Coordinating and strengthening Aged Services on the Mornington Peninsula

Nick Jones  Frankston-Mornington Peninsula Medicare Local
Dianne Berryman  Frankston Mornington Peninsula Primary Care Partnership
One side of our catchment

- Population: approx 282,000 people
  - 100,000 increase in population over summer
- Commonly regarded as a playground for Melbourne
- Beautiful geography and amenities
- Images of wealth, fun and leisure
Another side to our catchment...
Catchment enablers

- Surrounded on 3 sides by water
- Single LHN (includes community health)
- Medicare Local, PCP and LHN similar boundaries
- 2 LGAs
- Strong history of partnerships
- Representation from LHN on ML board
Background to the Peninsula Model

Primary Care Partnership

The Frankston Mornington Peninsula Primary Care Partnership commenced work in 2011 on developing a multi agency planning process. These processes aimed to:

- improve integration of disparate mandated plans
- reduce duplication of efforts
- strengthen collaboration
Medicare Local

The establishment of the Medicare Local in early 2012 expanded the thinking around the structure and governance of the model to enable a functional primary health care planning framework for the catchment.

Focus on;

- Service integration
- Population health needs
Peninsula Health

- Primary Care and Population Health Committee

Local Government

- Municipal Public Health and Wellbeing Plan
Gather fact base to define focus of work

Establish Alliance / Wkg Group & ways of working

Identify and root causes

Develop case for change & set targets

Identify issues and root causes

Develop service options & business case

Build the team, shared goals, TOR, timelines

Set consumer focussed targets for improvement

Redesign collaborative care delivery model

Pilot planning & evaluation

Plan, pilot, implement, track and adjust

Identify population health needs to focus on

A

B

C

D

E

F
PM Service Development Tools

A. Gather fact base to define focus of work
   1. Population Health Needs Analysis
   2. Service mapping
   3. Service utilisation
   4. Gap analysis

B. Establish Alliance / Wkg Group & ways of working
   1. TOR
   2. Agenda / minutes
   3. Timelines

C. Identify issues and root causes
   1. Prioritisation tool
   2. Alliance priorities agreed
   3. Working group workplans

D. Develop case for change & set targets
   1. Program logic
   2. SMART measures for success
   3. Barriers to change

E. Develop service options & business case
   1. Future-state Care delivery model
   2. Business case
   3. Risk analysis

F. Plan, pilot, implement, track and adjust
   1. Implementation and change management plan
   2. Evaluation plan
The Peninsula Model

8 alliances
36 projects being progressed across the alliances
28 working groups
280 meetings/year
Over 30 agencies, 28 GPs and 40 other primary care providers represented on Alliances and working groups
## Shared Goals

<table>
<thead>
<tr>
<th>Category</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consumer</td>
<td>Address the service gaps for local consumers</td>
</tr>
<tr>
<td>Service Delivery</td>
<td>Provide consumer-centred coordinated and integrated services</td>
</tr>
<tr>
<td>Health</td>
<td>Impact the long term health of the local community through targeted and impactful health promotion initiatives</td>
</tr>
<tr>
<td>Promotion</td>
<td></td>
</tr>
<tr>
<td>Service system</td>
<td>Improve capacity to deliver evidence based care</td>
</tr>
</tbody>
</table>
Benefits

Greater collective impact through joint ownership . . .

• Shared vision
• Avoids duplication
• Best use of a substantial pool of resources to greater effect
• Consistent use of a robust service redevelopment methodology and evaluation
• FMPML provides a catchment resource for population planning, links to services directories, and service utilisation data
• Provides a platform to expand the work of the FMPPCP
• Promotes the strengths and builds on the well established partnerships of FMP
Process

- Establishment of Alliances for each priority area
- Service mapping and needs analysis within each alliance
- Identification of sub priorities for each Alliance
- Development of workplans and working groups for each Alliance
- Commencement of work on projects with an equity focus
Ageing Well Alliance

Key Priorities:

1. Improve coordination and access to services for people living with dementia and their carers

2. Increase the number of people with Advance Care Plans (ACP) and the number of ACPs being respected

3. Identify older people in the community who are not well connected and provide opportunities for these people to connect with each other and the general community
ACP completed work

- ACP – competent and non-competent
- RACF protocols
- Consumer fact sheet
- Provider fact sheet
- Baseline measures of ACP use (PH, RACF, PHH) average 7%
ACP information

- 90% local government HACC assessment officers trained
- 10 GPs received target information on ACP for RACFs
- 25 GPs attended 40 minute ACP talk
- 58 nurses (from 19 RACFs) attended 2 RACF ACP meetings
- 19 Practice nurses attended training

- Overall 38% of practices and 16% of GPs have received face-to-face ACP information
Promotion of ACP

- All new HACC assessments and 2 yearly reviews (8000 people)
- All Peninsula Home Hospice assessments
- All BSL package assessments
- Variety of GPs, package providers
- Support from private hospitals
Coming up

- Electronic ACP – due August 25
- One of 3 themes at Ageing Well Expo
- Further promotion
- Monitor usage
Dementia

Care pathway


Service listing

Provider training listing
Training

- 40 GPs from 19 practices received face-to-face discussions about dementia
- 25 attendees at GP dementia day (175 hours)
- 19 Practice nurses attended training
Coming up

- Development of ‘Caring passport’ to accompany people with dementia when they transition to new services
- Development of Day Respite for people with dementia in RACFs
Social connectedness

Aim is to identify people with poor social connections and to connect them with existing social programs

Plans

- Expand existing community directory
- Come and try month for community groups
Contacts


- Nick Jones njones@fmpml.org.au
  5971 0929

- Dianne Berryman DBerryman@phcn.vic.gov.au
  9788 1544