medicare local
NORTHERN ADELAIDE
Connecting health to meet local needs

Northern Adelaide Medicare Local

Submission to

Senate Select Committee on Health

October 2014

1. The role of Medicare Locals and their performance against stated objectives

- NAML – February 2012 – Tranche 2 – Metropolitan region with a small country footprint.
- Population = 400,000+ which includes the highest metropolitan number of Aboriginal people (7,500)
- SEIFA scores range from 748 – 1067 (average 951)
- IRSD of 957 = one of the MOST disadvantaged areas in Australia
- 2nd lowest of the 31 metropolitan MLs and 9th lowest of all 61 MLs

1 in 5 families are unemployed, 1 in 4 children are assessed as being developmentally vulnerable, 1 in 3 people have a respiratory disease, 1 in 3 have a musculoskeletal disease, 1 in 4 pregnant women smoke during pregnancy and 3 out of 5 people have at least one of the following health risk factors - smoking, harmful use of alcohol, physical inactivity or obesity.

Our population health planning **analysis** shows a startling array of chronic disease burden, indicating that the cost of health care services for a significant number of our population would far outweigh the cost of service provision, per head, in more advantaged areas. The spread of service provision in our region is random and private providers are a rarity. Refer to **Appendix 1**.

- Completed the Comprehensive Needs Assessment process - a circular process beginning with community experiences of primary health care, collection and analysis of data and ending with community where lived experience gaps are discovered and collaborative solutions agreed, these have been addressed in our Annual Plan
- We have 9 Membership Consortium Groups (MCGs): Palliative Care, Mental Health, General Practice, Aboriginal Health, Carers and Consumer, Medical Specialists and Older people and Aged care, Childhood and Disability. Refer to **Appendix 2** for more details.
- We have 155 individuals and 93 organisations represented across our MCGs which are open groups, ensuring the ability to include all stakeholders.
- Additional MCGs will be added as new population health priority areas are identified
- We are made aware of the current system “market failure” by our community engagement and consultation
- We continue to build on the extensive relationships created over 20 years by the Divisions and continue to support the 106 General Practices in our region
- We recognise the wider scope of Medicare Locals, across the health care spectrum
- We continue to map all service providers, clinicians and frontline service providers in our region
- We provide membership of specific health priority MCGs and ensure that all Allied Health, Nursing, Medical Specialists and Practice Managers are supported and contributing to identifying needs and gaps to improve patient care.

We have a list of the 3 top priority needs, confirmed by all stakeholders to be worked on collaboratively and work has indeed begun! Refer to **Appendix 3** for more information.

- Key partners - Northern Adelaide Local Health Network (NALHN) and Country Health SA – Gawler cluster, incorporating the 3 hospitals in our region: Lyell McEwin, Modbury and Gawler, and two local councils; Gawler Town and Playford
- **Appendix 4** details the collaborative work that is currently underway with our key partners
- Our CEO and Executive team meet monthly with both LHN counterparts for strategic planning focused on driving system improvements and
- NAML has several seconded staff from NALHN and SA Health and NAML also have key staff in areas such as the Emergency Department of the Lyell McEwin Hospital assisting with discharge to community and follow up care
- Chair of the NAML (Dr Nick Vlachoulis) is a member of the NALHN Governing Council
- Dr Hendrika Meyer who chairs the SA Health Clinical Senate, is a Director on the **NAML Board**
- Strong and sound Governance and Management structure – skills based Board
- Amazing diversity across skills, professions, age, gender and cultural background
- 5/9 have completed the Australian Institute of Company Directors (AICD) course
- We have Finance, Risk and Compliance, Clinical Governance and Governance and Membership Sub Committees with a Nominations Sub Committee planned for implementation in 2014
- Organisation chart attached at **Appendix 5**

Our role is:
- To ensure the connectivity, coordination and integration of services across health care delivery in our region
- Make improvements to both the patient journey and health outcomes
- We will not replace, replicate or take over any existing, quality service delivery ensuring that all significant stakeholders in an identified priority are brought together to work collaboratively on improvements
- Improve health literacy, information, early intervention, empowerment and prevention

2. The performance of Medicare Locals in administering existing programmes including after hours

- We have successfully and seamlessly transferred over existing service provision (over 13 years) from our Divisions with all staff intact
- We are the largest provider of clinical mental health services in the region – where there are few private providers and high disadvantage
- We have 11 mental health programs providing clinical therapeutic interventions, individual and group across the age range and diagnostic criteria – delivered over 24000 occasions of service this year
- We have built and sustained our Mental Health Clinical workforce, providing student placements and this year, 2 Mental Health Intern positions to ensure sustainability
- We provide high quality and efficient services in Mental Health and Aboriginal Health
- We have built on the existing excellent work of the Divisions – ensuring key long standing and enduring stakeholder relationships
- We build health literacy, promotion, early intervention and client empowerment into every program we deliver
- We provide services under **Closing the Gap** to ensure that our Aboriginal and Torres Strait Islander peoples can exercise choice, care coordination, empowerment and self-management
- We ensure that General Practice has access to assistance in providing culturally appropriate services – providing 5 sessions of cultural awareness training to our service providers
- We have implemented a new model of After Hours Incentive funding – with 100% uptake from General Practice
- We are focused on service accessibility and types of after-hours service provision, not patient registration numbers
- Last financial year, we provided $1.8 million in after-hours funding that went directly back to service **providers**
- We have facilitated 2 competitive grant rounds to fund GPs in after hours care, sustainability and innovation
- We have minimised “red tape” and ensured equity, transparency and accountability
- We have developed a new reporting tool to minimise the reporting requirements for General Practice
- We employed a Health Economist to examine the model and make **improvements** which has been endorsed by the GP advisory group and implemented
- We have advanced the Electronic Health Record, actively engaging and signing up General Practice, Pharmacy, Allied health and patients

