



HEALTHPATHWAYS MELBOURNE COMMUNITY RESOURCES PROJECT

Short Report – October 2015

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EXECUTIVE SUMMARY

HealthPathways Melbourne (HPM) is a web-based system for General Practitioners (GPs) that helps coordinate patient care across the acute and primary care system and provides guidance for GPs on assessment, management and referral details for common medical conditions. The HealthPathways Melbourne Community Resources project was a collaboration between Inner East Melbourne Medicare Local (IEMML) and Inner East Primary Care Partnership (IEPCP) between February and June 2015.

The aim of the project was to extend HealthPathways Melbourne content to include community resources to meet the needs of patients with chronic and complex health needs, represent the services of community agencies in the Inner East region of Melbourne and provide new material to GPs about the range of services and supports available in their area.

The project involved consulting with consumers with chronic conditions and carers, utilising focus groups, surveys and a phone interview. Feedback provided by these groups was used to inform the community resource information added to the HPM website.

Other key stakeholders were also consulted including local Community Health Services, subject matter experts and service providers working in relevant fields. The Project Officer worked closely with the IEMML HPM team and GP Clinical Editor.

This project resulted in extending existing pathways and creating new pathways relating to aged care assessment, bereavement, grief and loss, carer support, carer stress, community transport, dementia and younger onset dementia and elder abuse and neglect. The existing localised cardiac, diabetes and respiratory pathways on HPM were also reviewed to determine whether there were any missing community resources.

The HealthPathways Melbourne Community Resources Project has demonstrated the complimentary skills and approaches of Primary Care Partnerships and Medicare Locals. Primary Care Partnerships have close working relationships with a wide range of community organisations and this created an opportunity to add “the next layer” to the information provided on HealthPathways.

Recommendations for future actions are:

- Extend the Community HealthPathways work to cover the whole Eastern Primary Health Network catchment
- Increase the number of chronic disease community pathways
- Increase information about local government services on HPM
- Tap into PCP knowledge and skill in community consultation processes
- Expand the range of resource information for GPs and consumers
- Apply the model developed within this pilot project to other Primary Health Network regions across Victoria, in collaboration with local Primary Care Partnerships
- Evaluate the Community Resources component of the HealthPathways project.

BACKGROUND AND CONTEXT FOR PROJECT

HealthPathways is a web-based system for General Practitioners (GPs) that helps coordinate patient care across the acute and primary care system. The pathways provide guidance for GPs when seeing patients in their practice for assessment, management and referral details for common medical conditions. HealthPathways was originally developed in New Zealand by the Canterbury District Health Board and a number of Australian Medicare Locals subsequently developed local content to meet the needs of GPs in their catchment areas.

HealthPathways Melbourne (HPM) is a website which contains pathways that have been localised or developed for Melbourne's Inner North West and Inner East regions (<https://melbourne.healthpathways.org.au>). HPM is currently managed by Inner East Melbourne Medicare Local (IEMML) (now Eastern Melbourne Primary Health Network) and Inner North West Melbourne Medicare Local (INWMML) (now North Western Melbourne Primary Health Network).

The aims of HealthPathways Melbourne are to:

- Enhance clinical knowledge and promote best practice care
- Build collaboration and reduce fragmentation across the health service network
- Reduce the number of patients referred to specialist care who could be managed in a primary/community care setting.

The HealthPathways Melbourne Community Resources project was a collaboration between IEMML and Inner East Primary Care Partnership (IEPCP). A Project Officer was employed by IEPCP between February and June 2015 working at 0.8 EFT. The project was funded by the Victorian Department of Health and Human Services.

Project Aim and Objectives

The aim of the project was to extend HealthPathways Melbourne content to include community resources to meet the needs of patients with chronic and complex health needs, represent the services of community agencies in the Inner East region of Melbourne and provide new material to GPs about the range of services and supports available in their area.

