Joint Select Committee – Preventative Health Care Feedback Submission

1) **The Current Impact of inequalities in the major social determinants of health on the health outcomes, including mental health outcomes of Tasmanians and the capacity for health and community services to meet the needs of populations adversely affected by the social determinants of health**

Health reform Change does not have to mean starting from scratch as there are currently a number of positive examples of how across regions and across acute/sub-acute/community sectors where some services are working very well in collaboration and achieving positive outcomes for clients/patients and communities, including those people from low socio-economic backgrounds. As a starting point it is always good to first find out more information about current positive models that are already in existence and run further consultation with those direct staff on the ground + clients/patients of those services to find out why their model is effective, what has worked and how can things like this be replicated as part of the system reform to avoid re-inventing the wheel and to assist with positive cultural change E.g. Community Options Service North, Community Podiatry North, the Personal Helpers and Mentors Program (PHaMs with Mission Australia), Community Dementia Service, John L Grove, Outpatient Rehabilitation Service, Northern Integrated Care Service (NICS), Hospital Aged Care Liaison Team (HALT), Partners in Recovery etc.

Difficulties occur when a person's needs become complex and due to their level of complexity in a number of different areas many services deem the person 'not eligible' as many services funding only provides support to a person around 1 targeted area, not the full holistic support needs of the person e.g. Gateway Service (Disability) where issues are readily deemed to be due to medical, mental health or Dementia (aged-related) issues rather than a primary disability even when there is supporting documentation/evidence and the person is in receipt of a disability pension, Mental Health Services only providing support specific to the mental health issue at the time and not in a long term support model, Tas Medicare Local only providing short term coordination support which again focuses on the chronic health issue but is not long term support and not holistic in its approach to other needs that fall outside of this category. This creates a lot of service gap areas and frustrations for people who have complex needs when they are bounced from one service to another to continue to be told they don't meet their eligibility criteria, including those people affected by the social determinants of health and poor health literacy skills. This approach to service delivery and provision is not supportive of the achievement of positive outcomes for the individual, their family and the health system.

Another identified gap area is lack of appropriate transport, especially in rural/remote areas of Tasmania is one of the largest identified gap areas in Tasmania and is impacting on people's access to health services, treatment, community and social participation which is contributing to poor health outcomes.

- In relation to accessing required transport services to assist the new health care model, this is going to be of major importance as current demand for this service clearly exceeds the supply levels.

- There is not enough transport funding and availability across all areas of Tasmania, especially in the more rural and remote areas to currently be able to meet future requirements of this reform.

- There needs to be more transport assistance options e.g. 1) hospital to hospital patient transport 2) home to hospital/health service transport (including stretcher options where required) + across regions and 3) home to community transport for social support needs.

- There also needs to be considerable growth in the number of wheelchair accessible vehicles across all areas + more training and support for drivers and transport providers regarding transportation of people with more complex needs i.e. cognitive impairment, Dementia and people with behavioural and/or mental health issues, as these are the client groups that currently experience barriers to accessing required transport services.

- A good start to looking at the current transport system and how it is working is via the current Community Transport Study that professor Corinne Mulley is involved in as there has been a lot of consultation in 2014 occurring around Tasmanian HACC funded transport services where this information could be useful.

- This transport assistance must be at an affordable cost for low income earners/pensioners who will be required to travel to receive future treatment in the new state-wide health care model

2) The challenges to, and benefits of, the provision of an integrated and collaborative preventive health care model which focuses on the prevention and early detection of, and intervention for chronic disease

Current barriers exist when there are so many different entrance points into the health system (community and inpatient) and all services have funding and standards requirements to provide all the required information to the patient/client e.g. Privacy and Confidentiality, Advocacy, Rights and Responsibilities, complaints let alone the information regarding their condition, treatment or medication etc. It is difficult for many to know all the different services and supports out there available to people across both community and acute + sub-acute and private sectors and with ongoing funding changes, this can at times be difficult to keep up to date with for community organisation's/services let alone GP's, specialists and other health care professional who don't have the time to research what is available in an integrated health care model.

Some things to consider in addressing this with focus maintained on early detection, intervention and prevention;

- Ideally a <u>centralised health information system</u> for Tasmania which is accessible by all and at all different levels e.g. the general public and consumer themselves, DHHS, all THS staff, GP's and specialists/clinicians, non-government and private providers - ensuring everyone is accessing and using the same information, hence consistency across Tasmania.
  - I am aware that this has been tried many times across different states and has failed either because of inadequate resourcing and/or technical difficulties. To be successful this would

require provision of the appropriate resourcing and ongoing support from Government i.e. staffing to ensure at all times the information remains current and maintained by DHHS as central point and holder of funding contracts.

