Service Redesign

Co-design Report Summary

December 2021

Supporting general practice, commissioning health services into gaps and driving service integration.

phn WESTERN VICTORIA

An Australian Government Initiative

Acknowledgements

Western Victoria Primary Health Network acknowledges the Traditional Owners and custodians of the lands and waterways - the Waddawurrung, Gulidjan, Gadabanud, Keeray Wurrung, Peek Wurrung, Gunditjmara, Djab Wurrung, Wotjobaluk, Dja Dja Wurrung, Jadawadjarli, Wergaia, Jaadwa and Jupagalk peoples.

We recognise their diversity, resilience, and the ongoing place that First Peoples hold in our communities. We pay our respects to the Elders, both past and present and commit to working together in the spirit of mutual understanding, respect, and reconciliation. We support self-determination for First Nations Peoples and organisations and commit to working together on Closing the Gap.

We acknowledge people who bring a lived experience of illness and recovery and the experience of people who have been carers, families, or supporters. Your voice is essential in the development of services moving forward.

We acknowledge the many organisations, service providers and community members who work in partnership with us and who share their views, their knowledge and expertise to help shape our work, working together moves us closer to a coordinated and connected system.

Executive Summary

Western Victoria Primary Health Network (WVPHN) supports the delivery of best practice primary health care across the western Victoria region. Primary health care includes the services you may go to first for your health.

WVPHN's role in the community includes:

- Supporting general practice
- Funding health services into areas of needs
- Bringing services together to improve access for the community

There have been many reviews and evaluations undertaken across health in the last year or so. What has been learned from these activities is that there is a need for improvement in the services that you may access when you are unwell. As WVPHN fund health services it is important that the organisation looked at these findings and heard from community members to understand and learn what is needed to improve service delivery.

Over the course of 2021, WVPHN met with health service professionals, people with lived experience and other interested members of our community as part of a far-reaching co-design process to look at the future possibilities for the services we fund*. The co-design focused on services for mental ill health, chronic conditions management, and alcohol and other drugs (AOD) support.

Co-design or collaborative design is a way of looking at a problem and working together to think out a solution.

Using a co-design process is helpful when

- The solution will be for other people with different experiences to WVPHN
- There may not be a complete understanding of the problem
- There is a need to work with other people who have different perspectives and experiences

Working in this way allowed WVPHN to get a deeper understanding of what matters to people providing and visiting WVPHN funded services.

The aim of co-design was to make sure the services WVPHN fund add value to the health system and the care provided improves the health of the community.

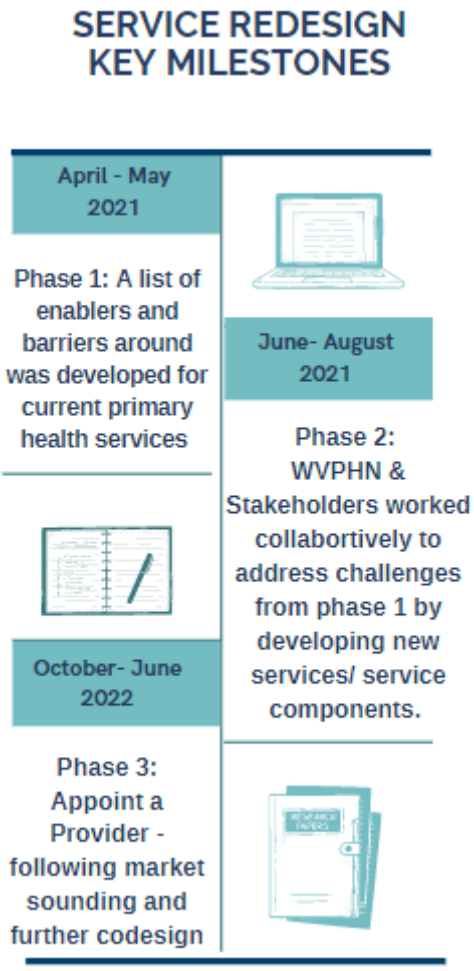

Figure 1. Key Milestones for the Service Redesign

*Current funded programs include Chronic Conditions Model of Care (CCMC), after hours, immunisation, cancer, social connections, Care Monitor, mental health, and AOD

Co-design Process

Phase 1: Learn Phase

This phase of the co-design focused on learning who to work with, learning about things that impact how we work, and learning about the issues or problems

The problem WVPHN wanted to learn about further was accessing health services in the region. Participants talked about the challenges they may have experienced.

The Learn Phase also looks at information from research, how other services work and operate and program evaluation findings.

Workshops were held for service providers, community members and Lived Experience representatives across April and May 2021. This round of sessions were separated into those with an interest in Chronic Conditions or Mental Health or AOD. Keeping the subject areas separated at this learn phase allowed WVPHN to get a deeper understanding of each of the challenges for each specific health area.

