

The Collaborative

working together for better health

cohealth

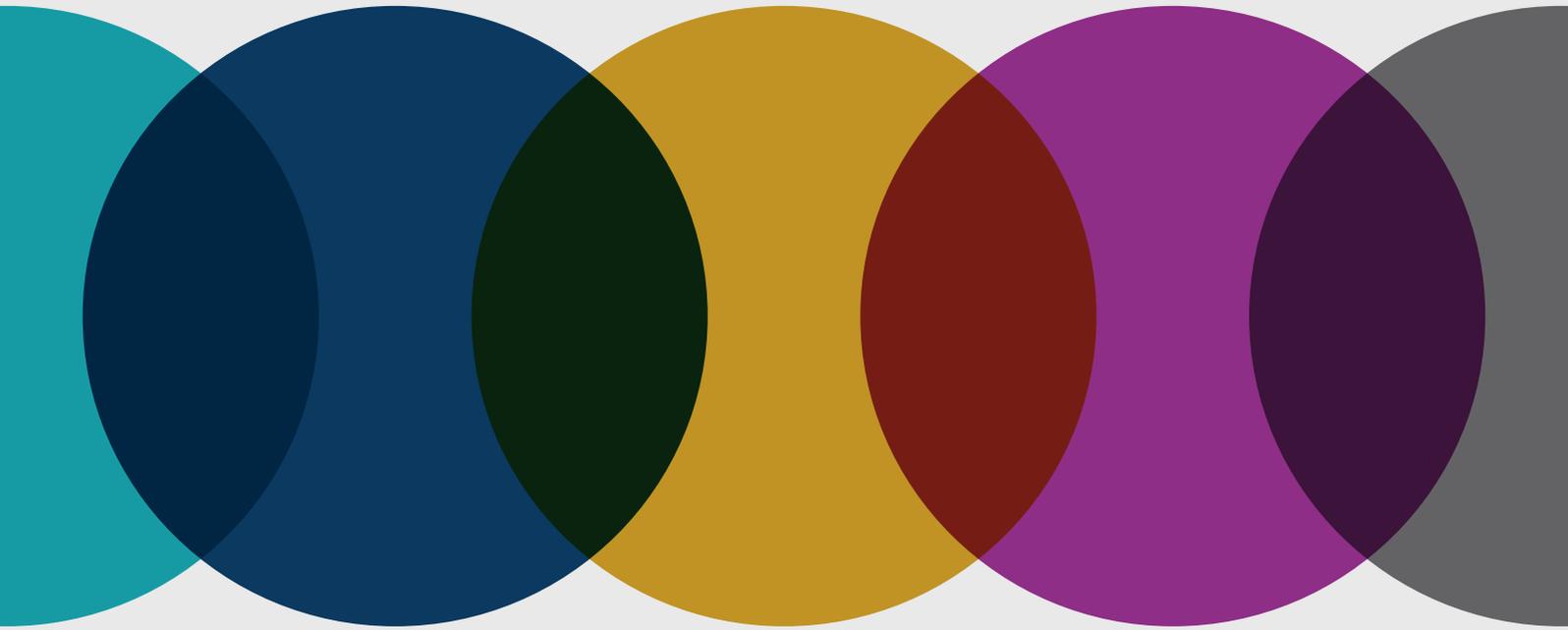


The Royal
Melbourne Hospital



Merri Health
Healthcare that moves with you

phn
NORTH WESTERN
MELBOURNE
An Australian Government Initiative



Collaborative Framework

2016 – 2020

Working together to strengthen health care outcomes of our communities.

Introduction and foreword

North Western Melbourne PHN, cohealth, Merri Community Health Services (MCHS) and The Royal Melbourne Hospital are pleased to present The Collaborative Framework for 2016 – 2020.

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.

We already have a strong and long standing partnership, working together on initiatives such as the Hospital Admissions Risk Program (HARP) and Health Workforce Australia Clinical Placements Project, as well as representation on the Melbourne Health Primary Care and Population Health Advisory Committee, and Primary Care Partnership.

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.

The framework also sets out specific outcome measures for the collaborative partnership as we seek to address the escalating prevalence of chronic conditions, increased demand for health services, and the need for improved prevention strategies.

