

IMPROVING THE JOURNEY

JIM KILLEEN: ...the work of Jonathan Pietsch, who was sitting down the back of a room at some point. But Jonathan, when he was the Executive Officer of the Inner East Primary Care Partnership, dragged me along to a meeting with Tracey Batten, the CEO of Eastern Health, to start to talk about some of the challenges that you heard from the Minister this morning in relation to the impact of type 2 diabetes. So in the eastern region what we did was to look at the magnitude of that issue and to take a small step, and I want to outline to you today some of the progress in that journey.

Just a quick snapshot of the Eastern Metropolitan Region: a population of just under a million people; the PCPs collectively have 40 member agencies but also have 60 participating agencies, so it's a big group; seven local government areas; one rural shire; seven community health services; three metropolitan health networks, so that makes it quite a complex environment; and four general practice divisions. So the membership of the two PCPs includes health, mental health, disability, importantly local government, gambling, housing, drug and alcohol and youth services. And, as we've heard today, collaboration is the key to PCP work and really builds on the principles of combining resources for maximum benefit and working together to really support local communities. That's the focus.

The three key steps that we have in the eastern region around our PCP work is pretty simple really: planning for local priorities; negotiating the change process across agency and across systems, including, very importantly, government departments; and, lastly, evaluating the outcomes, which I'll talk about in a moment.

So today I'll briefly talk about and describe improving the journey project, for which the two PCPs have come together to build an alliance to work on the challenge of type 2 diabetes and really focus on trying to improve service delivery.

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We heard from the Minister today. I won't go into a lot of it, but the six chronic disease groups account for approximately 70 per cent - the Minister was saying nearly 80 per cent - of Australia's burden of disease. We are in and increasingly facing a major crisis. But there is a real opportunity to manage these diseases outside the hospital system. However, approaches to chronic disease need to be significantly different from our traditional health care provision, with its over-reliance on episodic treatment once a person presents as ill. People with chronic conditions require long-term support and need access to services across the hospital, GP, community health and, very importantly, the community service sector, including access to recreational and exercise facilities such as gymnasiums and swimming pools. So when you start to think of that continuum, it's quite complex.

So the partnerships through the PCP provide us with an opportunity to link health and community services through working together across, as I said before, both organisational and sector boundaries to try to build a better coordinated whole-of-system approach.

So just the goal of improving the journey is to improve the health and well-being of people with or at risk of type 2 diabetes through development of a regional systems approach. The objectives include: improve consumer experience of coordinated care, and I think that's been one of the strengths of this process to date, and I'll talk some more about that in a moment; improve processes to support prevention, early identification and intervention; improve awarenesses of services available; development of processes to support coordinated care across services and disease stages; and increased integrated processes across prevention and management. This, of course, is a very ambitious aim, which requires active collaboration and partnership work across agencies, as I said before, but also, increasingly, government departments. The Department of Human Services, both regionally and centrally, have been very important to this process.

The key principles that were developed early on include a focus on

equity and high-risk populations, building from an evidence base and making sure that we had a consumer-centred approach. These principles inform and plan and underpin the work of the project over its lifespan. So some examples of how these principles work in practice.

Equity of access. We need to make sure that all services have the tools to identify chronic disease risk factors at a client's first contact. It's very important, given the Minister's comment about we're now facing nearly a million people with type 2 diabetes. That's huge for a system that's already under strain.

Secondly, focus on populations at risk. We need to identify through coordinated data collection and analysis key population groups that are even more at risk - for example, Indigenous and cold communities, and in my own catchment in the City of Whitehorse we know, for instance, that some of the data analysis around the Chinese population is quite frightening. They have a risk profile in terms of type 2 diabetes and gestational diabetes nearly double the Anglo-Celtic population.

Evidence base. We need to develop a clear evidence base from international and Australian sources for the development of consistent consumer educational material and clinical tools, and I think the evidence base is very important in relation to also galvanising diverse agencies with diverse interests and language around a common task. The evidence base, I think, really engages both management and clinicians around that task.

And, lastly, in terms of principles, very importantly, consumer centred. Initial project planning included consumer consultation alongside clinician-led service reviews. So we think that we've been successful to date, and we've got a long way to go because we have engaged with consumers, number one, and we heard from Julie the disengagement of clinicians in England. I was on a recent study tour with a number of peers here, and we know that the English really have learnt from their last eight to 10 years of reform to say you cannot not engage clinicians, and I think that's something that we need to be careful of as we continue with

partnership work in Victoria: to make sure that clinicians are engaged and doing some fair dinkum work.

As the project progressed consumer engagement emerged as an invaluable process for supporting partnership between diverse agencies, facilitating whole-of-system thinking and driving systems change based on consumer needs, not particular service sector or professional needs. So, again, it was something that could actually harness the interests across a diverse group.