Once the sessions had finished, the information that was shared went through an analysis to look at the common challenges and issues for each health area. This left WVPHN with a list of challenges, things that work and other considerations regarding health services, as the work moves along.

Phase 2: Design phase

This phase of the co-design builds on the list of challenges, what works and things to think about, of the Learn Phase to work together to make and test a new program or service. The aim for the design sessions is to think of a solution to the challenges raised during the Learn Phase.

The design phase brought service providers, community members and lived experience together in each session. The three main areas of Mental health, AOD and chronic conditions were combined for each of the design phase sessions. As the aim of this session was not only to address challenges but also to design a new service with this integration in mind, it was best that all experiences and interests were brought together to make sure the whole health system was spoken about.

A similar analysis of the information shared during the design phase was done. This time the similar solutions raised were grouped together. The key themes can be shown in the diagram below, each coloured dot stands for a group of solutions heard from the participants. To make sure the diagram is not confusing, each dot is not linked by arrows or lines as each coloured dot could be grouped with more than one other coloured dot.

The key themes or the summary of the solutions heard were then pulled together into an idea that would be tested in the next phase of the co-design.

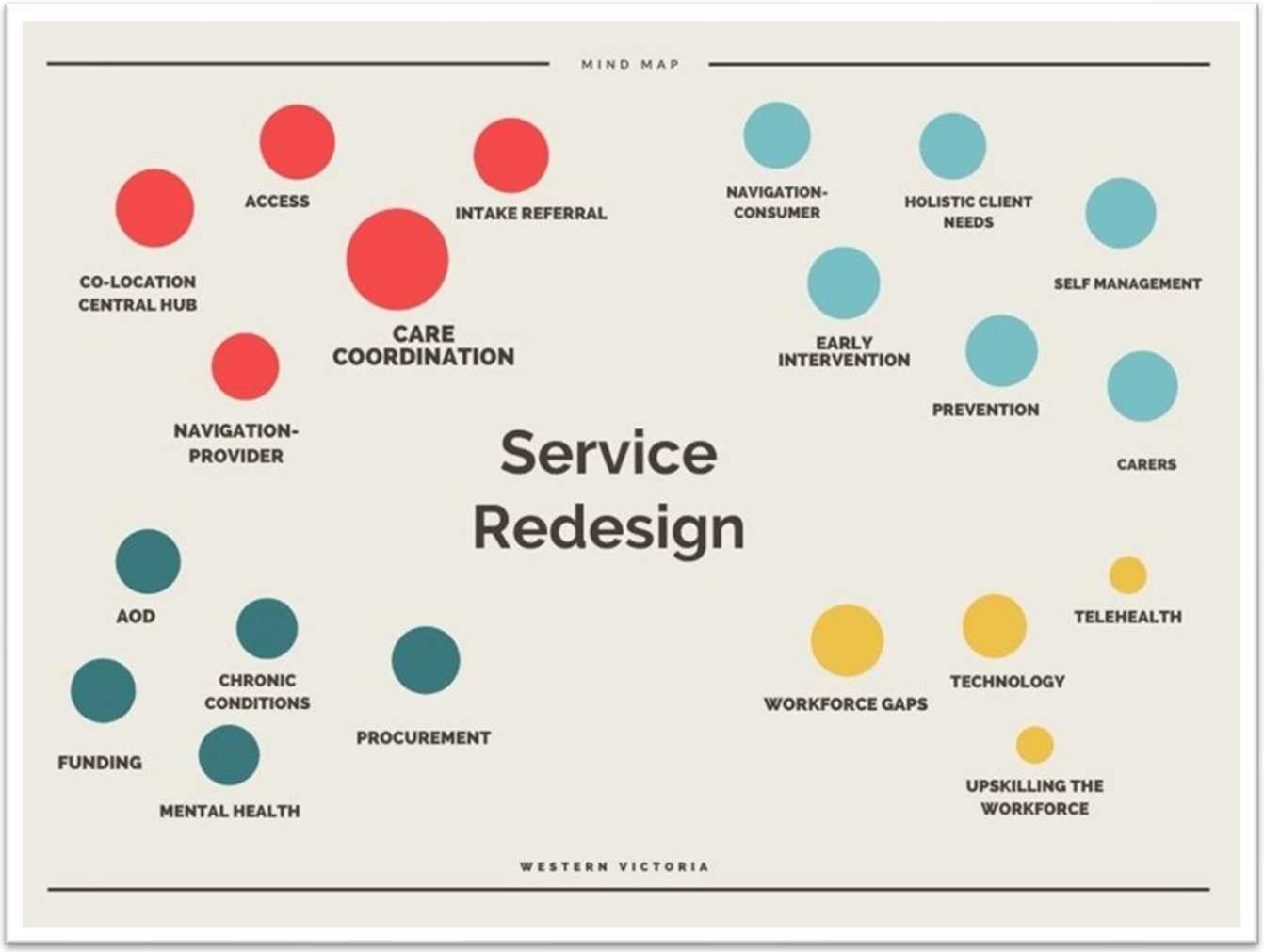

Figure 2. Key themes from the design phase

Phase 3: Test and Refine Phase

Participants from the Learn Phase and the Design Phase were invited to attend four Test and Refine sessions in September. The aim of the Test and Refine session was to give feedback on the ideas developed from the learnings and themes of the co-design process so far.