- We have provided over 1600 services to the Aboriginal and Torres Strait Islander community this year
- We have 9 Aboriginal staff members providing services across our organisation
- We have over 200 Aboriginal clients receiving services

67% of our After Hours funding goes directly to incentivising General Practice to provide needed after hours services

- Evaluation and research on programs effectiveness and responding to the reports of these to improve services or help bridge the gap
- Designated research and evaluation staff member
- Strong commissioning and monitoring framework

3. Recognising General Practice as the cornerstone of primary care in the functions and governance structures of Medicare Locals

- We have wholeheartedly embraced the Medical Home Model
- General Practice is essential as the cornerstone of primary care as the most effective and efficient patient-centred care coordination model – see **Appendix 6** for this overview
- We seek to provide services to people where, when and how they need them
- Patient centred care with the expansion of the Medical Care team as required for varying individual health needs as required
- We aim to keep people well, informed, empowered and out of hospital!
- General Practice forms an important and integral skill base on the **NAML Board**
- We have the Northern Regional GP Council (NRGPC) set up in early 2012 – the first such GP Council to influence Medicare Local strategy and operations – see **Appendix 7** for details
- We have GP input from this council on the Northern Respiratory Partnership, the Palliative Care Group and the Oral Health Committee
- We have implemented a “sentinel” practice project - supporting General Practice in a range of initiatives that maximise improved coordinated patient care.
- We provide Workforce Support to develop the capacity of general practice workforce across the region
- We continue to assist with the integration of International Medical Graduates (IMGs) to general practice in our region

4 GPs, Medical Specialist, Aboriginal Health/community, Finance, Nursing/CEO private hospital and CEO health and consumer NGO. The skill matrix of our Board demonstrates skills in health professions, policy development and planning, strategic planning, business management, finance, accounting, legislation and compliance.

- We provide a Quality Support program assisting General practice in achieving and maintaining accreditation as well as offering advice on human resources and staffing issues.
- We have developed a Chronic Disease Community of Practice to coordinate and integrate general practice support.
- We have developed the Living Well with Persistent Pain program that is GP focussed and seeks to address the extraordinary wait list for people in the North to access a pain clinic.
- We auspice and support the Northern Nurse Network to ensure that practice nurses are upskilled and resourced adequately.

4. Ensuring Commonwealth funding supports clinical services, rather than administration

- We are a change leader, continuing the efficient and effective work of the previous Division and ensuring we assist with change management across the sector, including General Practice
- We add value – not bureaucracy with 87% of our Commonwealth funding returned directly to service delivery
- 13% supports the frontline service delivery and includes 6% for administration positions such as Finance and Executive Management

5. Assessing process for determining market failure and service intervention, so that existing clinical services are not disrupted or discouraged

- We continue to strive to ensure that priority needs, gaps and “market failures” are identified and that we bring strategic direction, influence, considerable leverage in key stakeholder and partner relationships, staffing and in some cases funding resources to provide solutions in these key areas

6. Evaluating the practical interaction with Local Hospital Networks and health services, including boundaries

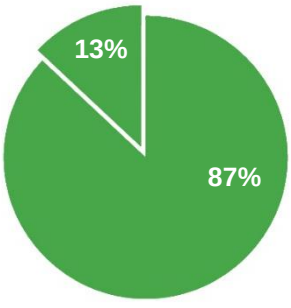
- We have two Local Hospital Networks in our region with the State boundaries of the LHNs differing from the Commonwealth interpretation
- Gawler, is considered to be Country by the State, and metropolitan by the Commonwealth
- There is overlap as the Country Health SA boundaries extend well beyond Gawler into the Country North SA Medicare Local region
- We have a strong strategic partnership with Country North SA Medicare Local which ensures collaboration for patient journey, referral pathways, workforce development and capacity building
- Aboriginal clients who move across both regions experience seamless and coordinated care

7. Tendering and contracting arrangements

- We have a sound Commissioning and Service Development framework to ensure effective, quality agreements
- We pride ourselves on collaboration, maintenance of contractual relationships, monitoring and accountability and quality assurance

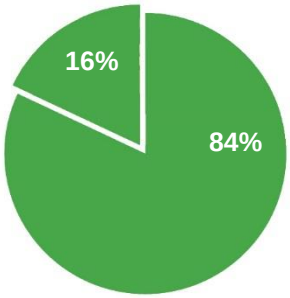
8. Any other related matters

- We are highly efficient and effective, maximising the use of Commonwealth, State and other funds
- We were awarded full accreditation status (with zero non-compliance or review items) achieving a MET status against all 12 Medicare Locals Accreditation Standards. This accreditation is for three years: 17 June 2014 – 16 June 2017 and we were congratulated by the assessors on our achievement and commended for our commitment to quality improvement and acknowledged for our focus on positive health outcomes for the population; sound Governance and Leadership Focus on quality and continuous improvement; proactive approach to engagement with stakeholders and service delivery; professionalism and responsiveness; communication strategies; systems development; and education and learning.