Our communities, and those who rely heavily on our services, can be confident in our ongoing commitment to actively work towards achieving the outcomes outlined in this framework. That means better health outcomes for our communities and the people who live here.

A/Prof Christopher Carter
North Western Melbourne PHN



Ms Lyn Morgain
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Mr Nigel Fidgeon
Merri Community Health Services



Dr Gareth Goodier
The Royal Melbourne Hospital



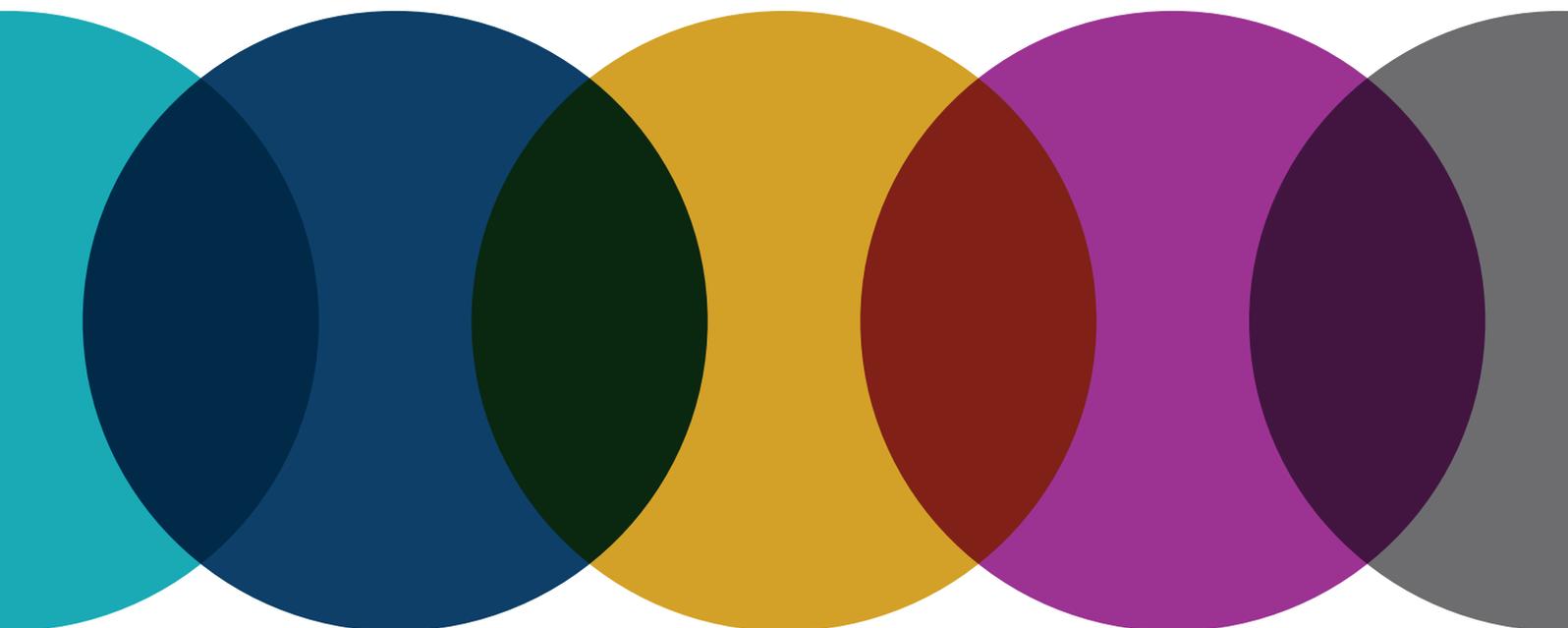
1. Background

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

We recognised the importance of primary healthcare providers and hospitals working together to ensure services are tailored in the best possible way to meet the needs of local communities. That commitment resulted in the Collaborative Framework 2012 – 2017. In this new Collaborative Framework 2016 – 2020, we have reaffirmed and strengthened that commitment.

Each of the collaborative partners has a significant and shared interest in the health of The Collaborative catchment. We have reaffirmed that The Collaborative catchment will be used as a basis to assess, prioritise and plan for services to best meet local health care needs.