To make sure the ideas were well informed, other documents were reviewed and included. This includes:

- findings from the co-design sessions
- Internal staff workshop discussions
- Evaluation recommendations
- Program guidance across mental health, alcohol and other drugs and chronic conditions

Three ideas were presented to the participants and asked to reflect on two questions, “What works?” and “What needs development?”

The three key ideas that were presented during the test and refine session are shown below.

A detailed breakdown of the findings from the Learn Phase and Design Phase follows this diagram.

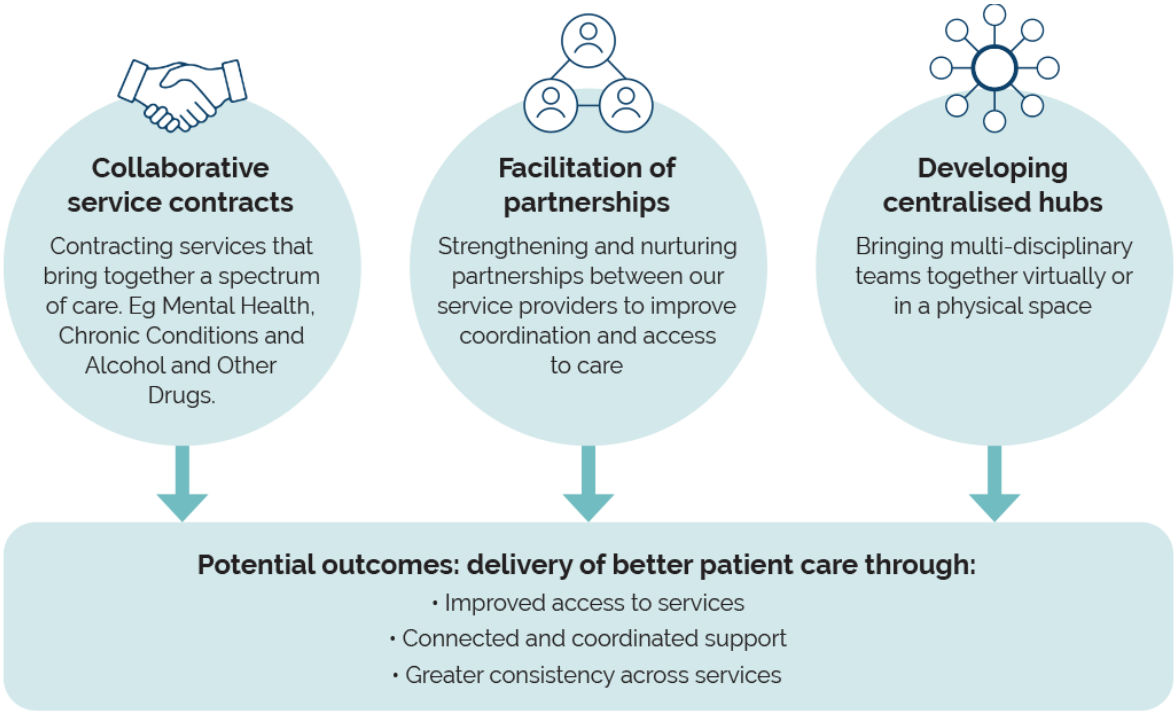

Figure 3. Key ideas presented at test and refine sessions

Findings

The key findings and learnings from each phase of the co-design, informed the next. The below demonstrate how the Learn Phase had informed the Design Phase and finally into the three ideas presented at the Test and Refine sessions.

Idea 1

Phase 1.

Enablers and Challenges

- Fragmentation of the system is disruptive and leads to the duplication of services
- Eligibility criteria adds to access difficulties
- There is a need for connection across the system, coordination of care encourages partnerships
- While supporting an individual, carers need their own support. Services are not often directed or offered to them. There is a risk of carers developing their own health concerns
- Building better partnerships needs to be a priority as patient handover is an issue

Phase 2.

