthOne mount Druitt Patients). On the subject of the hub and the bringing together of health and non health services providers through the HOMD model, one Steering Committee member said:

…it seemed to me that the really missing link was a hub that could bring some of the fragmented players together – most importantly the two key players who really need to be working in partnership with disadvantaged groups, general practice and community health. And the other players kind of group around those both within health and external to health – if you can get those two in a firm partnership then everything else tends to reorient itself around them.

Development and Operation of the HOMD Model of Care

The HOMD model of care developed gradually, with false starts and successes often tied to its ability to engage GPs and other local health professionals. The chronic care stream had a false start targeting 'frequent flyers' – patients who presented to ED regularly, typically three to four times in one year. Few patients were identified and enrolled, as a Community Health committee member explained "it just didn't work because the GPs didn't understand what we were doing." Community Health went 'back to the drawing board' to find a solution that started from "knowing who our clients were and who our GPs were and then starting the process from there" (Committee Health Steering Committee member).

From this point, and with continuing input from the Steering Committee, the HOMD model rapidly took shape with potential HealthOne clients/patients identified by GPs, community health workers, and GPLNs. The linchpin of the HOMD model of care became the two GPLNs who identified the patient's needs based on referrals received and assessments made by Community Health. The GPLNs then facilitated multi-disciplinary communication, case conferencing and care coordination between the various health professionals and other service providers involved in the patient's care. Case conferencing could occur in a range of locations from the HOMD hub or the GPs surgery to the patient's/client's home, or in some instances the hospital, sometimes coordinated through discharge planning services if available. Health professionals and other service providers participated in case conferencing either in person or by telephone.

Enrolment into HOMD was split into either the Chronic Aged and Complex Care arm or Child and Family arm (see section 2.1 for eligibility criteria). As the implementation of HOMD proceeded some eligibility criteria were re-aligned according the local community's profile. In particular it was noticed that patients with chronic and complex conditions tended to be younger than 75 years in the local area, so the age limit was adjusted downward accordingly.

The GPs drove the inclusion of Child and Family arm in the HOMD model. GP representatives on the Steering Committee and the wider community of local practice GPs saw a pressing need for child and family services and support. Steering Committee members argued that case conferencing and care planning for Child and Family clients of HOMD frequently required a broader array of disciplines than the chronic and complex clients needed, and involved a wider range of health and other service providers and agencies, such as the Departments of Community Services, Housing or Education.

Because Community Health was committed to providing some level of service or information provision to all potential Community Health clients, the HOMD model developed two service levels to accommodate this. Level One provided basic information to clients not eligible for either Community Health or HealthOne services. In these circumstances, when the potential client did not meet community health inclusion criteria, GPLNs offered information to the referrer about alternative support options external to community health services. Level two clients were eligible for enrolment in HOMD so received HealthOne services appropriate to their illness, care and support needs (see section 4.3, HealthOne Mount Druitt Patients for case studies and further details of the operation of the HOMD model for Chronic Aged and Complex Care). For level two clients, consent was gained from the GP of the potential HOMD patient before enrolment proceeded. Enrolments could result from referrals received internally (via community health referral processes) or externally via GPs, SWAHS service providers, government and non-government agencies and family members.

HealthOne services were to cover the spectrum of care from prevention and health promotional activities to intensive case management and care planning. As part of the HOMD model, the GPLNs were also involved in community outreach and health promotional activities. The GPLNs and HOMD had an ongoing relationship with the Aboriginal community at Butucarbin in Mount Druitt during the course of the evaluation, for example, providing its Koori Life Club with information on Aboriginal Health Assessments and health advice. The community nurses' spoke at Willmot where Child and

Family Health, Women's Health and Mature Aged Person's clinics were run is another example of HOMD's community outreach.

The GPLNs carried out joint health promotional activities with local ethnic and community groups, including an annual Hepatitis C awareness campaign with the local Arabic community. The GPLNs also forged links with local Pacific Island communities and future health promotion work is planned. Both the Chronic Aged and Complex Care and the Child and Family GPLNs extended their outreach activities during the evaluation, visiting hospital wards and maternity services to improve existing links, and also establishing new links, with acute services. Despite strong support from the Steering Committee, this community outreach, prevention and health promotion work remains constrained by limited resources especially in staff time.

Flexibility of the HOMD Model

NSW Health policy makers saw the strength of making the HealthOne model adaptable to local conditions. One policy maker commented that even though there are some general principles to the HealthOne initiative, each 'system' has to work out for itself what is going to work:

> … whoever you're working with, you're going to have to deal with … personalities to work out what your systems are. I think you could get to a point where there's some commonalities, you know, some general principles, and those type of things you can take from the different systems, but each system is going to have to work out for itself as to what is going to work best for them. So no two systems are going to be exactly the same. (policy maker)

However, a decision maker pointed out difficulties with this decentralised approach:

> … we knew from what the GPs were telling us we had started to make some attempt to improve communication and here was a vehicle [HealthOne] … that came along, i.e. it had some dollars attached to it, that might actually help some of this to occur. But once the conversation started it was clearly much, much, much harder to do that [improve communication and coordination] … (decision maker)

And finally, a policy maker points out that the capital funding program that initiated HealthOne was the easy part. The hard part was developing a model of care based on cooperation with diverse and conflicting partners:

> … but how do you keep in parallel process the whole model of care development and the sort of clinical service design along with this tedious capital works program. And you know, we find that the focus can so often go to bricks and mortar because that's the easy bit and we've got to bring people back to say, you know, well how are your models of care being developed … (policy maker)

7. Partnership between GPs and Community Health Services

7.1 Building Trust between GPs and Community Health Services

Policy and decision makers described the difficulty in forming a partnership between GPs and Community Health to implement HOMD as having to juggle competing interests at local, state or national level: As one policy maker put it:

> … taking on board GPs' issues, community health issues and where the state was hovering at … a lot of hard work in actually getting that process together. From trying to interpret what New South Wales Health was saying, what the Commonwealth Government was saying, what … various aspects of GPland wanted. (policy maker)

According to a decision maker 'the most impressive thing' was that, despite differing views and competing interests, HOMD was very good at building trust across the partners. As a result GPs were very positive and wanted to participate in HOMD.

Building trust was considered difficult because there was "a level of scepticism" about the AHS from GPs. As one policy maker described it, "GPs need to know, have confidence, be reassured that the program was ongoing, that it was not going to fold, that it was not going to be "another one hit wonder", continuing that GPs had these ideas "quite firmly in their mind" and to change this takes a while to "work through." According to this interviewee GPs had questions of sustainability on their mind about programs such as HOMD, questions such as "is it going to last? Is it going to survive? Is it worthwhile investing our time and energy? Will this continue on? What is it that will continue on?"

Policy and decision makers talked about "taking counsel" from HOMD Steering Committee members and GP leaders that the trust would be built and that the partnership would develop. However, interviewees also discussed that this was a slow process because partners have to demonstrate to each other that it is "a trustworthy respectful equal relationship". According to one policy maker it was inevitable that some relationships were "robust" and others were "a bit more fragile" – hence there was a need to, as another policy maker put it, "try to move to a place where people felt that they were true equal partners around the Steering Committee table." The first policy maker described it as "let's just take little steps at a time, rather than … rush in."

A common theme in these discussions was that this process took time, particularly in a big AHS where according to one policy maker "there's baggage and there's a history" of failed earlier attempts to build relationships, coordinate and/or integrate services, and of earlier initiatives that "promise much but deliver little or nothing in terms of support for GPs." Another policy maker was of the view that lengthy implementation periods were related to "… trying to work out what it is that we were doing."

According to one policy maker, taking plenty of time to slowly build trust was also related to "needing to be careful in building trust and confidence with a largely overseas trained medical workforce who aren't really engaged in Division activities and Government activities."

The sentiments and concerns outlined above for policy and decision makers echoed with the Steering Committee members. However, committee members provided a great deal more detail of the process and issues involved in forming a viable partnership between GPs and Community Health.

As with policy and decision makers who talked about a level hof scepticism from GPs about the AHS, Steering Committee members also noted this with one person describing it as "lots of antagonism, lots of antipathy" because the AHS had "been promising things for years" and "never delivered on them." Another committee member described the same thing, "I think GPs had been promised a

lot that hadn't been delivered, Area Health was suspicious of GPs and what they were doing, no one talked, no one knew what each other was doing, so it was coming from a low level of trust." The first formal gatherings between GPs and Community Health to discuss integrated primary care also suffered from this "baggage" and "history" (as a policy maker labelled it, see previously), with Steering Committee members describing it as "…we didn't really mix... [there were] their issues and we had our issues but not a lot of collaboration really… everybody was coming from their own perspective … we were trying to work together but not knowing how to do it."

Other committee members discussed the key concept of trust as a way to move forward in the formation of the partnership. Committee members also talked about how a shared focus on the client/patient also proved to be a way of beginning to work together. One committee member talked about two levels of trust, "the trust between people who originally started talking" which was not "a big issue because I think most …had worked together in various ways already and understood the broad goodwill and also the tremendous skills that lots of people brought". However, for this committee member the bigger issue was developing trust both with the wider Community Health staff and GPs in the area. This committee member continued that for Community Health staff it was not so much a lack of trust, but rather "not quite knowing whether the GPs would be interested" and "not quite knowing how to work with [them]" but for GPs, as previously discussed, it was "a strong sense of suspicion mixed up with lack of trust." For a GP Steering Committee member trust was closely linked to respect, "because trust depends on mutual respect, you cannot trust somebody that you don't respect" and respect was gained through demonstrating professional competence and credibility.

Several committee members also discussed building the relationship between GPs and Community Health through "a shared focus on the wellbeing of the patients" as one person put it. The partnership then began to come together through a recognition that, as one Community Health Steering Committee member said, "we were all in there for the patients or the clients and we agreed on some principles around what we wanted to achieve and how we were going to do it." Another committee member commented that despite some initial apprehension and differences between partners "there was a unity around the vision from people who didn't often share a vision" and "compatibility of values was really high" continuing that:

> Everybody agreed that high complexity patients need a completely individualised approach; you need to be working to wrap around a flexible bundle of services, whatever that patient, whatever that family needs, it doesn't matter if it's a social problem or a school problem or an anything else problem, if you don't deal with that problem the patient is just switched off to anything else. (Steering Committee member)

From here it was relatively straightforward, with Community Health management "absolutely committed" to this vision, for work to begin: As a Community Health Steering Committee member explained:

> …because what we could do is we could communicate with GPs who were involved with the clients, we can provide them with information about the assessments that we do … let's test a little process and try and build a relationship with GPs around the clients that we're already working with. Give them information about what we're doing. Offer the information to them so that they can use it. (Community Health Steering committee member)

7.2   GPs – Leadership and Engagement

GP engagement – both gaining trust and building continuing relationships – was considered a fundamental and necessary first step in the implementation of HOMD by policy and decision makers alike. One policy maker described the process "[s]tarting off working with a few GPs first of all who

were a bit more of the leaders if you will, you know, showed an interest. And then that slowly start trickl[ing] out to others." These small beginnings led to big returns after six months:

> The GPs were sitting around the table fully engaged, fully talking about their patients, whereas before it was kind of like hmm, yes. Yeah, so there was quite a marked shift, and a feeling that things have been working better. That there's a shared, you know, that there's ways of doing business together across community health, and GPland … (policy maker)

The HOMD Steering Committee argued for a two stage process: winning the support of GP leaders before appealing to the rest of their colleagues. A GP committee member said "you have a level of regard and level of respect for them and you know that despite differ[ing] sometimes, that whenever they're involved that the outcome will be good." This required some forbearance from partners. One policy maker explained, "I remember as an Area Health Service [decision maker] I was feeling a bit frustrated, because I just wanted to go out and talk to everyone" but GPs on the HOMD Steering Committee were very clear to:

> … talk to the leaders, and we'd bring in the others when and as ready. So, I think [it's about] how you stage your communication and in hindsight that was very good advice. Very, very good advice. So, the leaders came on board. They started to get their heads around it [HOMD]. We started to work with them. We started to work it through, and then we chose our times to have communiqués with the rest of GP, you know, GP world. (policy maker)

Once GPs and Community Health leaders were fully engaged then it was a matter of the success of HOMD filtering out to other health professionals in the local area. As a Community Health committee member observed, "isn't the rule a third of people will embrace change, a third of people will resist change and a third of people will sit on the fence and see what happens."

The process was pushed by exploring ways to make HOMD solve some local practice problems. A one committee member argued:

> … so for [GPs] the only thing that matters is it actually makes their life easier and it makes the quality of care they can deliver better and more comprehensive, and preferably makes them more financially viable. And to some extent, I mean we just have to accept that's the way it is – if you're going to get the service to the patient, you have to take the GP to where they're at … many of them will change to some extent, they will begin to realise the value of that broader team, genuinely understand the virtue in having a home case conference with the family and others that they may not have ever thought about having before, so they will genuinely embrace it.

Another committee member pointed out "we basically supported GPs who claimed for the case conference and the health assessments and the care plan [MBS] item numbers and that helped." One of the GP committee members commented that sometimes it was worth pointing out to GPs what information HOMD could provide that they otherwise would not know, "I tell them, you don't know what happens after you give the patient a script, what happens at home, whether they can afford it, whether they will take it, whether somebody else is taking it, you don't know, and I find with HealthOne I get more insight of what's happening outside that 15 minute consultation."