So our process? From the establishment of agreed principles we then developed agreed processes. One important aspect of this was proactively planning for change, and I'll talk a little bit more about some of the challenges around partnership work, but change management processes are very important, so we discussed those and refined them and then enacted with feedback loops along the way about how we were going to deal with the change management. PCP resources were essential in facilitating the change processes and simultaneously taking both a top-down and a bottom-up approach. The early identification of change champions or opinion leaders, regardless of their position in an organisation, whether they be a CEO, service coordinators, a diabetes nurse educator, or whatever, has been also central to the success of this project. Everybody at all levels within organisations in the sector has a role to play, and I think it's very important that we make sure that management engage with clinicians around both those agendas, because they are different, they have different imperatives, but where you have too much distance in terms of that engagement and conversation around our varied interests, I don't think projects like this will succeed. So both are very important, not one or the other. I'll move through.

So consumers are well placed to diagnose the problems of our service system and can provide us with a whole-of-system helicopter view. This is very important, as I said, to build a regional systems approach. We engaged via our partnership agencies 119 consumers in telephone consultations and 26 in focus group and individual consultations. Our consumers provided us with the

following insights. Type 2 diabetes is the tip of the iceberg when financial, personal crises or social circumstances were also present in people's lives. Andrew's presentation of Helen's circumstance is spot-on. We know that the broader social situation of people's lives absolutely needs to be actually engaged with, assessed and worked upon before you can expect someone to actually deal with their chronic disease, and, again, that's about stitching up across local government, across family support, the whole plethora of community services as well as health services; the key role of partners, friends and family in consumers' well-being, health and management of type 2 diabetes; the importance of communication between providers; a greater focus on prevention at its broadest level, including people's social circumstances, or what we call in the health sector, social determinants or in, say, a local government context issues around structural issues - housing, employment, transport - all those sorts of issues need to be tackled as well, otherwise we're not facing the real problem; timely access to services; work force development - a quick comment on that. We really need to be able to further develop a flexible, adaptable and generalist work force as well as having specialists, and I think that's one of the biggest challenges that will come out of this project. It's going to really challenge agencies and individual workers about their roles. I think that's the next, in a sense, big barrier that we need to actually grapple with and we need to grapple with very quickly; proactive individual follow-up; support to positive dietary management; and, lastly, clear and consistent information.

Some of the challenges, and again to pick up, I think, on the very important work that Julie's doing, include: various interest priorities and philosophies; speaking different languages, particularly, I think, between the health and community services areas and also between primary care and the acute sector; varying capacities; knowledge and expertise is an issue; policy and funding frameworks; time and resources.

Given the challenges we all know about in doing partnerships, having a vision that players can commit to and then partnership

structures that are aligned with your vision and objectives is vital. I can't emphasise this enough. An aligned structure can hold the inevitable tensions and conflicts and, indeed, contain conflict so its potential as a creative energy can be harnessed at both an executive and also clinician level.

I'll just whip through the rest of these.

So the journey so far. We've selected a pilot area, including the testing of diabetes risk tools; agreed packages of care - that was a very complex task to get across a whole range of players - for type 2 diabetes; a client information pack on diabetes; and systems and processes from intake to discharge. We've also looked at some detailed evaluation. I won't go into the detail of that now, given the time, but we are very, very focused on the importance of making sure we evaluate this and do a plan-do-study-act cycle, so to feed back into our processes currently, because we think our plan at the moment is okay for where we're at, but we know that we're going to need to change that as circumstances and feedback inevitably means we need to meet those challenges.

So what PCPs can deliver, just in finishing up, I think what they have to offer is established and proven partnership structures that have brought authority and resources to this improving-the-journey process. We have a systems perspective through the PCPs. We share expertise, knowledge and capacity building. We have a platform for building relationships, trust and recognising and managing differences, and I think that's one of the key outstanding achievements of PCPs in the last eight years. It has forced us together, as Phillip Adams said, somewhat shackled at times, but it has forced us together to relate and to engage, and I think that's going to be essential as we go forward, and particularly in our current and national-state reform context, that vehicles for establishing and developing crossed cross-sectoral partnerships is increasingly important. PCPs have been a good example of a partnership enabler, providing structures for both, as I said before, managers and clinicians to come together.

And just in finishing up, when taking a consumer-centred approach, which I think has been essential, we need to shift from looking at the world through our agency-tinted glasses. We need to utilise the expertise of our consumers. It allows us to look at our system from a different perspective, which challenges service and agency boundaries.

Partnerships are key to developing consumer-centred, whole-of-system approaches, build on the existing strengths of individual agencies across a region such as the east, and improve outcomes, finally, for people in our communities. Thank you for your kind attention.

END OF TRANSCRIPT