Solution development

- No wrong door rather than person not meeting eligibility criteria
- Increase in outreach and visiting clinicians travelling to smaller town centres
- Element of coordination needs to be focused on organisations and a willingness to connect with other providers to improve accessibility for clients
- Support is provided during time on waitlists. Client is still connected into services
- Peer workers are included in coordination or take on the role themselves
- GP invited to work from organisations or services and vice versa
- Client autonomy to select care that is not constricted by eligibility and funding streams
- Establishment of networks that bring local providers together. Networking is missing as providers are too busy

Phase 3.

Idea tested

Contracting of a service that brings services together across a spectrum of care (across mental health, AOD and chronic conditions)

A well delivered and simplified intake process is needed when looking at a three-service model of care. The intake process is not burdensome, culturally safe and brings the patient/client to the centre of the decision making. Clients are supported in their decision making by "generalist" or navigator role who bring their understanding of available services including warm referrals.

Idea 2

Phase 1.

Enablers and Challenges

- There is a need for smoother referral pathways and improved communication between service providers.
- Service system issue – while we fund silos we will operate in silos. The poor system means we lose clinicians, and therefore lose workforce.
- Navigating the system difficult. There's no clear pathways to services.
- Many services around and not all in one place. Clients can get overwhelmed with service providers also – too many options making it difficult.
- There are huge difficulties attracting credentialed workers to rural areas. Overseas workers have issues getting their qualifications recognized. We need to focus more on skills rather than credentials.
- Three levels of care: face to face, video, and telephone. Most important thing is to give people a choice, easier to engage initially in the video/phone space instead of us deciding as clinicians what we think is best. Can get treatment to people who otherwise might not get treatment.

Phase 2.

Solution Development

- Physical spaces that bring MH and AOD together, brings agencies together that generally work separately
- Build into current services and leverage what already exists. No need to re-create services completely
- Wrap-around services are considered. What other aspects does a client need to improve their health
- Coordinator role assists with keeping client in care, complex cases have ongoing support and connection. Not lost in the cracks
- Coordination extends to information sharing to avoid warning signs being missed
- There is a need for connection across the system, coordination of care encourages partnerships
- Future models of care focus on strategies that maximise consumer self- monitoring and management following the completion of a brief intervention

Phase 3.

Idea tested

Commissioned services working in partnerships to improve care coordination and access

Session Feedback

Organisations not delivering across the spectrum of care would benefit from a partnership model as they would not need to try and deliver on expertise they may not have in house. Support however will be needed for smaller agencies who may not be able to be the lead partner. Communication and engagement will be key to the success of this idea that needs to be monitored and supported across the contract period.

Idea 3

Phase 1.

Enablers and Challenges

- Co-locating services within a hub to provide a simple entry point to services and support coordinated care. Also, to provide an alternative to emergency department as point of access.
- Long waitlists to access services can be detrimental to consumer health
- Limited access to specialists with knowledge of specific areas of chronic disease management
- Lack of transport, particularly in rural areas, restricts access to support services
- Centralised intake, case management, and supported referrals should be used to improve system navigation for providers and people with lived experience.
- Lack of service coordination prevents providers from delivering patient-centred care.
- Knowing what and where services are available is a challenge for service providers and consumers alike

Phase 2.

Solution development

Addressing barriers to accessing services

- A no wrong door approach is taken rather than looking at the eligibility criteria
- Outreach is increased with visiting specialists travelling to smaller town centres

Care coordination

- A coordinator or navigator role are present within organisations to support the care of consumers
- Clear referral pathways are established

Client centred care

- The client has the autonomy to select care and is not constricted by eligibility and funding
- Care is timely, responsive, and easy to access

Phase 3.

Idea tested

Centralised hubs bring multi-disciplinary teams together from one location/place

Session Feedback

A one size fits all approach cannot be applied to the hubs. The hub will need to be responsive to the communities within the region its servicing. The location of hubs is very important particularly for rural and remote areas. Do not want to increase travel for consumers to access care as this is a big enough barrier now. There does need to be an element of outreach available from the hubs. The hubs utilise and integrate current services such as my health record to capture patient records to avoid duplication.

Next steps

Western Victoria PHN will use the learnings from the co-design to inform the how, where and when we appoint providers to deliver primary health care services in our region.

We will now continue to work with others within the health care sector in western Victoria to develop the service ideas further.

We will then move on to tendering for providers to deliver a renewed set of health services for mental health, chronic conditions and AOD support.

Our priority is to get this right and we will ensure we take all time necessary to develop services that provide the best outcomes for our region.

Thank you

Western Victoria PHN thanks everyone who participated in our co-design process. This includes people with lived experience of illness and recovery along with their carers, families, and supporters. Thanks also to the many organisations, health service providers, health professionals and community members who have worked with us to their views, knowledge, and experience.

All your voices have been essential in helping us move toward a coordinated and connected system.