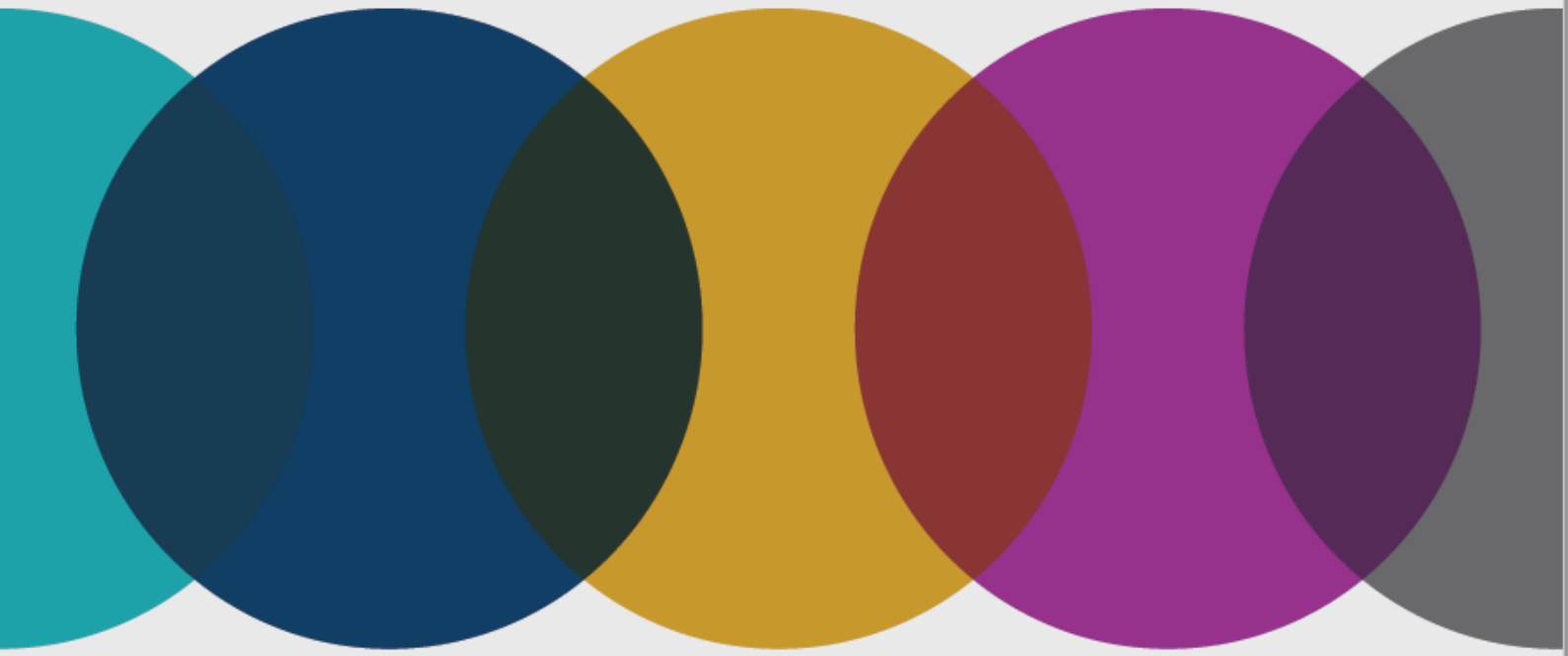
The Collaborative
working together for better health

cohealth

The Royal Melbourne Hospital

Merri Health
Healthcare that moves with you

phn NORTH WESTERN MELBOURNE
An Australian Government Initiative



Collaborative Framework

2021 – 2022

Working together to strengthen health care outcomes of our communities.

collaborative.org.au

Introduction and foreword

North Western Melbourne PHN, cohealth, Merri Health and The Royal Melbourne Hospital are pleased to present The Collaborative Framework for 2021 – 2022.

The framework outlines our shared commitment and principles supporting our common goal: collaborating to move more care into primary health settings.