7.3 Community Health

Community Health and the Partnership

The other key partner in HOMD was the Community Health services of the SWAHS. As stated previously, a number of parallel processes were occurring within Community Health to align all clinicians (nursing and allied health) to one or other of the new priority HomeFirst or ConnectFirst models of care. For community nurses in particular this involved a significant period of change to support the transition from a generalist to targeted nursing model. As with general practice, the constructive involvement of Community Health in working with the HealthOne approach required change management built on slowly nurtured relationships of trust and open communication.

> In terms of the community health staff, it was a whole new learning exercise for many of them going from that generic health model into working in different streams and working with different cohorts. So you've got a whole range of change management processes, of which communication is absolutely vital. And supporting a new skill development, a new set of processes and systems about how they are to work. (policy maker)

Once Community Health had embraced their new way of working, they also had to embrace working with GP's and recognising how GPs worked as generalists "seeing everyone and providing that primary care level" (policy maker). Each professional group had to overcome some well-established suspicions of the other to develop shared understandings on complementary activities and cooperation. Initially this service integration was 'hard work.'

> Working with the GP who has a slightly different way of working. Get a shared understanding of what each other does, and how those roles can complement each other, and that's not an easy thing as you're coming from very different places. And, you know, it's just a lot of hard work to actually work that through to get that shared understanding (policy maker)

Building mutual respect, although time-consuming, could break down the barriers between professional groups working in health, often referred to as 'silos', allowing a dialogue between groups who do not usually communicate with each other.

> … there are barriers between doctors and nurses and [you must] respect community based workers who go out there and go into people's homes, and the NGOs. You've got to engage them all in this dialogue. That's a hard job and why won't people do it? You've got to have time to do it. Got to be passionate about it and people sense that I think. (decision maker)

Steering Committee members pointed out how Community Health had 'come to the party' noting that Community Health "genuinely appreciate that the GPs can provide a medical expertise" and that Community Health had "taken time to be educated about what general practice is." Community Health assured local GPs that no HealthOne service would be in competition with them, but rather, would support them or "add value" to the care provided by GPs.

Focus Group with Mount Druitt Community Health Staff

A focus group was conducted with Mount Druitt Community Health staff including community health nurses, chronic disease nurse specialists and allied health staff who had involvement with HOMD through their daily work activities but did not perform key HealthOne tasks. Focus group questions included if HOMD had changed how staff conducted their day to day activities with community health clients, including conducting multidisciplinary case conference, care coordination and care planning (see Appendix Two, Interview Schedules for further details). The focus group consisted of nine people and lasted one and a half hours. It was electronically recorded and later transcribed.

Mount Druitt Community Health staff agreed with other groups and individuals interviewed for the evaluation that HOMD had made a marked difference to multidisciplinary involvement, teamwork and case conferencing. As one staff member put it:

> …like with HealthOne now I think it's kind of linked all of the centres together so for me personally … I feel that it's – it's enabled us to have like case conferences with the client, the GP, and all of the other multi-disciplinary teams involved. So for me that's been a positive, and before HealthOne I thought that was a little bit difficult to have … a structured type handover of the client type thing. (Mount Druitt Community Health staff member)

For an allied health professional, HOMD was particularly helpful in addressing the needs of complex clients with needs ranging from the physical to the emotional:

> I've found HealthOne particularly useful for clients who have got complex needs or [when I] have been stuck as to what to do to help them – their needs range from physical to emotional – I mean I'll go ahead and make the necessary referrals to colleagues in the Centre but then you don't have that communication with the GP, and having that HealthOne to coordinate that, speak to the GP, bring all the health professionals together to look at a plan of care involving a client has been great. (Mount Druitt Community Health staff member – allied health)

Another staff member contrasted this experience by recalling what it was like trying to bring different health professional and service providers together before HOMD, "I just think it just wasn't really there, like I mean you couldn't get everyone together." Furthermore, any information gained about appropriate services or care was often more by good fortune than planning. As one community nurse commented "you found out accidentally who the other service providers were, even though you'd done a case history and gone through an assessment – but the client for some reason didn't know, or wasn't happy to tell you, or totally forgot about it … it was all accidental most of the time."

One staff member pointed out that experienced staff had learnt over time referral pathways and services available but that HOMD provided this information for newcomers 'in a structured way':

> I think that often the care of the clients was reliant on, and the referrals and stuff were reliant on, how much experience you had and that if you had a great deal of experience then you knew which pathways to take to case manage your clients adequately. Whereas for the newcomers to the service they often – it would take many years to become comfortable with community health. It's quite a diverse role. There's a lot involved so for new grads HealthOne was a structured way to refer clients adequately to the services they might need. (Mount Druitt Community Health staff member)

However, some staff members pointed out that even with experienced staff it was difficult to get information or refer to some services or agencies in non health sectors, such as non-government organisations.

For one community nurse, it was the GPLN's link to hospital that had assisted her in getting her client admitted for an urgent procedure, "the GP Liaison Nurse was able to also liaise with the hospital and actually bring a procedure forward because of the urgency of it, and I wouldn't know where to start – like I wouldn't know the connections in the hospital." This staff member also thought HOMD case conferences reduced anxiety levels for clients "because they know that I guess everything is being done that can and it clarifies a lot of issues as well." As was also commented on by GPs (see section 4 for further detail of GPs views of HOMD), this staff member felt more comfortable phoning other care providers because HOMD liaison had allowed her to put "a face to a name" which allowed her to feel more comfortable discussing the client's care, as she put it, "if you've got any issues I guess

it's easier to kind of talk about those things." Another staff member made similar comments but also pointing out the benefit of a good outcome for clients, "you get to know all of the other players and you get to know their faces, you can ring them up, it's much more comfortable, but it's a good outcome for the client too." This staff member later said "I refer quite a lot of people through to the HealthOne program and actually have found it really, really good, sometimes there's a slight hiccup but the outcome for the client has been excellent."

A community nurse staff member noted that issues that might seem overwhelming could easily be resolved by case conferencing bringing together all the players. Other community nurses agreed issues that service providers were not previously aware of could be identified and resolved, including complex questions, such as eligibility for palliative care.

Three issues arose in the focus group concerning the difficulties in adapting to HOMD and the associated new ways of working. The group identified a lack of clarity and consistency of message within the organisation about eligibility criteria and services provided by HOMD. The second issue that arose was a perceived increase in workloads associated with increased referrals generated by the HOMD program. The third issue raised was confusion about the relationship between HOMD and similar programs such as the NSW Chronic Disease Management Program - Connecting Care in the Community.

An issue of confusion arising from a number of new and emerging roles within Community Health was discussed by the focus group. In the early process of developing HOMD and the role of the GPLN, the Community Health Service was conducting a parallel internal process to improve information flows and referral management. The creation of the community nursing clinical coordinator role proved very beneficial for the coordination of nursing workloads, but created some confusion about position roles and responsibilities. One community nurse argued "it has probably saved community nurses hours and hours on the telephone." However, this role was limited to clinical and other health related information gathering, not the broader social and community support information that GPLNs collected along with clinical information for HOMD clients.

8. Challenges to Implementation

8.1 GP Fee-For Service versus Community Health Salaried Staff

Differing funding structures, remuneration and methods of operation set some of the more formidable hurdles in the path of integration of services. GPs are largely remunerated by fee-for-service through the national Medicare rebate scheme. Community Health staff are employed on salaries by the AHSs. The business models developed in general practice have been built around the incentives – and limitations – of the Medicare model, often encouraging a rapid turnover of short services to maintain the financial viability of a practice. This contradictory set of incentives were often cited as a barrier to the implementation of HOMD. One policy maker described this situation as "incredibly challenging." A Community Health Steering Committee member agreed it posed "an interesting challenge" continuing that "it's just a completely different mindset and it took all of us a while to work out where everyone else is coming from…" Much of the 'trust' that has been emphasised in this evaluation as essential to the HOMD model emerged through a gradual understanding, by each party, of the incentives and limits faced by their partners.

These differing arrangements had ramifications that affected the implementation of HOMD. The salaried staff of community health had greater flexibility than GPs to attend meetings and carry out other various activities to improve integration and coordination of services for people with chronic illness, such as driving to patients' homes and attending the HOMD Steering Committee meetings. This flexibility sometimes allowed community health staff to spend more time assessing and providing care for these patients, activities for which GPs receive little funding. The main exception, five MBS items specifically for care planning and case management of people with chronic illness, while welcomed, were still considered by several evaluation interviewees as offering insufficient payment for the time it takes to assess and manage patients with chronic multi-morbid illness. As one policy maker put it:

> I mean if you had your GPs who were all paid on a salary and you're all sitting around the table together, and you could go to meetings at night and things like that, it would make life much easier … I'm not saying that one system is better than the other, but they're just, you know, different systems. And that the salaried system allows for more flexibility about what you can incorporate within a day. Whereas the fee for services is very, you know, it's very specific things that get funded. (policy maker)

This interviewee also went on to explain that building integration around MBS items, navigating the complex GP fee-for-service structure, proved difficult and time consuming. Success was built on jointly building new ways of working together:

> So, it's been a lot of work just to try and work out 'well how do we work together' and what are the MBS items that GPs get paid for so that we're working in that particular way. So that they can get the benefit of a payment while they're working with these types of patients. Our staff, they get paid five days a week or whatever it is, nine hours a day. So they're covered, you know, hopping in their cars and driving around, but how do you actually make that work with GPs? (policy maker)

Potentially this could include financial incentives to encourage GPs to engage more by enrolling their chronically ill patients in HealthOne programs.

> We tried to use some of the enhanced primary care (EPC) item numbers as a vehicle to fund the HealthOne centres but for some reason we were told that that couldn't happen and again I think that's – they're some of the things we need to tweak and get right. So we need to get some of those financial indicators, financial markers to drive that behavioural change with the general practitioners. For example if a GP had to – the

only way they could get a new EPC item number for a particular individual was through a HealthOne centre or working in partnership with a HealthOne centre, that would drive some of those general practitioners to make certain that their patients actually were streamed through that type of approach. (decision maker)

8.2   Capital Development Funding

The initial emphasis on the bricks and mortar hub at Mount Druitt was generally seen as a barrier to implementation. While acknowledging the importance of a physical location for HOMD (the hub), both policy makers and Steering Committee members believed the focus on physical infrastructure diverted attention from less tangible, but vital human resources. At the outset, time and money were scarce for hiring and developing the specific roles of new HOMD staff and for support of other community health staff as they adjusted to the new program. Policy and decision makers and Steering Committee members commented on this. As one Community Health committee member suggested "… the money [for capital works] complicated things I think. And I think most of the other HealthOne sites would say that the building and the money [for capital works] has stopped the process rather than assisted it."

One policy maker said the emphasis on a physical location caused 'extra hiccups' for the implementation of HOMD "how the program was funded, sitting in capital development it just meant that there w[ere] all these extra hiccups about getting dollars out." Initially, the lack of recurrent funding for staffing and other resources was considered restrictive and resulted in an early and necessary reliance on the leadership, good will and commitment of key people in the HOMD partnership.

> … no recurrent funds only capital funds, which is really terribly restrictive. So we really needed to rely on people's leadership, commitment, passion to keep working at this without a funding source to support the change management process. (policy maker)

There were also no additional resources available to support capacity building within the broader primary health sector in Mount Druitt. Policy and decision makers regarded this situation as a significant initial barrier to the implementation of HOMD. As one policy maker put it:

> I mean we've tried to give support here, within the limited resources that I have available to me, and you know if you have your time over again you think more about having resources for capacity-building and support. (policy maker)

In this view, creation of "better capacity and systems of care"(decision maker) required far more than the construction of a new clinic. It depended on broader work to manage chronically ill patients in their homes, through community health services and by improving integration between the primary and acute sectors. The largest challenge came from a lack of resources to employ sufficient GPLNs to service both existing and potentially new target populations. This limitation was signalled by most of the interviewees involved in HOMD: policy and decision makers as well as Steering Committee members.

8.3   Setting

The success of a HealthOne program depended on the service setting and the type and nature of the partners engaged. Both policy and decision makers and Steering Committee members agreed on the importance of understanding this broader context. One policy maker was of the view that in smaller regional or rural settings where "everyone knows each other" this "either really facilitates it [implementation of HealthOne] or makes it fall over" adding that "you know pretty quickly how that's going to go." It was vital to understand the prior history of the various participating partners.

One Steering Committee member also discussed the importance of local setting and context describing the collapse of the previous GP Division in the area as a barrier to implementation because it resulted in "lost impetus locally" for integration and coordination initiatives.

Some problems came from the perceptions of Mount Druitt brought by well-meaning outsiders, fuelled by sensationalist press coverage of local problems. A Community Health Steering committee member complained that Mount Druitt is often seen as an area "that everybody wants to pilot everything" precisely because it was an area identified as high need because of its disadvantaged and vulnerable populations. For this person this situation was challenging because "your presence is constantly being demanded at a whole lot of different levels because there are so many things happening in the community." This particular challenge was rapidly overcome by HOMD through the leadership and commitment of the local partners.