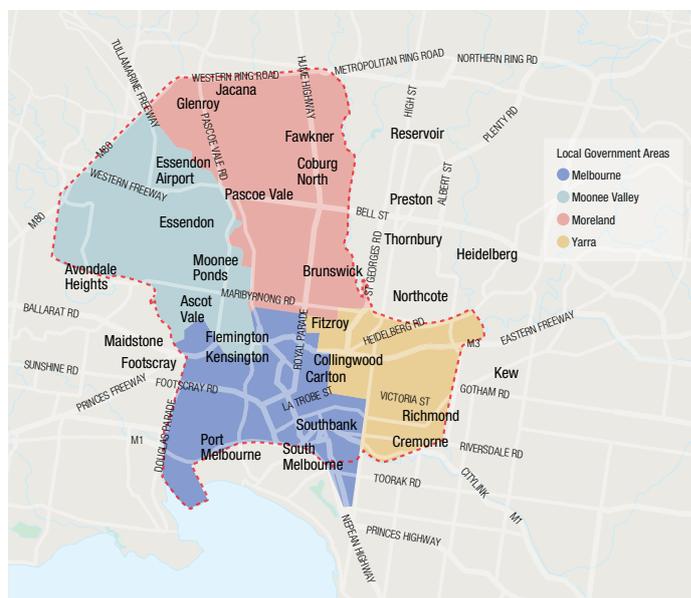
Our four organisations have a shared commitment to strengthening our collaboration, driving continual innovation to address systemic gaps and strengthen the interface between acute and primary care. We are committed to integrated models of care which support delivery in the appropriate settings and strengthen 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 North and West Melbourne Region reflects the four organisations' shared geography. The area is home to more than 470,000 people across the Local Government Areas (LGAs) of Moonee Valley, Moreland, Yarra and Melbourne (Victorian LGA Dataset PHIDU 2014 (May release)). This population is serviced by approximately 850 General Practitioners in 199 clinics, and six public hospitals. Two of the collaborative partners, Merri Community Health Service 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 underlines 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, 2008-2012. Source: PHIDU)

Most prevalent chronic conditions

1. Respiratory systems diseases
2. Musculoskeletal systems diseases
3. Circulatory systems disease
4. Arthritis
5. Mental and behavioral problems

(Australian Health Survey ASR/100, 2011-2013. Source: PHIDU)

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

1. Diabetes complications
2. Dental conditions
3. Congestive cardiac failure
4. Pyelonephritis
5. Asthma

(ASR/1,000, 2013/14. Source: VHISS)

* 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.