The objectives of the project were to:

1. Enhance and extend existing pathways to represent a wider range of health and community services.
2. Develop a range of new pathways for GPs on support services for patients with chronic and complex health conditions.
3. Source and/or develop a range of resources for GPs to print out for patients.
4. Document the process of developing these extended pathways for use in future projects.

METHODOLOGY

The project methodology included the following:

- An informal review of literature relating to services consumers with chronic illness and their carers find useful
- Identification of community service types through consultation with service providers, which resulted in the following service categories used to create questions in the carer and consumer surveys:
 - Allied health, counselling & nursing
 - Social support/Activities
 - Information & Advocacy
 - Practical support
- Consultation with consumers with chronic conditions and carers
- Consultation with key stakeholders including:
 - GP Clinical Editors
 - Service providers
 - Community Health Services
 - Subject Matter Experts
- Desktop analyses to identify community resources and services relevant to patients with chronic diseases and complex needs in the inner east Melbourne catchment.

Community consultations

A total of 87 community members were consulted by focus group, survey and phone interview regarding services they found helpful either in their caring role or to manage their chronic condition and remain independent in the community. They were also asked about information, websites or resources they would recommend for people in their situation. Surveys elicited both quantitative and qualitative data and focus groups elicited qualitative data. Fifty participants were carers of someone with a chronic condition and 37 participants were people living with a chronic condition such as heart disease, diabetes, respiratory conditions and musculoskeletal conditions. See Table 1 below for numbers of participants in each group.

Table 1. Number of participants consulted during project

	Focus group	Survey	Phone interview	Total
Carers	6	44	0	50
People with chronic condition	7	29	1	37
Total	13	73	1	87

The information collected during the carer consultation process led to the addition of resources and support services to the following new pathways and resource pages:

- Carer stress
- Carer resources and support services
- Dementia resources and support services.

Information and themes collected during the consumer consultation process were used to review the existing localised cardiac, diabetes and respiratory pathways on HPM to identify gaps in community resources.

KEY DELIVERABLES

The following key deliverables were completed during the project.

- Creation of new pathways:
 - [Elder Abuse and Neglect](#)
 - [Aged Care Assessment Service \(ACAS\)](#)
 - [Carer Stress](#)
 - [Dementia Resources and Support Services](#)
 - [Younger Onset Dementia Resources and Support Services](#)
 - [Community Transport Providers](#)
 - [Carer Resources and Support Services](#)
 - [Bereavement, Grief, and Loss](#)
 - [Bereavement, Grief and Loss Resources and Support Services](#)
- Creation of a printable Carer Services Patient Information sheet which was attached to the following pathways:
 - Carer Resources & Support Services
 - Carer Stress.
- Review of cardiac, respiratory and diabetes pathways to determine whether there were any missing community resources that had been mentioned by consumers with these conditions as being helpful.
- Documented process for creating community resources for future use.

OUTCOMES

The HPM Community Resources project has achieved the following outcomes:

- A successful collaborative partnership between Inner East Melbourne Medicare Local and Inner East Primary Care Partnership, sharing expertise and working on a common goal.
- Provided GPs and health professionals in the Inner East with access to a wider range of services for their patients and access to information on health and community resources.
- Added value to an existing e-health system that is utilised by GPs.
- Engaged local Community Health Services in the updating of current information and addition of new information on HPM.
- Incorporated consumer input into a resource which aims to improve patient outcomes.
- An increase in traffic on the HPM website to the new pathways created during this project in June 2015.

RECOMMENDATIONS

The HealthPathways Melbourne Community Resources Project has demonstrated the complimentary skills and approaches of Primary Care Partnerships and Medicare Locals. Primary Care Partnerships have close working relationships with a wide range of community organisations and this created an opportunity to add “the next layer” to the information provided on HealthPathways.

Participating in the project enabled IEPCP to deliver on two of its core deliverables: improving the coordination of services and chronic disease management. At the same time, it provided a very practical way to strengthen the relationships and working partnership with Inner East Melbourne Medicare Local.

Recommendations for future actions are:

- Extend the Community HealthPathways work to cover the whole Eastern Primary Health Network catchment
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