Our organisations are committed to working together to improve patient care, outcomes and pathways for our shared communities.

Our Collaborative Framework has been renewed to strengthen these existing shared commitments and support new and existing directions to increase capacity and sustainability at the interface of hospital services and primary healthcare.

During 2020, the partnership approach formed over many years working together was instrumental in the development of successful pathways that allowed COVID-19 positive patients to be treated effectively in the community with rapid access back to acute care when needed. This successful collaboration now forms the basis for our next chapter.

Over the next two years, The Collaborative will work together on a pathway to reduce readmissions for Chronic Heart Failure and Chronic Obstructive Pulmonary Disease in our catchment while building the capacity of the primary and community care workforces to treat and support these patients closer to home.

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1. Background

In April 2012, the Chief Executives of The Royal Melbourne Hospital, cohealth, Merri Health and Melbourne Primary Care Network (now operating North Western Melbourne PHN) made a commitment.

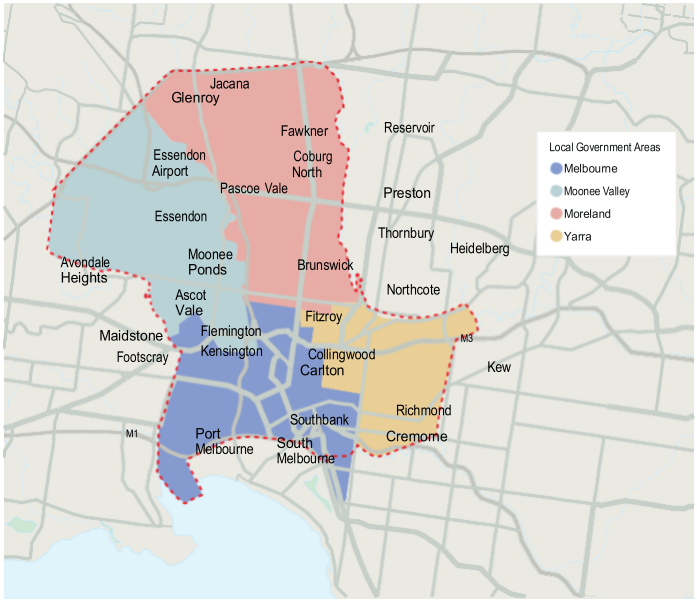
That commitment recognised the importance of primary healthcare providers and hospitals working together to ensure services are tailored to meet the needs of local communities. Two previous frameworks have outlined the vision and outcomes for The Collaborative over 2012 – 2017 and 2016 – 2020. In this refresh of the Collaborative Framework, the partners reaffirm and strengthen their commitment.

Our four organisations have a shared commitment to strengthening our collaboration, driving continual innovation to address systemic gaps and strengthen the interface between acute and primary care. We are committed to integrated models of care which support delivery in the appropriate settings and strengthen the effectiveness, efficiency, and health outcomes for all those who live in our catchment.

1.1 The Collaborative catchment

The Collaborative catchment area of the inner, northern and western Melbourne Region reflects the four organisations' shared geography. The area is home to more than 600,000 people across the Local Government Areas (LGAs) of Moonee Valley, Moreland, Yarra and Melbourne (Australian Government, Centre for Population 2020). This population is serviced by approximately 230 general practices and six public hospitals. Two of the collaborative partners, Merri Health and cohealth, provide community health services across The Collaborative catchment.

The four Local Government Areas in the catchment have similar profiles with regard to premature mortality, chronic disease and ambulatory care sensitive conditions. Our communities' specific health profiles underline the value of our work at the interface of acute and primary health care.