Other problems also derived from the Western Sydney context. Steering Committee members pointed to budget and recruitment challenges across SWAHS for part of the period of the HOMD implementation. At times, the AHS seemed more focussed on hospital based interventions than those located in the primary health care sector. However, this changed as the implementation progressed and understanding of the HOMD philosophy and practice grew amongst Area decision makers.

Another problem identified by interviewees was that "[t]he landscape shifts constantly" in the health sector (Community Health committee member). This made it difficult enough for Community Health staff to keep on top of new developments, let alone GPs who were often more isolated from the community health system. Organisations seemed in a constant state of restructure and reviews, with a steady stream of new models of care and service delivery, as well as the constant introduction of new initiatives, intervention and programs.

8.4   Perceptions and Personalities

Steering Committee members often commented on the troubled fate of previous attempts to bridge Community Health and General Practice. The perceptions generated from this history were a significant barrier to be overcome if HOMD was to be implemented effectively. Two Steering Committee members described the situation:

> General Practice and Community Health, they've worked apart for so long that generations of people have traditions of not working together. And if you add to that that in both corridors everybody's overworked, and have probably been exhausted by promises of change that were going to make a big difference but actually didn't. So the appetite for actually working together - I mean there are lots of reasons for it not to work. (GP Steering Committee member)

> And for each of them to stop resisting even the smallest overtures from the other side on the basis that you didn't have time, it was all too much, couldn't cope anyway, therefore no change thank you very much, put up the barriers... (Steering Committee member)

These views provided an undercurrent in the negotiation of how HOMD would work on the ground. One Community Health Steering Committee member described early HOMD meetings:

> …it was a very anxious time because there was lots of antipathy, and lots of antagonism, and lots of 'You've been promising things for years and you've never delivered on them,' and why should this be any different? (Community Health Steering Committee member)

As with Steering Committee members, policy makers also commented on the impact of partners' perceptions. For one policy maker, a barrier to the implementation of HOMD was the perception from some GPs that the program was not sustainable, that it was going to be "a one hit wonder, and go away …" The challenge was to work through this perception with GPs until HOMD was "considered more solid."

In a project based on local partnerships, the influence of individual personalities can be intense – providing effective leadership, or sometimes a less constructive influence.

> So, I think … personalities, unfortunately, can be a big issue. As I said, it's hard work … You have different personalities coming round the table. In the smaller rural areas the personalities can sit around a table. In the larger metro areas you have to fill up a conference facility with the players involved. If they're bickering and not getting on, and can't find a way over it, how are you going to get a service going? (policy maker)

8.5 Information Technology

IT, in particular an electronic health record, was considered important for the overall improvement of chronic disease management. As one Steering Committee member put it "… we desperately need a proper integrated electronic health record." One policy maker felt that unresolved IT issues were a barrier to the implementation of HOMD.

> … the things that have really cruelled us, the IT. I don't know how many person hours and how many dead-end rabbit burrows we've been down, we still don't have a solution to that … IT, you know, you can just chew up resources and never have any product at the end of it … (policy maker)

However, for another Steering Committee member the solution to this was not letting e-health be a barrier to the essential partnership building work that HOMD ultimately relied upon to get up and running.

> … we haven't let … the e-health get in the way of the work that we had to do … if you wait for e-health to come along and support you you'll be waiting 20 years. What you need is the partnerships, talking… e-health could support this but e-health would not have made this work, I think that's the difference. (Steering Committee member)

A similar sentiment was expressed by a Community Health Steering Committee member concerning not just e-health, but the range of challenges and barriers standing in the way of the implementation of HOMD considered here.

> It was such a challenge because everybody had different expectations and understandings and it was just a nightmare to try and navigate. I mean the fact is that we persevered and we had a really good rationale for why we were doing what we were doing and we wanted to start small and we didn't get hung up … I remember going to meetings in the early days and we were looking at IT issues and connectivity and evaluation and governance and all these sorts of things and they were all major process blockers really, rather than facilitators, and that's the message … don't get hung up on that big stuff because that actually will stop you from doing what you need to do which is simply starting to turn outwards and look, and really the hub is not the hub, the client is the hub that's where we got to with that. So yeah. Forget about the building, forget about IT, forget about you don't have secure messaging and we don't have joint medical records or you know, we don't have GPs sitting in the building because really at the end of the day it's irrelevant. It's whether or not we can work together around the clients. (Community Health Steering Committee member)

9. Factors for Successful Implementation

9.1 Committed People and Leadership

Policy and decision makers identified a number of keys to the success of the implementation and the continuing operation of HOMD. There was general agreement that strong, committed and passionate GP, Community Health and Division of General Practice leadership, successful partnerships and relationships, support from senior management, clear governance structures, defined patient pathways and target groups and finally patient success stories all contributed to the successful implementation and early operation of HOMD. As one policy maker summed it up:

> I think having strong GP leadership, a good Division of General Practice that's interested and wanting to come to the party and work with you … strong GP leaders, and strong leadership around the community health, having support from senior management within the Area Health Service … So, having those different layers of support are really quite important, and that's sorting through your governance, you know, and how you're going to work as an entity. Sorting out your patient pathway, and what's going to happen to patients as part of this service. Who's in, who's out, in terms of your patient group that you're dealing with … Having some successful stories as you're starting to get things working and that's just not necessarily success that the patient has had some miraculous recovery, but people are starting to feel good because the systems are working. Things are starting to kick in. If they're calling someone, they're getting a response, you know, so those types of things. So the systems are starting to gel and work, and people are feeling more comfortable about how those joint players are coming together and working. (policy maker)

This interviewee also felt that the GP Liaison Nurse positions and the goodwill of all the partners – who were "really wanting to make this work" – were crucial to the success of HOMD.

A decision maker commented that key elements to the success of HealthOne were improved patient experience, reduced duplication of services and improved access:

> Well I think something that would truly improve their [patients'] experience, in other words reduce duplication services, improve convenience, give better confidence to the individuals and better access in hours as well as after hours to the care when required. So in my mind they were the key elements for success. (decision maker)

This person also argued that HealthOne programs must add value to the services provided by GPs. This added value could be time saved by the GP, improved patient experience or non duplication of services provided. HealthOne programs should not compete with GPs to provide the same services.

> … I think we need to make certain that these centres [HealthOnes] add value to what the GP does. In other words if it's not going to, why would I send my patient there if it didn't add any particular value, save me time, improve the experience for my patient and I vicariously get credit for that. We must be certain that we don't threaten the GP by [causing them to lose] their patient. (decision maker)

This interviewee also summarised the elements required for successful implementation of a health care program such as HOMD by describing "the four T's" – time, trust, territory and tradition – pointing out it takes time to build up these elements (as also noted by other participants, see earlier sections) and that if you did not attend to these aspects then you got the "other two T's of torture and torment."

... you need enormous trust, you need to understand territory, in other words not to threaten each other's territory and respect that and also the fourth T was tradition, you need to understand where people are coming from, their different perspectives, you know the general practitioner will have a primary care perspective and a holistic approach, specialist care providers will have a much more narrow, hospital-based [view] … if you're not going to address those four T's you've got the other two T's of torture and torment, and that often led to these programs exploding. (decision maker)

Others saw it more simply. One policy maker stated "And the success of Mount Druitt really I mean it comes down to people. The people that were committed … prepared to go with it …. it really has been about the local players coming together and saying this is what we want to do and we will demonstrate that this will work." Another policy maker said:

> … and I think Mount Druitt, hats off to them that they have managed to get it going, and actually having it as a functioning service … many others fell over, you know, before they managed to get to that point. (policy maker)

As with policy and decision makers, Steering Committee members also spoke of the leadership and commitment of the people involved in the HOMD partnership as key to the successful development and implementation of the program. However, by virtue of their roles, Steering Committee members tended to particularise their comments, focusing on specific individuals and organisations. Policy and decision makers tended to look at broader systems that helped to launch and implement change.

Several Steering Committee members referred to the insight, vision or commitment of the program partners in understanding that 'things could be done better' within the primary health care sector and that HOMD could provide a mechanism through which improvements could be made. As one Steering Committee member put it:

> I think we've got GPs with great insight in that area who thought we could be doing things differently and HealthOne has given them a vehicle to be able to do that … all those guys that actually say there is a better way to do things and let's invest the time and energy into making it better. And then on the other hand we've also got community health that had the same thoughts and philosophy and managed to say, you know, let's look at a different way of doing things. (Steering Committee member)

Another factor identified as key to success was that these people were in leadership or influential roles within their professional or work groups, particularly GPs. There was a specific strategy to recruit influential local GPs to the Steering Committee to contribute to the development of the 'vision' of HealthOne and communicate its benefits to other GPs. A committee member explained the rationale:

> … because they are the people who are leaders within the general practice community and if you can get them on board there are a couple of quite key people where we needed to actually turn the attitudes around and if we could get them on board the others would follow … and that was why we needed to talk with the GPs and that's why we needed to find out what their critical issues were because we needed them. (Community Health Steering Committee member)

Equally important in this estimation was the commitment of Community Health to stand alongside GP representatives and reinforce the message of 'making it work' and getting the "right people around the table who could make the difference."

9.2 Community Health, AHS and Health Sector Context

Broader changes within regional health services were helpful to HOMD. The reviews and reorganisations that Community Health faced caused confusion at times, but also a new openness to change:

> Probably the important thing to say is that Community Health … had to make a decision, we had to change, we had to be the first ones to change, and we had to open ourselves up to flexibility and doing things in a way that maybe we're not comfortable with or maybe isn't quite how we would normally do business in order to engage with GPs, in order to have us both at the table, in order together to work out what's the sensible way of doing things… (Community Health Steering Committee member)

Two other Community Health Steering committee members commented on Community Health's flexibility at organisational level, the local Community Health Centre and at the program level to allow individual workers to do what they needed to do "to make it work." This flexibility extended to working with GPs, as one Steering Committee member put it "[s]o the thing we've learnt is that there's a wide range of GPs and their practices and what they can do and it's working with what you have and being supportive to those that need a bit more help."

As a consequence of Community Health's involvement in AHS initiatives such as clinical redesign was that the planning arms and Executive of the AHS saw Community Health as a serious partner in these planning activities. This major shift in perception allowed the planning and implementation of HOMD to proceed more effectively. GPs also accepted that the AHS was following through on the promise of improving working relationships between GPs and Community Health. This certainly facilitated GP involvement in HOMD. One Steering Committee member commented that the diverse membership of the committee allowed partners to advocate for HOMD across the various levels of the health sector from NSW Health and AHS level to Community Health and local GPs .This allowed 'blocks' to implementation to be negotiated and overcome.

9.3 Successful Elements of HOMD

Several committee members drew on their close involvement in developing and implementing HOMD to identify the keys to its success. HOMD provided a single point of contact for GPs to communicate and give and receive information with Community Health with individual, often face-to-face, interaction (see also section 4.2 GPs' Views of HealthOne Mount Druitt where local GPs commented they also valued this aspect of HOMD). As one Steering Committee member described it "I think the human relationship between the professionals involved is really important. … because the HealthOne nursing staff have made a point of communicating personally with, often going and visiting, the GP. So I think that's really important." (Steering Committee member)

Others also commented on HOMD's collaborative problem solving and information exchange as key to its success:

> Because most of these people have a complex set of problems that the GP is not in a position time-wise or skill-wise to necessarily sort … So if we take on that role then what the GP gets is the problems all sorted, so the care plan becomes much clearer, what they're able to do for the person is clearer and they know who they can call on to assist with the other aspects of the person's care. (Community Health Steering Committee member)

> … I don't know it kind of feels like you have to have a reason for talking with each other and if that means that you and I are now on the same page, you know what you're doing, you know what I'm doing, I feel like I've got something from you because I kind of, get a little bit of information maybe I didn't have - or a little bit of support maybe

that I didn't have or I can get advice about a different service that I didn't know existed, then that's a benefit to all of us. (Community Health Steering Committee member)

Steering Committee members also noted HOMD's emphasis on the well-being of the patient or client, while recognising the constraints imposed by the broader health system. As one person said, "I think it's always good to have a shared focus on the wellbeing of the patients … and then thinking through how do we work within our systems in order to achieve the wellbeing of the patient" (Steering Committee member).

Some Commonwealth funding changes of general practice through Medicare also helped. Some Steering Committee members emphasised the significance of care planning and case conferencing documents and other support from GPLNs to enable reimbursement of GPs through EPC items (GP Management Plans and Team Care Arrangements). Similarly, ATAPS (Access to Allied Psychological Services) funding improved access to Mental Health services for some HOMD clients.

The GPs on the Steering Committee identified much of the success of HOMD with the lightening of GP workloads, releasing them from the time consuming tasks of referrals and information gathering to provide better care to their patients. Time is the scarcest commodity in primary care.

> … so what we have found, clinicians on both sides of the fence, that is very busy community nurses or very busy general practitioners, here's Health One, don't tell me about it. I haven't got time. Oh, it actually makes it easier for me to do my work. This is not an added demand. This is something that actually provides support. So that is the way slowly but surely we've won clinician by clinician to the concept of the program, because they have discovered that it does in fact enable them to offer better quality care. (GP Steering Committee member)

Another GP committee member put the success of HOMD down to the fact that not only was the contact tailored to that particular GP's need, it was also prompt, unlike other services where GPs get frustrated because they cannot make contact.