2014 Funding Distribution

Administration 13%
Services Delivery 87%



Staffing Allocation

Service Delivery Support 16%
Services Delivery 84%

- We comply with Australian Accounting standards, audited annually

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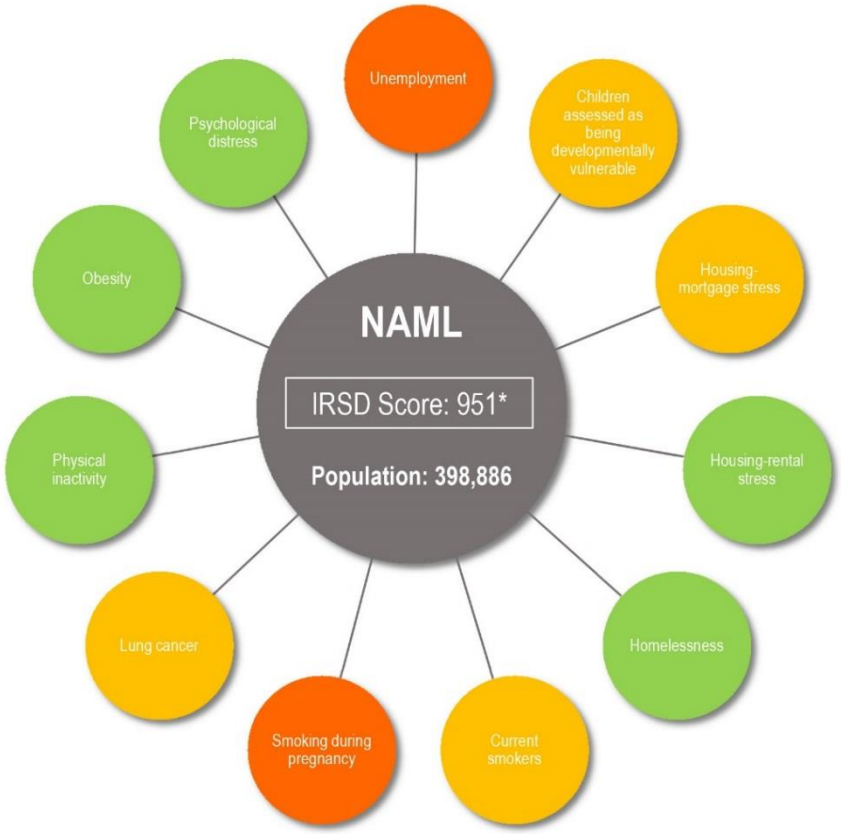


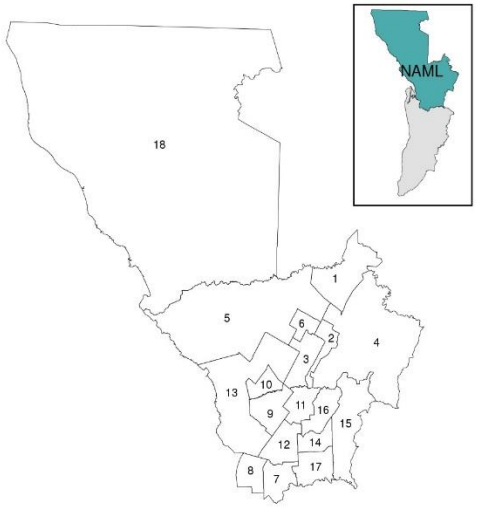
Selected health and wellbeing indicators by Statistical Local Areas (SLAs) in the Northern Adelaide Medicare Local (NAML) region^

** The Index of Relative Socio-economic Disadvantage (IRSD), is a measure of relative disadvantage that the Australian Bureau of Statistics (ABS) developed from the Census data comprising a range of socio-demographic/health factors. The IRSD score is interpreted using the Australian IRSD score of 1000 as a benchmark. Areas below this score of 1000 is regarded to have a greater relative disadvantage and conversely areas above are regarded to have a lesser relative disadvantage. Data source: Australian Bureau of Statistics 2011, Socio-economic Indexes for Areas (SEIFA), 2011, cat. no. 2033.0.55.001, ABS, Canberra.*

^ The diagram compares selected health & wellbeing indicators (see each "bubble" in diagram above) against the average for metropolitan Adelaide (see below shading legend) in each SLA in the NAML region. Data source: adapted from PHIDU (Public Health Information Development Unit) 2012. Population Profile of the Northern Adelaide Medicare Local: by Statistical Local Area. Produced for the NAML. Adelaide: PHIDU, The University of Adelaide.

	10% or more below Metropolitan Adelaide average		within +/- 10% of Metropolitan Adelaide average		10-29% above Metropolitan Adelaide average
	30-49% above Metropolitan Adelaide average		50% or more above Metropolitan Adelaide average		

Unemployment across the Northern Adelaide Medicare Local region



Key to areas

1 Gawler
2 Playford - East Central
3 Playford - Elizabeth
4 Playford - Hills
5 Playford - West
6 Playford - West Central
7 Port Adelaide Enfield - East
8 Port Adelaide Enfield - Inner
9 Salisbury - Central
10 Salisbury - Inner North
11 Salisbury - North-East
12 Salisbury - South-East
13 Salisbury Balance
14 Tea Tree Gully - Central
15 Tea Tree Gully - Hills
16 Tea Tree Gully - North
17 Tea Tree Gully - South
18 Mallala