The Collaborative catchment map

Collaborative catchment: health overview

Conditions causing premature mortality, in order of prevalence (0 – 74 years)

1. Cancer
2. Circulatory systems diseases
3. External causes
4. Ischaemic heart disease
5. Lung Cancer

(ASR/100,000, 2014-2018. Source: PHIDU)

Most prevalent chronic conditions

1. Mental and behavioural problems
2. Respiratory systems diseases
3. Arthritis
4. Diabetes
5. Circulatory systems diseases

(Australian Health Survey ASR/100, 2017-2018. Source: PHIDU)

Most common Ambulatory Care Sensitive Conditions (representing potentially avoidable hospitalisations)

1. Congestive cardiac failure
2. Dental conditions
3. Pyelonephritis
4. Iron deficiency anaemia
5. Chronic obstructive pulmonary disease

(ASR/100,000, 2017/18. Source: PHIDU)
* see Appendix One for more information

1.2 Our roles across the health care continuum

As partners, we recognise that each of our organisations has an important part to play across the health care continuum.

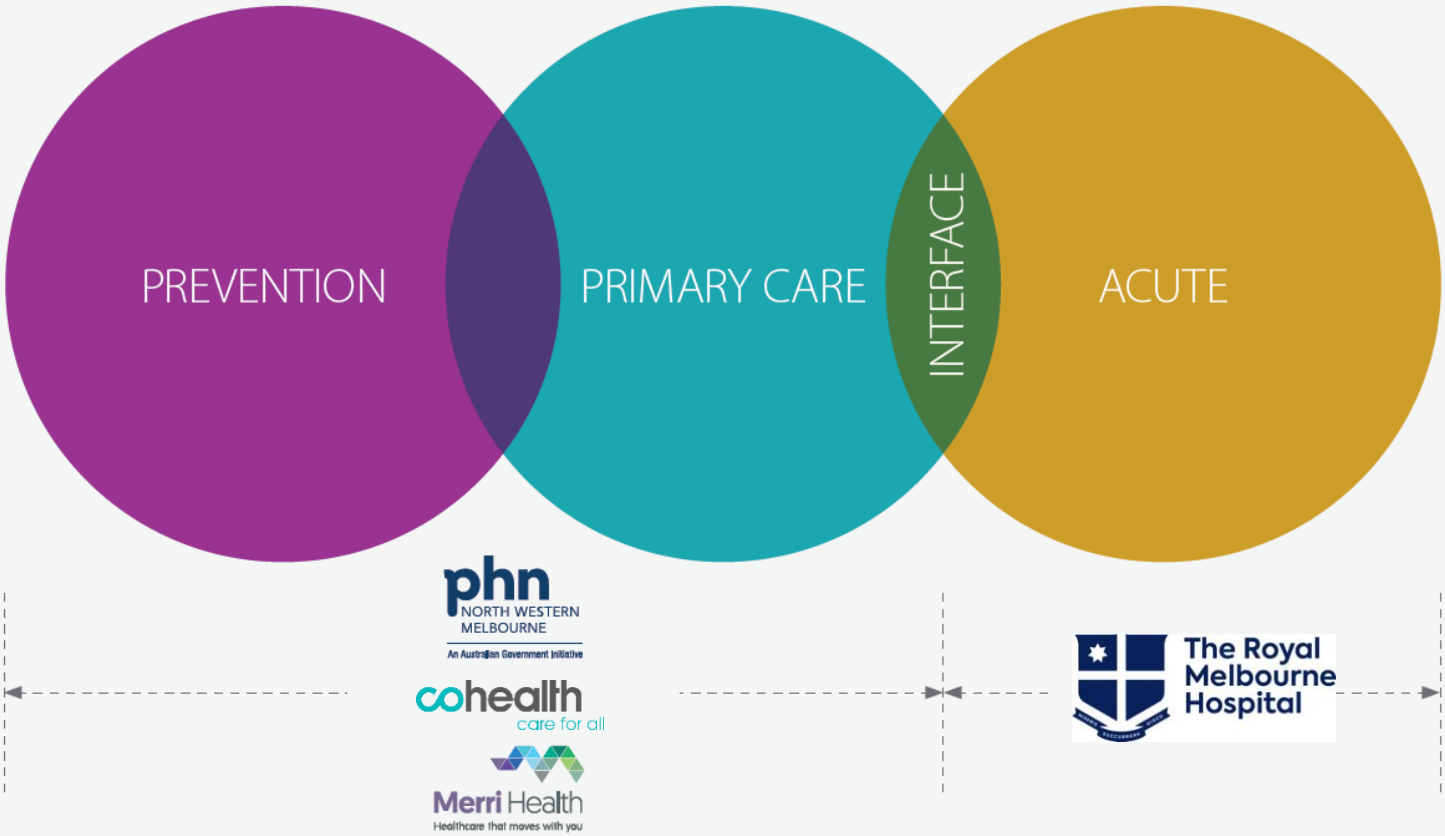
The diagram below represents our roles across the health care continuum, encompassing prevention, primary health care, and acute settings. Understanding our roles in the continuum supports us to design client centred models of care that delivers the right care in the right setting.