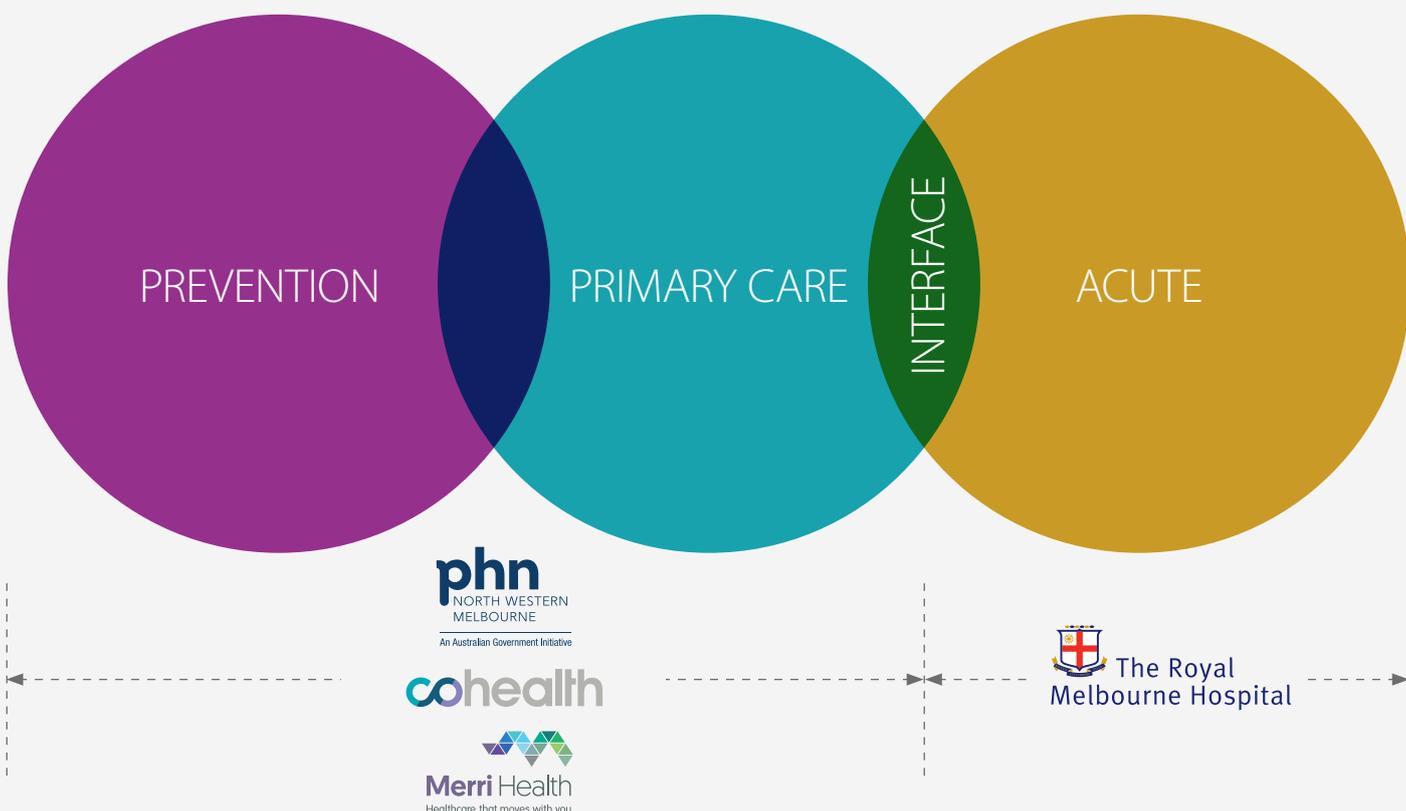
The diagram below represents our roles across the health care continuum, encompassing prevention, primary health care, and acute settings. Understanding our roles in the continuum supports us to design client centred model of care that delivers the right care in the right setting.

Our collaboration occurs where these roles overlap. Future and ongoing collaboration will recognise these roles and focus on intersections. For instance, primary prevention initiatives would involve the North Western Melbourne PHN and Community Health Services.

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 works to improve and support communication and pathways between parts of the health system, and to improve service planning and service delivery. It is also focused on system reform, such as, management and funding to improve efficiency and health outcomes.

Our roles across the health care continuum



2. Purpose of The Collaborative

We recognise that working together puts us in the best position to improve patient care, outcomes and pathways, by moving care, where appropriate, into the primary care setting. There is no “one size fits all” approach – instead, we will promote flexible approaches to meet our communities’ specific needs.

Driven by consumer 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
- Work collaboratively to deliver more care in the primary care setting
- Develop new 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:



Chief Executives' Committee

Senior Managers' Committee

Project Committees

Key stakeholder group

Annual forum and quarterly updates on implementation progress

- Comprises the Chief Executives of each partner organisation.
- Meets bi-monthly to provide formal oversight for the Collaboration and authorises or commissions joint work.
- Comprises senior managers from each of the partner organisations.
- Meets bi-monthly to oversee joint planning.
- Ensures progress on agreed 'measures of success' and timely progress on project deliverables, in keeping with our broader objectives.
- Meets as required.
- Oversees specific collaborative projects.

In addition, **annual stakeholder forums** provide a broader link with stakeholders and an overview of programs and services operating across the region.

A **project manager** also supports the work of The Collaborative. The establishment of this position in late 2015 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 this position.

5. Outcomes

The outcomes that The Collaborative aims to achieve from 2016 - 2020 are demonstrated by the following measures of success. These outcomes build on the outcomes of the previous Collaborative Framework 2012 - 2017 (see Appendix Two for progress to date).