	10% or more below Metropolitan Adelaide average		within +/- 10% of Metropolitan Adelaide average		10-29% above Metropolitan Adelaide average
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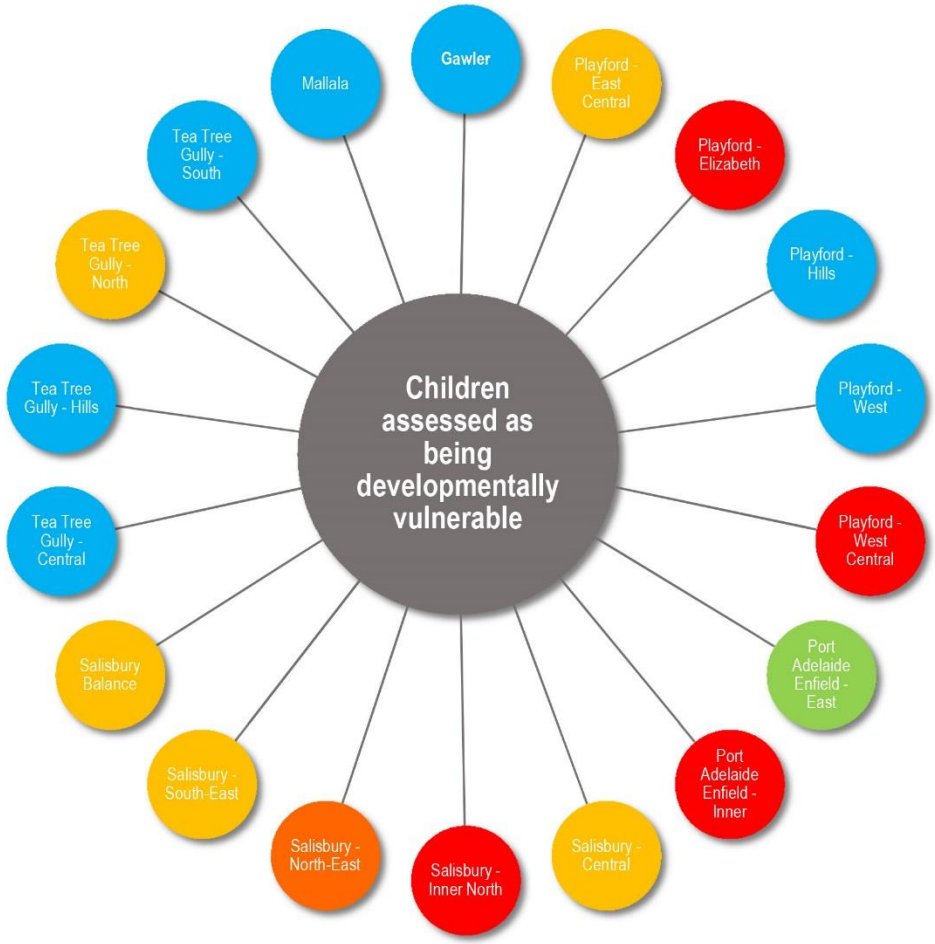
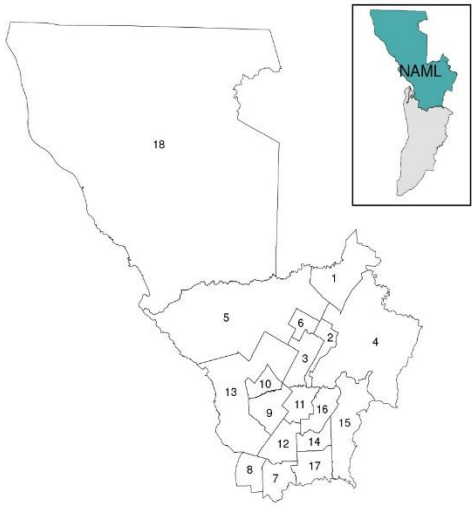
Children assessed as being developmentally vulnerable across the Northern Adelaide Medicare Local region





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	10% or more below Metropolitan Adelaide average		within +/- 10% of Metropolitan Adelaide average		10-29% above Metropolitan Adelaide average
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Ranking of selected chronic diseases of Medicare Locals (MLs) in Australia*

Ranking (MLs in South Australia within all MLs in Australia)	NAML	CAHML	SAFKI ML	CSSAML	CNSAML
Type 2 diabetes	**13**	39	41	14	28
High cholesterol	**1**	**2**	5	**3**	4
Males with mental and behavioural problems	**13**	30	21	8	16
Males with mood problems	**14**	24	25	11	20
Females with mental and behavioural problems	**13**	40	31	12	33
Females with mood problems	**7**	27	29	13	36
Circulatory system diseases	**2**	6	7	**3**	4
Hypertensive disease	**3**	13	12	4	**2**
Respiratory system diseases	**6**	12	8	59	61
Asthma	**37**	41	31	19	25
Chronic Obstructive Pulmonary Disease (COPD)	**18**	37	33	10	17
Musculoskeletal system diseases	**1**	15	6	47	54
Arthritis	**18**	40	32	9	10
Rheumatoid arthrities	**30**	49	50	33	18
Osteoarthritis	**16**	17	15	21	18
Female with osteoporosis	**47**	30	39	57	58

**Note: There are 61 MLs in Australia. The table is ranked in ascending order of rates of chronic diseases and the top five chronic diseases are shaded accordingly.*

Data source: adapted from PHIDU (Public Health Information Development Unit) 2012.
Population Profile of the Northern Adelaide Medicare Local: by Statistical Local Area. Produced for the NAML. Adelaide: PHIDU, The University of Adelaide.

Legend	
1	Highest prevalence of chronic disease within (all MLs in) Australia
2	Highest prevalence of chronic disease within (all MLs in) Australia
3	Highest prevalence of chronic disease within (all MLs in) Australia
4	Highest prevalence of chronic disease within (all MLs in) Australia
5	Highest prevalence of chronic disease within (all MLs in) Australia

Appendix 2

Membership Consortium Groups

Membership Consortium Groups (MCGs) represent population health priorities for the Northern Adelaide Medicare Local (NAML) region and will ensure feedback and input from all of our stakeholders. MCGs are designed to facilitate a broad range of input toward achieving our objectives.

Membership Consortium Groups currently established:

- General Practice (overseen by the Northern Health Network, previously the Adelaide Northern Division of General Practice)
- Medical Specialists
- Older People and Aged Care
- Mental Health
- Consumers and Carers
- Aboriginal Health
- Palliative Care
- Childhood (established in September 2014)
- Disability (established in September 2014)

Our aim is to establish further MCGs in future.

Membership Consortium Groups:

- Raise relevant primary health care issues with NAML, including gaps in services, patient journey issues, referral pathways, issues of accessibly and affordability.
- Work with NAML, and with its partners, advisory groups and other MCGs to advocate and work on solutions – solutions focused on efficient, effective and equitable health care.
- Consolidate and coordinate better referral pathways and information sharing.
- Receive regular updates and information about current and new NAML projects, services and initiatives.
- Receive a representative invite to the NAML Annual General Meeting and one vote per MCG. This will provide the group with a collective say in future strategic directions and nominations for Board directors.
- Have flexibility that allows the group to determine how and when they meet, how the group is organised, and how the group will raise issues with and collaborate with NAML, along with the resources to achieve this.
- Have no cap on the amount of members per group, meaning they are open to as many eligible members as they like.