The Collaborative works to improve service planning and service delivery. It is also focused on system reform to improve efficiency and health outcomes.

To better meet the needs of people with chronic conditions and complex needs, it is particularly important to focus on the interface between primary and acute care. The Collaborative will work to strengthen this interface through better communication pathways, digital solutions that allow safe sharing of information, and building the capacity of primary and community care workforces.

The Collaborative's major project for 2020 to 2022 is described in more detail in section 5: Our Work.

Our roles across the health care continuum



2. Purpose of The Collaborative

Working in partnership puts us in the best position to improve patient care, outcomes and pathways, and to move care, where appropriate, into the primary care setting. The Collaborative promotes innovative and flexible approaches to meet our communities' specific needs.

Collectively we aim to:

- Ensure a coordinated approach to service planning and delivery across our shared catchment, prioritising service gaps and challenges together.
- Develop agreed common, seamless and complementary pathways.
- Improve communication flows between existing care pathways.
- Work collaboratively to deliver more care in the primary care setting.
- Develop new and innovative ways of working together in partnership to improve patient care, access, outcomes and pathways, and
- Create opportunities for our people to share resources, ideas, knowledge and experience to improve care through partnerships at the frontline.

In order to achieve our aims, our Chief Executives have committed to advocating to Victorian and Australian Governments for more suitable and flexible funding mechanisms to support the efforts of The Collaborative.

3. Collaboration principles

The four partnering organisations have identified a set of principles that will be used to support the development of collaborative projects and programs.

These principles are intended to guide the way in which we will work together to achieve our shared purpose. In order to maximise the benefit to our community, we will ensure that our collaborative efforts adhere to the following guiding principles.

Foundation collaboration principles:

4. Governance

We have established a governance structure, providing a mechanism to coordinate our collaborative efforts and ensure our aims are achieved. The following committees have been established, representing three levels of governance:

- Comprises the Chief Executives of each partner organisation.
- Meets quarterly to provide formal oversight for the Collaboration and authorises or commissions joint work.

- Comprises senior managers from each of the partner organisations.
- Meets quarterly to provide advice and oversee joint planning and progress on project deliverables.

- Comprises subject matter experts that sit on:
  - Clinical Advisory Group
  - Technical Advisory Group
- Meet as required to oversee the dyspnoea pathway pilot.

A project manager and part-time project support officer undertake the work of The Collaborative. The establishment of these positions reflects an appreciation of The Collaborative's increased sphere of influence in driving primary/acute collaborations. The four Collaborative partners have each contributed to fund to these positions through until October 2023.

5. Our work

In 2021, The Collaborative partners are working together to pilot a new pathway for patients with dyspnoea due to congestive heart failure (CHF) and/or chronic obstructive pulmonary disease (COPD).

The new pathway will provide better links between Royal Melbourne Hospital and primary and community care services; build the capacity of GPs to manage patients in the community; and facilitate access to a Community Navigator to provide psychosocial supports that help drive better clinical and social outcomes.