- This centralised health information system would need to cover basic summary information regarding large range of health services and funding for Government as well as Non-Government and Private.

- This needs to be accessible to GP's/clinicians/specialists/THO staff via click onto 1 icon on their computer desktop (rather than having to search internet etc.) to ensure effective and efficient use of the system.

- This system could also have attached the relevant fact sheet and/ or service brochure and/or DVD presentation for each service which could summarise what services are provided, their contact details and basic funding info e.g. who is funding the service and funding date ranges if applicable.

- This could initially be built from current information systems that have already been established and who already have some local information RE what services and service types are out there e.g. Tas Carepoint, My Aged Care, DHHS internet and other health directories e.g. Council etc., so that there was a baseline of data/service information to start from.

- Any centralised health information system would need to be built around health literacy principles from the very beginning and have options to provide the hard copy fact sheets/brochures as well as video presentation options to consumers if the consumer is unable to access the internet/computer or has issues with language and literacy etc. Health Literacy is critical and needs to be taken into consideration so that the entire system meets required health literacy principles. This may also assist to decrease the burden and impact on consumers of every health service they access providing them with a handful of information and brochures that can be too overwhelming, not be effective for those with literacy or cognitive issues.

- Quality of current technology RE tele health/video conferencing needs to improve and this will hopefully increase the number of people accessing and using these resources as this also provides valuable opportunities to access interstate specialists in a more timely manner with better outcomes because of this. This technology does exist but I feel has not been implemented due to lack of commitment to provision of adequate resources to run it effectively and many Doctors/Health Professionals don't utilise the technology enough. The Community Options Service North Dementia Nurse has already utilised this technology to access a specialist which had positive outcomes for the consumer, carer and overall health outcomes.

- Utilisation of the rural hospital/health sites which need access to all community areas to be truly effective in an early identification/intervention and preventative model. Currently there are limitations in the number of community services accessible to the rural health sites e.g. Case Management Services, Community Mental Health, Community Nursing, Community Social Work, Community Allied Health e.g. Occupational Therapist, Physiotherapist, Speech Pathologist,

Podiatry etc. Having access to more of these health professionals across sites/regions would contribute to ensuring timely and earlier intervention, adequate discharge linkages/pathway support and very importantly maintaining a focus in community services at these sites on early intervention, preventative strategies and health promotion principles + the ability to provide local follow up support in the consumer's local community to ensure best patient and health outcomes are achieved and sustained. These more rural communities can still respond locally if the persons treatment has to occur in another region to assist the consumer through the treatment process and back home/into the community again and can still do this to a high standard with having local knowledge and networks and working in collaboration with other community and non-government services e.g. community mental health services like the Personal Helpers and Mentors Program, community and neighbourhood houses, local HACC providers etc.

- Acute systems discharge processes needs to be reviewed/improved. There needs to be a policy in place that ensures the patient is never discharged from hospital until the required supports are in place to ensure that person's safety and this process needs to be actively monitored to ensure it occurs.
  - Primary and Community Health can be more actively involved in hospital discharge planning prior to the discharge occurring, especially for those consumers who have complex needs and those from low socio-economic backgrounds where there are known risk factors as this would greatly improve discharge outcomes.

  - Currently we are experiencing +++ difficulties with this system and in some cases even after notifying hospital staff and writing in patient file notes etc. our community case manager is still not informed of discharge planning and at times finds out about this after the person has already been sent home without the appropriate equipment or set up of the equipment, without services in the home being reinstated, and there have been cases where this has even occurred without the appropriate transport home arranged i.e. a client of ours was discharged from LGH after hours and was required to catch a taxi from LGH to their home in the Scottsdale area because community transport does not operate after hours and the current patient transport system only transports people from hospital to hospital.

  - Current practices lend themselves to community and primary health services not actively providing a lot of support to clients when they are an inpatient as they are considered to be 'on hold'. I believe these practices can also be improved because when someone is admitted into hospital, for many people this is when they are the most vulnerable and I believe this is where community and primary health services can also be doing more where required and appropriate to integrate more into the hospital/acute systems and provide more active support to our clients whilst they are an inpatient.