Partners

NAML partners are any organisation or individual who brings funding, resources and strategic influence to the region and is prepared to work collaboratively with us to achieve our objectives.

Confirmed partners:

- Shine SA
- Royal Society for the Blind
- Northern Carers Network
- Arthritis SA
- Pakistan Medical Association of South Australia (PMASA)
- Northern Adelaide Local Health Network (NAHLN)
- Bangladesh Society of South Australia (BASSA)
- Aboriginal Health Council of SA
- UniSA: Division of Health Sciences
- KinCare
- SA Ambulance Service (SAAS)
- Heart Foundation Branch of SA
- WINspire
- City of Playford
- Adelaide to Outback
- Rural Doctors Workforce Agency
- SAMRHI
- RACGP

- Adelaide University
- Asthma Foundation SA
- Lung Foundation Australia
- Pharmaceutical Society of Australia

NAML is also working with the six local government authorities in the region to support public health planning and other partnership opportunities around service delivery, including immunisation.

Appendix 3

Current locally focussed and responsive projects that have been identified by key stakeholders as gaps are:

- Immunisation planning and support with Local Government areas, schools and SA Health that does not duplicate the services currently provided by GPs and SA health but rather addresses those targeted communities where immunisation rates are low
- Domestic and Family Violence and Offenders action research projects to gather evidence from community, other stakeholders and existing service providers around identifying key project areas that can be collaboratively implemented. This service work will commence in 2014.
- Assisting DAGBAGS (Dyslexia Action Group Barossa and Gawler surrounds) a small parent led community support group by assisting them to fund school and community workshops in effective teaching and learning styles for children with dyslexia
- Further breaking down the silos that currently exist in health and education by funding a Special Education Officer who will provide training to School Support Officers, families and children in the area of literacy (reading, writing and spelling). This position will also provide support and resources to teachers in primary schools, high schools, pre schools and child care centres to assist in the assessment and identification of children with learning needs. This priority need was identified by the two areas of “children assessed as developmentally vulnerable” and “secondary school retention rates) both of which are red priority areas in certain Statistical Local Areas (SLAs) in our region. Consulting with community in these areas identified that childhood health issues and social determinants of health are significantly impacting on literacy and learning. Refer to Appendix 3 for this population health priority data. This position will commence early in 2014.
- Emergency Liaison Officer – working closely with NALHN and the Lyell McEwin and Modbury Hospitals to assist in discharge information for community members visiting the Emergency Departments, ensuring connection back to a GP in the community and ongoing coordinated care. It is anticipated that this will assist in the health literacy and information that will affect patient behaviour in attending Emergency Departments for care that could be well provided in the community.
- Northern Respiratory Partnership – a collaboration between NAML, NALHN, DASSA, The Lung Foundation, Asthma Foundation SA and the Pharmacy Society SA to reduce hospital admissions for Asthma and COPD in the region by 10%. The project will work with pharmacies, schools, GPs, employers and specialists to create a supportive environment that will encourage people to improve their health.
- Chronic Disease Officers and help desk – assisting community and service providers (including General Practice) to navigate referral pathways for chronic disease conditions, such as cardiovascular, COPD, diabetes etc
- Metabolic Health Nurse for community members with mental health conditions and physical health comorbidities
- Identification of the need for a Pain Management Clinic in our region – the Royal Adelaide Hospital has a Chronic Pain Clinic which has a 3 year waiting list with 70% of referrals from our region. Collaboration between all stakeholders has seen NAML, NALHN, RAH, local GP Practice and a range of Allied Health professionals commit to the implementation of a Pain Clinic in the GP Plus Elizabeth. This program will commence with the first group of clients in November 2014. NAML considers this to be a key priority in ensuring that members of our community have access to relevant models of care, in their own region which will seek to reduce waiting lists and at the same time be the first referral point for General Practice in our community when they have a patient diagnosed with chronic pain. South Australia remains the only state in Australia to not implement recommendations from the 2010 National Pain Strategy.
- Refugee/New Arrival/CALD Officer who is working collaboratively with all stakeholders to improve the health literacy, empowerment and health status of our refugee, new arrival and CALD community.
- Development of an Aboriginal Health Clinic in a local General Practice to ensure culturally appropriate and safe health care coordination with the support of NALHN and the Aboriginal Health Service.
- Established in 2007, Adelaide Northern headspace is a Commonwealth-funded youth mental health service for young people aged 12-25. Services are delivered from 5 youth-friendly locations, with service provision including clinical intervention, youth work, counselling, GP services and psychiatry. We received 2,229 referrals and provided 13,888 occasions of service. We have a strong focus on community engagement,

delivering over 50 school based presentations in the last 12 months, and attending community activities to promote mental health literacy and awareness, and reduce the stigma around mental health.

