Connecting Care:
A Comprehensive Needs Assessment 2014
Priority Actions

medicare local ACT
Connecting health to meet local needs

1. IMPROVING PATIENT CENTRED TRANSITION OF CARE BETWEEN HOSPITALS, PRIMARY CARE AND AGED CARE	
Identified Need	Increasing levels of potentially avoidable GP-type Emergency Department visits and unnecessary hospitalisation for older people.
Priority Actions	In collaboration with ACT Health, ACTML will: • review potentially avoidable GP-type presentations and recommend solutions. • analyse the profile of 65+ ED attendances and hospitalisation to understand the drivers of unnecessary hospitalisation. • review the effectiveness and coordination between programs that are targeted primarily at preventing unnecessary hospitalisations of older people. • develop better ways of coordinating, configuring, integrating and funding services designed to prevent unnecessary hospitalisation of older people.
2. IMPROVING COORDINATED CARE PATHWAYS AND REFERRAL SYSTEMS	
Identified Need	Better coordination in the transition and management of care between service providers.
Priority Actions	In collaboration with ACT Health, Southern NSW Health District and Southern NSW Medicare Local, develop coordinated patient care pathways for episodes of care involving all providers (primary health, specialist and community care) and consumers to optimise care across the service delivery continuum. Delivered through *HealthPathways* involving: • clinical work groups to address any problems or redesign that may be required. • *HealthPathway* topics supported by health professional education. • local agreements on best clinical and referral practice in the context of available resources.

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3. ELIMINATING ACCESS BARRIERS AND BUILDING CAPACITY IN PRIMARY HEALTH CARE SERVICES FOR VULNERABLE COMMUNITIES	
Identified Need	Considerable barriers (cost, stigma, GP capacity, transport, service navigation) to accessing primary health care services, particularly for vulnerable communities (Indigenous communities, people affected by alcohol and drugs, people with mental health issues, refugees and the homeless).
Priority Actions	Work with ACT Health with the aim of: Extending the Early Morning Centre primary health care clinic model to other ***homeless*** client locations. Developing a program to support ***mental health patients*** without ready access to a GP-led health care home that makes optimum use of and better integrates existing resources: • Mental Health GP Liaison Nurse. • *Partners in Recovery* coordinators/navigators. • *Partners in Recovery* flexible funding. • Educational support. Extending this program to ***refugees & people with ATOD issues.***
4. IMPROVING THE UPTAKE OF END OF LIFE CARE PLANNING	
Identified Need	Low uptake and poor implementation of advance care plans and end of life care planning across care setting interfaces.
Priority Actions	In conjunction with work on prevention of unnecessary hospitalisation of older people, review for implementation best practice models for improving coordination and transfer of patients requiring end of life care across service boundaries (both within sectors and across sectors), including the uptake of advanced care plans. Continue ACTML's *Be My Voice* campaign.
5. STRENGTHENING THE CHILD DEVELOPMENT SYSTEM OF CARE IN THE ACT	
Identified Need	Limited success in developing a child development system of care that provides a streamlined, accessible, affordable and
Priority Actions	In conjunction with ACT Health, Community Services Directorate and Education and Training Directorate, finalise a review of the child development service system and ensure that early childhood and childhood development services feature integrated primary health care. Provision of GP education on early childhood development. Develop *HealthPathways* on maternal and child health.

Priority Actions

6. BUILDING CAPACITY FOR CHRONIC DISEASE MANAGEMENT	
Identified Need	Poor knowledge about available guidelines and tools and the use of different strategies amongst health professionals identified as barriers in the identification and management of patients at risk of cardiovascular disease, diabetes and renal disease. Lack of systematic and effective approaches to supporting health behaviour change for high risk CVD/diabetes/ renal disease patients.
Priority Actions	Deliver professional education to the primary health care workforce around chronic disease prevention and management, including the importance of evidence based early identification, diagnosis, self-management strategies and treatment for long term complications. Assist general practices with risk factor data collection, data management and analysis. Embed Lifestyle Advisors in general practice teams to connect high risk/obese patients with community based Lifestyle Modification Programs.
7. PROVISION OF AFTER HOURS CARE	
Identified Need	Access to quality after-hours primary health care services in the ACT and particularly for vulnerable groups.
Priority Actions	Continue ACTML's After Hours Incentive Payment Scheme to GPs. Continue funding the After Hours Patient Transport Assistance Scheme. Support improvement of after hours access to pharmacies in areas of need. Continue the *Know Your Options* campaign about after hours care.

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