- Consumer Engagement, consumer engagement, consumer engagement – and not just at the surface level, it is needed right throughout the new Tasmanian Health Service. A good starting point would be to ask the consumers first and involve them more in the implementation of these

health care reforms. This could initially commence with utilising the THO's consumer advisory groups and speaking with organisations such as TasCOSS who have done a huge amount of work around consumer engagement. This should also be a question that is asked to any consumer when they first enter the health system either as an inpatient or a community client. Ensure that all information about health services and clients rights is provided and discussed with consumers in a way which uses health literacy principles and ask the consumer where able to state how they would like information provided to them and how to assist them to best understand this information. Further examples to demonstrate;

- Not providing a consumer with a bulk of information and paperwork prior to discharge and when a person is still recovering from anaesthetic

- Ensuring where possible that there is a family member or support person/advocate present when information is being provided to and discussed with the consumer (so that there is another person hearing the information in case the consumer themselves do not understand)
- Follow up with the consumer via a phone call or follow up appointment within reasonable time frame (not 3-6 months post discharge) where there is opportunity for questions and answers based on the information provided to the consumer and their level of understanding

- Provision of information at the consumers own pace following health literacy principles – it may require 2-3 meetings/appointments over a 1 month period instead of 1 appointment to provide the required information in a staged way.

- Look at being creative in what media is used to communicate this information – i.e. client narratives, motivational interviewing and consumers speaking to consumers, public forums promoted by paper and television to encourage people in to learn about what health services are available in their area etc. could increase opportunities for increased understanding of these things (especially for those consumers who have issues with literacy, health literacy and cognitive impairment).

- There is <u>more need for complex case management services</u> within the new health system with the aim of having a central contact and coordination service (especially for those consumers with more complex needs, chronic health conditions and low socio-economic backgrounds who require linkages with multiple health and community services pre and post discharge).

  Case management is more than care-coordination as it takes a holistic approach to looking at client's needs, is not driven by a medical model and includes advocacy, care planning, pathway support and linkages etc. We provide a single point of contact for care recipients and caregivers who require a complex range of services and/or intensive levels of support.

  - This needs to have more open and flexible eligibility criteria to ensure that people with a temporary disability e.g. protracted hospitalisation, delirium, sub-acute mental health, and those recovering from acute illness can also access this service type when required.

- Primary Health North already provides a range of health promotion, early intervention, care and assessment, inpatient and outpatient treatment, residential aged care and community health services to individuals, groups and communities across Tasmania. Many Primary health services are delivered from community health Centre's and rural inpatient/health facilities. Rural inpatient facilities (including multi-purpose services) provide valuable and quality inpatient care and community health services. Some services are provided in isolated locations. Primary health services based at and delivered from these sites are generally targeted to meet the needs of the surrounding community. There is a commitment to complex clients and rural and disadvantaged communities and through its structure, is cognizant of the plethora of issues related to the provision of quality health care and aged care services.

- Within our service we have a very strong and positive model that we work within called the 'Active Service Model' which takes a wellness, strength based and person-centred care approach to working with consumers. This Active Service Model focuses on client and caregiver goals being central to needs identification and care planning. The core business of COS North for the last twenty three years has been the provision of complex case management services. Because of our current approaches to service delivery, our experience within this and current collaborative practices across the Northern Tasmania, Primary Health North services such as COS North are already strongly established and skilled in these areas. In relation to the COS North 'Active Service Model', it is much broader than a 'service delivery' approach, in that it looks at all aspects of a client's life, what clients would like to achieve, their social networks and personal relationships and support, what is important to the client, ongoing participation in life, their goals, and milestones towards them.

- We seek to enable people to do as much as possible for themselves by optimising a person's functional and psychosocial independence, with the focus on capacity building, re-enablement, maximising independence and restorative care where possible and practicable.

- This service type can be provided on a short term basis or a longer term basis if required and appropriate, ensuring positive outcomes are achieved. Keeping a care recipient engaged in every aspect of their life, for as long as possible, builds client confidence and their self-esteem.

- We utilise local resources and informal networks and supports, and are mindful of consumers' rights, values and preferences which respects, accommodates and dignifies changes that may occur in a care recipient or carer's life circumstances, including progressive cognitive deterioration. This enables us to flexibly respond to complex needs arising from interacting physical, emotional, psycho-social and cultural factors. It also supports a creative and lateral approach to care planning, maximising what already exists to maintain the care recipient's functional capacities and skills and ensuring the consumer remains central to these processes and decision making.

- Many other services (Government and Non-Government) are only funded to provide a care coordination element specific to the person's disability or chronic health condition e.g.

current models with services such as Mental Health, Outpatient Rehab, Tasmanian Medicare Locals, and Disability Gateway Model etc. This is very different to providing a holistic complex case management service which does look at and address all relevant areas of a person's life and health to ensure positive health outcomes are achieved and where longer term case management is required, to ensure the positive outcomes are sustained.

- It needs to be broader than the HACC target group to capture people who fall outside of other eligibility criteria e.g. someone recovering from acute illness, self-funded retirees, those with a temporary disability such as protracted hospitalisation, delirium, sub-acute mental health etc.

- More consideration needs to be given to enabling more carer support through carers also being able to access required services (again – need for review of all eligibility criteria/funding requirements) because as the carers decline, it impacts on the carer, the person being cared for and the carers immediate family.