> Yeah. And that's why HealthOne is totally different because you just ring the [GPLNs] bang … GPs are very easy to please, over the years I knew that. If you talk to them … instead of they're waiting, waiting, waiting, waiting, waiting, they get frustrated. (GP Steering Committee member)

10. Sustainability and Future Directions

10.1 Sustainability

Leadership versus Processes

The evaluation found some contrasting views on sustainability. Some of these followed on from different perspectives within the health system.

Some of the policy makers were the most optimistic, suggesting HOMD had become sustainable as it had developed "systemic arrangements" and so had gone "beyond personalities" – a transition they saw as essential given that the original success of HOMD was ascribed to the strong leadership and personalities of the people involved (see previous sections).

> I think it's gone beyond just the personalities … I mean it's a structured system. It does have policies and procedures. It does have assessment processes. Mount Druitt has gone way beyond personalities. (policy maker)

Not everyone interviewed for the evaluation held this view. Steering Committee members were more ambivalent arguing, in one case, that without the 'driving force' of leadership from key people HOMD could not continue "I don't think it would continue because the driving force is not there and if anybody who doesn't have the vision comes in then it could just be quite disastrous." Another Community Health Steering Committee member thought similarly because the HealthOne philosophy had not filtered through the whole organisation, "I think in Community Health we've still got work to do because I think it's being driven by the champions and the advocates. I don't think it's fully signed on to by the whole organisation." For this person further work was needed to embed the HealthOne philosophy into organisational practice and procedures.

> … this is not a funding dependant initiative but it is, at the moment, a leadership dependant initiative, and we need to move from it being that to being just part of everybody's business and way of working, and all the pathways and the protocols and the procedures all signed off and endorsed and part of normal governance processes. (Community Health Steering Committee member)

For one Steering Committee member HOMD had to be 'leadership driven' because the current health system was not structured to work in an integrative collaborative manner, "… in our system it's hard and it means you're constantly working across the barriers, therefore you have to have people who are pretty determined to keep it going."

'Culture Change'

To move beyond its leadership phase, some Steering Committee members argued HOMD needed a wider 'culture change' throughout the primary health care sector. Culture change that would ensure integrative multi-disciplinary practices and processes became embedded within partner organisations such as Community Health and extend to health professionals throughout the primary health care sector. While one Community Health Steering Committee member thought that HOMD was "starting to make some gains" on this front "particularly in changes of attitude, changes of internal [community health] culture" a GP Steering Committee member observed that this type of organisational transformation "takes time." Another Community Health Steering committee member summed up the situation "… for me it's been a about a culture shift and it's a reorientation of what we do so that we actually see the GP as a partner in the delivery of care to our clients and … that hasn't filtered through to all levels or all staff."

GP Liaison Nurses

All groups interviewed for this evaluation were unanimous in seeing the GPLN positions as vital to almost all aspects of the implementation, operation and sustainability of HOMD One committee member describing them as "mission crucial". Almost all (95%) of HOMD Partnership Survey respondents also thought that the GPLN role was important or very important to the functioning of HOMD. Other committee members argued that making the GPLN positions permanent would significantly contribute to the sustainability of the program. :

> If either of those nurses were to go and not be replaced by people equally as good, the whole thing would fail. So it would not last, because it's not enough in this environment to have middle management and above … agree that it's a good idea. (GP Steering Committee member)

Another Steering Committee member agreed that GPLN roles were important to the program continuing "if you lost those two crucial roles I think it would be hard to sustain." However, this person was more optimistic that HOMD has achieved some measure of culture change: "I think what would be maintained is the shared values and the shared partnership around community health and general practice."

Resources

The future of HOMD depends on adequate funding. Steering Committee members were of the view that funding needed to sustain the existing GPLN positions. The program needs to expand to become sustainable, and this requires funding to increase GPLN numbers and areas of specialisation across the Sydney West region. One GP committee member put it simply "I would say the threat to all of this is the funding." In a similar vein, 24% of HOMD Partnership Survey respondents did not think the HOMD partnership had the resources to achieve its purpose, with a further 36% unsure on this point.

Finally, when outsiders see the HOMD model working smoothly, supporting more effective work by health professionals and better care for patients, this creates its own momentum:

> So success breeds success so once you've demonstrated that not only are you competent at the relationships but you're actually making a difference to people, to patients and to the work force, that there are others that will then approach you and say we'd really like to do this ourselves. (policy maker)

10.2 The Future

The significance of the HOMD experiment goes well beyond the local community. One decision maker was of the view that once the HOMD model had been demonstrated to work, this raised questions about "how does it inform then … organisationally and structurally, and even physically, the design of settings for health care", adding:

> … if we could build enough capacity in the community to take out of the hospital, particularly the Emergency Department, some of these more chronic and complex care cases that didn't require admission, and then give them safety and confidence - for the carer and themselves - then we would actually have a very effective network. And that's still the vision. That's where we need to go. (decision maker)

This decision maker went on to also explain how this vision for a more integrated, coordinated primary health care and acute care sector could link a suite of other potential partners such as residential nursing homes and Aged Care Assessment Teams (ACATs).

So yeah, I think we still have a way to go, capacity building getting it right in the primary care sector, building physical centres, as well as virtual connections, to centres such as HealthOne. We need to understand how they then link that into the overarching care navigation strategy overall. How it links then into other things, residential nursing home facilities, other sorts of community care providers, ACAT teams. There's a huge suite of players that we haven't really linked too well, to the system. And they don't have to be too well linked but they, you know, we need to make certain that we can understand what the connection points are. (decision maker)

This striking vision would require greater capacity and many more links, formal and informal, extending from health care providers to embrace a wide range of other social and home care support agencies outside the health care sector, both NGO and state run. It could extend to partnerships with the private sector. It would require far more resources, both workforce and funding. This large scale transformation of the health care system has eluded state or federal governments, despite many reform attempts and agendas over several decades in Australia.

Again, Steering Committee members tended to take a more pragmatic and incremental view than their policy and decision maker counterparts. For example, one GP Steering Committee member argued particular services such as palliative care and mental health would benefit from a gradual extension of HealthOne type linkages, including "a HealthOne style mental health liaison position that can smooth the way to the linking of psychologists and psychiatrists." Another Steering Committee member saw the potential of HealthOne type models to be rolled out across a range of health and service delivery contexts through "shared management pathways, agreed local protocols, local management pathways." However, some Steering Committee members felt that new organisations coming into the primary healthcare sector such as Medicare Locals, GP Superclinics and the restructured Area Health Services in the form of Local Health Districts could undermine these prospects, as not all share the philosophy of working with other partners in the health sector in an integrated manner. Some Steering Committee members pointed to a wider political risk. Newly elected federal or state governments often make abrupt changes to health reform agendas, abandoning the painfully gained achievements of current integrated primary health care policies, programs and initiatives. For one Steering Committee member advocating for the HealthOne philosophy – especially its strong local connections – at the various levels of the health system, from NSW Health and AHS down to local level was one way to counter this uncertainty.

Some GP Steering Committee members had visions of an expanded relationship between GPs and Community Health growing out of the HOMD collaboration and hub at the Mount Druitt Community Health Centre. For one GP Steering Committee member this meant the inclusion of a university teaching and research function to the basic HOMD model "… we always dreamed of a practice dealing with HealthOne and community health and universities and teaching and research – definitely research and a lot of health professionals in a building where it is economically sustainable." Another Steering Committee member saw the logical extension of the HOMD model built on a more sophisticated working relationship between GP and Community Health:

> … if we kept on the trajectory that we're on and we manage to build up viable good quality practices, whether they were private practices or outreach publicly funded services or some mixture of – what you progressively do is build up the range of services that are provided in those practices, have community health nurses on site working with one or a group of practices, much expanded practice teams … fewer in the way of basic services sitting in the hub because most of them are out there. (GP Steering Committee member)

The hub would be transformed.

The hub then changes its function. It keeps on being a planning and coordination hub and a point of coordination for other sector services, but it might start to provide much more in the way of highly specialised services; it might even turn into a community hospital, it might do procedures, it might do after hours, it might do radiology or whatever. So is there still a need for a hub – it depends – it could be co-locating with a hospital. It could be part of a multi-purpose service where you've got aged care, whatever. There are already things like that happening so it's something that's designed for now that can evolve later. (GP Steering Committee member)

This Steering Committee member was of the view that regardless of the reality of these visions – or even the immediate prospects of HOMD, that:

… there's always going to be a need for a place that is a planning and coordination focus for communities, you know, to feel as though they've got some ownership in. For GPs, community health and others to have as a shared territory where they can sit and think and consider 'what next?'(GP Steering Committee member)

Another Community Health Steering Committee member stressed a simpler primary benefit, a sense of being connected rather than being isolated or out of the information loops, "they [GPs] really do feel that they're part of something and that they can access something or I don't know – that they're connected in some way."

Finally, another Steering Committee member pointed out just how far the Western Sydney health professional community had come in achieving a cultural change towards collaborative multidisciplinary partnerships. Once again, even if HOMD in its current incarnation did not progress, the desire of partners to continue to strive to work in collaboration would continue.

I think we've achieved in the last fifteen years in Western Sydney quite a strong culture amongst the more senior people both within and outside the health service to working together, to innovation, to achieving the benefits of partnership and collaboration which wasn't there in 1995 … The first attempt between the [GP] Division and Community Health years ago in the 90s, whilst there was definite commitment and goodwill on both sides, they were quite unproductive, they didn't get anywhere. I think it was partly lack of perhaps imagination, it was partly for whatever reason … Well I think that's different now. I think we know that we want to work together and we're committed to doing so. So I think projects like HealthOne, even if HealthOne itself is not sustainable, I hope it is, will continue to be developed and promoted and that's a good thing. (Steering Committee member)

11. Conclusion

There were two components to the evaluation of HOMD, a process evaluation and an outcome evaluation. Both components of the evaluation contributed to answering the evaluation questions. The evaluation addressed the following questions:

- In what ways has HOMD resulted in change in patient outcomes?

- In what ways has HOMD resulted in changes in health services?

- In what ways does HOMD make a difference in care provided to patients with chronic and complex conditions in Mount Druitt?

Changes in Patient Outcomes

Results of patient outcome analyses showed that among people with chronic and complex conditions enrolled in the HOMD program the number of emergency department presentations, and length of stay in the emergency department, in the 12 months following enrolment in HOMD was significantly less than in the 12 months prior to enrolment. Almost 30% of participants did not have any hospital presentations after enrolment in the program. However, there was no significant effect on the number of ward admissions, or on the amount of time a patient spent in the ward.

From these results it is clear that fewer emergency department presentations and shorter lengths of stay in hospital occurred among people with chronic and complex conditions enrolled in the HOMD program. However, it is worth noting that some emergency department presentations and hospital admissions are appropriate and necessary given the ongoing and recurrent nature of chronic illnesses amongst this group and the acute exacerbations of pre-existing conditions they experience.

There was also evidence from the case studies with HOMD patients that quality of life was improved by allowing people to remain in their own homes while receiving care, with assistance and support from their GPs, community health staff and home or personal care services.

Changes in Health Services

Results of health service utilisation analyses showed that the number of community health referrals for people with chronic and complex conditions was significantly less following enrolment in the HOMD program. The pattern of service utilisation changed in the 12 months after enrolment, with more referrals to allied health services such as physiotherapy, podiatry, occupational therapy, dietetics and psychosocial services but fewer referrals to community home nursing. Source of the referral also changed with fewer referrals from the acute care (hospital inpatient) setting and more from other health service providers and families, friends and neighbours.

Other changes in health services were also reported. As previously noted, a broader range of multidisciplinary services was able to be delivered to HOMD patients through case conferencing, care planning, and GPLN liaison and information provision. HOMD Partnerships Survey respondents thought that one of the benefits of HOMD was improved range of health services in Mount Druitt (see also section 3.4). Community Health also changed its service delivery model as a result of the implementation of HOMD and also changes within the Local Health District and the wider NSW health sector. New ways of working included delivering services through two streams, Chronic Aged and Complex Care and Child and Family, and what some described as a 'culture change' within Community Health instigated by HOMD, working with GPs in a more collaborative multidisciplinary integrated and communicative manner.

GPs also noted changes in health services as a result of HOMD. GPs answering the HOMD Partnerships Survey thought that the top benefit of HOMD was an improved range of health services in Mount

Druitt (see also section 3.4). For GPs who were interviewed, the HOMD GPLNs provided a single point of contact; they were 'user friendly' and tailored their interactions to fit GPs' needs. The GPLNs could organise care that the GP could not through lack of time or because they did not have the knowledge of services available e.g. Home Care, Counselling, other allied health services. GPLNs had the local knowledge of service boundaries and criteria for eligibility that GPS did not have. GPs valued highly GPLN support through knowledge about referral processes and other relevant information provided to them by fax, telephone, email, or face to face visits.

The process evaluation also provided information on the implementation of HOMD. The following sections detail the processes involved in implementation and address the evaluation questions by tracking changes over time, and clarify why and how changes in patient outcomes and delivery of health services occurred.