- NAML is the only agency to convene a roundtable of all players involved in smoking cessation initiatives for Aboriginal people in the North. Through this roundtable facilitated by Professor Lester Rigney of Adelaide University we will drive a coordinated approach to reducing smoking rates.
- In early 2013, NAML funded a new service called the Minor Trauma Centre in Golden Grove. Operating on a Sunday, the MTC is established to primarily treat sports- related injuries and thus, reduce demand on local emergency departments.
- NAML has recently provided funding for the establishment of a new service in Gawler called Doctor to Your Door. This medical service involves visits to private homes, aged care facilities, hospitals and other locations.
- We were involved in the Medicare Local National Wave 2 which aimed to enhance service delivery during after hours through information sharing and appropriate clinical handover via the use of an electronic discharge summary form. This form was completed by the GP conducting a consultation after hours, which was then transferred to the patient's usual GP. The desired outcomes of the project were to provide an effective clinical handover system that supported safe and continuing healthcare delivery for patients as they navigated through the primary health care setting. It provided a forum so that health professionals were not only relying on patient memory and meant that the next health professional attending to a patient could safely and effectively carry on the management of the patient.
- NAML is participating in the Australian Primary Care Collaborative's Wave 8 & 9 – Diabetes Prevention and Management. We worked with 8 general practices to improve diabetes outcomes such as Hba1c levels and with the number of Diabetes Risk Assessments performed. Practices involved in this Wave produced Plan, Do, Study, Act cycles and were creative in coming up with plans that translated into improved patient outcomes and in identifying new approaches.
- Wave 9 consumer engagement - as part of NAML's involvement in the Wave 9 Diabetes Prevention & Management project, we engaged a patient with type 1 diabetes. This patient worked closely with NAML staff and the recruited general practices to provide a patient perspective to assist the general practices when developing their improvement ideas. NAML coordinated a diabetes prevention information session in March 2014. This patient co-facilitated with a Diabetes Educator to educate attendees on how she dealt with the feeling/emotions/barriers associated with being diagnosed with a chronic disease.
- NAML participated in the Medicare Local Quality Improvement Partnership Wave. This Wave focused on improving outcomes for patients with Chronic Obstructive Pulmonary Disease.
- NAML also participated in Wave 10- Cardiovascular Disease and Chronic Kidney Disease. This project worked with selected recruited practices to improve care of patients with CVD and CKD.
- We were successful in securing a grant from SA Health to respond to low cervix screening rates across our region NAML. The project focus was to better understand the local women's experiences and barriers towards having regular Pap smears. Additionally we built health literacy, education and promotion into this project, highlighting the importance of regular Pap smears and using our consultation findings to deliver a training session in mid-2014 aimed at general practice staff to support them in improving Pap smear rates and quality amongst their patient populations based on the feedback provided by our community. Part of this project was the facilitation of two Pap and Pamper nights where women are able to attend a general practice, to receive some pampering, receive information about Pap smears, discuss their experiences with NAML staff and have a Pap smear. The Pap and Pamper nights have been held in SLA's where Pap smears rates are concerningly low as per our Needs Assessment.
- In response to community telling us that they were not aware of what primary health care services are open after hours, NAML has facilitated a range of activities to better inform our community with available after hours services information and locality guides.
- NAML has facilitated cultural awareness training for general practice staff who work after hours. This training aimed to equip staff on how to most effectively treat and build relationships with patients of Aboriginal and Torres Strait Islander and refugee backgrounds.
- NAML has established and laid the foundations of telehealth services in Residential Aged Care Facility to provide continuity of care for residents including services in the after hours period providing reduced avoidable ED presentations, timely access to services for intervention of acute illness, medication review and resident reassurance. To date evidence from the facilities include long waiting times for residents to see the provider of their choice, timely waits increases the risk of anxiety levels, as residents become unsettled and anxious they have indicated that the facilities are more likely to send residents to ED via ambulance regardless of clinical need.

Appendix 4

Joint Partnership area	Initiatives
After Hours Services (primary care)	Better access to after hours: • Opportunities to increase access to After Hours services in the NAML region e.g. through better utilisation of GP services
	• Emergency Department/Primary Health Care service demand management
	• Staff awareness programs for ED staff around alternative options
	• Collaborative approach between NALHN and NAML to optimise the awareness and use of the after hours GP Helpline
Chronic Disease Management (across continuum – health promotion, prevention, early intervention, diagnosis, self-management, chronic, complex):	Northern Respiratory Project (asthma, COPD): • NRP Project Management Committee (NRP PMC) • Working groups
	Patient focussed pathways • Including optimising and raising awareness of Healthdirect and the National Health Services Directory (NHSD)
	Coordination of annual health promotion/prevention events across NALHN & NAML
	Northern Region Chronic Pain Clinic
GP/Specialist interface	GP/ Medical Specialist networking events
	Medical Specialist Membership Consortium Group
	Northern Region GP Council
Community/Stakeholder Engagement	Community Forums (NALHN led)
	Membership Consortium Groups
	Community Engagement Workshops (NAML led)
Adult Community Mental Health	Shared training initiatives between NALHN Mental Health Service and NAML for interns
	Jointly hosted mental health services directory
	Develop shared referral pathways for youth mental health clients
	Strategic planning process around mental health services – identifying gaps in services, organisation roles and population coverage
Aboriginal Health	Develop referral pathways between Lyell McEwin Hospital/ Modbury Hospital and NAML Closing The Gap program
	NAML and NALHN to investigate IT support and training for MD3 software program in chronic disease care planning and mental health care planning
	Colocation of NAML Mental Health Clinicians at a Watto Purruna site to support Aboriginal clients with mental health conditions

Joint Partnership area	Initiatives
	Provision of clinical supervision by NAML to relevant Watto Purruna Mental Health clinical staff
	Health promotion screening initiatives in culturally safe environments
	Examine partnership opportunities for targeted immunisation programs (e.g. Aboriginal children)
CALD and Refugee Health	CALD and Refugee Health Coordinator will work with NALHN to identify issues around access and utilisation of health services including Emergency Departments