- With the current Commonwealth Aged Care Reforms, the aged care sector is already at risk and is highly likely to have negative flow on effects onto the State's Health System due to increased hospitalisations and length of hospital stays and a decrease in case management funding for this target group out of HACC Group 2 funding – this is going to create an even larger gap in this service type area when this starts to occur. These Commonwealth Reforms are also starting to have an impact that double disadvantages rural/remote clients where the cost of travel can be taken out of their allocated community aged care package funds, therefore leaving less money in their package for actual services.

3) Structural and economic reforms that may be required to promote and facilitate the integration of a preventative approach to health and wellbeing, including the consideration of funding models

The Tasmanian Health System and health outcomes for Tasmanian's could certainly be improved and we should always be open to change in order to improve outcomes with a focus on best practice evidence and continued improvement to achieve quality service delivery. The time for change is now and there is prime opportunity for the Government to do this better, starting with the Tasmanian Health System Reform which is due to occur 1st July 2015. In order for this change to be truly effective and sustainable into the future across a State-wide health system reform, the following also needs to be taken into consideration as part of the reform process;

- <u>A Staged Reform Implementation Plan</u> once the White Paper is completed, with attention given to the ongoing support and implementation needs of effective change management processes, some following examples include;

  - Looking at and properly evaluating past Tasmanian Health Care/System reforms over the last 10 years to confirm what did not work and why, what could have been done better and what was effective/what did produce positive outcomes, to avoid past mistakes and guide more effective and sustainable change management into the future

- Attention given to changing and supporting organisational/staff culture which should be at least a 3 year plan as a minimum and using a 360 degree model approach (top down and bottom up) and requiring commitment and ongoing support to succeed. Without change to attitudes and culture formed over decades there is a risk of continued silo operations across regions and between areas of the health system

- A strong Consumer Engagement strategy, utilising as a start point the THO consumer advisory groups that have been established. This is a prime opportunity as part of health care reform to involve consumers from all populations, including special needs consumers and advocacy groups throughout the implementation of this reform. This approach may assist in working with the smaller/rural communities who may be more resistant to any loss of clinical services in their local community as part of the health care reform. This is also an opportunity to forge stronger partnerships with other local community services such as the local neighbourhood and community houses.

- A review and change of the current funding structure and requirements, ensuring these are not working against the implementation of a new model and new way of working e.g. more focus on collaborative partnerships to try and decrease some of the competitive tendering that occurs and the impact this can have on collaborative practices at times, opening up eligibility criteria so that the services can be more flexible and wrap around the consumer to meet their needs, opening up catchment areas so that a service in the North can actively work with someone travelling to the North for procedure/treatment i.e. to provide support if required whilst they are in the North and assist in transition back to the region they live at the same time as working alongside the respective service in the client's home region (and this not being seen or perceived as double dipping or service duplication) etc.

- A review and change of the current reporting structures and requirements so that service providers are able to report on both quantitative as well as qualitative data and to have the ability to report more on outcomes rather than just outputs (as per outcomes reporting framework being developed and applied to Non-Government Organisations funded by DHHS).

- The problem for many community providers is in relation to funding limitations and lack of current capacity e.g. restrictive eligibility criteria based on funding type, competitive tendering processes and the influences this has on culture and attitudes – hence a new funding structure/contracts etc. is also required to adequately support the state-wide health service reform in a flexible way. If the structure around current and future funding changes to increase flexibility in provider approaches to service delivery, this would enable the best person/service at the time to be assisting the consumer with less focus on if the person meets the eligibility criteria. I am aware of a very large number of consumers (especially those with complex needs in the community) who continue to be 'hand balled' from 1 service to another being consistency told they don't meet eligibility criteria, many of these people are at risk of 'falling through the cracks' where positive health outcomes are not being met.

- Increased focus on Partnerships through funding submissions is needed where THO (Government) and community (Non-Government/Private) providers are required to submit funding applications based on partnership and collaborative approaches to service delivery to encourage this practice more and try and decrease some of the impacts of competitive tendering for limited funding. This will also support increased opportunities for smaller community/non-government organisations. A good starting point would be to find out who is already doing positive partnership work and learn from them i.e. what did not work/what to avoid, what did work, how it worked so that the positive aspects of these approaches and models can be used and built on e.g. THO North working in collaboration with providers such as Neighbourhood and Community Houses, Tas Medicare Locals, District Nurses (Hospice at Home), Gateway disability model , Community Mental Health Models such as the Personal Helpers and Mentors Program and Partners to Recovery etc.

- Need designated 'roles' with authority to step in, assess the situation, bring relevant services together and ensure they reach agreed plans for how the client can manage their situation. Then being able to go 'up the chain' if services don't cooperate or carry out the agreed plan.

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