Difference in Care Provided to Patients

HOMD patients reported that they felt more supported and less anxious through their involvement with HOMD. This support ranged from 'just being there', a friendly ear either on the telephone or by a home visit, to practical assistance for medical and other health and social needs either delivered through community health services (including allied health e.g. counselling, dietetics, occupational therapy) or arranged by the GPLN to be delivered through other service providers, including home and personal care via the NGO sector. Patients also reported that community health staff, whether GP Liaison Nurses or other community health staff, spoke to them in an open honest 'truthful' manner about their health and social situations.

A broader range of multidisciplinary care and services was able to be delivered to HOMD patients not only through the case conferencing and care planning mechanisms of HOMD, but also through liaison and information provided to all members of the multidisciplinary team by the HOMD GP Liaison Nurses. Ninety-six per cent of HOMD Partnerships Survey respondents thought that the GPLNs facilitated effective communication and information exchange between clients/patients and service providers. Eight-four per cent of respondents thought GPLNs crossed traditional boundaries to enhance care coordination between clients/patients and service providers. Nine-four per cent of respondents thought HOMD case conferences improved planning and coordination for HOMD clients/patients.

Partnership Between GPs and Community Health

Building Trust

Building trust between GPs and Community Health was a time consuming and difficult process. Partners built trust by acknowledging the history and context of the local setting including previous relations and work experiences between AHS, GP Division/GP, Community Health and any other parties, organisations or individuals participating in the partnership. A shared focus on the patient or client assisted in building trust as participants in the partnership had the common value of being 'there for the patients' (to improve their care and access to appropriate services). In a similar vein, 'unity of vision' assisted the development of trust especially when members of professional groups involved in the partnership did not usually share a common perspective. The way Steering Committee members communicated and collaborated with each other modelled the trust they wanted to develop between local GPs and Community Health staff.

GPs – Leadership and Engagement

It was a specific strategy to first recruit a small group of GPs already committed to the HOMD idea, and then have this group act as leaders to gain the trust of the wider local GP group. Choosing leaders from both GP and Community Health groups who were already respected as they had a reputation

for doing good work and delivering good outcomes for patients and health professionals was also a deliberate strategy employed by the HOMD Steering Committee. Leaders had to be 'committed and passionate', 'obviously altruistic' and not 'self-serving' to initiate change. Leadership for change initiative needed to occur at a number of different levels – organisational (GP Divisions/Networks/ Associations, Community Health) and governmental (NSW Health and AHS management and policy).

Community Health

Community Health embraced new ways of working as a result of the implementation of HOMD and also changes within the Local Health District and the wider NSW health sector. This included delivering services through two streams, Chronic Aged and Complex Care and Child and Family. Change management was a slow process using the strategy of starting with those who were committed to the HOMD idea and working outwards to the rest of the organisation – this is an on-going process and the changes in work practices are expected to take some to time to filter through to all parts of the organisation. Appreciating and respecting different roles, and being flexible in changing traditional organisational views, taking the time to be educated about 'what general practice is', assisted the change process for those involved with HOMD .

As for GPs, Community Health staff thought that HOMD had significantly improved communication, multidisciplinary involvement and teamwork in case conferencing and care planning within and outside Community Health. Again as for GPs, Community Health staff said GPLNs provided local knowledge, a single point of contact and a known face for other providers. Community Health staff could build on this existing relationship if it was necessary to contact providers and/or clients. This facilitated more frank and open discussion of care and support issues, and was particularly helpful when dealing with sensitive issues.

Challenges to Implementation

GP Fee-for-Service versus Community Health Salaried Staff

This was considered a barrier to the implementation of HOMD but also integration more generally. Community Health had the flexibility to attend meetings and carry out other various activities that were relevant to improving integration and coordination of services for people with chronic illness. This flexibility sometimes allowed Community Health staff to spend more time assessing and providing care for these patients, activities that GPs were largely not funded for (excluding the five MBS items specifically for care planning and case management of people with chronic illnesses). However, the application of (public) community health funds to directly assist general practices resulted in improved quality of care (patient centredness, continuity, coordination, scope of service).

Capital Development Funding

While all acknowledged that a physical location was necessary for the operation of HOMD, an initial emphasis on only the 'bricks and mortar' hub at Mount Druitt Community Health Centre was considered a barrier to implementation. All of those interviewed stressed the greater importance of developing the necessary partnerships, processes and relationships. Consolidation of HOMD requires sustained funding and resources for specific roles and support for Community Health staff as they adjust to the new program and for capacity building in the primary health care sector.

Setting

The service setting and the type and nature of the partners involved in a HealthOne service was considered an important contextual factor shaping the successful implementation of the program. Depending on the particulars of the setting and the dynamics of the partnerships involved this factor could be either a positive or a negative influence.

Perceptions and Personalities

Strong memories of the failures of earlier attempts to build collaboration between Community Health and General Practice created significant barriers to trust that HOMD had to overcome. Beyond the collective histories and perceptions of particular professional groups within the partnership, some interviewees also discussed how personalities could be a barrier. Interacting with setting, the dynamics of the various personalities involved in the partnership could be either a positive or a negative influence.

Information Technology

An effective Information Technology system, in particular an electronic health record, was considered important for the overall improvement of chronic disease management. Access to patient information by all providers involved in a patient's care can considerably enhance integration and coordination of services and care provided. Lack of IT capability and an e-health record was considered a barrier to integration/coordination.

Factors for Successful Implementation

Strong, committed and passionate Community Health and general practice leadership, successful partnerships and relationships, support from senior management, clear governance structures, defined patient pathways and target groups and finally patient success stories all contributed to the successful implementation and early operation of HOMD.

Committed People and Leadership

The insight, vision or commitment of the program partners in understanding that 'things could be done better' within the primary health care sector and that HOMD could provide a mechanism through which improvements could be made was a facilitator to successful implementation of the program. Another factor identified as key to success was that these people were in leadership or influential roles within their professional or work groups. As previously discussed, it was a specific strategy to ensure some influential GPs in the community were also Steering Committee members. An essential element was a deliberate broadening of the leadership group to involve influential GPs who had started indifferent or even sceptical about the worth of HOMD.

Community Health and AHS Context

Community Health was subject to a number of reviews and reorganisations over the period of the implementation of HOMD. This led to an openness to change that was essential to the success of HOMD. Community Health allowed individual workers to do what they needed to do 'to make it work' at organisational level, the local Community Health Centre and at the program level, a flexibility that enabled productive collaboration with GPs.

Community Health's involvement in the reviews and restructurings of the AHS meant it was regarded as a serious partner in planning activities (in particular by the planning arm and the executive). Previously Community Health was not seen in this way. This allowed the planning and implementation of HOMD to proceed more effectively.

In turn, GPs saw the AHS following through on the promise of improved working relationships between general practice and Community Health. This encouraged GP involvement in HOMD, a necessary component in the successful implementation of the program.

The diverse membership of the Steering Committee allowed partners to advocate for HOMD across the various levels of the health sector from NSW Health and AHS level to Community Health and local GPs .This allowed 'blocks' to implementation to be negotiated and overcome.

Successful Elements of HOMD

Through the GPLNs, HOMD provided a single point of contact for GPs to communicate and give and receive information with Community Health with individual, often face-to-face, interaction.

HOMD's collaborative problem solving and information exchange through an emphasis on the well-being of the patient or client was a key to its success.

Care planning and case conferencing documents and other support from GPLNs allowed reimbursement of GPs through EPC items (GP Management Plans and Team Care Arrangements)

HOMD was successful because it had lightened GPs workloads. It provided support to GPs who could then offer better care to their patients.

Sustainability

Leadership versus Processes

For some interviewed for the evaluation HOMD had gone 'beyond personalities' because it had developed systemic arrangements. However, for others HOMD could not continue without the 'driving force' of leadership from key people within the partnership. HOMD had to be leadership driven because the current health system was not structured to work in an integrative collaborative manner.

'Culture Change'

For many interviewed, the sustainability of HOMD required a wider 'culture change'. This would ensure practices and processes relating to working in an integrative multi-disciplinary manner were embedded not only within partner organisations such as Community Health but also established with other health professionals working throughout the primary health care sector.

GP Liaison Nurses

The GP Liaison Nurse positions were considered 'mission crucial' - vital to almost all aspects of the implementation, operation and sustainability of HOMD. Permanent and ongoing GPLN positions would significantly contribute to the sustainability of the program. However, shared values and the shared partnership around Community Health and General Practice may be maintained outside of the operation of the GPLNs.

Resources

Without sufficient funding for the existing GPLN positions, the sustainability of the program would be in question. Any expansion would require funding for more GPLNs.

The necessity to fund change management in system change programs should also be acknowledged in funding arrangments. HealthOne is a major system change initiative, yet change management funding was minimal and required sustained advocacy to achieve. Development of future HealthOne models and sites needs to take this into account.

Overall 'success breeds success.' When outsiders see the HOMD model working successfully, with health professionals working together and providing better care for patients, this creates a momentum for others to develop and implement a HealthOne model.

Future Directions

The HOMD model could be extended and refined in the primary health care setting through greater numbers of GPLNs and more areas of specialisation targeting a broader range of priority groups. A further extension of the HOMD model could enable more sophisticated working relationships between GP and Community Health with expanded multidisciplinary practice teams providing a greater range of outreach services, to the point where most services are delivered outside the hub. The hub would then change its function and become the centre for provision of more specialised services, or even develop into a 'community' hospital, while still retaining its integrative and coordinating functions.

There is also potential for HealthOne type models to be rolled out across a range of health and service delivery contexts through shared management pathways.

Lessons learnt from developing and implementing the HOMD model could be used to inform, organisationally and structurally, a more integrated coordinated primary health care and acute care sector linked up to a suite of other health and non-health sector partners. However, this would require greater capacity and many more links, formal and informal, not only with health care providers but also with social and home care support agencies outside the health care sector, both NGO and state run. This may extend to partnerships with the private sector. Considerably greater resources for workforce and funding for further linkage programs such as HOMD would be required. A full realisation of these larger aims would depend on broader reform of the health care system, a project still beyond the reach of Commonwealth and state governments.

However, even without these developments within the primary care sector or the health system more generally, there will always be a need for a 'shared territory' where GPs, Community Health and other service providers gather and plan for the future. At its simplest, perhaps the achievement of HOMD lies simply in the fact that health professionals in the primary health care sector within the Mount Druitt area have a sense of being connected rather than being isolated from 'information loops' and can better access information concerning patients and available service pathways, referral systems and eligibility criteria both within and outside the health sector.

During the course of the evaluation the governance arrangements of HealthOne services changed, with a new overarching governing committee overseeing HealthOne service sites within the WSLHD (formerly the SWAHS) established in 2012. Local HealthOne Steering Committees have continued operation but with new terms of reference which allows a focus on implementation issues within the local site setting. There are future plans to further consolidate governance arrangements of not only HealthOne services but also other programs and initiatives concerned with better integration, coordination and delivery of services in the Western Sydney area. To this end, working in partnership with the WSLHD and other partners, the Western Sydney Medicare Local has recently created a new senior management position dedicated to this role.

NSW Health funded a project in 2012 to develop a HealthOne toolkit. The project is standardising HealthOne policies, procedures, guidelines and administrative forms and processes that have been developed out of existing HealthOne services in Sydney West. It is proposed the toolkit will be used in the roll-out of HealthOne services in other locations throughout NSW.

HealthOne Policy Objectives

NSW Health states the main aims of NSW HealthOne services are to bring together Commonwealth-funded general practice and state-funded primary and community health care services in order to create "a stronger and more efficient primary health care system" and to increase integration and coordination of primary and community health services by facilitating communication and care planning between GPs, Community Health (including allied health) and other health and social care providers (http://www.health.nsw.gov.au/initiatives/healthonensw/index.asp).

The Evaluation of HOMD has collected evidence that clearly demonstrates HOMD has allowed General Practice and Community Health to work more closely together in the Mount Druitt area. It is also clear from the evaluation that integration and coordination of primary and community health services (including allied health and other non-health providers) has been improved by HOMD, and that this improvement has occurred through the HOMD GP Liaison Nurses who have facilitated communication, information sharing, case conferencing and care planning activities.

NSW Health lists key objectives of HealthOne NSW Services as: preventing illness and reducing the risk and impact of disease and disability; improving chronic disease management in the community; reducing avoidable admissions (and unnecessary demand for hospital care); improving service access and health outcomes for disadvantaged and vulnerable groups, and; building a sustainable model of health care delivery (http://www.health.nsw.gov.au/initiatives/healthonensw/index.asp).

The ability of HOMD to provide people with a broader range of health and social care services and so better quality of life in their own homes has reduced the impact of their illnesses and in some instances the disability associated with these illnesses. This, along with GPLN facilitation of communication, information provision and care planning has also improved chronic disease management in the community.

The HOMD GPLNs engaged in some prevention work in local communities but limited resources meant the full potential of the HOMD model was not able to be fully realised in this area. Given additional resourcing, further prevention work may be able to make significant inroads in preventing future illness via the HOMD model.

As previously discussed, fewer Emergency Department presentations and shorter lengths of stay in hospital occurred among people with chronic and complex conditions enrolled in the HOMD program. However, further analytical work is required to determine whether or not this reduction in Emergency Department presentations was the result of ED presentations that were categorised as 'avoidable.' As changes in health outcomes and services available occurred amongst clients living in Mount Druitt, an area known to be disadvantaged and for vulnerable populations (see section 2.1), then it can be concluded HOMD has improved the range of services available and health outcomes for disadvantaged and vulnerable people who were enrolled in the HOMD program. However, no specific data on the socio-economic status of HOMD clients was available either to the HOMD program or the evaluation.