The pathway aims to:

- Improve the clinical management of patients with COPD and/or CHF in the community by supporting GPs to manage these complex patients through enhanced discharge summaries, clear management and escalation pathways to acute care, access to telephone advice from General Medicine doctors, and provision of support, education and training.
- Improve the psychosocial management of patients with COPD and/or CHF in the community by providing access to a Community Navigator to undertake a psychosocial needs assessment and refer to a range of local community health and non-health services to help address social determinants impacting health and wellbeing.
- Improve patient satisfaction by linking existing pathways, improving information flows between professionals involved in a patient's care, and by providing high-quality care, closer to home.

6. Outcomes

The outcomes that The Collaborative aims to achieve from the dyspnoea pilot in2021 - 2022 are demonstrated by the following measures of success.

Measures of success

At 1 year

- Increased patient and carer knowledge of condition/s
- Improved ability of patients to self-manage
- Increase in social prescribing and referral to community and non-health services
- Identification of the key support services patients need to stay in community settings
- Increased health professional knowledge of pathways for complex patients
- Increased GP confidence managing COPD and CHF
- Improved information exchange between health professionals
- Reduced readmissions
- Reduced length of stay (decreased total bed days)

Long term outcomes

- Improved patient experience and quality of life
- Improved functional status of patients
- Increased information exchange between acute, primary and community care
- Improved understanding of available services between health professionals
- More efficient use of services
- Economic benefit

Additional documents that support this framework:

- Collaborative Work Plan (developed annually)
- Collaborative Communications Plan
- Evaluation Framework, Dyspnoea Pilot

Appendix One:

Population health data - The Collaborative catchment

	Melbourne	Yarra	Moreland	Moonee Valley	Collaborative catchment	Victoria
Population (ERP 2020)	**183,756**	**103,125**	**188,762**	**131753**	**607,396**	**6,696,670**
Top 5 Premature mortality (0-74 years) ASR/100,000, 2014-2018. Source PHIDU					*	
1	Cancer	Cancer	Cancer	Cancer	**Cancer**	Cancer
2	External causes	Circulatory systems diseases	Circulatory systems diseases	Circulatory systems diseases	**Circulatory systems diseases**	Circulatory systems diseases
3	Circulatory systems diseases	External causes	External causes	External causes	**External causes**	External causes
4	Ischaemic heart disease	Ischaemic heart disease	Ischaemic heart disease	Ischaemic heart disease	**Ischaemic heart disease**	Ischaemic heart disease
5	Lung cancer	Lung cancer	Lung cancer	Lung cancer	**Lung cancer**	Lung cancer
Top 5 Chronic disease prevalence (Australian Health Survey ASR/100), 2017-2018. Source PHIDU					*	
1	Mental and behavioural problems	Mental and behavioural problems	Mental and behavioural problems	Mental and behavioural problems	**Mental and behavioural problems**	Mental and behavioural problems
2	Respiratory systems	Respiratory systems	Respiratory systems	Arthritis	**Respiratory systems diseases**	Arthritis
3	Arthritis	Arthritis	Arthritis	Respiratory systems diseases	Arthritis	Respiratory systems diseases
4	Diabetes	Diabetes	Diabetes	Circulatory systems diseases	**Diabetes**	Circulatory systems diseases
5	Circulatory systems diseases	Circulatory systems diseases	Circulatory systems diseases	Diabetes	**Circulatory systems diseases**	Diabetes
Top 5 Ambulatory Care Sensitive Conditions (Avoidable hospitalisations) ASR/100,000, 2017/18.					*	
1	Pyelonephritis	Pyelonephritis	Congestive cardiac failure	Congestive cardiac failure	**Congestive cardiac failure**	Iron deficiency anaemia
2	Dental conditions	Dental conditions	Iron deficiency anaemia	Dental conditions	**Dental conditions**	Dental conditions
3	Ear, nose and throat infections	Iron deficiency anaemia	Dental conditions	Pyelonephritis	**Pyelonephritis**	Pyelonephritis
4	Diabetes complications	COPD	Pyelonephritis	COPD	**Iron deficiency anaemia**	COPD
5	Cellulitis	Congestive cardiac failure	COPD	Iron deficiency anaemia	**COPD**	Congestive cardiac failure

* Previous INWMML catchment

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