Organisation Chart

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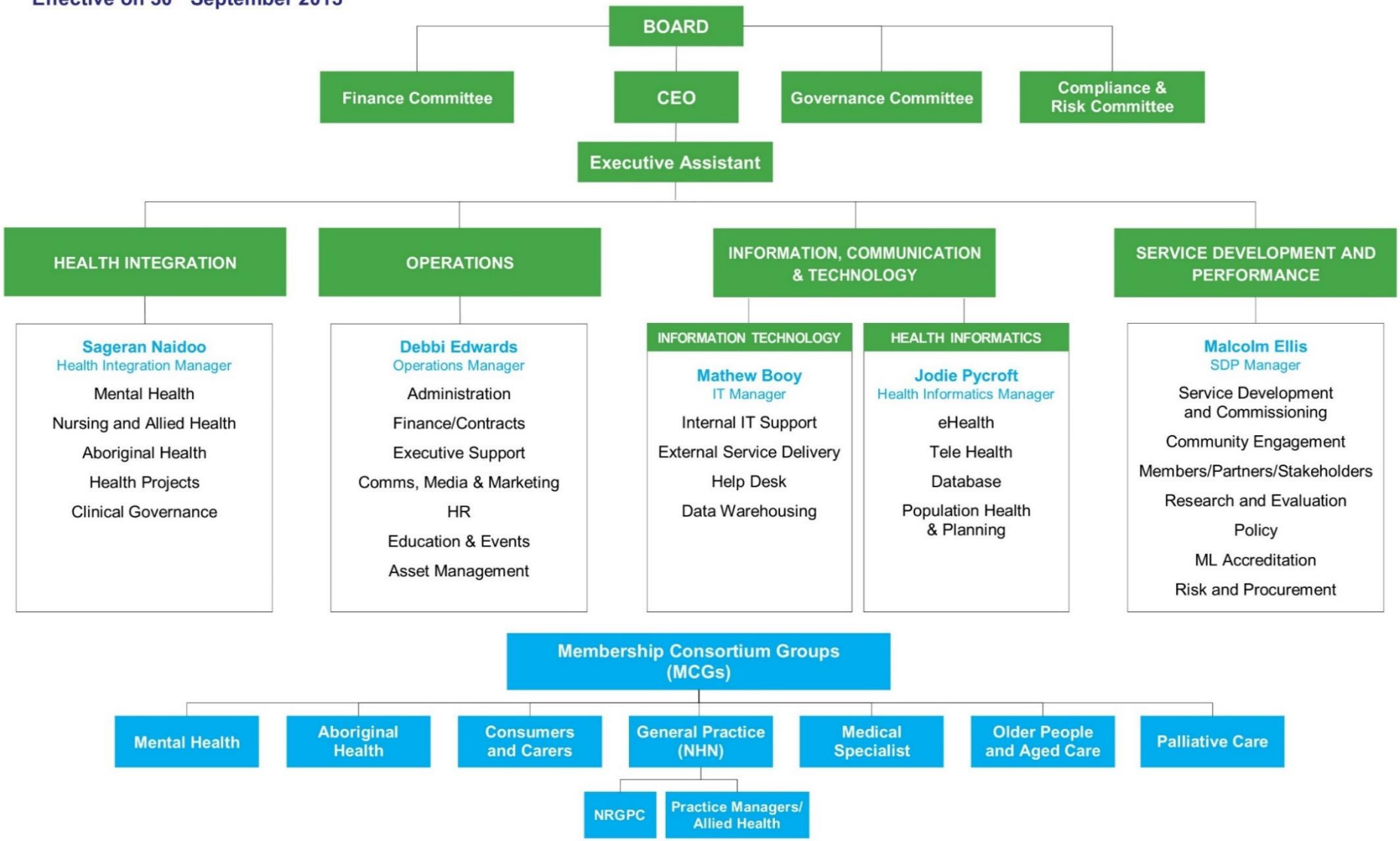
NORTHERN ADELAIDE
Connecting health to meet local needs

Effective on 30th September 2013



Appendix 6

Primary health care imperatives
A conversation with the Hon Peter Dutton

- Our health system is a 200+ year old legacy which is hospital centric, centralised, siloed, and no longer delivers the outcomes that were need now in 2013 and beyond
- We now have different expectations of health outcomes, we are living longer, and as a result we are seeing the impact of complex chronic conditions, along with natural ageing and associated denigration of the body – how to keep people living well for longer, independently?
- We need people, individuals to be responsive, responsible and in control of their own health – taking responsibility
- We cannot keep up, nor sustain the health dollars in relation to GDP
- We don't need more hospitals nor more hospital beds – we need to keep people well and out of hospital
- We need to redesign the health system so it can DELIVER our 2013+ expectations of health care – and what are they?
    1. We want and need health delivered when we need it and where we are living – so locally delivered health care
    2. We need health care to be urgently responsive when we have acute need
    3. We need to be empowered to have choices, take responsibility and ultimately control over our health choices, decisions and consequences
- Health Reform and Primary Health Care Organisations – is exactly that vision – conceptualised by the Liberals – enacted in a piecemeal way by Labour
- We now have Commonwealth Health dollars and State Health dollars and a system that is fragmented, operates in silos and is wasteful and inefficient. We have duplication, fragmentation and massive, ever widening gaps.
- We have layers of unnecessary bureaucracy – but what is unnecessary?
    1. Look at the Commonwealth Departments and layers that make up the machinery of government
    2. Reporting and accountability across Commonwealth funding grants is fragmented, muddy and difficult to access – no one system of contract management, and no readily accessible Key Performance Indicators (KPIs) for any funding stream
    3. We then have State funding – how is this utilised and how is it efficient – why does health have multiple "masters" and who is calling the shots?
- Medicare Locals – Primary Health Care Organisations – where do they fit in? – bad name, even worse publicity by the Commonwealth!
- Mandate – to coordinate and integrate primary health care to ensure improved patient outcomes, improve the patient journey, provide support to primary health care providers and assist in the facilitation and implementation of primary health care initiatives.
- **So what has Northern Adelaide done?**
    1. Built on existing stakeholder and community relationships, kept GPs engaged and supported, broadened outlook to include all primary health care providers AND the acute sector, including Medical Specialists (we have over 50 Medical Specialists working more than 50% of their practice time in our region and they are all involved with NAML)
    2. Engaged and consulted widely with our community – at all levels
    3. Set up Membership Consortium Groups which provides the on ground, coal face aspect of our community, from all providers and all community members across: Mental Health, General Practice, Aboriginal, Palliative Care, Childhood, Disability, Medical Specialists, Consumers and Carers and Older people and Aged Care
    4. Built on the long standing relationship (over 20 years) as a Division of General Practice, with our Local Health Network and forged collaborative projects and innovations where primary care and the acute sector intersect
    5. Shared Board Members who sit on the Local Health Network Governing Council and NAML Board, Aboriginal Community Sector and our Board – NAML Board skills based and inclusive of age range and gender
    6. We duplicate nothing in our region – if it is delivered and is not broken – why fix it? We don't seek to provide a single service that is already being provided. We know the gaps and the health priorities
    7. We seek to assist with coordination and integration of primary health with the acute sector – improve referral pathways, patient journey and outcomes
    8. Bring primary health care back to the regions, make health accessible and "easy" – up skill and build our health workforce
    9. Lessen the burden on our Accident and Emergency Departments and our Medical Specialist city clinics
    10. We have transferred our 15 year history of quality service delivery in mental health and Aboriginal health, seamlessly, from Division to NAML