As noted earlier, the evaluation found that the sustainability of the HOMD program was reliant upon: continued leadership and commitment of key partners; a 'culture change' ensuring practices and processes relating to working in an integrative multi-disciplinary manner were embedded within Community Health and other partner organisations; sufficient funding to ensure the continuation of the GPLN positions and to increase GPLN numbers and areas of specialisation across the Sydney West region. Information about the sustainability of the HealthOne model in other locations in NSW requires further evaluative work as different HealthOne models have emerged in different contexts and settings (urban, regional and rural).

Evaluation interviews with policy and decision makers, HOMD Steering Committee members and staff demonstrated that flexibility in how policy objectives were reached and a pragmatic willingness to make it work 'on the ground' allowed local input into how priority groups and service models were developed. In turn this assisted in the emergence of a common understanding of what HOMD was, and what it was trying to achieve amongst the partner organisations involved. This understanding grew out of a flexibility that allowed 'space' for innovation, experimentation and problem solving at the local level. Further evaluative work at other HealthOne sites may be able to establish whether these are key elements to the successful implementation and sustainability of HealthOne NSW services across a number of different primary health care settings.

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HealthOne Mt Druitt

MODEL OF CARE

Child and Family Health
and
Complex, Aged and Chronic Care

1. **Introduction**

    HealthOne is a New South Wales (NSW) Health funded initiative to integrate primary and community health services bringing together GPs, Community Health and other health professionals in multidisciplinary teams to better meet the health needs of people in NSW. This means that General Practitioners, community health services, other health care providers and community agencies collaborate to provide comprehensive and coordinated care for clients to improve their health outcomes.

    HealthOne at Mount Druitt aims to increase the capacity of the primary health and community care sector by providing equitable, accessible and comprehensive care by integrating general practice and state government funded Community Health services. It also engages non-government and private care and service providers with a focus on people with chronic and complex conditions, children and young families at risk, and disadvantaged local communities.

2. **Population Health and Demographic Data (Blacktown Southwest SLA)**

    Estimated Population: 102,309

    Population and Demographics

    *   People under 29 years comprise 47.8% of the population; people aged 30-64 comprise 41.3%; and people over 65 comprise 7%

    *   By 2020, people 65 and over are expected to comprise 11.2% of the population

    *   26.9% of the population are born overseas and 3.6% have poor English proficiency. The largest foreign born populations have emigrated from the Philippines (8.1%), India (1.8%) and Lebanon (0.5%)

    *   Highest proportion of people who identify as Aboriginal and/or Torres Strait Islander (4%)

    Social Determinants of Health

    *   62.5% of 16 year olds are enrolled in secondary education

    *   16.5% of families are single-parent with children under 15

    *   27.4% of families with children under 15 are jobless

    *   29.7% of children under 15 live in jobless families

    *   Highest proportion of Aboriginal and/or Torres Strait Islander single-parent families with children less than 15 years in Western Sydney (42.7%) and Aboriginal and/or Torres Strait Islander jobless families with children less than 15 years (54.8%)

    *   28.6% of people hold Centrelink concession cards

    *   13.6% of the labour force are unemployed; the SEIFA IRSD is 903; and 27.5% of households have difficulty paying rent

    *   39.6% of dwellings have no internet connection

Morbidity and Risk Factors

- 8.6% of all babies born have low birth weight (2nd highest percentage in Western Sydney); 24.1% of mothers smoke during pregnancy (2nd highest percentage in Western Sydney); and only 89% of children aged 12-15 months have been immunised (3rd lowest rate in Western Sydney)

- 19.1% of people report having fair or poor health and 18.7% report high or very high psychological distress (highest percentage in Western Sydney)

- The most prevalent chronic diseases are circulatory (11.7%), respiratory (21%) and musculoskeletal system diseases (20.4%); chronic disease rates are lower than Metro Sydney, but mortality rates are markedly higher than Sydney and all other Statistical Local Areas.

- Highest rates of type 2 diabetes (3.2%); and highest rates of people with type 2 diabetes and overweight across Western Sydney (3.6%)

- Highest rates of males with mental and behavioural problems (4.7%), and the 2nd highest rates of women with mental and behavioural problems (5.8%)

- Highest number of people in Western Sydney with at least one risk factor: smoking, alcohol use, physical inactivity or obesity (45.4%)

- Highest rate of people who are physically inactive (29.9%)

Mortality

- The highest number of premature deaths (male & female) for 15-64yrs. The all-cause premature death rate is 341 per 100,000

- The largest cause of premature mortality is cancer (130 per 100,000), and Mt Druitt has the highest number of premature mortality rates for circulatory system disease, COPD and the 2nd highest rate of respiratory system disease The largest cause of avoidable mortality is cancer (78 per 100,000)

- The 2nd highest number of hospital separations due to diabetes co-morbidity and coronary heart disease (Mt Druitt, Blacktown & Westmead Hospitals)

Source: WentWest, *Western Sydney Population Health and Workforce Needs Assessment Summary* (September 2010)

3. **Current Primary Healthcare services in the Mt Druitt Area**

- **Acute Care**: Mt Druitt Hospital provides acute care services in the region. The hospital has a capacity of 200 beds providing clinical services which include Pre-Admission Clinic, Day Procedure, Surgical, Cardiac, Paediatric, Children's Outreach Service and Paediatric Ambulatory care, Palliative Care, High Dependency Unit, Rehabilitation and Aged care, and CADE (Confused and Disturbed Elderly) Unit. The hospital is supported by Blacktown Hospital and by Westmead hospital for more specialised care**.**

- **Primary Care**: There are approximately 124 GPs within the Mt Druitt area providing primary care. 55% of General Practices are solo practices and there are hardly any practice nurses. GPs are supported by Western Sydney Medicare Local (WentWest) and by Mount Druitt Medical Practitioners Association which is a member based organisation of local GPs.

- **Community Health**: Community health services are provided by Mount Druitt Community Health Centre which provides community based services and allied health services for the region. The Complex, Aged and Chronic Care service provides services to individuals via Home Nursing, Wound Clinic, Occupational Therapy, Physiotherapy and Dietetics. Services via Aged Day Care Centres are also provided. The Child and Family Health Service provides services to individuals and families via Child and Family Health Nursing, Speech Pathologists, Occupational Therapists, Physiotherapists, Social Workers, Psychologists, Women's Health Nurses, Continence Service, Audiometry Service and Vision Screening Service. Other services that operate from Mount Druitt Community Health Centre include Drug and Alcohol, Problem Gambling, Mental Health, Sexual Health, Population Health and Health Promotion and an Adolescent Health Service.

- **Private Providers**: There is limited access to private providers in the local area for specialist and allied services.

4. **The Establishment of HealthOne Mt Druitt's Hub and Spoke Model**

    4.1 HealthOne Philosophy

    HealthOne brings together GPs, Community Health staff and other service providers to collaborate in the care of identified clients, facilitate communication processes, support care planning and coordination. HealthOne adds value to the current Community Health services based on the Child and Family Health and the Complex, Aged and Chronic Care models of care.

    4.2 Consent to HealthOne

    - Consent is obtained from the client to enrol in HealthOne Mt Druitt and to share information with the GP.

    HealthOne Mt Druitt's service model is based on a "hub and spoke" virtual service approach.

    4.3 The HealthOne Mt Druitt Hub

    - HealthOne Mt Druitt (HOMD) is based on a "hub and spoke" model and virtually integrates care providers and services to achieve better health outcomes for its clients. It involves the collaboration of care providers such as GPs, Community Health and other service providers by facilitating communication, influencing multidisciplinary care planning, and coordinating care for them.

    - Potential clients are identified by GPs, Community Health, Hospitals, and GP Liaison Nurses, once identified and appropriately screened the patient is enrolled into HealthOne.

    - The GP Liaison Nurse (GPLN) position is the linchpin of this model. The GPLN works in partnership with the client and service providers to identify and support the client's care needs during their journey across the care continuum. The GPLN facilitates collaboration, communication and coordination of care. The GPLN enhances the coordination of care for the client by facilitating effective exchange of information. Enhanced health outcomes are achieved through the development of new partnerships and the strengthening of existing partnerships. There are 2 GP Liaison Nurse positions at HealthOne Mt Druitt; one focusing on Complex, Aged and Chronic Care and the other on Child and Family Health.

    4.4 The HealthOne Mt Druitt Spoke

    - HealthOne Willmot is an outreach site located on the periphery of Mt Druitt. It provides a shopfront service within the local community which does not have ready access to GPs and other health service providers due to its low socio-economic status, lack of infrastructure, transport and geographic isolation. Effectively this service operates as a 'spoke' in the HealthOne Mt Druitt model. HealthOne Willmot commenced operation on the 20th May 2009 after extensive community and stakeholder consultation.

    - The spoke centres around improved clinical relationships and service pathways between service providers (including Community Health and GPs and through links with Aboriginal Health, Sexual Health and other community agencies) to provide health services that meet the needs of the local community.

- The model identifies culturally appropriate and accessible service locations where coordinated care responses can be delivered to achieve maximum reach and effectiveness. Willmot has a high Aboriginal population so services such as the Aboriginal Chronic Care Outreach Service and the Aboriginal Outreach Workers from the Closing the Gap program support improved service provision and coordination to this population. Other HealthOne Services

4.5.1 HealthOne for Aboriginal Population at Butucarbin

An invitation was extended to HealthOne staff to attend the Koori Life Club (KLC), operating out of Butucarbin, Mt Druitt. The group requested information regarding Aboriginal Health Assessments and advice on health issues. Participants have made appointments for Health Assessments with the Chronic Illness Management Nurse. A HealthOne consent form is completed allowing staff to contact the person's GP.

The GP is contacted to determine if an Aboriginal Health Assessment has previously been claimed. A Health Assessment is initiated and the GP is contacted suggesting the need for completion of the assessment. Health information and counselling as appropriate is provided and a copy of the Assessment is given to the GP and the client.

Appropriate clients from Butucarbin are also introduced to SHAPE (Sessions for Health and Physical Exercise) a program run and managed by Western Sydney Medicare Local (WentWest) for clients who are overweight and obese to educate on diet and nutrition, encourage active lifestyle, and offer motivation and support in their weight loss journey.

4.5.2   Midwives Pregnancy Care Clinic

This clinic commenced at HealthOne Mt Druitt in February 2009. This is a partnership between Western Sydney Local Health District (WSLHD) Primary Care and Community Health Network, WSLHD and Blue Mountains Local Health District Women's, Children's and Youth Health Networks, Western Sydney Medicare Local (WentWest) and local GPs. Midwives from the 2 local hospitals, Blacktown and Nepean offer an outreach antenatal service to local families. The success of the Midwives Pregnancy Care clinic has exceeded all expectations with clinics increasing from 2 per week to 6 per week within 4 months of commencement.

4.5.3   Perinatal ATAPS (Access to Allied Psychological Services)

This is a partnership between Western Sydney Medicare Local (WentWest), GPs, WSLHD Primary Care and Community Health Network and private Psychologists to provide psychological services to women experiencing Perinatal Depression.

4.5.4   Breastfeeding

Information is provided to general practices about local breastfeeding support services, particularly promoting the role of the Child & Family Health Nurse in working with families to support with breastfeeding.

5.0   HealthOne Priority Areas

The role of the GP Liaison Nurse is to ensure care continuity, implement a coordinated care approach with clear communication processes and improve the ongoing health and wellbeing of clients in the community. The long-term aim of this strategy will include supporting clients to have improved understanding of and control over their health.

5.1 Complex, Aged and Chronic Care (CACC) Clients

5.1.1 Enrolment Criteria for HealthOne Complex, Aged and Chronic Care

The GPLN and referrer can discuss if the client is appropriate for a HealthOne enrolment. To be enrolled in HealthOne the client needs to be eligible for Complex, Aged and Chronic Care services through Community Health. For HealthOne, priority will be given to any CACC client where the case manager/service provider identifies that they require further support including service collaboration, joint care planning and partnerships for ongoing care.

All enrolments need to meet *at least ONE* of the following criteria to be eligible:

- Diagnosis of chronic and complex illness

- Severe end stage disease

- Risk factors for older age such as

  - Aged 75 plus years

  - Risk of falls

  - Cognitive impairment

  - Reduced nutritional status

- 4 or more ED/Hospital presentations in past 12 months

- Acute exacerbation

- Readmission to hospital within 28 days

Other risk factors: lack of social support and/or major life event. These risk factors on their own would not meet the Complex, Aged and Chronic Care criteria however for people with chronic disease and/or older age, a lack of social support or a major life event might increase symptoms so needs to be considered in addition to the criteria listed above.

Where the referral does not meet Community Health inclusion criteria, the GP Liaison Nurse will offer information to the referrer about alternative support options external to Community Health services.

For a **HealthOne referral** the client needs to be considered in terms of how HealthOne can add value to the current care being provided. Generally this is where the referrer and GP Liaison Nurse consider the client's needs are reasonably complex and would benefit from the support of the GP Liaison Nurse.