Measures of success

2 years

- Two collaborative projects/programs implemented to address priority areas with a focus on Ambulatory Care Sensitive Conditions
- Annual collaborative forums continued
- Collaborative presentations on integrated service models delivered
- Strategic Priorities 2014-2017 reviewed
- Findings from the Shared Evaluation Framework disseminated on the effectiveness of the collaboration
- Scope and develop an agreed position on a region-based Electronic Medical Record
- Shared training/staff development activities conducted

5 years

- New to follow up outpatient ratio at Royal Melbourne Hospital reduced
- Collaborative research projects established to provide academic focus to priority area projects/programs
- Two collaborative projects are adopted as ongoing, sustainable activities within the work plans of partner organisations
- Joint research grants awarded
- Mechanism for collecting and analysing client feedback on their journey through the system established
- Advocacy by the collaboration undertaken resulting in new funding and service models to address shared chronic disease priorities

Additional documents that support this framework:

- Inner North West Melbourne Health Collaborative Strategic Priorities 2014 - 2017
- Collaborative Action Plan (developed annually)
- Collaborative Communications Plan
- Evaluation Framework



Appendix One:

Population health data - The Collaborative catchment

	Melbourne	Yarra	Moreland	Moonee Valley	Collaborative catchment	Victoria
Population (ERP 2013)	116,447	83,593	160,029	115,097	NA	5,739,341
Top 5 Premature mortality (0-74 years) ASR/100,000, 2008-2012. Source PHIDU					*	
1	Cancer	Cancer	Cancer	Cancer	Cancer	Cancer
2	Circulatory systems diseases	Circulatory systems diseases	Circulatory systems diseases	Circulatory systems diseases	Circulatory systems diseases	Circulatory systems diseases
3	External causes	External causes	Ischaemic heart disease	External causes	External causes	External causes
4	Ischaemic heart disease	Lung cancer	External causes	Ischaemic heart disease	Ischaemic heart disease	Ischaemic heart disease
5	Breast cancer	Ischaemic heart disease	Breast cancer	Lung cancer	Lung cancer	Lung cancer
Top 5 Chronic disease prevalence (Australian Health Survey ASR/100), 2011-2013. Source PHIDU					*	
1	Respiratory systems diseases	Respiratory systems diseases	Respiratory systems diseases	Respiratory systems diseases	Respiratory systems diseases	Respiratory systems diseases
2	Musculoskeletal systems diseases	Musculoskeletal systems diseases	Musculoskeletal systems diseases	Musculoskeletal systems diseases	Musculoskeletal systems diseases	Musculoskeletal systems diseases
3	Circulatory systems diseases	Circulatory systems diseases	Circulatory systems diseases	Circulatory systems diseases	Circulatory systems diseases	Circulatory systems diseases
4	Arthritis	Arthritis	Arthritis	Arthritis	Arthritis	Arthritis
5	Mental and behavioural problems	Mental and behavioural problems	Mental and behavioural problems	Mental and behavioural problems	Mental and behavioural problems	Mental and behavioural problems
Top 5 Ambulatory Care Sensitive Conditions (Avoidable hospitalisations) ASR/1,000, 2013/14. Source: VHISS					*	
1	Diabetes complications	Diabetes complications	Diabetes complications	Diabetes complications	Diabetes complications	Diabetes complications
2	Dental conditions	Dental conditions	Congestive cardiac failure	Dental conditions	Dental conditions	Dental conditions
3	Pyelonephritis	Pyelonephritis	Asthma	Congestive cardiac failure	Congestive cardiac failure	COPD
4	COPD	Congestive cardiac failure	Dental conditions	Pyelonephritis	Pyelonephritis	Pyelonephritis
5	Congestive cardiac failure	Other vaccine preventable conditions	Pyelonephritis	COPD/ Asthma	Asthma	Congestive cardiac failure

* Previous INWMML catchment



Appendix Two:

Collaborative Framework 2012 – 2017 progress to date

First 2 Years	
Two collaborative projects/programs implemented to address priority areas	✓
Annual collaborative forums established and continued	✓
Collaborative presentations on integrated service models delivered	✓
Strategic Plan for the Collaborative developed with shared understanding of population health needs of Inner North West	✓
Shared Evaluation Framework developed to measure effectiveness of the Collaboration	✓
Scope and develop an agreed position on a region-based Electronic Medical Record	*

*partially achieved

Planned for 5 Years	
New to follow up outpatient ratio at Royal Melbourne Hospital reduced	✓
Collaborative research projects established to provide academic focus to priority area projects/programs	✓
Two collaborative projects are mainstreamed in priority areas	✓
Joint research grants awarded	✓
Client feedback collected and analysed on their journey through the system	*
Advocacy by the collaboration undertaken resulting in new funding and service models to address shared chronic disease priorities	*

*partially achieved