11. We have not "returned" After Hours incentive payments as the Commonwealth did previously. We have set up a fairer, more transparent, more equitable and more accountable model and we have full sign up across our region for eligible practices

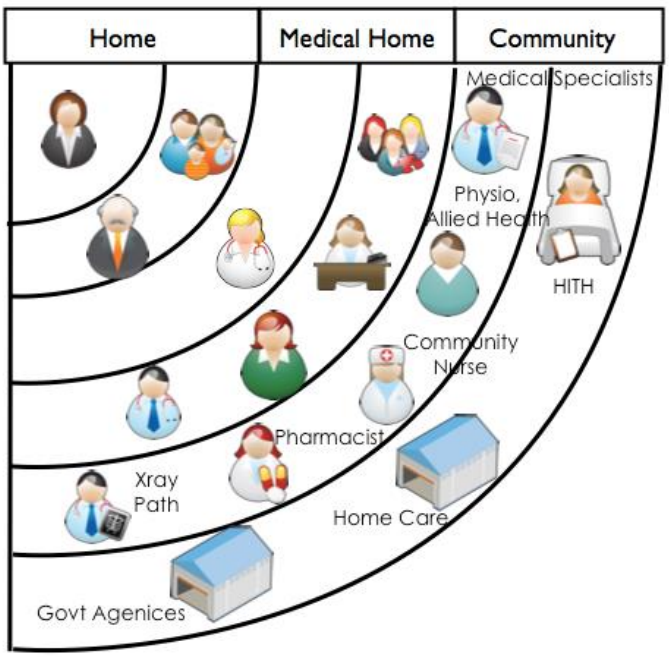
- **So what do we see as being possibilities for our region? What are the NAMLs future plans and strategies?**

1. To improve the primary health care regional models of local care – to work in collaborative, genuine partnership with innovators in primary health
2. Create and enhance hub and spoke models of primary health care interventions with multi-disciplinary teams
3. Sentinel practices that offer holistic, wrap around care – well coordinated with well-defined and seamless referral pathways and well-coordinated care that empowers patients – we would have a minimum of 12 practices that we could roll this out in soon (best practice works by osmosis – other practices will follow the lead). Data collection around outcomes and evidence based practice is embedded in Sentinel sites
4. Ensure good integration and coordination of care across acute (hospital) and primary health care – ensure sound referral pathways and discharge and community care information (including rehabilitation etc – locally)
5. Bring Medical specialisation out to the regions to ensure we cut down long wait lists for city central hospitals (Royal Adelaide has a 3.5+ year wait list for its Chronic Pain Clinic) – 70% of these referrals come from the NAML region. Set up Tele-health communication to allow specialists GPs to link in with city specialists for complex assessments and consultation – provide training and support to these regional specialised GPs. Cut the wait list for the RAH by 2/3 – so those truly acute referrals can be seen sooner
6. Mental Health – set up the same utilisation of specialised Psychiatric assessment via telehealth to ensure timely access to intervention and prevent acute admissions where possible – back this up with high quality clinician care until midnight 7 days a week – on call
7. Aged Care – residential facilities and the elderly in their own homes – different models of care and intervention – Nurse led clinics, home visiting and telehealth – much less expensive and more effective than acute measures (avoidable hospital presentations and admissions for treatable symptoms prior to escalation) Keeping people well in the community and out of hospital

- **What do we have now and what do we need to achieve this?**

1. We have all the services and the funding
2. We don't necessarily need additional funding – we need the funding to shift from the acute sector to back up what is needed in the community as a sustainability measure
3. What we don't have is coordination and integration of services
4. We have the Northern Adelaide Medicare Local and lots of primary health care providers – along with 3 hospitals
5. We can run pilot models of primary health care hubs, with care coordination and innovative models of care delivery, patient centred and GP oversight
6. NAML brings staffing resources, IT resources, research and evaluation resources, coordination and leverage of stakeholder relationships – it has no territory to guard nor conflict of interest

- We would like to change the face of primary health care delivery in the community – (but we need more time to show you what that could look like!)
- **Gawler is a prime site** to begin this exploration with General Practice that is willing to advance this concept of coordinated and integrated primary health care – changing the face of General Practice and primary health care!



Appendix 7

The aim of the Northern Region GP Council (NRGPC) Committee is to provide a forum for GPs in the Northern region to raise issues that affect General Practice and its ability to provide effective Primary Health care in our Community.

Over 600 GPs are represented by the NRGPC. All GPs in our Region are automatically members, represented by the Committee consisting of 6 Peer Elected members.

The Committee;

1. Provides a forum where GP issues and concerns around the delivery of Primary Health care in the Community can be discussed, with an emphasis on how to improve health care outcomes for individuals
- Provides GP input, advocacy and linkage into and across other health care organisations
- Ensures that GPs across the Region are given opportunity to provide input and consultation
- Ensures that a consensus view around issues is provided to NAML and as such acts as the conduit for GPs across the Region.