For example the client may have in addition to the Complex, Aged and Chronic Care criteria listed above:

- Multiple services involved or needing to be involved in the client's care

- Multiple medications which need monitoring (and where the client may benefit from a Home Medication Review)

- A need for improved communication between service providers and care coordination (where generally a case conference will be required).

- Identified psychosocial needs.

5.1.2 CACC Enrolments to HealthOne

Enrolments to HealthOne for Complex, Aged and Chronic Care services are supported by 2 processes: internal enrolments and external enrolments.

Internal enrolments:

a. Community Health receives referrals for home care services from various sources. Clients who fit the criteria for Complex, Aged and Chronic Care are identified by the case manager from Community Health as potential HealthOne clients. GP Liaison Nurse teams up with the case manager to enrol them under HealthOne in consultation with the clients and initiates care coordination and collaborative care planning while keeping the GP linked in through the whole process.

b. GP Liaison Nurse participates in the Adult Co-ordination Group (ACOG), a multidisciplinary forum in Community Health to ensure a holistic, comprehensive and coordinated approach is provided to chronic and complex clients. Potential HealthOne clients are identified and the GP Liaison Nurse works with the case manager and facilitates care coordination and feedback to the GP.

External Enrolments:

a. GP Liaison Nurses receive referrals from GPs, primary care providers, Western Sydney Local Health District (WSLHD) providers; Government and Non Government Organisations and family members.

b. The GP Liaison Nurse participates in active case finding within the acute care facilities by attending hospital ward meetings to identify clients with complex care needs to be enrolled under HealthOne.

c. Through Total Care Navigation (TCN). TCN is a process of coordinating care within the acute care setting done through care coordinators from the Patient Flow unit within Blacktown-Mt Druitt Hospital. Care coordinators identify patients and are notified to the GPLN for possible enrolment and further care coordination in the community.

d. Through Connecting Care. The Connecting Care program is aimed at enhancing existing chronic disease management services to reduce unnecessary hospital admissions by providing coordinated, connected care and self management support.

Some of the enquiries result in referrals to both Community Health services and enrolment with HealthOne Mt Druitt. Where the referral does not meet Community Health inclusion criteria, the GP Liaison Nurse provides information to the referrer about alternative support/care options external to Community Health services.

5.2 Child and Family Health (C&F) Clients

5.2.1 Enrolment Criteria for HealthOne Child and Family Health

Vulnerable families have been identified as an important HealthOne priority group. To be enrolled in HealthOne the child or family member needs to be eligible for Child and Family Health services through Community Health (refer to the Mt Druitt Community Health Service Directory).

Referrals may include:

- Any child and family where the case manager identifies that they require further support including collaboration, joint care planning and partnerships for ongoing care

    - Children in out of home care

    - Children with chronic illness

    - Children living in a family with identified complex psychosocial issues

    - Maternal/Paternal mental health issues impacting upon the health and development of the child

- Any child and family where the level of care has been determined as Level 2 or Level 3 (NSW Health: Families NSW Supporting Families Early Package, Maternal and Child Primary Health Care Policy)

Where the referral does not meet Community Health inclusion criteria, the GP Liaison Nurse will offer information to the referrer about alternative support options external to Community Health services.

For a HealthOne referral the client needs to be considered in terms of how HealthOne can add value to the current care being provided. Generally this is where the referrer and GP Liaison Nurse consider the client's needs are reasonably complex and would benefit from the support of the GP Liaison Nurse.

For example the client may have in addition to the criteria listed above:

- Multiple services involved or needing to be involved in the client's care

- A need for improved communication between service providers and care coordination (where generally a case conference will be required).

5.3 C&F Enrolments to HealthOne

Enrolments to HealthOne for Child and Family Health services are also supported by 2 processes; internal enrolments and external enrolments.

Internal enrolments:

a. Clients who fit the criteria for Child and Family Health services are identified by the case manager from Community Health as potential HealthOne clients. GP Liaison Nurse works in partnership with the case manager and the client and family to enrol with HealthOne, and initiates care coordination and collaborative care planning while keeping the GP linked in through the whole process.

b. GP Liaison Nurse participates in the Child & Family Multidisciplinary Assessment Clinic – an internal process to provide multidisciplinary assessment and case management for clients, and to provide multidisciplinary support and case discussion for Community Health staff. On identifying potential clients through this process, the GPLN along with the case manager work in partnership with the client and family to enrol with HealthOne, and the GPLN initiates care coordination for ongoing care, with feedback provided to the GP.

c. GP Liaison Nurse participates in Early Childhood Coordination Group – a multidisciplinary forum to ensure a holistic, comprehensive and coordinated approach is provided to families identified as vulnerable or at risk. Potential HealthOne clients are identified and the GP Liaison Nurse works in partnership with the case manager and client and family to enrol with HealthOne, and facilitates feedback to the GP.

External enrolments:

GP Liaison Nurse receives referrals from GPs, Western Sydney Local Health District (WSLHD) providers, Government and Non Government Organisations and family members. Some of the enquiries result in referrals to Community Health services and enrolment with HealthOne Mt Druitt. Where the referral does not meet Community Health inclusion criteria the GP Liaison Nurse will offer information to the referrer about alternative support options external to Community Health services.

6.0 Principles of Care

6.1 Collaboration and Care Coordination

As the client is being enrolled they are provided with a 'HealthOne Mt Druitt Information for Patients' brochure. If the client does not have an identified GP then the GP Liaison Nurse will consult with the client and offer information about possible GP options and also provide the client with the 'Having Your Own GP your key to good health for you and your family' brochure.

Once the patient has identified their GP, the GP and the GPLN work together to provide holistic, continuing and coordinated care. Following is some examples of how coordinated care is delivered through HealthOne Mt Druitt:

A feedback letter and if available a copy of the Community Health assessment is given to the GP. Wherever possible the GP Liaison Nurse will visit the GP in person to offer feedback about the client's health needs and progress. This offers the GP an opportunity to clarify any information, obtain additional information about Community Health services and assists to strengthen the partnership between client, GP and Community Health.

In some cases a follow up telephone call to the client is also provided in order to inform the client that the GP has been given information and this also offers the client an opportunity to clarify any issues or discuss their health needs in more detail. The client's case manager is informed of the above and is then encouraged to continue to coordinate care with the client's GP as appropriate. Where there are other service or care providers involved in the care of the client e.g. allied health, mental health, home services etc the information is shared with the GP which is utilised to prepare a GP Management Plan, Team Care Arrangement or Health Assessment and a community case conference is organised if appropriate supported by the GP Liaison Nurse.

6.2 Multidisciplinary Care

The GP, Community Health worker and other health professionals including private providers are brought together as a team to deliver comprehensive care as required based on clients needs. Case Conferencing provides an opportunity to bring stakeholders together and build multidisciplinary care plans resulting in a common management plan to deliver care based around client's psychosocial needs, circumstances, and priorities to achieve better health outcomes and optimum utilisation of resources between care providers.

GP Liaison Nurse is also involved in the discharge teleconferences with the GP and multi disciplinary case conferences where appropriate within the hospital setting. GP Liaison Nurse either initiates a discharge teleconference in consultation with the teams in the hospital for a HealthOne client or is informed of a teleconference for an appropriate client by the hospital. GPs are notified 24 to 48 hours prior to a discharge teleconference by the GP Liaison Nurse and are called on their telephone to discuss the management and treatment at the hospital to continue care in the community. GP Liaison Nurse documents the case conference with patient consent and sends the document with the details of the conference to GPs to continue care. This document also support GPs to claim appropriate MBS item numbers for the teleconference.

Patients enrolled with Complex, Aged and Chronic Care are assisted to record their health outcomes in the My Health Record book. They are encouraged to utilise this record and take responsibility for ensuring all services involved in their care are aware of this document. Also carers needs have been identified and included in care plans which have lead to referrals to carer support groups and other services.

6.3 Relationships with GPs

HealthOne has engaged GPs from the planning stage, with GPs providing guidance to formulate the strategic framework and being a part of the implementation process through representation in HealthOne committees and workgroups. GP Liaison Nurse has augmented this partnership through improved communication and care coordination for the patients referred by GPs. HealthOne Mount Druitt virtually integrates health care providers by providing coordination, collaboration of multidisciplinary teams, offering support to processes like community case conference and ongoing support for GPs to manage patients with complex conditions. As a consequence there is improved trust and confidence by GPs in the partnership and in HealthOne. Engagement of GPs, improved communication and ongoing support has resulted in strong relationships between GPs and Primary Care and Community Health Network.

6.4 Partnerships built through HealthOne

The following services and key positions have been involved in HealthOne:

- Inpatient Facilities

- Total Care Navigation

- Respiratory Ambulatory Care Service (RACs)

- Cardiac Failure CNC

- Aged Care Assessment Team (ACAT)

- Aboriginal Medical Service Western Sydney

- Butucarbin Aboriginal Corporation

- WSLHD Falls Prevention Co-ordinator

- Our Lady of Consolation Aged Care Services

- HACC Services

- WSLHD Carer Support Service

- Home Care

- Diabetes Education Centre

- General Practitioners

- Western Sydney Medicare Local (WentWest)

- NSW Ministry of Health

- WSLHD Women's, Children's & Youth Health Network

- WSLHD Western Sydney Area Adolescent Team

- WSLHD Mental Health Service

- Department of Family and Community Services

- Uniting Care Burnside Brighter Futures program

- Mission Australia

- Schools and Department of Education

- University of Western Sydney

- University of Sydney

Information Technology Systems

The GP Liaison Nurse has access to a number of IT systems (CHIME, Healthelink, and Cerner Millennium). A number of these systems are not linked to each other so information is often fragmented. The GP Liaison Nurse role assists to minimise the impact of such fragmentation and facilitate coordination of care for the client. The Obstetrix system is utilised by the midwifery staff who facilitate the Midwives Pregnancy Care Clinic at HealthOne Mt Druitt. This system can be accessed via the outreach site at HealthOne Mt Druitt enabling the midwives to coordinate clients' care from a community venue. Initial discussions between Western Sydney Medicare Local (WentWest) and WSLHD are underway to implement Secure Messaging at the HealthOne Mt Druitt site and Hospital, so that GPs, HealthOne Mt Druitt, Community Health and Hospitals can communicate electronically.

Enrolment based on criteria

Ongoing monitoring

Individual agreed partnership for care with GP - CHC

Specific service provision e.g. clinics; referral- Home Medication Review; allied health intervention

Client/ Patient/ Carer

Designated communicator with care partners

Agreed Care Plan

Co-case management between GP & CH clinician

Case Conference
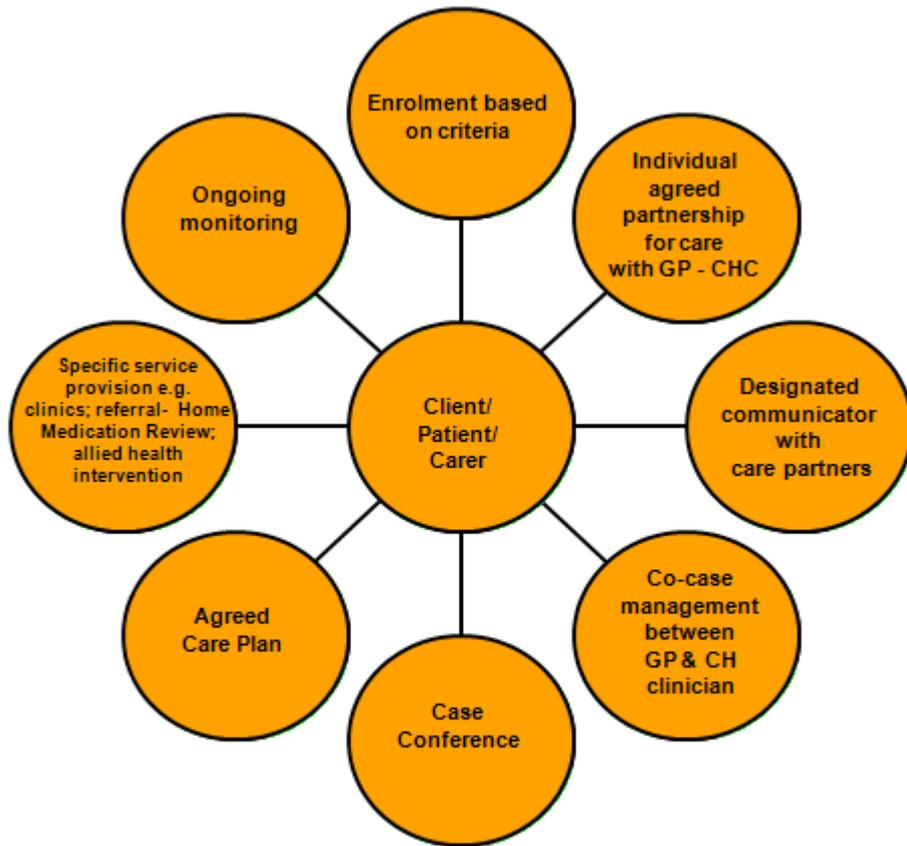
PRINCIPLES
Defined communication at critical care points.
HealthOne NSW concept to be adapted across WSLHD Community Health Services.
May be adapted and modified to suit local needs.

Appendix Two: Interviewees and Interview Schedules

Interviews with Policy and Decision Makers

Five individual interviews were carried out with NSW Health and Western Sydney Local Health District (previously Sydney West Health Service) policy and decision makers who had a role in the development and implementation of chronic disease management policies particularly HOMD and covered the following broad areas: history and development of chronic disease management policies; description and history of development of care coordination and service integration policies including HOMD; and perceived barriers and facilitators to the implementation of HOMD, both organisational and with regard to specific roles. Interviews were of approximately one hour duration and were electronically recorded and later transcribed.

HOMD Interview Schedule – NSW Health Policy and decision Makers

General description, history and development of chronic disease management policies

Description and history of development of care coordination and service integration policies

Specific details of the policy development process behind HealthOne Mount Druitt

>	prompts

>	- how and why was care coordination and service integration between hospital and primary care (community health service, allied health, GPs) identified as a problem, and HealthOne (including HealthOne Mount Druitt) developed as the solution

>	- use of (research) evidence

>	- use of NSW Health policy documents, initiatives, strategic plans, objectives -	expected changes to local (and central?) services

>	- evaluation of policies in the area and/or HealthOne Mount Druitt in particular

Dissemination and Implementation of HealthOne Mount Druitt

>	Prompts

>	- strategies used to communicate broader chronic illness, care coordination, service integration, self management policies and issues

>	- strategies used to communicate specifics of HealthOne Mount Druitt to key stakeholders at Mount Druitt Community Health Service and other relevant primary care and NSW Health staff

Perceived barriers and facilitators to the implementation of HealthOne Mount Druitt

>	prompts

>	 - organisational culture and context of Mount Druitt Community Health Service and GPs in the Area (and/or primary care in general)

>	- broader NSW Health organisational context and culture

>	- state and federal interaction

>	- effect of other similar care coordination and service integration initiatives, programs, policies operating in the Area

Any other comments about HealthOne Mount Druitt, management of chronic illness, self management, care coordination or service integration?

Interviews with HOMD Steering Committee Members and HOMD Staff

Eleven individual interviews were also carried out with Steering Committee members and operational staff in key roles regarding the development and implementation of HOMD and covered the following areas: specific details and processes of the policy development process behind HOMD and its implementation; barriers and facilitators to the implementation, both organisational and with regard to specific roles. Key roles for HOMD operational staff included two GP Liaison Nurses (Chronic Aged and Complex Care and Child and Family streams) and the Mount Druitt HealthOne Steering Committee consisting of: the Network Director, Primary Care and Community Health Sydney West Area Health Service (SWAHS); President, Mount Druitt Medical Physicians Association (GP); President, Blacktown Medical Physicians Association (GP); General Manager Practice Support, WentWest; Australian Better Health Initiative (ABHI) Project Manager, WentWest; three local GPs; and the Group Manager, Mount Druitt Community Health Service. Interviews lasted 45 minutes to an hour and a half and were electronically recorded and later transcribed.

Focus Group Discussion with Mount Druitt Community Health Staff

A focus group was conducted with Mount Druitt Community Health staff including community health nurses, chronic disease nurse specialists and allied health staff who had involvement with HOMD through their daily work activities but did not perform key HealthOne tasks.

The focus group consisted of nine people and lasted one and half hours. It was electronically recorded and later transcribed.

HOMD Interview and Focus Group Schedule – Mount Druitt Steering Committee Members and HOMD Staff

General perceptions of the implementation of HealthOne Mount Druitt

Specific details and processes of the policy development process behind HealthOne Mount Druitt and its implementation (managers)

> prompts

> - how and why was care coordination and service integration identified as a policy problem

> - use of evidence

> - organisational culture and context of Mount Druitt Community Health Service and GPs in the Area (and/or primary care in general)

> - broader NSW Health organisational context and culture

> - effect of other similar care coordination and service integration initiatives, programs, policies operating in the Area

Barriers and facilitators to the implementation

> prompts

> - what worked, what didn't, why

> - organisational culture and context etc, a help or a hindrance, neither, both …?

Intended and unintended consequences of HealthOne Mount Druitt

> prompts

>> - changes in work loads and work practice

>> - changes in organisational culture

Relationship and communication between managers, GP Liaison Nurses, other Mount Druitt Community Health Service staff and GPs

> prompts

>> - can you describe an interaction or event that illustrates this relationship?

Did HealthOne Mount Druitt interfere with your day to day work?

Any other comments about HealthOne Mount Druitt, management of chronic illness, care coordination or service integration?

Interviews with Patients and their Carers.

Ten individual interviews were carried out with patients (and conjointly with one carer who was available and consenting) and focused on changes in experience of chronic illness and its management as a result of HOMD. Where possible, paired interviews were carried out with the patient's GP, if available and willing, to gain a fuller picture of care and management of illness from the points of view of care providers and care recipients.

HOMD Interview Schedule - Patients and Carers

Experiences living with/coping with chronic obstructive pulmonary disease, chronic heart disease, diabetes (patient and carer responses sought)

Most challenging aspects of living with COPD/CHF/diabetes (patient and carer responses sought)

> prompts

>> - what happened, why it happened

>> - how it affected other people

>> - what might prevent a similar thing happening

Experience of HealthOne Mount Druitt (patient and carer)

> prompts

>> - GP Liaison Nurses

>> - communication between GP Liaison Nurses, GPs, other allied health and community health service workers

Overall experience of HealthOne Mount Druitt (patient and carer)

> prompts

>> - did it help, if so, how did it help

- others?

Any other comments about HealthOne Mount Druitt, your care, management of your/ your family member, relative's condition?

Interviews with GPs

Six patients' GPs were interviewed. In some instances GPs interviewed had more than one patient enrolled in the HealthOne program. Three GPs did not wish to be interviewed for the evaluation. Interviews with GPs lasted half an hour. GPs were paid a standard consultation fee ($130/hour) by HOMD to participate in interviews. This was in keeping with HOMD's commitment to value GP time and input and to acknowledge that, unlike salaried staff, GPs are not renumerated for participating in non fee-for-service activities. Interviews with patients and their carers lasted half an hour to forty-five minutes and focused on the areas of discussion specified but still allowed space for participants to pursue relevant topics of discussion not initiated by the researcher. Patient and GP interviews were electronically recorded and later transcribed

HOMD Interview Schedule – General Practitioners

Experiences of providing care for people living with chronic illness - chronic obstructive pulmonary disease, chronic heart disease, diabetes

Problems or difficulties in providing care for people living with COPD/CHF/diabetes

What problems do you think patients and their carers face in managing their condition

Perceptions and/or experiences of HealthOne Mount Druitt

     prompts

- did it contribute to or change how you provide care for your patients with chronic illness

- if so, how did it help, either overall or which parts (care in the community, care plans, care coordination)

- Did HealthOne Mount Druitt change or improve communication, referrals etc between hospital, community health and your practice

Effect of other similar care coordination and service integration initiatives, programs, policies operating in the Area

Any other comments about HealthOne Mount Druitt, management of chronic illness, coordination and integration of health care between hospital, community health and GPs.

Appendix Three: HealthOne Mount Druitt Partnership Survey

(HealthOne Mt Druitt - Survey of Service Providers)

Thanks for taking the time to complete this survey. Please note, we use the words 'patient' and 'client' interchangeably. We use the term 'Partnership' to mean providers and services working together with the aim of improving care and health outcomes.

1. What is your professional discipline or organisational affiliation? [Please tick one]

GP   ___

Community Health Worker [Nursing]   ___

Community Health Worker [Allied Health]   ___

Mental Health Worker/Professional   ___

Medical Specialist   ___

Government organisation [e.g. Housing, Community Services]   ___

Non-Government organisation   ___

Other   ___ [please describe:_____]

2. In what ways have you been involved with HealthOne [Please tick all that apply]

___   Received information about client/patient involvement in HealthOne

___   Made referrals

___   Participated in a case discussion [one-to-one]

___   Participated in a case conference [multi-disciplinary/group discussion]

___   Other [please describe: [_____]

For sections 3 to 6, please circle the response that best reflects your opinion regarding each item.

3. Determining the need for the partnership

There is a need for a partnership approach to client care in Mt Druitt.

strongly agree   agree   unsure   disagree   strongly disagree

The HealthOne Mt Druitt initiative has a clearly stated goal.

strongly agree   agree   unsure   disagree   strongly disagree

I am committed to this goal.

strongly agree   agree   unsure   disagree   strongly disagree

4. Making sure partnerships work

Partners lack the necessary skills for collaborative action.

strongly agree   agree   unsure   disagree   strongly disagree

Partners have the time for collaborative action.

strongly agree   agree   unsure   disagree   strongly disagree

GPs and other service providers have complementary ways of working.

strongly agree   agree   unsure   disagree   strongly disagree

The roles, responsibilities and expectations of partners are poorly defined

strongly agree   agree   unsure   disagree   strongly disagree

The day-to-day administration and communication processes of Health One are cumbersome.

strongly agree   agree   unsure   disagree   strongly disagree

The GP Liaison Nurse role facilitates effective communication and information exchange between clients and identified service providers.

strongly agree   agree   unsure   disagree   strongly disagree

The GP Liaison Nurse role crosses the traditional boundaries to enhance the care coordination between clients and service providers.

strongly agree   agree   unsure   disagree   strongly disagree

How important have the liaison positions been to the functioning of the project?

very important   important   unsure   unimportant   very unimportant

5. Planning collaborative action

All partners are involved in planning and setting priorities to improve client care.

strongly agree   agree   unsure   disagree   strongly disagree

I understand the referral processes for HealthOne.

strongly agree   agree   unsure   disagree   strongly disagree

HealthOne duplicates services and processes already provided in Mt Druitt.

strongly agree   agree   unsure   disagree   strongly disagree

There are regular opportunities for contact between individual providers and staff from the different agencies involved the partnership.

strongly agree   agree   unsure   disagree   strongly disagree

6. Minimising the barriers to partnerships

HealthOne would benefit from broader involvement from health practitioners.

strongly agree   agree   unsure   disagree   strongly disagree

HealthOne provides opportunities for resolving disputes and/or confusion surrounding client care.

strongly agree   agree   unsure   disagree   strongly disagree

Do you think the partnership has the resources it needs to achieve its purpose [consider financial and non-financial e.g. skills, access to data/information, community connections etc.]?

      yes   no   unsure

If not, please comment:

_____
_____
_____

Please complete section 7 only if you have participated in a case conference through HealthOne. Otherwise go to Section 8.

7. Case Conferences

Case discussions are time consuming, with few constructive outcomes.

strongly agree   agree   unsure   disagree   strongly disagree

Case conferences have improved the planning and co-ordination of care

strongly agree   agree   unsure   disagree   strongly disagree

Case conferences are held at convenient times and locations

strongly agree   agree   unsure   disagree   strongly disagree

8. Benefits and Drawbacks

Listed below are some of the benefits and some of the drawbacks people identify from working in a partnership. **Please tick as many as definitely apply to HealthOne Mt Druitt:**

i.   There is access to more knowledge about the community in which you work. __

ii.   The partnership is inefficient in its use of resources. __

iii.   Progress is sometimes too slow in moving towards objectives. __

iv.   There is access to a wider range of services for the benefit of patients. __

v.   Power tends to be usurped by the bigger players. __

vi.   Relationships with individual health workers have been enhanced. __

vii.   Involvement in Health One means less control for individual health practitioners as well as organisations over their own agendas. __

viii.   HealthOne provides closer working links with other organisations. __

ix.   There are frustrations with different personalities/conflicting points of view. __

x.   It provides a more comprehensive approach to planning individual client services. __

xi.   Participation in HealthOne opens up other areas for collaboration between practitioners and participating organisations. __

xii.   HealthOne is improving the range of health services provided in Mt Druitt __

xiii.   Involvement in HealthOne makes more work. __

xiv.   Individual contributions are not sufficiently acknowledged. __

xv.   HealthOne assists in the development of your own personal skills. __

xvi.   The reputation of individual organisations is adversely affected by the reputation of other participants. __

xvii.   It provides a single point of contact for GPs with the community health service.__

xviii.   HealthOne patient priorities conflict with other work commitments/priorities. __

xix.   It improves the co-ordination of Health Services for patients with multiple needs. __

xx.   Participation in Health One by individual practitioners is variable.__

9. In Summary

Finally, please circle the rating which best describes the overall balance between the benefits and drawbacks of your participation in the Mt Druitt HealthOne initiative:

      a. Benefits far outweigh drawbacks.

      b. Benefits are greater than drawbacks

      c. About equal

      d. Drawbacks are greater than benefits

      e. Drawbacks far outweigh the benefits

Thank you!

Menzies Centre for
Health Policy

THE UNIVERSITY OF
SYDNEY

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NATURAM PRIMUM COGNOSCERE RERUM

Report of the Evaluation of HealthOne Mount Druitt

The Menzies Centre for Health Policy is a collaborative Centre between The Australian National University and the University of Sydney. It aims to provide the Australian people with a better understanding of their health system and what it provides for them. The Centre encourages informed debate about how Australians can influence health policy to ensure that it is consistent with their values and priorities and is able to deliver safe, high quality health care that is sustainable in the long term.

The Menzies Centre:

• produces and publishes high-quality analyses of current health policy issues;

• delivers public seminars and education programs on a wide variety of health policy topics;

• undertakes comprehensive research projects on health policy issues.

For more information

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